To one as young as you, I'm sure it seems incredible, but to Nicolas and Perenelle, it really is like going to bed after a very, very long day. After all, to the well-organized mind, death is but the next great adventure.

ALBUS DUMBLEDORE, IN *HARRY POTTER AND THE SORCERER'S STONE*

The Role of Death in Life

Prior to the 20th century, people were used to seeing death. It was considered a typical part of life. Before the industrial revolution transformed the way people lived in Western societies, one third of all children died within their first year and half died before their 10th birthday. The institution of seemingly simple innovations, such as clean drinking water and organized waste disposal, along with improvements in health care, contributed to a rise in living standards and fall in death rates. Interestingly, over the past 100 years, deaths from some causes (such as tuberculosis, influenza) have declined significantly, while deaths from other causes (for example, cancer) have increased (see Table 12.1).

It remains the case, however, that in modern Western societies, death comes mostly to the elderly. This has been especially true in recent years, as seen in the trend of death rates for men and women over 85 declining by 3.9% for men and 4.1% for women (CDC, 2006c). In the United States, the **mortality rate** has declined from 17 per 1,000 people in 1900 to 8 per 1,000 in 2004 (Minino et al., 2006). The average life expectancy has been reported at an all-time high of nearly 78 years. Overall, a family may expect to live 20 years (on the average) without one of its members dying (see Figure 12.1).

mortality rate The number of deaths in a population for a given year; typically, number of deaths per 1,000 people per year.

As death rates fell over the past century, and death became less a part of life, ironically, the subject of death seemed to become more and more taboo. Avoidance of death, even discussion of death, has become entrenched in the dominant U.S. culture. As a result, social scientists spent little time studying the role of death in life. Fortunately, in recent decades, this has begun to change, and death has become a more approachable subject of both research and public discourse, including media attention. Research and theory from the social and physical sciences tend to focus on three major concerns: What is death? How do we deal with the death of others? How do we deal with our own death?

WHAT IS DEATH?

Establishing when people are truly and finally dead has been a medical, and therefore social, problem for centuries. Fear of being prematurely buried alive has been one of humankind's oldest fears. The fear was so strong in the 19th century that in 1882 a patent was granted for a life signal called "Fearnaught," a warning flag device that

TABLE 12.1

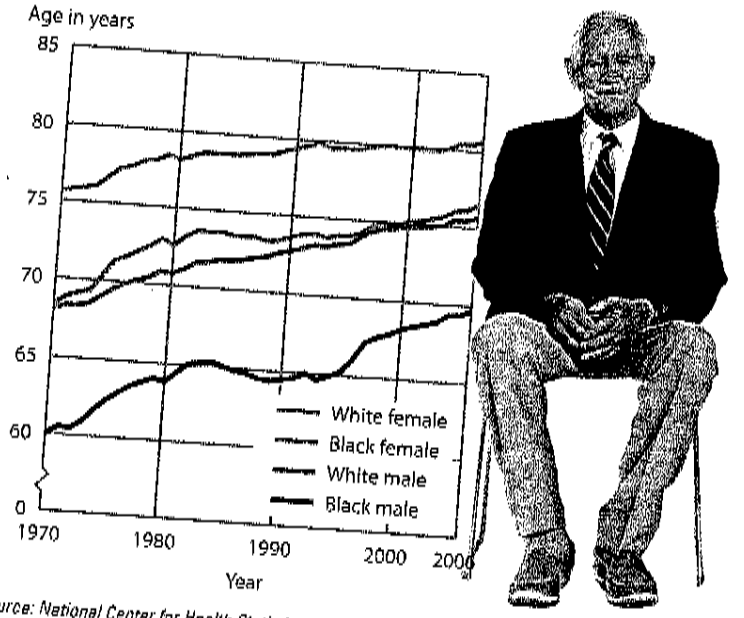
Death Rates by Cause of Death, 1900–2005 (per 100,000 population)

Year	Tuberculosis, all forms	Malignant neoplasms (cancer)	Major cardiovascular diseases	Influenza and pneumonia	Motor vehicle accidents
1900	194.4	64.0	345.2	202.2	N.A.
1920	113.1	83.4	364.9	207.3	10.3
1940	45.9	120.3	485.7	70.3	26.2
1960	6.1	149.2	521.8	37.3	21.3
1980	0.9	183.9	436.4	24.1	23.5
2005	0.2	188.7	288.8	21.3	15.3

Source: 1900–1970, U.S. Public Health Service, Vital Statistics of the United States, *annual, Vol. I and Vol. II; 1971–2001, U.S. National Center for Health Statistics,* Vital Statistics of the United States, *annual;* National Vital Statistics Report (NVSR) *(formerly* Monthly Vital Statistics Report*); and unpublished data.*

FIGURE 12.1

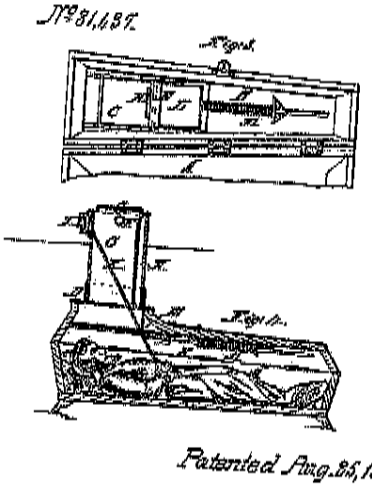
Average Life Expectancy by Current Age Group



Source: National Center for Health Statistics, 2005.

FIGURE 12.2

"Fearnaught" Device



Fear of being buried alive motivated the invention of this casket device. A rope placed in the hands of the coffin occupant could be pulled to ring the bell above ground.

could be activated if someone was buried alive inside a coffin (see Figure 12.2). It is no coincidence that Edgar Allen Poe, one of the greatest writers of all time, known for his spine-tingling tales of horror and misfortune, wrote a story titled *The Premature Burial* (1850).

Professionals no longer have any serious problem determining whether a person is dead. Of more concern is determining exactly when death occurs. Because all of the body's systems do not cease at once upon death, disagreements sometimes exist over which system is most significant in judging whether a person is dead.

FOUR TYPES OF DEATH

Today, four types of death are recognized: clinical death, brain death, biological or cellular death, and social death.

