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3HRS. PSYCHOLOGICAL ASPECTS OF DEATH AND DYING
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Segment 2: Cultural Attitudes toward Death
Segment 3: Processing the Death of a Loved One through Life’s Transition
Segment 4: The Psychology of Dying

Segment 5: System Coordination Approach for the Dying Patient

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PART 1: DEATH AWARENESS AND ANXIETY

SEGMENT OUTLINE:

1. Bringing Death Out of the Shadows
2. Death Awareness: One Out of One Dies
3. Fear of Death
4. Fear of the Process of Dying
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6. Lessening the Fear of Death
   i. Goals for Death Care Professionals
7. Summary

SEGMENT OBJECTIVE

Upon the completion of this segment of the course, you will be able to:

1. Develop a historical understanding about the universal theories of death and dying.
2. Review three primary styles of denial used to avoid the reality of death.
3. Identify three components that shape the fear of death.
4. Recall various works of literature that has conceptualized the apprehension generated by death awareness.
5. Generate a list of goals for assisting death care professionals with assisting the bereaved.

**NARRATIVE SUMMARY**

Death is a commanding human concern that has been intellectualized as a powerful inspiring force behind much creative expression and philosophic inquiry throughout the ages. Leo Tolstoy, distinguished 19th-century Russian moral thinker and novelist, fittingly illustrated the human challenges in confronting the unavoidability of death and the anxiety it incites as he vividly describes the last three days of Ivan Ilych's egocentric, seemingly meaningless existence in "The Death of Ivan Ilych." Included in this tale is a depiction of death as a metaphorical private black sack that the anguished Ivan Ilych struggled against but was driven toward by an imperceptible, resistless power (Tolstoy, 1960).

In spite of death's universal claim on each of us, the discussion of death is frequently uncomfortable and even distressing to many Americans. Our culture is uniquely anxious on this subject, demonstrating degrees of denial and avoidance that other societies, which regard death as a "natural part of life," might very well find amusing, not to mention futile. It is important for death care professionals to increase their own personal death awareness and to grasp the issues and concerns that underlie our society's attitudes and behaviors around death and dying. The quality of care, reassurance, and comfort they are able to offer will be greatly influenced by their own beliefs and personal ease with death.

This section of the course offers a brief historical perspective on death in America and goes on to describe the current social, scientific, and cultural forces that contribute to death awareness and anxiety. It concludes with a review of death anxiety measurement instruments and some ideas for caregivers that might enable them to normalize or reduce excessive fear of death among the populations they serve.

**BRINGING DEATH OUT OF THE SHADOWS**

Americans have lost their intimacy with death. For a variety of reasons that will be discussed later in this course, death has been removed from the common American experience. In our future-oriented society, with its high value on individual achievement, death is almost unthinkable because it eliminates both of those possibilities. There is no life, liberty, or pursuit of happiness when one dies. It is the destruction of the American dream and, as such, is repudiated, shunned, and replaced with silence, hostility, and fear.

This was not always the case. What might it have been like to experience dying and death 150 years ago in rural America? First, when someone was dying, everyone in the community knew it. A dying person was not in a hospital but was nursed and remained in the home. He or she was attended by family members, and visitors—including children—were welcomed. Family and friends were expected to speak "last words" to the individual and frequently witnessed the cessation of breathing, relaxation of the body, and loss of skin color.
With the assistance of the local "undertaker," the family would prepare the corpse for last rites and burial. On the day of the funeral, all work would stop and virtually everyone would attend the service. The community would see the body, carry it to the grave, and bury it. While the balance of community life at that moment was upset, the funeral, by virtue of its participative nature, was the first step in establishing the new balance that would be created in the aftermath of that individual's removal from the community. Death awareness and intimacy were deeply woven into the social fabric.

Today the situation is quite different, and several significant factors have contributed to the propensity toward avoidance and denial of death. First is the secularization of American society. Almost all religions view death as a "door" to a better life. In the Christian religion Jesus said, "I go to prepare a place for you, that where I am there you may be also" (John 14: 2, 3). Saint Paul said, "To be absent in the body, is to be present with the Lord" (1 Corinthians 5: 8). Even with the portent of judgment, death is seen as a transcendent experience, offering the possibilities of atonement and salvation. In our modern world, however, many people are uncertain about (or even reject) the traditional values and rites that accompany this transcendent view.

This leads to the second factor that has diluted Americans' intimacy with death: the deritualization of grief (Rando 1984). Every society has developed accepted rituals and behaviors to follow the death of one of its members, such as the Jewish custom of sitting shivah. In America's fast-paced, pluralistic, and sometimes cynical society, griever and those who would support them often feel "without guidelines"—at a loss for appropriate actions and words. This might be compounded by criticism and resentment of funeral practices as being overly expensive, exploitative of a family's grief, or possibly even irrelevant.

Further undercutting our intimacy with death is the growth of impersonal technology around dying people. As our high-tech society increasingly promotes computer diagnosis of disease, institutional treatment with technically researched chemicals, and updated pathology printouts, the sick or dying person becomes literally and figuratively "detached" from loved ones, removed from the home, and possibly connected only to machines. This phenomenon does not lend itself to the patient's and/or the family's need for personal care: it might become difficult for a relative to even hold the patient's hand or kiss a cheek, and it builds an even greater sense of mystery and fear around death.

Parenthetically, it is ironic that, while children's direct exposure to dying and death has dramatically decreased due to medical advances and institutionalized health care, there has been a simultaneous increase in our culture's unrealistic attention and focus on death. Cartoons (Figure 1-1), horror and "slasher" films, books, magazines, and even some "legitimate" news broadcasts use death as a titillation and a vehicle to shock audiences, thus reducing it to a commodity. Fleshe, death care professionals (e.g., physicians, clergy,
therapists, funeral directors) must be prepared to be called upon to interpret or make death “real” to the people they serve. In order to be effective and successful in this aspect of their work, it is vital that such professionals come to terms with and work through their personal death anxieties.

Take a moment to think about your own intimacy with death. Answer the following questions yes or no:

1. Have you ever seen a body fully prepared for a funeral?
2. Have you ever seen a body that was not embalmed?
3. Have you been with a person when he or she died?
4. Have you been in a situation in which you thought you might die?
5. Is anyone in your family, or a close friend, dying now?

Now take some additional time to answer the following questions from the Death Anxiety Scale (Templer 1970), which examine the thoughts and attitudes you hold around your own death:

1. How often do you think about the possibility of your own death?
2. Would you want to know the exact time of death?
3. Would you want to know the exact mode of death?
4. What do you fear about death?
5. Do you have a will?
6. Do you have life insurance?
7. Are you willing to have an autopsy?
8. Are you willing to donate your organs?
9. How do you want to have your body disposed?
10. What kind of rites do you desire?
11. Would you sign a living will?
12. List the three most significant losses you have experienced.
13. In which of these losses do you feel you have basically completed your grief and moved toward creative living in the absence of the individual?
14. When you were a child, did your family talk about death?
15. Briefly describe how you would like to die.

The ability to come to terms with the reality of one's own death, to address the personal issues associated with it, and to understand the roots of any fears and anxieties (and, if needed, “remake” them) is a required task for any death care professional or death educator who hopes to bring death “out of the shadows” and create a climate of support, respect, tolerance, and caring for bereaved individuals.

DEATH AWARENESS: ONE OUT OF ONE DIES

Intellectually, everyone knows the statistics. But emotionally, everyone plans on a single exception: themselves. Our society’s lack of intimacy with death has led to widespread denial of death, which, although manifested in a variety of ways, can be grouped into three primary styles of denial.
One style of denial is to simply ignore death. People make plans, save money, daydream, and wax poetic about “someday,” as if the future were a never-ending ocean of time and possibility. Some people have never attended, or flatly refuse to attend, a funeral, believing that if they are not around to witness or experience the reality of death, they will somehow be immune to it—or better yet, that death must not exist at all! (See Figure 1-2.) The life insurance industry is skilled in using verbiage that plays into people’s conviction of their own immortality. The sting of death is quite different when the policy salesperson asks, “How would your family be taken care of if you had died yesterday?” as opposed to “How will your family be taken care of if you die tomorrow?”

A second style of denial involves efforts to lessen the harshness of death. This most commonly takes the form of euphemistic language to hide or couch the painful reality grievers are confronting. Friends or associates might make vague references to the loved one “going on to a better place,” or might deny death with expressions such as “departed,” “expire,” “pass away,” and “just passed.” The funeral industry has surfaced with marketing efforts targeted at “pre-need memorial planning,” or other such phrasing that avoids the words “die,” “death,” or “dead.” Further, it has become an expected function of the funeral director to lessen the harshness of death through beautification of the corpse—perhaps even trying to create the illusion of life or, at least, sleep. Family and friends visit the funeral home hoping to be able to comment “truthfully” that the deceased looks “natural,” “lifelike,” or “at peace.” Certainly this final, visual impression of a dead loved one is important, but it should never be used to escape or deny the reality of the death and the necessary grieving that must take place.

The third style of denial that will be discussed here is far more subtle, and indeed morbid, than the other two. It consists of a distorted preoccupation with death that, to some degree, mimics pornography in its danger of dehumanizing genuine human feelings and emotions. According to anthropologist Geoffrey Gorer, the word “pornographic” relates to that which is obscene or offensive to one’s taste (Gorer 1967). It is usually employed in a sexual context, referring to writing, photography, or works of art that are created specifically to excite people sexually and promote fantasies allowing them to “control” situations around which they feel anxious or out of control. A necessary component of sexual pornography is the objectification of people, body parts, and sexual activity. Robert Neal, in his book The Art of Dying, states, “It is a way of fulfilling a sexual need without being involved with another person. It occurs when a society is prudish. When society says that sex is disgusting or immoral and not to be talked about, sexual need is not destroyed but only forced into inhuman paths” (Neal 1973).

The pornography of death follows a similar pattern. Our society has prudish notions about death, seeing it as offensive, an unfit topic for conversation, perhaps even immoral or disgusting. Therefore, it should not be surprising that many people seek to objectify and thereby “control” death by perverting and distorting it.

It is difficult to delineate the degrees of desensitization that take place as our society is exposed to the increasingly detached manner in which death is presented by the news media, the frequency with which
fictional bad guys are “blown away” on television while the “good guy” flirts with death, the special-effects thrills of film and cartoon “superheroes” dispatching their opponents, and the rumored traffic in “snuff” films, in which real people are purportedly murdered for entertainment purposes. There can be no doubt that death is everywhere. The real issue is not finding appropriate means of denial but instead finding avenues and activities that allow us to be authentic about it—that shed light on our deepest and highest feelings around it.

A person who becomes morbidly preoccupied with death or indulges in bizarre fantasies involving death closes himself or herself off from the genuine emotions and opportunities for self-growth and self-discovery that a realistic, mature look at the subject can provide. Grief reactions might be stifled and grow complicated; healing might be prolonged and/or require professional intervention. Denial of death is rampant in American society, and any death professional should be alert to its various styles and manners of expression. In addition, he or she might wish to make a personal as well as a professional commitment to inject a calm, rational, authentic approach to any discussion of death or dying and the feelings that might be attached to it.

FEAR OF DEATH

Some readers might be familiar with the tale of the Baghdad merchant who sent his servant out to buy provisions. The servant came back pale with fear, saying: “Master, just now in the bazaar I was jostled by a man in the crowd. I turned about, and I saw Death. He stared at me and made a threatening gesture. Therefore, lend me your horse and I will ride to Samarra, where Death cannot find me.” The good merchant lent the horse, and the servant mounted it and rode off as fast as the horse could gallop. The merchant himself then went down to the bazaar, and as he strolled around, he too saw Death standing in the throng. He approached him, asking, “Why did you make a threatening gesture to my servant when you saw him earlier this day?” Death replied: “That was not a threatening gesture—merely a start of surprise. You see, I was astonished to find your servant in Baghdad, for tonight I have an appointment with him in Samarra” (Neal 1973).

The fear of death has many real components and is shaped by an individual’s age, intellect, health, family history, psychological state, and religious background. Even current events—such as recent mass murders, natural disasters resulting in death, or deaths of well-known, prominent people—can influence a person’s degree of fear. There are, however, three primary categories of fear associated with death that should be examined, and that might stimulate a more personal and accepting awareness of death among readers.

FEAR OF THE PROCESS OF DYING

Because the timing and nature of one’s death are unknown, human beings recognize that, unless they die suddenly, they run the risk of dying over some greater or lesser amount of time. They are able to project and imagine the conflict between “dying with dignity” and “fighting for life.” This intra-psychic struggle creates tension and fear around the process of dying. Let’s continue to look at specific fears connected with the process of dying.

FEAR ONE: THE PROCESS OF DYING AS PAINFUL

Historically, the Christian faith has taught that, in the “end,” the forces of good and evil fight to claim the immortal soul, and such separation of the soul from the body involves pain. The more contemporary view is that disease disrupts the natural biological processes, and people fear the agonizing pain they know might
FEAR TWO: THE PROCESS OF DYING AS UNDIGNIFIED

It is possible that our high-tech, scientific mind-set toward health care treatment, coupled with our prudishness about death, has dehumanized the process of dying to such an extent that some people might be ashamed or even embarrassed to die. On the other hand, there are genuine dignity issues for many people who might not readily accept hospital gowns, tubes, catheters, needles, and machines, as well as the pushing, probing, and prying nurses, interns, residents, and physicians. Men and women alike fear the “humiliation” of urinating in a bedpan, bedsores causing unpleasant odors, and the severe weight and/or hair loss that might accompany illness, terminal or otherwise.

FEAR THREE: THE PROCESS OF DYING AS A BURDEN TO OTHERS

Statistically, few people die by accidental means, and with medical science prolonging life or (depending on how you look at it) prolonging the process of dying, it is not unrealistic to fear becoming a burden to others. Dying gives rise to a wide range of emotions among family members. Depending on the nature of the relationship, a dying person might evoke feelings of sympathy, love, tenderness, pity, hate, disgust, or guilt among individuals in his or her immediate circle. Some of the feelings might be linked to the financial or time constraints that the dying person’s illness places on others. This fear of being a burden to others is likely to be particularly acute in societies like ours that place a high value on independence and self-sufficiency.

FEAR OF THE LOSS OF LIFE

Death is the loss of life as we know it and can trigger feelings of enormous vulnerability. Loss of life means loss of control—over self, perhaps others, and life experiences. Death seems passive, not active. It flies in the face of a participative, masterful, alternative-filled existence. Individuals might fear the power of death to which they must ultimately submit.

Another facet of fearing the loss of life is the sense of incompleteness or failure. Death has no respect for unmet goals or ambitions, or unfinished tasks. People with a well-developed sense of responsibility—or sense of adventure—might become depressed or angry at the prospect of no more opportunity, creativity, new experiences, or fulfillment of a life’s dream.

Finally, death as loss of life is feared because it means separation from people, places, and things that are loved and treasured. This fear is often accompanied by feelings of sadness, grief, and worry over the future of survivors.

FEAR OF WHAT HAPPENS AFTER DEATH

This final category of fear encompasses physical, moral, and mystical components. Death means the destruction of the body whether through decay, fire, or disassembly for educational or humanitarian purposes. Few people can be expected to find these prospects pleasant, or even imaginable. The “fate” of the
body can be of extreme concern to individuals who have spent years of effort trying to preserve it through proper nutrition, exercise, and rest. The funeral industry responds to this fear with embalming, sturdy caskets, and graves lined with metal. While a funeral director might be of help to clients in visualizing the services and rites that will be performed, there remains difficulty in associating oneself with the concept of a corpse.

Another fear associated with what happens after death involves fear of judgment. Although this thought is traditionally linked to certain religious teachings, it also can surface among nonreligious people. Stated simply, people wonder if there is a God, and wonder what God thinks about them—whether God likes them. Like a child who is fearful of an angry father, some people are afraid that eventually they will confront a hostile, punishing God who will make them suffer for mistakes they have made on earth.

Ultimately, fear of what happens after death is largely related to fear of the unknown. How can people prepare for a “post-death” experience when no one knows for certain if there is such a thing? As in life, when there is no information, and no control, anxiety increases.

DEATH ANXIETY: LITERATURE AND MEASUREMENT

“Death anxiety” is a term used to conceptualize the apprehension generated by death awareness (Abdel-Khalek, 2005). Humans are unique in that they must learn to live and adapt to the consciousness of their own finiteness (Becker, 1973). Thus, a major task for cultural systems is to provide a symbolic structure that addresses death and provides meaning for its occurrence and a context for its transcendence (Becker 1973; Kübler-Ross, 2002). Confronting death and the anxiety generated by knowledge of its inevitability is a universal psychological quandary for humans. For health care providers, death is an ever-present reality despite increasing technologically advanced health systems, longer patient survival, and cure from life-threatening conditions. Although helping individuals and their families manage death is a central responsibility of nursing worldwide and an increasing literature suggests that death anxiety contributes to important emotional and behavioral outcomes, theoretical and empirical background of the concept has not been systematically examined in the nursing literature. This limitation has led to a dearth of literature that has explored death anxiety as an important variable in empirical nursing inquiry, a finding that may compromise the development of interventions to assist nursing personnel and the myriad of patients affected in their ability to cope with this profound existential issue. To date, few efforts have been directed toward clarification of this critical concept in nursing (Nyatanga & de Vocht, 2006), although death anxiety is included as a nursing diagnosis with NANDA nursing outcome criteria (Carpenito-Moyet, 2008; Moorhead, Johnson, Maas, & Swanson, 2008).

Caring professionals both inside and outside the field of thanatology, most notably psychologists, are taking both a theoretical and an empirical interest in the subject of death anxiety. The topic is covered in an increasing variety of scientific and professional journals, if not mass-market publications. To date, more than five hundred articles on death anxiety and closely related constructs have been published, providing the largest single body of material in the overall thanatological arena, and the field continues to attract new researchers (see Figure 1-3) (Wass, Berardo, and Neimeyer 1988). This diffusion of interested professionals, their various focuses of study, and wider publication outlets might bode well for a future that brings a better understanding of death and grief among a greater segment of the population.
Much of the literature is based on or makes reference to a small group of assessment instruments that have become widely accepted for their theoretical and empirical soundness. While many surveys and questionnaires about death anxiety have been developed, readers should be familiar with the four most well-known measurement instruments.

**THE DEATH ANXIETY SCALE**

Developed by Templer in 1970, the Death Anxiety Scale (DAS) involves fifteen short statements and questions to which participants respond. It is considered to have high reliability and has been used in more than 60 percent of studies published in the past ten years. Empirically, it is multidimensional and measures the following factors:

- General death anxiety
- Thoughts and talk of death
- Subjective proximity of death
- Fear of pain and suffering
- Fear of unknown

The DAS appeared earlier in this course as an exercise for readers.

**THE THREAT INDEX**

Developed by Krieger, Epting, and Leitner in 1974, the Threat Index (TI) is conducted in an interview format. Used in 23 percent of the studies published in the past ten years, it is considered to have a high degree of reliability while offering more “interpretability” than the DAS (Krieger, Epting, and Leitner 1974).

**THE COLLETT-LESTER FEAR OF DEATH SCALE**

The Collett-Lester Fear of Death Scale (CL) assesses thirty-six items connected to four dimensions of death anxiety:

1. Death of self
2. Dying of self
3. Death of others
4. Dying of others
Although Collett and Lester developed the scale in 1969, it has been used in only 18 percent of the studies published in the past ten years, and its reliability is not considered to be especially high (Collett and Lester 1972).

THE HOELTER MULTIDIMENSIONAL FEAR OF DEATH SCALE

Used in only 4 percent of the studies published since its development by Hoelter in 1977, the Hoelter Multidimensional Fear of Death Scale (MFODS) features eight independent subscales, each containing six items on which respondents indicate the extent of their agreement. No reliability tests have been performed (Hoelter 1979).

LESSENING THE FEAR OF DEATH

If death is to come out of the shadows and our culture is to become more educated, mature, and realistic in its attitudes and approach to dying, death, and grief, a great deal of the responsibility lies with death care professionals themselves—their personal death awareness, their tolerance and acceptance of death anxiety, and their ability to communicate with informed concern and understanding. This section of the course has attempted to be a starting point for that process. Death care professionals also might wish to review and consider the following six additional goals:

GOALS FOR DEATH CARE PROFESSIONALS

1. Tactfully avoid euphemisms in speaking and writing so as to remove the “taboo” aspects of death language.
2. Promote and demonstrate comfortable and intelligent interaction (be socially and emotionally present!) with dying patients, who are living until they are dead.
3. Encourage death education for children so they can grow up with a minimum of death-related anxieties.
4. Perceive health care workers and other caregivers as professionals and human beings, neither omnipotent nor omniscient, but worthy of respect for their competency and connection to the dying person and his or her family.
5. Stay educated on changes and trends in the funeral industry.
6. Encourage, communicate, or participate in meaningful research in the field of death studies, grief, and bereavement.

SEGMENT SUMMARY

For a variety of reasons, Americans have lost their intimacy with death. Today several significant factors have contributed to the propensity toward avoidance and denial of death. First is the secularization of American society. The second factor is the deritualization of grief. Third, the growth of impersonal technology around dying people has further undercut our intimacy with death. As our high-tech society promotes computer diagnosis of disease, the sick or dying person becomes “detached” from loved ones, removed from the home and possibly connected only to machines. In addition, cartoons, films, books, magazines, and even news broadcasts have used death to titillate and shock audiences, thus reducing death to a commodity. The ability to come to terms with the reality of death, to address the personal issues associated with it, and to understand individuals’ fears and anxieties is a required task for the death care professional.
The lack of intimacy with death has led to denial of death. Three styles of denial are (1) to simply ignore death, (2) to lessen the harshness of death, and (3) to distort death in such a way that it mimics pornography in dehumanizing genuine human feelings and emotions.

The fear of death is an issue in every culture. In America the fear of death has many real components and is shaped by an individual's age, intellect, health, family history, psychological state, and religious background. There are three categories of fear associated with death: the process of dying as painful, as undignified, and as a burden to others.

Death care professionals are taking a theoretical and empirical interest in the fear of death, or what is referred to as death anxiety. The topic is covered in an increasing variety of scientific and professional journals. Much of the literature is based on or makes reference to a small group of assessment instruments that have become widely accepted and are used for studies of death anxiety. The objective is to lessen the fear of death through close examination of anxiety issues. This section of your course provides goals for death care professionals who want to make a contribution to bringing death out of the shadows in our culture.

REFERENCES

SEGMENT 2: CULTURAL ATTITUDES TOWARD DEATH

SEGMENT OUTLINE:

1. Patterns of Response to Death
   i. Death Acceptance
   ii. Death Defiance
   iii. Death Denial
2. Cultural Diversity and Funeral Practices in the United States
   i. Jewish Religion and Culture
   ii. African-American Culture
   iii. Native American Culture
   iv. Mexican-American Culture
3. The Individualization of Funerals within a Culture
4. Summary

SEGMENT OBJECTIVES:

Upon the completion of this segment of the course, you will be able to:

1. Identify patterns of response to death.
2. Characterize cultural diversity and funeral practices in the United States.
3. Highlight individual funeral preferences within specific cultures.
NARRATIVE SUMMARY

Every human being on the planet eats. Every human sleeps, laughs, cries, bleeds, and, of those who wear pants, probably each puts them on one leg at a time. Death is another human experience that crosses all national, racial, religious, and ethnic boundaries. But within such social and cultural parameters lies a wide range of beliefs and behaviors, approaches and actions that different cultures bring to death rituals and to a family experiencing the loss of one of its members. In this segment of the course we briefly explore the dominant philosophical attitudes and ideas regarding death that give unique shape and character to a society’s death and funeral customs. Then we examine the diversity, as well as effects of assimilation, among various significant groups within the United States as it affects their funeral traditions and influences current practices. The course concludes with information and examples for funeral professionals regarding education and outcomes when cultural differences are respected, accommodated, and embraced as a necessary part of the grief process.

PATTERNS OF RESPONSE TO DEATH

In general, a society's response to death is a function of how death fits into its teleological view of life, that is, the design or purpose of death, especially as it pertains to nature. Across all societies there seem to be three general patterns of response to death: death acceptance, death defiance, and death denial (Rando 1984).

DEATH ACCEPTANCE

A society that accepts death views death as a natural part of the life cycle. Shakespeare expressed a powerful death-accepting philosophy in Henry V when he wrote, "We owe God a death." Death-accepting societies are well represented throughout history, as illustrated by the story "Kisa Gotami" from Buddhist literature:

Kisa Gotami lost her only infant, and she went in search of a remedy for her dead son. Carrying the corpse, she approached the Buddha and asked for a remedy.

"Well, sister, can you bring some mustard seed?"

"Certainly, Lord!"

"But sister," said the Buddha, "it should be from a house where no one has died."

Mustard seeds she found, but not a place where death had not visited. She understood the nature of life. (Narada 1973, p. 657)
In the present day there are cultures that not only naturally accept death but even celebrate it. In Mexico, Dia de las Muertes, or “Day of the Dead,” are observed on November 2, the Catholic Church’s traditional All Souls’ Day. This is a time for celebration at the cemetery with friends and family. Food, song, and dance are shared at the graves of loved ones. Cakes are baked in the shape of skulls, and candies are passed out in the form of cadavers. During this “Day of the Dead” party atmosphere, death does everything the living do. There are displays of death dancing, death playing music, and cutout designs of death decorating the town. It is evident that life and death are celebrated together.

DEATH DEFIANCE

In death-defying societies, the belief is that in death nothing need be lost—you can take it with you. A historical example of such a society was discovered in the 1960s on an archaeological dig near Moscow. Skeletons of two boys who died approximately twenty-three thousand years ago were found. Their elaborate grave suggested they were laid to rest amid solemn ritual, perhaps with a view of the afterlife. Both had been dressed from head to toe in clothing decorated with ivory beads carved from mammoth tusks, and both wore bracelets and rings of the same material. Both were further equipped with an assortment of ivory lances, spears, and daggers.

An example of a present-day death-defying culture is the Hmong, an ethnic minority found throughout southern China, Vietnam, Laos, Thailand, and Burma. One funeral ritual practice by the Hmong is reciting from the "TusQuabke," or guide for the deceased to the spirit world. If the proper verses are not recited, the person will not know he or she has died. The ritual is believed to help start the deceased's soul on its first major trip to the spirit world, and explains to the deceased how to make the trip.

DEATH DENIAL

The most profound example of a death-denying culture is found in the United States. This philosophy suggests that death is unnatural. American society’s denial is exemplified by the following:

1. Through language—using terms such as "passed on" or "expired"
2. By the detachment of families from the funeral process—leaving all details to the funeral professional
3. By relegating family members to nursing homes or hospitals to die, removing them from familiar and comfortable surroundings
4. By avoiding conversation about the deceased for fear of loved ones' being upset

It would seem that Americans accept the notion that if they avoid talking about death, it will not happen. When a death actually occurs, the ability to successfully cope with that death can be difficult not only for the immediate family but also for the friends and other extended family members who want to help.
CULTURAL DIVERSITY AND FUNERAL PRACTICES IN THE UNITED STATES

In general, people who live in the United States deny death. But the maintenance of certain cultural influences can be a great source of comfort to family members. The table below shows a small sample of ethnic, cultural, and religious groups in the United States that provide traditions that can be beneficial to members in the grief process. It is important to be aware that within broad cultural groups there can be considerable differences. For example, in Table below the Asian category includes Chinese, Japanese, and Filipino, each of which has specific customs.

How does awareness of cultural differences help the funeral director?

<table>
<thead>
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<th>Type of Group</th>
<th>Number of U.S. Groups (1,000s)</th>
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<td>Total U.S. Population</td>
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<td>Religious preference:</td>
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<td>Jewish*</td>
<td>5,944</td>
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<tr>
<td>Christian**</td>
<td>136,407</td>
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<td>Ancestry groups in the U.S.:</td>
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</tr>
<tr>
<td>Native American</td>
<td>1,959</td>
</tr>
<tr>
<td>African-American</td>
<td>199,686</td>
</tr>
<tr>
<td>Asian</td>
<td>7,373</td>
</tr>
<tr>
<td>Hispanic</td>
<td>22,354</td>
</tr>
</tbody>
</table>

* Estimates of the Jewish community include those identified with Orthodox, Conservative, and Reformed synagogues.

**Estimates include Catholic, Protestant, Church of Latter-Day Saints, and Jehovah's Witnesses communities.


Ultimately, sensitivity to cultural variances offers the funeral professional an opportunity to provide the best service possible. For example, in the Mexican-American culture, the emotional response to death is typically more open and demonstrative than in other groups. People stay longer at the graveside, walk about the cemetery, look at other graves, and reminisce. Funeral directors who are aware of these cultural nuances can anticipate and plan accordingly.

The following general overviews of four important cultural or religious groups in the United States provide an introduction to their traditions and rituals.
JEWISH RELIGION AND CULTURE

In the Jewish religion there are different denominational affiliations with certain constants among the mourning rituals, but each has its variants. There are two overriding values at the heart of the Jewish tradition in regard to death. One is kavod hamet, the requirement to "honor the dead"; the second is nichum avelim, the obligation to comfort the mourners. This concept speaks to the sanctity of the deceased, while simultaneously helping to bring comfort to those who are grieving.

The readying of the body for burial traditionally is done by a cheura kadisha, or holy society. This service was usually performed by laypeople but now has become more professionalized. After the preparation of the body, called tahara, the body is draped with a tachrigin, or simple linen garment.

Cremation is rare in the Jewish family. Most Jews rely on burial to conform to scripture: "From dust we came, to dust we return" (Genesis 3:19) Cremation also is associated with the Holocaust and therefore is repugnant to many Jews. Among traditional Jews there is a yearning to be buried in Israel. It this is not possible, earth 01 did from Israel is brought to be placed in the casket or mixed with the dirt that covers it. Also, there is the concept of "official mourner." The tradition designates seven relationships to be official mourners—father, mother, brother, sister, spouse, son, or daughter.

Usually the funeral service is held at a funeral home or synagogue, depending on local custom. The actual service begins with the cutting of a garment or black ribbon, symbolizing the individual being "cut away" from loved ones. Then there is the reading of Psalms, followed by the eulogy. After the eulogy, the family goes to the cemetery, where family members participate personally in placing earth (dirt) on the casket. As a final act, the family recites the homecoming prayer. The service begins the actual period of mourning, called shivah, Hebrew for seven. There is a break from the usual daily routine during this time. The shivah period (lasting seven days) enables the mourners to fully experience their grief. Families can share stories and memories of the deceased. The shivah ends when the family members say final prayers and go for a walk outdoors. This act signals the return to their responsibilities in this world.

Additional customs are observed after the burial. Family members might choose to change some regular activities to remind them that their lives were altered by a death. The time after the death is sometimes used for reflection and study as well. On the first anniversary of the death (Yahrzeif), the family gathers at the synagogue to remember the individual who died. It is a time to reflect on the life and gifts of their loved one. Also, it is customary to dedicate the headstone on this one-year anniversary. This is done with prayers and remarks about the de-ceased. As a final custom at the Yahrzeif, a donation is made in the name of the deceased to those in need.
AFRICAN-AMERICAN CULTURE

While it is impossible to make definitive statements about how blacks die and mourn because of the diversity that exists across such a wide and varied community, J. L. White, in The Psychology of Blacks: An Afro-American Perspective, writes:

Death in the black community is perceived as a celebration of life, a testament to the fact that a life has been lived, that the earthly journey is completed. Those who serve as witness in the presence of death, extended family, friends and church members, all affirm the essence of the person’s existence, are ready to testify to the fact that the deceased has fought the battle, borne the burden, and finished the course. They are ready to understand and say well done. (1984, p. 46)

No matter how particular customs have changed or evolved over time (either through the influence of other cultures or through increased urbanization), mourning customs among blacks are seen as a means of strengthening the community. A number of traditional customs continue to be part of African-American funerals:

- Church "sisters" come and prepare meals.
- "Flower girls," the female counterpart of pallbearers, give special attention to the closest family members.
- "Nurses," dressed in white, care for those who are overcome with emotion.
- Vocal music, such as solos and choir renditions, is a prominent part of the service.
- Flowers give visual comfort, a necessity for grievers.
• Church members say "their words" about the dead.
• Reception lines at the service are set up according to age, oldest to youngest.

These mourning practices exemplify some of the most organized efforts to aid mourners that funeral professionals are likely to encounter. These rituals provide direction not only to the immediate survivors but to the entire church community to which the deceased belonged.

Uniquely African-American art forms provide some distinctive expressions of grief. Music with "black" or gospel roots makes manifest the moods and essences of how grievers feel and how they express their feelings when faced with the death of a friend, a loved one, or a family member (Irish, Lindquist, and Nelson 1993). The musical customs of present-day African-American funeral rituals trace back to African origins, which are based on oral tradition. In his study connecting these traditions to the celebration of death in the black church, Craggett (1980) gave examples of dirges and laments, which are mournful musical compositions. The link between African-Americans and the continent of Africa remains strong and is reflected among the cultures of African people as well. Alassane Sow, a native of Senegal who spent ten years in the United States, observes that there is a striking similarity to the fact that, as in the United States, Senegalese funeral customs are a combination of tradition, acculturation, and urbanization with multiple influences from the Senegalese culture, other Islamic African nations, and Islam itself.

In Senegal, as in the United States, there is a "reinterpretation" of various customs to meet the changing needs of the population. For example, Islam dictates that there can be no weeping on cemetery grounds. Sow infers that women had never been allowed to go to the cemetery because they were more susceptible to crying. Today, more women attend cemetery services in Senegal because it has in-come more culturally acceptable for both men and women to cry.

Another similarity Sow identifies in both African culture and that of the United States is the celebration aspect. In Senegal, after the funeral service but before socializing between family and friends begins, a large pan of water is set out; it is used by those who attend the social to wash their hands as a spiritual symbol of detaching from the dead and giving life. It is said that those who do not wash wish to join the deceased. Clearly, there is an evolution of African American funeral custom and ritual, but there remain distinct links of symbolism and attitude that assist in understanding or accepting death.
Native American traditions are better defined by culture than by race. Identity focuses on the tribe or nation rather than on simply having Native American ancestry. For example, the Apache regard a dead person's body as an empty shell, while the Dakota speak to the body, visit it, and consider it sacred. The Navajo do not believe in an afterlife, while most other Native American tribes or nations do.

As expected, there have been varying degrees of influence by the dominant culture. The Dakota (Sioux) customs can serve as an example. This tribe, or nation, is the second largest in the United States and the largest in the upper Midwest. Among the Dakota, death is understood to be a natural counterpart of birth, and, because of this cyclic quality, both death and birth is sacred. The afterlife begins after death, when the soul journeys south until it comes to the Ghost Road. This road leads to Wagagi McKoce, the spirit land. This is the place where all dead go, whether human or animal. Spirituality focuses on how to live in the here and now, not on a reward in the afterlife.

When a Dakota person knows that death is near, he or she will gather valuables and goods and distribute them to significant family members and friends. This is done to acknowledge the impending death and to show appreciation to the recipients for their relationships to the tribe member. When the person dies, an extensive gathering of family and friends takes place, and it is not unusual to have up to a thousand people attending a funeral service. As each person greets the family mourners, the mourners' expression of grief is renewed in intensity. Cutting of hair, cutting or scratching the forearms and face, tearing clothing, and wearing black are considered common and appropriate displays of grief.

**MEXICAN-AMERICAN CULTURE**

The Spanish translation of grief has at least two distinct meanings: dolar, meaning pain, and Pena, meaning worry. Mexican-Americans see grief as both an emotional and a physical process. Females exemplify the emotional and males the physical symptoms of grief. Muerie, or death, is followed by luto, or mourning. Luto is practiced more rigidly by first-generation Mexican-Americans than by members of the second or third generation. The first-generation mourners adopt a restricted lifestyle that can last up to two years. The women wear black, rarely smile, and pray daily. During the initial stages of luto, the women tend to be very emotional.
The second and third generations of Mexican-Americans began the practice of using professional funeral services. Unlike for first generation mourners, their mourning period typically is shorter, dress is not restricted, and television and radio can be enjoyed during mourning. Prayer remains important and is seen as a sign of respect and a demonstration of the ongoing grief. Also, the family unit is very important to all generations of Mexican-Americans. There is a strong bond between the nuclear family and the extended one, and death of a loved one is seen as an important time to reconnect with relatives who might not be around routinely.

Even with the increased use of professional funeral services, Mexican-Americans maintain certain customs that assist in maintaining a cultural identity. Following a traditional Catholic philosophy, novenas are said during the nine-day period following the death, and candles are lit in church for the deceased. The religious influence and family cohesiveness are cultural factors requiring respect by professionals servicing this particular group.

THE INDIVIDUALIZATION OF FUNERALS WITHIN A CULTURE

The understanding of death and life and the normal grief process might seem odd in other cultures when compared with one’s own. To work effectively with the bereaved from different traditions, it is necessary to step outside one’s own cultural beliefs. It would be difficult, as well as inappropriate, to pretend to fully understand an individual’s unique cultural perspective. A more practical course is to respect the customs and rituals of those being served in order to meet their needs.

Texts and literature provide a good starting point to gain respect and insight into other cultural beliefs. However, even within a specific culture, ethnic differences and economic distinctions can be found, as well as particular individuals who do not have past personal experience with death and dying. Another source of understanding is the person or people you are trying to help. Active curiosity and genuine interest is the key. Asking someone for assistance in learning and posing sincere questions are powerful tools toward understanding an individual’s needs, expectations, and expressions of grief when they differ vastly from the normal patterns in one’s own belief system.

In their book Helping the Bereaved, Alicia Skinner Cook and Daniel Dworkin (1992, p. 167) present the following guidelines for servicing a culturally diverse population:

1. Recognize cultural influences in your own life and how they affect your work.
2. Acknowledge your own limitations when working with culturally diverse groups. Be creative and explore alternatives for overcoming these limitations.
3. Be open to learning about cultural traditions and beliefs. Identify strengths from the person’s cultural background and use them as resources in the process of service.
4. Appreciate the history and experiences of different cultural groups in the United States (e.g., refugees or first-generation immigrants) and identify areas of greatest vulnerability and strength.
5. Accept the wide variation in experiences of grief and ways of coping with loss.
6. Recognize that loss is a universal experience, having a profound effect on our lives regardless of our differences in language, lifestyle, and patterns of relating.
David Black, of Elton Black & Son Funeral Home in Union Lake, Michigan, shares this successful story. A Native American family, with its roots in two South-west tribes, came to the funeral home. The family's twenty-four-year-old daughter had been tragically killed in an automobile accident. Unfamiliar with the family's customs, Mr. Black's staff ably "tackled" the situation. The family clearly communicated what traditions, customs, and rituals were most important, and the Black Funeral Home was able to accommodate many of the requests. The daughter's best friend came to the funeral home to prepare the special braid for her hair. The body lay in state at the parents' home for two days, then was returned to the funeral home for the final service. Family members brought firepots to the funeral home but were respectful of fire codes and brought asbestos pads. Throughout the entire funeral process, there was ongoing communication between the funeral professionals and the family. The respect for customs by the funeral home and the sharing of information by the family created a meaningful funeral experience.

What insights did the Black Funeral Home gain from this experience? Perhaps many, but most important was an appreciation for cultural diversity. After the funeral services were completed, a thank-you note was received at the funeral home. The family stated that "nothing could have been done better." It was a testament to this firm's sincere desire to be respectful and the family's ability to communicate its needs.

**SEGMENT SUMMARY**

While death and dying are universal, natural, and predictable, experience shows that the expression of grief is far from uniform around the world or even within a given culture. Although our society continues to diversify, it is still possible to distinguish groups by shared cultural traits. Even distinctive groups, however, have assimilated to varying degrees into the mainstream group's patterns. For example, as our country has evolved, funerals or wakes have moved from being held in private homes to the now-dominant practice of utilizing a professional funeral home. While certain customs and rituals have been maintained across generations, others have ceased to exist due to modernization, acculturation, and practicality. Therefore, respecting cultural traditions, as well as respecting the individual's wants and needs, is crucial in providing sensitive and professional funeral service.

Throughout this course information is provided on (1) three general responses to death, (2) cultural diversity in the United States, (3) specific cultures and brief overviews of general cultural traditions, and (4) the cultural influence balanced with assimilation. Cook and Dworkin's guidelines for serving culturally diverse individuals offer information that could be considered and applied by quality funeral professionals.
The influences of family, religion, culture, and tradition combine to create the individual's own unique perspective, outlook, understanding, and acceptance toward the death of a loved one. (Dr. John D. Canine and Therese McNeil, Maximum Living Consultants, Inc., Birmingham, 1995)

- Represents individual unique grief experience
- Represents the influences on the uniqueness of grief
REFERENCES


SEGMENT 3: PROCESSING THE DEATH OF A LOVED ONE THROUGH LIFE'S TRANSITIONS
SEGMENT OUTLINE:

1. Childhood Awareness of Death
   a. Nagy
   b. Piaget
   c. Canine and Dates
   d. Conclusion
2. Young Adults
3. Midlife
4. Geriatric Group
5. Summary

SEGMENT OBJECTIVES

Upon the completion of this segment of the course, you will be able to:

1. Review the research of Piaget, Canine, and Dates relating to "Childhood Awareness of Death".
2. Discuss Marie Nagy’s well-known research regarding a child’s gradual development of death concepts.
3. Identify indicators of death symbolisms in children’s drawings by considering Canine and Dates’ research.
4. Analyze research, which highlights midlife death coping psychology.

NARRATIVE SUMMARY

Although we do not assume that infants think of themselves as "being" or "non-being," there is enough research to suggest that basic phenomena surrounding death are sensed by the child. For example, in 1961 Adah Maurer found that infants as young as six months already have an orientation toward existing and not existing. She cites the infant-adult interaction called "peek-a-boo" as the infant’s exploration of appearance and disappearance, and further states that a "healthy baby is ready to experiment with these contrasting states" (Maurer 1961; see also Koocher 1973; Hoffman and Strauss 1985; Prichard and Epting 1992). As the infant gets older, "peek-a-boo" becomes "hide-and seek," a childhood game that permits the participants to not exist (hide) so as to avoid the capture of the person designated as the seeker ("It"). Could the "It" be the personification of death? Nevertheless, most observers of infant and children agree that death-related themes conveyed through play, games, speech, toys, and pictures are prevalent. This is a notion that can benefit death care professionals when they are ready to learn about these early manifestations.
This segment of the course discusses awareness of and perspectives on death from childhood through the later stages of life. These viewpoints on death are based on the research of psychologists, sociologists, and bereavements counselors. They provide fundamentals for death care professionals as they attempt to understand the needs of the bereaved.

CHILDHOOD AWARENESS OF DEATH NAGY

It was Marie Nagy's well-known research regarding a child’s gradual development of death concepts that first suggested three levels of awareness for children. These levels are:

- **Level 1 (birth to age five)** - The child’s perception of death is more "sensed" than "intellectualized." The dead are only less alive, more like a deep sleep. They are not void of sensation and functioning. Children at this level have a lot of questions about the body, casket, grave, cemetery, and so on. There is no connection with death being final. The dead are only temporarily gone.

- **Level 2 (ages five to nine)** - During this period the irreversibility of death is accepted by the child. There is awareness that life is limited. This suggests a higher degree of mental development. However, children at this level manifest two other interesting characteristics. One is that death is viewed as a "person." It can be an old man, a clown, or simply a mysterious figure that makes the rounds at night. Second, the children believe a person can "hick out" and escape death. If a person is clever enough, death can be outwitted. Hence, the anxiety associated with the finality of death is lessened by giving the child some control over avoiding the "death person." Nagy believed that even at this age death is still "outside" the child.

- **Level 3 (age nine and up)** — At this point the child’s ability to conceptualize and intellectualize death permits an understanding not only of finality but also of inevitability and universality. Everyone dies, and it cannot be avoided. (Nagy 1948; Cotton and Range 1990; Donders 1993)

PIAGET

Most students of human development have turned to Jean Piaget for an understanding of how one level of mental functioning leads to another (Piaget 1965). Some believe there is a conflict between Nagy and Piaget in the area of finality. Although Piaget had little to say about death, his developmental theory seems to suggest that a child would have to be older than nine or ten years to cognitively grasp the personal finality of death. However, it is important to point out issues on which Nagy and Piaget do agree, namely, during the ages of approximately five to eleven when children can comprehend what is real, universal, irreversible, and inevitable. Therefore, while children might struggle with the personal finality of death, they do see it as real. This point is supported by Canine and Dates (1993) in their analysis of drawings of death that were obtained from second and third graders in a Michigan elementary school.
The most significant aspect of the study reported by Canine and Dates (1993) was in the area of content coding. The following is an excerpt from their report:

The drawings were coded according to the content of the pictures without regard to colors used to portray the content. This was accomplished by means of a content analysis of the drawings followed by the coding of each drawing inclusive of each content category. The interrater reliability of the three raters for content was 0.92 (See the Table Below).

### Indicators of Death Symbolism in Drawings by Second and Third Grade Children

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interpersonal violence:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td>11</td>
<td>13.0</td>
</tr>
<tr>
<td>Not Indicated</td>
<td>73</td>
<td>87.0</td>
</tr>
<tr>
<td><strong>Violence of non-personal nature:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td>9</td>
<td>11.0</td>
</tr>
<tr>
<td>Not Indicated</td>
<td>75</td>
<td>89.0</td>
</tr>
<tr>
<td><strong>Spirituality:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td>16</td>
<td>19.0</td>
</tr>
<tr>
<td>Not Indicated</td>
<td>68</td>
<td>81.0</td>
</tr>
<tr>
<td><strong>Pastoral/nature:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td>17</td>
<td>20.0</td>
</tr>
<tr>
<td>Not Indicated</td>
<td>67</td>
<td>80.0</td>
</tr>
<tr>
<td><strong>Funeral service:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td>35</td>
<td>42.0</td>
</tr>
<tr>
<td>Not Indicated</td>
<td>49</td>
<td>58.0</td>
</tr>
<tr>
<td><strong>Death as peaceful:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td>26</td>
<td>31.0</td>
</tr>
<tr>
<td>Not Indicated</td>
<td>58</td>
<td>69.0</td>
</tr>
<tr>
<td><strong>Deceased as distressful:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td>54</td>
<td>64.0</td>
</tr>
<tr>
<td>Not Indicated</td>
<td>30</td>
<td>36.0</td>
</tr>
</tbody>
</table>
With respect to interpersonal violence, indicated on the drawings by one person doing harm to another, only 13 percent of the drawings viewed death as occurring through interpersonally violent means. Non-personal violence, depicted by a violent death as the result of an accident, was found in 11 percent of the drawings. No drawings had both interpersonal and non-personal violence. Thus, a full 22 percent of the drawings had views of death as violent occasions as depicted in the drawing below:

Twenty-two percent of children’s drawings had views of death as violent occasions.

Inclusion of spiritual signs, both religious and nonreligious, in the drawings appeared in 19 percent of the students’ protocols, and indicated that most children of this age do not consider death as a spiritual event. Pastoral signs, or signs of nature, appeared in only 20 percent of the drawings.

Indications of funeral preparations, funeral ceremonies, or interment appeared in 42 percent of the drawings [see the drawing below]. Consideration of spiritual, pastoral and funeral signs together indicates that most children surveyed often drew the deceased without any persons, deity or spirit, or inanimate surroundings. In fact, many of the drawings including signs of funerals also included pastoral surroundings or some type of spiritual de-notion.
Forty-two percent of children’s drawings related to funerals.

Only 31 percent of the children viewed death as a peaceful event, while 64 percent indicated that the deceased was in a distressed circumstance. Often, this was portrayed as the deceased yelling for help or crying.

Forty-eight percent of children’s drawings depicted the deceased possessing all body parts.

The final category of content analysis was concerned with the portrayal of the deceased as having retained physical instrumentation such as arms, legs, eyes and ears. Somewhat under half (48 percent) of the children indicated the deceased as still possessing all body parts, while 52 percent indicated the deceased as missing instrumental abilities as denoted in the drawing above.
CONCLUSION

Canine and Dates’ research seems to support Nagy’s and Piaget’s findings that children struggle with personalizing death and seeing it as final. In six out of eight categories, the "not indicated" percentage was much higher than the "indicated." Was this because the children had no opinion on the subject surveyed? Did they have no opinion because they could not personally relate to the subject matter? As stated, most of the children "drew the deceased without any persons" (Canine and Dates 1993, p. 71). Why? Also, it seems significant that 64 percent said the dead were "distressed" and almost half said the dead had "physical abilities." Obviously, although death is real for these children, they do not view it as final. Nevertheless, while there is a need for more research on the subject of children and death, especially research that will utilize different methodologies, some basic conclusions can be drawn for the death care professional.

From early childhood through adulthood, the developmental phases from one age in life to another cause changes in human perceptions of death, resulting in different perspectives on death during each stage of life.

First of all, how a child interprets death depends on many factors, as listed in the following:

- **The developmental stage:** Usually one can determine by age the mental developmental functioning of a child. However, maturation varies considerably, so age should be used as only an approximate guide to how well a child can reason. Generally, a child begins to conceptualize death at about age seven (lig and Ames L955; Reilly, Hasazi, and Bond 1983; Speece and Brent 1984, 1992).

- **Personality:** Each child has his or her own personality characteristics. A child who is highly communicative will probably talk about death. A child who is ad-venturous is likely to ask questions about death. A child who has a strong bond and is close to his or her parents probably will "take on" the parents’ attitudes about death at the expense of his or her own ideas and thoughts. Whatever makes a child unique also influences the way that child views death (Prichard and Epting 1992).

- **Life experiences:** When a child experiences a death or loss (especially the death of a parent or sibling) at an early age, it forces the child to cope. Whatever coping skills the child adopts, right or wrong, probably will influence the way he or she deals with loss the rest of his or her life. However, many other life experiences have the potential to affect a child’s interpretation of death, such as illness, separation from loved ones, changes of environment, socioeconomic level, parental occupation, and so on. With this in mind, it is easy to understand why a child of a funeral director probably would have a concept of death unlike that of other children (Stambrook and Panker 1987).

- **Emotional support:** If a child has bonded to parents and other family members, and has the freedom to express feelings, chances are good that the anxiety associated with death will be lessened through communication of death-related issues. To this child, death education begins at home. For the death care professional, this means that any type of helping intervention, whether educative or therapeutic, can support and nurture the family values (Silverman and Worden 1992).
Second, the child’s realization that death is personal and inevitable can be achieved through many different situations. The reality of death can be a spontaneous act of comprehension, like an "existential awakening," or a series of events that enable the child "to put things together" relative to the notion "I am going to die." Either way, death becomes real. In many cases the death care professional is challenged with helping the child balance this death awakening with the continuous pursuit of goals and dreams.

Third, when the child senses that the subject of death is forbidden, and his or her quest for understanding death is deferred, the potential for personal growth and development is hindered. When death is treated as an overwhelming catastrophe and not discussed, there seems to be enough evidence to suggest it will have a negative impact on the child’s future.

**YOUNG ADULTS**

According to Piaget, the young adult is capable of concepts of time, space, and causality. The adolescent can hypothesize, theorize, and personalize. In short, adolescence is when a fully developed mental apparatus is possessed by the child. As Wass and Stillion (1988) report:

Adolescents formulate abstract ideas about the nature of death. For example, adolescents describe death as darkness, light, transition, or nothingness. They also formulate their own theologies about life after death which includes belief in reincarnation, transmigration of soul, spiritual survival on earth, and spiritual survival at another level in a state of indescribable peace and beauty, in addition to beliefs about heaven and hell or total annihilation at death. These findings are consistent with Piaget’s period of formal operations. Thus, research with healthy children and adolescents dispute an array of methodological problems seems to suggest that concepts of death develop generally in accordance with the Piagetian model of cognitive development.

Adolescence is a time of one's life. From a statistical standpoint, taking 1,000 males, fifteen years old, it is likely that 999 will reach the age of sixteen. For females the statistics are even better. Out of 2,000 females, fifteen years old, 1,999 will reach age sixteen. An adolescent can contemplate many years of life (Feifel 1977). However, there is a mortality rate even at this young age. Therefore, death-related thoughts and ideas need to be discussed.

In adolescence, as in childhood, personality and life experiences are important. Additionally, it is likely that males and females differ in their orientations toward death. An example of this is our society’s encouragement of risk-taking behavior among young men.

As Feifel states:

Anthropological observations could be used to make a case that young men tend to be high risk takers in most, if not all, cultures. Yet there seems to be an especially lethal interaction in our own society between cultural incitements for young men to "prove" themselves and the means that are popular and available for these activities. Hazardous use of automobiles, drugs, alcohol, and unnecessary risks in athletic competition are among the modalities of life-threatening behavior encouraged by the attempt to establish that one is not "chicken," and can do all that is expected to
demonstrate masculine powers ... As more young women move into activities previously dominated by men, there is at least the prospect for an increase in injury and death related to this risk-taking orientation. (1977, p. 33)

Feifel’s point is well taken. Developmentally, adolescents have the mind to manipulate concepts to make rational decisions. An adolescent can understand the world in which he or she lives. However, being an adolescent is being somewhere between adulthood and childhood, which means, among other things, that decisions will be made that are not well thought out and that give the appearance of being childish. This is especially true of death-related issues. As we have discussed, an adolescent can understand death in a rational, reasonable manner. However, many death-related issues are "acted out" rather than being understood. For example, music has an important influence on adolescents, and rock music seems to be the choice. It is mass-produced and encompasses every area of our society. Rock music is marketed on MTV, radio, videos, tape cassettes, compact discs, and record albums. We can hear rock music in our homes, schools, places of business, health clubs, and even in our churches. Most sociologists agree that it started almost forty years ago as an expression of "counterculture," and continues to the present.

In 1986 Attig provided a list of categories of death-related themes in rock music that includes:

- Immortality
- Grief
- Suicide/homicide
- War
- Apocalypses
- Death via drugs
- Violence (including those of sexual nature)

In 1989 Wass, Miller, and Stevenson published an article entitled "Factors Affecting Adolescents’ Behavior and Attitudes toward Destructive Rock Lyrics." Among their many findings, they state: "If indeed a portion of the adolescents are interested in rock music with destructive themes and do know the words of the lyrics, as our data suggests, the likelihood that they may be influenced is increased, especially if rock musicians serve as a role model" (p. 301).

In 1993 Plopper and Ness identified ninety death-related songs that have appeared in the Top 40 during the last thirty-seven years. They concluded the following:

- Death songs constitute a disproportionately popular subset of Top 40 music.
- Males dominate as the person who dies in the songs.
- Grief responses in the songs are confused and restricted.

Even with these findings, there still is an absence of research on adolescents’ perceptions of rock music and the effect it has on their attitudes and behavior. However, it is obvious that this type of music provides an avenue for the young adult to express or act out death themes.
Another avenue to express death themes is games. Childhood games such as cops and robbers, cowboys and Indians, and war have given way to more sophisticated video games that are popular among teenagers. Laser Tag is a game that includes a pistol, a holster, and a sensor that automatically records each "hit." It is a fair assumption that this toy simulates killing. On the other hand, Tech Force, Mortal Kombat, Cosmic Carnage, and Fatal Fury are all computer games that simulate war. In this age of the computer, we have little doubt that more video and computer games with a death theme will be marketed. The question is, what impact will they have on the values and attitudes of our young adults (Wass and Stillion 1988)?

Finally, adolescents are not limited in their expressions of death themes. From fairy tales, comic books, novels, and magazines to the care of pets, young adults explore the subject of death. It is up to the death care professional to pick up on these subtle expressions so that assistance can be given in understanding and accepting death.

**MIDLIFE**

The adult in the middle years usually has a focus on the immediate family as well as a concern for his or her family of origin. More people today have parents alive than at any other time in history. Hence, the middle-aged person feels the pressure from both sides. Nevertheless, how a middle-aged person copes with life and death depends on his or her development in the previous years. Whatever factors influenced a middle-aged person’s thoughts on death, related issues will continue through the middle years. With few exceptions, this seems to be a safe assumption. However, some death issues seem to be unique to this time of life.

First of all, to be middle-aged and have to care for a dying parent can be very distressing. A parent who has lived a long time provides psychological insulation from an acceptance of mortality. The daughter finds it hard to live without the mother who has been there "forever.” Of course, there is very little understanding from society when a parent dies. Everyone will grieve with a parent whose child dies unexpectedly, but not many people seem to encourage an intensive display of grief when a parent dies whose "time had come” or who lived a "fulfilled" life. Also, there is the issue of a mother being a burden to her daughter while she was dying. Or possibly mother and daughter had not gotten along through the years. In either case, it leaves the daughter with post-death conflicting feelings of guilt and liberation.

Second, the death of a parent also validates one's own mortality. After his father's death, one patient said to his therapist, "I looked into the casket and realized that is the dead state and I am in the alive state, but I am moving to the dead state.” His statement is consistent with midlife reality, namely, that death is no longer uncommon, as opposed to when a person is young. The chance of dying during one's forties is about twice as great as in the previous decade, and will double again during that person's fifties (Feifel 1977). This phenomenon does not make one feel very secure, but it can be the impetus for developing a mature death-accepting attitude.
Third, the midlife adult must find some balance between a society that places value on youthfulness and a physical body that is getting older. As Feifel states, "Growing older is akin to growing deader" (1977, p. 38). Anxiety over physical changes (e.g., wrinkled skin, poor eyesight, extra weight) can lead to depression. The body that has been nurtured for so long now is experiencing "partial" death. The physical losses seem to mount with each passing year, bringing death closer and closer. If an individual tries desperately to hold onto a youthful self, further growth and development can be hindered. The midlife years should not be a time of looking back, which only promotes stagnation. Rather, the midlife adult should focus on the fact that "life is not over"; as long as there is life, there is growth. The middle years can be a time of redefining personal goals, interpersonal relationships, career objectives, and, of course, one's own mortality. In short, these are the years in which the self is "reborn."

GERIATRIC GROUP

It is difficult to define this group of Americans. To be a member of the American Association of Retired Persons, you must be at least fifty years old. Most companies still look at sixty-five years as retirement age. The government issues Social Security checks to men who are sixty-five years old and to women who are sixty-two years old. The situation becomes more complex when one moves from chronological age to levels of functioning. We may know someone who is "old" at forty years and someone else who is "young" at seventy. Should a college professor be retired at age sixty-five when her mind has more information stored than ever before, her intellect is sharp, and her years of experiences have made her very wise? One would think not. However, for the sake of convenience, we will refer to the geriatric population as those age sixty-five years and up.

Currently, there are over twenty-two million individuals in America who are sixty-five years or older. That is more than 10 percent of the population. Due to advances in science, medicine, and geriatric health care, the number of "elders" in our society will continue to increase. However, 71 percent of the 2,141,000 estimated deaths in the United States in a given year (1989) occurred in persons sixty-five years of age and older (National Center for Health Statistics 1990). Truly, death is associated with aging. How does the geriatric population view death? There is never a good time to die. Older people today are more active and have a higher level of functioning than at any other time in American history. They seem to place a lot of emphasis on life and living. For the last twenty years, studies have shown that death does not intimidate the old person. As early as 1966, Munnicks found that the aged come to terms with their finitude. Although they differed in their methods of coping, they seemed acutely aware and accepting of the closeness of death. More recently, Thorson and Powell (1988) found that "elders" had a lower death anxiety than younger age groups, but, more importantly, the meanings of death were different. Older persons were concerned about being in control and about life after death, whereas young people were attentive to the fear of pain, isolation, and the decomposition of the body.

From a practical standpoint, growing older should include preparation for death. This preparation can occur at the spiritual level through reflection and a review of one's life as well as thoughts on a better life hereafter. Or it can occur at the social level through the establishment of a will, making funeral arrangements, distribution of personal possessions, and saying "good-byes" to family and friends. Sometimes growing old means losing one's life mate.
In 1989 Kirschling and McBride found that widows experienced a greater loss of vigor and more physical symptoms than widowers. Women reported a high pro-portion of support from their ideas and beliefs. Men, on the other hand, had more evidence of denial. However, their study concluded that, despite differences in expressions of distress, widows and widowers used the same coping strategies. Nevertheless, this study, as well as others, provides evidence that older people perceive death and work through grief by establishing values, beliefs, and adaptive behavioral patterns. In essence, they are as prepared as they can be for death.

Death care professionals who are oriented toward helping older people cope with death-related experiences need to be alerted to those individuals whose behavior is maladaptive. The following lists some factors that cause difficulties for older adults when coping with the death of a loved one:

- Wanting to die and low self-esteem (Lund et al. 1986)
- Feelings of having contributed to the death in some manner (Murphy 1983)
- A pessimistic outlook on life in general (Rowe 1982)
- Limited support resources (Kirschling and Austin 1988)

Helping older people to cope with death-related transitions requires the death care professional to be focused on emotional needs, physical concerns, and realistic goals. While the aged might accept death with minimal anxiety, death-related issues bring them face-to-face with new situations that require instrumental problem solving in nearly every area of life.

SEGMENT SUMMARY

Nagy's well-known research regarding a child's gradual development of death concepts first suggests three levels of death awareness for children. This theory is supported by Jean Piaget's work in the area of childhood development. Also, Canine and Dates, in their 1993 study of children's drawings of death, support the fact that children seem to have an unsatisfied notion of death because they have not been challenged to personally relate to the subject. However, children at an early age do understand that death is real. How a child interprets death depends on the child's developmental phase, personality, life experiences, and emotional support.

In adolescence the child has the mental apparatus to comprehend death. However, adolescence is the time when behaviors vacillate between those of the adult and the younger child. Males seem to take more risks. Rock music is a channel for both males and females to express feelings about death and grief, yet adolescents are not limited to this avenue of expression. They also express their feelings through games, toys, literature, and the care of pets.

The midlife years are difficult because one is caught between caring for the immediate family and the family of origin. Watching a parent die or dealing with a sudden death of a parent reinforces one's own mortality. The midlife years are when the body experiences a "partial death." It is a time when physical limitations are quite noticeable.
The "geriatric group" is increasing in numbers, and generally seems to be accepting of death. However, they are faced with tremendous choices and decisions in confronting the death of their friends, their own grief, and their own death.

REFERENCES

SEGMENT 4: THE PSYCHOLOGY OF DYING

SEGMENT OUTLINE:

1. Psychological Responses to Dying
   I. Kubler-Ross Denial Anger
   II. Bargaining Depression
   III. Acceptance Lofland Space
   IV. Population Knowledge Stance
2. Contributions by Other Researchers
3. Duties of the Dying
4. The Role of the Funeral Director with the Dying Patient
5. Summary

SEGMENT OBJECTIVES

Upon the completion of this segment of the course, you will be able to:

1. Derive at an understanding of the psychological response to dying.
2. Define and describe Dr. Elizabeth Kubler-Ross’s five stages involving the psychological response of dying.
3. Break down Lofland’s approach to dying, which defined dying as being terminally ill or having a limited life expectancy.
4. Outline the “Adaptive Tasks” research of Moos and Tsu, Kalish, and Rando concerning the duties of dying.
5. Identify the role of the funeral director with the dying patient.
NARRATIVE SUMMARY

The role of the funeral director with the dying patient is varied. As a caregiver, the funeral director might act as planner, adviser, and counselor. Working with dying patients requires certain personal prerequisites such as dealing with one's own mortality, understanding the grief process, learning to listen, and committing oneself to the role of caregiver.

The research included in this segment will assist the funeral professional with the much needed ability to remain ever aware of the needs of the bereaved.

PSYCHOLOGICAL RESPONSES TO DYING

Beginning with Dr. Elizabeth Kubler-Ross and her book On Death and Dying, (1969), there has been widespread appeal to the notion that, once they realize death is close at hand, people go through several distinct psychological stages in response to their impending demise. Basing her observations on interviews with over two hundred limited life expectancy patients, Kubler-Ross presupposed that five stages were involved in the process of psychological response to dying. These stages are:

1. Denial
2. Anger
3. Bargaining
4. Depression
5. Acceptance

This section of the course aims to define and describe these stages, as well as bring to light the perspectives of other well-known authors on this subject. Responsibilities that dying individuals feel they must meet are recognized, and the role of the funeral director with the dying patient is reviewed.

KUBLER-ROSS

As human beings approach death, nature seems to prepare us for letting go of our need and desire to live our worldly existence, the only existence we have consciously experienced. When we learn that we have little time left on earth, we respond in a series of emotional reactions that eventually lead us to acceptance. These reactions are as follows.
DENIAL

When people discover they are dying from a terminal illness or condition, often their initial response is to deny the inevitable event in order to cope with the shock of finality. Such a reaction might cause a person to simply state, “It cannot be true.” Usually, this is a temporary response that allows the individual time to collect him- or herself and deal rationally with the situation.

ANGER

Once the patient has come to realize that death is close at hand, anger replaces the denial. The patient is angry because he or she feels unjustly chosen for death. Envious and resentful of those who will continue to live, the patient might say something similar to this: “Why couldn't this have happened to George? He doesn't deserve to live.” Striking out at family members, doctors, and nurses is a typical reaction. In fact, anyone who approaches the dying person might feel the hostility the patient is experiencing.

BARGAINING

Over time, people reach a stage at which they try to strike bargains with death. They begin to accept the inevitable and start looking to “extend the lease.” They want to postpone death, so they bargain, most often with God, for more time to live as a reward for their “good behavior.” They might say something like, “If I can just live through Mary’s graduation next spring, then I won’t ask for anything else.”

DEPRESSION

The next stage a dying person moves into is depression over the loss of personal life. The purpose of this emotional state is to prepare the individual for full acceptance of death. For some people the depression spills over into other areas of life. They might be depressed about the loss of a job, money, future dreams, or their friends.

ACCEPTANCE

Finally, the dying individual fully accepts that he or she is about to die. At this time many people are void of feelings. They have not “given up,” but they need time to rest before the end comes. Their interests might diminish, and they might want to be left alone in silence. At this stage in the process, the dying patient’s family need more help, patience, and understanding than the patient does (Kubler-Ross 1969).

Kubler-Ross was careful to make clear that not all dying patients move through these stages in this sequence. However, many health care workers, patients, and families of patients have interpreted her work in that way and have tried to force their understanding of “limited life expectancy” into a particular mold. It is not uncommon to hear people in the medical field talk about a patient who has not accepted his death, and question, “Why is this patient stuck in denial?” The implication is that he should go beyond denial to some other mode of coping so he can eventually accept his death.
As a pioneer, Kubler-Ross put a great deal of effort into directing our attention to the emotional needs of dying patients and their families. However, there is very little scientific evidence to support the fact that patients proceed through definable stages. In fact, psychologist Edwin Shneidman (1973) writes:

Indeed, while I have seen in dying a person’s isolation, envy, bargaining, depression, and acceptance, I do not believe that there are necessarily “stages” of the dying process, and I am not at all convinced that they are lived through in that order, or, for that matter, in any universal order. What I do see is complicated clustering of intellectual and affective states, some fleeting, lasting for a moment or a day or week, set not unexpectedly against the backdrop of that person’s total personality, his “philosophy of life.” (P. 6)

Nevertheless, a “stage” approach to dying has made us aware of the prolonged period in which modern persons can “be dying.” It is in this context that sociologist Lyn Lofland defined “dying scripts” to be individualistic, varied, emergent, and uncodified. She writes: “Being dying is relatively problematic because it is a role in the modern world, and such roles are frequently more akin to improvisational theater than to traditional drama. Parameters of some sort may be given . . . but within those, the actor has considerable freedom to shape the role’s detailed stylistic enactment as he or she sees fit” (Lofland 1978, p. 49).

According to Lofland, “being dying” is being terminally ill or having a limited life expectancy. The “dying script” is how the dying patient decides to live out his or her last days. In attempting to understand the personal and social decisions the patient has to make, she suggests the use of “construction materials” such as space, population, knowledge, and stance.

**SPACE**

Lofland defines “space” as the area within one’s life span that is set aside and dedicated to fulfilling the dying role. Logically, we could say that from the time of birth until the time of death we are moving toward extinction. However, most will choose a portion of space between the time of diagnosis (of a terminal condition or illness) and the time of death. Within this space there is an enormous amount of flexibility. Lofland cites the difference between two public figures’ use of their space: journalist Steward Alsop and author Jacqueline Susann. Alsop wrote about his acute leukemia from the time he entered the hospital until his death. On the other hand, Susann shared the knowledge of her cancer with very few people and apparently committed nothing to paper concerning her movement toward death.

**POPULATION**

Lofland’s term “population” refers to the question of whether the patient chooses to play out the dying role alone or in the company of others who are dying also. Since many people die in a hospital surrounded by other patients who are dying, it might seem next to impossible to die alone. However, with the rising popularity of hospice (home palliative) care, it is possible for one to have some degree of privacy during the final days and at the moment of death.
An important issue for the dying patient is who will be told when this person is expected to die. Minimally, only the medical doctor and the patient would have this information. The question is, Who else should know? Conceivably, anyone and everyone might be told if the patient so desires. Since expressing one’s feelings about death is important, discussing it with selected individuals could be therapeutic. However, an anonymous letter to Ann Landers explains why discretion should be used when telling others about one’s impending death.

Dear Ann Landers: This may be one of the most unusual letters you have ever received. You see, I am dying, but don’t become alarmed, and please don’t feel sorry for me.

After all, we are ALL dying. From the moment we are born, we are headed toward inescapable death.

Three years ago, I learned I have chronic leukemia (I was 31 then). The doctor told me the truth at once because I insisted on knowing. The news came at a crisis time in my life. (I had just gone through a divorce and had young children to raise.)

Would you believe I had to move out of town to a larger city because people would not accept me as a normal person? I was devastated, not by the disease, which has been controlled by drugs, but by the way I was treated.

After I moved to this distant city, my life changed dramatically. No one here knows of my illness and I am keeping my mouth shut, I work part-time, attend college, have many friends, and am involved with community activities and participate in sports. What a pity that I had to move to a town where nobody knew me in order to live a normal life.

Although I feel well, look fine, and am managing beautifully, I know it can’t last forever. I dread the day my friends must be told of my illness. I don’t want to be pitied. And, of course, I fear that I may be deserted as I was once before.

(Sacramento Union, May 12, 1975)

STANCE

As a dying person assumes her dying role in the philosophy by which she lived, her life will never be more significant. To some patients, their dying space offers a time to lean on religious beliefs. St. Paul wrote for the Christians, “Death, where is thy sting?” and “Death has been swallowed up in victory” (1 Corinthians 15:54, 55). To others, it is the time to show what years of education and rational thought have taught them. After all, death is inevitable; everyone dies, accepts it, and moves on. Still, for some people, the moments before death might be a time to mend broken relationships, confess wrongdoings, or cram as much pleasure into “being dying” as possible. To this end, “stance” is existential and its types are as many as human inventiveness can create. Lofland has given the patient a model that emphasizes choice as she constructs her “persona” during her “being dying.” Lofland’s greatest contribution to “being dying” is informing the patient that she can have some control right up to the time of death.
CONTRIBUTIONS BY OTHER RESEARCHERS

Kubler-Ross and Lofland are just two of many thanatologists, sociologists, and psychologists who have worked to define some aspect of the dying mode. The following are brief descriptions of conclusions drawn by other researchers.

In his essay on the living-dying process, E. M. Pattison (1978) simply divided the dying process into three clinical phases:

1. The acute crisis phase in which one learns of the terminal illness
2. The chronic living-dying phase
3. The terminal phase

In each phase the dying patient would have different initial responses.

Another researcher who has written extensively on death is A. Weisman. His greatest contribution is his definition of denial and what he calls appropriate death. Weisman (1984) concluded that there are three degrees of denial. First-degree denial is when the patient unequivocally denies the facts that have produced the diagnosis of being terminally ill. Although family and friends demand medical treatment, the patient steadfastly refuses and continues to disbelieve or ignore the advice of the physician. Second-degree denial is when the patient accepts the diagnosis with all its complications but refuses to believe the illness is terminal. This patient might even discuss the physical debilitation of the illness and be fully aware of the limitations caused by the disease. However, in the next breath this patient might discuss long term career advancement plans. Third-degree denial is when the patient vacillates between “open acknowledgment of death and its repudiation” (p. 65). This patient might wake up one morning and plan his funeral, revise his will, and contact a hospice organization in preparation for his death. However, the next day he is angered by a chemotherapy treatment that interferes with his weekend plans.

From a psychological standpoint, denial does not always produce dysfunctionalism. In fact, Lazarus and Folkman (1984) reported that denial can be useful within the context of active coping strategies. In their opinion, “denial” needs to be further defined so that there is a clear understanding of favorable and unfavorable outcomes.

Weisman (1984) also developed the idea of “appropriate death.” He writes: “I realized that not only some deaths were better than others, but that certain deaths were so fitting that they could be called “appropriate.” These were not, of course, ideal deaths, nor particularly propitious, but they did share characteristics that were consistent with good coping and sustained morale. Appropriate death, in brief, was the opposite of suicidal death, in which an unhappy person appropriates death” (p. 80).
Weisman determined four factors that describe appropriate death:

1. The intrapsychic conflict of death is lessened.
2. The dying posture of the individual is consistent with his ego idea.
3. Important relationships are preserved or restored.
4. Basic instincts, hopes and wishes of fantasy, and goals for growth reemerge and give the patient some degree of fulfillment.

What is appropriate for one person will not necessarily be so for another. To some extent, the behavior of a person who is dying will mirror the times of his or her life when a crisis produced varied psychological responses. It is not uncommon for a dying patient to have a vast array of emotions such as rage, guilt, terror, surrender, heroism, and dependency. Nevertheless, how an individual behaves during a crisis will give clues to how the person will respond to dying. A death is appropriate if it is consistent with what a person has been, if it continues to promote what is meaningful and important to the individual, and if it maintains important relationships (Weisman 1984).

Sociologists Glaser and Strauss, in their book Time for Dying (1968), reported on the involvement of limited life expectancy patients with hospital staff members. They identified four “contexts of awareness.”

First, when a staff member knows of the patient’s terminally ill diagnosis but does not share the information with the patient or family, a “closed awareness” exists. Since the research of Glaser and Strauss, there has been much more emphasis on full disclosure to consumers in many fields, including health care. However, if a closed awareness happens just once, it is once too often. The patient has a right to know about the diagnosis, prognosis, and treatment of the terminally ill disease.

Second, a patient might suspect his or her illness through a variety of hospital information, such as the following:

- Indirect statements from the physician
- Comments overheard from the physician to other staff members
- Direct statements from hospital staff members (aides, nurses, social workers, etc.)
- Statements overheard from family and friends in the hospital room
- Changes in the behavior of others toward the patient
- Changes in medical care, procedures, medications, and so on
- Changes in the patient’s physical location within the hospital
Third, the phase of “suspicion” is so unstable that it does not last long. Usually, it will give way to “mutual pretense.” This happens when the patient and staff are quite aware of a terminally ill diagnosis but pretend it is not true. Even though mutual pretense is an activity that is not consistent with the patient’s reality, Glaser and Strauss point out that it does serve a purpose. It enables the staff to keep a safe emotional distance from the patient, and it gives the patient more dignity and privacy. However, the danger of mutual pretense is the possibility of alienation, where the patient is left without any genuine relationships.

Finally, “open awareness” occurs when both patient and staff are aware that the patient is dying and they openly acknowledge and discuss it. This permits the patient to “put his life in order” by taking care of practical matters such as finalizing a will, arranging for the funeral, caring for the children, saying good-bye to family and friends, and so on. Open awareness can place considerable strain on hospital staff who continuously work with dying patients. As Glaser and Strauss point out, there should be attention given to the psychological needs of the caregiver.

DUTIES OF THE DYING

In coping with a terminal illness, the patient is forced to perform some basic existential duties. These duties vary depending on the nature of the illness, the personality characteristics of the individual, and the environmental circumstances. Moos and Tsu (1977), Kalish (1970), and Rando (1984) have referred to these duties as “adaptive tasks.” They are listed in the following:

1. The patient must arrange a variety of affairs, including the management of pain and discomfort for funeral arrangements. Each duty brings the patient one step closer to death.

2. The patient must adapt to the loss both of loved ones and of the self. The patient might be concerned about the survivors and what effect “my death” will have on them. Typical questions are: Will they be legally and financially vulnerable? Will they have replacement relationships? There is potential for bringing loved ones closer together if feelings can be openly and honestly discussed. At the same time, the patient must be attentive to the loss of her entire world as she has known it. Being responsible to personal loss can be terrifying to the dying individual.

3. The patient must manage her medical needs as well as balance her emotions. The choice of medical treatment and when it will begin and end is left to the patient. The identification and expression of emotions about the disease and treatment are critical to maintaining her emotional equilibrium. All of this needs to be done with some degree of hope, even when it is limited by the realities of the illness.

4. The patient must plan for the future while anticipating the loss of various forms of sensory, motor, and cognitive abilities. Whatever time and energy the patient has left might be used for a vacation, general travel, or to visit friends. The patient should continue to plan for and enjoy life as long as possible. At the same time, the patient should make arrangements for a time when she will no longer be capable of carrying out her plans.
5. The patient must identify and cope with the death encounter. Living with the reality of death inevitably brings up concerns of immortality. Many patients are comforted through their religion; others are thrust into a “state of despair” when they face their own extinction. Although the research on the role of religion in the face of death has produced mixed results, generally it is agreed that the patient’s will to live influences the dying process. If it is relinquished, for whatever reason, the patient might hasten death.

THE ROLE OF THE FUNERAL DIRECTOR WITH THE DYING PATIENT

To some extent the funeral director is a “caregiver” to the dying patient. When the patient faces the reality of his death and makes a conscious decision to plan his funeral, he will turn to the funeral director for counsel, care, and preplanning. There are some necessary prerequisites for those funeral directors who work with dying patients.

These include:

- Coming to grips with one’s own mortality.
- Understanding the grief process of a dying patient.
- Engaging in effective listening and responding appropriately. This includes nonverbal as well as verbal communication.
- A commitment to give a part of oneself to the dying patient and family.
- Knowledge of one’s own personal limits; knowing how to avoid “burnout.”

In preplanning the funeral, the patient has the assurance, witnessed by the funeral director, that he has performed what will be the final duty of his dying process. He will experience some control over his death by knowing what he wants for his funeral, how much it will cost, and where it will be held. The responsibility of the funeral is removed from the surviving family members, and, by discussing it frankly, the patient and family are better able to meet death when it comes. At the preplanning arrangement meeting, the funeral director can encourage the dying patient to make the funeral and burial fit his personal beliefs, standards, and lifestyle. It has been said in the funeral industry that the funeralization process should reflect the way the deceased lived. However, in light of this course, the funeral director might want to consider the way the patient is dying, and arrange the funeral to reflect the positive characteristics of the dying phase. For example, if the dying patient is working on restoring broken relationships, then the funeral might include the theme of forgiveness. If the dying patient was courageous in attempting to control his disease as well as his emotions, then the theme of tenacity, fortitude, and steadfastness might be encouraged as a major part of the funeral.
Nevertheless, the role of the funeral director in the limited life of the patient is significant. He or she should encourage the patient to talk about changes in attitude or perspective brought on by the illness, and should provide support and comfort for the patient during the preplanning meeting. Acceptance, clarity, candor, and compassion should be exemplified by the funeral director at all times. Each dying patient should be treated as an individual, with respect and recognition for his or her needs, fears, hopes, and expectations. This requires more than sensitivity from the funeral director. It calls for continued learning about the needs of the dying.

SEGMENT SUMMARY

Kubler-Ross pioneered work that focuses on the needs of the dying patient. Although her stages of the dying process are supported by little scientific evidence, they define the dying process in a manner that has enabled many individuals to gain understanding of limited life expectancy.

Lofland’s attention to the “dying script” and the use of construction material such as space, population, knowledge, and stance emphasizes choice and gives the dying patient a feeling of control right up to the time of death.

Pattison divided the dying process into clinical phases. Weisman wrote about denial and “appropriate death.” Glaser and Strauss defined “contexts of awareness” between hospital staff and the dying patient. The dying patient is forced to perform “adaptive tasks,” which essentially are responsibilities that the dying person feels must be fulfilled. These tasks include arranging one’s affairs, adapting to the loss of loved ones and the self, managing both medical and emotional needs, planning for the future, and coping with the death encounter.

The role of the funeral director with the dying patient is varied. As a caregiver, the funeral director might act as planner, adviser, and counselor. Working with dying patients requires certain personal prerequisites such as dealing with one’s own mortality, understanding the grief process, learning to listen, and committing oneself to the role of caregiver.

REFERENCES


SEGMENT 5: SYSTEM COORDINATION APPROACH FOR THE DYING PATIENT

SEGMENT OUTLINE:

1. Death Plan: Order Out of Chaos
2. "Working" the Plan
3. Professional Systems Coordination: Standards and Education in the Care of Dying Patients
4. The Funeral Firm as Part of System Coordination
5. Summary

SEGMENT OBJECTIVES

Upon the completion of this segment of the course, you will be able to:

1. Review research that highlights the system coordination approach designed to make the dying and death as personal, comfortable, rational, satisfying, and accurate as possible for the individual.
2. Develop a working plan for the dying patient and his or her family.
3. Outline professional systems of coordination to meet the needs of clientele.
4. Identify the funeral firm’s part of the system coordination process.

NARRATIVE SUMMARY

Our society includes a variety of individuals, resources, and organizations that may, at different times, need to become involved in the dying process of a patient. For the purposes of this segment of the course, we will refer to any of these people or groups who have an impact on dying and death as a “system,” and will attempt to show how systems can best interrelate while providing support for the terminally ill. The advantages of a death plan and the importance of good communication also will be addressed. Toward the end of the course there are some discussion questions based on case information; these should assist death care professionals in better understanding the full service-to clients and the community at large—that quality funeral firms are able to provide.
A "system," by definition, is a group of elements that interact and function together as a whole. All of us may be dependent at various times on the medical care system, an emotional support system, or the legal system. These, however, are only three of the systems that can easily become involved (perhaps even simultaneously) in the experiences of a dying patient—along with the family system, clergy or spiritual system, social services system, and funeral firm system.

The system coordination approach recommended here is designed to make the dying and death as personal, comfortable, rational, satisfying, and "accurate" as possible for the individual (see Figure below). But this goal is not without its problems.

The worry and flurry that often follow a terminal diagnosis understandably create confusion and miscommunication as shock and denial set in. Many different people may have their own particular ideas on "what to do" for the dying patient. The patient may have strong ideas of his or her own, presuming the illness and treatment allow for clarity of thought. Too often, though, the patient can be ignored among the clatter and chatter of family members, nurses, friends, lawyers, clergy—and anyone else who gets into the act. At such a time, decisions are far too important to be made in an atmosphere of chaos, contradiction, and cacophony. The question of whether to continue medical treatment may arise, as may the question of removal to a hospice.
Each system, of course, has its own objectives, points of view, feelings, and concerns. Thus, it is not difficult to see the benefits of developing a death plan that will serve to coordinate the efforts of all the constituents in a way that satisfies the dying patient. A death plan, quite simply, is a commitment made by all systems to follow through on agreed-upon actions that support the dying patient. Some plans are more formalized than others and may be impacted by the nature of the illness, the complexity of the patient’s personal and business affairs, and the number and relationships of involved family members. What is important about the death plan from a systems perspective is that it must clearly express the roles and responsibilities of each system and how they will interrelate on behalf of the patient.

Obviously, a death plan needs to be flexible. Adjustments, additions, and deletions may be required as the patient’s situation changes. If one goal of the plan is proper care and support, adjustments may have to be made in terms of visiting the patient (who and when), exploring medical and environmental (housing) options, and dealing with the patient’s personal affairs (paying bills, banking, etc.) if he or she is no longer able to handle such chores. Therefore it is vital that all systems agree to

- Share new information with other, affected systems
- Compromise
- Remain accountable to the patient and to other systems involved in the death plan

The following story is an example of how the lack of communication (sharing new information) caused conflict for a patient:

In 1993, a sixty-five-year-old male with four adult children was diagnosed with lung cancer. The two children who live in the area were told of the situation, and the two out-of-town children were not. During a subsequent hospital admission for an infection, the two out-of-town children came to visit him in the hospital. The attending physician entered the room and began discussing the cancer as it related to the current infection. When the doctor left, the out-of-town children confronted their ill father with a mix of anger, hurt, and surprise.

He said since they lived so far away, he didn’t want to burden them with the bad news.

It is hard to blame the out-of-town children for their reaction, isn’t it? And what sort of dynamic or framework does this situation set up between the four siblings? Between the out-of-town siblings and the doctor? What other thoughts, fears, or suspicions might be going through the minds of the out-of-town children? And, under the circumstances, how easy will it be for the “in-town” children to ask the others for help, should that be necessary? Most important, what are the possible ramifications for the dying patient?

- If this family is to ultimately function in a system coordination approach for the dying patient, they will need to develop a death plan. In so doing, they will need to complete the following tasks:
• Identify each responsible system involved with the dying patient.
• Define the current and long-term goals, jobs, roles, and communication “paths” within the death plan.
• Determine methods for periodic “review” of the plan.
• Consult with the dying patient, allowing him as much control over the plan as he wishes to assume.
• Identify the dying patient’s “representative,” who ultimately coordinates and monitors the plan, assuring its implementation.

"WORKING" THE PLAN

The dying patient and his or her family are dependent on a number of society’s systems to assure that the patient receives appropriate care, is able to “make the most” of the present life experience, and ultimately dies and is memorialized in a manner consistent with his or her wishes. The single most critical task to achieving these goals is communication. Consistent communication among the systems promotes a deeper and current understanding of the patient’s (changing) needs. For example, if the patient asks her physician to place a “no code” order on her chart, this must be communicated to any other doctors involved and all shifts of the nursing staff the hospital social worker and/or chaplain may also want this information. Family members may wish to take this as a signal to investigate or implement other services, such as a hospice or preplanned funeral arrangements. Without this constant sharing of information, families of dying patients and the professional systems who interact with them may encounter situations that create frustration, confusion, embarrassment, or open conflict—taking away focus and energy that are better spent on the dying patient.

The most favorable situation, of course, is when the patient himself is able to direct the plan. This allows the individual to maintain the positive feelings that come with empowerment, control, and self-reliance, as well as facilitates a healthy and realistic acceptance of the coming death. If the patient is not able to direct the plan, he or she may still be able to select an appropriate representative, gaining a sense of security and trust that the “preferred” person will be implementing his or her wishes and making “good” decisions. The role of representative can be filled by a family member, close friend, attorney, and health care professional or spiritual adviser. Regardless of who takes on the job, communication is still the essential task of the death plan. The designated representative must see to it that all systems are sharing information so they may function according to the plan agreements.

In addition, there are practical activities and techniques that people “working the plan” can use to share needed information and to help with staff, personal, and the patient care. While the particular circumstances of every dying patient will be different, some possible, useful activities include the following:
• Have the patient (or someone close to the patient, if he or she is unable) make a list of favorite foods, flowers, music, or anything that might constitute an allowable special treat.
• Have the patient list his or her regular, monthly sources of income and expenditures, as well as bank information, or assign someone to do so.
• If practical, give the patient a tape recorder to record any thought, needs, concerns, or questions he or she may have; encourage faraway friends or relatives to tape a "letter" or greeting for the patient.
• Schedule regular discussions with physicians, nurses, hospice workers, or other appropriate individuals.
• Learn hospital procedures, visiting hours, overnight opportunities, and so on for families of dying patients, or assign this job to someone.
• Assemble resource information from other systems: home care assistance, meals-on-wheels, markets and pharmacies that make home deliveries, transportation services, hospice, funeral firms, and appropriate clergy.
• Ask other systems (social workers, senior centers, religious institutions, funeral firms) how services to dying people interrelate in the community.
• Join or refer other system members to support groups that may be available through hospitals, hospices, or religious organizations.

As the death plan shifts into high gear and various tasks are completed, designated representatives should be sure to invite all systems to use their initiative to explore any means or opportunity to meet the dying person’s needs. And, as always, share the information!

PROFESSIONAL SYSTEMS COORDINATION: STANDARDS AND EDUCATION IN THE CARE OF DYING PATIENTS

Any professional system, regardless of its purpose, requires continuing education to meet the needs of its clientele. This is equally true for professional systems involved with dying and death. Many health care organizations and licensing boards require continuing education as a condition to maintain employment. But whether mandated or not, the constant updating of knowledge, information, and techniques based on new research and/or peer learning is extremely valuable in helping the professional system service dying patients and their families.

A number of organizations also establish written standards that, in their judgment, should be maintained in order to deliver a preferred level of professional assistance and care. An excellent illustration of this type of effort can be found in the second volume of the Accreditation Manual for Home Care (1995), by the Joint Commission on American Hospital Organizations (JCAHO).

The manual includes well-developed guidelines that deal with, on one side, continual assessment of patients’ needs to accurately meet their needs and those of their families. Answers to the assessment can help professionals develop a death plan that is suited to the particular circumstances of the client being served, and indicate what additional systems may need to be included for optimum care. Assessment areas encompass the following:
• Severity of pain
• Patient’s and family's religious or spiritual orientation
• Emotional needs and concerns, such as despair, depression, or fear, among patients and family
• Patient’s and/or family’s involvement in educational or support groups around the disease and/or dying
• Psychosocial status-social history, coping skills, family relationships, availability, and openness to use additional resources
• Caregiver options allowing adequate respite

Answers to the assessment process become the starting point for professionals within the system to deliver quality, established standards of care and performance. These individuals are required (the flip side of the guidelines) to be educated and proficient in the following areas:

• Concepts of death and dying
• Communication skills with dying patients and families
• Handling and helping with death in the home
• Psychosocial and spiritual issues related to death and dying
• Grief and bereavement
• Stress management for staff individuals involved in care of dying patients

Continuing education for death care systems professionals (classes, workshops, seminars) is often available through community colleges, colleges, and universities and their extension systems, most often through their departments of psychology, mortuary science, social work, and sociology. Departments of religious studies as well as seminaries may also offer educational opportunities for professionals in service to the dying and their families.

Professional associations and their local chapters (e.g., National Association of Social Workers, National Funeral Directors Association, and National Hospice Organization) are another source for standards, guidelines, and opportunities for ongoing professional learning (see Figure below).
Steps for individuals in service provider systems. The goal of professional service can be reached by completing the objectives in each step. (Dr. John D. Canine and Therese McNeil, Maximum Living Consultants, Inc., Birmingham, 1995)

To summarize, the most important point for any death care systems worker or professional to remember is to respect the dying patient. Therese Rando, in her book Grief Dying, and Death (1984), outlines principles that underlie all standards for dealing with the terminally ill:

- These patients require highly competent professionals, skilled in terminal care.
- Pain should be controlled in all its respects. The patient should be kept as pain-free as possible, while remaining as alert and comfortable as possible.
- Staff must recognize that other services may need to be involved but that continuity of care should be provided whenever possible.
- The terminally ill patient’s own framework of values, preferences, and outlook on life must be taken into account in planning and conducting treatment.
- The patient’s wishes for information about his or her condition should be respected; the patient should be allowed full participation in the care and a continuing sense of self-determination and self-control.
- The patient should have a sense of security and protection; involvement of family and friends should be encouraged.
- Twenty-four-hour care must be made available seven days a week for the patient and family, when and where it is needed. (Pp. 294-95)

THE FUNERAL FIRM AS PART OF SYSTEM COORDINATION

Unquestionably, the funeral firm (home) and its staff have a major role to play in death plans for the terminally ill. The efficacy and success of the funeral home’s involvement depend heavily on the commitment of the staff to develop and sustain a strong rapport with other related systems in the community and its internal continuing education mandate to stay abreast of changes and expansion in quality services available to dying patients and their families (see Figure below).

Funeral firm networking to provide quality service. When the funeral home maintains communication with other systems, the home’s service to the patient can improve. The ability to share information among staff within the funeral home allows for consistent service by all staff members. (Dr. John D. Canine and Therese McNeil, Maximum Living Consultants, Inc., Birmingham, 1995)
Funeral firms must develop a strategy for their services. The first component of such a strategy should be determining exactly what the firm can and cannot do for a dying patient. Funeral home administrators and managers should ask themselves the following questions regarding their operation and services, in terms of both clients and employees:

- Who in the firm is responsible for establishing and monitoring the firm’s procedures and policies?
- Are all staff members familiar with the firm’s services, guidelines, and procedures?
- Does the firm have procedures in place for making prearrangements for a dying person?
- As changes occur within the firm’s procedures, policies, guidelines, or scope of services, are dying clients and their families informed, so as to make any necessary adjustments in the death plan?
- When changes are made in a death plan, can the firm adapt smoothly?
- Does the funeral firm provide opportunities and information for its staff regarding continuing education in working with dying people and their families?

A second component of a funeral firm’s overall strategic planning involves dissemination of information and communication with other systems that support dying patients. Funeral firms need to identify the full spectrum of organizations and institutions within the geographic area they serve and determine the “messages” (and image) they wish to convey, along with appropriate methods for that communication.

**SEGMENT SUMMARY**

Various individuals, resources, and organizations need to become involved in the dying process of a patient. A system coordination approach to the dying process can make the dying and death as personal, comfortable, rational, satisfying, and accurate as possible for the individual. Each system, of course, has its own objectives, points of view, feelings, and concerns. Thus, the development of a death plan that will coordinate the efforts of all the necessary constituents can be an important step in caring for the dying patient.

A death plan is a commitment made by all systems to follow through on agreed-upon actions that support the dying patient. It is vital that all systems are in agreement with new information, compromising, and remaining accountable to the patient and to the other systems involved. The single, most critical task to achieving the goals of the plan is communication. Consistent communication among the systems promotes a deeper and current understanding of the patient’s needs. It is preferable that the patient direct the plan. However, if necessary, the patient should be the one to designate a representative to serve in this capacity. The designated representative must see to it that all systems are sharing information so they can function according to the plan agreements.
Any professional system requires continuing education to meet the needs of its clientele. The constant updating of knowledge, information, and techniques based on new research and/or peer learning is extremely valuable in servicing the dying patient. However, the most important point for any death care systems worker is to respect the dying patient. Principles are provided in this course for death care professionals to follow when dealing with the terminally ill.

REFERENCES


SEGMENT 6: LEGAL IMPLICATIONS FOR THE DYING PATIENT AND THE FAMILY

COURSE OUTLINE:

1. Disposition of Personal Property
   a. Probate
   b. The Will
   c. Trusts
   d. Death Taxes
2. Disposal of the Body
   a. What to Do with the Body
   b. Anatomical Donations
   c. Health Regulations
   d. Federal Trade Commission
3. The Right to Die
   a. Kevorkian
   b. In Michigan, Whom Should I Appoint as My Patient Advocate?
c. How Do I Make My Michigan Designation of Patient Advocate for Health Care Legal? Should I Add Personal Instructions to My Michigan Designation of Patient Advocate for Health Care?
d. In Michigan, What If I Change My Mind?
e. What Other Important Facts Should I Know?
f. In Michigan, How Do I Make My Living Will Legal?
g. Can I Add Personal Instructions to My Living Will?
h. What If I Want to Revoke My Living Will?
i. What Do I Do After I Have Completed My Document?

4. Summary

SEGMENT OBJECTIVES

Upon the completion of this segment of the course, you will be able to:

1. Outline the disposition of the personal property of the deceased.
2. Review health regulations that govern body disposal.
3. Highlight the Right to die research studies and their role in the preparation of wills.

NARRATIVE SUMMARY

As we go through life we assimilate personal property. At the time of death this personal property becomes the "estate". While most people are somewhat hesitant to confront the details of their deaths, they have a general idea of how they want their personal property distributed. However, the only way to be sure that family and friends will be financially and physically cared for is to distribute the estate according to the law. Arranging for the transfer of ownership of all of the deceased's personal property is a complex task in most cases. It should be undertaken with the assistance of an attorney and should be discussed long before the individual dies. It should also be pointed out that the disposition of a person's body is also regulated by law and varies from state to state. Therefore, where a person lives at the time of death controls the disposition of both personal property and the body. Thus, state laws have an impact on the family's planning, as does federal law, which is applied nationwide.

The purpose of this segment of the course is to acquaint the reader with the laws regarding disposition of personal property, the legal disposal of the body, and right — to — die issues. The reader should review the exact laws from his or her state, and any estate planning should be periodically reviewed and updated because of changes in the law.
DISPOSITION OF PERSONAL PROPERTY

PROBATE

The word "probate" comes from the Latin for "to prove." It refers to the court proceedings required to settle on the estate. A probate estate includes any property held in the deceased’s name, which means joint assets are not included. When all assets were joint or plans were made for all assets to be distributed outside the will, an estate does not require settlement by the probate process. On the other hand, some of the estates settled through probate are quite complex and time-consuming. Under the supervision of the courts, the administration of the estate is handled by the deceased’s personal representative. He or she is called either the executor or, if appointed by the court, the administrator. Usually the representative has thirty days to file the will with the court following the death. Once the court recognizes the will and the representative, it authorizes the management and transfer functions by the executor on behalf of the estate. The executor is responsible for taking an inventory of the estate, connecting assets, paying all debts and claims against the estate, paying taxes, arranging for the preparation of documents, distributing property to those who are entitled to it, and eventually closing the estate. In most states the executor will publish notices that all creditors who have claims against the estate must file them within a four-to-six-month period. When that period expires, no further claims against the estate can be considered. The entire probate process can take anywhere from six to twenty-four months and, in some cases, longer (Dukeminier and Johanson 1983).

THE WILL

A person who writes a will is called a "testator". A will must be probated to be effective, and is considered the normal and legal manner in which one transfers personal property following death. In many states it is a crime to withhold a will. If a person has not prepared a valid will, he has died intestate. Sheryl Scheible explains in Dying: Facing the Facts (1988):

Intestacy statutes are drafted and enacted by a state’s legislators based on their assumptions of how a typical person would want his or her property distributed.

The details of these statutes vary considerably between states, but general patterns of heirship exist. A surviving spouse and children are preferred heirs. If a child of a decedent has predeceased his or her parent, that child’s children or other descendants take the decedent’s child’s share as representatives of their parents. In the absence of descendants, some states allow a surviving spouse to take the entire estate, while others apportion the estate between the spouse and the decedent's parents, if living. When a person dies leaving no surviving descendants or spouse, the property passes to the descendant’s ancestor and descendants of those ancestors.
Except for a surviving spouse, only parties related to a descendant through bloodlines or by legal adoption are considered heirs; persons related by marriage, such as in-laws, or by informal relationships, such as cohabitants, foster children or friends, are excluded from intestacy statutes. The statutes often prohibit inheritance by persons only distantly related to a decedent. When an intestate person leaves no one who qualifies as an heir under the state's intestacy statute, the estate "escheats" or passes to the state. (Pp. 302-303)

Basically, Scheible’s point is, if you don’t write a will, the state will write one for you. And if you don’t have a preference in terms of transferring personal property, the state will keep your property! The following are some facts concerning wills:

1. Any adult of "sound mind" is permitted to dispose of his or her personal property (estate) by will.
2. If the testator is influenced by another party to the extent the will does not represent his or her true intentions, it can be invalid.
3. A legal and formal will must be witnessed by at least two people.
4. Most states will recognize handwritten wills ("holographic"), but this is extremely risky and should not be encouraged.
5. A will is regarded as “ambulatory”-meaning it can be changed at any time prior to the testator’s death. (Scheible 1988)

### TRUSTS

A trust is a means by which an individual can share assets (primarily financial) with others without making an outright gift. For example, moneys can be placed in a fund by a third party, such as a bank, trust company, or individual experienced in managing and investing property, and the income and capital of that trust are distributed to the beneficiary in accordance with the guidelines established by the benefactor. The two most often stated reasons for a trust are (1) the assurance that funds will not be mismanaged by a relative and (2) the assurance that the money will be used for an exact purpose (e.g., college education).

The trust can be formal, managed and operative while the benefactor ("trustor") is still in good health. In fact, the trustor has a great deal of control over the distribution of funds both before and after death. If the trust is established after the trustor’s death according to the instructions of the will, it is called a testamentary trust.

Flexibility is one of the major advantages of trusts. A testator might design a trust virtually any way he or she wishes. For instance, in providing for minor children, the trust might be set up as a single fund for all the children, or in separate shares. In a single-fund trust, the trustee is directed to provide for the needs of all children until the youngest child reaches twenty-one (or whatever age the parents determine). Although the youngest child did not have the benefit of the parents’ love and encouragement as many years as the older siblings, at least their financial support will be available until the child reaches the specified age. Following the parents’ death, a separate share trust can give older siblings a larger share than would be theirs under a single-fund arrangement.
However, this is not always fair to the younger siblings. There still might be restrictions regarding disbursing of income, and eventually perhaps the principal of the trust at designated ages or life events such as marriage, birth of a child, purchase of a home, or graduation from college.

Money from the trust might come from the existing estate or a life insurance policy. Trusts usually are managed by a trust company or trust department of a financial institution, taking only a small percentage of the money for making the investments. The trustor can name anyone as trustee, himself included as long as he is alive. He can name successor trustees upon his death or the death of the original trustee.

Trusts are versatile and efficient and, if handled properly, can be a considerable tax savings. There are many trust options when planning an estate (Vail 1982).

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**DEATH TAXES**

There are two basic types of taxes following a death: estate tax and inheritance tax. The purpose of these taxes is to generate revenue for the government and to restrict inheritance of great amounts of wealth. An estate tax is levied on the decedent’s estate and paid by the executor from the estate before any assets are transferred to beneficiaries. On the other hand, an inheritance tax is imposed on individuals who receive property through inheritance.

The federal estate tax is based on the total assets of the estate minus the debts and deductions (spouse, children under twenty-one years of age, and charities). As of 1987, only estates valued at six thousand dollars and above are subject to the federal estate tax. It should be noted that the marital deduction applies if the decedent is survived by a spouse. Using it, one spouse can transfer an unlimited amount of property tax-free to the widowed partner.

Although a beneficiary does not have to pay federal income tax on gifts, most states will tax them either instead of or in addition to an estate tax. If an individual receives property that is taxed by the state, usually the tax is paid by the executor from the estate. Then it is deducted from the beneficiary's share. As one can see, estate planning is extremely complex, and professional estate planners should be consulted to minimize estate losses due to federal and state taxes (Scheible 1988).

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**DISPOSAL OF THE BODY**

The disposal of the body following a death is a matter of social custom. Within American culture there is much similarity among individuals in the funeralization process. However, other countries and cultures watch in amazement as we select elaborate and expensive caskets, embalm and dress up our dead for display, and finally inter them in magnificent stainless steel and concrete underground vaults in a gardenlike cemetery. Some legal restrictions on disposal of the body are designed to protect the public health and safety. The law further tries to protect survivors from unfair funeral practices in the purchasing of goods and services relating to the funeral, burial, or some other disposition of the body. On the other hand, it is apparent that the law is either silent or
uncertain in many areas of rights and duties in the disposition of the body and the entire funeralization process. The following discussion is intended to acquaint the reader with the way our culture treats its dead.

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WHAT TO DO WITH THE BODY
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Like all other legal rights, the control of one's body ends at death. Therefore, any requests a person might have expressed during his or her life about the death, funeral, burial, or cremation, either orally or written might be considered but are not legally binding. After a death occurs, the right to arrange the funeral and plan for the disposal of the body is granted to the nearest relative, next of kin, a household member, or, in some cases, the executor of the estate. When there is a conflict over the intentions of the deceased or who should arrange for the disposal of the body, the courts have tried to intervene. However, case law in this area is very inconsistent and state statutes are inadequate.

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ANATOMICAL DONATIONS
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Since gifts of anatomical parts at death are a source of life to transplant patients, our society in general has taken kindly to those who choose to donate their bodies, in part or in whole, for legitimate medical purposes. The Uniform Anatomical Gift Act (1983) permits a person's request to donate an organ (or body) to be honored without the consent of the surviving family. The act also allows the following:

1. Any adult can donate an entire body or specific organ to any hospital, physician, medical school, or dental school.
2. The donation can be used for medical education, research, therapy, or transplant purposes.
3. The gift can be made in "general" or to a specific individual.
4. When an individual has not executed a donor card or the card cannot be found at death, family members can consent to an anatomical gift.
5. After the donation has been made, the body can be returned to the family for disposal or cremated (except for body donations).

The Uniform Anatomical Gift Act encourages states to have a short and simple form that can be included in the will. Some forms are so short they can be included on the back of a driver's license or senior citizen's card. Two witnesses are required, and the donor must be competent at the time the instrument is executed.

While the act has had some effect on increasing the number of organs available for transplant, many potential donors are still undiscovered. The demand for organs greatly surpasses the supply. It is currently illegal in all states to routinely remove organs without the consent of the donor or the survivors. Furthermore, if certain organs have been donated, it is illegal to remove other body parts.
There are still many issues—medically, ethically, and legally—to be worked out concerning anatomical gifts. However, at the present time in American culture, donation of a body and body parts is not only accepted but also appreciated.

**HEALTH REGULATIONS**

Most states have health restrictions concerning the disposal of a body. These regulations protect both the survivors and the general public. The following are some of the most common regulations:

- To control sanitation and prevent the spread of contagious or infectious disease, the location and operation of a funeral home are subject to certain restrictions.
- If the body is not disposed of within a certain amount of time, embalming is mandated.
- A burial permit might be required by a state or local health board.
- Local zoning laws might restrict the site in a cemetery.
- Some states have laws regulating the transportation of a body.
- Some states prohibit the scattering of crematory ashes.
- Most states have laws regulating the exhuming of a body. A body might be dis-interred by a court order in a criminal case, or less frequently, in civil cases such as a suit brought on an insurance claim. (Scheible 1988)

**FEDERAL COMMISSION**

Because individuals in the funeral service business work so closely with the general public, all states have regulations pertaining to the education, training, and licensing of funeral directors and embalmers. State agencies supervise sanitation, professional conduct, and advertising and business practices of the funeral profession. The funeral industry provides merchandise and service to over two million American families a year at an average cost of over $2,400.00. Since many individuals are emotionally distraught at the time of making funeral arrangements, and must make decisions on the purchase of expensive funeral items, federal regulations provide protection from deceptive funeral business practices (Roybol 1984).

The Bureau of Consumer Protection of the Federal Trade Commission began investigating the funeral industry in the early 1970s. As a result of this investigation, federal restrictions known as the "funeral rule" were enacted in 1984. As Scheible states:

The rule requires full disclosure of costs related to funeral goods and services and requires the sale of individual items as an alternative to a complete package. Alternative prices of types of caskets and outer burial containers must be revealed, and the requirements imposed by both the law and the selected cemetery with regard to specific goods must be disclosed. Funeral providers may not make claims that expensive products are necessary for cremation. The provider must inform the consumer when embalming is not required by law and must make no inaccurate claims regarding any preservative effect of particular items. (1985, p. 317)
All funeral service items must be itemized with cost disclosure. By providing the consumer with full information regarding funeral services, the funeral professional is enhancing a more educated choice by the consumer as well as projecting a more positive business image in the community.

THE RIGHT TO DIE

Over the last few years there has been much social dialogue on the subject of euthanasia. Euthanasia, meaning "good" death, is taken from the Greek words for easy (m as in euphoria) and death (Thanutos, the Greek god for death). In the past, if an individual did not die in an accident or commit suicide, then the death was considered "natural." However, with the ambiguity that advanced medical technology brings to prolonging life, and the lack of a clear definition of when death occurs, the public is confused as to what constitutes death with “unnatural interference.” The purpose of this section is not to resolve the ongoing debate over the right to die but rather give the reader some thoughts on preserving life, preventing suicide, assuring the integrity of the medical profession, and protecting the patient’s family members.

Many states have enacted "death-with-dignity" or "right to die" legislation.

These laws legitimize an individual's desire to decline life-prolonging treatment when death is imminent. The expression of this desire occurs through a document referred to as a "living will." Many organizations (e.g., Concern for Dying Education Council, Society for the Right to Die, Choice in Dying) have drafted living wills to disseminate to the general public. However, without state law, these wills are not legally binding, but still might offer some assurance that family and physician will honor a formalized stated intent. "Right-to-die" statutes vary from state to state; answers to the following questions will vary according to your state legislation.

1. Does the patient have to be terminally ill before executing a living will?
2. How many witnesses does the living will require, and do the witnesses have to be someone other than family and medical team?
3. Is the living will revocable?
4. Does the living will have a time limit?
5. What happens to the physician or medical team if they fail to comply?
6. What happens to patients who are comatose, incompetent, or of minor age?
7. What happens if the patient is a pregnant woman?

By 1986 many states had adopted the Uniform Determination of Death Act, which declares that an individual can be pronounced dead ".... Who has sustained either: (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem. A determination of death is to be made in accordance with acceptable medical standards." Since this definition of death is highly scientific and medical, it is open to debate by other nonmedical professionals, specifically the clergy, who believe in "miracles." Nevertheless, it is a beginning, and it does offer some protection as well as guidance for patient, physician, and family members.
The “right-to-die” issue has reached a pinnacle with the question of “physician assisted suicide.” According to Denzian (1992), on an average 5,800 Americans die each day. Over 75 percent of these deaths are timed or negotiated. Some hospitals will ask terminally ill patients if they have a death plan. Medicine, assisted suicide, planned death, and the new medical humanism are present everywhere in our culture. To some, a self-managed death is the only recourse against the impersonal and inhumane medical establishment. Life at any cost is no longer desirable. People are seeking a less expensive way to die, especially when the last days of life in an intensive care unit can cost in excess of one hundred thousand dollars. This is where Dr. Jack Kevorkian, a retired physician from Michigan, enters the scene.

KEVORKIAN

To Dr. Kevorkian, “positive” death is rooted in a new medical humanism that would allow a patient and family to determine death. The benefits are less suffering for the patient, less psychological and emotional pain for the family, and a savings in resources that would have been spent on prolonged care. However, these benefits do not counterbalance the loss of life. Hence, Kevorkian adds another benefit—the dying patient can time his death so that donated organs can save the life of another. Even after death occurs the individual (dying patient) can make a contribution to medicine, science, and the society of humankind.

Kevorkian makes a distinction between negative and positive death. Negative death is that which offers no benefit to science or medicine. Those would include “obligatory” (death row), “assisted” (euthanasia), and “optional suicide” (mental illness) types of death. To him, negative death is a loss without meaning or positive social consequences. On the other hand, positive death is merciful to the patient and a process that gives something of value to the “suffering humanity left behind”.

In his book Prescription: Medicine-The Goodness of Planned Death, (1991), Kevorkian expands his theory of positive death. Some of the highlights of his theory are as follows:

- An orbitoria would be a suicide center centrally located, organized, and well controlled so that merciful dignified death could occur.
- Following a death at an orbitoria, ethical and experimental manipulations on the body would occur.
- The doctoring of death to achieve some sort of beneficial result is called obituary. Thus, a new medical practitioner would be born to administer obituary.
- Mercitron is the machine that will be used to bring merciful death to the patient.
- Every community would have a five-member group of medicine specialists who would make final decisions on who should be connected to the mercitron. All members of the group must agree before death can occur.
Obviously, Kevorkian’s theory of medicine needs to be further developed before a reluctant and skeptical society accepts it. However, he has brought a great deal of attention and thought to the issues of death with dignity and the right to die. Listed in the following are some definitions of terms that are generally accepted in the medical profession concerning the subject of merciful death. (Note: Dr. Jack Kevorkian’s terms of medicide are not listed because they are not to date generally accepted by the medical profession.)

- **Mercy killing** — a deliberate and empathic act to end the life of a person who is suffering terribly from an illness or condition that will probably end life soon anyway.
- **Euthanasia**: A decision not to interfere with the inevitable death process.
- **Antidysthanasia**: “Dyes” means difficult or painful. Therefore, antidysthanasia means against a difficult or painful death.
- **Active Euthanasia**: Taking a decisive measure that will lead to early termination of the life of a patient already close to death.
- **Passive euthanasia**: Failure to begin or continue treatment that would prolong the life of a terminally ill person.
- **Direct and positive euthanasia** — a deliberate act to shorten a life, such as injection of a large volume of air directly into the bloodstream.
- **Indirect and negative Euthanasia**: Allowing death to occur unimpeded by medical intervention.
- **Voluntary euthanasia**: The patient consents to, or even requests and cooperates in, bringing his or her life to an early death.
- **Involuntary Euthanasia**: Shortening a patient’s life for reasons of mercy without his or her consent.

The following questions are often asked by patients and their families. The responses are consistent with the law in the State of Michigan, and were prepared by the national organization Choice in Dying, Inc. (Choice in Dying 1994). Other states must be contacted regarding their laws, which do not necessarily match those in Michigan.

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**IN MICHIGAN, WHO SHOULDN’T I APPOINT AS MY PATIENT ADVOCATE?**

Your patient advocate is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your patient advocate may be a family member or a close friend whom you trust to make these serious decisions. The person you name as your patient advocate must be an adult who clearly understands your wishes and is willing to accept the responsibility of making medical decisions for you. (A patient advocate may also be called an "attorney-in-fact," "agent," or "proxy".)

You can also appoint a second person as your alternate patient advocate. The alternate will step in if the first person you name as patient advocate is unable, un-willing, or unavailable to act for you.
HOW DO I MAKE MY MICHIGAN DESIGNATION OF PATIENT ADVOCATE FOR HEALTH CARE LEGAL?

The law requires that you sign your designation in the presence of two witnesses, who also sign the document to show that you voluntarily signed the designation in their presence and that you appear to be of sound mind and under no duress, fraud, or undue influence. These witnesses cannot be any of the following:

- Your spouse, parent, child, grandchild, or sibling
- A person who stands to inherit from your estate, either by law or through a will
- A physician or patient advocate
- An employee of your life or health insurance provider
- An employee of your treating health care facility
- An employee of a home for the aged, if you are a patient in that facility

SHOULD I ADD PERSONAL INSTRUCTIONS TO MY MICHIGAN DESIGNATION OF PATIENT ADVOCATE FOR HEALTH CARE?

The answer to this question is no. Although space is provided where you may list limitations on your patient advocate’s authority, Choice in Dying advises you not to restrict your patient advocate’s authority. One of the strongest reasons for naming a patient advocate is to have someone who can respond flexibly as your medical situation changes, and can deal with situations that you did not foresee. If you add limitations to this document, you might unintentionally restrict your patient advocate’s power to act in your best interests. Instead, we urge you to talk with your patient advocate about your future medical care, and to describe what you consider to be an acceptable quality of life. If you want to record your wishes about specific treatments or conditions, you should use your Choice in Dying Living Will.

IN MICHIGAN, WHAT IF I CHANGE MY MIND?

In Michigan, you may revoke your designation at any time and in any manner, regardless of your ability to make medical decisions. If your revocation is not in writing, you are required to have a witness to your revocation who must sign a written description of the revocation and, if possible, notify your patient advocate. Your designation is automatically revoked under any of the following circumstances:

- Your death occurs.
- Your patient advocate resigns or is removed by a probate court for failing to act in your best interest (unless you have appointed an alternate).
- You execute a subsequent designation.
- You have explicitly made a provision for revocation in your document.
- You name your spouse as your patient advocate and your marriage ends (unless you have appointed an alternate).

What Other Important Facts Should I Know?
IN MICHIGAN, HOW DO I MAKE MY LIVING WILL LEGAL?

Because Michigan does not have a statute governing the use of living wills, there are no specific requirements to make your Choice in Dying living will legal. Choice in Dying recommends that you sign your living will in the presence of two adult witnesses. Your witnesses should not be any of the following:

- Related to you by blood or marriage
- Beneficiaries of your estate
- Your health care provider or an employee of your health care provider
- Your health care agent or proxy

CAN I ADD PERSONAL INSTRUCTIONS TO MY LIVING WILL?

Yes. In Michigan, you can add personal instructions in the part of the document called "Other directions." For example, if there are any specific forms of treatment that you wish to refuse that are not already listed on the document, you may list them here. Also, you can add instructions such as "I do not want to be placed in a nursing home," or "I want to die at home." If you have appointed a patient advocate, it is a good idea to write a statement such as "Any questions about how to interpret or when to apply my declaration are to be decided by my agent."

WHAT IF I WANT TO REVOKE MY LIVING WILL?

You may revoke your living will in Michigan at any time by doing any of the following:

- Executing a new living will
- Tearing, burning, or otherwise destroying your document
- Notifying your doctor orally or in writing of your intent to revoke your document

• In Michigan, other important facts include the following:
• Due to restrictions in the Michigan state law, a patient advocate does not have the authority to decide to withhold or withdraw life support from a pregnant patient.
• Your patient advocate and alternate (if any) must receive a copy of your document and must date and sign an acceptance to the designation before he or she makes medical decisions on your behalf.
• If you have religious convictions that prohibit you from being examined by a physician, you can add instructions to your designation stating that you do not wish to be examined by a physician. You must state in your designation how it shall be determined when your patient advocate has authority to make decisions on your behalf.

• In Michigan, how do I make my living will legal?
• Because Michigan does not have a statute governing the use of living wills, there are no specific requirements to make your Choice in Dying living will legal. Choice in Dying recommends that you sign your living will in the presence of two adult witnesses. Your witnesses should not be any of the following:
  • Related to you by blood or marriage
  • Beneficiaries of your estate
  • Your health care provider or an employee of your health care provider
  • Your health care agent or proxy

• Can I add personal instructions to my living will?
• Yes. In Michigan, you can add personal instructions in the part of the document called "Other directions." For example, if there are any specific forms of treatment that you wish to refuse that are not already listed on the document, you may list them here. Also, you can add instructions such as "I do not want to be placed in a nursing home," or "I want to die at home." If you have appointed a patient advocate, it is a good idea to write a statement such as "Any questions about how to interpret or when to apply my declaration are to be decided by my agent."

• What if I want to revoke my living will?
• You may revoke your living will in Michigan at any time by doing any of the following:
  • Executing a new living will
  • Tearing, burning, or otherwise destroying your document
  • Notifying your doctor orally or in writing of your intent to revoke your document
WHAT DO I DO AFTER I HAVE COMPLETED MY DOCUMENTS?

1. Your Michigan Designation of Patient Advocate for Health Care and Choice in Dying Living Will are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original forms in a safe-deposit box or any other security box that would keep others from having access to them.

2. Give photocopies of the signed originals to your patient advocate and alternate patient advocate, to your doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.

3. Be sure to talk to your patient advocate (and alternate), your doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.

5. Remember, you can always revoke your Michigan Designation of Patient Advocate for Health Care or your Choice in Dying Living Will.

The moral, ethical, and medical questions that are raised from the right-to-die issue go far beyond the scope of this course. There are no easy answers. The concerned student can only continue to try to understand. As Arthur Zucker states: “To seek a clear and easy answer is only to ensure a dissatisfaction which is more likely to lead one astray than is the tortuous path to legitimate understanding” (1988, p. 343).

SEGMENT SUMMARY

Upon death, our personal property becomes the “estate.” Laws governing estate planning, including probate (court proceedings required to settle an estate), wills, trusts, and taxes, vary from state to state. It is important to review and understand the exact laws in your state.

The disposal of the body following a death is a matter of social custom. The American way is called a funeral. Funerals incorporate body preparation, viewing, caskets, vaults, and burial or cremation. In 1983 the Uniform Anatomical Gift Act was passed; it permits an individual to donate an organ or body for legitimate medical purposes. There are also state laws regulating the disposal of the body. Most states control the location of a funeral home, embalming, site of burial, transportation of a body, cremation and ashes, exhuming, and location of the cemetery. In 1984 the federal government passed funeral industry restrictions known as the “funeral rule.”

Right — to — die issues have raised many moral, ethical, and medical questions concerning euthanasia. With the 1980 Uniform Determination of Death Act, the federal government took a step toward defining death. Although open to debate, the act does offer protection and guidance for a patient, physician, and family members. Jack Kevorkian has kept the right — to — die debate very much “alive” with his emphasis on physician-assisted suicide, or what he calls “positive” death.
However, the debate is far from over, and currently American society has no clear definition as to a patient’s right to die.

REFERENCES

Click Here To Take Test Now

(Complete the Reading Material first then click on the Take Test Now Button to start the test. Test is at the bottom of this page)

3 HR. PSYCHOLOGICAL ASPECTS OF DEATH AND DYING QUIZ (TRUE/FALSE QUESTIONNAIRE)

PART 1: DEATH AWARENESS AND ANXIETY

1. The fear of death has many real components and is shaped by an individual’s age, intellect, health, family history, psychological state, and religious background.

2. Because the timing and nature of one’s death are unknown, human beings recognize that, unless they die suddenly, they run the risk of dying over some greater or lesser amount of time.

3. Historically, the Christian faith has taught that, in the “end,” the forces of good and evil fight to claim the immortal soul, and such separation of the soul from the body involves pain.

4. “Death anxiety” is a term used to conceptualize the apprehension generated by death awareness (Abdel-Khalek, 2005).

5. Used in only 4 percent of the studies published since its development by Hoelter in 1977, the Hoelter Multidimensional Fear of Death Scale (MFODS) features eight independent subscales, each containing six items on which respondents indicate the extent of their agreement.
PART 2: CULTURAL ATTITUDES TOWARD DEATH

1. Shakespeare expressed a powerful death-accepting philosophy in Henry V when he wrote, "We owe God a death."

2. Ultimately, sensitivity to cultural variances offers the funeral professional an opportunity to provide the best service possible.

3. There are two overriding values at the heart of the Jewish tradition in regard to death. One is kavod hamet, the requirement to "honor the dead"; the second is nichum avelim, the obligation to comfort the mourners.

4. No matter how particular customs have changed or evolved over time (either through the influence of other cultures or through increased urbanization), mourning customs among blacks are seen as a means of strengthening the community.

5. Mexican-Americans see grief as both an emotional and a physical process. Females exemplify the emotional and males the physical symptoms of grief.

PART 3: PROCESSING THE DEATH OF A LOVED ONE THROUGH LIFE’S TRANSITIONS

1. It was Marie Nagy’s well-known research regarding a child's gradual development of death concepts that first suggested three levels of awareness for children.

2. Although Piaget had little to say about death, his developmental theory seems to suggest that a child would have to be older than nine or ten years to cognitively grasp the personal finality of death.

3. Canine and Dates’ research seems to support Nagy's and Piaget's findings that children struggle with personalizing death and seeing it as final.

4. Adolescents formulate abstract ideas about the nature of death. For example, adolescents describe death as darkness, light, transition, or nothingness.

5. Due to advances in science, medicine, and geriatric health care, the number of "elders" in our society will continue to increase.
PART 4: THE PSYCHOLOGY OF DYING

1. According to Dr. Kubler-Ross’s book on Death and Dying, when we learn that we have little time left on earth, we respond in a series of emotional reactions that eventually lead us to acceptance. These reactions are as follows.

2. When people discover they are dying from a terminal illness or condition, often their initial response is to deny the inevitable event in order to cope with the shock of finality.

3. Striking out at family members, doctors, and nurses is a typical reaction. In fact, anyone who approaches the dying person might feel the hostility the patient is experiencing.

4. Over time, people reach a stage at which they try to strike bargains with death. They begin to accept the inevitable and start looking to “extend the lease.”

5. Lofland’s term “population” refers to the question of whether the patient chooses to play out the dying role alone or in the company of others who are dying also.

PART 5: SYSTEM COORDINATION APPROACH FOR THE DYING PATIENT

1. A “system,” by definition, is a group of elements that interact and function together as a whole.

2. A death plan, quite simply, is a commitment made by all systems to follow through on agreed-upon actions that support the dying patient.

3. What is important about the death plan from a systems perspective is that it must clearly express the roles and responsibilities of each system and how they will interrelate on behalf of the patient.

4. Without this constant sharing of information, families of dying patients and the professional systems who interact with them may encounter situations that create frustration, confusion, embarrassment, or open conflict-taking away focus and energy that are better spent on the dying patient.

5. Regardless of who takes on the job, communication is still the essential task of the death plan.
PART 6: LEGAL IMPLICATIONS FOR THE DYING PATIENT AND THE FAMILY

1. The word "probate" comes from the Latin for "to prove." It refers to the court proceedings required to settle on the estate.

2. The executor is responsible for taking an inventory of the estate, connecting assets, paying all debts and claims against the estate, paying taxes, arranging for the preparation of documents, distributing property to those who are entitled to it, and eventually closing the estate.

3. A person who writes a will is called a "testator".

4. Except for a surviving spouse, only parties related to a descendant through bloodlines or by legal adoption are considered heirs; persons related by marriage, such as in-laws, or by informal relationships, such as cohabitants, foster children or friends, are excluded from intestacy statutes.

5. Upon death, our personal property becomes the “estate.”