LIBERTY BAPTIST SEMINARY

# DEATH ANXIETY: THE NEED FOR DEATH EDUCATION IN THE CHRISTIAN COMMUNITY

A Thesis

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# INTRODUCTION

The American culture is a youth-centered culture. This can be illustrated from the amount of advertisements on television, in magazines and on billboards. It is a culture interested in grabbing all the "gusto" in living a "good" life. Yet, a problem exists with our society. We deny death. To our mind no one gets sick and dies. Elisabeth Kubler-Ross (1972b) wanted to interview some terminally ill patients, and in a hospital that had a capacity of 600 beds, she was told that no one was dying. She asked for permission to talk to some seriously ill patients. To this request, the response was "He's too weak," or "too tired," or "He doesn't feel like talking" (p. 304).

We speak of people "passing away," "passing on," and "expiring." Our funeral "homes" take the remains of loved ones to serve the purpose of denying death in our society as described in the following manner:

> My father, I say, was ninety-two. In his later years he had wonderfully chisled wrinkles. I had helped to put them there. His cheeks were deeply sunken, his lips pale. He was an old man. There is a kind of glory in the face of an old man, not so with the stranger lying there. They had my papa looking like he was fifty-two. Cotton stuffed in his cheeks had erased the best wrinkles. Make-up, powder, and rouge plastered his face up to his hair and around his neck and ears. His lips were painted. He looked ready to step before the footlights of a matinee performance. I fiercely wanted to pluck out the cotton, but was afraid. At least the make up could come off. I called for alcohol and linen. A very reluctant mortician brought them to me and I began the restoration. As the powder, the rouge and the lipstick disappeared, the stranger grew older. But he never recovered the looks of his ninety-two years. But the man in the coffin became my papa (Kubler-Ross, 1972b, p. 304).

Our society tries to cover up the fact that we all die, so much so that doctors, patients, nurses, family, and even clergy deny the reality of death. We ignore the statements in the book of Genesis:

> And Adam lived . . . and he died.
> And Seth . . . and he died.
> And Enos . . . and he died.
> And Cainan . . . and he died.
> And Mahalaleel . . . and he died.
> And Jared lived . . . and he died.
> And Enoch lived . . . and he walked with God.
> And Methuselah lived . . . and he died.
> And Lamech . . . and he died. (Genesis 5:1-31).

Inevitably we will grow older and we will become more aware of death as we lose our family members to this enemy we call "death." To this situation the minister is beckoned. There are several functions that the clergy are qualified to fulfill.

> Concern for the terminally ill person must be demonstrated: the sense of the individual's relationship to enduring values must be communicated and reinforced; the insecurity and guilt of the medical staff can be reduced; and the grieving relatives must be comforted and given guidance through and beyond the time of death (Rodabough, 1981, p. 89).

It is true that this function of the minister is no easy task, but one thing that complicates the situation is the minister's own discomfort with death.

The writer is interested in seeing this situation remedied so that ministers of the gospel will fee more competent in meeting the needs of the dying . By becoming acquainted with these needs, the minister will be able to educate the Christian community and the fears associated with death will be lessened.

The writer is interested, not just in experiencing the "good life," but being prepared for a "good death."

## Statement of the Problem

In our seminaries men are prepared to pastor the local congregations. The ministry is typified by preaching, visiting, baptizing, conducting communion services, marrying couples, counseling, and performing funerals. Many people, because of their culture and denial of death, are not acquainted with death, and when someone is dying, the pastor is looked to for comfort and spiritual consolation. Often the pastor is not prepared to deal with this situation. There are courses which deal with the theology of death and the consequences of sin, but in the two seminaries the writer has attended, there have been no classes dealing specifically with the anxiety and grief of the death crisis. There has been only one chapel message that dealt with the death situation, and far too often men leave seminary prepared to preach the gospel of Jesus Christ, but ill prepared to minister or provide skilled care for the needs of both the dying and the bereaved. The young minister generally shares his funeral duties with an older pastor which allows for clear role modeling.

Tillman Rodabough (1981) commenting on this preparation says,

> None of these equate with the actual experience of helping another person confront and cope with the knowledge of his imminent death. It is only natural that some anxiety results when one finds himself helping another in life's ultimate crisis (p. 101).

While it is preferable to "learn by doing," the young pastor frequently make mistakes that result in missed opportunities to minister to the terminally ill and their families.

## Statement of Purpose

The question this thesis will answer is: Can pastoral counselors be prepared to deal with death and effectively minister to the Christian community through the death process? The intention of this thesis is to analyze and explore death and its accompanying anxiety.

## Statement of Importance of the Problem

Within the past fifteen years a new area of study has arisen. Much credit belongs to Dr. Elisabeth Kubler-Ross, who in 1969, presented her book, On Death and Dying. Thanatology, the study of death, has come to be a separate field of study and courses are being taught at the university level. "Myths and Symbols of Death and Dying" and "Death and Dying" are but two examples of these courses which have been taught at the University of Southern California (Larue, 1980, p. 13). Most death research and education presents only a psychological (Bugen, 1978, 1979; Clarke, 1981; Henney and Barnhart, 1980; Morgenstein, 1980; Neufeldt and Holmes, 1979) and humanistic point of view (Edwards, 1979; Lefkowitz, 1980; Parham, Romanuik, Priddy and Wenzel, 1980).

Chapter 1

# DEATH AND THE PROFESSIONAL

## The Models of Death

The meaning of death has been a central human concern since the beginning of time. Paul Robinson (1981) maintains that death is as much a cultural as a biological reality: it is experienced so differently in different ages that it demands historical analysis (p. 85). In his own words, death has progressed through five models which may be summarized in the following:

1. The Tame Death - Familiarity with death.
2. The Death of Self - Rise of individualism and fear of the unknown.
3. The Remote and Imminent Death - Death begins to be put out of the mind; it loses its obscessive presence.
4. The Death of the Other/The Beautiful Death - This model sees death as a reunion of family members so they might commune with their happily departed loved ones.
5. Denial of Death or Medicalized Death - Death is unmentionable and indecent. We ignore that it exists (p. 85-87)

Expanding these five models, Robinson (1981) surveys death from the Middle Ages to the present. The focus is on Europe, particularly France, yet there is much to say about America.

These five models of death have succeeded one another over the past millenium. The oldest model is called the "tame death." It is associated with the Middle Ages, though elements of it persist in our own time. Robinson (1981) points out, "tame" is meant to suggest, not the absence of fear, but a familiarity that, from our standpoint, verges on indifference (p. 85). The men and women of the Middle Ages viewed death as a part of life: it was a common and visible element of everyday experience and for this reason, its foreignness, its "wildness," was muted.

As is pointed out (Robinson, 1981):

> The chief evidence of death's familiarity is provided by the funerary practices of the time: over the course of the Middle Ages the old Roman tradition of burying the dead outside the city gave way to burial alongside and ultimately even within the church, a practice that will be familiar to anyone who has seen Westminister Abbey (p. 86).

It was there that the medieval burial ground became a kind of town square--not merely a park, but a major center of business, government, and social life. It was there that the living and the dead intermingled, and death itself came under the taming yoke of civilization. It was assumed and accepted that "all die:" one confronted death with resignation.

The second model, associated with the later Middle Ages and the Renaissance, is called the "death of self" (Robinson, 1981, p. 86). The important fact here is the rise of individualism, and along with it, a terror of death unknown to the full socialized self of the higher Middle Ages. As is pointed out:

> Late medieval and Renaissance man was profoundly in love with life, and, above all, with the good things of life. He was the ultimate materialist and appalled at the prospect of his final separation from those things (Robinson, 1981, p. 86).

Reflecting this horror of separation were two major cultural artifacts: the epitaph and the will. The epitaph on the tomb was a miniature biography that sought to fix a man's life for all time, to record his achievements so they would not be swallowed up in the anonymity of history. Even more important was the will. In it the dying man attempted to retain some sort of control over his financial affairs by dictating how it was to be distributed. To a very large extent, it was hoped that he would assure his own salvation by means of an elaborate system of posthumous devotions. In all of these precautions there was an awareness of the individual and his destiny. Death had now come to be experienced in a new way, namely, as the painful loss of identity.

The third model of death, that of the 17th and 18th centuries, was more elusive. It was called "remote and imminent death" (Robinson, 1981, p. 86) and it could not be linked to any striking alterations of death, such as the transference of the grave from outside the walls to the center or town or the development of the epitaph and the will. It was a change in imagination, in the collective consciousness. It was the beginning of the process through which death would eventually become invisible. Death began to be put out of the mind (hence "remote"), losing its obsessive presence.

This conception of death was associated with the rise of modern science, particularly the science of anatomy. The dead person is now a cadaver and thus the object of scientific investigation, as can be observed in Rembrandt's painting, "The Anatomy Lesson of Dr. Nicholas Tulp."

The 19th Century brought a new and altogether unexpected conception of death. It has been termed "the death of the other" or "the beautiful

death." The "other" whose death now occupies such a prominent place among one's mental processes is generally a member of the family. This is a very romantic death which was elevated by John Keats in "Ode to a Grecian Urn" and William Cullen Bryant in "Thanatopsis." The beautiful death transpires in an operative bedroom scene with all members of the family present and with all bidding their due farewell. It also corresponded to a new conception of the after-life, in which the principal event was no longer the divine vision, but reunion with one's loved ones.

The Romantic model of death was accompanied by the most dramatic change in funerary practices since the dead were brought within the walls in the Middle Ages. Due to the growth of cities and an aversion to burying people on top of one another, there was no longer room for the dead within the city, and they had to be moved to the countryside. It was there that one finds the origin of the modern cemetery, a garden with monuments. The members of the family now commune with their happily departed loved ones on "a visit to the cemetery."

The dominant feature of death in the 20th Century is its invisibility. It is characteristic of this culture to deny death. The dying are not given the truth because death has become somehow indecent and unmentionable. Just as the truth is held from the dying, so the dying holds the truth from the living and from himself. Death has become "medicalized." The dying are put into hospitals to reduce suffering, but also to remove them from view. Finally, mourning is discouraged; mourning - the "natural" expression of grief at a time of great loss.

## The Fear of Death

Society has become cold to the reality that death exists. Bryer (1979)

has said that "the basic concern of people throughout history has been the concept of their mortality" (p. 255). Becker (1973) stated that "the fear of death is natural and present in everyone, that it is the basic fear that influences all others, a fear from which no one is immune, no matter how disguised it may be" (p. 15).

Society fears death because it is something that has been put far from them. There has been a divorcing of oneself from the presence of death. There has, indeed, been a moving from the place of seeing people die because of epidemic, to where there is now no concept of death and the problems associated with it. There are now miraculous medical facilities and better child care to reduce the mortality among children. New medicines have allowed the eradication of disease which would have devastated our population a few years ago. Society now realizes a very crucial point. Society is involved with a faceless enemy. In the Middle Ages, when confronted with a foe, there was hand-to-hand combat. Now, we do not see our foe. It creeps in, it attacks, it kills, and we cannot tell of its appearance; we can only see that it has been here. Kubler-Ross (1969) has said "Destruction can strike out of the blue skies and destory thousands like the bomb at Hiroshima; it may come in the form of gases or other means of chemical warfare--invisible, crippling, killing" (p. 12).

Man tries to defend himself, but what weapon does he have? His physical defense is getting smaller and smaller. He must now increase his psychological defenses. He denies death. Death does not exist anymore. It has moved from home, to the cemetary, to the hospital and the intensive care unit, to not existing. Most people cannot stand to look at

death or people who are daying. Science has been left the responsibility to provide support and guidance on issues of death and hospitals are allowed to provide the framework for death. "The manner of dying in modern society has become solitary and hidden, one that can put individuals into frightening isolation that cuts them off from family and friends" (Bryer, 1979, p. 256).

There is a definite trend that, more and more, death is occurring in a hospital as opposed to the home. In 1949, approximately 50% of all deaths occurred in hospitals. By 1959, this figure had increased to 61%, with the large majority of deaths occurring in general hospitals. Data collected for New York suggests that this trend is continuing (Schulz, 1978, p. 51). Schulz (1978) goes on to say, "The percent of deaths in institutions increased steadily from 66% in 1955 to 73% in 1967. Deaths occurring at home showed a corresponding decrease over time from 31% in 1955 to 24% in 1967.

Illustration 1.1 shows that the trend has been toward an increased number of deaths in institutions.

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Schulz (1978) states:

> The increased institutionalization of death has at least two important consequences. First, it means that the medical staff becomes a more significant part of the dying person's life, since these are the people he or she is likely to interact with most frequently before death. A patient may, for example, come to rely on the medical staff for both social and emotional support in addition to medical care. A second consequence of increased institutionalized deaths is that death becomes removed from our everyday lives. Some persons feel that our present day avoidance of death and death-related topics

Illustration 1.1 Number and percent of deaths occurring in institutions by type of service of institution, United States, 1949 and 1958.

| | 1958 | | 1949 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Total Deaths | 1,647,885 | 100.0 | 1,443,607 | 100.0 |
| Not in institution | 644,548 | 39.1 | 728,797 | 50.5 |
| In institution | 1,003,338 | 60.9 | 714,810 | 49.5 |
| Type of service of institution | | | | |
| General hospital | 784,360 | 46.6 | 569,867 | 39.5 |
| Maternity hospital | 1,862 | 0.1 | 2,249 | 0.2 |
| Tuberculosis hospital | 9,097 | 0.6 | 13,627 | 0.9 |
| Chronic disease, convalescent and other special hospitals | 24,180 | 1.5 | 12,402 | 0.9 |
| Nervous and mental hospitals | 57,675 | 3.5 | 45,637 | 3.2 |
| Convalescent and nursing homes, homes for the aged, etc. | 98,444 | 6.0 | 22,783 | 1.6 |
| Hospital department of institutions, and other domiciliary institutions | 3,646 | 0.2 | 41,841 | 2.9 |
| Type of service not specified. | 24,074 | 1.5 | 6,404 | 0.4 |

Source: Lerner, M. "The demography of death." In E. S. Schneidman (Ed.), Death: Current perspectives. Palo Alto, California: Mayfield, 1976, p. 140.

> is largely attributable to the removal of death from the home. It used to be that exposure to death was a natural and common seasoning experience and thought to be essential for a mature and anxiety-free outlook on life (pp.55-56).

With the increase in the number of deaths occurring in institutions one might assume that the medical staff would be able to cope with death. One American psychologist, Dael Wolfle, stated, "We have the curious situation that medical progress has made death more stressful for relatives, more expensive for the family, and more troublesome for society" (Quoted by Troup and Greene, 1974, p. 4).

According to Aries (1975):

> Common attitudes toward death, such as are being discovered today by sociologists, psychologists, and doctors, seem so unprecedented, so bewildering, that, as yet, it has been impossible for observers to take them out of their modern context and put them into historical perspective (p. 136).

What might be some of the causes for people not being able to calmly face death? It is, in fact, lonely, mechanical, and dehumanized (Kubler-Ross, 1969, p. 9). Due to the fact of the dehumanizing element in death in an institution, it is difficult to determine the actual occurrence of death.

Death becomes impersonal because the patient is taken out of his familiar environment and rushed to an emergency room. In this environment the patient is no longer regarded as a feeling, sensitive human. In the rush of trying to save the life, the medical personnel forget to hold a hand or listen to a question.

During times of severe illness a patient will often be treated like a person with no right to an opinion, when in fact, it is his life, and he has a right to be heard.

In the emergency room there will be a melange of busy nurses, orderlies, interns, residents, lab technicians to take blood samples, and technicians to take electrocardiograms. The patient is on the road to becoming a "thing." He will have no choice and no opinion. He will not be consulted. His only function is to get well, and if any attempt is made to resist, he will be sedated. From this point the patient is cared for by surgery or being taken to the intensive care unit. He will receive excellent care physically, but too many times, during this entire process, no one takes the time to consult the patient.

What would be the cause for this lack of feeling? Could it be that doctors and other medical personnel are unable to deal with the possibility that the patient might die? And, if it is possible for the patient to die, then, we too, are candidates for death. This would entail a re-evaluation of the myth of our mortality.

## The Doctor and Death

Among the medical professionals, what is being done to prepare them for dealing with death? In November of 1976 a questionnaire (Willey, 1980) was sent to the 114 medical schools currently accredited, asking about their "death and dying" related curricular offerings. Of the 96 medical schools responding, a total of 57 (59%) gave academic credit for a course in which death education was incorporated. The majority, 44 (45%), of these courses were required courses in "Behavioral Science"(or "Human Behavior" or its equivalent) in which death education was considered as "just one unit" of the entire survey course. In no case was there offered a required course dealing exclusively with death education. Twenty-nine

schools offered death education only in one section of the required Behavioral Science course. Twelve schools offered a full term elective course including death education in addition to the required course. Three schools offered a non-credit elective on the subject in addition to the required course.

Thirteen (14%) of the schools offered only an elective course dealing with death education. Of these, only two elective courses dealt exclusively with issues of death and dying, while 11 elective courses were, like the required Behavioral Science courses, offered elsewhere and included only one unit on death education in the entire course (Willey, 1980).

Six (7%) of the schools offered only optional, non-credit programs or seminars in death education.

A total of 33 (34%) of the medical schools answered that they did not presently deal in any formal way with death education. Sixteen schools planned to begin a death education course within the next two to five years. Seven schools answered that they had no death education per se, but noted the subject was adequately dealt with in the Behavioral Science (or equivalent) course. Willey (1980, p. 52) comments:

> This answer suggests that these seven schools deal with death education in the same way the 29 other schools responding "yes" do. However, the initial "no" response of these seven administrators may indicate that they consider the impact of death education offered in the Behavioral Science class to be negligible.

It appears that death education courses were offered to first-year medical students. First-year students at 62% of the schools were required or may have been chosen to be involved in death education, followed by 45% of all second-year students, 22% of third-year students, and

14% of fourth-year students. Willey (1980) states, "Seldom is death education available throughout a student's medical school career" (p. 62). Only 12% of the schools offered some death education to students in each of their four years.

Willey (1980) points out the consequences of such a program:

> The decreasing availability of death education as medical students progress through their medical school curriculum and near their clinical internship and residency, indicates that at the point when medical students are most likely to be facing dying patients clinically in their third and fourth year, they are least likely to be involved in any kind of "back up" death education program. Further, the fact that death education is typically presented as a small part of a first-year survey course makes it unlikely that knowledge gleaned from such an overview three years earlier will be much help to the third or fourth year medical student facing his first dying patient (p. 62).

Further, of those individuals teaching death education courses, there was a predominance of chaplains (40%), psychiatrists (52%), and other medical doctors (52%) as course instructors (Willey, 1980, p. 63).

The predominant number of medical doctors, chaplains, and psychiatrists used as instructors indicates that medical schools are using largely "in-house" staff members as instructors, rather than bringing in such "outsiders" as specialists in thanatology or medical sociologists. By using such personnel, there is a danger of being trained by someone poorly trained in death education and thus perpetuating the trend of poorly trained medical students in the area of thanatology.

Very few schools take advantage of the nurses, who have the most constant contact with dying patients, and the patients themselves, to help teach medical students about the needs of the terminally ill, their families, and attending staff (Willey, 1980, p. 63).

The Minister and Death

Often due to the fear of one's existence and lack of training, a pastor is called. He is the man "trained" to help care for people and minister to theri needs.

The average graduate of a seminary will have studied theology, evangelism, church planting, Greek and Hebrew, but will not be prepared for facing a situation involving the terminally ill. Most would ask, "What do I say?" or "How do I act?"

There are several ways to deal with this pressure ministers feel, and Reeves (1969) suggest three ways:

1. By cultivating objectivity - By refusing to be moved by grief, he is able to stifle it for a period sufficient for him to complete his visit and depart.
2. By the copious use of ritual - A tactic approved by religious tradition, he may club the patient into submission with a prayer when he or she really wants to curse.
3. By the exercise of doctrine - He responds to expressions of anguish by defending and justifying the ways of God and emphasizing faith (pp. 5-9).

Bowers, et al. (1969) identified five masks used to isolate the clergy from meaningful expressions of emotion: 1) Being set apart - He is ordained a "keeper of the mysteries of God." It is assumed that he must have direct communication with God; 2) Ritualized action - He has a host of "formalized" prayers and traditional procedure to enable him to avoid specific communication about individual problems; 3) Special

language - "church words" which would have an impact on a senior seminarian, such as "saving grace" and "redemptive power." These are generally words which have very little meaning to the patient, but the thought is that the words will evoke some type of symbolism which would provide "magic" and it protects the minister from emotion and really communicating with the patient; 4) Special attire - The clergyman's clothing can indicate differentness when the patient would rather share feelings and emotions; 5) Being busy - The minister may be very adept as seeming to be too busy to stay and visit very long, hence, to really have an opportunity and communicate.

Ministers themselves feel discomfort with terminal patients and out of defense, often will employ these defense measures. A recent study (Rodabough, 1981) illustrates 13 roles enacted by ministers when they interact with the dying persons. The study extended over a period of eight years and involved ministers in four states - Oregon, Texas, Mississippi, and New York. There were 100 ministers from eight different protestant denominations.

The roles observed were enacted during visits with the dying usually in a hospital setting, but sometimes in the home. Of the thirteen roles discussed here, six fall into a mood category, seven into an occupational category.

Mood:

By mood we mean an attempt is being made by the minister, intentionally or unintentionally, to affect the emotions being experienced by the dying person. Most ministers perceive dying as an ultimate crisis and realize that the ability to cope varies among individuals. The attempts

by ministers to affect mood are intended to be positive and usually are (Rodabough, 1981, p. 91).

1. The Optimistic Deceiver. This minister believes that what he doesn't know won't hurt him; everything is "going to be alright." He believes that if dying persons were to learn the truth of their condition, they might lose hope, become difficult, withdraw completely, or even more threatening - force those who interact with them to openly confront and deal with the reality of their condition. For this type of minister, he joins the ranks of so many when he reacts in the most popular method to the news of impending death - by denying it.

For this type of person there is the idea than an "agreement" exists. Never discuss the true nature or consequences of the illness and this will necessitate the avoidance of the future and never mentioning death.

2. The Scorekeeper. In this role, which is closely related to the Optimistic Deceiver, the minister points to the "stars" earned by the dying person for his or her "heavenly crown." (Rodabough, 1981, p. 91). Everything that has been done by the dying person will be enumerated so that the person will feel he has earned enough merit so God, the Scorekeeper, will allow the person into His heaven. Surely, he will be rewarded in his after-life for all of the work that has been done. This will take into account the Sunday School classes taught, the church positions held, the activities of the church and civic groups, and all the people that had been won to the Lord.

3. The Anecdotal Analoguer. This person has some analogous parallel for every development or change in the condition of the ill. There will always be stories, and the favorite phrase will often be heard, "that

reminds me." Much to the surprise of this minister, often what will be said will depress the ill person rather than cherring him up. He will renerally make the situation appear to be worse, or the circumstances will have no parallel to the present situation.

4. The Loquacious Visitor. This role is frequently performed by the nonministerial visitors who are afraid of silence, although it can be exhibited by the inexperienced minister. This role is often characterized by an excessive talkativeness. Generally, the minister may be a person who is quite able to verbally express himself, and if he feels there is an awkwardness he may fill the gap with an explosion of verbage. Often there is a feeling of ambiguity in the room which will give an uncomfortable atmosphere. The minister will not be sure how the patient will react so, as a defense, the situation is structured by the visitor so the topic will not be approached. Once the visitor begins to talk, politeness dictates that he not be interrupted. This pattern, having been established, will then be the pattern for the norm. Each time these two get together, the minister will be the talkative individual and the patient will remain the quiet one.

5. The Silent Sentinel. The minister realizes the value of his presence during times of crisis, both as God's representative and as a concerned individual. Where it may be normal for some people to avoid interaction because they don't know what to say, this person is not reticent. In contrast to the Loquacious Visitor, who doesn't know when to be quiet, the Silent Sentinel does. He is the type of person who doesn't feel the necessity to "chatter," but knows that during the dying process silence and touch can be reassuring. They communicate care and concern

and minimize the anxiety of the individual.

6. The Despondent Pessimist. For this minister, life is difficult. There would be no reason to cheer up that patient because things would only get worse. There is no hope; good and evil are at war with one another and good is losing. He is unable to demonstrate real concern when it is needed. He often sees himself as a kind of "suffering-servant" who is unable to meet all the needs of all the people, so he feels depressed that he just can't do more. In reality, it is best that he can't do more.

Occupational:

This category of role types refers to the tendancy of some pastors to perceive the responsibilities of the ministry in terms of the requirements for functioning in some occupation. Each of the roles subsequently discussed varies from an obvious identification with another professional orientation to a slight orientation complementing the general pastoral role (Rodabough, 1981, p. 95).

1. The Harried Businessman. This person has been seen in almost every hospital situation. He is the one who walks in, immediately has the situation in control and mentions how he is so overworked, but he just had to make time in his busy schedule for the hospital visit. To make sure his heavy demands are understood, he may give a rundown of his busy schedule. The patient will generally appreciate his time in sharing with them a portion of the day, yet there will be no attempt to fill a comforting role in this situation.

> I rushed right over as soon as the associational meeting concluded. The church secretary called me there about the visits that must be made before the long-range planning committee's meeting tonight. When I leave here, Mrs. Jones is expecting me to address her social club (Rodabough, 1981, p. 95).

2. The Medical Man. This minister always keeps informed on the medical advances. In addition to subscribing to Bibliotheca Sacra, he will also receive the Bulletin of the Menniger Foundation. He will remember the symptoms and outcomes of various diseases. He may well offer an interpretation of the comments of the nurses and medical staff, and may offer his own prognosis. To an extent, this person may prove very beneficial should the doctors and nurses feel uncomfortable in the situation and offer little explanation about the illness. He may alleviate the patient's fears due to his ability to share his knowledge with the patient. However, if the medical staff is communicative, the Medical Man will only appear redundant.

3. The Eternal Evangelist. This minister feels that one of his major responsibilities is to check the dying person's relationship with God. Frequently this is a strong fundamentalist who will make inquiry about where eternity will be spent. If there is any question in the evangelist's mind, he will make sure the patient is able to answer each inquiry until the evangelist has been satisfied in his own mind of the patient's spiritual condition.

> This is the most important decision that you will ever make. Think of the load of anxiety that will be removed from your loved ones by your acceptance of eternal life offered by God through Christ. They will be assured of seeing you again in the next life (Rodabough, 1981, p. 95).

The problem with this role enactment is the difference of opinion about spiritual things. Often the patient will only be interested in

using salvation as a "fire escape" while the minister may have another idea. As the minister may keep himself available to answer spiritual questions and give direction, this can provide a very supportive role.

4. The Concerned Minister. The title alone would make one believe this is the type of role they would be satisfied to enact. Yet, it is one characterized by the "ministerial tone" and sometimes certain pronunciation such as "Gawd" sets the minister aside from the "common man." He has planned how he should act and how he should dress. He comes into the room and asks the questions which pertain to the situation in general. He has allotted time for the answers, and if there has been no response, he continues on in his monologue. His visit will consist of reading Scripture which is intended to provide encouragement, followed by a prayer of entreaty, a pat on the arm, and his departure. For the most part, this serves two purposes. It allows the patient to receive a visit and it allows the minster to remain uninvolved. The dysfunction (from the patient's view) is that it looks too rehearsed and may leave the patient feeling as though he really doesn't matter.

5. The Theologian. There is an explanation for every crisis and this minister is able to provide his counsel based upon his theological perspective of God and man. This role may provide comfort because it can be based upon God's benevolence. However, the theologian may provide answers for questions which are not being asked. Frequently, a "why" from a patient is just a sign of grief, but the theologian will attempt to provide an answer. At a time when grief and heartache are being experienced, a pastor is needed, not an "intellectual" theologian.

6. The Counselor. This, says Rodabough (1981) "is another role, the title of which sounds good, but which, if used exclusively, blocks meaningful interaction" (p. 97). In a situation entailing interaction with the dying, he may use a counseling model learned in seminary to structure the situation. He enjoys being able to label stages of a dying person, and although he may be able to identify the particular stage, he is unable to aid the patient and is less comforting than the presence of a concerned individual.

7. The Comforter. This minister is a combination of all the roles previously mentioned. He is truly one who "walks alongside." Rodabough (1981) writes that "The comforter always responds to the need of the dying person--not to external structure" (p. 99). He is not limited in style nor is he rigid in his approach. He knows when to talk and when to be silent, when to express optimism and when optimism is not appropriate. He knows when to turn to Scripture and prayer and when to explore psychological models. He knows when to point to past accomplishments and when to look at statistics which provide hope for the future.

This minister does his homework and allows the patient to work through his grief. To express concern, Wood (1976) suggests five steps:

1. Gathering relayed information - From family, medical staff and friends so that he will know how to interact with the patient.
2. Gathering situational information - Physical condition, responsiveness, all become clues for interaction.
3. Reduction of ambiguity - Using counseling techniques to get the person to talk, express feelings and share.
4. Scheduling concern - The minister validates what is said to

determine what is relevant and what is not.

5. Attenuating concern - When the dying person appears to have received comfort relative to his situation, the conversation moves on to other things.

As the ministers develop their roles and become acquainted with each of the strengths and weaknesses, "homework" must be done to understand the actual stages of death.

## Reference Notes

Aries, P. The reversal of death: Changes in attitudes toward death in western societies. D. Stannard (Ed.), Death in America. Philadelphia: University of Pennsylvania Press, 1975.

Becker, E. The denial of death. New York: Free Press, 1973.

Bowers, M., Jackson, J. & LeShan, L. Counseling the dying. New York: Thomas Nelson & Sons, 1964.

Bryer, K. Amish way of death: A study of family support system. American Psychologist, March 1979, 34, 255-261.

Bugen, L. Effects of death education on stability of concern about death. Psychology Reports, November 1979, 43, 1086.

Clarke, P. Exploration of countertransference toward the dying. American Journal of Orthopsychiatry, January 1981, 51, 71-77.

Edwards, M., How my father died: A story of participation and revelation. Journal of Humanistic Psychology, Summer 1979, 19, 57-65.

Henney, M. & Barnhart, R. Death education: Do we need it? Psychological Reports, June 1980, 46, 996-998.

Kubler-Ross, E. On death and dying. New York: Macmillan, 1969.

Kubler-Ross, E. What's it like to be dying? American Journal of Nursing, Janury 1971, 71, 54-61.

Kubler-Ross, E. The right to die with dignity. Bulletin of the Menninger Foundation, May 1972, 36, 302-312. (b)

Larue, G. Death and the humanist counselor. Humanist, May-June 1980, 40, 13-15.

Lefkowitz, D. Come darkness, and end the twilight. Advances in Thanatology, 1980, 4 (2), 69-75.

Morgenstern, A. Reliving the last goodbye: The psychotherapy of an almost silent patient. Psychiatry, August 1980, 43, 251-258.

Neufeldt, D. & Holmes, C. Relationship between personality traits and fear of death. Psychological Reports, December 79, 45, 907-910.

Parkham, I., et. al. Widowhood peer counseling (Program at Virginia Center on Aging). Aging, May-June 1980, 307-308, 42-46.

Reeves, R., Jr. To tell or not to tell the patient. Austin H. Kutscher (Ed.), Death and bereavement. Springfield, Illinois: Charles C. Thomas, 1969.

Robinson, P. Five models for dying. Psychology Today, March 1981, 15, 85, 87, 90-91.

Rodabough, T. The minister as death counselor: A typology of role enactments. Pastoral Psychology, Winter 1981, 30(2), 89-102.

Schulz, R. The psychology of death, dying and bereavement. Massachusetts: Addison-Wesley Publishing Company, 1978.

Troup, S., & Greene, W. (Eds.), The patient, death, and the family. New York: Scribner's, 1974.

Wood, J. The structure of concern: The ministry in death-related situations. L. Lofland (Ed.), Toward a sociology of death and dying. Beverly Hills: Sage Publications, 1976.

Willey, D. On death and doctors: an exploration of how medical students are trained to deal with the emotional needs of their dying patients. Advances in Thanatology, August 1980, 2, 61-68.

# Chapter 2

## DEATH AND THE PATIENT

Strange as it may seem, our human nature tends to act on the supposition that "surely I can get what I want if I try hard enough." We are often taught, either overtly or covertly, that when things go wrong, there is something we should be doing differently. The emphasis is on being right, or not making mistakes, so that we deserve to get what we want. Davenport (1981) says:

> Often the things we wanted were related to our deepest needs for parental love and approval; consequently, many of us struggled hard to do the "right" things to forestall possible parental abandonment. If we failed, we typically blamed ourselves, and often resolved to try harder the next time in order to succeed (p. 332).

Loss, or the threat of it, comes to be associated with being "bad;" the implication being that it is within our power to control or stop the loss, if only we are better.

This belief is not only reinforced in the family. Teachers, too, are quick to point out that we deserve punishment - low grades or whatever, because we have failed somehow to do what should be done (Glasser, 1975).

The assumption underlying this narcissism is, we are, or could be in control. It is this belief that is threatened when we experience loss, either as children or adults.

Loss will touch all our lives. It can be something we notice, as when we feel that we could have prevented a situation, or, we may fail

to recognize its existence. Frears and Schneider (1981) have compiled a model that attempts to include varying aspects of loss.

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There have been several who have written on grief (Lindemann, 1944; Kubler-Ross, 1969; Bowlby, 1973; Engel, 1971; and Parkes, 1972). These individuals have dealt with grief in the following manner: Kubler-Ross, based her model chiefly on observation of the terminally ill; Bowlby on infants; Engel on the chronically ill; Parkes on widows; and Lindemann on survivors of catastrophes.

Due to the nature of the material and its application to death, we will explore the progress of the dying patient through, what appears to be, the critical drama of death.

## Stages of Death

Concerning this period, Carl A. Nighswonger (1971) has said:

> We are talking about the very real human experience of walking through the Valley of the Shadow with another, of sharing in the last chapter of his personal pilgrimage and of reflecting on the meaning of those experiences as they affect our understanding of ourselves and of our pastoral roles as ministers (p. 101-102).

According to Kubler-Ross (1969, 1970, 1971) these stages don't always follow one another; they sometimes overlap and may go back and forth.

Nighswonger (1971) briefly stated these stages or dramas as:

I. The Drama of Shock: Denial vs. Panic.

II. The Drama of Emotion: Catharsis vs. Depression

Illustration 2.1 Dimensions of Loss - Examples

| EXTERNAL | | | | INTERNAL | |
|---|---|---|---|---|---|
| Ease of Recognition | Relationships | External Objects | Environment | Self | Natural |
| Apparent losses | Death of loved one<br>Permanent involuntary separation<br>Incest | Theft<br>Destruction<br>Disappearance | Natural disasters (Floods, tornados, etc. | Failure<br>Being fired<br>Rape<br>Arrest<br>Chronic ill-ness | Illness<br>Injury/ disability<br>Miscarriage |
| Loss as a part of change | Divorce<br>Role reversals<br>Intense involvement<br>Separation | Moving<br>Buying/selling<br>New Job | Change in pace rhythm, space noise level, "environmental press" | Changing roles<br>Leaving home<br>Retirement | Weaning<br>Puberty<br>Mid-Life<br>Aging |
| Unnoticed loss growth or competence related | Marriage<br>Birth of a child<br>Terminating therapy | Being able to buy anything desired<br>Achieving long sought after prize | Living in "ideal" environment<br>Homogenous environment | Promotion<br>Graduation<br>Success<br>Creativity | Maturation<br>Insight |

Source: Frears, L. H. & Schneider, J. M. Exploring loss and grief within a wholistic framework, Personnel and Guidance Journal, February 1981, 59, 325+.

III. The Drama of Negotiation: Bargaining vs. Selling Out.

IV. The Drama of Cognition: Realistic Hope vs. Despair.

V. The Drama of Commitment: Acceptance vs. Resignation.

VI. The Drama of Completion: Fulfillment vs. Forlornness.

On the other hand, Dr. Elisabeth Kubler-Ross (1969) is well known for her description of the stages of death.

I. Shock and Denial.

II. Anger.

III. Bargaining.

IV. Depression.

V. Acceptance.

As one looks at these stages it will be noticed that they are quite similar. The first stage is shock and denial. This begins when the patient receives the information that he is terminal. "Denial," states Nighswonger, "is the emotional shock absorber that allows us to pretend that we did not hear that which we cannot emotionally accept" (1971, p. 102). The patient will often react with responses such as, "No, it can't be me. It's not possible," "Not me." Says Rev. Nighswonger, "Such a 'not me' response to the news of one's diagnosis may be a healthy and normal response to shock"(1971, p. 102).

As denial may provide time to master inner forces to cope with the situation, so, prolonged denial indicates a person's inability to deal with the situation. There are some patients who will even maintain their denial to the very end. They cannot admit they are actually mortal. A family member or minister can be the subject of such denial. If a family is involved the patient will not talk to them about the seriousness of

the illness or how he feels. The minister shares in his own denial system and reinforces the patient's need to pretend that it really is not happening. If the minister continues to deny the reality after the patient has begun to move through the stages and to drop the denial, the patient often recognizes the minister's need, takes his cue from the minister, and continues to pretend in the presence of the minister.

Seemingly, communication is the key. If they, or we, can tell the terminally ill that we are ready to talk about dying, that we are willing to listen, the patient will drop the denial quite quickly and will talk about the situation (Kubler-Ross, 1971, p. 55).

Kubler-Ross (1971) further comments:

> Patients usually drop part of their denial when they have to take care of unfinished business or financial matters, especially when they begin to worry about their children. But they can also drop their denial if they know that the person with them will help them to express the multitude of feelings that emerge when they face the given reality (p. 56-57).

It would appear that the Christian community may be responsible for many not having the opportunity to work through this beginning stage and the second stage of anger. A person who has been told that he is going to die will often experience emotional reactions which result in tears or complaints. Someone who has been regarded as a strong Christian may seem very helpless. The Christian community response is too often one of condemnation and void of understanding. Such outward indications of emotional unrest may manifest themselves as complaints against well-meaning doctors, nurses, friends or family; the doctors are ordering too many tests, the intern does not know how to start an i.v., the nurse comes in to shake a pillow when the patient is just dozing off, the family visits

too often or not enough. The patient rings for the nurse constantly, only to wait longer and longer for the call to be answered (Kubler-Ross, 1970, p. 112). He is then met with the personnel's frustrations, hurt feelings and anger. What is not realized is that the patient is not angry with the personnel as individuals, but is expressing resentment at all the medical and professional personnel represent: all the health and functioning that the patient is in the process of losing.

Because of the patient's anger, everyone withdraws. In the hospital, a study was done to measure the time it took nurses to answer a patient's calling light. It was discovered that the patients who were beyond medical help (terminally ill) had to wait twice as long as the others (Kubler-Ross, 1971, p. 57).

What can be done to help the patient at this stage who is saying, although not verbally, "Why me?" It has been suggested that we help them discover why they are angry or simply to express that anger rather than supressing the emotions and frustrations. This is the meaning of the stage of anger stated by Dr. Kubler-Ross. It is anger, range, a sense of impotence, and of helplessness. She states "You can help not only the patient to express his range and anger, but the family, too, because they go through the same stages (Kubler-Ross, 1971, p. 58).

The next stage or drama is that of negotiation or bargaining. This has been described as a type of truce and temporary peace for everyone. Most bargaining is done with God and involves a promise in exchange for some prolongation of life. In the bargaining stage the feeling is, "Yes, me, but . . ."

The patient may be willing to do anything, either being more obedient to God or following all the doctor's orders if life can be extended. Such negotiations are normal, often unrealistic, but they do aid the patient in his readiness for the next stage.

It is interesting to note the blending of Kubler-Ross and Nighswonger on this next stage. Kubler-Ross states that this next stage, denial, is illustrated by the statement, "Yes, me." The patient has the courage to acknowledge, or as Nighswonger would say is cognizant that death has "come nigh" to him, and he is naturally depressed (Kubler-Ross, 1971, p. 58). The patient realizes that it really is happening to him. In such a state, the patient is faced with despair which may intensify gloom and hopelessness. The patient should be allowed to grieve. Instead of being encouraged to "cheer up," we should allow mourning. If the author's wife was to die, everyone would allow--even expect him to grieve. It would be normal because he would have lost one person he loved. "The dying patient is about to lose, not just one beloved person, but everyone he has ever loved and everything that has been meaningful to him" (Kubler-Ross, 1971, p. 58).

To work this situation into something that has meaning is the goal of the counselor or minister. Nighswonger (1971) states, "The patient may be helped to experience a realistic hope in the future of his pilgrimage by discovering some sense of meaning and purpose which offers the possibility of personal fulfillment in his own death" (p. 107).

It appears that this is the understanding of Erik Erikson (Erikson, 1964). He felt that in the "Generativity vs. Stagnation" stage of development, a person moved from the self-centeredness to helping others. It

is reaching out in an attempt to leave behind something, even if only the thought that "there is no need to fear death."

When a person has come to accepting his illness he moves from intellectual assent to emotional response. The patient may express few needs, except for the care and companionship of a loved one; expressed by sitting silently and comfortably by his side, without words, but just touching his hand or perhaps stroking his hair or just being there.

This is true acceptance. It is not resignation as Nighswonger believes; resignation is a bitter kind of giving up. Kubler-Ross believes that acceptance is a good feeling (1971, p. 58).

"I am ready to die," is the capstone to this progressive drama. The patient is not happy, but he is not sad. This stage is experienced as a type of victory after a long and gallant battle. The patient is not afraid to die; he is ready.

The minister's role, now, is to prepare the family for the death and to avoid their interference in the extension of life. At this junction, the author is not referring to withholding life-giving procedures, but there seems to be a point where the patient is ready to stop the fight. Paul, in II Timothy, seems to mirror this stage when he says, "For I am ready to be offered, and the time of my departure is at hand. I have fought a good fight, I have finished my course, I have kept the faith" (II Timothy 5:6-7).

As an example of interference with a patient death, Dr. Kubler-Ross (1971) gives this illustration:

> Mrs. W. was ready to die, but felt unable to "let go" because of her husband's inability to face the fact that she was close to death. She spoke in a soft voice of her happy marriage of 25 years and

> her readiness to "go" as she put it. She was very disturbed by the fact that her husband was able to accept this reality and asked for help, not for herself, but for him. Without our knowledge the husband simultaneously asked around for another intervention, surgery or the like, "to turn the clock back" A radical surgery procedure was finally agreed upon and the patient did not dare to refuse, out of pity for her husband. From the moment she signed the permission papers, she lost her calm and dignity. She became quite disturbed and asked constantly for pain relief. We urged reconsideration, but in vain. When she was brought to the operating room, she suddenly became psychotic, screamed, and carried on--"They are going to kill me"--until the operation was cancelled.
>
> In her psychotic stage she asked us to "talk to this man" and we finally succeeded in explaining to her husband the extreme defenses his wife had to mobilize to prevent prolonging her life when she was ready to die. When he was able to express his acceptance and surgery was permanently cancelled, Mrs. W. resumed her dignified appearance and became the lady her husband had loved for many years. She returned home and lived for one more week, thus helping her husband reach the stage of acceptance with courage and strength (p.114).

If ministers can understand their feelings and fears about death, then their service to their congregation or community can be a gratifying experience as opposed to something morbid or depressing.

How do ministers integrate this understanding of death into their ministry? It is by education, and yet, there is a question as to when this tupe of education should begin. Another question to face relates to the amount of research that has been done in the area of death anxiety.

## Anxiety and Death

Fear and anxiety are often used interchangeably. Schulz (1978) writes, "A distinction often made by psychoanalysts is that fear is experienced in reference to specific environmental events or objects, while anxiety is a negative emotional state that lacks a specific object" (p. 21).

Anxiety may be a burden, but it may also have positive aspects. "The behaviors and psychological energies invested in self-preservation

are products of death anxiety" (Zilboorg, 1943). Most of the time, these anxieties exist, and like water is to a boiling teapot, so they exert their pressure on the behavior. If, or when, these pressures become too great, they manifest themselves in neurotic or psychotic behaviors (Becker, 1973; Meyer, 1975). It has been argued that many of humanities heroic achievements represent an attempt to master this anxiety and conquer death (Becker, 1973).

Death anxiety has been measured in a variety of populations and settings with a wide assortment of assessing devices (Collett and Lester, 1969; Dickstein, 1975; Hoelter, 1979; Kalish, 1963; Nelson and Nelson, 1975; Stevens, et al., 1980; Vernon, 1970). These have ranged from projective techniques to the measurement of galvanic skin responses. It is the aim of this chapter to review the existing death anxiety literature and to bring order and direction to the field. For the sake of the literature that will be examined, it must be pointed out that the distinction between death <u>fear</u> and <u>anxiety</u> has not been made by empirical researchers. As a result, the two terms are used interchangeably in the following discussion.

Direct and indirect techniques have been used to assess death anxiety. Direct techniques include questionnaires, check lists, and rating scales, while indirect techniques include projective tests, the measurements of galvanic skin response, and reaction times during death-related assocation tasks. At the present time, direct techniques are more frequently used, and there are six widely used death anxiety questionnaires (Boyar, 1964; Collett and Lester, 1969; Lester, 1967a; Sarnoff and Corwin, 1959; Templer, 1970; and Tolar, 1967).

An example of one death anxiety scale is presented in Illustration 2.2.

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Insert Illustration 2.2 here

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After reading each statement, the respondent decides for him or herself whether a particular statement is true or false. These responses are then coded according to a key, and a death anxiety score is derived.

Concerning these scales, Schulz (1978) says:

> Only Boyar's (1964) Fear of Death Scale (FODS) and Templer's (1970) Death Anxiety Scale (DAS) have been validated. Validation is a procedure for determining whether a scale measure what it was designed to measure--in this case, death anxiety. Exactly how this should be done varies with the type of scale used. Boyar attempted to validate his scale by administering it to subjects before and after viewing a highway accident movie that was intended to increase their death anxiety. Fear of death scores rose significantly more in the experimental group than in the control group that saw an innocuous movie.
>
> Templer validated his scale both with psychiatric patients in a state mental hospital and with college students. High-anxiety psychiatric patients independently assessed by a clinician were found to have significantly higher DAS scores than control patients.
>
> The remaining scales (Dickstein, 1972; Kreiger, Epsting and Leitner, 1974) have neither been validated nor compared to the six scales discussed above. Kreiger, Epsting, and Leitner's (1974) Threat Index has the interesting feature of being theoretically based, but it has poor test-retest reliability ($r$=0.49 with one of 13 subjects dropped). Test-retest reliability is a measure of the reliability of the scale over time. That is, if an individual completes the same scale at different times, his or her scores should be very similar even though several months have passed between the first and second time the scale was administered. This is based on the assumption that the scale measures permanent dispositional characteristics of the individual which should not vary greatly over time (pp. 23-24).

Studies (Ewalt and Perkins, 1979; Templer and Lester, 1970)

ILLUSTRATION 2.2
Templer's Death Anxiety Scale

| Content |
| --- |
| I am very much afraid to die. |
| The thought of death seldom enters my mind. |
| It doesn't make me nervous when people talk about death. |
| I dread to think about having to have an operation. |
| I am not at all afraid to die. |
| I am not particularly afraid of getting cancer. |
| The thought of death never bothers me. |
| I am often distressed by the way time flies so very rapidly. |
| I fear dying a painful death. |
| The subject of life after death troubles me greatly. |
| I am really scared of having a heart attack. |
| I often think about how short life really is. |
| I shudder when I hear people talking about a World War III. |
| The sight of a dead body is horrifying to me. |
| I feel that the future holds nothing for me to fear. |

Source: Templer, D. The construction and validation of death anxiety scale. Journal of General Psychology, 1970, 82, p. 167.

in the field of death research have emphasized the need for standardized measures of the fear of death. Only a few scales have been developed with consideration of reliability and validity in mind. With these measures, content varies greatly, with themes that include fear of dying, fear of being dead, and reactions to such death-related topics as funerals, hospitals, cancer and grave yards. Because of the wide variety of range in these scales, it is difficult to determine if these scales are measuring the same things or what component parts are being tapped.

Joseph A. Durlak (1972) investigated the concurrent validity of four different psychometric scales that assess fears and anxieties about death (p. 345). Also under investigation was whether these scales were relatively stronger measures of concern about death itself or the process of dying and whether the concern manifested in scale scores was personalized (death/dying of self) or generalized (death/dying of others) in nature.

As indicated, the death measures studied were developed by Lester (LE), Boyar (BO), Sarnoff and Corwin (S-C), Tolar (TO) and Collett and Lester (C-L).

To test these measures 94 undergraduate psychology students at Vanderbilt University (47 males and 47 females, aged 18-27) were used.

In the development of the scales, final items had been determined on a rational judgment basis (LE, TO) or item analysis (S-C, BO, C-L). As Durlak (1972) states:

> The number of questionnaire items, internal (split-half) consistency, and test-retest reliability figures for the above scales were: 21 .65, .58; 20, unknown, .85; 5, un-

known, unknown; 18, .89, .79; and 38, unknown, unknown, respectively (p. 546).

Some assessment of validity had been undertaken through experimental procedures for all by C-L, which assessed fear in four different areas based upon a face-validity content basis. The four subscales with representative scale items were: Fear of Death on Self (Dth-Self): "I would never get over the death of someone close to me.", Fear of dying of Self (Dy-Self): "The pain involved in dying frightens me.", Fear of dying of Others (Dy-Other): "I would avoid a friend who was dying."

In administering these tests students were asked to state their disagreement-agreement rating scale. On these four scales, ratings are reversed for low fear items and them summed. On LE, the student stated his simple disagreement or agreement with each item. Each item had a Likert scale value that indicated the degree of fear of death that agreement with the item implied, and the student's fear of death was the median scale value of those statements with which he agreed. On all of the death scales, higher scores reflect higher fear of death.

Table 1 (see Appendix A) represents the correlations between the death and social desirability scales. The death scale correlations are all significant at the .01 level and moderate in magnitude. There is no general association between scale scores on the death measures and social desirability indicators. Only the correlation between BO and SDS is significant ( $r$ = -.21), although low. (The correlations between the four subscales of C-L and SDS were also low and insignificant; all $r$s were -.14 or below).

The data lend support to the concurrent validity of the death measures.

Table 2 (see Appendix A) presents the correlations between each death measure and the four C-L subscales. Durlak (1972) reports:

> Each death scale has its highest correlations with the Dth-Self subscale, its second highest correlations with the Dy-Self subscale, and, in comparison, relatively lower correlations with the Dth-Other subscales. If C-L is accepted on a face validity basis, the data indicates that the death scales are relatively stronger and better measurements of personal fears and anxiety about death and dying (i.e., when the self is the referrant) then they are measures of generalized fears or anxieties about death (i.e., when the other is the referrant) (p. 547).

It has been shown (Vargo, 1980) that the Templer Death Anxiety Scale and the four subscales of the Collett-Lester Fear of Death Scale were significantly correlated (p. 561). The Templer Death Anxiety Scale was most highly correlated with those Collett-Lester subscales which measure fears of one's own death and dying ($rs$ = .61, .51).

In this study (Vargo, 1980), 72 undergraduate nursing students were used. They were involved in a larger study of death education at Murray State University. Sixty-seven were female, five were male, and their mean age was 20.5 years. These subjects were administered the two death anxiety scales, including the four Collett-Lester subscales, Fear of Death of Self, Fear of Dying of Self, Fear of Death of Others, and Fear of Dying of Others (see Table 3 Appendix A).

Vargo (1980), in his study reports:

> Product-moment correlations were largest for scores between the Templer Death Anxiety Scale and the Fear of Self ($r$ = .609), followed by the Fear of Dying of Self ($r$ = .524), Fear of Death of Others ($r$ = .434), and Fear of Dying of Others ($r$ = .396) subscales. All values were significant ($p$ = .01; see Table 4) (p. 561).

As Vargo (1980) relates, these data indicate that the two scales are moderately correlated and support their concurrent validity (p. 562). The correlation between the Templer Death Anxiety Scale and the Collett-Lester subscales proportedly measuring fears of one's own death and one's own dying suggest that the Templer scale may measure anxiety concerning personal demise. Vargo (1980) also points out that this is consistent with work by Durlak (1972), who found four death anxiety scales, other than the two discussed here, to be more highly correlated with the Fear of Death of Self ( $rs$ = .78, . 69, .55, .47) and Fear of Dying of Self ($rs$ = .47, .58, .52, .46) subscales than those measuring fears of others' demises.

The Templer Death Anxiety Scale, like other measures of the fear of death, provides a measure of fear concerning personal demise, as well as one of death anxiety in general (Vargo, 1980, p. 562).

There has been an attempt to provide a multidimensional conception of the fear of death and to develop a reliable scale for its measurement, with some initial evidence for validity. This is in contrast to the usual unidimensional scales of Boyar's (1964) Fear of Death Scale, and Templer's (1970) Death Anxiety Scale which have both been found to be reliable and valid.

For this study, questionnaire data were collected at a mid-western university in 1977. The sample included 143 male and 232 female undergraduates ranging in age from 17-37 years.

To provide an explanation of the questionnaire, Hoelter (1979) writes:

> The questionnaire contained several Likert-type fear of death indicants developed by the present researcher

> (based on two pretests). Boyar's (1964) Fear of Death Scale, Templer's (1970) Death Anxiety Scale, and Putney and Middleton's (1961) Religious Orthodoxy Scale. The latter scale was chosen as a criterion variable to compare the different dimensional approaches to fear of death for two reasons. First, this scale measures a salient religious orientation and has been shown to be both internally consistent and unidimensional. Second, several theorists have suggested that the failure to obtain concrete findings relating fear of death to religiosity is due in part to the prevalent unidimensional approach to measuring fear of death (p. 996).

The factor structure providing the clearest interpretation of the proposed fear of death dimensions is shown in Table 5 (see Appendix A). The structure of this eight-factor solution provides empirical support for a multi-dimensional conceptualization of the fear of death. Based on the theoretical aspects of Collett-Lester (1969); Diggory-Rothman (1969); Kalish (1961); Nelson and Nelson (1975), this research proposed a multi-dimensional fear of death scale (MFODS).

Hoelter (1979) summarizes these dimensions:

1. Fear of the dying process. This dimension deals with the specific act of dying rather than with any related consequences accompanying death.
2. Fear of the dead. This dimension simply pertains to people or animals that have died.
3. Fear of being destroyed. This dimension deals with human destruction of one's body immediately following death.
4. Fear for significant others. This dimension relates to fear of significant others dying as well as fear associated with the effects one's death may have on significant others.

5. Fear of the unknown. This dimension deals with the ambiguity of death and the ultimate question of existence.
6. Fear of conscious death. This dimension deals with living out horrors associated with the immediate process subsequent to death whereby the pronouncement of death is not accepted to be the final termination of consciousness.
7. Fear for body after death. This dimension is associated with concern for bodily qualities after death.
8. Fear of premature death. This dimension is based on the temporal element of life and concerns the failure to achieve goals and experiences before death (p. 998).

In Table 5, the internal consistency coefficients are also shown. Due to the previously reported reliability coefficients for fear of death scales, as well as for general attitudes scales, the reliability of the proposed measuring instruments has been adequately demonstrated.

Due to the large number of suggested fear of death dimensions, it is necessary to remember that this should only be considered a starting point. Hoelter (1979) states, "The relation between fear of death and religiosity has been theorized to be both positive and negative in direction" (p.998). Becker (1973) said that "religion solves the problem of death" (with respect to the unknown) (p. 204), Vernon (1970) stated that religion understands the general death factor (thus increasing levels of such fear) (p.103 ). Due to this, theory suggests that fear of the unknown aspects of death is negatively related to religiosity, whereas other types of fear of death relate

positively to religiosity (Hoelter, 1979, p. 988).

Upon examination of the MFODS subscales in relation to religious orthodoxy, it can be seen that this is the first empirical support for both of the above theories and, also, provides evidence for the construct validity of the proposed instrument. Commending, Hoelter (1979) says:

> Four of the MFODS subscales correlated positively with religious orthodoxy: fear for significant others ($r$ = .20, $p < .01$), fear of conscious death ($r$ = .21, $p < .01$), fear of being destroyed ($r$ = .14, $p < .01$), and fear for body after death ($r$ = .01, $p < .05$). The fear of the unknown subscale, as expected, had a strong negative relationship to religious orthodoxy ($r$ = .64) (pp. 998-999).

Boyar's Fear of Death Scale and Templer's Death Anxiety Scale both failed to significantly correlate with religious orthodoxy ($rs$ = .08 and -.02 respectively).

It has been hypothesized that the elderly would be less anxious about death. To test this hypothesis, Stevens, Cooper, and Thomas (1980) obtained a cross-sectional sample of 295 adults drawn from college courses, church and civic groups, and a local association for retired persons in central Connecticut area. It was reported that all were middle-class, established business or professional persons, training for such a position, or married to someone in such a position. Questionnaires containing the Death Anxiety Scale, as well as several other measures, were administered during regular class or organizational meetings. Participants were asked to complete the questionnaire at home and either return it by mail or at the next group meeting.

The participants were divided into four groups: adolescents and

youth (ages 16 to 22 yrs., 26 males and 79 females); young adults (ages 23-39yrs., 15 males and 36 females); middle-aged adults (ages 40-59 yrs., 31 males and 40 females); and elderly adults (ages 60-83 yrs., 23 males and 45 females).

Stevens, et al. reported:

> A two-way (sex X age group) analysis of variance indicated no significant main effect for sex ($F_{1/294} = 1.08$, $p < .3$), although the mean scores of females were higher than those of males, and no significant interaction of sex and age ($F_{3/294} = .69$, $p < .6$). The main effect for age was significant ($F_{3/294} = 4.40$, $p < .005$), however, and *post hoc* contrasts (Least Significant Differences) indicated that the test scores of the oldest age group were significantly different from those of other groups ($p < .05$). Inspection of Table 6 (see Appendix A) which presents the mean scores of the four age groups, indicates that the oldest members of the sample possessed less death anxiety than their younger counterparts, as hypothesized (p. 206).

It is important to note that in a life-span, cross-sectional sample of 295 adults, using Templer's Death Anxiety Scale: the results showed that those over 60 years had lower fear of death scores than the remainder of the sample.

Lastly, we will look at the study of Schulz and Aderman (1977). They investigated the relationship between physicians' death anxiety and the length of their patients' survival in the hospital. It was hypothesized that physicians high in death anxiety would be less willing to admit that their patients were terminal and therefore more likely to use heroic measures to keep them alive. Schulz and Aderman (1977) felt that these patients, once admitted to the hospital, should survive longer than the terminal patients of physicians with low death anxiety (p. 37).

To test this hypothesis, 27 physicians at a Southern community hospital were told that the researcher was calling on a variety of professional people as part of an attitude survey and that the survey dealt with attitudes toward death. After explaining that they were to indicate their agreement or disagreement, using a scale from -3 to +3, the following give their statements (Sarnoff and Corwin, 1959) were read to each physician:

1. I tend to worry about the death toll when I travel the highways.
2. I find it difficult to face up to the ultimate fact of death.
3. Many people become disturbed at the sight of a new grave, but it does not bother me.
4. I find the preoccupation with death at funerals upsetting.
5. I am disturbed when I think of the shortness of life.

The 27 physicians interviewed were divided into three groups which reflected the degree of death anxiety: (1) high ($n$ = 8); (2) medium ($n$ = 7); and (3) low ($n$ = 9). Their hospital records were examined to determine the number of patients each physician treated, the number that died, and the average length of stay in the hospital of dying patients and nondying patients. The relevant data are presented in Table 7 (see Appendix A).

Schulz (1978) recorded the conclusions in the following:

> The length of stay for dying patients varied directly as a function of the physicians' death anxiety. Patients of physicians with high death anxiety were in the hospital an average of 14.49 days before dying, while patients treated by physicians of medium and low-death anxiety were in the hospital 9.98 and 8.45 days, respec-

> tively. One possible interpretation of these data is that physicians with high death anxiety admit terminal patients earlier and/or are more likely to use heroic measures to keep them alive (p. 39).

Table 7 also shows that the nondying patients do not differ as to length of stay in the hospital as a function of their physician's death anxiety. It can be seen that the percent of deaths per group of physicians does not vary as a function of level of death anxiety. The data suggests that death anxiety may affect the physician's policy regarding the treatment of terminal patients.

It is worth noting that these data are only correlational, and additional information would be necessary to substantiate the hypothesis. Furthermore, the experiment represents only one way of relating death anxiety to some specific behavioral outcomes.

Man has been concerned about death since the fall of man. Yet, he is not well informed as to the extent of the study of death education and the ensuing anxiety. Many speculations have been made concerning death anxiety, and for the most part, they have been based on intuition and individual case studies.

What is it that makes death such an undesirable prospect? The negative aspects of death and dying can be classified under two general and interacting categories--psychological and physical suffering. They are interactive because each can intensify the other and neither exists in isolation (Schulz, 1978, p. 19). Briefly, these negative aspects are:

1. Fear of physical suffering. This aspect is associated with the psychological and physical suffering associated with the deterioration of the body that is associated with

cancer. For a person who has been active, this can be devastating.

2. Fear of humiliation. This is a psychological fear, but may be the result of physical suffering. There is fear of not being brave in the face of suffering (pain) or of ourselves not existing bodily (i.e. being dead).
3. Interruption of goals. This is interference of achievement of goals due to the anxiety of death. Mankind measures length of life by accomplishments rather than absolute time. This is especially true in the field of academics where the student has a desire to obtain additional degrees or the professor's desire to write more books. Due to these goals, a person may feel anxious if they feel death will hinder them from achieving a goal.
4. Impact on survivors. Another source of death anxiety may be the psychological and economic impact one's death may have on emotionally involved survivors. This is especially true for the person who may have a large family dependent upon him for economic support.
5. Fear of punishment. This anxiety stems from people believing they will atone for their deeds in an after life.
6. Fear of not being. "Man is the only creature who must live with constant awareness of the possibility and inevitability on nonbeing" (Coleman, 1972, p. 71). Man may be driven to deep concern over the meaning of life. This leads to a speculation of fulfillment and achievement. Anxiety concern-

ing our possible nothingness can influence our whole life.

7. Fear of the death of others. This is anxiety that affects us when others die because we feel vulnerable and closer to our own death. We also suffer the loss of friendship.

Due to the anxiety that we feel when faced with the prospect of death, there is the need to be educated. With education, anxiety can be lessened. This topic will be discussed in the following chapter.

## Grief

> . . . The loss of my little one began to be real. It had happened. The song of mourning was rising to a deafening fortissimo in my ears. It was as if the music had been written and orchestrated only for the percussion instruments and everything was pounding, striking, or clanging together. The only lyrics I could come up with were, "Lord, why did You do that?"
>
> Someone, somewhere inside of me, seemed to be beating out a slow, throbbing rhythm on the tympani drums and the pulsing sounded like the ugly word dead. "Dead--dead--dead---" (Landorf, 1974, p. 59).

Joyce Landorf describing her anger, her pain, quite adequately describes her feelings of grief as loss. Schulz (1978) said, "Grief and bereavement have long been recognized as characteristic human responses to loss, whether it be the loss of a person or the loss of some other important organism or object (p. 136). Collins (1980) was even more succint as he wrote, "Grief can be stated simply: Something or someone has been lost..." (p. 413).

To the terminally ill patient he is facing the most grievous situation of his life, the loss of all that has been dear to him. The response of the Christian community rarely looks upon grief as being normal. Carse (1981) has said, "The more ordered and habitual our

universe, the more we can be shattered by grief" (p. 6). What we do with grief is very important for we learn that our own universe is personal. Our universe is affected by the death of another and we come to a discovery: we are free to rebuild it. One discovers that the world is subject to change, nothing remains as it was. The universe has no consistency, it will all pass away, it will all change. The loss that we experience can never be restored. On the other hand, we must realize that we can build a new life because we share it with others. When we share that life, integrate it, rebuild it, we heal our bereavement.

Grief is a normal process, not a psychiatric disorder. The Lord Jesus said, "Blessed are those that mourn, for they shall be comforted" (Matthew 5:4). When the Lord was met by Mary, and was told that Lazarus had died, He wept (John 11:35). Mourning was, and is, to be expected. It is not a sign of weakness to cry, and it is not something unhealthy to mourn.

Although grief is normally associated with the survivors of a terminally ill patient, the patient may have all of the symptomatology of grief.

Arthur Freese (1977) comments on the work that is involved in the grieving process:

> "Grief work:...is just what it says, the task of mourning. And it is work--hard, long, painful, slow, repetitive, a suffering through the same effort over and over. It's a matter of rethinking and refeeling, reworking the same long-past fields, the same old emotional material, over and over--breaking through the denial and disbelief that the past and the deceased are both dead; reexamining one's past life repeatedly and seeing each thought, each intimate experience, with and without the deceased, looking at everything that has gone before from a thousand or more points of view until finally the past, like the deceased, is ready to

> be buried. Out of this a whole new mourner emerges with new attitudes, new concepts, new values, new appreciation of life itself and if these are better than the old, then there has been growth and change and all the suffering has been worthwhile, then the grief has been good (p. 48).

But the grief is not always good. It can be turned inward so that it becomes acute or pathological grief. Pathological grief is grief that is intensified, delayed, prolonged, or otherwise deviating from normal grief, resulting in a bondage to the deceased that prevents one from coping adequately with life (Collins, 1980, p. 414). Symptoms that seem to be remarkably uniform in pathological grief are:

> Sensations of somatic distress occurring in waves lasting from twenty minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing, an empty feeling in the abdomen, lack of muscular power, and an intense subjective distress described as tension or mental pain (Lindemann, 1963, p. 9).

As Dr. Lindemann points out, the patient will soon learn that these symptoms are associated by visits, by receiving sympathy or by mentioning the name of the deceased. Due to this fact, the patient will want to avoid thinking about any references to the deceased.

Lindemann (1963) lists striking features associated with acute grief:

(1) The marked tendancy to sighing respiration; this respiratory disturbance was most conspicuous when the patient was made to discuss his grief.

(2) The complaint about lack of strength and exhaustion is universal and is described as follows: "It is almost impossible to climb up a stairway." "Everything I lift seems so heavy." "The slightest effort makes me feel exhausted." "I can't walk to the corner without feeling exhausted."

(3) Digestive symptoms are described as follows: "The food tastes like sand." "I have no appetite at all." "I stuff the food down because I have to eat." "My abdomen feels hollow." "Everything seems slowed up in my stomach" (p. 9).

There are questions as to what causes grief to be normal or pathological. It is believed that of the many things that influence a person, four reasons might be the griever's beliefs, personality, social environment, and circumstances surrounding a person's death (Collins, 1980, pp. 416-417).

1. Beliefs. If there are no religious backgrounds of the mourner, there seems to be a greater potential for pathological grief. There appears to be a sustaining power in a person's religious beliefs. There may be problems associated with denial, anger, and rebellion against God, but natural healing appears to come to those who have a religious belief. It is worth noting that a Christian believes that the third Person of the Godhead, the Holy Spirit gives supernatural comfort and peace in times of mourning.

2. Background and Personality. It appears that an indicator of how one will react to a situation is how he has reacted in the past. It will be remembered that it is not an easy science to predict the behavior of another person since there are so many variables. Some people are more secure than others, hence a person who has always been used to receiving their identity from their partner may have difficulty handling their new situation. As Collins (1980) has pointed out, "Grievers differ in their personal needs, closeness to the deceased, typical ways of handling feelings, willingness and ability to face

the reality of the loss, closeness to others who can give support, personal views about life after death, flexibility and ability to cope with crisis" (p. 415). For some people, grieving may be more difficult to cope with.

3. Social Environment. The area in which one grows up or lives will often dictate the way that one may or may not appropriately vent his feelings or emotions concerning grief. The culture of America denies that death exists. One may encourage a rational, non-emotional grieving process that should end as quickly as possible. One may be encouraged only to respond to bereavement of others by sending a card, a flower, or providing a cassarole. In other societies, there may be the encouragement to take as long as needed to work through the bereavement period, but, all of this will depend on the social background.

4. Circumstances Accompanying the Death. This circumstance deals with the illness or the circumstances associated with the death. If the illness were a prolonged, degenerative type of illness, the grief will probably not be as long, nor would it tend to be acute.

Grieving may be prolonged or more acute when:

1. The death is considered untimely--"so young," at the "height of his career."
2. The mode of death is considered incomprehensible--as in suicide.
3. There is a sense of guilt at having "participated" in the event which caused the death - driving the car in which someone died.
4. There was such a close, intimate relationship with the deceased.

5. There was an extreme dependency on the lost person to give the mourner identity, self-confidence or meaning to life.

6. There is an excessive attachment to the deceased person's possessions--allowing the mourner to believe that the deceased is still alive.

7. The dead person may exact a promise from a survivor that they are incapable of fulfilling--not remarry, not grieving.

8. There is disallowance of the expressions of grief by family, employer, or environmental circumstances (Collins, 1980, pp. 416-417).

The person who is grieving is not always looking for someone who has answers to unasked questions. More often the mourner is looking for someone to listen. Normal grief is an extremely difficult time for all concerned. It will usually take care of itself if there are those who will help cushion the blows of life. One way in which one may give healing is to encourage the mourner to discuss the deceased or the death before it occurs. This will mean that the counselor, whether doctor, minister, or family member, will need to face their own feelings of fear concerning death. They will have to commit themselves to understanding themselves in order to help give understanding to either the terminally ill patient or to the mourner.

In dealing with acute grief, Vachon (1981) lists reactions that frequently appear in most acute grief circumstances.

1. The news of sudden death should be broken to family members carefully and supportively, preferably by someone who was with the person when he died.

2. The use of heavy tranquilizers at this point is usually inappropriate.

3. Close family members should be encouraged to see the deceased, but not forced to do so.

4. The role of hallucinations in the bereaved can be therapeutic and should not be thought to be indicative of severe emotional disturbance in most cases.

5. When obvious grieving does not occur in the stage of acute grief, future problems may follow.

6. Generalized anger toward one's social support system during the bereavement period may be predictive of later problems.

7. The bereaved is susceptible to physical and psychological illnesses. Symptoms must be assessed carefully and not simply dismissed as being a normal part of bereavement.

8. With terminal illness, family involvement is important; but be aware--there may be covert family dynamics operating in what appears to be an open, loving family.

9. As far as possible, family members should be encouraged to be with the dying person through the final vigil.

10. Follow-up phone calls or visits should be done with the bereaved by the family physician, public health nurse, or concerned funeral director (p. 21).

There are many things that may hinder aiding the mourner. The Biblical counselor may wonder what he can do to give comfort, to help when the person is not conversant. Steen (1958) said, "The minister must perform his pastoral functions in spite of hindrances to communication; however, he can perform them more efficiently if he understands the obstacles" (p. 27). The difficulties of communication seem to result from three sources: the patient's inability to talk, the patient's inability to think clearly, and interference from beyond the patient.

In the first circumstance the minister must take the initiative in offering support from the Christian faith. This may mean reading Scripture that will speak to the situation at hand. Many times the

patient will be unable to vocally communicate, yet he will be able to offer thanks or show gratitude by the expression on his face or the look in his eyes.

When the person is unable to think clearly, the minister may have to draw upon past experiences with the patient to determine what he is requesting. If the minister is unable to determine the need because of lack of prior contact, it may be necessary to perform spiritual "first aid" for the emergency patient and refer him to his own minister. In such a situation a patient who is fearful of losing his life may respond to simple rituals presented to him by an old acquaintance, usually his own minister. Steen (1958) would suggest that two of the most important rituals are recitation of the Lord's prayer and the twenty-third Psalm (p. 31). The familiarity of these passages has a stabilizing effect on the patient and often will give him a ground work for communication.

The third hindrance to communication with the dying patient is the interference that emanates from the environments. This can manifest itself in two ways. It may be the natural circumstance of medical personnel working to administer life saving techniques, but primarily the interference will come from relatives of the patient. In dealing with the dying patient who is anxious about eternity, a relative may offer unsound assurance, "That's alright, we've all done wrong." A solution to this problem is to ask the relative to step out of the room. This then provides a private and uninterrupted environment for his pastoral duties. One compromise for the minister, who feels reluctant to send the family of a dying patient out of the

room, is to ask them to stand at the foot of the bed in order that the minister might be closer to the patient. As the time for prayer is anticipated the pastor may invite the relatives to stand nearby so that they may also feel as if they are included in the counseling situation.

Preparation for grief is a concept that is rarely exercised in our society. It seems fitting that the Amish have a unique practice which helps the family prepare for the eventual death of the terminally ill patient. If death is accepted as just another stage of life, if it was greeted as a teaching experience for families and friends; it would provide a legacy. Even in working through the stages of death, it can give strength to others to pattern their lives and deaths after.

In this preparation of grief the family can provide one of the greatest sources of strength. Yet, the family will be severely handicapped unless the religious element is emphasized. Larue (1980), a humanist counselor has said of his position, "The humanist counselor cannot give the assurance of sin forgiven, guilt assuaged, life beyond death, heaven, a loving God or a caring Jesus" (p. 15). Calm acceptance of death, undergirded by a deep religious faith, is an integral part of Amish culture (Bryer, 1979), p. 257). The anticipation of death lies at the core of much religious activity:

> The inevitable fact of death needs to be reckoned with and accounted for; it has to be explained and included in a wider scheme of representations, a belief system, a religion...J. Bowker argues that religion has failed to disappear because of the great "constraint of death; the role of religion is to find a way through this limitation of human existence (Goody, 1975, p. 1).

In research conducted by Templer on death anxiety, results in-

dicated that those who have a strong attachment to their religious belief system, who are certain of life after death, and who believe in a literal interpretation of the Bible apparently have lower death anxiety.

The Amish have a marvelous way of taking care of their loved ones. They maintain an extended-network system which allows the needy individual to go from one family to another each month. This may appear to be a difficult hardship for the physically impaired, yet, the benefit of having a family with a fresh supply of interest and patience, which is freely given, seems to outweigh the negative aspects.

Regardless of the length of time, most deaths occur in the Amish home so that death is a common experience in the Amish families. Bryer (1979) conducted her study to find how many had taken care of a terminally ill family member. One Amish woman responded to the question as to whether she or her husband had ever taken care of a dying member by saying, "Oh yes, we had the chance to take care of all four of our old parents before they died. We are both so thankful for this" (Bryer, 1979, p. 258). In their intensive caring they had the opportunity to work through their grief in the anticipation of the death of each parent. Bryer continues to comment, "In the process, they were moving toward the personal reorganization that is needed in order to return to the tasks of living that follow the death of a loved one" (Bryer, 1979, p, 258).

A British study conducted by Cartwright, Hockey, and Anderson in 1973 disclosed that even though the primary care-takers often become physically and psychologically exhausted during the terminal

period, they probably had the least guilt and the fewest feelings of having unfinished business of anyone in the family.

The Amish family, at the time of death, is upheld by the community. The family does not view death as frightening, they view it as immortality, and they look to the community to provide resources and nurturance for the bereaved.

It is not unusual for the sister to come and help her brother raise his family in the event that his wife should die. Other Amish families may travel great distances to the home of the grieving family so that they might share the experience of death. Bryer points out that, "These words of sympathy and support and their presence at the funeral provide a same-experience therapy that can be of great help for the bereaved family and community" (1979, p. 259).

The community is a great source of help at the time of death, and usually it will take care of all the aspects of the funeral occasion.

The funeral is not for the one who died; it is for the family. It is a time to grieve, and to prepare for the process of living. At the time of death, close neighbors assume the responsibility for notifying others of the death. The bereaved family has only two tasks:

1. The appointment of two or three families to take full charge of the funeral arrangements.
2. The drawing up of a list of the families who are to be invited to the funeral.

The Amish community takes care of all aspects of the funeral occasion with the exception of the embalming procedure, the coffin, and the horse-drawn wagon. Bryer (1979) states that, "These matters

are taken care of by a non-Amish funeral director who provides the type of service that the Amish desire" (p. 257).

The embalmed body is returned to the home within a day of the death. Family members dress the body in white garments in accordance with Revelation 3:5. For a man, this consists of white trousers, a white shirt, and a white vest. For a woman, the usual clothing is a cape and apron that were worn by her at both her baptism and her marriage. At baptism a black dress is worn with the white cape and apron; at marriage a purple or blue dress is worn with the white cape and apron. It is only at her death that an Amish woman wears a white dress with the cape and apron that she put away for the occasion of her death. "This is an example of the life-long preparation for death, as sanctioned by the Amish society" (Bryer, 1979, p. 257).

One Amish woman related that each month her aged grandmother carefully washed, starched, and ironed her own funeral clothing so that it would be ready for her own death. This act appears to have reinforced herself and her family of her life-long acceptance of death. It also contributed to laying the foundation for effective grief work for herself and her family.

After the body is dressed, it is placed in a plain wooden coffin that is made to specifications handed down through the centuries. The coffin is placed in a room that has been emptied of all furnishings in order to accommodate the several hundred relatives, friends, and neighbors, who will begin arriving as soon as the body is prepared for viewing. The coffin is placed in a central position in the house, both for practical considerations of seating and to underscore the

importance of the death ceremonial.

The funeral service is held in the barn in the winter months and in the house during the colder seasons. The service is the same for each funeral, lasting 1 1/2 hours and conducted in German. The body is viewed when the guests arrive and as they leave to take their place in the single-file procession of their carriages to the burial place.

At the cemetery entrance the body is viewed one more time. Then the procession gathers around the grave dug by neighbors. As all watch silently, the grave is filled. After Scripture reading and prayer, followed by a hymn and the Lord's prayer, the mourners bow their heads in silent prayer. Following the interment, the family and close neighbors return home where a meal has been prepared by the families in charge of the arrangements.

Within the Amish community, Bryer (1979) listed the following conditions as the most helpful aspects of coping with death in their society:

1. The continued presence of the family, both during the course of the illness and at the moment of death.
2. Open communication about the process of dying and its impact on the family.
3. The maintenance of a normal life style by the family during the course of the illness.
4. Commitment to as much independence of the dying person as possible.
5. Continued support for the bereaved for at least a year following the funeral, with long-term support given to those who do

not remarry (Bryer, 1979, p. 260).

The family situation, one where love and concern can be given, appears to be a "healthy" place to die for all concerned. For the love of the terminally ill and for the family as they adjust to the grieving process, and even for the younger children, the anxiety of death diminishes with exposure to death.

Citing again, Lifton and Olson: Childhood responses to death affect personality development; conversations with older people about death can make a decided difference in the way a child absorbs experiences with death. In a conversation with two Amish girls, Bryer (1979) illustrates the concepts of positive personality development:

> Two sisters, aged 11 and 13, related in detail their experience two years earlier with the death of their beloved grandfather who lived with them in a three-generational household. The girls spoke of their treasured early childhood memories of their grandfather. As he became more feeble and unable to move about the farm, the sisters looked after him and entertained him each day with word games and reading aloud to him. One day the care of the aged man was left to the sisters while the parents visited distant friends. The old man died that morning. The sisters' calm recital of the death experience and their feelings at that time demonstrated their ability to deal with the fact of a loved one's death, in spite of the unusual conditions of the situation (p. 259).

In certain instances, it is being noticed that a more active participation of family members in the preparation for a funeral might be therapeutic. This has been illustrated by Irene Seeland, Associate in Clinical Psychiatry, College of Physicians and Surgeons, Columbia University. Her husband became acutely ill with acute lymphoblastic leukemia. He had expressed a desire to remain at home during the final phase of his illness. This was made possible due to concerned care by friends who took turns providing the care that was needed.

Two months before his death a funeral director was found who could provide the services requested by the husband: to have the body remain at home following his death until the time of cremation; to have a small, informal ceremony conducted in the home and not at the cemetary; and in general, to keep the process simple.

The contact was made with a funeral director and the arrangements were made; the stress was thus eliminated and would not be taking its toll when emotions would generally be very high.

During the last day, when death seemed to be approaching, the closest family members stayed with the comatose patient, spending the time in reflection and preparing for the death. Others were notified, and those who expressed a desire to be with the patient were encouraged to do so.

After the death, those friends closest to the patient stayed with the body for a while before notifying the physicians and the funeral director, all of whom had been previously alerted to the impending death.

The wife remained with the body during the embalming process. After the embalming, friends helped to wash the body and assisted the funeral director in placing the body into the casket.

The casket remained in the house surrounded by candles and flowers, and momentos that had been meaningful to the husband. This room became the central point for the family and friends for the next 36 hours. Friends offered to stay with the body overnight, thus allowing those who had spent the last few months taking care of the husband some opportunity to get some rest. Other friends took care of the meals,

watched the children, and notified friends and co-workers.

During the next day, people gathered and were invited to read from the Scriptures, poetry, or other sources meaningful to them or to sing songs the husband had loved.

This afforded an opportunity to deal with their grief and acknowledge the reality of death. The next morning, the funeral director came for the body and only the family accompanied the casket to the crematorium where a final prayer was said.

Much was gained and learned during this time, and the learning had taken place in several fairly distinct processes:

The illness provided little doubt that the condition was incurable and would lead to death in the near future. The time was used to the fullest. Communication was open, and all arrangements were made.

Funeral arrangements proceeded without conflict or complications during a stressful time. The meetings with the funeral director alleviated much anxiety and concern and established a rapport and trust that proved invaluable.

The death, being at home, contributed to making it a peaceful and constructive experience. It also enabled people to give each other support; to reflect on the life, the illness, and the death of the patient; and to begin slowly to prepare psychologically for the time after death.

After the death, sitting by the bedside of the deceased allowed the process of acceptance of the long-anticipated and now finally actual fact of death of the loved person to begin.

The wake allowed for a need to spend time with the body, to reflect,

and to say personal good-byes. The individual could review past times together, deal with unresolved issues, have times of sorrow and peacefulness--all in the presence of the body--and at all times to find confirmed, the fact of death.

Much work must be done by the family to prepare for "healthy" death. Collins (1980) offers some insights to prepare the family for death which will help prevent "unhealthy" grief reactions.

1. Develop healthy attitudes in the home. When parents are open and honest about death, children learn that this is an issue to be faced honestly and discussed openly.

2. Clarifying family relationships. Grief can be complicated by guilt, anger, jealousy, bitterness and other issues that are not resolved at the time of death. These may be prevented, and grief lessened if the family would:

    a. Learn to express and discuss feelings and frustrations.

    b. Verbally forgive and accept forgiveness from each other.

    c. Express love, appreciation and respect.

    d. Develop a healthy interdependence which avoids manipulation or immature dependency relations.

3. Building friendships. Grief is easier to face if there is a support group which can provide intimate support for the individual.

4. Activity development. Be involved in a variety of recreational and other activities which have meaning to help soften the pain of death.

5. Stimulating mental health. Learn to handle "little crises"

so that when a large crisis comes, it will be easier to handle. This involves expressing emotions, facing frustrations, and admitting and discussing problems.

6. Anticipating and learning about death. Learn about death through death education courses and the problems associated with death (Collins, 1980, p. 423).

Patient and Death Realization

Death education can basically serve two purposes. In the type of program employed by Dr. Elisabeth Kubler-Ross, it can make the final phase of life more predictable and controllable and it can give the individual the opportunity to understand and express his emotions about death and dying. "In short, it can be didactic and/or cathartic" (Schulz, 1978, p. 169). It can have an information giving, cognitive level in that pastors, counselors, doctors and relatives will know what to expect and be prepared to deal with the situation. Yet, it can give a cleansing for the person who expresses his grief and his anxiety. He will be prepared to face the final phase of his life.

It is evident that the terminally ill patient has very special needs which can be fulfilled if time is taken to sit, listen and find out what they are. The important fact is to communicate that there is someone (doctor, chaplain or friend) ready and willing to share in the concerns of the patient (Kubler-Ross, 1969, p. 269). In another work, Kubler-Ross, (1970) stated:

> Most of them (the patients) appreciated a physician who was frank with them or made them aware of the seriousness of their condition, provided the physician expressed two points: (1) "I will stay by you as long as it is needed, no matter what happens" and (2) "There is always hope" (p. 110).

A two-fold question arises: Who should be the one to tell the patient he is terminally ill? In what manner does one inform the patient of his terminal illness? There is a struggle between the medical profession and clergy as to who should be the one to tell the patient he is terminally ill. Kastenbaum (1966), an advocate for not telling the patient about death, said "Perhaps we are losing something that is essential to a balanced view of life when we isolate and neutralize death" (p. 5.). With the medical profession bearing the majority of the burden for the care of the patient, they are usually responsible for informing the patient of the news of impending death. Kubler-Ross (1970) explains that most of her patients knew when they were terminally ill, even when they had not been explicitly informed (p. 110). It would appear that all people are doing a great disservice by not being honest about the severity of a person's illness. Dr. White, a medical friend of Joyce Landorf, believes that it is the responsibility of the physician to inform the patient. He does this by offering a glimmer of hope to the patient, thereby helping a person through the death-knowledge crisis. No matter how slight the hope, how far-fetched or illusive, Dr. White feels it is absolutely necessary to talk of hope with the patient. Maintaining his honesty, he gives no false hopes, but he does find some ray of hope to leave with his patient (Landorf, 1974, p. 38).

One patient dying of leukemia has said:

> A man who must die will die more easily if he is left a little spark of hope that he may not die after all. My rule would be: Never tell a victim of terminal cancer the whole truth--tell him that he <u>may</u> die, even that he <u>probably</u> will die, but do not tell him that he <u>will</u> die (Alsop, 1973).

It must be remembered that honesty must be maintained, yet, bluntness can cause the final blow to any terminally ill patient. There is not one person who can say exactly when another will die. There are those who have been medically trained, and they can give educatedly wise medical guesses and judgments, yet, the truth remains that no one really knows when the death will come.

In dealing with the divulging of information concerning the terminal illness, Landorf (1974) explains the procedure Dr. White employs which involves four words: "Gradual with the information" (p. 36).

Landorf (1974) shared this wise doctor's procedure:

> A wise doctor will watch carefully the patient's responses and reactions and give information out as the patient is able to take it in. If the patient asks a direct question, the caring doctor will give a direct answer. It is important for the doctor to not, at any time, lie to a patient. (Lying to the patient, even by implication would not uphold an honest level of communication between patient and doctor).
>
> Very often a patient will ask, "Is it a tumor?" I'll answer, "Yes." Then a day, maybe two days later, the same patient will look up at me and ask, "Malignant?" I'll say, "yes," and depending on the patient's responses after that, I will talk with him as long, or as little, as he wants (pp. 36-37).

Notice the willingness to talk, to spend "as long, or as little time, as he wants." The worst thing that any counselor, whether it be medical or pastoral, can do is to leave the patient alone. In such a state he feels that he is abandoned. He feels that he may not express what he is feeling. What he needs is that "door-opening" interview where two people can communicate without fear and anxiety. The therapist, whether doctor or chaplain, must attempt to let the patient know that he is not going to run away if the word cancer or dying is mentioned (Kubler-Ross, 1969, p. 269). It is necessary

that the therapist takes the cue from the patient; it may not be time for the patient to discuss his feelings. In such an instance, the therapist must communicate, and reassure the patient of his return at an opportune time. These opportunities must be given so that patients will have an opportunity to finish some business, whether it is taking care of last details for the family, seeking forgiveness of sins, or discussing a fear about dying. By giving of self, minstering to the needs of the terminally ill, that one will be prepared to face the future, no matter how long or short it may be.

It is human to call for help when one hurts. It is also necessary to be there when the terminally ill patient asks for that help. Dr. Kubler-Ross (1971) relates that one day she went to see an old man the day before she was to see him with her students. She said, "He put his arms out and with pleading eyes said, 'Please, sit down now' with the emphasis on now" (p. 55). The next day she returned with her students only to find the patient in oxygen, unable to breathe, and the only thing he could say was "Thanks for trying, anyhow." He died a short time later. What he communicated to Dr. Kubler-Ross and the students was that when a terminally ill patient says, "Sit down now," you must sit down now. Somehow these patients sense that now is the time that they can talk. There may not be such a time again. So, even if you feel you can sit down only two or three minutes, you will feel better, and so will the patient.

## The Hospice

Within the past few years a unique approach to death has been instituted. This has been in response to seeking a "healthy" death.

It is an attempt to hold back the onslaught of the medical profession to save the individual from death at all cost. In the opinion of several, "The doctor is worse than the disease" (Kastenbaum, 1979, p. 162).

The hospice is the concept developed recently which represents the skill and compassion in the care of the terminally ill person rather than simply talking about dying and death (Kastenbaum, 1979, p. 197). It requires the talents and energies of many different kinds of people, ranging from fund-raisers and legal experts, to architects, health-care planners and the entire spectrum of care-providers.

The idea of a hospice is not really a new idea. The term itself was known as early as the 12th century. The Knights Hospitallers of the Order of St. John of Jerusalem decreed that the sick pilgrim should be carried to bed, refreshed charitably with food, and cared for tenderly. The sick would be served cheerfully without grumbling or complaining. Strangers were to perform these acts of kindnesses for people journeying to and from sacred places. Life itself was to be conceived as a journey from earthly existence to a more blessed state (Kastenbaum, 1979, p. 197).

The hospice today is a system or network of care for people who have limited life expectancies. Usually, the hospice is thought to be simply a place, yet, it is much more. There are hospice organizations which offer only services for the patient at his own home. Many times this will be a first step until the patient must be moved into the institution for more complete care. The hospice orientation attempts to maintain continuity of care for the individual regardless of his or her location at the moment.

At the present time, the most influential hospice is St. Chris-

topher's Hospice in London. Their primary concern is to provide love and help patients control their pain. This is an emphasis of "comfort care." Staff do not come running from all sides for frantic exercises in medical "heroics." "Comfort care" is interpreted as including careful assessment of the person's total condition and the continuation of those measures which might prolong useful/desirable life (Kastenbaum, 1979, p. 199).

There is much to be said concerning this unique approach of care. The philosophy of the hospice can be read in statements such as the following:

> Use of personal name cards, greetings by name, and bedside flowers are part of the unit's style of operation. Both patient and family are familiarized with ward routines and the family is reassured that they can continue to be involved in the patient's care to whatever degree they feel comfortable. There are no "visiting hour" restrictions and no age minimum for visitors. A family may stay overnight if need arises. A pet may visit if it is important to the patient. The family is encouraged to bring the patient's favorite foods-there is a microwave oven, a refrigerator, etc. for preparing meals and snacks (Wilson, Ajemian and Mount, 1978, p.10).

The focus of the hospice care is the patient-family unit. Although many professional people play an integral part in the care of the patient, if the patient desires, he may return home. For the patient near death, the emphasis is on comfort and reassurance to the to the patient-family unit rather than strenuous "heroic" efforts to prolong life.

The home care program is staffed by nurses and physicians on a 7-day, 24-hour basis, with additional support by volunteers, physiotherapists, and social workers. The goals are not only pain control, but resolution of difficulties in the emotional, interpersonal and

financial spheres. The families know that they may call on somebody for help at any time, or they may gain re-admission to the residential unit if necessary.

The services offered by the hospice continue even after the death of the patient. This takes place in helping the survivors through the grief period. Staff-family relationships are begun in the hospice, and contacts are maintained following the death. The staff will then meet to assess the situation of the bereaved family members and will make recommendations.

The hospice program, as evidenced in London, seems to be effective in the control of pain, and does facilitate "healthier dying." During the stay at the hospice a person is able to maintain self-integrity during the terminal phase of life. This is in contrast to the isolation of many patients in hospital programs.

Having looked at death, we realize that there are stages that every individual must work through in the process of grief. This process involves not only the terminally ill patient, but the surviving family members. Due to a fear of death, anxiety builds in each one exerting pressure on the individual. By means of testing (Boyar, 1964; Collett & Lester, 1969; Lester, 1967; Sarnoff and Corwin; Templer, 1970; and Tolar, 1967) it has been shown that those measured demonstrated a decrease of anxiety due to the death education course.

Grief is a normal response for anyone facing the probability of losing all that is dear to him. There are ways to minister to these particular needs. The counselor must be acquainted with the symptoms of normal and acute, or pathological grief and be willing to give of

himself to help the terminally ill face the reality of death. Then, the counselor needs to help the terminally ill work through his grief, thereby preparing him to face his future. This may be accomplished by extending the medical care to the home or by employing hospice care which allows compassionate comfort care for the patient and family. Thus, this unique care provides a basis for a re-examination of basic human values and begins the grieving process for the patient and family.

## Reference Notes

Alsop, S. Stay of execution. New York: Lippincott, 1973.

Becker, E. The denial of death. New York: Free Press, 1973.

Boyar, J. The construction and partial validation of a scale for the measurement of fear of death. Dissertation Abstracts, 1964, 25, 2041.

Bryer, K. Amish way of death: A study of family support system. American Psychologist, March 1979, 34, 255-261.

Carse, J. Grief as a cosmic crisis. In O. Margolis, H. Raether, A. Kutscher, J. Powers, I. Seeland, R. DeBellis, D. Cherico (Eds.), Acute Grief, New York: Columbia University Press, 1981.

Coleman, J. Abnormal psychology and modern life. Glenview, Illinois: Scott, Foresman and Company, 1972.

Collett, L. & Lester, D. Fear of death and fear of dying. Journal of Psychology, 1969, 72, 179-181.

Collins, G. Christian counseling: A comprehensive guide. Waco, Texas: Word, 1980.

Davenport, D. A closer look at the "healthy" grieving process. Personality and Guidance Journal, February 1981, 59, 332-335.

Diggory, J. & Rothman, D. Values destroyed by death. Journal of Abnormal and Social Psychology, 1961, 63, 205-210.

Dickstein, L. Self-report and fantasy correlates of death concern. Psychological Reports, 1975, 32, 147-158.

Durlak, J. Measurement of the fear of death: An examination of some existing scales. Journal of Clinical Psychology, 1972, 28, 545-547.

Erikson, E. Childhood and society. New York: Norton Publishers, 1964.

Ewalt, P. & Perkins, L. Real experience of death among adolescence: An empirical study. Social Casework, November 1979, 60, 547-551.

Freese, A. Help for your grief. New York: Schocken, 1977.

Goody, J. Death and the interpretation of culture; A bibliographic overview. D. Stannard (Ed.), Death in America. Philadelphia; University of Philadelphia Press, 1975.

Hoelter, J. Multidomensional treatment of fear of death. Journal of Consulting and Clinical Psychology, October 1979, 47, 996-999.

Kalish, R. An approach to the study of death attitudes. American Behavioral Scientist, 1963, 6, 68-70.

Kastenbaum, R. Death and responsibility. Current Psychiatric Opinion, 1966, 3, 5-6.

Kastenbaum, R. Healthy dying: A paradoxical quest continues. Journal of Social Issues, 1979, 35 (1), 196-206.

Kubler-Ross, E. On death and dying. New York; Macmillan, 1969.

Kubler-Ross, E. Psychotherapy for the dying patient. Current Psychiatric Therapies, 1970, 10, 110-117.

Kubler-Ross, E. What's it like to be dying? American Journal of Nursing, January 1971, 71, 54-61.

Landorf, J. Mourning song. Old Tappan, New Jersey: Fleming H. Revell, 1974.

Larue, G. Death and the humanist counselor. Humanist, May-June 1980, 40, 13-15.

Lester, D. Fear of death of suicide persons. Psychological Reports, 1967, 20, 1077-1078.

Lindemann, E. Symptomatology and management of acute grief. American Journal of Psychiatry, 1944, 101, 141-148.

Lindemann, E. Symptomatology and management of acute grief. Pastoral Psychology, September 1963, 14, 8-18.

Meyer, J. Death and neurosis. New York: International University Press, 1975.

Nelson, L., & Nelson, C. A factor analytic inquiry into the multidimensionality of death anxiety, Omega, 1975, 6, 171-178.

Nighswonger, C. Ministry to the dying as a learning encounter. Journal of Thanatology, March-April 1971, 1, 101.

Sarnoff, I., & Corwin, S Castration anxiety and the fear of death. Journal of Personality, 1959, 27, 374-385.

Schulz, R. The psychology of death, dying, and bereavement. Massachusetts: Addison-Wesley Publishing Company, 1978.

Schulz, R. & Aderman, D. Physician's death anxiety and survival of patients. Manuscript submitted for publication, 1977.

Steen, J. Hindrances to pastoral care of the dying. Pastoral Psychology, March 1958, 9, 27-32.

Stevens, S., et. al. Age norms for Templer's death anxiety scale. Psychological Reports, February 1980, 45, 205-206.

Templer, D. The construction and validation of a death anxiety scale. Journal of General Psychology, 1970, 82, 165-177.

Tolar, A. & Reznikoff, M. Relationship between insight, repression-sensitization, internal-external, and death anxiety. Journal of Abnormal Psychology, 1967, 72, 426-430.

Vachon, M. Type of death as a determinant in acute grief. In O. Margolis, H. Raether, A. Kutscher, J. Powers, I. Seeland, R. Debellis, & D. Cherico (Eds.), Acute grief. New York: Columbia University Press, 1981.

Vargo, M. Relationship between the Templer death anxiety scale and the Collett-Lester fear of death scale. Psychological Reports, April 1980, 46, 561-562.

Vernon, G. The sociology of death: An analysis of death-related behavior. New York: Ronald Press, 1970.

Zilboorg, G. Fear of death. Psychoanalytic Quarterly, 1943, 12, 465-475.

# Chapter 3

## DEATH AND EDUCATION

Society lives in the midst of a death-denying culture. It is realized that death anxiety can be measured. It is the need for death education, the effectiveness of this education, and who is to teach it that is questioned.

In many situations where death occurs in a family, the young children are sent to stay with a relative who is removed from the death environment. The common explanation for the death of a parent is "God took your father away because He loves him," or "Your mother has gone on a long journey." The reason for such avoidance is that few people understand the childhood thoughts about death.

A child is not immune to the consequences of death. Many children have classmates that die and they have members of their family that die (grandparents, favorite aunts or uncles, etc.).

Variations in childhood perceptions of death are related to differences in developmental stages, particularly life experiences, and family and social influences (Rodabough, 1980, p. 19). Nagy (1948) suggests that children appear to go through at least three developmental stages in their understanding of death.

### Children's Developmental Stages of Death

In the first stage, when the child is under five or six, there is

definitive death. He does not see death as an irreversible fact, but as something gradual or temporary. Death is living, but under changed circumstances. Further, this stage is referred to as a period of no understanding since the beliefs are so different from adult perspectives (Anthony, 1940).

The second stage personifies death and occurs at approximately ages five to nine. This stage is perceived as something such as a skeleton or a ghost. It can be escaped by running away, but for the child, it is not yet natural or inevitable.

The third stage begins around age nine and is the stage of mature understanding. Death is recognized as final; children can be told that a pet died because it was run over by a car or that grandmother died of cancer.

Stage models of death are general and they often overlap. This is due to the difference between children. Melear (1973) illustrated this overlap in his model: Ages 0-4, relative ignorance; 4-7, death as reversible, temporary stage with biological functions; 5-10, death as final and irreversible with biological functions; and ages 6 and over, death as final and irreversible with no bodily functions.

## Death Education and Children

Often there is a fear that children will not understand death. Yet, childhood responses to death affect personality development; conversation with older people about death can made a decided difference in the way a child absorbs experiences with life (Lifton & Olson, 1974). Kastenbaum (1977) stated that:

> The reality of early insights and the process through which the child moves toward a network of death conceptions have a definite impact on the overall pattern of cognitive and personality development.

He illustrates this statement:

> Should death take on the aura of overwhelming catastrophy (something that even big, strong adults cannot cope with or even talk about), then the child may be en route to long-standing problems in thinking about the future in general (p. 30).

There are some schools that have introduced discussions of death into the classroom at the kindergarten and elementary levels. Children can be asked to make a distinction between living and non-living things. They can discuss different funeral practices and religious beliefs of various cultures (Schulz, 1978, p. 163). As Schulz (1978) points out, "the effect of participation appears to be quite positive" (p. 163).

## Death Education and Adolescents

It appears that the isolation of young people from the reality of death has been exaggerated (Ewalt & Perkins, 1979, p. 547). A survey of high school juniors and seniors indicated that many more students than might have been suspected had real experiences with death and their concerns about death emanated, not from their fantasies, but from the death of close relatives and friends or from the near loss of their own lives (Perkins, Todd, & Ewalt, 1978).

It cannot be ignored that young people are aware that people die. It is now that schools have become aware of the need to provide counseling for grieving students and act as death educators. Yet, one question remains unanswered. Can counselors accomplish this task? While counselors and counselor educators felt it was appropriate to counsel grieving

students, it was found that little was being done to help counselors acquire the skills they needed to work in this area (Rosenthal and Terkelson, 1977).

Death Education and Counselors

How did counselors respond to a series of questions concerning death education and its importance of integration in the classroom? Rosenthal (1981) reported the following statistics from his questionnaire:

> Discriminant analyses were performed on the counselor data to determine if responses differed with regard to sex, geographic area, and level of employment. Level of employment was the only significant discriminant function ($p < .05$) found. The discriminant function was most evident for elementary level counselors responding to question 19 which concerned training teachers to deal with grieving students. Sixty-six percent of the elementary counselors stated that counselors should train teachers in this area while 50% of the junior high and 42% of the senior high counselors thought counselors should perform that task. No other significant differences were found and the results below are reported for the total group of counselor respondents.
>
> Prevalance and appropriateness for counselors. Eighty-seven percent of the respondent counselors reported they had counseled grieving students and 97% reported feeling comfortable with their clients when dealing with the issue of death. Fifty-nine percent of the respondents believed themselves adequate to counsel a client who had a fear of dying, while 6% thought counselors should not counsel grieving students but should, instead, refer those students to a counselor with more experience in grief counseling. Fewer respondents, 3%, thought grieving clients should be referred to the clergy.
>
> Training for counselors. Of the responding counselors, 93% thought that counselor training programs needed to help trainees deal with the concepts of death and dying and 97% believed that counselors should attend training sessions to help them assess their attitudes and feelings about death. While 70% of the respondents stated they would be willing to attend a workshop or seminar on death, 41% of these counselors had attended such training sessions. Approximately 33% of the counselor attendees had participated in training conducted by persons in counselor education programs.

> Death Education. Seventy percent of the responding counselors believed that schools should provide death education for the students, while 22% believed that death was too personal a topic to be dealt with in the schools. Although 70% of the respondents believed that exploration of the topic of death should be provided for students on a regular basis, 8% thought that teachers should implement death education in their classrooms and only 22% of the responding counselors had actually done anything themselves to implement death education in their own schools.
>
> Additional Questions. Eighty-four percent of the respondents indicated they believed themselves capable of counseling grieving students and 73% of them were willing to teach a full-length or mini-course on death and dying. While 84% of the responding counselors thought teachers should have training in dealing with grieving students, only 52% thought counselors should conduct such training for teachers. When counselors who responded they had not attended a workshop (course, seminar) were asked about their reasons for not attending, 52% stated that training was not available; 20% indicated it was not one of their priorities; 11% stated that courses (seminars, workshops) were not offered at a convenient place; 8% stated "not convenient" as their reason: 5% indicated time as a factor; and one individual stated that he "avoided them" (pp. 205-206).

In some areas of the country, courses on death education are almost non-existent. On the other hand, the popularity of such courses and their availability seem to be growing. Leviton (1977) reported:

> In 1970 no more than 20 death education courses existed at the post-secondary level, while four years later (1974) 1100 courses were in existence for students in classes beyond high school. Such course offerings have increased, not only for adults, but for students in grades K-12.

Knott (1977) estimated that in 1977 nearly 10,000 courses with death themes existed in primary, middle and secondary schools.

## Death Education and the Reduction of Anxiety

One specific area that seems to need further investigation is the "relationship between death education and the reduction of death anxiety" (Rosenthal, 1981, p. 95). There is the idea that death education would not only be enlightening, but also therapeutic. This idea has caused

many instructors to assume that such coursework might aid in reducing death anxiety as well as enhance knowledge. It would seem logical to assume that discussing death would lessen the stigma of anxiety due to the understanding of this topic. Yet, there are a number of people who feel that such courses, dealing with death, would only frighten students. There is the feeling that discussing topics such as death with adolescents can arouse anxiety, not lessen it. In an attempt to determine change in anxiety resulting from a death education program, McClam used 91 people in health-care and helping professions. This group included: licensed practical nurses, registered nurses, nursing assistants, ministers, teachers, education directors, social workers, physical therapists, counselors, psychologists, speech pathologists, medical secretaries, housewives, and program administrators. Seventy-six were females and 15 were males, ranging in age from 16 to 66 (mean = 38.85). They participated in one of five two-day workshops in five different locations in South Carolina. Each workshop provided the same material and all were administered the Death Anxiety Scale of Templer (1970) and the fear of death of self subscale of the Fear of Death Scale of Collett and Lester (1969) at the beginning of the first day of the two-day program, at the conclusion of the second day, and for 73 subjects, four weeks after program participation. All of the participants were treated as a single sample because insignificant differences were not obtained on pretest scores on the Death Anxiety Scale ($F4.90 = .38$) on the fear of death of self subscale of Collett and Lester ($F4.90 = 1.66$).

In reviewing the results, McClam (1980) reported:

> The pretest mean on the Death Anxiety Scale changed from 5.64 to a post-test mean of 5.57 ($t$ = 1.41). For 91 subjects, $SD$'s were 2.57 and 2.12. Changes in post-test and follow-up means were from 5.75 to 6.15 ($t$ = 1.87). $SD$'s were 2.17 and 2.43 for 73 subjects. The change from pre-test to follow-up was also non-significant ($t$ = 1.12). The fear of death of self subscale of Collett and Lester changed from a pre-test mean of 23.59 to a post-test mean of 23.96 ($t$ = .51). $SD$'s were 9.30 and 8.99. Post-test and follow-up means were 23.78 and 22.71 ($t$ = 1.60). $SD$'s were 9.02 and 9.37. The change from pre-test to follow-up was also non-significant ($t$ = .12) (p. 513).

Rosenthal (1981) felt, since death education courses are increasing, and the possibility of increasing adolescents' death anxiety as a result of such courses, it was important to conduct further research in this area. Rosenthal conducted research to assess the effect of a death education course on adolescent death anxiety.

The participants were enrolled in two classes; one being a course entitled "Death and Dying," and the other being "Marriage and Family." The experimental group consisted of 18 students (8 male, and 12 female).

The instrument used to assess participants' level of death anxiety was Nelson and Nelson's death anxiety scale. This is a 20-item Likert scale that measures four dimensions of death anxiety. These dimensions were identified by factor analytic methods. Rosenthal (1981) described these factors as follows:

> Factor 1. Death Avoidance. (Unwillingness to be near or to touch the dead).
>
> Factor 2. Death Fear. (Fear of death itself).
>
> Factor 3. Death Denial. (Reluctance to confront the reality of death and its consequences).
>
> Factor 4. Reluctance to Interact With the Dying. (Unwillingness to work with or visit the dying ) (p. 96).

The participants of both groups were completed with the Nelson and Nelson death anxiety scale at both the beginning class and the last class session. Instruction consisted of reading required books and journal articles; completing worksheets; participating in simulation exercises; interviews; small groups and class discussions; and listening to and viewing various films and filmstrips. Cognitive knowledge was assessed by midterm and final examinations.

In the "Death and Dying" class participants considered the following courses:

> Death on a personal level, terminal illness, and psychological stages, grief, euthanasia and its medical-legal controversy, suicide, children and death, aging and physical disability, and capital punishment and murder (Rosenthal, 1981, p. 96).

"Marriage and Family" class (the comparison group) considered the following topics:

> Self-concept, psychological, physical and social aspects of puberty and adolescence, human sexuality, love, dating, mate selection, engagement, marriage ceremony, family planning, starting a family, child raising techniques, divorce, family finances, effects of children on a marriage, living together before marriage and sex roles (Rosenthal, 1981, p. 97).

Rosenthal (1981) discussed the results from the research conducted:

> Means and standard deviations for the pre and post-test scores on each factor of the anxiety scale, as well as the unfactored index (summation of scores on all 20 items) are reported in Table 8 (see Appendix A). Initially the experimental and comparison groups pretest scores were compared by use of a two-tales $t$-test for two independent means. Since no significant differences were found between the two groups prior to treatment [Table 9 (see Appendix A)], the groups were considered equivalent and a series of non-directional $t$-tests were used to further analyze the data (p. 98).

In analyzing the pre to post-test scores of both the comparison and the experimental group, the comparison group scores indicated that pre to post-test changes were not significant for Factors 1, 2, 3, or for the

unfactored index scores, while measures of Factor 4 indicated significant pre to post-test increases in the level of death anxiety $t$ (18) = 2.15, $p < .05$. "Scores for the experimental group indicated significant pre to post-test scores on Factor 1, $t$ (15) = 3.65, $p < .05$, and Factor 4, $t$ (16) = 2.96, $p < .05$ (Rosenthal, 1981, p. 98). No significant differences were noted on measures of Factors 2 and 3 or on the unfactored index scores (Table 10, see Appendix A).

When using a $t$-test for two independent means for pretest comparisons between both groups; the experimental group's level of anxiety was significantly lower than the comparison group's anxiety on Factor 1, $t$ (36) = Z.08, $p < .05$, and Factor 4, $t$(36) = Z76, $p < .05$. No significant differences were noted on Factors 2 and 3 or on the unfactored index scores (Table 11, see Appendix A).

Commenting on the results of this study, Rosenthal (1981) said:

> The results of this study indicate than an 18-week course on death and dying designed specifically for high school students can significantly reduce participants' levels of death anxiety. More specifically, participants' willingness to be near or to touch the dead (Factor 1) and also their willingness to work with or visit the dying (Factor 4) was affected (p. 99).

## Reference Notes

Bryer, K. Amish way of death: A study of family support systems. American Psychologist, March 1979, 34, 255-261.

Collins, G. Christian counseling: A comprehensive guide. Waco, Texas: Word, 1980.

Freese, A. Help for your grief. New York: Schocken, 1977.

Goody, J. Death and the interpretation of culture: A bibliographic overview. D. Stannard (Ed.), Death in America. Philadelphia: University of Philadelphia Press, 1975.

Kastenbaum, R. Healthy dying: A paradoxical quest continues. Journal of Social Issues, 1979, 35 (1), 195-206.

Landorf, J. Mourning song. Old Tappan, New Jersey: Fleming H. Revell, 1974.

Larue, G. Death and the humanist counselor. Humanist, May-June 1980, 40, 13-15.

Lifton, R., & Olson, E. Living and dying. New York: Praeger, 1974.

Lindemann, E. Symptomatology and management of acute grief. Pastoral Psychology, 1963, 14, 8-18.

Schulz, R. The psychology of death, dying and bereavement. Massachusetts: Addison-Wesley Publishing Company, 1978.

Steen, J. Hindrances to the pastoral care of the dying. Pastoral Psychology, 1958, 9, 27-32.

Wilson, D., Ajemian, I., & Mount, B. The Royal Victoria hospital palliative care service. Death Education, 1978, 2, 3-20.

# Chapter 4

## CONCLUSIONS

It would appear that there is a lack of communication concerning dying in the Christian community. For the most part, man fantasizes about his dying. As Christians, there is a tendancy to believe that one will simply go to sleep and awake in heaven. Yet, the majority of people will suffer a degenerative illness that they will not be prepared to handle.

Along with the illness there will be the testing as to whether or not real integration has been made in one's life. There is evaluation of the way a lifetime has been spent. Older people ponder whether their lives have fulfilled their earlier expectations or have conformed to deeper beliefs and values (Craig, 1980, p. 482). Erikson calls this final crisis of adult ego development "Integrity vs. Despair." Those who can look back and feel satisfied that their lives have had meaning will have a sense of integrity. Craig (1980) points out that "those who see nothing but a succession of wrong turns and missed opportunities will feel despair" (p. 482). Erikson (1964) has said that "despair expresses the feeling that the time is now short, too short for the attempt to start another life and to try out alternate roads to integrity. Disgust hides despair, if often only in the form of 'a thousand little disgusts' which do not add up to one big remorse" (p. 269).

Erikson (1964) further states "healthy children will not fear life

if their elders have integrity enough not to fear death" (p. 269).

The pastors of most churches seem to believe that they will be taken into heaven before they will suffer physical death. They will be called on to minister to bereaved families, yet, because of a lack of education concerning death, the response will be fear and denial of death.

Folta (1981) states "continuing education is based on the principle that education needs to be an enduring, ceaseless, lifelong endeavor" (p. 11). It is implied in this principle that one has basic preparation in a particular area. There needs to be a basic educational program on grief and develop a continuing education program that would involve at least two levels.

Folta (1981) suggests a program that would be a public education program for both lay public and professional groups:

> This program should consist of basic information necessary to understand what loss and stress are, what normal grief reactions are, what to expect in the process of grief, what constitutes inappropriate and/or abnormal grief reactions, what community resources are available, how best to use the referral systems within the community, what impact death and grief have on family structures and relationships, and what changes, if any, loss creates in people's lives (p. 11).

On another level, intensive programs should be developed on pathological grief and its manifestations. Kaplan (1964) refers to three levels of prevention, and these levels of the continuing education program should be regarded from the same perspective.

Level one should contain basic information and basic preparation which would serve as a first level of defense and prevention of further problems.

Level two assists in preventing any delayed or untoward reaction

that might occur as a consequence of the grief.

Level three deals with more serious pathological problems. Here, there is a need for more professionals trained to identify problems associated with pathological grief. Problems secondary to grief, such as hypertension, ulcers, and coronaries require treatment by health care professionals educated to understand that it is not the physical disease per se that is the problem. There is a need to be aware that success in treating the physical disease depends on the success with which they treat the grief.

The anxiety of death has been shown to be significantly reduced when a program of education has been instituted. All ages seem to benefit from an open communication of the reality of death. Further, this understanding of death can be focused in a positive direction by caring for the terminally ill patient. With the care given, anxiety of the patient appears to be lessened because they know that they are loved, as evidenced by personal family involvement, and their length of time seems to be spent preparing the family for the bereavement period which will be hastened after death.

The hope needed by terminally ill patients is best provided by the Christian concept of eternal life. If the Christian community were to be activity involved in a hospice program, great meaning of life would be derived by the staff, and anxiety of each person would be lessened.

When the pastor, the patient, the family, and the Christian community are informed, others who are outside the Christian sphere of influence would experience the assurance of their faith and the hope that is within each of them. The truth of I Corinthians 15:51-57 would not be

intellectual knowledge, but also experiential knowledge:

> Behold, I shew you a mystery; we shall not all sleep; but we shall all be changed,
>
> In a moment, in the twinkling of an eye, at the last trump; for the trumpet shall sound, and the dead shall be raised incorruptible, and we shall be changed.
>
> For this corruptible must put on incorruption, and this mortal must put on immortality.
>
> So when this corruptible shall have put on incorruption, and this mortal shall have put on immortality, then shall be brought to pass the saying that is written, Death is swallowed up in victory.
>
> O death, where is thy sting? O grave, where is thy victory?
>
> The sting of death is sin; and the strength of sin is the law.
>
> But thanks be to God, which giveth us the victory through our Lord Jesus Christ.

## References Notes

Craig, G. Human development (2nd ed.). New Jersey: Prentice-Hall, 1980.

Erikson, E. Childhood and Society. New York: Norton Publishers, 1964.

Folta, J. Grief, grief therapy and continuing education. In O. Margolis, H. Raether, A. Kutscher, J. Powers, I. Seeland, R. Debellis, D. Cherico (Eds.), Acute grief. New York: Columbia University Press, 1981.

Kaplan, G. Principles of preventive psychiatry. New York: Basic Books, 1964.

# APPENDIX A

# TABLES

Appendix A

TABLE 1. INTERCORRELATIONS BETWEEN THE DEATH AND SOCIAL DESIRABILITY SCALES*

| | LE | BO | S-C | TO | SDS |
|---|---|---|---|---|---|
| BO | .56 | | | | |
| S-C | .41 | .65 | | | |
| TO | .40 | .61 | .47 | | |
| SDS | -.10 | -.21 | -.13 | -.14 | |

*With 94 *Ss*, *rs* of .20 and .26 are required for significance at the .05 and .01 levels respectively.

TABLE 2. CORRELATIONS BETWEEN THE FEAR OF DEATH SCALES AND THE FOUR SUB-SCALES OF THE COLLETT-LESTER SCALE

| | DEATH SCALES | | | |
|---|---|---|---|---|
| C-L Subscales | LE | BO | S-C | TO |
| Dth-Self | .78 | .69 | .55 | .47 |
| Dy-Self | .47 | .58 | .52 | .46 |
| Dth-Other | .31 | .46 | .37 | .39 |
| Dy-Other | .36 | .40 | .41 | .40 |

Appendix A

TABLE 3. MEANS, STANDARD DEVIATIONS, AND RANGES FOR DEATH ANXIETY SCALE

| Measure | *M* | *SD* | RANGE |
|---|---|---|---|
| Templer Death Anxiety Scale | 7.47 | 2.83 | 13 |
| Collett-Lester Fear of Death Scale | | | |
| Fear of Death of Self | 1.11 | 10.20 | 47 |
| Fear of Dying of Self | 4.72 | 6.64 | 35 |
| Fear of Death of Others | 2.22 | 5.98 | 28 |
| Fear of Dying of Others | -11.08 | 7.94 | 43 |

TABLE 4. CORRELATIONS AMONG DEATH ANXIETY SCALES*

| Measure | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 1. Templer Death Anxiety Scale | | | | | |
| 2. (C-L) Fear of Death of Self | .609 | | | | |
| 3. (C-L) Fear of Dying of Self | .434 | .314 | | | |
| 4. (C-L) Fear of Death of Others | .524 | .544 | .235 | | |
| 5. (C-L) Fear of Dying of Others | .396 | .352 | .352 | .545 | |

* Significant levels: .233 + ($p$ = .05); .302 + ($p$ = .01).

Appendix A

TABLE 5. ORTHOGONALLY ROTATED FACTOR SOLUTION FOR THE MULTIDIMENSIONAL FEAR OF DEATH SCALE

| MFODS item | Variable no. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | $h^2$ |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Fear of the dying process (a=.80) | 1 | .70 | .12 | -.06 | .05 | .09 | -.09 | .06 | .18 | .55 |
| | 2 | .55 | -.01 | -.08 | .03 | .01 | .19 | .20 | .03 | .39 |
| | 3 | .67 | .22 | -.02 | -.02 | .03 | -.05 | .12 | .10 | .52 |
| | 4 | .51 | .09 | .02 | .03 | .04 | .10 | .13 | .11 | .33 |
| | 5 | .51 | .03 | .02 | .08 | .01 | .27 | .16 | .12 | .33 |
| | 6 | .57 | .08 | .05 | .05 | .09 | .26 | .10 | .12 | .43 |
| 2. Fear of the dead (a= .72) | 7 | .28 | .48 | .02 | .05 | .13 | -.03 | .01 | .11 | .34 |
| | 8 | .05 | .64 | .07 | .05 | .00 | -.01 | .10 | .08 | .48 |
| | 9 | .17 | .60 | -.04 | .35 | -.05 | -.03 | .03 | .06 | .51 |
| | 10 | .09 | .42 | -.08 | .19 | -.01 | .27 | .10 | -.05 | .32 |
| | 11 | .02 | .51 | -.01 | .15 | .09 | .11 | .17 | -.03 | .30 |
| | 12 | .07 | .48 | .02 | .05 | .15 | .19 | .32 | .13 | .41 |
| 3. Fear of being destroyed (a=.81) | 13 | -.12 | .21 | .85 | .04 | .00 | .02 | .07 | .00 | .77 |
| | 14 | -.06 | .01 | .81 | .03 | .00 | .07 | .18 | -.05 | .69 |
| | 15 | -.05 | .21 | .35 | .16 | -.05 | .06 | .28 | .02 | .27 |
| | 16 | .00 | -.04 | .76 | .05 | .11 | .03 | .19 | .01 | .63 |
| 4. Fear for significant others. (a= .76) | 17 | .24 | .26 | .01 | .40 | .08 | .10 | .14 | .26 | .40 |
| | 18 | .07 | .29 | .06 | .57 | .06 | .00 | .14 | .18 | .45 |
| | 19 | .11 | .07 | .09 | .63 | -.08 | .11 | .17 | .11 | .48 |
| | 20 | -.03 | .21 | .06 | .46 | -.03 | .02 | -.07 | .12 | .26 |
| | 21 | .14 | .33 | .08 | .39 | -.02 | .11 | .09 | .07 | .31 |
| | 22 | -.03 | .01 | -.01 | .72 | .04 | .06 | .09 | -.07 | .53 |
| 5. Fear of the unknown (a= .73) | 23 | .05 | .09 | .06 | -.08 | .69 | .04 | .08 | .17 | .54 |
| | 24 | -.06 | .24 | -.03 | .00 | .33 | .00 | .21 | .01 | .21 |
| | 25 | -.02 | .03 | .04 | -.02 | .68 | .03 | .21 | .06 | .50 |
| | 26 | .06 | -.07 | .02 | -.04 | .73 | -.05 | .03 | .04 | .53 |
| | 27 | .10 | .05 | .00 | .09 | .36 | .05 | -.03 | -.07 | .15 |

TABLE 5 (Continued)

| MFODS item | Variable no. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | $h^2$ |
|---|---|---|---|---|---|---|---|---|---|---|
| 6. Fear of conscious death (a= .65) | 28 | .00 | .05 | .11 | .05 | -.01 | .45 | -.01 | .12 | .22 |
| | 29 | .35 | .07 | .05 | .08 | .06 | .44 | .22 | -.02 | .37 |
| | 30 | .13 | .03 | .01 | .20 | .07 | .37 | .15 | .03 | .22 |
| | 31 | .17 | .10 | .01 | -.05 | -.02 | .57 | .29 | .12 | .45 |
| | 32 | .14 | .05 | -.02 | .23 | .05 | .43 | .31 | .15 | .37 |
| 7. Fear for body after death. (a= .82) | 33 | .31 | .11 | .14 | .14 | .09 | .09 | .55 | .09 | .48 |
| | 34 | .18 | .16 | .13 | .04 | .08 | .08 | .67 | .18 | .58 |
| | 35 | .22 | .24 | .10 | .16 | .03 | .31 | .47 | .11 | .48 |
| | 36 | .08 | .04 | .24 | .09 | .03 | .06 | .39 | -.03 | .23 |
| | 37 | .16 | .09 | .17 | .05 | .16 | .14 | .61 | .19 | .53 |
| | 38 | .17 | .16 | .10 | .06 | .14 | .22 | .61 | .08 | .52 |
| 8. Fear of premature death. (a= .72) | 39 | .19 | .03 | -.03 | .10 | .08 | .08 | .13 | .70 | .58 |
| | 40 | .15 | .08 | .04 | .17 | .07 | .15 | .39 | .36 | .26 |
| | 41 | .25 | .09 | -.11 | .17 | .15 | .15 | .17 | .64 | .59 |
| | 42 | .21 | .14 | .10 | .11 | -.08 | .20 | .17 | .44 | .35 |
| % explained variance | | 2.90 | 2.43 | 2.33 | 2.26 | 1.91 | 1.66 | 2.90 | 1.62 | |

Note. MFODS = multidimensional fear of death scale. Definitive loadings are underlined.

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TABLE 6. MEANS AND STANDARD DEVIATIONS FOR DEATH ANXIETY SCALE

| | Youth | | Young Adult | | Middle-Aged | |
|---|---|---|---|---|---|---|
| | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| Males | 7.73 | 3.59 | 6.87 | 3.04 | 6.61 | 2.92 |
| Females | 7.43 | 3.64 | 7.42 | 2.79 | 7.02 | 2.67 |
| Total | 7.50 | 3.61 | 7.25 | 2.85 | 6.85 | 2.77 |

| | Elderly | | Total | |
|---|---|---|---|---|
| | *M* | *SD* | *M* | *SD* |
| Males | 4.91 | 2.79 | 6.56 | 3.22 |
| Females | 6.16 | 2.97 | 7.06 | 3.19 |
| Total | 5.74 | 2.95 | 6.89 | 3.20 |

TABLE 7. AVERAGE STAY IN HOSPITAL OF DYING AND NON-DYING PATIENTS AND PERCENT OF TOTAL PATIENTS WHO DIED BY THE LEVEL OF DEATH ANXIETY OF ATTENDING PHYSICIANS

| | Level of death anxiety of attending physicians | | |
|---|---|---|---|
| | High ($n$=8) | Medium ($n$=7) | Low ($n$=9) |
| Average stay of dying patients* (in days) | 14.49 | 9.98 | 8.45 |
| Average stay of non-dying patients (in days) | 11.20 | 9.76 | 10.46 |
| Percent of total patients treated who died | 3.25 | 5.32 | 3.32 |

*$F(2,22) = 3.52$, $p < 0.05$.

Appendix A

TABLE 8. MEANS AND STANDARD DEVIATIONS FOR EXPERIMENTAL AND COMPARISON GROUPS ON NELSON AND NELSON'S DEATH ANXIETY SCALE[a]

| Factors | Experimental Group | | Comparison Group | |
|---|---|---|---|---|
| | M | SD | M | SD |
| Factor 1 | | | | |
| Pretest | 2.91 | .33 | 2.79 | .24 |
| Posttest | 2.46 | .57 | 2.81 | .49 |
| Factor 2 | | | | |
| Pretest | 2.53 | .31 | 2.71 | .16 |
| Posttest | 2.65 | .55 | 2.74 | .41 |
| Factor 3 | | | | |
| Pretest | 3.08 | .54 | 3.19 | .50 |
| Posttest | 3.38 | .57 | 3.24 | .54 |
| Factor 4 | | | | |
| Pretest | 2.45 | .30 | 2.15 | .24 |
| Posttest | 2.03 | .55 | 2.50 | .49 |
| Unfactored Scale | | | | |
| Pretest | 2.81 | .10 | 2.85 | .06 |
| Posttest | 2.77 | .33 | 2.88 | .24 |

[a]Since some items were reversed to avoid response sets, a decrease in score on Factors 1 and 4 represents a decrease in anxiety; an increase in score on Factors 2 and 3 represents a decrease in anxiety.

Appendix A

TABLE 9. PRETEST SCORES FOR THE EXPERIMENTAL AND COMPARISON GROUPS ON NELSON AND NELSON'S DEATH ANXIETY SCALE

| Factors | Experimental Pretest | Comparison Pretest | |
|---|---|---|---|
| | M | M | t-Test |
| Factor 1 | 2.91 | 2.79 | .85 |
| Factor 2 | 2.53 | 2.71 | 1.34 |
| Factor 3 | 3.08 | 3.19 | .66 |
| Factor 4 | 2.45 | 2.15 | .98 |
| Unfactored Index | 2.81 | 2.85 | .45 |

TABLE 10. PRE- TO POSTTEST CHANGES FOR THE EXPERIMENTAL COMPARISON GROUPS ON NELSON AND NELSON'S DEATH ANXIETY SCALE[a]

| Factors | Pretest | Posttest | |
|---|---|---|---|
| | M | M | t-Test |
| Experimental Group | | | |
| Factor 1 | 2.91 | 2.46 | 3.65** |
| Factor 2 | 2.53 | 2.65 | 1.29 |
| Factor 3 | 3.08 | 3.38 | 2.04 |
| Factor 4 | 2.45 | 2.03 | 2.90* |
| Unfactored Index | 2.81 | 2.72 | 1.92 |
| Comparison Group | | | |
| Factor 1 | 2.79 | 2.81 | .41 |
| Factor 2 | 2.71 | 2.74 | .41 |
| Factor 3 | 3.19 | 3.24 | .44 |
| Factor 4 | 2.15 | 2.50 | 2.15* |
| Unfactored Index | 2.85 | 2.88 | .73 |

[a]Since some items were reversed to avid response sets, a decrease in score on Factors 1 and 4 represents a decrease in anxiety; an increase in score on Factors 2 and 3 represents a decrease in anxiety.

*$p < .05$. **$p < .01$

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TABLE 11. POSTTEST SCORES FOR THE EXPERIMENTAL AND COMPARISON GROUP ON NELSON AND NELSON'S DEATH ANXIETY SCALE.

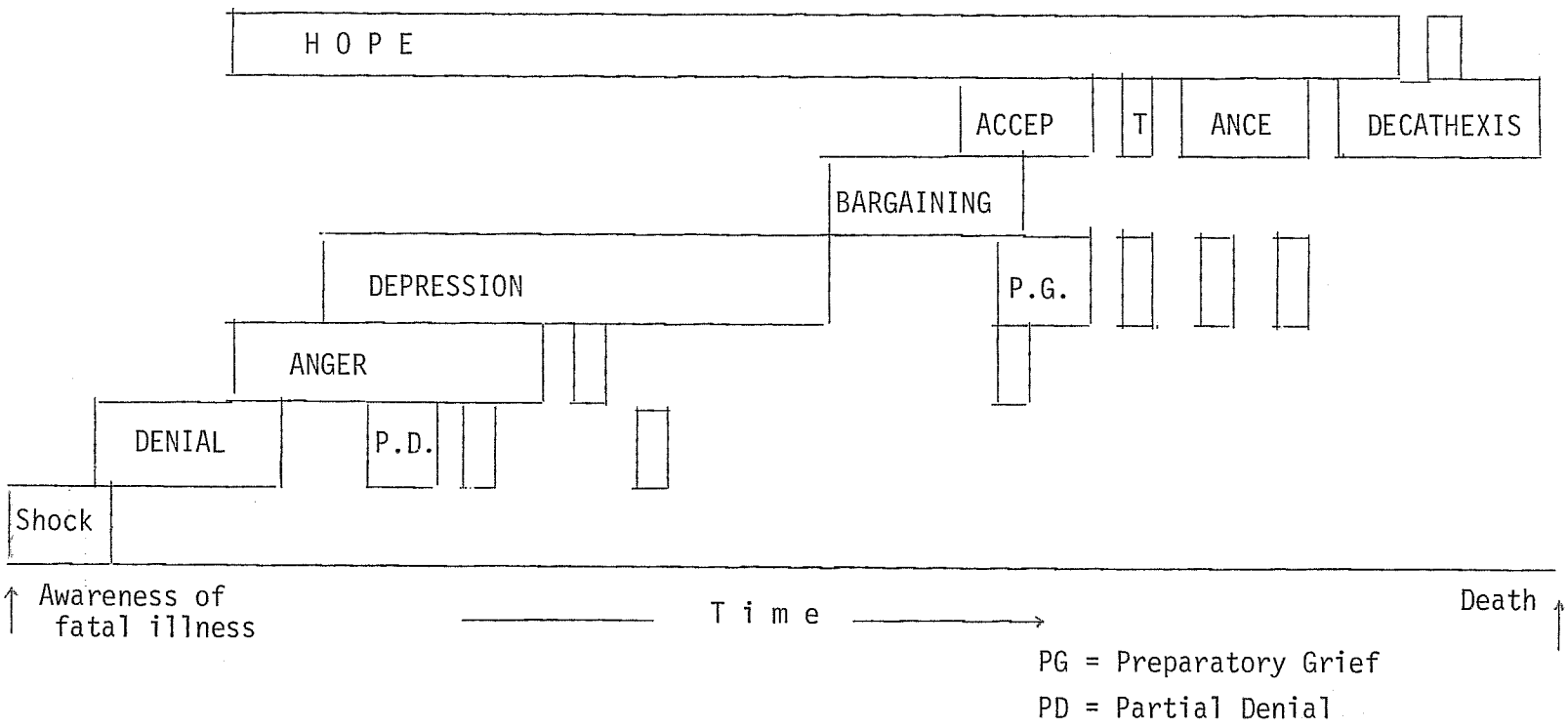
| Factor | Experimental Posttest | Comparison Posttest | |
|---|---|---|---|
| | M | M | t-Test |
| Factor 1 | 2.46 | 2.81 | 2.08* |
| Factor 2 | 2.65 | 2.74 | .60 |
| Factor 3 | 3.38 | 3.24 | .77 |
| Factor 4 | 2.03 | 2.50 | 2.76** |
| Unfactored Scale | 2.77 | 2.88 | 1.18 |

*$p < .05$. **$p < .01$

# APPENDIX B

CHART

# STAGES OF DYING




PG = Preparatory Grief

PD = Partial Denial

# APPENDIX C

# SERVICE ORGANIZATIONS

Appendix C

## SERVICE ORGANIZATIONS

The following national organizations will provide aid through a central office at the address indicated. Generally these offer information and referral through printed material. Names and addresses are given alphabetically. Services and other comments are added where appropriate.

| NAME/ADDRESS | SERVICE/COMMENT |
|---|---|
| Administration on Aging<br>Department of Health, Education, and Welfare<br>Washington, D.C. 20201 | Information on continuing education |
| National Council on Aging<br>1828 L Street, NW<br>Washington, D.C. 20036 | Specific aspects of aging |
| State Office on Aging<br>(Capital city, your state) | Services and employment opportunities |
| American Association of Retired Persons<br>1225 Connecticut Avenue, NW<br>Washington, D.C. 20036 | Information and group services to the elderly |
| National Office of Arthritis Foundation<br>166 Geary Street<br>San Francisco, CA 94108 | Information |
| National Cancer Program<br>Office of Public Affairs<br>Bethesda, Md. 20014 | Information on different body sites for cancer, explanation, therapy |
| Cryonics Society of California<br>216 Pico Boulevard<br>Santa Monica, Ca. 90405 | Freeze-Wait-Reanimate information, newsletter |
| Center for Death Education and Research<br>Robert Fulton, Director<br>Department of Sociology<br>University of Minnesota<br>Minneapolis, Minn. 55455 | Cassette tape programs on death, grief, and bereavement. Listing on request |

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| | |
|---|---|
| The Medical Secretary<br>Society of Compassionate Friends<br>27 A Street Columbus Close<br>Coventry CV1, 4BX<br>Warwickshire, England | Care for bereaved parents with fatally ill children |
| Ars Moriendi<br>3601 Locust Walk<br>Philadelphia, Pa. 19083 | Information and membership: "the art of dying," health and human values |
| Equinox Institute<br>Melvin J. Krant<br>11 Clinton Street<br>Brookline, Mass. 02145 | Information and consultation in care for the dying and their survivors |
| Widow to Widow Program<br>Mary Pettipas<br>Laboratory of Community Psychiatry<br>58 Fernwood Road<br>Boston, Mass. 02115 | Report of mutural help efforts by survivors how to develop local programs. Cost $2.50 for printed matter |
| Epilepsy Foundation of America, Suite 1116<br>733 15th Street, NW<br>Washington, D.C. 20005 | Information and brochures |
| Eye Bank Association of America<br>110 Irving, NW<br>Washington, D.C. | Condensed list for posthumous donations |
| E. Doheny Eye Foundation<br>228 Lake Street<br>Los Angeles, Ca. | |
| Presbyterial Medical Center<br>2018 Webster Street<br>San Francisco, Ca. | |
| Lions Eye Bank<br>420 E. 9th Street<br>Denver, Co. | |
| Boston Eye Bank<br>243 Charles Street<br>Boston, Mass | |

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| | |
|---|---|
| National Drug and Safety League<br>3146 Francis Street<br>Jackson, Mich. 49201 | Information on drug abuse and other hazards to life |
| Family Service Association of America<br>44 E. 33rd Street<br>New York City, NY 10010 | |
| Family Life Bureau<br>National Catholic Welfare Conference<br>1312 Massachusetts Ave., NW<br>Washington, D.C. | |
| Department of Family Life<br>National Council of Churches of Christ of USA<br>475 Riverside Drive<br>New York City, NY 10027 | |
| National Council of Family Relations<br>1219 University Avenue, SE<br>Minneapolis, Minn. 55414 | |
| Continental Association of Funeral and Memorial Societies<br>50 E. Van Buren Street<br>Chicago, Ill. | Also see Jessica Mitford's book, The American Way of Death, for suggestions and list of memorial societies |
| Gerontological Society<br>One Dupont Circle<br>Washington, D.C. 20036 | Information and membership |
| National Associations of Mental Health<br>10 Columbus Circle<br>New York City, NY 10019 | Mental health information for aid in mourning and dying |
| United Ostomy Association<br>1111 Wilshire Boulevard<br>Los Angeles, Ca. 90017 | Information and self-help for ostomy patients (ileostomy and colostomy) |

Appendix C

| | |
|---|---|
| Public Affairs Pamphlets<br>381 Park Avenue South<br>New York City, NY 10016 | Explanations for various public health problems with suggestions for self-help |
| American Association of Suicidology<br>c/o Charlotte Ross, Secretary<br>220 W. 26th Avenue<br>San Mateo, Ca. 94403 | Information, referral and membership |

# APPENDIX D

# A SHORT DEATH EDUCATION COURSE

Appendix D

## A SHORT DEATH EDUCATION COURSE

Including a history of funeral services and the purpose of the service in the grieving process, the introduction is to be followed by a session on the dying and grieving process. The next two sessions would use both written and verbal exercises with the intent to help participants examine their attitude towards their own death. Study helps for such a course may include material from Kubler-Ross (1969), Lindemann (1944), Westberg (1962), and Worden and Proctor (1976).

The first session would consist of a presentation and discussion on "Questions and Answers About Funeral Services," which would involve the history of funeral services, the funeral service today, and the purpose of a funeral--particularly as it relates to the grieving process.

The second session would consist of a presentation of the dying and grieving process. For the dying process, the five stages developed by Kubler-Ross would be outlined and discussed. For the grieving process, the work of Erich Lindemann and *Good Grief* by Granger Westberg would be summarized. The session would be concluded with a discussion on how to facilitate the grieving process during counseling.

The third session would include several verbal and paper-and-pencil exercises. These activities would include a "Draw Death" exercise, "Choosing a Death" exercise, and "Writing One's Own Obituary," plus discussions.

In the final session another paper-and-pencil activity would be used,

entitled, "Planning One's Own Funeral" and a "Fear of Death" inventory would be administered. This session would be followed by a discussion on common fears of death.

# APPENDIX E

## SYLLABUS FOR "DEATH AND DYING" (18 WEEKS)

## AMHERST REGIONAL HIGH SCHOOL

Appendix E

# SYLLABUS FOR "DEATH AND DYING" (18 WEEKS)
# AMHERST REGIONAL HIGH SCHOOL

## Introduction

Death is a subject seldom studied in school and often misunderstood and unnecessarily feared by a large number of people. Although Edna St. Vincent Millay once described it this way: "Death, however, is a spongy wall, is a sticky river, is nothing at all;" there is ample evidence that many people have a tremendous interest in the subject because it is a biological reality, a cultural phenomenon, a spiritual event, an economic reality, and a psychological process. Alfred North Whitehead has said, "There is only one subject matter for education, and that is life in all its manifestations."

## Content

The readings and media in this course will draw from a number of disciplines, among them literature and poetry, art, music, psychology, economics, cultural anthropology, and law. More specifically, you will have the opportunity to study topics ranging from Poe to Shakespeare to funeral customs around the world, from interviews with doctors to the spirituals of Black America and the tones of requiem mass, from wills and trusts to the issue of euthanasia.

There will be some speakers from the community whose work in some way involves death--e.g., doctor, funeral director, lawyer, clergyman--so as to help answer technical or philosophical questions. Also, it is planned to visit a cemetery and funeral home to further enhance the understanding of societal values and practices.

Finally, it is important to note that while this is a study of ideas, customs, and values of different individuals and societies, in the end there are some personal decisions for the individual to make. The student is encouraged to question different views and practices and develop his own opinions. It is hoped that there will be an understanding as to why different poeple and cultures believe and practice the way they do in regard to death so as to enable one to better appreciate the subject's relevance to the student. It is also hoped that as a result of the course one will gain a better appreciation of life and living.

## Phases 3, 4, and 5

A. Introduction: Values Clarification

Objective: The student will identify and explain his or her individual views and values about death and discuss American cultural

values about death--past and present.

Activities

1. Analysis of a series of selected short quotations on death.
2. Attitude survey (adapted from Psychology Today. August 1970, pp. 67-72).
3. Film: Death Be Not Proud.
4. Berg and Dougherty: "How America Lives with Death," pp. 43-55. Also, for Phases 4, 5: Stannard, "Death and the Puritan Child," pp. 9-29; Feifel, "The Fear of Death," pp. 16-29.

B. Physical Death

Objective: The student will explain the medical components of death, i.e., defintion, functions of coroner and pathologist, procedures at death, and the medical establishment's attitudes towards death.

Activities

1. Berg and Dougherty: "A Doctor Talks about Death," pp. 3-8; "Defining Death Anew," pp. 9-11; "Facing Death with the Patient" An Ongoing Contract," pp. 12-26; "The Coroner and Death," pp. 27-30.
2. Speaker: Community Doctor
3. Film: Death

C. Dying

Objective A: The student will state and explain several theories of Kubler-Ross regarding the stages of dying and the nature of relationships among terminal patients, families, and medical personnel in general.

Activity

1. Kubler-Ross, selections to be determined. Also, for Phase 4, 5: Feifel, "Personality Factors in Dying Patients," pp. 237-250; Kubler-Ross, Death: The Final Stage of Growth, pp. 7-24, 106-116, 119-126; writing assignment.

Objective B: Given a series of case studies, the student will identify and evaluate the attitudes expressed by patients, families, and medical personnel in each of the cases.

Activities

1. Film: To Die Today
2. Film: Dying

D. The Arts and Death

Objective: The student will identify various values and themes

present in art, music, and literature dealing with the subject of death and explain to what extent such values and themes correspond to his or her own.

Activities:

1. Audio-tape: Death Themes in Music from Perspectives on Death kit.
2. Filmstrip: Death in the Eyes of the Artist, idem.
3. Audio-tape: Death Themes in Literature, idem.
4. Berg and Dougherty: Selected poems and prose, pp. 51-74.
5. Modern musical selections to be determined.

Optional

1. Feifel: "Mortality and Modern Literature." pp. 133-156; "Modern Art and Death," pp. 157-158.

E. The American Funeral

Objective: The student will identify various customs and procedures employed in the American funeral today and will also identify alternatives that are available to the public. Finally, the student will explain what procedures and practices he or she would want in the event of his or her own death and why. Relevant factors include: (a) embalming, (b) wake, (c) coffin, (d) services, (e) disposition of body, (f) other.

Activities

1. Berg and Dougherty: "The Question of Funeral Services," pp. 68-79; "The Panorama of Modern Funeral Practice," pp. 119-145; "What a bout Funeral Costs?" pp. 146-150.
2. Speaker: Funeral Director
3. Field Trip: Funeral Home
4. Film: Since the American Way of Death
5. Field Trip. Cemetery
   Also, for Phases 4, 5: Stannard, "The Cemetery as Cultural Institution," pp. 69-91.

F. Grief, Mourning, and Counseling: The Psychology of Death

Objective: Given a series of case studies regarding the aftermath of death and the effects on survivors, the student will indicate the courses of action he or she would take in helping the individuals deal with the reality of death in terms of loss, understanding, and gradual acceptance.

Activities

1. Berg and Dougherty: "You and Your Grief," pp. 56-57; "Some

Questions and Answers About Your Child and Death," pp. 113-118.
2. Susan Selinger, "Therapeutic Funerals."
3. Speaker: Psychologist on death
4. Pincus, Death and the Family, chaps. 4, 7, 9, 10.
5. Filmstrip, Death of a Child
   Also, for Phases 4, 5: Feifel, "The Child's View of Death," pp. 79-98 and "Grief and Religion," pp. 218-223; Kubler-Ross, "A Mother Mourns and Grows," pp. 97-104.

G. Comparative Cultural View of Death

Objective: The student will identify and describe several major beliefs, values, traditions, and practices of a different culture, not his or her own, explain why these mores exist, and what factors might cause them to vary from locality to locality.

Activities

1. Filmstrip: Funeral Customs Around the World
2. Speaker: on comparative religious views of death
3. Film: The Nuer
4. Film: Dead Birds
5. Van Gennep handout, "Funerals," pp. 146-165.
   Also, for Phases 4, 5: Feifel, "Death and Religion," pp. 271-283; group presentation on suggested topics.

H. Special Topics: Euthanasia and Suicide

Objective A: Given a series of readings and media on the subject of euthanasia, the student will develop and defend or attack a position on the following resolution: "Should any form of euthanasia be legalized?"

Activities

1. Paul Wilkes, "The Right To Die," Life, Jan. 1976.
2. Bender: Problems of Death, pp. 43-81.
3. Film: The Right To Die
4. Exerpts from newspapers on euthanasia.
   Also, for Phases 4, 5: Downing. "Patient's Bill of Rights," Euthanasia Educational Council, pp. 13-24, 61-84; "A Fatally Ill Doctor's Reaction to Dying," New York Times, July 24, 1974; Paper/debate option.

Objective B: The student will compare and contrast several views on suicide, using these views to develop a personal philosophy on the question: What should society's values reflect and its response be on the issue of suicide? Also, students will be able to relate this subject, where appropriate, to the issue of euthanasia.

1. Bender, Problems of Death, pp. 114-125
2. Downing, Euthanasia and the Right to Death, pp. 152-162, 173-192.

I. Special Topics: Wills and Insurance

Objective: On the subjects of life insurance and wills, the student will identify and explain:

1. The purposes of having such "coverage."
2. The options or types that exist and the advantages and disadvantages of each.
3. The factors that can be considered in deciding what selections, if any, of these coverages will be made.

Activities

1. Sample policies and wills.
2. Speaker: Lawyer.
3. Speaker: Insurance Agent
4. Berg and Dougherty, "Legal Aspects of Death," pp. 181-185; "Issues on Insurance," pp. 186-191.

J. Final Activities

1. Review of attitude survey.
2. Film: How Could I Not Be Among You.
3. Selected handouts for future consideration.

## Special Requirements for Phase 5

### Introduction

According to the Program of Studies, a Phase 5 student is capable of doing rigorous academic work, including independent research, creative and analytical writing, and the reading of fairly sophisticated materials. Also, it is the belief that a Phase 5 student should be able to demonstrate leadership abilities in classroom discussion and related course activities. Therefroe, it is assumed that one is competent in the above mentioned areas and is willing to devote a significant amount of time and energy to the pursuance of the goals of this course.

### Objectives

While spending a certain portion of time working on issues and problems specifically oriented to Phase 5, it is imperative that one demonstrate an understanding of the basic components of the Phase 4 course, because much of Phase 5 work assumes and depends upon such a background. Therefore,

the student will be expected to satisfy the basic objectives of the Phase 4 unit. Since one should be able to handle these objectives without a great deal of difficulty, it will not be necessary for the student to attend all classes. Specific arrangements regarding attendance at these times will be worked out on an individual basis. When in class--as opposed to working independently on these basic objectives or the Phase 5 goals--the student will be expected to make significant contributions to the class, exercising some degree of leadership where appropriate. Finally, there are a few Phase 4 objectives the student might omit, depending upon the research topic chosen (see section III below).

Phase 5 students will meet with the instructor individually at least once during each cycle in the schedule. At that time, the student can make progress reports and the instructor can made suggestions regarding the student's work.

The Phase 5 goals are broken into three categories; appropriate information and approximate due dates for each category are given below.

## I. Critical Analysis of a Book or Articles

You will prepare a critique of a book or two articles related to the subject of death and dying. Such critiques should include a brief summary of the major arguments or themes and an analysis and evaluation of such things as:

1. Nature of documentation
2. Quality of arguments
3. Style and readability
4. Questions raised but not fully answered by the author
5. Overall usefullness
6. Other?

Length: 5 pages (approximately). Due Date: End of 5th week.

Possibilities:

1. Jessica Mitford, The American Way of Death
2. Lessa and Vogt, Reader in Comparative Religion
3. Carl Jung, "The Soul and Death."
4. Paul Tillich, "The External Now"
5. Walter Kaufman, "Esistentialism and Death."
6. Herbert Marcuse, "The Ideology of Death."
7. Frederick Hoffman, "Mortality and Modern Literature"
8. Carla Gottleib, "Modern Art and Death"
9. Herman Feifel, "Attitudes Toward Death in Some Normal and Mentally Ill Populations"
10. Curt Richter, "The Phenomenon of Unexplained Sudden Death in Animals and Man."

(Note: Articles 3-10 are all in Feifel, The Meaning of Death.)

Appendix E

## II. Experimental Project

(Choose one)

1. Conduct a survey on student or adult attitudes on some aspect of death in which you develop a hypothesis, create and administer a questionnaire that reflects good sampling, and analyze and evaluate the results obtained. The description, structure, and findings, including analysis and evaluation, will be submitted in the form of a 5 to 10-page paper.

or

2. Conduct an interview with a person who is employed in some capacity related to the field of death (cemetery or crematory owner, funeral director, coroner, psychologist, etc.). Interview questions should be planned carefully beforehand so that specific objectives are addressed. Also, a brief 5 to 7 page paper should be submitted in which you analyze and evaluate the experience in terms of the quality of the actual interview (i.e., were the objectives satisfied in your estimation?) and overall usefulness for you.

Due date: End of 10th week.

## III. Independent Research Project

Write a term paper (15-20 pages) on a topic of your choice (subject to approval). The general objective would be to choose a particular issue, subject, problem, etc., which interests you and:

1. Discuss to some extent any relevant historical factors which have contributed to the present situation.
2. Identify and analyze the nature of the situation, weighing the validity of evidence from different sources.
3. Offer viable solutions, if any and if relevant to your topic, reflecting the arguments developed in your analysis and pointing out any possible problem areas in your proposed solutions.

Your bibliography should be fairly extensive and a topic should be selected within four weeks.

This project represents a long-term commitment to individual research. In addition to the requirements noted above you might be asked to provide an oral defense of your paper before a panel of teachers, to be followed later by a discussion with the instructor concerning the report, a defense, and a self-evaluation of your overall performance.

Possible Topic Areas:

1. Cultural. Research the concept of death as it applies to another

society. For example, if the death ceremony is quite simple, is such the case of societal values in general regarding the importance of material goods?

2. Philosophical. Research the works/essays of a number of philosophers-past and/or present-in terms of their views of death generally and/or suicide specifically. Compare, contrast, analyze, and evaluate these ideas in relation to any personal definition of and attitudes about these areas. Writers who could be considered: Hume, Kant, Nietzche, Durkheim, James, Freud, Camus, Sartre.

3. Humanities. Research a subject such as "Death Themes in Art, or Music, or Literature," beyond the scope of those themes introduced in class. Analyze and evaluate the approaches that various authors or artists bring to bear on the themes, comparing and contrasting where appropriate. (A project on art or music lends itself well to oral presentation--to the teacher or the class as a whole).

4. Other

Due date: End of 15th week.

# BIBLIOGRAPHY

Alsop, S. Stay of execution. New York: Lippincott, 1973.

Anthony, S. The child's discovery of death. New York: Harcourt, Bruce and World, 1940.

Apfeldorf, M. Religious belief, emotional adjustment, and constructive ward behavior in the elderly patient during the period of reduced life expectancy: Research plans. Journal of Thanatology, 1975, 3, 113-141.

Aries, P. The reversal of death: Changes in attitudes toward death in western societies. D. Stannard (Ed.), Death in America. Philadelphia: University of Pennsylvania Press, 1975.

Bakhtiar, J. Care of the dying patient. International Journal of Social Psychiatry, August 1980, 26, 167-177.

Bane, J. Death and ministry. New York: Seabury Press, 1975.

Bayly, Joseph. The view from a hearse. Elgin, Illinois: David C. Cook, 1969.

Beatty, D. Shall we talk about death? Pastoral Psychology, 1955, 6, 11-14.

Becker, E. The denial of death. New York: Free Press, 1973.

Beilin, R. Social functions of death denial. Omega, 1981/82, 12, 1:25-35.

Bonnell, G. The pastor's role in counseling the bereaved, Pastoral Psychology, February 1971, 22, 27-36.

Boots, D. D. Helping the cancer patient: The minister and the social worker. Pastoral Psychology, January 1971, 22, 35-40.

Bowers, M., Jackson, J. & LeShan, L. Counseling the dying. New York: Thomas Nelson and Sons, 1964.

Boyar, J. The construction and partial validation of a scale for the measurement of fear of death. Dissertation Abstracts, 1964, 25, 2041.

Bryer, K. Amish way of death: A study of family support system. American Psychologist, March 1979, 34, 255-261.

Bugen, L. Effects of death education on stability of concern about death. Psychology Reports, November 1979, 43, 1086.

Bugen, L. State anxiety effects on counselor perceptions of dying stages. Journal of Counseling Psychology, January 1979, 26, 89-91.

Cappon, D. The psychology of dying. Pastoral Psychology, 1961, 12, 35-44.

Carrigan, R. L. The hospital chaplain, research and pastoral care. Pastoral Psychology, June 1966, 17, 39-48.

Carse, J. Grief as a cosmic crisis. In O. Margolis, H. Raether, A. Kutscher, J. Powers, I. Seeland, R. DeBellis, D. Cherico (Eds.), Acute Grief. New York: Columbia University Press, 1981.

Cavanaugh, J. R. The chaplain and the dying patient. Hospital Progress, November 1971, 52, 34-40.

Cherico, D. J., et al, (Eds.), Thanatology Course. New York: MSS Information, 1975.

Clarke, P. Exploration of countertransference toward the dying. American Journal of Orthopsychiatry, January 1981, 51, 71-77.

Coleman, J. Abnormal psychology and modern life. Glenview, Illinois: Scott, Foresman and Co., 1972.

Collett, L., & Lester, D. Fear of death and fear of dying. Journal of Psychology, 1969, 72, 179-181.

Collins, G. Christian counseling: A comprehensive guide. Waco, Texas: Word, 1980.

Consultation Clinic. On fatal illness. Pastoral Psychology, February 1955, 6, 42-53.

Craig, G. Human development (2nd ed.). New Jersey: Prentice-Hall, 1980.

Cryer, N. & Vayhinger, J. (Eds.), Casebook in Pastoral Counseling. Nash-

Cutler, D. Death and responsibility: A minister's view. Psychiatric Opinion, August 1966, 3, 8-12.

Cutter, F. Coming to terms with death. Chicago: Nelson-Hall, 1974.

Davenport, D. A closer look at the "healthy" grieving process. Personnel and Guidance Journal, February 1981, 59, 332-335.

Dickstein, L. Death concern: Measurement and correlates. Psychological Reports, 1972, 30, 563-571.

Dickstein, L. Self-report and fantasy correlates of death concern. Psychological Reports, 1975, 32, 147-158.

Diggory, J. & Rothman, D. Values destroyed by death. Journal of Abnormal and Social Psychology, 1961, 53, 205-210.

Durlak, J. Measurement of the fear of death: An examination of some existing scales. Journal of Clinical Psychology, 1972, 28, 545-547.

Edwards, M. How my father died: A story of participation and revelation. Journal of Humanistic Psychology, Summer 1979, 19, 57-65.

Erikson, E. Childhood and Society. New York: Norton Publishers, 1964.

Eshelman, B. Death row chaplain. Englewood Cliffs: Prentice-Hall, 1962.

Ewalt, P. & Perkins, L. Real experience of death among adolescence: An empirical study. Social Casework, November 1979, 60, 547-551.

Fairbanks, R. Ministering to the dying. Journal of Pastoral Care, 1948, 2, 6-14.

Feifel, H. The meaning of dying in American society. Journal of Pastoral Counseling, Fall-Winter 1974-5, 9, 53-59.

Fogelman, W. J. Physicians, clergymen and privileged communications. Journal of the American Medical Association, May 1967, 200, 235.

Folta, J. Grief, grief therapy and continuing education. In O. Margolis, H. Raether, A. Kutscher, J. Powers, I. Seeland, R. Debellis, D. Cherico (Eds.), Acute grief. New York: Columbia University Press, 1981.

Freese, A. Help for your grief. New York: Schocken, 1977.

Fulton, R. Death, grief and bereavement, a bibliography: 1945-1975. New York: Arno Press, 1977.

Gade, E. & Kuhler, D. Death education unit for student personnel and counseling students. Journal of College Student Personnel, 21, September 1980, 458-459.

Garfield, C. & Jenkins, G. Stress and coping of volunteers counseling the dying and bereaved. Omega, 1981/82, 1: 1-13.

Givelber, F. & Simon, B. Death in the life of a therapist and its impact on the therapy. Psychiatry, May 1981, 44, 141-149.

Glasser, W. The Identity Society. New York: Harper and Row, 1972.

Goin, M., et al. Timeless attachment to a dead relative. American Journal of Psychology, July 1979, 136, 988-989.

Goody, J. Death and the interpretation of culture: A bibliographic overview. D. Stannard (Ed.), Death in America. Philadelphia: University of Philadelphia Press, 1975.

Gorer, G. Death, grief and mourning. Garden City, New York: Doubleday, 1965.

Hartley, M. Coping with life after death: The counselor's responsibility. Personnel and Guidance Journal, December 1980, 59, 251-252.

Henney, M. & Barnhart, R. Death education: Do we need it? Psychological Reports, June 1980, 46, 996-998.

Hoelter, J. Multidimensional treatment of fear of death. Journal of Consulting and Clinical Psychology, October 1979, 47, 996-999.

Hoelter, J. & Epley, R. Religious Correlates of fear of death. Journal For the Scientific Study of Religion, December 1979, 18, 404-411.

Jackson, E. Understanding grief. Nashville: Abingdon Press, 1957.

Jackson, E. For the living. New York: Channel Press, 1963.

Jackson, E. Telling a child about death. New York: Channel Press, 1965.

Jackson, E. The Christian funeral. New York: Channel Press, 1966.

Jaffe, L. Use of terminal candor in system change. Advances in Thanatology, 1980, 5, 1: 1-26.

Johnson, J. Death anxiety of rehabilitation counselors and clients. Psychological Reports, February 1980, 46, 53-54.

Kalish, R. An approach to the study of death attitudes. American Behavioral Scientist, 1963, 6, 68-70.

Kaplan, G. Principles of preventive psychiatry. New York: Basic Books, 1964.

Karasee, T. and Schwartz, A. On death and dying. Advances in Thanatology, 1980, 5, (1) 27-37.

Kastenbaum, R. Death and responsibility. Current Psychiatric Opinion, 1966, 3, 5-6.

Kastenbaum, R. Death and development through the lifespan. H. Feifel (Ed.), New Meanings of Death. New York: McGraw-Hill, 1977.

Kastenbaum, R. Healthy dying: A paradoxical quest continues. Journal of Social Issues, 1979, 35 (1), 196-206.

Knott, E. Educating for death: A prospectus. Correspondence from Forum for Death Education and Counseling, 1977.

Kreiger, S., Epsting, F., & Leitner, L. Personal constructs, threats, and attitudes toward death. Omega, 1974, 5, 299.

Kubler-Ross, E. On death and dying. New York: Macmillan, 1969.

Kubler-Ross, E. Psychotherapy for the dying patient. Current Psychiatric Therapies, 1970, 10, 110-117.

Kubler-Ross, E. What's it like to be dying? American Journal of Nursing, January 1971, 71, 54-61.

Kubler-Ross, E. On the use of pscyhopharmacologic agents for the dying patient and the bereaved. Journal of Thanatology, Winter-Spring, 1972, 2, 563-6.

Kubler-Ross, E. The right to die with dignity. Bulletin of the Menninger Foundation, May 1972, 35, 302-312.

Kubler-Ross, E. Lessons from the dying. Sociologico de la Muerte, 1979, 35, 15-24.

Kubler-Ross, E. Questions and answers on death and dying. New York: Mac-Millan, 1974.

Landorf, J. Mourning song. Old Tappan, New Jersey: Fleming H. Revell, 1974.

Larue, G. Death and the humanist counselor. Humanist, May-June 1980, 40, 13-15.

Lefkowitz, D. Come darkness, and end the twilight. Advances in Thanatol-ogy, 1980, 4 (2), 69-75.

Lester, D. Fear of death of suicide persons. Psychological Reports, 1967, 20, 1077-1078.

Leviton, D. The scope of death education. Death Education, 1977, 1 (1), 41-56.

Lewis, C. A grief observed. New York: Bantam Books, 1961.

Lifton, R. & Olson, E. Living and dying. New York: Praeger, 1974.

Lindemann, E. Symptomatology and management of acute grief. American Journal of Psychiatry, 1944, 101, 141-148.

Lindemann, E. Symptomatology and management of acute grief. Pastoral Psychology, September 1963, 14, 8-18.

McClam, T. Death anxiety before and after death education: Negative results. Psychology Reports, April 1980, 46, 513-514.

McCleave, P. Medicine seeks the clergy. Journal of Religion and Health, April 1963, 2, 239-247.

Macon, L. Help for bereaved parents. Social Casework, November 1979, 60, 558-561.

Malinak, D., et. al. Adult reactions to the death of a patient. American Journal of Psychiatry, September 1979, 136, 1152-1156.

Melear, J. Children's conceptions of death. Journal of Genetic Psychology, 1973, 123 (2), 359-360.

Meyer, J. Death and neurosis. New York: International University Press, 1975.

Miller, W. When going to pieces holds you together. Minneapolis: Augsburg, 1976.

Morgenstern, A. Reliving the last goodbye: The psychotherapy of an almost silent patient. Psychiatry, August 1980, 43, 251-258.

Nagy, M. The child's theories concerning death. Journal of Genetic Psychology, September 1948, 73, 3-27.

Nelson, L., & Nelson, C. A factor analytic inquiry into the multidimensionality of death anxiety, Omega, 1975, 6, 171-178.

Neufeldt, D. & Holmes, C. Relationship between personality traits and fear of death. Psychological Reports, December 1979, 45, 907-910.

Nighswonger, C. Ministry to the dying as a learning encounter. Journal of Thanatology, March-April 1971, 1, 101.

O'Connor, B., et. al. The role of the minister in caring for the dying patient and the bereaved. New York: MSS Information Press, 1975.

Paige, R. The living and the dying. American Journal of Nursing. December 1979, 2171-2172.

Parkham, I., et al. Widowhood peer counseling (Program at Virginia Center on Aging). Aging, May-June 1980, 307-308, 42-46.

Patrick, J. Personal faith and the fear of death among the divergent religious populations. Journal For the Scientific Study of Religion, September 1979, 18, 298-305.

Perkins, L., Todd, B., & Ewalt, P. High school English courses as potential contributants to adolescent mental health. Panel presentation at the Annual Scientific Meeting of the American Association of Psychiatric Services for Children, Atlanta, Georgia, November 11, 1978.

Perske, R. Death and ministry: Episode and response. Pastoral Psychology, September 1964, 15, 25-35.

Pucetti, R. Experience of dying. Humanist, July 1979, 39, 62-65.

Reeves, R., Jr. To tell or not to tell the patient. A. Kutscher (Ed.), Death and Bereavement. Springfield, Ill.: Charles C. Thomas, 1969, pp. 5-9.

Roberts, W. Needs of the bereaved. Pastoral Psychology, 1950, 1, 17-21.

Roberts, W. Ye shall be comforted. Philadelphia: Westminster Press,1950

Roberts, W. The pastor's work with grief. Pastoral Psychology, Spring 1953, 14, 24.

Robinson, P. Five models for dying. Psychology Today, March 1981, 15, 85+.

Rodabough, T. Helping students cope with death. Journal of Teacher Education, November-December 1980, 31, 19-23.

Rodabough, T. The minister as death counselor: A typology of role enactments. Pastoral Psychology, Winter 1981, 30, 89-102.

Rogers, W. The pastor's work with grief. Pastoral Psychology, September 1963, 14, 19-26.

Rosenthal, N. & Terkelson, C. Death education and counseling: A survey. Counselor Education and Supervision, 1978, 18, 109-114.

Rosenthal, N. Adolescent death anxiety: The effect of death education. Education, 1981, 101, 95-101.

Rosenthal, N. Attitudes toward death education and grief counseling. Counselor Education and Supervision, March 1981, 20, 203-210.

Rupert, D. (Ed.), Loss (Symposium). Personnel and Guidance Journal, February, 1981, 59, 325+

Sanders, J., et al. Death anxiety among the elderly. Psychological Reports, February 1980, 46, 53-54.

Sarnoff, I. & Corwin, S. Castration anxiety and fear of death. Journal of Personality, 1959, 27, 374-385.

Scheff, T. Unresolved grief (with discussion). Center Magazine, January-February 1980, 13, 14-24.

Schulz, R. The psychology of death, dying and bereavement. Massachuttes: Addison-Wesley Publishing Company, 1978.

Schulz, R. & Alderman, D. Physicians' death anxiety and the stages of dying. Omega: Journal of Death and Dying, 1974, 5, 137-143.

Steen, J. Hindrances to pastoral care of the dying. Pastoral Psychology, March 1958, 9, 27-32.

Stern, M. Remarks on fear of death and human behavior. Advances in Thanatology, 1980, 4 (2), 33-42.

Stevens, S., et. al. Age norms for Templer's death anxiety scale. Psychology Reports, February 1980, 45, 205-206.

Switzer, D. The dynamics of grief. Nashville: Abingdon, 1970.

Tanner, I. The gift of grief. New York: Hawthorn Books, 1976.

Templer, D. The construction and validation of a death anxiety scale. Journal of General Psychology, 1970, 82, 165-177.

Tolar, A., & Reznikoff, M. Relationship between insight, repression-sensitization, internal-external and death anxiety. Journal of Abnormal Psychology, 1967, 72, 426-430.

Toth, S. & Toth, A. Empathetic intervention with the widow. American Journal of Nursing. September 1980, 80, 1652-1654.

Troup, S., & Green, W. (Eds.), The patient, death, and the family. New York: Scribner's, 1974.

Vachon, M. Type of death as a determinant in acute grief. In O. Margolis, H. Raether, A. Kutscher, J. Powers, I. Seeland, R. Debellis, & D. Cherico (Eds.), