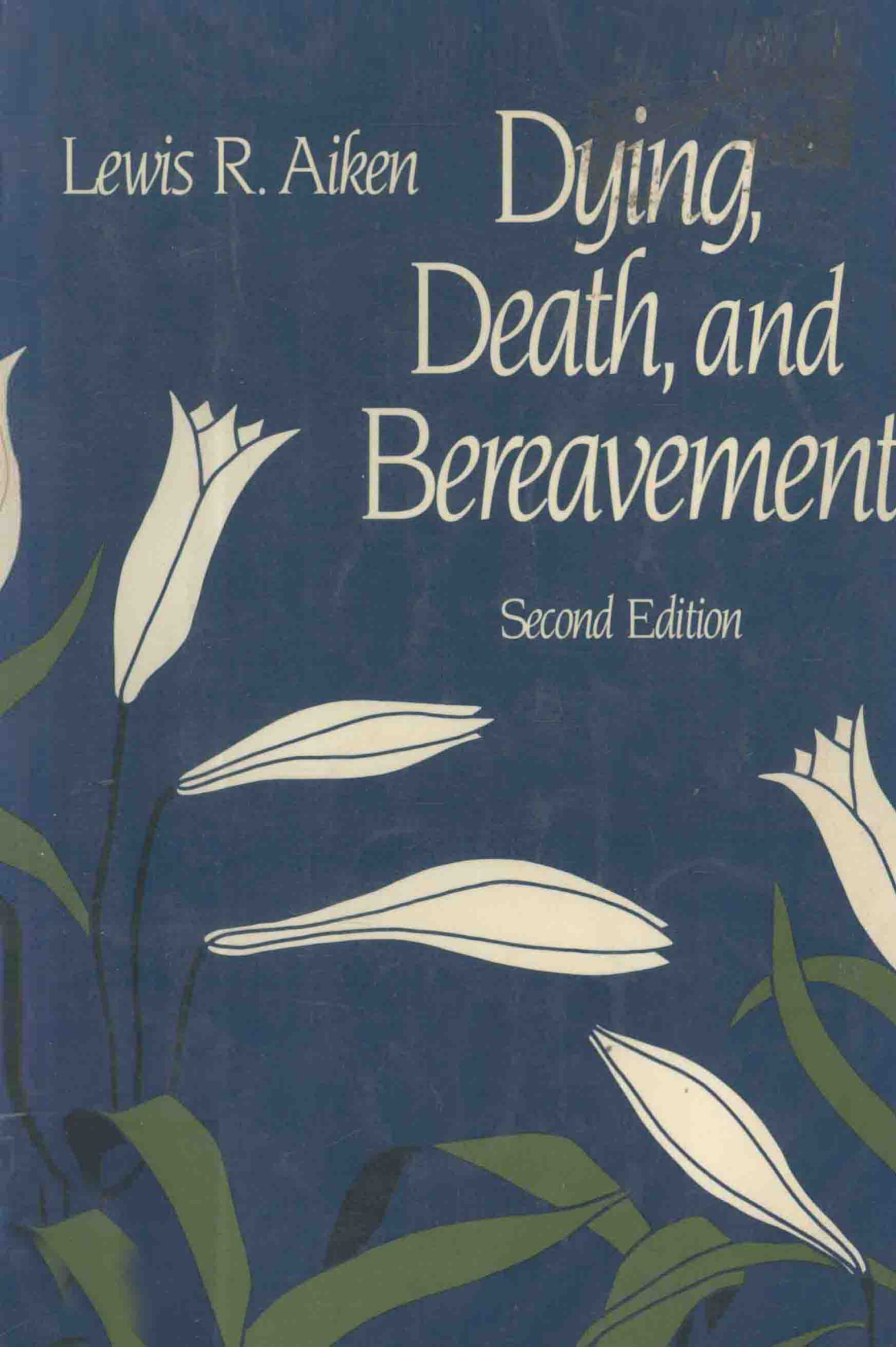
Lewis R. Aiken

Dying, Death, and Bereavement

Second Edition



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Dying, Death, and Bereavement

The great tragedy of life is not death,
but what dies inside of us while we live.
—Norman Cousins

◆ PREFACE

Thanatology, the study of dying and death, has made important strides since the 1950s. Prior to that time, death and dying were viewed primarily as the concerns of poets, clergy, and mystics, to be avoided as much as possible by physicians and somewhat taboo topics even for social scientists. The research and writings of Philippe Aries, Herman Feifel, Geoffrey Gorer, Richard Kalish, Robert Kastenbaum, Elisabeth Kübler-Ross, Edwin Shneidman, and others, however, have helped to make thanatology a legitimate topic of scientific research and theory. The growing elderly population, the decline in infant mortality, and the popularization of the topics of dying and death by the media have also contributed to an interest in research in this area.

During the past three decades, hundreds of articles and books dealing with the results of medical, psychological, anthropological, and sociological studies of death and dying have been published. A number of bibliographies and abstracts of such source materials have been compiled (e.g., Fulton, 1981; Guthmann & Womack, 1978; *Thanatology Abstracts*, 1978). Responding to the growing volume of research, the periodical *Omega: The Journal of Death and Dying* began publication in the early 1970s. Other professional journals concerned with death and dying were also launched, including *Advances in Thanatology* (formerly *The Journal of Thanatology*) and *Death Studies* (formerly *Death Education*). In addition to reports of empirical investigations, theoretical and other speculative writings concerning death, dying, and bereavement have increased; creative works of literature and art pertaining to the topic also abound. Media reports and features on dying and death, including many excellent television documentaries and files (e.g., CBS's "A Time for Dying," ABC's "The Right to Die," and PBS's "Near Death") are now almost commonplace.

In response to the increased interest in thanatology, courses devoted exclusively to the topic have become more popular; a number of outlines for such courses have been published (e.g., Cherico, 1976, 1978; Margolis, 1978). Despite the many courses concerned with the topic, relatively few comprehensive, integrated textbooks on dying and death have been written from an interdisciplinary perspective. However, many excellent books of readings can be used as supplemental material for an introductory survey text such as this one. Among the best-known books of readings are Herman Feifel's *New Meanings of Death* (1977), Elisabeth Kübler-Ross's *Death: The Final Stage of Growth* (1975), Edwin Shneidman's *Death: Current Perspectives* (1984), Robert Weir's *Death in Literature* (1980), and Sandra

Wilcox and Marilyn Sutton's *Understanding Death and Dying* (1985). There are also books on more specialized topics such as children and death, suicide, the funeral industry, hospices, life after death, and bereavement and widowhood.

Dying, Death, and Bereavement is designed to fill the need for a truly interdisciplinary, compact but comprehensive survey of death and dying. The book is sufficiently complete to serve as the principal text in a semester course on death and dying but brief enough to be used as a supplementary text in many other courses. The focus of the book is holistic or eclectic, considering medical, psychological, religious, philosophical, artistic, and demographic matters pertaining to dying, death, and bereavement. Because I am a psychologist, psychological factors in death and dying are emphasized. However, this book is not a narrowly focused treatise on the psychology of death and dying. A variety of viewpoints and research findings on the multitude of topics subsumed under thanatology receive thorough consideration in individual chapters.

The first edition of this book was truly a labor of love—a product that received many favorable comments and reviews and reportedly brought tears to the eyes of my copyeditor. Even now, six years later, I believe that the first edition can stand on its own merits as worthy of consideration for courses or units on dying, death, and bereavement. These courses are taught in various schools and departments, including psychology, sociology, social work, nursing, religion, education, health sciences, physical education, medicine, counseling, and human development. However, in addition to inevitable changes in the rates and demographics of human mortality, subsequent events and emphases necessitated a revision of the book. This second edition of *Dying, Death, and Bereavement* includes information on several new topics, such as moral issues and court cases concerned with abortion and euthanasia, the problem of AIDS and other deadly diseases, the growth of health psychology and behavioral medicine, and the increased social and political concerns for health care of the elderly. Finally, and perhaps most important of all, is my effort to communicate the growing awareness of health and mortality on a global scale. Although the past few years have been a relatively peaceful period in the history of the world, the question of global survival is a problem of international scope that continues to haunt us.

As with the first edition, an effort has been made to write the second edition of the book in an informative, factually correct style. In addition to including a wide range of empirical findings and theoretical viewpoints, it has been designed with the emotional needs of students and other readers in mind. Motives for taking the kinds of courses for which the book is designed vary from person to person, not the least of these being the needs to achieve some understanding of the death of a close relative or friend and to come to grips with the inevitability of one's own mortality. Additional insights can be obtained from the individual and group activities and projects described throughout the text.

Acknowledgments

The production of a textbook typically owes a great deal to the efforts of many people. Those individuals whom I wish to recognize and thank for their contributions to this book are my editor at Allyn and Bacon, Diane McOscar, and the reviewers of my text, David E. Balk (Kansas State University), Arthur S. Evans, Jr. (Florida Atlantic University), and Robert E. Francis (North Shore Community College, Beverly, MA). Finally, I wish to acknowledge all those students who worked and wept their way through the first edition.

◆ CONTENTS

Preface ix

Part I ◆ Characteristics and Causes of Death

1 **Mortality and Thanatology** 1
Denial versus Acceptance of Death 2 Definitions and Determination of Death 3 Demography, Death Rate, and Life Expectancy 8 Group Differences in Life Expectancy 17 Public and Professional Interest in Thanatology 21 Summary 23

2 **Aging, Disease, and Accidents** 26
Aging and Longevity 27 Theories of Aging 32 Fatal Diseases 35 Accidents 48 Summary 54

3 **Murder and Suicide** 58
Homicide and Murder 59 Suicide 70 Euthanasia 81 Summary 82

Part II ◆ Cultural Beliefs and Practices Concerning Death

4 **Funerary Rituals and Religion** 86
Funerary Rites and Customs 87 Religious Beliefs 99 Summary 106

5 **Death in the Arts and Philosophy** 109
Death in the Nonverbal Arts 110 Death in Literature 117 Death in Philosophy 124 Summary 129

6 **Legal Aspects of Death** 132
Cause of Death and Disposal of the Corpse 134 Abortion and Euthanasia 140 Capital Punishment 145 Bequests and Taxes 152 Summary 157

Part III ◆ Attitudes toward Death

7 **Children and Death 160**
Developmental Changes in Conceptions and Fears of Death 162 Death of a Child 170 Death of a Parent 179 Death Education 181 Summary 187

8 **Adult Development and the Dying Process 190**
Attitudes and Fears about Death 192 Religious Beliefs and Near-Death Experiences 200 Personal Timing and Control of Death 204 Psychological Stages in Dying 208 Summary 213

9 **Treatment of the Dying and the Dead 215**
Dying in Institutions 216 Hospice Treatment of the Terminally Ill 221 Communicating with and Counseling the Dying 225 Modern Funeral Practices 230 Summary 236

Part IV ◆ Problems of Survivors

10 **Bereavement and Widowhood 239**
The Bereavement Process 241 Effects of Bereavement on Illness and Mortality 247 Grief Counseling and Therapy 252 Widowhood in the Western World 255 Summary 261

Appendix 265

Glossary 269

References 279

Author Index 298

Subject Index 305

◆ CHAPTER 1

Mortality and Thanatology

Questions answered in this chapter:

- *How do people feel about death?*
- *How is death defined and determined?*
- *What are the causes of death and how common are they?*
- *What is the death rate in a population and what factors are related to it?*
- *Why has public and professional interest in death and dying increased during the past two decades?*
- *What professions are concerned with death and dying and in what activities are they engaged?*

Death eventually comes to everyone—poet and peasant, saint and sinner, the wise and the foolish. It is a fate human beings share not only with each other but with all living things. The inevitability of death and the shortness of life have been expressed frequently in literature and art, from the time of Cicero's statement that

> *No man can be ignorant that he must die,*
> *nor be sure that he may not this very day,*

to Longfellow's

> *Art is long, and Time is fleeting,*
> *And our hearts, though stout and brave,*
> *Still, like muffled drums, are beating*
> *Funeral marches to the grave.*[1]

and Millay's

> *Death devours all lovely things:*
> *Lesbia with her sparrow*
> *Shares the darkness,—presently*
> *Every bed is narrow.*[2]
>
> —from "Passer Mortuus Est" by Edna St. Vincent Millay

Depressing though these sentiments may seem, they underscore the certainty of death and the importance of not wasting the time one has. Sooner or later, each person must face his or her own vulnerability and the inevitability of death. Distraction and denial may postpone the realization and acceptance of the inevitable, but they cannot eliminate it.

Denial versus Acceptance of Death

Humans are presumably the only creatures who know they are going to die, but how do they cope with this knowledge? How does it shape their attitudes, beliefs, and actions?

Human attitudes toward death generally are not polarized; instead they form a continuum. At one end of the attitude-toward-death continuum, death is viewed as humanity's mortal enemy, the fearsome Grim Reaper equipped with scythe for cutting down human lives. According to this viewpoint, death must be actively combatted with whatever heroic measures are necessary. Both medical science and religion have promoted the idea of death as an enemy. At the other end of the continuum is the acceptance and even welcoming of death as a passage to a more blissful state of being. Somewhere near the center of the continuum, and perhaps most typical of people's perceptions, is a feeling of mystery or bewilderment about death—as Shakespeare writes in *Hamlet*—the "undiscovered country from whose borne no traveler returns."

Familiarity with Death

To a great extent, fear and acceptance of death vary with its familiarity. Dying and death were more visible in the Middle Ages and Renaissance Europe than they are today. Publicly viewed executions, mortal skirmishes involving ordinary people, and mass epidemics that claimed the lives of thousands were common before the nineteenth century. For example, the Black Plague killed approximately 25 percent of the entire population of Europe in the fourteenth century. And travelers to London in the sixteenth century likely viewed the severed heads of the king's enemies spiked on London Bridge.

Before the nineteenth century, a dying person frequently organized a ritual in his or her own bedroom. This deathbed ritual was largely replaced by a postmortem ritual during the nineteenth century, and by the middle of the twentieth century even these postmortem activities had been minimized (Aries, 1974). A typical funeral in the United States in the 1990s is a rather cut-and-dried affair, often noted more for its efficiency than for its ritualism and expression of grief for the departed. In addition, because the great majority of people now die in institutions rather than at home or in public, personally witnessed death has become a rare event for most individuals in Western countries.

Denial of Death

The decline of public dying and death rituals reflects and promotes the denial of death in contemporary society. This denial is not completely successful, however. Modern humans are aware of death, or at least become aware of it from pictures and reports of violence, disease, and deterioration vividly displayed and portrayed by newspapers, television, and other media. Many of the deaths during this century have been caused by war, often considered a noble and romantic human enterprise in previous times. But two world wars, the Korean War, and the Vietnam War have reduced the seeming nobility of armed conflict for many people in the United States. Television and motion pictures, with their graphic depictions of violent death, have horrified some but anesthetized many more to the reality of dying. Death in the media and movies is usually impersonal. If it does become upsetting, the spectator can simply turn off the TV set, throw away the paper or magazine, or walk out of the theater. Consequently, without thinking about it too much, one can maintain the illusion of personal invulnerability and even exemption from death for some time. Freud's statement that no one is truly capable of imagining his or her own death is not even an issue for such a person; he or she simply never tries.

Understanding death, and especially one's own death, is particularly difficult for young children. Adolescents comprehend it better, but to a typical teenager death is a distant and perhaps even romantic event. The reality and imminence of death become clearer as one ages and experiences the demise of his or her contemporaries. Then the illusion of personal invulnerability in the face of death becomes harder to maintain.

The tendency to deny or overlook death obviously does not keep it from occurring. Estimates indicate that over 110 million "unnatural" or "human-caused" deaths have occurred in the twentieth century alone: 50 million from violent acts and 60 million from starvation and deprivation. Every year approximately 50 million people worldwide die from all causes, and in the United States alone 1 million people are in the process of dying at any one moment (Population Reference Bureau, 1989; Simpson, 1979).

Definitions and Determination of Death

Dying is a process, but *death* is an event. *Random House College Dictionary* defines *death* as "the end of life; the cessation of all the vital functions of an animal or plant." This definition is closest in meaning to *biological death* (somatic death), the irreversible breakdown of respiration and the consequent loss of the organism's ability to utilize oxygen. Biological death is characterized by the cessation of vital functions such as respiration and heartbeat. When the respiratory center in the brainstem fails, oxygen is no longer inhaled and diffused by the lungs into the blood, and when the heart fails, oxygenated blood is not pumped through the blood vessels.

When a person is in the process of dying, the cells of the higher brain centers, which are very susceptible to oxygen deprivation, die first—within 5–10 minutes after their oxygen supply is cut off. Next, cells in the lower brain centers die, including those in the medulla oblongata, which regulates respiration, heartbeat, and other vital reflexes.

Thus, the death of a human being does not occur in a single instant. Certain body structures, such as the thymus gland, deteriorate before a person is fully mature. In fact, body cells are constantly dying and being replaced by new cells even before an individual is born. The building up and breaking down of body cells and structures (*anabolism* and *catabolism*) are complementary metabolic processes. As a person ages, the rate of breakdown begins to exceed the rate of building up, a point reached earlier in some body structures than others.

Cessation of the heartbeat is a natural consequence of brain death, but the brain is not always dead when the heart stops. The heart can stop and its pumping action can be restored before the vital centers of the brain are affected. Restoration of the heartbeat by use of electric shock (countershock) is a common procedure in hospitals today. Unfortunately, if the heart has stopped for too long or for other reasons the blood supply to the brain is interrupted, the higher brain cells are deprived of oxygen and their functioning affected. In this case, the sensorimotor and mental skills of the person may undergo some deterioration.

The cells of certain glands and muscles die only after the medulla has stopped functioning, but skin and bone cells can live for several hours longer. The hair is still growing some hours after death, and the growth of fingernails has often been observed even after interment. The liver continues to convert glycogen to glucose, and other intestinal tissues also keep functioning for some time after a person is pronounced clinically dead. In fact, such tissue has been kept "alive" for years when placed in a special physiological solution.

Multiple Meanings of Death

Biological death is not the only kind of death. One is said to be *psychologically dead* when his or her mind (seat of conscious experiencing and knowing) ceases to function and *socially dead* when other people act toward the person as if he or she were dead. The usefulness of these distinctions is seen, for example, in conditions such as catatonic stupor, an extreme form of withdrawal in which a person becomes immobile and unresponsive. Such a person is biologically and perhaps psychologically alive but is treated by others as being not present or dead (socially dead). An individual may also be biologically dead and yet be talked about and related to as if he or she were socially alive, as is the case in certain mental disorders.

Another concept is that of *legal death*, in which a person is adjudged dead by a legal authority and his or her possessions are distributed accordingly. In such instances, the individual may or may not be biologically

dead, as when a person who is missing in action or otherwise cannot be found is declared legally dead. A related term, *civil death*, is no longer used, but in old English common law it referred to a person who had lost his or her civil rights but was not naturally dead. An individual who entered a religious order, was convicted of a serious crime, or was banished from the state or nation could be declared legally dead (Kalven, 1974).

Determination of Death

The definition and determination of death are not exclusively medical matters; ethical, legal, and economic considerations are also important. For example, in certain legal cases it is necessary to set an exact moment of death, difficult though it may be. Both ethical (moral) and economic factors are involved in deciding if and when to "pull the plug" on a seriously brain-damaged patient who is in an irreversible coma, or to attempt a costly heart transplant that may prolong a life for only a year or less. Biological scientists and medical specialists are understandably more concerned with the medical aspects of death, but these individuals also need to be aware of the legal, ethical, and economic ramifications of their activities.

Traditional Indicators of Death

Among the traditional clinical indicators of death are cessation of heartbeat (and peripheral pulse) and respiration; unresponsiveness of the eyes to light and of other sense organs to sound, touch, and pain; and bluing of the extremities (mouth and lips). Signs of further progression in death include purplish-red discoloration of the skin (livor mortis), stiffening of the muscles (rigor mortis), and gradual decline in body temperature to that of the external environment (algor mortis).

In a dying person, loss of sensorimotor functions begins in the legs and spreads gradually to the arms. The sense of pressure remains, but pain and other cutaneous sensations diminish. The decline in peripheral circulation frequently produces a drenching sweat, followed by a cooling of the body surface. Characteristically, a dying person, who may be conscious until the very end, turns his or her head toward the light (Gray, 1984). Rigor mortis sets in about 2 hours after death and continues for approximately 30 hours.

The methods employed in previous times to determine death (no fogging of a mirror when placed near the mouth, no response to a feather about the nose, no constriction of the pupils to light, no reaction to a pinprick, etc.) were imperfect indicators and on occasion led to premature burial. Premature burials were more likely to occur during epidemics or wartime, when for hygienic reasons there was a greater urgency to bury the dead and the determination of death was often slipshod. As a result, many tales from the nineteenth century describe the fear and potential danger of being buried alive, one of the most famous being Edgar Allan

Poe's fictional account "The Premature Burial" (see Report 1–1). Such fears led to the practice of not burying the body of a deceased person until it began to putrify, which was accepted during the last century as the only certain indicator of death.

There are, of course, many cases in which a patient has been pronounced clinically dead but has "come back to life" before being buried. Furthermore, some believe that a resurrection of the body at some future time is possible, even when a deceased person is not immediately restored to life. For example, one occasionally reads a newspaper story about a deceased person whose body was deep-frozen in liquid nitrogen at the time of death (*cryonics*) and is being kept in a special aluminum capsule. It is an article of faith of the Cryonics Society that a body preserved in this manner can be thawed and restored to life at some time in the future when a cure for the disease from which the person died has been discovered. Whether those few bodies that are being preserved in this way can be restored to life with any semblance of the former self is debatable, but most authorities are dubious.

Contemporary Indicators of Death

Until fairly recently, loss of heartbeat and respiration were the principal medically accepted signs of death. But cessation of heartbeat and respiratory movements are no longer interpreted as sufficient for a clinical diagnosis of death. Emergency measures such as cardiopulmonary resuscitation (CPR) and countershock are frequently successful in restoring these functions, while artificial pacemakers, mechanical respirators, and heart-lung machines sustain them.

According to the laws of most states, a person is alive as long as a heartbeat and respiratory movements, no matter how they are maintained, can be detected. In states that have not passed legislation defining death, the definition is based on hospital policy. But because different hospitals may follow different procedural definitions, it is conceivable that a resident of a particular state could be pronounced dead in one hospital and not in another.

The concept of *brain death* has gained credence during the past 20 years or so, and irreversible cessation of all functions of the entire brain, including the brainstem, has now joined loss of circulation, breathing, and responsiveness to external stimuli as criteria for determining death. Although about half the states have passed legislation linking legal death to brain death, the usual definition of death centers on the loss of *all* vital functions. The importance of indicators other than brain function varies from state to state.

The following four clinical indicators, known as the *Harvard criteria*, are widely accepted by the medical profession throughout the world in the determination of death or irreversible coma (Ad Hoc Committee of the Harvard Medical School, 1968):

◆ **REPORT 1–1**

The Premature Burial

The wife of one of the most respectable citizens—a lawyer of eminence and a member of Congress—was seized with sudden and unaccountable illness, which completely baffled the skill of her physicians. After much suffering she died, or was supposed to die. No one suspected, indeed, or had reason to suspect, that she was not actually dead. She presented all the ordinary appearances of death. The face assumed the usual pinched and sunken outline. The lips were of the usual marble pallor. The eyes were lustreless. There was no warmth. Pulsation had ceased. For three days the body was preserved unburied, during which it had acquired a stony rigidity. The funeral, in short, was hastened, on account of the rapid advance of what was supposed to be decomposition.

The lady was deposited in her family vault, which, for three subsequent years, was undisturbed. At the expiration of this term it was opened for the reception of a sarcophagus;—but, alas! how fearful a shock awaited the husband, who, personally, threw open the door! As its portals swung outwardly back, some white-apparelled object fell rattling within his arms. It was the skeleton of his wife in her yet unmoulded shroud.

A careful investigation rendered it evident that she had revived within two days after her entombment; that her struggles within the coffin has caused it to fall from a ledge, or shelf to the floor, where it was so broken as to permit her escape. A lamp which had been accidentally left, full of oil, within the tomb, was found empty; it might have been exhausted, however, by evaporation. On the uttermost of the steps which led down into the dread chamber was a large fragment of the coffin, with which, it seemed, that she had endeavored to arrest attention by striking the iron door. While thus occupied, she probably swooned, or possibly died, through sheer terror; and, in falling, her shroud became entangled in some iron-work which projected interiorly. Thus she remained, and thus she rotted, erect.

Source: From *The Complete Poems and Stories of Edgar Allan Poe,* Vol. 1 (p. 532) by A. H. Quinn & E. H. O'Neill, 1976, New York: Alfred A. Knopf, Inc. Reprinted by permission.

1. Unreceptivity or unresponsivity to touch, sound, light, and even the most painful stimuli that it is ethical to apply.
2. Absence of movements, notably those of spontaneous respiration, for at least one hour. Patients on respirators must not breathe by themselves for at least 3 minutes when the respirator is turned off.
3. Absence of reflexes, namely, no pupillary constriction to light; no blinking; no eye movements when ice water is poured into the ears; no muscular contractions when the bicep, tricep, or quadricep tendons are tapped; no yawning or vocalizing.
4. A flat electroencephalogram (EEG) for at least 10 minutes.

Several commissions established to study and make recommendations concerning the determination of death have pointed out, however, that these four signs are not always foolproof. For example, in patients with severe barbiturate overdoses or marked hypothermia (body tem-