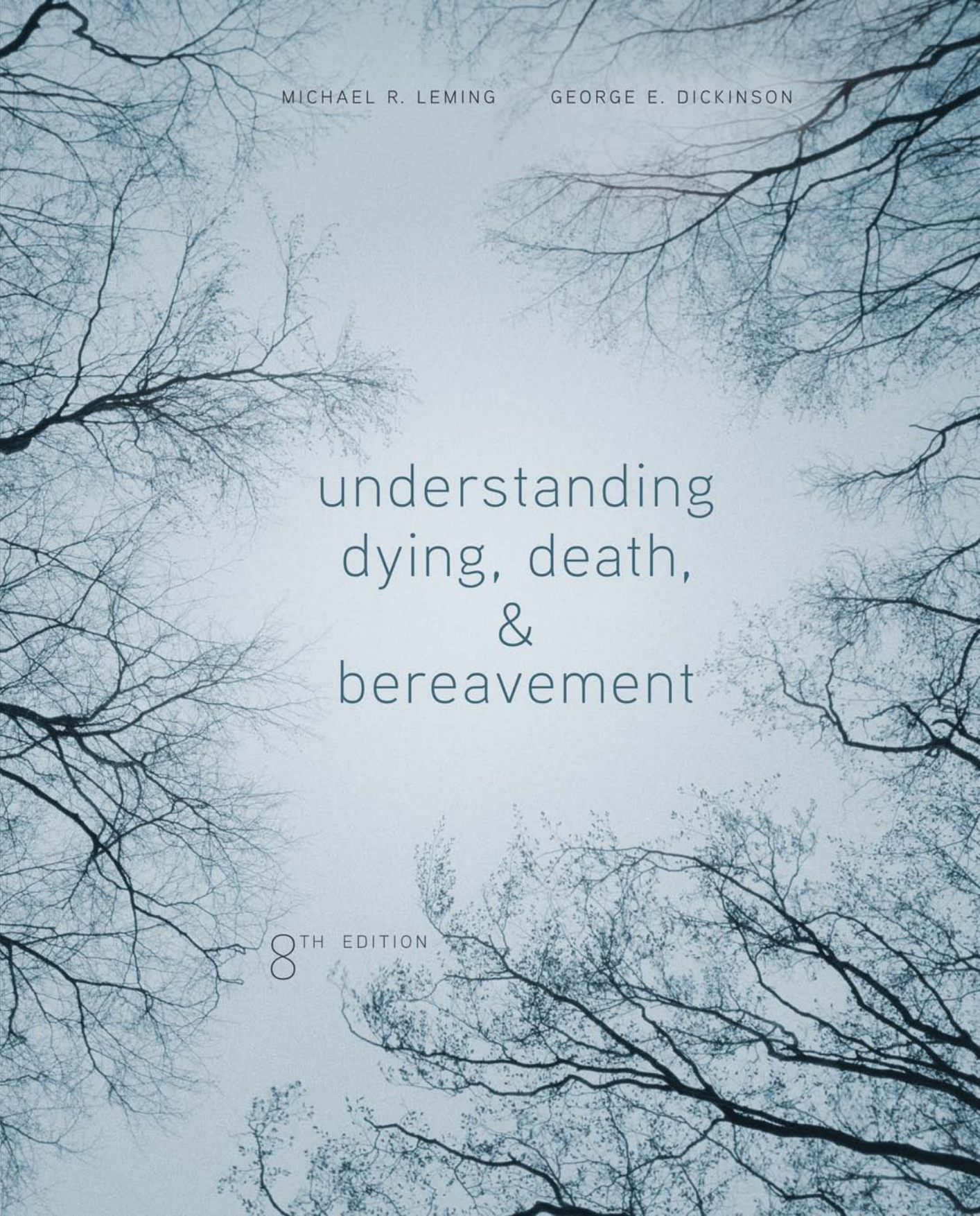
MICHAEL R. LEMING GEORGE E. DICKINSON

understanding dying, death, & bereavement

8TH EDITION



Understanding Dying, Death, and Bereavement

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EIGHTH EDITION

Michael R. Leming
St. Olaf College

George E. Dickinson
College of Charleston

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Understanding Dying, Death, and Bereavement, Eighth Edition
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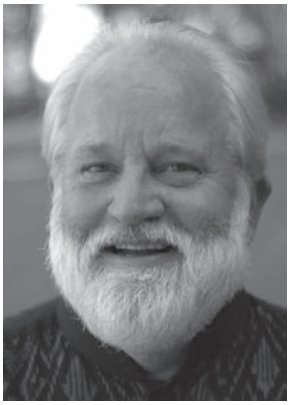

Michael R. Leming is professor emeritus of sociology and anthropology at St. Olaf College in Minnesota and co-director, Spring Semester in Thailand. He holds degrees from Westmont College (B.A.), Marquette University (M.A.), and the University of Utah (Ph.D.), and he has done additional graduate study at the University of California at Santa Barbara.

He is co-editor (with George E. Dickinson) of *Annual Editions: Dying, Death and Bereavement*, 14th ed. (McGraw-Hill, 1993, 1994, 1995, 1997, 2000, 2002, 2004, 2005, 2007, 2008, 2010, 2011, 2012, 2014) and co-author of *Understanding Families: Diversity, Continuity, and Change* (Allyn & Bacon, 1990; Harcourt Brace, 1995). He is also co-editor (with Raymond DeVries and Brendan Furnish) of *The Sociological Perspective: A Value-Committed Introduction* (Zondervan, 1989; Wipf & Stock Publishers, 2009). In 1995 he produced a documentary film entitled *The Karen of Musikhee: Rabbits in the Mouth of the Crocodile*. His most recent film project is a documentary film on the Karen produced by the BBC, for which he was the chief research consultant.

Dr. Leming was the founder and former director of the St. Olaf College Social Research Center, former member of the board of directors of the Minnesota Coalition on Terminal Care and the Northfield AIDS Response, and has served as a hospice educator, volunteer, and grief counselor. He has been teaching courses on death and dying for over 35 years. For the past 14 years he has directed The Spring Semester in Thailand program (http://www.springsemesterinthailand.com), which is affiliated with Chiang Mai University, and he lives in Thailand during Minnesota's coldest months.

George E. Dickinson is professor of sociology at the College of Charleston in South Carolina. He holds degrees from Baylor University (B.A. in biology and M.A. in sociology) and Louisiana State University (Ph.D. in sociology, minor in anthropology). He has completed postdoctoral studies in gerontology at Pennsylvania State University, thanatology at the University of Kentucky School of Medicine, and medical sociology at the University of Connecticut. He was visiting research fellow in palliative medicine at the University of Sheffield's School of Medicine in England in 1999, the International Observatory on End of Life Care in the Institute for Health Research at Lancaster University in England in 2006, and the University of Bristol School of Veterinary Science's Department of Animal Behavior and Welfare in England in 2013.

He has published more than 90 articles in professional journals and has co-authored other books with Michael Leming, as noted above. Like Dr. Leming, he has been teaching courses on death and dying for nearly 40 years and has been actively involved as a hospice educator. Dr. Dickinson is on the international editorial board of *Mortality* in the United Kingdom and on the editorial review board of the *American Journal of Hospice & Palliative Medicine*. He received the South Carolina Governor's Distinguished Professor Awards in 2003 and 2008 and was the recipient of the 2009 Death Educator Award from the Association of Death Education and Counseling. At the College of Charleston he was awarded the Distinguished Teacher-Scholar Award in 2002 and the Distinguished Research Award in 2008.

PREFACE

WHY DID WE WRITE A BOOK ON DEATH AND DYING?

Back in the early 1970s, following a Nobel Conference at Gustavus Adolphus College in St. Peter, Minnesota, entitled "The End of Life," George Dickinson's cultural anthropology students began writing term papers on how different cultures dealt with dying, death, and bereavement. About this same time one of his former students, then in his third year of medical school, stopped by the office for a visit. Dickinson naïvely asked about the student's death and dying course in medical school. With a somewhat bewildered look on his face and a shrug of his shoulders, he replied that they did not have anything like that. Would not one think that medical schools offered a course on dying and death? Both the students' written papers and the encounter with the medical student sparked an interest in Dickinson's research and teaching in the area of death and dying.

Soon thereafter, Michael Leming, a friend and former colleague who had written his Ph.D. dissertation about terminally ill cancer patients, contacted Dickinson about co-authoring a textbook on dying, death, and bereavement. Both were then teaching death and dying courses. There were very few texts available at the time. Leming and Dickinson became frustrated over a lack of reading materials appropriate for students. Thus, the conception of this textbook back in the early 1980s came from the experience of having limited classroom materials and from the interest and enthusiasm of students in the topic of thanatology.

WHAT DO WE HOPE TO ACCOMPLISH IN THIS BOOK?

It has been over 30 years since we began work on the first edition of *Understanding Dying, Death, and Bereavement.* Our goal in the eighth edition, as in the previous editions, has been to create a book that is both informative and practical, yet theoretical, and a book that was reader-friendly to the students. We visualized a

humanistic text that was cross-cultural, multidisciplinary in orientation, and inclusive of the major foci of the interdisciplinary subject of social thanatology. Indeed, many changes have occurred in end-of-life issues since the first edition. The topic of dying, death, and bereavement has come out of the closet and is less a taboo topic than it was in the early 1980s. Though thanatology is not yet a household word, it is certainly better known than it was a quarter century ago. End-of-life issues are more "in" today, especially in the context of highly publicized and all-too-frequent school shootings, terrorist attacks in various parts of the world, and the much-debated U.S. Affordable Care Act of the 21st century, which was, at one juncture, falsely accused of including a measure to euthanize the elderly. Additionally, body disposition options are changing in the 21st century, as environmentally correct ways of disposal are evolving. The current edition reflects these changes. Specifically, we have the following objectives for this book:

1. To sensitize students to the subject of dying, death, and bereavement.
2. To aid students in adjusting to the death of a significant other.
3. To help individuals examine their own feelings and reactions to death and grieving.
4. To make readers aware of different cultural groups' death and bereavement customs in America and internationally.

The eighth edition of *Understanding Dying, Death, and Bereavement* will equip the reader with the necessary information to both understand and cope with the social aspects of dying, death, and bereavement. Because we have each taught courses on thanatology for some 40 years, we are convinced that every student carries both academic and personal agendas when approaching the subject. Although every student reading this book may not have family crises such as divorce and violence, every individual will eventually have to deal with deaths in her or his family (if they have not already done so). Having been exposed to the material in this text, we hope that each student will be in a better position to cope with dying and death. One does not "get over" the death of a significant other, like getting over the flu or a bad cold, but one must learn to live with the fact that the loved one is indeed dead and will never again physically be with us. One of our more satisfying experiences in academia is the occasional e-mail, letter, or phone call from a former student who shares with us the usefulness of this book in his or her dealing with the death of a significant other. For some, it is the benefit to themselves; and others relate how they were a good information source and support for other family members.