Clinical Death

In one sense, the individual is dead when his or her breathing and heartbeat have stopped, which is termed **clinical death.** Actually, clinical death is the least useful to the medical profession and to society at large because it can be unreliable and temporary. Owing to the success of **cardiopulmonary resuscitation (CPR),** many individuals, whose lungs and heart would have ceased to function decades ago before the technique was put into practice, have been saved. In other cases, spontaneous restarting of the heart and lungs has occurred after failure. New CPR findings suggest that mouth-to-mouth breathing may not be necessary to sustain a person's life until emergency aid arrives. Pushing on a person's chest approximately 100 times per minute seems to do the trick, according to several recent studies, and pushing to the beat of the Bee Gee's (1977) song "Staying Alive" gives the approximate number of compressions/minute (Harman, 2008).

clinical death The individual is dead when his or her respiration and heartbeat have stopped.

cardiopulmonary resuscitation (CPR) Technique for reviving an individual's lungs and heart that have ceased to function.

Brain Death

Death of the brain occurs when it fails to receive a sufficient supply of oxygen for a period of time (usually 8 to 10 minutes) and all electrical activity has stopped. The cessation of brain function occurs in stages,

According to most studies, people's number one fear is public speaking. Number two is death. Does that sound right? This means to the average person, if you go to a funeral, you're better off in the casket than doing the eulogy.

JERRY SEINFELD

brain death Occurs when the brain fails to receive a sufficient supply of oxygen for a short period of time (usually 8 to 10 minutes).

Electroencephalogram (EEG) Recording of the electrical activity produced by the firing of neurons in the brain.

biological death Occurs when it is no longer possible to discern an electrical charge in the tissues of the heart and lungs.

social death Point at which a patient is treated essentially as a corpse, although perhaps still "clinically" or "biologically" alive.

legal death A legal pronouncement by a qualified person that a patient should be considered dead under the law.

involving the cortex, the midbrain, and the lower brain stem. When the cortex and midbrain cease functioning, **brain death** has occurred, and the person enters an irreversible coma. However, the body can remain alive in this condition for a long time, because the nervous systems functions such as breathing and heartbeat are governed by the brain stem. When the brain stem ceases functioning, the person is dead. Consciousness and alertness, however, will never be regained (Sullivan, Seem & Chabelewski, 1999). It is the loss of these skills, and associated abilities that we equate with being human, that is commonly linked with the concept of brain death. One indication of death is a flat **electroencephalogram (EEG)** for a specified period of time.

Biological Death

Biological death follows clinical death and brain death, and cells start dying from lack of oxygen. **Biological death** occurs when it is no longer possible to discern an electrical charge in the tissues of the heart and lungs, thus signaling the permanent end of all life functions. If clinical death is responded to quickly enough, it is possible to prevent biological death, although all tissues and organs would sustain injury from lack of blood supply.

Social Death

Researcher David Sudnow (1967) was the first to suggest the concept of **social death,** the point at which an individual is treated as dead although the person is still biologically alive. He cites cases in which body preparation (for instance, closing the eyes) was started while the patient was still alive, to save time and complete necessary tasks efficiently.

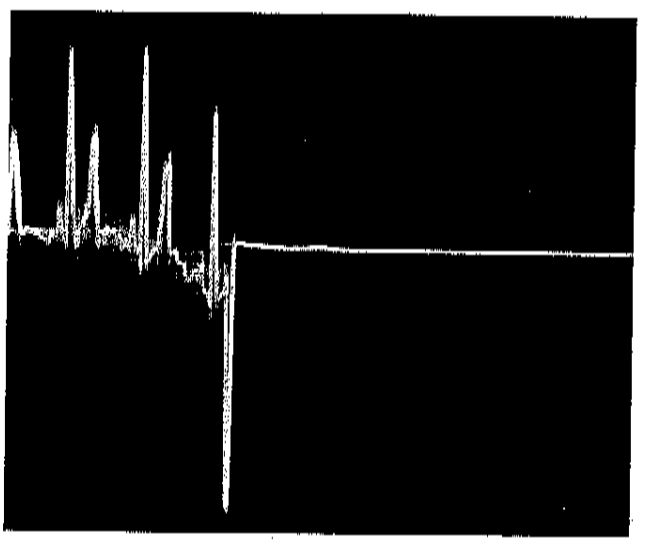
THE LEGAL DEFINITION OF DEATH

The various definitions pertaining to death can be quite confusing. In the legal profession, where language is of utmost importance and words are examined and interpreted on a case-by-case basis, death is regarded as a status, not a process. Proof of death is required for such status to be acknowledged as fact, meaning that there is no room for competing definitions or ambiguity. In an attempt to narrow the definition of death, the Harvard Ad Hoc Committee to Examine the Criteria of Brain Death suggested the following criteria for **legal death** in 1968: "unreceptivity and unresponsivity, no movements or breathing, no reflexes, and a flat EEG reading that remains flat for 24 hours."

Although people may disagree on the exact nature of death itself, passionate debates have helped inform the field of lifespan development about how people deal, and how they should deal, with the death of their loved ones.

LIFESPAN PERSPECTIVES ON DEATH

Although most people associate dying with late adulthood, we know that death can occur at any point throughout the lifespan—birth through old age. The causes of death can be as varied as the interpretations that people have once death is pending or after it has occurred. A person's age and corresponding level of cognitive development influence that person's perspective of death and dying. For example, infants are certainly attached to their parents and loved ones, but not in the same way as toddlers, for whom attachment is a major focus of their cognitive and social development. If a child is



A flat EEG that occurs for a period of time is one indication of brain death.

Whose Right to Decide?

Take a STAND

Advances in medical technology have made it possible to prolong a person's time living, but is this desirable? Many people would prefer to die than live in a painful or unconscious state, placing emotional and physical demands on loved ones.

Children, who are dependent on adults to care for them in a safe and consistent manner, are not typically consulted as to their wishes for medical treatment. A recent court case that received national attention focused on Daniel Hauser, a 13-year-old whose family wished to cease chemotherapy treatment for his Hodgkin's lymphoma. The court ruled that Daniel's parents were medically neglectful, even though they had their own preferred methods of treating his lymphoma—noninvasive treatments that were acceptable based on their religious beliefs. Doctors argued that without chemotherapy and radiation treatment, Daniel's hopes for survival were greatly compromised. The doctors believed that Daniel's health and general well-being outweighed any sort of parental "imperative" in which the parents knew best.

Do you believe there is a specific age that should be reached before someone can make his or her own decisions regarding health and medical treatments? Who should decide the age, and who should enforce or deny a family's wishes?

sick or dying, she might fear that her caregivers will leave her. Hospitalization often requires caregivers to be absent at least some of the time, while children rest or receive treatment, and medical professionals—no matter how kind or well intentioned—are no substitute for close family. If a child's parent or close relative is dying, the child will likely fear abandonment in a similar sense, with very real concerns about "who will take care of me?" Older children often mourn the loss of a pet quite deeply, and their grief is not to be underestimated. Children do not yet have the ability to think abstractly about death, spirituality, or the afterlife, so close contact and reassurance is helpful to their preoperational or concrete operational levels of understanding.

Adolescents, whose thinking is in the formal operational stage of cognitive development and who can think abstractly and reason logically, may still feel confused about death and dying, for they can imagine any number of possibilities to account for their own death or loss of a loved one. Teens, who feel they are invincible to some degree and experience adolescent egocentrism, might not worry about death as younger children do. However, young adults who have served in the military, or have friends or family who have served, have a quite different view of death. They may feel that some kind of cosmic order is not functioning fairly if someone dies before old age.

A rational outlook on death and dying develops during adulthood, as people now care for others—children and/or aging parents—and wish to ensure that their loved ones will receive care as long as possible. Risky behaviors are therefore not as common. Death is something that people

tend to want to avoid as much as possible so that they may see all tasks through to completion with regard to family and career. Adults have a different perspective on death as they begin to see fewer years of living ahead, compared to the number of years behind them.

Once adults reach the stage of late adulthood, they have likely experienced loss of family and friends. Older adults tend to reconcile their feelings about their own mortality, and often loosen previously rigid ideas about individual differences between people of all races, social classes, religions, genders, or sexual orientations. A general sense of acceptance tends to replace resistance to those who are

No one ever told me that grief felt so like fear. I am not afraid, but the **sensation** *is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. . . . There is a sort of* **invisible** *blanket between the world and me. I find it hard to take in what anyone says. Or* **perhaps**, *hard to want to take it in."*

C. S. LEWIS

grief An emotional response to the loss of another; includes feelings of anxiety, despair, sadness, and loneliness.

anticipatory grief Grief that is experienced before the death of a person.

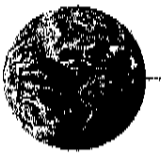
"different," as the imminent journey into the unknown (death) is something that all people will experience together, regardless of race, social class, or other distinctions. Those who are aware of the state of their own health are often compelled to get all of their business in order concerning finances and personal property so that their death does not cause undue stress on loved ones after their passing.

The Role of Grief

Grief is an emotional response to the loss of another person, and includes feelings of anxiety, despair, sadness, and loneliness. Most psychologists who have examined the role of grief have concluded that it is an essential aspect of a healthy encounter with the crisis of death. Grief has a great deal in common with fear, and most grieving people really are afraid, if only unconsciously. They are frightened by the strength of their feelings, and they often fear that they are losing their sanity. Grieving people often feel that they cannot go on, that they are losing control, and that their loss is so great that their own lives are in danger.

Grief not only follows death; when there is advance warning, it frequently precedes it. Known as **anticipatory grief,** it has four phases: depression, a heightened concern for the ill person, a rehearsal of death, and finally an attempt to adjust to what is likely to occur after the death. Indeed, the grieving process can seem to have a yo-yo effect—a person feels less conscious grief one minute and terrible despair the next.

Numerous factors are involved in how one processes grief, including personality, perception, religion, and family dynamics (Dunne, 2004). The fact that people experience grief differently reflects personal, as well as cultural, beliefs and practices (Haas, 2003).



perspectives on Diversity

Victims Left Behind

While the decrease in U.S. deaths from AIDS is significant, it is not the same in other parts of the world, and all too often, children are the ultimate victims who are left behind when a parent (or parents) dies from complications of AIDS. Estimates are that AIDS has orphaned 15 million children around the world, with even more children being "lost" because their communities are unable to care for them. Statistics show that 11.6 million of these children live in sub-Saharan Africa.

In 2009, in an effort to bring global awareness to the crisis affecting millions of children, an international group (FXB International) proclaimed May 7th to be World AIDS Orphans Day. Founder and president of FXB International, Albina du Boisrouvray, stated, "This day gives a visibility, a voice to a dropped generation, dropped because it does not vote and does not buy and does not count in the global game. Alone we can do nothing, together we can do everything."

perspectives on Diversity

Cultural Variations in the Mourning Process

Grieving is a feeling about the death of a loved one; **mourning** is the action taken as a result. For example, some people mistakenly believe that the Japanese don't grieve because in their society, highly emotional displays of mourning are not shared in public. On the other hand, keening (loud lamentations) is an expected mourning behavior in some Irish cultures, as well as among indigenous peoples in Asia, Africa, and Australia. How do geography and social custom affect the mourning process? There is strong evidence to support biopsychosocial influences on the process of mourning.

In terms of biology, the universal responses to sadness, fear, or despair, such as crying or fainting, occur across cultures. People in all cultures experience other physical symptoms, such as headaches, stomachaches, or sleep disturbances, after a death that is significant to them. In any culture, the deceased person need not be a biological relative to evoke the biological response. For instance, media images showed people around the world crying at the passing of Senator Ted Kennedy in 2009.

Psychological factors, such as love, perception of loss, and sadness, can spark physical and social reactions to the event (such as crying or wearing black). Culture influences the manifestations of how people perceive loss and the mourning practices that follow (such as attending a wake that is boisterous versus one that is somber). Similarly, society as a whole shapes acceptable grieving and mourning practices, and sends messages about what is considered normal and what is considered extreme (such as waiting a certain period of time before dating/remarrying or refusing to wash a deceased loved one's clothes). People who experience a death, whether of a family member, celebrity, or a stranger in the obituary column of a newspaper, may experience similar feelings that manifest themselves quite differently because of cognitive and cultural factors.

UNRESOLVED GRIEF

mourning Actions taken as a result of grieving

delayed grief Grief that is postponed for an inordinate time.

The process of grieving, painful as it is, is resolved by most individuals. In some cases, however, morbid grief reactions occur that prevent the successful conclusion of this life crisis. Three types of these grief reactions are delayed reaction, distorted reaction, and complicated grief.

Delayed Grief

In some cases, the intense reaction of the first stage is delayed for days, months, and in some cases years. In cases of **delayed grief,** a seemingly unrelated incident may bring to the surface an intense grieving that the individual does not even recognize as grief. Take, for example, the case of a 42-year-old man who underwent therapy to deal with a mysterious depression. During conversation he disclosed that when he was 22, his 42-year-old mother committed suicide. Apparently, the occurrence of his own 42nd birthday

ADMIT ONE

FEATURED MEDIA

Films About Death and Personal Connections to a Higher Power

***The Bucket List* (2007)** – What would you do if you learned you have terminal cancer and still have a long list of things you want to do before you die?

***Defending Your Life* (1991)** – Could you move ahead to the next phase (in the afterlife), or would you return to Earth (reincarnated) to make up for things you didn't do well, or to your fullest capacity, the first time around?

***Ordinary People* (1981)** – How does grieving, or the inability to grieve, affect a family—even years after the death of a family member?

***Heaven Can Wait* (1978)** – How hard would you fight to live again if you found out that your death was an administrative accident by the powers that be?

brought to the surface many feelings that he had managed to repress.

distorted grief Normal grief carried to an extreme degree; adoption of deceased person's ailments.

psychosomatic Physical illness or symptom brought about by mental factors.

complicated grief Prolonged and intensified grief; may take weeks or months to pass.

Distorted Grief

In most cases, **distorted grief** reactions are normal grief symptoms carried to an extreme degree. They include adopting the behavior traits of the deceased, such as aspects of the deceased's fatal illness or other **psychosomatic** ailments—physical illness or symptoms caused by mental factors such as stress. One example is a young man whose mother died of lung cancer. At the end of her life, she often had painful coughing fits and sometimes coughed up blood. Some weeks after she died, her son began experiencing pain in his chest and started coughing. Upon examination, he was found to be in perfect health, and his chest X-ray appeared normal. His doctor decided that the only explanation of the symptoms was the young man's grief over the loss of his mother. The ultimate distorted reaction is depression so deep that it causes the physical deterioration—even death—of the surviving loved one. This is especially likely to happen to widowers (Asch-Goodkin & Kaplan, 2006).

Complicated Grief

With **complicated grief,** the grieving process is prolonged and intensified. Complicated grief can last a long time, whereas distorted grief is not characterized by length of time. Frequently, people suffer from impaired physical and/or mental health caused by complicated grief. The difference between complicated grief and distorted grief is that while people who experience distorted grief reactions may adopt the symptoms of the deceased, people who experience complicated grief can bring about an illness that may be quite different than what the deceased experienced. Extensive therapy helps people experience normal and healthy grief and move on with their lives.

Experts on the grieving process believe that open confrontation with the loss of a loved one is essential to accepting the reality of a world in which the deceased is no longer present. Attempts to repress or avoid thoughts about the loss are only going to push them into the subconscious, where they will continue to cause problems until they are dragged out and fully accepted. Dealing with grief is difficult and can exact a cost. For example, the mortality rate among grieving persons is seven times higher than it is for a matched sample of nongrieving persons.

THE ROLE OF THE FUNERAL

One of the most difficult aspects of dealing with the death of a loved one is deciding how the funeral (if there is to be one) is to be conducted. Funerals have historically been an important part of American life, whether the elaborate burial rituals practiced by Native Americans, the simple funerals of the colonial settlers, or the diverse practices of the numerous ethnic groups that have immigrated to the United States.

Once the intimate responsibility of each family, care for the dead in the United States has been transferred to a paid service industry. The need for this new service was brought about by changes in society during the first part of the 20th century. The more mobile, urbanized workforce had less family support and less time to devote to the task of caring for the dead. In a relatively short time, funeral homes and funeral directors became the accepted form of care for one's dead relatives.

This commercialization of care for the dead has had mixed results. Although the services that external agents provide take some of the burden away from grieving families, they also potentially prevent the family from confronting the realities that death entails. This emotional buffer is reinforced by some funeral businesses. For example, during the 1950s and 1960s, funeral homes came under stinging criticism for their high costs and their low levels of sensitivity to the needs of the surviving family members. In recent years, coffins have become available for pur-

Career Apps

As a grief counselor, how would you assist an adult son deal with the sudden loss of his parents due to an accident?

TECH TRENDS

Online Healing

Many people suffering from grief and the anger that often accompanies it believe that their only option is to "wait it out" and "just get through it." In fact, grief sufferers have a number of options available online that afford people as much or as little communication with others as they want. Options range from websites with information about grief and anger, such as facts and frequently asked questions, to discussion groups and chat rooms where people can meet and exchange thoughts and feelings. Here are a representative sample of online resources:

Website – Grief Recovery Online (http://www.groww.com/index.htm) is a comprehensive site providing answers to common questions and opportunities to communicate with others, news, and other information.

Discussion/Support Group – Webhealing.com (http://www.webhealing.com), established by Tom Golden in 1995, was the first interactive website on the Internet. It offers discussion forums as well as general information.

Podcast – "Healing the Grieving Heart" is a free podcast subscription available through iTunes. Created by a marriage and family therapist and adjunct faculty member at Columbia University, the content is geared toward parents of children who have died and their grieving siblings.

Application – "Stress Relief–Blowaway" is an application available on iTunes that incorporates breathing and visualization. Users can view the peaceful scene of a windmill and tulips, and the interactive feature allows users to blow the windmill into action or blow flower petals away. The use of breath encourages breathing practices, which are fundamental to relief from anxiety, anger, and stress.

chase in warehouse stores, such as Costco, and the juxtaposition of such items with everyday staples such as eggs and light bulbs takes the concept of one-stop shopping to a whole new level.

Dealing Successfully With One's Own Death

Many people find facing death a much harder experience than Michel de Montaigne, an essayist of the French Renaissance, would have us believe. The acceptance of death is quite painful to many people, who often choose to deny it, and yet concern over death can occur in every stage of human development. At the root of most anxiety is a person's belief that she will die if the thing that she most fears comes to pass. For example, a woman who fears flying may truly believe at the deepest level that she will die if she rides in an airplane.

Psychiatrist Elisabeth Kübler-Ross is the most famous student of the process of death and dying. Kübler-Ross discovered that, far from wanting to avoid the topic of death, many dying patients have a strong urge to discuss it. She interviewed hundreds of terminally ill people in the 1960s and, on the basis of these interviews, developed a five-stage theory describing the emotions underlying the process of dying (see Figure 12.3). The stages in her theory are flexible, in that people can move through them quickly, slowly, or not at all. Some fluctuation occurs between the stages, but by and large people tend to move through them in this order:

The HBO series Six Feet Under presented the humorous and poignant sides of life and the commercial aspects associated with death.

If you know not how to die, never trouble yourself. Nature will in a moment fully and sufficiently instruct you; she will exactly do that business for you; take you no care for it.

MICHEL DE MONTAIGNE, ESSAY XIX, *OF PHYSIOGNOMY* (1580)

FIGURE 12.3

Kübler-Ross's Stages of Grief

1. *Denial.* In the first stage, a person denies that death is going to happen. This often happens when a terminal diagnosis is first given, but eventually the person must interact with others to consider the practical and logistical matters that need to be addressed.

2. *Anger.* Once a person can no longer deny the fact that death is a reality, she often experiences anger and resentment. A dying person may feel robbed of time on earth, goals unattained, or bitterness that it is her and not another person who will meet this end. A loved one may feel angry at the dying person for abandoning her, at God or another higher power for taking this person away, or the medical professionals for being unable to save the dying person.

3. *Bargaining.* In the third stage of dying, a person comes to hope that the death can be avoided or delayed in exchange for other thoughts or behaviors. Promises are sometimes made to oneself, others, or God in hopes of making a narrow escape a reality.

4. *Depression.* In the fourth stage of dying, the dying person or loved one begins to accept the inevitable conclusion. The dying person may attempt to isolate herself from others, to disconnect from relationships in preparation for death and to help loved ones disconnect. Kübler-Ross deemed this behavior appropriate, as the person needs to confront the reality of dying.

5. *Acceptance.* In the final stage of dying, a person comes to a state of peace and resolution, and no longer attempts to resist the end of her life. Any pain or suffering is no longer viewed as a burden but, rather, part of the natural cycle of life. A feeling of greater connectedness to a higher power is common.

euthanasia The ending of a life, usually in a person with a terminal illness, to prevent a prolonged and painful death.

passive euthanasia Refraining from continuing efforts to sustain someone's life.

living will Legal document that describes specific life-prolonging medical treatments.

health-care power of attorney Legal document giving someone authority to make health-care decisions if one is incapacitated.

active euthanasia Intentionally ending a person's life.

physician-assisted suicide (PAS) Active euthanasia whereby doctors give patients death-inducing drugs.

One criticism of Kübler-Ross's stage theory is that no scientific evidence confirms that her sequence of stages is typical or universal. Another criticism is that her theory overlooks the effects of personality, ethnic, or religious factors. For example, people in cultures such as some Native American and Asian ethnic groups view death as just another stage of existence and do not dread it. Whether or not you choose to accept Kübler-Ross's model, the biological, psychological, and social aspects of the process of dying are obviously very complex. Knowledge gained through careful research can help answer questions that emerge as a result of examining the model, but her theory, like all good theories, continues to provide us with constructs that help guide research.

Another theory, also based on observation and describing five stages, is that of psychologist and bereavement researcher Catherine Sanders (1989), who identified five states of the grief process: shock, awareness of loss, withdrawal, healing, and renewal. The similarities with Kübler-Ross's stages are noteworthy. Many researchers agree with the themes presented by Kübler-Ross and Sanders, but suggest that they do not occur in set stages for all people. Rather, these studies find that the themes are intermingled, with some people ending on a positive note and others ending with feelings of anger or depression.

Death and dying are complicated and important topics that have an important place in the study of life. Over the course of the lifespan, humans have options to cope with death in various ways that are influenced by biological, psychological, and social factors.

DEATH WITH DIGNITY

No doubt most people would rather not suffer serious physical pain when they die, and many would prefer to avoid the emotional pain that often attends death. Until recently, however, it was the rare occasion when a person would have any choice. Today, debates have formed around two alternatives, both of them forms of **euthanasia** ("good death" in Greek), the act of ending a life in a painless manner to relieve or prevent suffering.

Passive euthanasia refers to refraining from continuing efforts to sustain someone's life, such as turning off life-

perspectives on Diversity

The Funeral in Other Times and Countries

Looking at the funeral practices of former cultures shows us not only how they buried the dead, but also something about their values.

Ancient Egypt. Egyptians believed in life eternal, and thus the body of the dead person was embalmed, or treated with preservatives, in order to prevent decomposition. The body was placed in a tomb, the elegance of which was determined by family wealth and prestige.

Ancient Greece. Within a day after death the body was washed, anointed, dressed in white, and laid out for 1 to 7 days, depending on the social prestige of the deceased. The ancient Greeks prepared their tombs and arranged for subsequent care while they were still alive. About 1000 B.C.E. the Greeks began to cremate their dead. Although earth burial was never superseded, they came to believe in the power of the flame to free the soul.

The Roman Empire. For reasons of sanitation, burial within the walls of Rome was prohibited; consequently, great roads outside the city were lined with elaborate tombs erected for the well-to-do. For the poor, there was no such magnificence; for slaves and aliens, there was a common burial pit outside the city walls.

Anglo-Saxon England. The body of the deceased was placed in a hearse for the funeral procession, which included

priests, friends, relatives, and strangers who deemed it their duty to join the party. Mass was sung for the dead, the body was laid in the grave (generally without a coffin), the mortuary fee was paid from the estate of the deceased, and alms in the form of money, food, or clothing were given to the poor.

Colonial New England. Neighbors or a nurse washed and laid out the body. The local woodworker built the coffin, and in special cases, metal decorations imported from England were used on the coffin. Funeral services consisted of prayers and sermons said over the cloth-covered coffin. Sermons often were printed (with skull and crossbones prominently displayed) and distributed to mourners.

support systems or withdrawing medicine or food. These methods can be covered by a **living will** (legal document that describes a person's wishes for specific life-prolonging treatments) or determined by the patient's **health-care power of attorney** (legal document giving someone authority to make health care decisions for one who is incapacitated).

Active euthanasia means intentionally ending a life, either through directly killing the person or by **physician-assisted suicide (PAS)**, which occurs when a doctor gives a patient death-inducing drugs. It is against the law almost everywhere for the physician to give the patient a death-inducing drug, and Dr. Jack Kevorkian is a Michigan-based doctor who gained notoriety for doing precisely that. He served 8 years of a 10- to 25-year prison sentence for second-degree murder before being paroled in 2007 due to good behavior and his own failing health.

In the Netherlands, doctors administer lethal drugs to patients who request them, but with strict legal guidelines. Closer to home, a law was passed in Oregon in 1997 (upheld in 2006 by the U.S. Supreme Court) called the Death With Dignity Act. This law allows doctors to prescribe lethal medications to patients who

Career Apps

As a licensed practical nurse (LPN), what would you do if a close colleague asked you for help ending her pain and suffering by administering potentially lethal drugs to her?

The Pros and Cons of Physician-Assisted Suicide

Take a STAND

Legal attention has been brought to the subject of whether a person has the right to enlist the help of a physician to end his or her life.

> The right of a competent, terminally ill person to avoid excruciating pain and embrace a timely and dignified death bears the sanction of history and is implicit in the concept of ordered liberty. A state's categorical ban on physician assistance to suicide—as applied to competent, terminally ill patients who wish to avoid unendurable pain and hasten inevitable death—substantially interferes with this protected liberty interest and cannot be sustained.
>
> American Civil Liberties Union, Amicus Brief, *Vacco v. Quil* (1996)

> The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.
>
> U.S. Supreme Court Majority Opinion, *Washington, et al., v. Harold Glucksberg et al.* (1997)

Which of these court decisions do you agree with? Why?

request them, but the patients must administer the medications themselves (Oregon.gov, 2007).

There is debate over the appropriateness of physician-assisted suicide (Bernat, 2001). Those who support it claim a number of advantages for the option: the time of death is up to the patient; it can be used by those for whom the hospice or hospital is inappropriate; and death is painless if the patient is given a high enough dose of morphine.

Almost 80% of Americans die in hospitals, and 70% of those deaths involve some aspect of medical technology such as breathing, feeding, and waste-elimination equipment. Therefore, it is essential that those who do not want to be maintained on life-support systems if they become terminal put their wishes in writing according to their state's laws. Open communication with one's doctor is also essential (von Gunten, Ferris, & Emanuel, 2000). This type of decision making before the end of one's life seems to be increasing and is practiced in many European countries (van der Heide et al., 2003). In England and Wales, living wills are called *advance decisions*, while in nearby Ireland they are known as *advance health-care directives*.

An increasing number of cases illustrate the ethical problems involved with maintaining the life of individuals, with the support of technical equipment, in the absence of such legal documents. Terri Schiavo collapsed in her home in 1990, due to heart failure that may have been associated with bulimia. Her husband Michael, as her legal guardian, battled against her blood relatives to allow her to be taken off the life-support mechanisms and die peacefully, as he claimed she would have wanted. In 2005, the courts determined that Terri Schiavo was in a vegetative state from which she could never return, and therefore her feeding tube was removed. She died 15 days later. A number of medical professionals, philosophers, and theorists have debated the issue of life support, arguing whether maintaining life under these conditions is wrong.

Media coverage closely followed the Terri Schiavo case.

THE HOSPICE: "A BETTER WAY OF DYING"

In 1978, *Time* magazine brought attention to the **hospice**, a program providing comfort and supportive services to

those near the end of life and to their families, stating that it provides patients "a better way of dying." At that time, hospices were still considered a new form of care, although the concept of hospice care dates back many centuries. The first U.S. hospice opened in New Haven, Connecticut, in 1974. Hospices became a more mainstream part of the American medical establishment when the hospice Medicare benefit was enacted in 1982. Since then, the National Hospice Organization has been formed to help promulgate this movement, and hundreds of groups have organized hospice programs that focus on often-neglected areas of care, such as pain management, psychological counseling for patients and their families, and recognition of terminal illness. Figure 12.4 illustrates the number of hospices per county in the United States. Currently, hospice programs in the United States are primarily home-based care, with the sponsorship of such programs evenly divided between hospitals and community agencies. Approximately 1.45 million patients were treated in U.S. hospice settings in 2008, and many insurance programs now cover hospice care.

The hospice is a relatively new philosophy of patient care in the United States. Hospice care is different from other types of care because it provides

- a team approach to caring for the individual,
- attention to the spiritual and psychological needs of patients and their families,
- pain and symptom control,
- services in the home or hospice setting, and
- family conferences and bereavement care.

The collaborative nature of hospice care is one of the major factors that distinguishes such care from hospital treatments. Hospice teams include doctors, nurses, social workers, and spiritual supports. Families are consulted to ensure that decisions are made with as much input as possible from all concerned parties.

hospice A program providing comfort and supportive services to those near the end of life and to their families.

Because there is an emphasis on quality of life for the patient and family, as opposed to impending death, control of pain and symptoms are goals of hospice care. A patient is typically treated for pain with over-the-counter pain medications such as ibuprofen, aspirin, or acetaminophen. For terminally ill patients, pain levels often increase to the point where these medications no longer help. At that point, the physician will prescribe narcotic medications alone or in combination with other medications. The main objective of medication is to relieve symptoms that interfere with one's quality of life. A major goal of the hospice is to keep the person's mind as clear as possible at all times. A person whose mind is clear can think more cogently about the dying process and to explore the feelings associated with death and the meaning of dying (Dobratz, 2003).

Suicide: The Rejection of Life

There are times that people feel that their personal pain outweighs their ability to cope with the pain. Such thinking occurs in different people for different reasons, at different

FIGURE 12.4

Hospice Statistics

This map shows the number of hospices per county per capita in 2007.

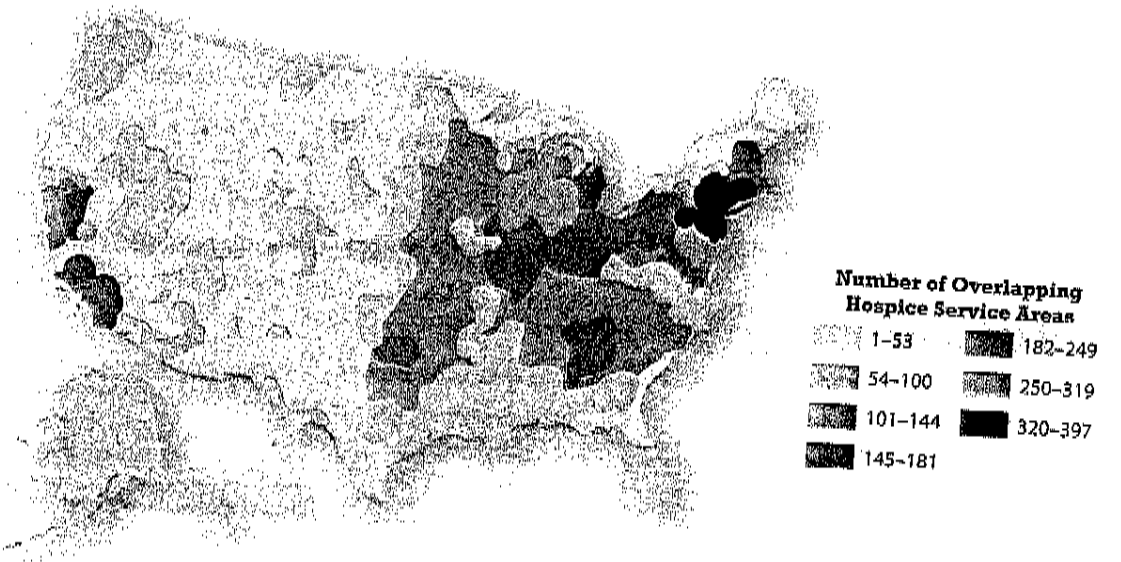


TABLE 12.2

Fact Sheet on Suicide: Adolescents and Young Adults

- The rate of suicide increases tenfold between early adolescence (ages 10–14) and young adulthood (ages 20–24). Suicide rates continue to increase in adulthood until age 49, decrease between ages 50–74, then increase again at age 75.
- Adolescent and young adult males aged 10–24 have a consistently higher suicide rate (84%) than their female peers.
- American Indian/Alaskan Native non-Hispanics have the highest suicide rate, 2 to 4 times that of same-age males in other racial/ethnic groups and 11 times that of same-age females. Suicide is the second leading cause of death for American Indian/Alaskan Native non-Hispanic males age 10–24. Black/non-Hispanic and Hispanic females are least likely to commit suicide (National Adolescent Health Information Center, 2006).

times of life, regardless of socioeconomic class, religion, race, or gender (see Table 12.2).

Although suicide ranks as the second leading cause of death among people 13 to 19 years of age, the rate for those 65 and older is higher—17.4 per 100,000, for non-Hispanic males (CDC, 2006b). For the elderly, poor health is often a cause of suicide because it is linked to depression.

THE INFLUENCE OF GENDER

At all ages, there are major gender differences in suicide. Males are about four times more likely to die of suicide attempts than are females, owing to the methods used, the lethality of the attempt, and a person's present state of mental health (CDC, 2006b). Attempt rates show even more dramatic gender differences. Failed attempts at suicide among females are much higher than those for males (Curran, 2006). A major reason for the high survival rate among females is the method used. Whereas males often resort to such violent and effective means as firearms and hanging, females tend to choose less violent and less deadly means, such as drug overdose. Suicide attempts for men and women may be influenced by factors such as alcohol and drug use, unemployment, divorce, and death of a spouse or other close friend or relative.

No single factor is in itself a clear cause of suicide, and no one warning sign can be a clear indicator of intent. Several factors or warning signs, however, are cause for concern (see Figure 12.5). Anyone talking about committing suicide should be taken seriously and a mental health professional should be consulted, even when you feel sure the person is only seeking attention or sympathy.

Health-care professionals can play an important role in suicide prevention, providing support and information that highlight alternatives to choosing to end one's life. Examining the practical role of community support in relation to death sheds light on the way we handle the reality of death, which is a fundamental part of the lifespan.

Spirituality

Spirituality refers to issues affecting the spirit or soul. It may involve the attempt to better understand the reasons for living through striving to know the intentions of a higher power. While spirituality is not the same as religion, there is a clear spiritual element to organized religion, which often involves reflective practice, gathering in a specific place, and considering the self in relation to other people and places, and it specifies an accepted body of teachings that defines answers to spiritual questions.

A basic spiritual goal is trying to discern life's purpose. People engage in spiritual practices by, for example, examining historical trends and biological changes (such as the study of written texts or scientific advances) to debate the forces underlying human existence. In any case, spirituality includes all of our efforts to gain insight into the forces of life. For many, it is the only justification for moral and ethical behavior.

Spirituality does appear to develop with age. A number of theories have been offered as to how and why this is so, including those of Viennese psychoanalysts Viktor Frankl and Carl Jung and American sociobiologist E. O. Wilson.

FEATURED MEDIA

Films About Suicide

***Harold and Maude* (1971)** – After a chance meeting at a funeral, how does a life-changing relationship between a teenage boy and a 79-year-old woman blossom?

***Scent of a Woman* (1992)** – How does a young man handle the challenge of caring for a cranky ex-colonel who has his own agenda—to end his life?

***The Hours* (1993)** – How are three different women, from three different generations, affected by the same novel?

***Leaving Las Vegas* (1995)** – When a man who thinks he's lost everything goes to Las Vegas to drink himself to death, can new love save him? Or is he determined to end his life?

FRANKL'S THEORY OF SPIRITUALITY

Frankl (1967) described human life as developing in three interdependent stages, according to the primary dimension of each stage:

1. *The somatic (physical) dimension.* According to the somatic dimension, all people are motivated by the struggle to keep themselves alive and to help the species survive. This intention is motivated entirely by instincts. It exists at birth and continues throughout life.
2. *The psychological dimension.* Personality begins to form at birth and develops as a result of instincts, drives, capacities, and interactions with the environment. The psychological dimension and the somatic dimension are highly developed by the time a person reaches early adulthood.
3. *The noetic dimension.* The noetic dimension has roots in childhood but primarily develops in late adolescence and beyond. It is spiritual in the totality of the search for the meaningfulness of life.

Frankl believed that development in the physical and personality dimensions results from the total sum of the influences bearing upon an individual. The developmental nature of the theory is recognizable here, as individuals acquire more skills and understanding throughout their lives, based on interactions with others and the environment. The noetic, however, is greater than the sum of its parts. This means that we as adults are responsible for inventing (or reinventing) ourselves! Whatever weaknesses or challenges we may have been given through biology or our environment, they need not govern our lives; we can and should try to overcome them.

JUNG'S THEORY OF SPIRITUALITY

Carl Jung, a student of Freud's, agreed to a large extent with Freud's description of development in the first half of human life. But he felt that Freud's ideas were inadequate to describe development during the second half of life, middle adulthood and beyond.

The First Half of Life

In Jung's view, the personality develops toward individuation, or the process of coming to know, giving expression to, and harmonizing the various components of the psyche. Most people are well individuated by the middle of life, at approximately age 35; that is, we have become distinct individuals and are most different from one another at this age (see Figure 12.6).

The Second Half of Life

The goal of human development in the second half of life is just the opposite. Somewhere around midlife, people begin turning inward, turning attention to the development of their inner self, which marks the beginning of true adult spirituality. The goals of this introspection are to discover a meaning and purpose in life, determine which values and activities one is willing to invest energy and creativity in, and prepare for the final state of life—death.

By nourishing qualities of oneself that are less developed (such as typically gender-stereotyped characteristics like sensitivity or assertiveness), one comes to recognize the spiritual and supernatural aspects of existence. The Dalai Lama has been a source of inspiration for millions of people who wish to learn how mindfulness and meditation lead to greater awareness of life's ordinary moments—pleasant as well as challenging.

WILSON'S THEORY OF SPIRITUALITY

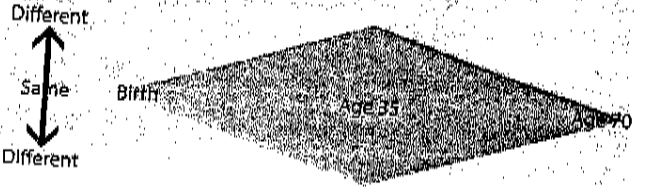
In contrast to the self-determination of spirituality seen in Frankl's and Jung's psychological points of view, sociobiology sees spirituality as determined almost entirely by instinct—that is, as a function of genes and heredity. Harvard sociobiologist Edward O. Wilson, the leading spokesperson for the sociobiological point of view, argued that religion and spirituality are inseparable and that together they grant essential benefits to believers.

In Wilson's view, religion is one of the few uniquely human behaviors. He argues that all societies, from hunter-gatherer bands to socialist republics, have religious practices with roots that go back at least as far as the Neanderthal period. Wilson argued that humans have a need to develop simple rules for handling complex problems. Furthermore, religious learning is almost entirely unconscious—most religious tenets are taught and deeply internalized early in life.

I find hope in the darkest of days, and focus in the brightest. I do not judge the universe.

DALAI LAMA

FIGURE 12.6
Jung's Theory, Differentiation by Age



The predisposition to religious belief is the most complex and powerful force in the human mind and in all probability an ineradicable part of human nature.

E. O. WILSON

The sociobiological explanation of spirituality, then, is that through religious practice, the survival of practitioners is enhanced. Those who practice religion are more likely to stay alive (or at least they were in the past) than those who do not practice religion. The potential for self-sacrifice can be strengthened in this manner because the willingness of individuals to relinquish rewards or even surrender their own lives will favor group survival. The first responders who died trying to save lives in the 9/11 attacks are an excellent example.

Wilson saw science as taking the place of theology today, because science has explained natural forces more effectively than theology. In fact, he asserted that science has explained theology itself. Although he saw theology as being phased out, he argued that the demise of religion is not at all likely. As long as religions make people more likely to survive and propagate themselves, Wilson suggested, they will continue to enjoy popularity.

If I Had My Life to Live Over

The following question was asked of 122 retired people:

> If you could live your life over again, what would you do differently?

Most people responded that the pursuit of education would be the area they would most like to choose if given

another chance. This emphasis among retirees may be because they feel their lack of education led to missed or limited opportunities. Although people indicated they would have spent more time doing a variety of things, they said that they would have spent less time worrying about work.

These feelings are summed up in this poem, attributed to Nadine Stair, an 85-year-old poet:

If I had my life to live over,
I'd dare to make more mistakes next time.
I'd relax. I would limber up.
I would be sillier than I have on this trip.
I would be crazier. I would be less hygienic.
I would take more chances, I would take more trips.
I would climb more mountains, swim more rivers, and watch more sunsets.
I would burn more gasoline. I would eat more ice cream and less beans.
I would have more actual troubles and fewer imaginary ones.
You see, I am one of those people who lives
Prophylactically and sensibly and sanely,
Hour after hour, day after day.
Oh, I have had my moments
And if I had it to do over again, I'd have more of them.
In fact, I'd try to have nothing else.
Just moments, one after another.
Instead of living so many years ahead each day.
I have been one of those people who never go anywhere
Without a thermometer, a hot water bottle, a gargle, a raincoat, and a parachute.
If I had to do it over again, I would go places and do things.
I'd travel lighter than I have.
If I had my life to live over, I would start barefooted
Earlier in the spring and stay that way later in the fall.
I would play hooky more. I wouldn't make such good grades except by accident.
I would ride on merry-go-rounds.
I'd pick more daisies!

As you have reached the end of this book, think back to the case study of Amshula Khare presented in Chapter 2. Knowing what you now know about lifespan development, about the biopsychosocial forces that influence us across the lifespan, what do you predict for Amshula? How might she experience adolescence, middle adulthood, or old age, based on what you know about her early childhood situation and family dynamics?

The study of the lifespan allows us to make some educated guesses about the "why" beneath all of human development. Hopefully your curiosity has been piqued and you found ideas that challenged as well as validated your opinions. Best wishes as you continue your own life's journey!

CONCLUSIONS & SUMMARY

The goal of living a good life has many meanings and takes different forms. The same may be said for achieving a successful death. The stages of death and grief reflect the values of a society and culture, and our interpretation and responses to death and spirituality, in turn, contribute in some small way to achieving a good life.

What is the role of death in life?

- Today, four types of death are recognized: clinical death, brain death, biological death, and social death.
- In modern Western societies, death comes mostly to the old. Unfortunately, this is not true in many other areas of the world.

What is the purpose of grief?

- Grief both follows and can precede the death of a loved one.
- In some cases, morbid grief reactions occur that prevent the successful conclusion of the life crisis. These are known as delayed reactions, distorted reactions, and complicated grief.
- Most experts who have examined the role of grief have concluded that it is a healthy aspect of the crisis of death.
- Funerals have always been an important part of American life. Research has indicated that the rituals surrounding funerals have therapeutic benefits that facilitate the grieving process.
- Kübler-Ross has offered five stages of dying: denial, anger, bargaining, depression, and acceptance.