This textbook will make a significant contribution to your class because it is a proven text informed by some 80 years of combined experience of teaching and researching on this topic. *Understanding Dying, Death, and Bereavement,* Eighth Edition, is comprehensive and covers the wide range of topics in social thanatology. It is scholarly and academically sound, and it is practical for students because it addresses personal issues relating to an individual's ability to cope with the social and psychological processes of dying, death, and bereavement. The book has a strong cross-cultural emphasis that allows one to understand both the universality of death, dying, and bereavement and also the incredible diversity and similarity of social customs relating to this experience. This text appeals to a vast audience, not only because of its wide adaptability on college and university campuses, but also because

of its practical implications for all persons. Although intended primarily for undergraduate students in sociology, psychology, anthropology, nursing, social work, kinesiology, religion, gerontology, health science, family studies, public health, philosophy, and education courses, it is also appropriate for professional courses in medicine, nursing, mortuary science, social work, child life, and personal and pastoral counseling. We have been somewhat surprised at the variety of disciplines and professional schools where earlier editions of this book have been used, including one large business school where the focus was on consumer efforts about dying and death.

WHAT'S NEW ABOUT THIS TEXT IN THE 21ST CENTURY?

We have both added and removed boxed inserts in the chapters but have maintained the four box categories: (1) **Practical Matters** boxes basically offer practical advice; (2) **Listening to the Voices** boxes consist of excerpted material from people writing about their own experiences with dying and death; (3) **Words of Wisdom** boxes contain excerpted materials—poems, literature, and other words of wisdom; and (4) **Death Across Cultures** boxes examine cross-cultural examples of death practices and beliefs. In addition to the boxes, chapter **conclusions**, **summaries**, and **discussion questions** at the end of each chapter serve as study aids. A **glossary** also appears at the end of each chapter with definitions of words in bold print in the chapter. Additionally, **suggested readings** are given at the end of each chapter for additional reading if desired. New tables have been added in several chapters at the request of reviewers. Some new boxes include child life specialists, death and the musical requiem, lessons for the end of life, resistance to pain medication across cultures, U.K. and U.S. prison hospice programs, animal hospices, veterinarians and end-of-life issues, a guide to survival following a suicide of a friend or family member, a letter to one's dad some ten years after his suicide, a suicide risk assessment, suicide rates in the military, bullying and suicide, capital punishment, a letter on why one should always go to a funeral, a story of Hmong funeral traditions and why one needs to return home, an explanation of the high cost of saying goodbye, and a box on diversity in death—body disposition and memorialization.

New material in the eighth edition includes updates of statistical material throughout the text and new information on various topics since the 2010 edition, including new sections on homicide and accidental deaths, personal death trends in body disposition and memorialization, and pet loss.

As in previous editions, pictures and cartoons are scattered throughout the book. Numerous new pictures and cartoons have been added to this edition, making it the most comprehensive of all of our books on the topic.

SUPPLEMENTS

An online test bank and online instructor's manual are available for instructors. The test bank contains 25 to 30 true/false questions, 25 to 30 multiple-choice questions, and 10 to 15 essay questions for every chapter, to save time creating tests. Answers to the true/false and multiple-choice questions are provided. The instructor's manual contains detailed chapter outlines and sample syllabi, which list suggested readings and class projects.

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As in the past, we acknowledge those we have encountered in life. We have learned so much from significant others and our students who have shared their experiences with dying and death. Our own lives have indeed gained from these experiences. We hope our readers will experience an appreciation for life as they begin to understand, both intellectually and emotionally, the social-psychological processes of dying, death, and bereavement. This book is about dying and death, but it is really about living and life. May your reading of this book help to make your life more meaningful.

Michael R. Leming and
George E. Dickinson

The symbols of death say what life is and those of life define what death must be. The meanings of our fate are forever what we make them.
—Lloyd Warner, The Living and the Dead

The day we die the wind comes down to take away our footprints.
—Song of the Southern Bushmen

Studying Dying, Death, and Bereavement

CHAPTER I

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You are enrolled in a course in death and dying. Note the reactions of others when you inform them of this. They are likely okay with your saying you are taking such courses as Principles of Biology, English Literature, Introduction to Philosophy, History of the United States, or Calculus, but *Death and Dying*? Being informed of this course may raise some eyebrows. That sounds weird and certainly morbid, or so some seem to think. We often experience startled reactions when we tell that we teach a course entitled "Death and Dying." We wonder what images pop into individuals' minds when so informed. One woman, when introduced to George Dickinson and told that he taught a course on death and dying, drew back and in a rather startled voice said, "How could you do such a thing?" She must have imagined Dracula team-teaching and Frankenstein working as a lab assistant, along with the Grim Reaper. She then said, "What do you do in a course *like that*?" After giving her a quick synopsis of the course, she seemingly breathed a sigh of relief and said, "Oh, that doesn't sound so bad."

Imagine the responses funeral home personnel must endure if we receive such startled looks from just teaching about dying, death, and bereavement, and not actually dealing with dead human remains. Stephanie Schim and colleagues (2007) in various health care professions note that responding honestly at a party to the question of "What is your area of study?" with "Oh, I'm working with death and dying" is a real conversation terminator. From reactions that many individuals have to death-related issues, it appears that death discussions are considered in bad taste and something to be avoided. **Road Scholar** programs (formerly called Elderhostel), for example, can present any topic of interest to older persons *except dying and death*. Likewise, at least according to a survey in the late 20th century, U.S. high school physical education and health teachers spend less time teaching death and dying than any of the 21 health topics, and the topic of dying and death is less likely to be required in the 50 states than are any of the other 21 health topics.

Dying in the United States occurs offstage, away from the arena of familiar surroundings of kin and friends, with 80 percent of deaths occurring in institutional settings—hospitals and nursing homes. Back in 1949, deaths in institutional settings accounted for 50 percent of U.S. deaths; thus there has been a rapid rise in away-from-home deaths. Grandfather seldom dies at home today, where he spent most of his life; rather his death likely occurs in an impersonal institutional setting. Over the course of U.S. history, death has migrated "from a position of prominence to one of near invisibility" (Jones, 2008, p. 2). The removal of death from the usual setting prompted Dumont and Foss (1972, p. 2) to raise the question: "How is the modern American able to cope with her/his own death when the deaths experienced are infrequent, highly impersonal, and viewed as virtually abnormal?" For some time now, modern-day Americans have been as repressed about death as the Victorians were about sex. We have become rather adept as a society at avoidance tactics, at removing sickness and dying from everyday life (Thomson, 2008).

Death and dying is a topic to which college students should be able to relate easily—the dead body and its management are mysterious, yet most students likely

have aged relatives at or near the end of their lives, notes British sociologist Tony Walter (2008). Death and sexuality are exotic, yet familiar. Our bodies, being living organisms, eventually deteriorate and die, yet the death of a human body is also inherently social. How we understand dying and death and how we explain our reactions to death are major themes throughout this book. We will look at how academics approach the study of death. A medical doctor will focus on the biological aspects of dying and may rely on an autopsy to definitely determine the cause(s) of a particular death. There are also social, psychological, and spiritual aspects of dying and death as well. Dying and death can be examined from a developmental perspective, viewing death at all stages of the life cycle. In the end, however, what is important to many individuals is the meaning of death. We feel, therefore, that an examination of the meaning of death and death-related behaviors is one of the most important ways to approach the study of dying, death, and bereavement.

CURRENT INTEREST IN DEATH AND DYING

Many Americans express death anxiety, yet many also have an obsessive fascination with death, dying, and the dead. This paradox is apparent in our popular culture, as television programs, movies, songs, and the print media are fraught with thanatological content (Durkin, 2003). The fascination has been fueled by various legal bodies and by legal gymnastics surrounding several prolonged and much-observed deaths of individuals. Though we have a tendency in general to avoid the topic of death, Americans are finally willing to acknowledge that death is part of life and seem to want to talk about it (Foderaro, 1994). As Muriel Gillick (2000) noted, "Death happens 55 million times each year throughout the world and 2.3 million times annually in the United States. Of the tens of billions of people that have ever existed, everyone born before 1880 has died, and nearly everyone currently alive today will perish in this century." Today's **thanatology** (the study of dying, death, and bereavement) student is bombarded by pressing issues of the day that involve death and death-related matters: memories of September 2001; terrorist attacks on the United States and threats of future attacks; the tsunami caused by the earthquake off the West Coast of Northern Sumatra in 2004; Hurricane Katrina hitting the Gulf Coast in 2005; the shootings at Virginia Tech in 2007; the war in Afghanistan; the shootings at Fort Hood, Texas in 2009; the earthquake in Haiti in 2010; the "perfect storm" Hurricane Sandy in New England in 2012; the shootings at the elementary school in Newtown, Connecticut in 2012; the typhoon in the Philippines in 2013; the bombings at the Boston Marathon in 2013; the Malaysia Airlines Boeing Flight 370 disappearance with 239 individuals on board in 2014: the worldwide AIDS crisis; the prolongation of dying from cancer; the growing incidence of chronic illnesses with uncertain courses; murder; ecological disasters; fetal transplants; cloning; and abortion. The topic of death is alive and well in today's contemporary society. Let's look at some of the reasons why dying and death as topics of discussion have come into their own in recent years.

LISTENING TO THE VOICES | DEATH ON THE FARM

As one brought up exposed to a farm environment, George Dickinson remembers on one occasion helping his father dispose of the body of a polled Hereford bull. The bull had been dead for about a day before he was found in the woods. The buzzards circling overhead were a good indication of where the lost bull would be. When he was actually found, about a dozen buzzards were already there. Just shooing those aggressive vultures away from the death scene was indeed a grim portrayal of death. Since the bull weighed approximately 2,000 pounds, Dad decided against earth burial and we then proceeded to cremate the animal. After soaking him in kerosene and putting numerous pieces of timber over the corpse (not completely unlike a pyre, as discussed in Chapter 10), we set him on fire. The corpse was still smoking several days later, though the buzzards had long since gone away. On other occasions, we would have to "put down" a cow and thus practice euthanasia (to be discussed in Chapter 8). At other times a calf would be born dead or die soon after birth. Exposure to births and deaths is commonplace in such a setting.

WHY THE INCREASED INTEREST?

Though death has been around since the beginning of humankind, in recent years a near fascination with death has evolved. Such an increased interest in thanatology is due to several reasons: An aura of mystery surrounding death perhaps brought on in part because of lingering deaths due to chronic illnesses rather than the acute illnesses of an earlier day, terrorism, an interest in ethical issues concerning death and dying, and increased media coverage of deaths, especially violent deaths.

THE MYSTERY OF DEATH An aura of mystery developed. One is taken to the hospital or nursing home and is next seen dead. Thus, a child may begin to wonder what is going on with this thing called death that takes people away, not to return. As one little boy said in writing a letter to God, "Dear God, What is it like when you die? I don't want to do it. I just want to know." Often small children are not allowed to go into certain parts of a hospital; thus, the taboo nature of a hospital setting makes one wonder what is going on in there—"I just want to know." Hospitals do not allow such entry in part because of contagious diseases to which small children would be more vulnerable than adults. Such rejection is not unlike Charles Schulz's saying "no dogs allowed" as Snoopy tries to enter a forbidden area. "No children allowed" is indeed the strong message of rejection here. To say "no" to a child often increases his or her curiosity tremendously. "Why is this place such that I cannot enter?" the child may ask.

A desire to examine this mysterious thing called death has contributed to a growing interest in thanatology. Our society has done little to achieve formal **socialization** of its members to deal with death on personal and emotional levels. Even though the hospital may not allow children to enter certain areas or at particular times, parents have often tried to shield their innocent children from death scenes. Medical and theology schools have not had significant curricular offerings to prepare their students for this death-related work. Overall, our socialization to dying and death situations has been unsystematic and ineffective.

Today's lack of familiarity with death may be in part due to fewer individuals being raised on farms than was the case in the early 20th century. Being brought up in a rural environment gave one direct exposure to birth and death as everyday events. Children were surrounded by the alpha and omega of the life cycle. Kittens, puppies, piglets, lambs, calves, chicks, and colts were born—and also died. Thus, it was commonplace to make observations of death and to deal with these situations accordingly.

Death can be very visible down on the farm. With less than 10 percent of the U.S. population engaged in farming today, birth and death scenes have largely been removed from the personal observations of most individuals. The mystery of these events at the beginning and at the end of life is at least somewhat addressed with farm dwellers—less likely the case with urbanites.

TERRORISM In the post 9/11 era, the ever-present threat of terrorist attacks has injected the unpredictable nature of mortal danger and mass destruction into our collective awareness. Victory in the war on terror depends in part on our ability to live with death threats (Wong & Tomer, 2011). Such fear of an invasion had not presently occurred in the lifetime of most living Americans. A stunned nation watched on television that day, and the days that followed, absolutely in disbelief that such an attack had occurred. Many television viewers saw the second plane hit New York's World Trade Center. In one of the more horrific images, the dead and the doomed plummeted from the skyscrapers. A nightmare of this magnitude was unknown to the majority of U.S. citizens. Not since the attack on Pearl Harbor had such a surprise occurrence taken place, yet this time it hit the U.S. mainland. The sense of security and self-confidence that Americans take as their birthright suffered a grievous blow, from which recovery will take a long time, observed Washington, DC reporter R. W. Apple, Jr. (2001). These deaths were sudden and violent, thus more intense than lingering or expected demises. More guilt may occur as a result because there is no opportunity to say goodbye, express feelings, or make amends (Dickinson, 2011a).

In the aftermath of September 11, 2001, more than 60 percent of Americans who were asked about their emotions responded that their personal sense of security had been shaken, compared with 24 percent in the preceding year; 54 percent feared that they or a member of their family would become a victim of a future terrorist attack (Jonas & Fischer, 2006). Regarding children, in counseling after the 9/11 attack, N. B. Webb (2002) observed that the overwhelming magnitude of this tragedy affected even those children who did not suffer personal losses. Terrorist attacks induce fear, anxiety, and concern about death and seem to be a natural reminder of mortality.

Ken Doka (2003) stated that one of the most significant elements of public tragedy involves the degree to which it is perceived as being caused by humans, particularly in an intentional way. Assigning blame, Doka notes, provides a target for anger, which may help promote an illusion of safety and control. Regarding adolescents' reactions to the terrorist attacks, some good may come out of the bad. For instance, it is suggested in the midst of stress-related disorders that many active attempts at coping and adapting to difficulty may be seen. Following the 9/11 attacks, there was the potential to seriously compromise adolescents' sense of

fairness and justice, yet their increased capacity to think in abstractions and ability to problem solve leaves the potential for adolescents to cope by constructing a sense of order and justice even in the face of senseless acts (Noppe, Noppe, & Bartell, 2006). Such positive approaches to negative circumstances may enhance resilience by promoting greater flexibility in thinking and openness to new information.

Religiousness is generally associated with lower death anxiety, thus religious belief plays a protective role in terror management (Jonas & Fischer, 2006). For example, 84 percent of individuals asked if they had said special prayers in response to the September 11 terrorist attack answered in the affirmative (Smith, Rasinski, & Toce, 2001). Additionally, following the 9/11 attack, the highest level of church attendance since the 1950s was observed in America, with similar spikes in Canada, England, and Australia (Pyszczynski, Solomon, & Greenberg, 2003). Terror management studies have suggested that the reminder of mortality leads people to defend their religious faith (Jonas & Fischer, 2006).

Terror management theory (TMT) suggests that people adhere to cultural worldviews and beliefs in order to suppress death and mortality-related thoughts. TMT says that individuals combat the terror of their mortality with the same cognitive abilities that cause this terror to arise, by developing "death-denying cultural belief systems" (Goldenberg et al., 2000). TMT could explain why many people have trouble interacting with people from different cultures.

Studies by Eva Jonas and Peter Fischer (2006) suggest that those intrinsically vested in their religion (those for whom religion serves as a framework for life by providing both meaning and value) derive terror management benefits from religious beliefs. Religion is unique among meaning systems because it equips individuals to respond to situations in which they come face-to-face with the limits of human control and power and are confronted with their finitude (Smith, Pargament, Brant, & Oliver, 2000).

The September 11 attack contributed to an omnipresent feeling of compassion and a yearning to believe something redemptive could come out of horrific tragedy, noted New York reporter N. R. Kleinfield (2002). Altruism, patriotism, and a sense of unity followed this event, as is often true following a disaster. A sharing of grief, even with strangers, seems to console; it helps to know that others care. The 9/11 dead were like us, and identification with and connections to them happened through the media. Grief shared is grief relieved (Dickinson, 2011a). This event helped many individuals realize just how precious life is and that we should be thankful for what we have. One wakes up in the morning not knowing what the day may bring. An outcome of 9/11 is that individuals today are more aware that the beginning of a bright sunshine-filled day could end up in tragedy.

The events of September 11, 2001, have caused our society to become more paranoid. We tend to "look over our shoulder" more often. We are more suspicious of certain individuals whom we fear might harm us. Airports, government buildings in the United States and abroad, and any facility where large crowds gather have more surveillance and personnel to guard the premises. The possibility of death from terrorism is all around us today, and, unfortunately, it is not likely to go away anytime soon.

ETHICAL ISSUES Individuals are living longer today in part because of medical breakthroughs such as life-support equipment, organ transplants, penicillin and other miracle drugs, clean water supplies, sanitation and other public health measures, healthier diets, more exercise, and improved personal habits (e.g., stopping smoking). We do have a problem with obesity, however, which counters the positive aspects of 21st-century living. Such prolongation of life has raised ethical issues dating back to the 1970s (e.g., Karen Ann Quinlan and Baby Jane Doe) that involve the right to die, causing a furor in philosophy, law, and medicine. The case of Terri Schiavo in Florida in 2005 brought this end-of-life issue to the forefront. With the media highly publicizing these cases, the public was alerted to moral and legal questions on death not previously posed. Whether or not to "pull the plug" and disconnect life-supporting equipment present questions for which ready answers are not found. An elderly woman summed up this dilemma when she spoke to Jinny Tesik of Compassion in Dying (Sturgill, 1995), an organization providing education regarding terminal care: "We used to be afraid to go to the hospital because that's where you went to die; now we're afraid to go because that's where they won't let us die."

The whole issue of when death occurs evolves from these medical developments. The question of who determines when one is alive or dead has been addressed by physicians, lawyers, philosophers, and theologians. These questions, along with the controversy over abortion rights, were a few of the significant ethical issues of the 1970s that provided an open forum for discussion and debate concerning the topic of dying and death. Specific definitions of death were not as necessary, prior to the coming of these 20th-century medical breakthroughs.

POPULAR CULTURE Having grown up in Texas, George Dickinson has fond memories of spending the night with his grandparents on Fridays and going to the movie with his grandfather. The movie was always a Western with basically the same theme—the "good guys" (the cowboys) wore white hats, and the "bad guys" wore black hats. Though toward the end of each movie it appeared that the good guys were going to be wiped out, military reinforcements would always come to the rescue just at the last minute by fighting fair and because the good guys were morally superior. The guys in the white hats would be rescued, and the bad guys would receive their just reward of death. Similarly, recent research (Yokota & Thompson, 2000) of G-rated animated feature films released in theaters between 1937 and 1999 revealed that characters portrayed as bad were much more likely to die of injury than other characters.

In the early 1970s, however, Hollywood began to additionally produce films revolving around the theme of death in which the good guy (the box office star) died. One of the first of these movies to deal with death was *Love Story,* in which one of the two main characters is dying throughout much of the film and eventually does die during the film. Then Tom Hanks dies of AIDS in *Philadelphia Story*, and Susan Sarandon dies of cancer in *Stepmother*. Other movies provide a realistic portrayal of historical events involving mass deaths, such as *Schindler's List* and *Saving Private Ryan*. Twenty-first-century movies include (1) *Igby Goes Down, a* portrayal of two brothers helping their terminally ill mother die with the aid of drugs and a plastic bag, (2) *The*

Hours, with an undercurrent theme of the reasons for suicide, an attempted suicide, and a rational suicide, (3) *The Event,* about a series of unexplained deaths that occur among the gay community in New York City, (4) *The Sea Inside,* about the death of a sailor who became a quadriplegic after injuries in a diving accident, (5) *Million Dollar Baby,* with an underlying theme of assisted suicide, and (6) and *You Don't Know Jack,* a 2010 HBO TV movie about Jack Kevorkian, a medical doctor who helped over 100 individuals die from physician-assisted suicide. Almost an obsession and certainly a fascination with death seem to occur in today's society—especially on the screen in a somewhat imaginative world.

Likewise, many situation comedies on prime-time television in the 1970s, 1980s, 1990s, and now the 21st century have addressed the topic of death. Some have viewed death in a serious vein, whereas others have taken a humorous approach. Among the first situation comedies to talk about death was *The Cosby Show*, starring Bill Cosby. This popular late-1980s and early-1990s program showed an episode in which a goldfish had died. Bill Cosby gathered the family around the toilet bowl in the bathroom and insisted that they have a proper funeral for the deceased fish. One read scripture, one said a eulogy, and then another flushed the fish out into its eternal resting place in the sewer. The episode made a serious effort to explore some issues involving the death of pets, even though one might not experience the death of a goldfish in the same way as the death of a dog.

In addition, *Sesame Street* devoted a 15-minute segment on the death of Mr. Hooper, a few days after his death. However, rather than explore the feelings of loss, the characters focused on all the good qualities of Mr. Hooper. Only in the end did Big Bird, who seemingly was having a more difficult time with the death of his friend, say, "We're going to miss you, Mr. Looper," to which the entire cast said in mass, "That's Hooper, Big Bird, Mr. Hooper." We do miss individuals when they die. Big Bird's comment was a most realistic way of expressing his feelings about the death of a friend on a popular children's television program. Although these two programs were both rather serious, we often respond to both death and sex as topics about which we joke. They are uneasy topics; thus, to laugh about them is a way to cope. More recently from *Sesame Street* in 2010, Katie Couric appeared with Elmo in a special in which they dealt with families coping with the death of a parent.

The sudden, untimely death of John Ritter, just a week before the beginning of the 2003 fall season, posed a dilemma for the producers of his popular show *Eight Simple Rules for Dating My Teenage Daughter*. After much discussion, the producers decided to do a tribute to John Ritter and then to air the first three programs that were previously taped. After the airing of these three programs, the network chose to work John Ritter's sudden death in September into the plot of a special one-hour episode in November. That program opened with Ritter's wife receiving a telephone call about his dying of a heart attack in the supermarket, leaving her and three teenage children to deal with their shock and loss. Thus, the network chose to deal with the death of the primary actor in a real way on the show.

Some of the earliest television programs to discuss death appeared in the early 1970s. *Living with Death* presented various death-related situations observed through the eyes of a CBS reporter. ABC's *The Right to Die* addressed moral questions of mercy killing and suicide. The National Endowment for the Humanities sponsored a program entitled *Dying*. For two hours this program very sensitively portrayed four cancer patients, ranging in age from their late 20s to early 70s. Each died during the course of the filming. A PBS documentary in 1979 showed the last three years of Joan Robinson's life. This film revealed the experience of a woman and her husband as they tried to live with her cancer of the breast and uterus. In the fall of 2000, *On Our Own Terms: Moyers on Dying,* a four-part, six-hour series, explored issues related to death and dying, including candid conversations with people dying in their homes and in hospitals. This series was followed by a companion show, *With Eyes Open*, a four-part PBS series of half-hour interviews examining grief, mortality, caregiving, and the afterlife. HBO's comedy-drama *Six Feet Under* came onto television screens at the beginning of the 21st century and depicted life in a funeral home. Such a weekly encounter gave viewers an idea as to what goes on behind the scenes in a funeral home, thus adding to the audience's awareness of death. *Six Feet Under* received critical acclaim and was praised for being so frank about death and its effects (Harper, 2009). *Death and the Civil War* aired on PBS in 2012 and gave a vivid depiction of death on the battlefield and discussed how death in that time period contributed to changes in the way death is viewed in the United States. The 2014 HBO show *Girls* twice addressed the issue of grief and death, with the show highlighting how the Internet has made grief more casual and public, and another episode with the sudden death of the editor on the show (Seligson, 2014).

Violence, including death, is highly revealed on television today. For example, a study by the Parents Television Council (2011) found that 2002 depictions of violence in television programs were 41 percent more frequent during the 8 p.m. Family Hour, and 134 percent more frequent during the 9 p.m. hour than in 1998. Television violence has become more graphic over time, with frequent use of guns or other weapons, more depictions of blood in violent scenes, and more on-scene killings and depictions of death in 2002 than in 1998. UPN and Fox had the highest rates for violence during the Family Hour in 2012.

Two movies with military themes, *Black Hawk Down* and *We Were Soldiers*, showed U.S. military attempts to recover fallen soldiers in Somalia and Vietnam. In that same theme, *Platoon* gave a rather realistic view of the Vietnam War. Such movies bring to life on the screen what is happening in military encounters in various places in the world even today. Death is alive and well in contemporary U.S. movies. The media are bringing death into movie theaters and right into our homes. By these occasional reminders of death, our interest in death is probably increased.

The topic of dying and death maintained a high profile throughout the 1990s, in part because of Dr. Jack Kevorkian. His "suicide machine" to terminate the life of a terminally ill patient with Alzheimer's disease in Michigan in 1990 drew headlines in the media. Subsequent suicide deaths assisted by Dr. Kevorkian through the

1990s fanned the fire of this controversy. Kevorkian's actions peaked with the video showing on *60 Minutes* in 1998, after which he ended up in prison. Much was aired about the whole controversy of CBS's showing this on television. This "shot" was heard (and seen) around the world. The various trials of Dr. Kevorkian brought extensive coverage in the media. What more drama could the media request? Although some individuals might have viewed Kevorkian more or less as a serial killer, he continued to be allowed to practice his physician-assisted suicide in defiance of the law. His goal was to change the law and make this behavior legal. In standing up for that which he felt to be right and at the risk of his own life, Kevorkian fought on and gained many supporters. After all, here was a man who would risk life and reputation (no matter how obnoxious he seemed to many) to prove his point. The media loved it and gave him the publicity he desired.

In addition to Dr. Kevorkian's actions, the issue of physician-assisted suicide made headlines when voters in Washington, California, and Oregon went to the polls in the early 1990s to decide the legality of this issue. Although the final vote counts in Washington and California were close, such action was not approved. On the other hand, the voters of Oregon successfully approved physician-assisted suicide in 1994 (and again in 1997). The Oregon voting was followed by court action and ultimately action by the Supreme Court (see Chapter 8). The pros and cons of assisted deaths were debated on talk shows on both radio and television. Individuals tend to have strong opinions regarding topics such as abortion and assisted deaths. Therefore, such controversial topics solicit heavy media coverage. Then in 2008 the voters of Washington returned to the polls and this time approved physician-assisted suicide. In 2010 the Supreme Court of Montana, not the voters, ruled that state law protects doctors from prosecution for helping terminally ill patients die. The Montana Supreme Court, in taking such action, sidestepped the larger landmark issue of whether physician-assisted suicide is a right guaranteed under the state's constitution (Enck, 2010).

Peter Nardi (1990) analyzed how the media handles AIDS and obituaries. He noted that one of the main issues raised by obituary reporting is personal privacy versus journalistic ethics. Unlike other diseases often unreported in earlier generations such as tuberculosis and cancer, AIDS raises questions of both medical and sexual ethics. The dilemmas faced by the media in AIDS-related deaths draw attention to the continuing stigma attached to AIDS. Sociologists and other social scientists have the task of identifying the circumstances and social-psychological processes underlying these negative attitudes.

The media have been a positive force in bringing the topic of AIDS out of the closet. For example, when a celebrity or sports hero is infected with human immunodeficiency virus (HIV), the media have contributed to *AIDS* and *HIV* becoming household words (Lemelle, Harrington, & Leblanc, 2000). Back in 1991, when NBA star Magic Johnson publicly announced that he was HIV-positive, this hero for many, a heterosexual athlete, produced new ways to respond to AIDS from both the media and the public. Today, the public is more accepting of the identification of HIV infection and the testing procedures for detecting HIV antibodies. Yet, these discoveries were scientific breakthroughs and altered life for many, noted Lemelle and colleagues.

Historically, thanatological themes have been present in numerous musical styles from operas and classical music to folk songs about serial killers dating back into the 19th century (Schecter & Everitt, 1997). Music popular with young people often has a morbid element that highlights death in a catastrophic and destructive manner such as in heavy metal and rap. Ice Cube's "Death Certificate" and "Lethal Injection" rode high on the charts in the 1990s. Some heavy metal bands have death-associated names: Megadeth, Anthrax, Slayer, and Grim Reaper. Examples of their song titles include "Suicide Solution," "Highway to Hell," and "Psycho Killer." One of the more successful rap recording companies is named Death Row Records. Rap song titles include "Murder Was the Case," "Cop Killer," "Sex, Money, and Murder," and "Natural Born Killers" (Durkin, 2003). Lyrics of some of the songs have such wording as "Baby join me in death, this life ain't worth living," with these lyrics being repeated over and over by the Finnish group HIM. Yet there is Bob Dylan's "Death is not the end," which tries to give hope to the listener, with various lines such as "and you just can't find a friend" or "you don't know what's around the road" sang just before "death is not the end."

Reports of dying and death are found in daily newspapers through death notices, sometimes accompanied by a photo of the deceased individual. Newspapers also highlight sensational deaths or catastrophic events. Printed matter such as novels and crime books are often filled with deaths, both violent and natural. Weekly magazines typically have a section referred to as "transitions" where they denote deaths of celebrities. In addition to media interest with death and dying is the rise of spontaneous shrines to victims of road accidents, a reminder to travelers of a death at that roadside spot.

George Dickinson

Roadside memorials are often placed near the spot where a highway fatality occurred. Typically the memorial has a religious significance, such as the crosses seen here. Such memorials are found in many countries around the world.

DEATH EDUCATION

The topic of dying and death did not come into its own in recent times until the 1970s. Certainly death, like sex, was not a new event, yet was something joked about but rarely discussed openly. Sex, as a subject of discussion, came "out of the closet" in the 1960s, followed by death in the 1970s.

THANATOLOGY CLASSES If the mission of colleges and universities is, in part, to prepare students for personal challenges, then undergraduate education is an excellent place to include death and dying education, as this is something which all students will definitely face (Ratner & Song, 2002). Some of the goals of death education are to promote discourse about death, explain the developmental processes of death understanding, integrate the dying with the living, heighten sensitivity about cultural variations in dying, death and grief, and appreciate the universal and individual course of the grief experience (Cupit, Sofka, & Gilbert, 2012). Death and dying offerings began to flourish back in the 1970s. Though a count as to the number of offerings in different departments in the United States is not available, Lizabeth Eckerd (2009) found in a recent survey of psychology departments in nine midwestern states that approximately 20 percent had offered a course in death, dying, and bereavement within the last five years. Overall, death and dying courses in the United States tend to be offered in psychology, sociology, social work, religious studies, philosophy, human services, and health sciences departments and have increasingly become legitimate topics of study over the past decade (Cupit, Sofka, & Gilbert, 2012).

In elementary and secondary school curricula, death and dying is on the "approval list" in many states, yet such an option does not always have a high priority. When we ask students in our death and dying classes if they had any death and dying orientation in public schools, very few answer in the affirmative. Students who attended a parochial school are more likely to have had such instruction. Hannelore Wass, a pioneer in death education in the United States, observed that even though death education and crisis intervention programs exist, they are available to only a minority of the 48 million students attending public school in the United States (2004).

Some outcomes of death education have demonstrated greater cognitive understanding and behavioral changes for students exposed to such education (Rocco, Jaclyn, & Heather, 2007). There has also shown to be a decrease in fear, less concern about dying, and a decline in death anxiety for those with death education, resulting in affective changes and changes of knowledge and behavior about death. Most schools have established protocols for crisis intervention, although preventative education through the study of death and dying remains controversial. Yet, death education could be part of a student's cultural education and could promote life-affirming and constructive attitudes about behavior toward self and others, note Rocco and colleagues. A better understanding of life, respect, empathy, and compassion all contribute to a higher quality of life.

Fergus Bordewich (1988) stated a quarter of a century ago that death was less likely than sex to be found as a subject in the curricula of American public schools. If death was acknowledged at all, it was usually discussed within the context of literary classics. In recent years, courses treating dying and death far more explicitly have begun to appear in schools across the country. Many schools have

"I think you'll be interested in the next patient. He's ninety two years old and accompanied by his parents."

Campbell, Martha/CSL, CartoonStock Ltd.

blended some of the philosophies and techniques of death education into health, social studies, and literature courses. Others have introduced suicide-prevention programs. With various shootings in high schools around the United States, interest in thanatology has increased significantly since the mid-1990s.

An argument for death education, noted by Bordewich said:

> An underlying, but seldom spoken, assumption of much of the death-education movement is that Americans handle death and dying poorly and that we ought to be doing better at it. As in the case of many other problems, many Americans believe that education can initiate change. Change is evident, and death education will play as important a part in changing attitudes toward death as sex education played in changing attitudes toward sex information and wider acceptance of various sexual practices. (1988, p. 31)

Edward Ratner and John Song (2002) observed that not enough is being done with death education. They noted that the most common approach to death education is to create an elective course for students interested in studying thanatology or in providing health care to dying patients. Such electives, they argue, reach very few students and often treat dying as a separate field of study, rather than as a part of everyone's future. Instead, colleges and universities should require students to take a general course on dying or integrate material on death into the curricula of as many disciplines as possible—or do both, they suggested. Furthermore, Ratner and Song, faculty members in the Center for Bioethics at the University of

Minnesota, argued that every undergraduate major and postgraduate field of study could include information on death.

Death education provides an opportunity to familiarize students and professionals with the needs and issues surrounding dying and death. One of the goals of courses on dying and death for all age groups is to increase knowledge about death and about the professions involved with death—funeral directors, medical personnel, and governmental organizations. Other goals are to help students learn to cope with the deaths of significant others, to deal with their own mortality, to be more sensitive to the needs of others, and to become more aware of different cultural groups' death and bereavement customs. A more abstract goal is to understand the social and ethical issues concerning death as well as the value judgments involved with these issues. As some students with personal problems may enroll in a death and dying course, instructors should be alert to this and not want to heighten their anxieties regarding unresolved losses. Instructors should look for signs displayed by at-risk students in death education classes.

The emotional conflicts related to dying and death are particularly acute for primary care health professionals. Although limited emphasis has historically been placed on death education in schools for health professionals in the United States, more recent studies of death education offerings in nursing, medicine, pharmacy, dentistry, child life specialty, and social work are somewhat encouraging (Dickinson, Sumner, & Frederick, 1992; Dickinson, 2007a; Parvin & Dickinson, 2010; Sirmons, Dickinson, & Burkett, 2010; Dickinson, 2011b; Dickinson, 2012a; Dickinson, 2012b).

As more emphasis is placed on relating to terminally ill patients and their families in the health professions, we would hope that more positive attitudes toward treatment of the dying patient will emerge when these students become practitioners. Helping students deal with their own anxieties about death at the time of actually facing terminally ill patients would seem to be an appropriate time for intervention. In the end, the young professional, the patient, and the patient's family all should benefit from this emphasis on death education.

THANATOLOGY PUBLICATIONS In the 1970s Michel Vovelle (1976) published an article entitled "The Rediscovery of Death," in which he documented the sudden flurry of publications on the subject of death that appeared in the Western world from the 1950s on. Geoffrey Gorer's 1955 essay on "The Pornography of Death" seemed to open the door for publications on the subject of death. Gorer argued that death had replaced sex as contemporary society's major taboo topic. With death in the community becoming rarer and with individuals actually seeing fewer corpses, a relatively realistic view of death had been replaced by a voyeuristic, adolescent preoccupation with it, observed Gorer. Vovelle argued that the focus of attention represented by these texts amounted to nothing less than the "displacement of a deeply seated taboo on a subject that had lain hidden in the shadows of the western psyche since some unspecified point in the 19th century" (Prior, 1989, p. 4).

One of the early texts for thanatology, published in 1959, was an anthology by psychologist Herman Feifel entitled *The Meaning of Death*. Feifel's work was an interdisciplinary attempt to restore death to cultural consciousness. In 1963, Jessica Mitford's *The American Way of Death* was very critical of the funeral industry. Elisabeth Kübler-Ross's *On Death and Dying*, published in 1969, advised

Tennessee Tech University Department of Archives

Though some early parish registers did not list the deaths of babies, this early 20th-century portrait of an Appalachian family reveals the importance of every member of the family, even the deceased one. This was obviously a sad time for the family, yet the somber expressions on the members' faces were typical of photos from this period.

LISTENING TO THE VOICES | STILL LIFE

Take photographs of a dead child? No way. To me, it was creepy, exploitative, and completely out of the question. I could not stop envisioning scenes typical of forensic crime lab dramas. Gray-hued cadavers placed on shiny tables in a windowless, disinfected room.

I was already a hormonal mess, sleep-deprived, and completely traumatized by what was about to happen. First of all, this is not at all how I had foreseen my first childbirth experience. I was supposed to be at least eight months along with a lost mucous plug or ruptured membranes. I was supposed to be fat with rosy cheeks (like Mrs. Claus, only with anxiety and contractions).

My husband and I had never been parents before, and now we were about to meet a child we'd never change, feed, or soothe. Our pastor told us that our pain was that of mourning our dashed hopes and anticipated joys. I just wanted this stillbirth nightmare to be over so I could go home and scream at the top of my lungs and pack away the crib and blankets. I wanted to hide in my bedroom and reflect upon why I was not meant to be a mother. I even felt like a disappointment to the labor and delivery staff in that I could not produce what so many thousands before me had.

My arrival at the hospital was like that of any normal expectant mother for a scheduled induction. I wore house socks and held my husband's quivering hand. We entered the business office and received identification bracelets. We waited in a stark white room with a wall clock and a barrage of television infomercials declaring the merits of Magic Bullets, OxiClean, and bareMinerals. When the doctor finally delivered her, I was afraid to look. After all, she was arriving so early, with so many internal abnormalities of which we were already aware, that I thought she might appear alien-like. Nevertheless, when my very first flesh and blood production was placed lifeless in my arms, she looked like a sleeping cherub. With the pink tone of life slowly fading from her face, she appeared strangely content with her unfortunate fate, as if she had maturely accepted it long before we had. It was difficult knowing that for so long (six months to be exact), I had essentially been her life support (her ventilator, if you will). According to the doctors, I wasn't doing her any favors. I held her and stared at her for a very long time. I talked to her. My husband rocked her. We most definitely did not want the video camera. But several family members were really pushing the photograph issue.

"That way you'll never look back and say, 'I wish I had.'"

"That way you will know that you did every thing you could to honor her."

But I was afraid to take her picture. The mere suggestion felt like an invasion of privacy. Would we not be disrespecting the deceased? I began contemplating the meaning of a "snapshot." What purpose does it serve? I suppose it's how we, as humans, attempt to hard-wire a memory. Among other things, we also use photos for evidence, protection, justification, and art. Did I wish to place on a back burner in my mind the physical and emotional despair of this day? Or did I need to prove to myself what a glorious part in the circle of life I had played? Granted, my most significant role in the universe thus far would be short-lived. However, I had indeed become a parent. I was the only female who would ever nurture this one-pound, 15-ounce being. Even though life had failed her, I was still a proud mother. I describe the experience as the single best and worst day of my life. My child had not lived, but I had met her. That was enough.

And we *did* take photographs—moments that to this day have only been witnessed by my husband and very few family members. I even made a small keepsake album that I keep hidden away. From time to time, I will glance at these sacred images even today, six years later. Looking back now, I don't know why I was so opposed to taking these photographs. No, they did not include Santa, her teammates, pets, or birthday cakes, but they are ours to touch and stare at when we need proof of that wonderful nightmare. I can marvel at how her features resemble those of her younger sisters, who are still too young to comprehend her tragic fate.

I now do not know how I would cope *without* those photographs. I shudder to think that my fear of the unknown nearly destroyed my firstborn's opportunity to achieve a physical permanence within her mother's life. And that would have been *my* greatest tragedy.

Source: H. Philpot. (January 2010). Still Life. S*kirt*, p. 24. Heather Philpot is a wife, mother, and freelance writer who lives in Travelers Rest, South Carolina.

Americans that they can play a significant role in the lives of the dying. Ernest Becker's *The Denial of Death*, published in 1973, argued that denying death is commonplace in our society. Both Kübler-Ross's and Becker's books became best-sellers. It was Kübler-Ross, a physician, who was a real catalyst in making the medical profession realize that terminally ill patients are more than the cancer patient in Room 713 and are warm, living human beings who have personal needs. Both of these books alerted the public to the issue of dying in America.

A popular book discussing dying that was on the bestseller list from 1998 through 2001 is Mitch Albom's *Tuesdays with Morrie* (1997), in which the author writes about his former college professor who is dying of amyotrophic lateral sclerosis (ALS). Sandra Gilbert's *Death's Door: Modern Dying and the Ways We Grieve* (2006) combines literary and cultural criticism with the intimacy of memoir. From a physician's perspective, Christine Montross's *Body of Work: Meditations on Mortality from the Human Anatomy Lab* (2007) gives a glimpse into the day-to-day life of a medical student dealing with dying and with dead human bodies. Shelly Kagan's *Death* (2012) invites the reader to take a fresh look at one of the central features of the human condition—the fact that we will die. Karla Erickson's *How We Die Now: Intimacy and the Work of Dying* (2013) is about what can be learned from those who work with the dying. Candi Cann's *Virtual Afterlives: Grieving the Dead in the Twenty-First Century* (2014) investigates emerging popular bereavement traditions.

Two professional journals on thanatology emerged in the United States in the 1970s: *Death Studies* (formerly *Death Education*) and *Omega: The Journal of Death and Dying*. In 1996 in England, *Mortality* evolved as a thanatology journal. Whereas the U.S. thanatology journals are psychology-oriented, *Mortality* has more of a mix of disciplines, with an orientation toward sociology. Other related journals in the United States and United Kingdom are *The Hospice Journal*, *Progress in Palliative Care*, *Palliative Medicine*, *Social Science and Medicine*, *American Journal of Hospice and Palliative Medicine*, *Suicide and Life-Threatening Behavior*, and *Illness, Crisis & Loss*. The number of articles on death also expanded considerably in journals of education, family, medicine, health, nursing, psychology, social work, and sociology.

Death education should not only prove useful in coping with dying and death situations, but also should actually improve the quality of our living. As Elisabeth Kübler-Ross noted, relating to the dying does not depress her, but rather it makes her both appreciative of each day of life and thankful each morning that she awakes with the potential of another day. Learning more about dying and death should provoke one to strive to make each day count in a positive way. Educating oneself about death will tend to make one "look for the good in others and dwell on it," as the late author Alex Haley suggested on his letterhead stationery.

MORTALITY STATISTICS

Ask an individual how he or she wishes to die. With the exception of the comical reply, "When I am 92 and at the hands of a jealous lover," most people will respond, "When I am very old, at home, unexpectedly, in my own bed, while sleeping—and with my full mental and physical capabilities." Unfortunately for most of us, we will not die as we would like. For some, this fact may be a source of apprehension and anxiety.

DEATH ETIOLOGY AND LIFE EXPECTANCY

Mortality rates have been declining in most developed countries since the mid-1800s. There has been a steady upward trend in the highest life expectancy at birth with an average increase of about three months per year since 1840 (Crimmins & Beltran-Sanchez, 2010). Recent increases in life expectancy have depended on increasing survival among the older adult population, however. A study using the World Health Organization's mortality data from 1955 to 2004 for 50 countries (Viner et al., 2011) revealed that in the 1950s, mortality in the one-to-four age group far exceeded that of all other age groups in all regions studied. In the 50 years leading up to 2004, however, death rates in children aged one to nine fell by 80 to 93 percent, mostly due to reductions in deaths from infectious diseases. By contrast, declines in death rates in those aged 15 to 24 years were only about half that of children, mainly because of increases in injury-related deaths, particularly in young men. For example, by the start of the 21st century, injuries (e.g., car crashes and street or gang violence) were responsible for 70 to 75 percent of all deaths in males aged 10 to 24 in all the regions studied. By 2004, suicide and violence were responsible for between one-fourth and one-third of deaths in males aged 10 to 24 years, and death rates in males between ages 15 and 24 are now two to three times higher than in boys aged one to four.

Whereas in the 19th century the mortality rate was particularly high among children and continued at a high level throughout adult life, the incidence of death is now heavily concentrated among the elderly. Thus, average life expectancy is now much longer. For most individuals, death approaches slowly over years of gradual decline. For example, the number of years individuals will live with conditions like vision or hearing loss and mental health issues such as depression is also increasing (Cheng, 2012). As noted in Table 1.1, the cause of death (**etiology**) for nearly half of us will be from one of two chronic diseases—heart disease or cancer. With these **chronic diseases**, deaths are usually prolonged and are not sudden and unexpected, as most people might desire. In the early 1900s, infectious diseases accounted for more deaths, whereas today cardiovascular diseases and cancers account for over half of deaths in the United States. While chronic diseases are killing more people nearly everywhere, the overall trend is the opposite in Africa, however, where illnesses like AIDS, malaria, and tuberculosis are still major threats (Cheng, 2012).

Cardiovascular disease has been the leading cause of death in the United States since the 1950s. Likewise, heart disease is thought to be the largest cause of death worldwide with estimates of 16.7 million lives annually, with cancer accounting for some 7.9 million deaths (Howarth, 2009). Yet in the United States, mortality rates from cardiovascular disease declined between 1970 and 2000, accounting for much of the increase in life expectancy at birth during this period (Crimmins & Beltran-Sanchez, 2010). The reduction of high cholesterol and hypertension, largely resulting from prescription drugs, has likely contributed to this decline. The growing problem of obesity, however, is projected to increase in the future, contributing to cardiovascular disease and diabetes. Additionally, mortality rates from a number of cancers, the second-leading cause of death in the United States, have decreased in recent years. Leading causes of cancer deaths are from lung, breast, prostate, and colorectal cancer.

In the United States, cigarette consumption remains the single most preventable cause of sickness and premature death (Anderson, 1996). Although smoking rates have declined since the 1960s, rates have leveled off in the past decade. About

Table 1.1 | Leading Causes of Death in the United States, 1900 and 2010 (in Death Rates per 100,000 Population)

Causes of Death	Death Rates Per 100,000 Population
1900*	
1. Pneumonia	191.9
2. Consumption (tuberculosis)	190.5
3. Heart disease	134.0
4. Diarrheal diseases	85.1
5. Kidney diseases	83.7
6. All accidents	72.3
7. Apoplexy (stroke)	66.6
8. Cancer	60.0
9. Old age	54.0
10. Bronchitis	48.3
2010	
1. Heart disease	192.9
2. Cancer	185.9
3. Chronic lower respiratory diseases (lungs)	44.6
4. Stroke (cerebrovascular diseases)	41.8
5. Accidents (unintentional injuries)	38.2
6. Alzheimer's disease	27.0
7. Diabetes	22.3
8. Kidney diseases	16.3
9. Influenza and pneumonia	16.2
10. Suicide	12.2

*These data are limited to the registration area, which included 10 registration states and all cities having at least 8,000 inhabitants. In 1900 this comprised 38 percent of the entire population of the continental United States. Since accidents were not reported in the 1900 census, this rate was taken from Lerner (1970).

Sources: *Abstract of the Twelfth Census of the United States, 1900*. Table 93. Washington, DC: U.S. Government Printing Office, 1902; National Center for Health Statistics, *National Vital Statistics Reports*, 2010, *60*(4), Centers for Disease Control and Prevention. Atlanta, GA, January 11, 2012.

21 percent of U.S. adults and nearly 20 percent of high school students smoke cigarettes (Salahi, 2011). Smoking is responsible for the deaths of more people each year than alcohol, AIDS, car accidents, murders, suicides, and illegal drugs combined. Overall, smoking kills 434,000 Americans each year. Perhaps even more alarming, over a three-week period, second-hand smoke kills an equal number of innocent Americans to those killed in the World Trade Center attacks of September 11 (Snell, 2005). American women did not begin smoking in large numbers until after World War II, and their rates of lung cancer are now matching those of men (Cockerham, 2012). Worldwide, cigarette smoking has increased significantly in recent years and is now responsible on a global basis for about 5 percent (a conservative estimate) of all deaths (approximately 20 percent of all deaths in the United States) (Anderson, 1996).

In the United Kingdom, a ban was imposed on public smoking in July of 2007 (Leake, 2009). The ban on smoking has caused a fall in heart attack rates of about 10 percent within a year. In Scotland, where the public ban on smoking was introduced a year earlier, heart attack rates have fallen by about 14 percent because of the ban. The success of the smoking ban is emerging as one of the most significant improvements in public heath that Britain has seen. There are now movements in England to ban smoking in cars where children are present and at home in front of children. Each year in the United Kingdom 114,000 die of smoking-related diseases.

In June of 2011 the U.S. Food and Drug Administration unveiled the final nine graphics to appear on cigarette packs starting October 22, 2012. These include images of a man with rotting teeth and smoking from a tracheotomy hole with one-line facts like "cigarettes cause cancer" (Salahi, 2011). Graphic health warnings displayed in other countries seemingly work better than text warnings to motivate smokers to quit. For example, images used on cigarette packs in countries such as Canada are so disturbing that some smokers buy covers for their cigarette packs to block out the images. Though the United States was the first country to require health warnings on tobacco products, it is now playing catch-up to more than 30 countries that already require large, graphic cigarette warnings.

Yet despite lower death rates with bans on cigarette smoking, cigarette smoking is becoming more popular in movies today, as it was recently reported that there are as many people smoking on screen today as there were in 1950 (Rifkind, 2006). In the 1970s and 1980s, films featured or made reference to smoking an average of eight times; by the late 1990s, this number had risen to 25 times. Some 85 percent of the 250 top-grossing films in the 1990s featured smoking. Smoking is often considered to be cool, sexy, and glamorous in movies. What kind of image is this presenting for movie-goers in the 21st century?

Life expectancy has increased considerably in the United States since 1900, when it was 47 years at birth, compared to 78 in 2011. A hundred years ago, only 4 percent of the U.S. population was over the age of 65; today, that figure is 13 percent and is projected by 2050 to constitute 20 percent of the American population. Since 1950 life expectancy for males in the United States has increased from 66 years to 75 years, whereas females' life expectancy during this same period has increased from 71 to 80 years. Whites live nearly seven years longer than blacks in the United States. According to a study reported in the *New York Times* ("Is Life Expectancy Now Stretched to Its Limit?", 1990), however, there may be a limit to how long our bodies can hold out. The study concluded that science and medicine have pushed human life expectancy to its natural limit of about 85 years. The researchers note that even if a cure were found for most fatal diseases such as heart disease and cancer, the natural degeneration of the body puts a cap of about 85 years on the average life span.

White Americans living to age 80 and older, however, can expect to keep on living longer than octogenarians in other industrialized countries. The United States, which ranks 25th among nations in life expectancy at birth, is having its average life expectancy lowered by a high **infant mortality rate** and higher death rates until middle age (National Center for Health Statistics, 2009). For example, infant mortality rates in Japan and Sweden (2.6 and 2.8, respectively) are much lower than those in the United States (6.7). Though the reason is not known for sure, demographers suggest that the explanation why the oldest Americans are so

George Dickinson

These cigarette cartons in England reveal the dangers of smoking. The smoker is warned as to his or her behavior prior to lighting up. But then the smoker may think, "That won't happen to me."

George Dickinson

These white crosses in a cemetery in Zermatt, Switzerland depict the deaths of infants. This entire section of the cemetery has only graves of infants with the year of birth and death, and a name. Note the flowers growing within the enclosed area of the small graves.

long-lived is because their universal health insurance through Medicare may provide better care than old people receive elsewhere. Another factor might be the effect of education. A more educated society means a higher standard of living, which ultimately contributes to longevity.

Though medical and scientific breakthroughs have obviously contributed to an increased life expectancy, the American public has also strived to change its lifestyle and improve its health in recent years. Priorities for health promotion are smoking cessation, physical exercise, nutrition and weight control, stress management, safe sex, and appropriate use of alcohol and other drugs. Although one cannot change his or her heredity, one can have an impact on life expectancy through exercise, nutrition, and patterns of living.

GENDER DIFFERENCES IN MORTALITY RATES

Beatrice Gottlieb in *The Family in the Western World: From the Black Death to the Industrial Age* (1993) observed that in spite of childbirth always being risky for women—riskier in the past than now—men do not as a rule outlive women, nor did they in the past. The only exceptions worldwide are in southern Asia in countries such as Bangladesh and Nepal where men outlive women by a slight margin (Cockerham, 2012). Nutritional deprivation and lessened access to medical care are among the possible reasons for this reversal of the usual female superiority in life expectancy. Outside of southern Asia, women have a definite advantage over men in longevity.

In modern Western countries life expectancy is longer for women than for men, but this is not a new development. Although female infants initially are almost always outnumbered by male infants, a more equal balance is reached now, and also in the past, because male infants had a higher death rate. Indeed, the danger of childbirth was an important experience of families in the past; yet

whatever is said about women dying in childbirth has to be put into this context of overall female survival (Gottlieb, 1993).

In the 19th-century United States, however, women typically died younger than men (Freund & McGuire, 1995). Reasons included women incurring risks in pregnancy and childbirth and women often getting what food was left after men and children ate their share. However, by the 1920s the gender patterns in mortality rates in the United States had changed, and women generally were living longer than men, as had seemingly been the case in the rest of the Western world. Today, mortality rates for the two leading causes of death in the United States, heart disease and cancer, are higher for men than for women (Weiss & Lonnquist, 2009). Higher death rates from heart disease in men could be attributed to a higher rate of smoking and a harder-driving personality; also, sex hormones secreted by women's ovaries may provide some protection against heart disease. Higher cancer rates in men are probably attributed again to smoking cigarettes, drinking alcohol more excessively, and being exposed to cancer-causing agents in the workplace. Indeed, men are more likely than women to die from almost all of the most common fatal diseases.

Biological advantages contributing to greater longevity for women may come from hormonal differences. Also, the monthly menstrual cycle of women reduces their iron count; thus women are less likely than men to build up a surplus of iron in their bodies. In addition, the conception ratio, projected to be higher than 120 males per 100 females, favors males in the United States, yet the **sex ratio** at birth is down to 105. Thus, male embryos and fetuses are the "weaker" of the sexes and die off more quickly. In the teens the sex ratio levels off, and after age 80, the ratio is less than 50 males per 100 females. There is evidence that female life expectancy is also higher among many other animal species (Sagan, 1987). Perhaps females simply have better-built bodies. Their bodies have the potential of carrying and supporting an embryo or fetus. Thus, females are the Porsche or Lamborghini model, whereas males are the more thrown-together model.

Regarding cultural differences between the sexes, conceivably females watch their diet more carefully than do males due to their traditional knowledge about food and a special cultural emphasis on weight maintenance. With more current emphasis on diet and exercise for both males and females, however, this difference may diminish.

Anthropologist Ashley Montagu (1968) suggests that women have a superior use of emotions because they are more likely to cry than men. Because it is not macho to cry, men generally refrain from such behavior, resulting in more psychosomatic disorders such as peptic ulcers. Montagu asks, "Is this a superior use of emotions?" Perhaps being freer to express themselves through the release of emotional feelings contributes to a decrease of stress for women.

Males have historically been involved in more risk-taking activities, as mentioned earlier, through masculine behavior such as smoking (the rugged Marlboro man, for example) and drinking. Males have also been more inclined to drive fast cars, live the James Dean devil-may-care life, and participate in violent sports. Accidents cause more deaths among males than among females (Cockerham, 2012). Males also have had more dangerous jobs, such as coal mining. Males have been in higher stress-producing positions, such as CEOs and other high-ranking administrative positions, than have females, though this is changing in the 21st century.

Despite the fact that men die earlier and have more life-threatening illnesses, women have higher **morbidity** (illness) rates than men (Freund & McGuire, 1995). Chronic illnesses are more prevalent among women than men, but they are less severe and life threatening. When sex differences are considered, an inverse relationship appears to exist between mortality and morbidity (Cockerham, 2012). Women may be sick more often but live longer. Men may be sick less often but die sooner. Women report more episodes of illness and more contact with physicians. Perhaps women are more willing than macho men to report that they are sick. Because illness indicates weakness, men are less likely to visit a physician or admit that they are anything less than healthy. A recent **longitudinal study** of 1,000 middle-age men in Wisconsin (Springer & Mouzon, 2009), for example, revealed that men who strongly endorse "old-school" notions of masculinity were half as likely as other men to seek preventive health care, such as an annual physical exam. Even men with a high level of education were less likely to seek preventive health care if they adhered to the ideal of the macho man. Such evidence contributes to the explanation of the gender longevity gap with women outliving men.

As gender roles continue to change, as females are found in greater numbers and in a greater variety of nontraditional occupations, as males share more in domestic tasks, and as the sexes come together in more unisex behaviors (more women smoking and drinking, having more stressful jobs, and living the "fast" life), stresses and strains of life should be more equally distributed between men and women. The argument of biology versus culture as influencing life expectancy by sex can then be better addressed.

APPROACHES TO THE STUDY OF DYING AND DEATH

There are several ways to approach the study of dying and death. The two primary areas of study are the natural sciences and the social sciences. Natural sciences include the biological approach. Social sciences include the sociological approach. The anthropological and psychological approaches mainly fall within the social sciences arena—certainly the case for studying death and dying—though they have sub-areas that lean toward the natural sciences. In addition, the humanities may address dying and death through literature, music, history, and philosophy.

In following the scientific method for research purposes, all the approaches use the same empirical methodology—the specific ways of gathering data simply vary. Nonetheless, the methodology is based on observation and reasoning, not on supernatural revelation, intuition, appeals to authority, or personal speculation.

The theoretical approach of this book is largely sociological, though somewhat slanted toward social psychology (the discipline that bridges sociology and psychology). We will take an anthropological approach at times, particularly when we discuss different cultures. The psychological orientation is woven into the social psychology bent of the book. A philosophical approach is another way to approach the study of dying and death. The biological approach is evident when medical issues pertaining to the human body (structure and function) are discussed. Medical issues regarding causes of disease, for example, are biological (genetic causes), yet also social (environmental causes).

The Biological Approach

Biology is the study of life. Though this is a book on dying and death, it is really about living and life. Thus, the biological approach indeed has merit in a book like this. The process of dying is primarily a biological process—something that the body does to the person. In this book, however, we are more concerned with what people *do* with that process. For example, biologists and medical personnel (or anyone else, including social scientists) respond to the *meaning* of the biology rather than to the biology per se. The physician's decisions are made on the basis of what the biological condition means to that physician. Making a medical diagnosis is the process by which the physician decides the meaning of the biological factors. This diagnosis, then, represents the process of transposing biological factors into meaning factors.

A recurring dramatic illustration of the fact that the behavior of the physician and others stems from the meaning rather than from the biology per se can be seen each time the news media report that a corpse in the morgue has come back to life after being wrongly pronounced dead by the experts. The physician's belief that a body is dead does not guarantee that it is. Behavior follows from the meaning, not from the biological factors per se—a *living* body was sent to the morgue.

A later discussion of dying in the American health care system (see Chapter 7) will focus on the medical model. The medical model suggests that when sick, we go to a physician to be made well. Yet the dying patient in the later stages of the illness cannot usually be made well. The dying patient then becomes the "deviant" within the medical system—the body is beyond healing. Chapters 5, 6, and 7 will discuss the dying process and will bring in biological issues (Chapter 8 is about biomedical issues) but will also bring out relationships between physicians and patients and families (more of a social science orientation). Indeed, the biological approach is about life, yet life includes dying and death.

The Psychological Approach

A psychological approach to dying examines, among other issues, the experiences of pain (see Chapter 6), death anxiety (discussed in Chapter 2), and emotional stages in dying (discussed in Chapter 5). Research on death anxiety has been almost exclusively conducted by psychologists. Death anxiety (fear) might involve the unknown, the nature of one's identity, fear of growing old (**gerontophobia**), and immortality, and continues across the life span. The psychological approach looks at dying from a developmental perspective (sometimes called life stages) and examines attitudes toward dying and death from the cradle to the grave (the womb to the tomb). Chapter 3 in this book takes such a developmental perspective; thus, psychology plays a particularly large role in looking at death through the eyes of children, adolescents, and adults (younger, middle-aged, and older).

A psychological approach to dying and death looks at death denial in different cultures, examines the influence of mass media desensitization, and studies death denial in both patients and physicians. As noted in Chapter 5, a very common reaction to the announcement of a terminal prognosis or the death of someone is denial (shock and disbelief). This kind of reaction is a type of defense mechanism: "I must

have heard incorrectly." Psychology also analyzes emotions around dying and death and thoroughly studies the process of grief both before and after the death of a significant other, as discussed in Chapters 13 and 14.

The psychoanalytic perspective comes out of psychology and bases much of its argument on the unconscious portion of the mind. This approach looks back into the patient's past to help explain current behavior. Death fear is often taken to be the result of repressed guilt, traced to unresolved earlier experiences. Such a perspective has an applied function and can be useful in helping one to cope with dying and death.

THE PHILOSOPHICAL APPROACH

Socrates said that the true philosopher welcomes death. Death is not an end, but a transition. We human beings are unique among the inhabitants of the earth in being creatures both of emotion and of reason (Rosenberg, 1983). As feeling beings, it is fitting for us to be touched and moved by the death of someone close to us, as through death that individual is lost to us irredeemably and forever. Thus, we should seek some comfort and solace in the face of such a loss. It is also fitting for us, as thinking beings, not to find our comfort and our solace only in myth and in muddle and in self-delusion. Rather, we should search out our consolations from the standpoint of a clear and reasoned understanding of the truth, which only rational beings such as we humans could ever achieve.

An **existentialist philosophical** approach to death is a rather practical one and suggests that we must all face death. We can face death. Death becomes an extraordinary event to each of us. No matter how surrounded by others we may be at the time, we will face death alone. Not unlike the little engine that could, "I think I can, I think I can, I think I can," and "I did." We can "do it."

Existential issues could be defined as including philosophical, psychological, and religious aspects of all kinds and should be seen as an overall concept. Existential means being in space and time, grounded in existence, or the experience of existence. For example, for some women with breast cancer, spiritual/existential issues are represented as faith in God, and faith might be seen as a source of strength in coping with a changed life situation (Vargens, 2012).

An offshoot of the existentialist philosophical perspective is **phenomenology**. This aspect of philosophy studies "the thing itself"—the phenomenon. The phenomenological study of dying would, for example, try to discover what dying is to those experiencing it. It studies the phenomenon directly and how it is constituted. If one were studying near-death experiences, who better could discuss these than persons having had near-death experiences? Or if one wished to study suicide and wanted to know what it is like, who better to ask than individuals who have attempted to take their own lives? What was the person thinking when trying to commit suicide? Study the phenomenon—the suicide attempt, the person who had the near-death experience. Obtain a first-hand account straight from the "horse's mouth."

The phenomenologist most fundamentally attempts to describe the objects of perception or those held in consciousness (Charmaz, 1980). The commonsense meanings of individuals and their construction become the special interest of sociologists who take a phenomenological approach in their work. This view of

human nature assumes that individuals are capable of reflective thought and are not simply products of social forces. The phenomenological method assumes that the researcher may not share this experience or understand its rationality. The phenomenological sociologist must understand the logic of the actor's experiences from her or his particular perspective. Sociologist Kathy Charmaz observes that descriptive terms and concepts used to define and describe the study of death need to be systematically clarified, if using a phenomenological approach.

The Anthropological Approach

Anthropologists, particularly cultural anthropologists, study rituals through which people deal with death and hence celebrate life. As anthropologists Huntington and Metcalf (1992) observe in *Celebrations of Death: The Anthropology of Mortuary Ritual*, the study of death rituals is a positive endeavor. In all societies, the issue of death throws into relief the most important cultural values by which people live their lives and evaluate their experiences. Life becomes transparent against the background of death—fundamental social and cultural issues are revealed. For example, death for Native Americans is very much a part of life. As we shall see, this is a very different view than that held by many Americans.

Chapter 10 relies heavily on the research of cultural anthropologists in looking at death rituals in different cultures. Cultural anthropologists also look at emotional responses in different cultures, how different groups prepare the body for final disposition, and how they dispose of the body. Whereas in the United States we primarily bury a body in the ground, other cultures might place the dead person in a tree, and others are likely to cremate the body. Cultural anthropologists study these kinds of rituals.

Another subfield of anthropology, physical (biological) anthropology, however, leans in the direction of the biological sciences. Such a specialist, for example, might work with bone identifications (from humans and other animals) both from the past and present. This specialty often assists in identifying the remains of a human body and helps to determine age, sex, and other physical characteristics. Thus, anthropology (the study of humankind) has subfields in the social and the natural sciences.

The Sociological Approach

The sociological approach to the study of dying and death generally includes four theories: structural-functional theory, conflict theory, social exchange theory, and symbolic interaction theory. Social exchange and symbolic interactionism differ from structural functionalism and conflict theory on two crucial points. The first is that social exchange and symbolic interactionism examine the individual in society, whereas structural functionalism and conflict theory examine social facts, institutions, and forces. Second, interactionists and exchange theorists contend that the essential feature of society is its subjective character, in contrast to the focus on the objective approach taken by the other two.

In the view of interactionists and exchange theorists, social facts do not have any inherent meaning other than what humans attribute to them. W. I. Thomas (1923)

argued that if people define situations as real, the situations will be real in their consequences. Robert Merton (1968) took Thomas's idea a step further and argued that individuals *act* on their perceptions of the situation; thus, the prediction of the situation comes true. This is known as the **self-fulfilling prophecy**. Max Weber (1966) defined social action as human behavior to which the acting individual attaches subjective meaning and which takes into account the behavior of others.

Researchers using a social exchange or symbolic interaction approach are often required to develop empathy for the subjects they study. At times this will require the researcher to enter the subjective world of the subject by participating in that person's life experience. A Native American proverb encourages us not to judge the behavior of others until we have "walked a mile in their moccasins." In this context, social behavior is explained from the perspective of the subjective meanings of the actors' intentions for their behavior.

Structural-functional theory assumes that society is in a state of equilibrium and that the various social institutions (e.g., family, religion, economy, and politics) function on behalf of each other. This approach might be used to explain how a particular death ritual maintains social structure. The conflict perspective assumes that society is in a state of disequilibrium (imbalance), and tends to focus on inequalities in society. This approach would examine, for example, the unequal access to medical care for the terminally ill. Let's look more carefully at these four sociological approaches to studying dying and death.

STRUCTURAL-FUNCTIONAL THEORY French sociologist Emile Durkheim's work served as the primary foundation for theoretical frameworks relating to group actions and societal structures. Durkheim defined sociology as the study of social facts, which are external to the individual. Language, religion, and money-exchange systems, for example, are all social facts that were in the world before we were born and will be here after we die. Social facts are constraining—they place limitations on what we can do (rules and regulations that we must follow).

Durkheim (1964) believed that society is a social system composed of parts which, without losing their identity and individuality, constitute a whole that transcends its parts. From this point of view, social groups or collectivities (e.g., a particular nuclear family) cannot be reduced to merely a collection of individuals, and social phenomena have a reality of their own that transcends the constituting parts. This perspective, therefore, studies group-related phenomena (e.g., death rituals, structures that provide care for dying patients, and professional groups of funeral functionaries) rather than behaviors of particular individuals.

Group behavior provides strength to the individuals involved and shows "togetherness" to outsiders. After the death of a police officer in the line of duty, for example, hundreds of police officers from around the area will attend the funeral and ride in the funeral procession. As a large group, in essence, they are saying to the world, "Though one of our members is gone and a void occurs within our ranks, we are banding together to cover for the dismemberment within the police family. We remain strong and ready to function to protect society." The message is loud and clear. And in their behavior, they are consoling each other. With the deaths of Nelson Mandela, Michael Jackson and Princess Diana, many individuals brought flowers to central places in countries around the world. Being together and "sharing grief" is helpful. Being in the presence of other individuals is indeed consoling.

As stated earlier, the structural functionalists believe that society is in a state of balance, of equilibrium. Death itself is functional to the overall "balance" of a society. As Charlotte Perkins Gilman so wisely put it, "Death? Why this fuss about death? Use your imagination and try to visualize a world without death. Death is the essential condition of life, not an evil" (Gilman, 1935).

Death is a normal aspect of society. Deaths create jobs—the funeral industry, cemeteries, and estate lawyers, for example. Deaths open up jobs within the structure of organizations—someone "dies off" and must be replaced; thus, death contributes to a smooth-running social system. The structure of society is such that deaths are expected to occur—they help to give equilibrium.

Structural functionalists view society as a social system of interacting parts in which death-related behavior is analyzed from two perspectives:

1. How do death-related meaning systems and death institutions contribute to the maintenance of the larger social system?
2. In what ways are death-related meaning systems and death institutions affected by their relationships to the larger social system?

Structural functionalists are interested in positive (**eufunctional**) and negative (**dysfunctional**) results of social interaction as well as the intended (**manifest**) and unintended (**latent**) consequences of death-related behavior. When family members commit themselves to caring for a dying family member, their behavior can be eufunctional for emotional ties within the family; however, the behavior can be dysfunctional (especially if family members must interrupt their employment) for the security of family financial resources. A manifest function of attending a funeral is to support the bereaved, as family members attempt to adapt to the loss of a loved one, but a latent function is to strengthen the relationships that exist within social groups (a funeral becomes a family reunion).

If structural-functional theorists were interested in the funeral rites and rituals, they might investigate one or more of the following research questions:

1. How do funerals help to celebrate and maintain society's most salient social values?
2. How do funerals help to promote relationships within kinship groups (grandparents, parents, children, aunts and uncles, cousins, brothers, sisters)?
3. How do funerals contribute to and/or affect the relationships between bereaved families and the larger society?
4. How do funerals facilitate the grieving process as one mourns the death of a loved one?
5. How do death-related rituals help return bereaved persons to their normal social responsibilities?
6. How do differing methods of body disposition and funeral rituals socially differentiate families regarding social status?

Utilizing a structural-functional perspective, sociologist Kathy Charmaz (1975) described the strategies used by coroner's deputies in maintaining the routine character of their work. The coroner's deputies attempt to get surviving family members to take over the responsibility for the care of the dead body and the financial obligations related to final disposition and to minimize personal involvement of the coroner's deputies. In Charmaz's description we can observe that if each party

LISTENING TO THE VOICES | LATENT FUNCTION OF A FUNERAL

Some two decades ago, following the unexpected death of my father, I* returned at the age of 50 to my native Texas to attend his funeral. I had moved away from home after graduation from high school, only to return once or twice annually to visit.

At Dad's funeral, I had an opportunity to reflect on changes in the family over time. At the end of the funeral service, various individuals filed by the open casket: kin, **fictive kin**, long-time friends, and others unknown to me. Cousins I had not seen in years (decades!) came from far and wide. They were all grown up now and showing signs of the aging process (not unlike myself). I recalled having played with one set of cousins as little children decades ago when we would visit our grandmother in another part of Texas, some 400 miles away. Seeing them once a year for a few years was all the contact we had. Then, there they were at my dad's funeral. Funerals become a family reunion, a latent function (hidden dimension) of a funeral.

Several great aunts (the uncles had all died), some of whom I had not seen for several years, seemed suddenly so old and frail (and indeed they were!). I recalled them as adults in their 40s and 50s when I was a small child. My, but they had changed with the passing of time. Former grade school and high school classmates walked by the open casket. They, too, showed what the passing of time can do to one's body (again, I only needed to look in a mirror).

It is within the family setting (including fictive kin) that one can observe these changes over time. These were individuals I had known all my life, both as a small child and now as a middle-aged adult. The dismemberment of the family through deaths left "gaps" from persons who previously played major roles in my life. My grandparents were now all dead. In the logical order of events in the family life course, it was time for my parents to die.

Babies are born, with most growing to old age, producing changes in the number, structure, and roles of families. Offspring of relatives that I had never before seen appeared at the funeral. They were born after I grew up and left the community. I was meeting **extended family** members for the first time. Changes had occurred in our extended family over the decades—changes which were obvious to me on this sad occasion.

The composition of the family life course produces changes as the clock ticks away. There is a time and a place for all things. There is a time to be born and a time to die. The family network is a setting in which these changing times are observed, as painful as it may sometimes be.

*George E. Dickinson

performs his or her socially prescribed role (or social function), the social system runs efficiently and social equilibrium is maintained.

Strategic control of the encounter between the coroner's deputies and the relatives of the deceased is enhanced by making the announcement in person. Part of the self-protection strategy is to remain polite and sincere, yet authoritative. The deputies must create the kind of ambiance wherein the announcement of the death is effective and believable. Unlike physicians in giving "bad news," the coroner's deputies lack their prestige and also do not have a relationship with the person. Deputies also lack the structural supports provided by the hospital situation; thus, they must devise tactics to get their work done without incident. Typically, their objectives are to announce quickly and then to turn to the responsibility of the body and its subsequent disposal. Deputies feel that they get a better response when they successively lead the relative into questioning them.

Charmaz noted that the deputies usually avoid the word *dead*, because it is such a harsh word, and use euphemisms instead. They try to manipulate the situation so that the relative actually uses the word *dead*, thus making the death more

"real." The deputies then reaffirm the statements and elaborate on them. When the strategies work, the transition from perceiving one's relative from alive to dead can be made rapidly. If the encounter is successful, the relative is likely to express appreciation for the deputies' sensitivity. Relatives ask about the circumstances of dying. The deputies give the information they have and can release and then turn to the funeral and burial arrangements. Thus, the deputies have played the role of officials who cut through the survivor's grief and shock by pointing to the work that has to be done and have strategically structured the situation in ways that foster the relatives' acceptance of their directives.

Conflict Theory Whereas structural-functional theory focuses on the issues of societal maintenance and social equilibrium, conflict theory focuses on issues related to social change and disequilibrium. Conflict theorists focus on competition, conflict, and dissension resulting from individuals and groups competing for limited societal resources.

In emphasizing social competition for limited resources, conflict theorists interested in death-related behavior would point out the inequality in the availability and quality of medical care and the differential death rates. For example, the poor are deprived of optimal care, in general, and of life-saving procedures, in particular (Weaver & Rivello, 2006–2007). Access to resources that might prolong life or postpone death depends not only on the absolute level available but also on their distribution across the population. Societies where resources are unequally distributed often experience higher levels of morbidity and mortality than those where resources are more equally accessible. Allen Kellehear argued that those who control life are the same as those who control death. According to Kellehear (1990) the power elite in any society determines one's life and death chances. Society determines not only what types of death will occur but also when deaths occur and to whom, and the chances, if any, of doing anything about it.

As will be discussed in Chapters 6 and 8, organ transplantations are an example of the conflict perspective. There simply are more recipients waiting for organ and tissue donations than there are donors. Thus, the issue becomes one of deciding which individuals receive the organs and which ones do not. There is competition for this limited supply of resources. Another example of conflict theory is health insurance. Some individuals have more limited choices as to their medical care options. The Affordable Care Act is beginning to address this issue in 2014, however. If conflict theorists were interested in funeral rites and rituals, they might investigate one or more of the following research questions:

1. What are the dysfunctional consequences of attending funerals?
2. What role conflicts and family disputes arise as a result of planning a funeral for family members?
3. How does not attending a funeral create conflicts between adults in neighborhood, friendship, and occupational groups?
4. What are the problems created by the presence of children at funerals?
5. How do particular family relationships contribute to increased competition for status among family members as they participate in the funeral of a family member?
6. How do methods of planning a funeral, and the related expenditures, contribute to increased family conflict and competition for scarce financial resources within the family?

7. In what ways might members of the clergy and funeral directors engage in social conflict because of the fact that family members allocate to each functionary differing amounts of authority and social rewards (money) for conducting the funeral?
8. How is it possible for unethical funeral industry personnel to exploit bereaved survivors during a time of emotional distress?
9. How does the death of a parent create sibling rivalry among the children, and how does the death of a child create marital problems between the parents?

In distributing property at death through a will or inheritance, if all beneficiaries want fair treatment, conflict may occur because beneficiaries have different perceptions of what is fair. Thus, conflict theory applies to this "fairness" issue after death (Titus, Rosenblatt, & Anderson, 1979). Even if the will seems fair, to some individual recipients a particular item, such as a rocking chair or antique

George Dickinson

Many sociologists trace the intellectual roots of conflict theory to Karl Marx. Marx is buried at Highgate Cemetery in London, England. The epitaph on his tomb reads: "Workers of all lands unite. The philosophers have only interpreted the world in various ways; the point is to change it."

clock, might be personally more valuable. Individuals simply have different perceptions of what is fair. Fairness can mean that something is divided equally, but fairness also takes into account various principles of deservingness or right. Because there are so many possible interpretations of what is fair or what is equal and because people often seek fairness or equality, a dispute may not be resolved easily. Disputes over inheritance may be one of the major reasons for adult siblings to break off relationships with each other. In some cases the inheritance dispute may be the final battle between competitive siblings, and in that sense it resembles the "last straw" reported in breakups in close relationships.

Social Exchange Theory Two traditions are followed by social exchange theorists. The first tradition is consistent with principles of behavioral psychology and stresses psychological reductionism and behavioral reinforcement techniques. The second tradition has been influenced by the work of Peter Blau (1964) and is committed to many of the assumptions held by symbolic interaction theorists. Social exchange theories of this type contend that human behavior involves a subjective and interpretative interaction with others that attempts to exchange symbolic and nonsymbolic rewards. It is important that such social exchange involves reciprocity so that each interacting individual receives something perceived as equivalent to what is given.

From this perspective, individuals will continue to participate in social situations as long as they perceive that they derive equal benefits from their participation. For example, the social exchange theorist would contend that individuals will attend funerals (even though they tend to feel uncomfortable in such situations and find viewing the body, if on display, as distasteful and anxiety-producing) because they perceive social benefit in being supportive of bereaved friends. An individual would want (or expect) a friend to attend the funeral of someone close to them, thus reciprocity occurs here—do unto others as you would have them do unto you.

If social exchange theorists were interested in funeral rites and rituals, they might investigate one or more of the following research questions:

1. Why do some individuals attend funerals—what are the social rewards acquired by attending?
2. Why do some individuals not attend funerals—what are the social punishments or sanctions acquired by not attending?
3. What are the social and personal costs and benefits for families when they provide wakes, funerals, and other death-related rites of passage?
4. What are the social and personal costs for families when they do not provide wakes, funerals, and other death-related rites of passage?
5. Why would the average American family spend thousands of dollars to bury its dead when it could accomplish the same purpose at a fraction of the cost?

Symbolic Interaction Theory The foundation of symbolic interaction theory is that **symbols** (meanings) are a basic component of human behavior. People interact with each other based on their understanding of the meanings of social situations and their perceptions of what others expect of them within these situations.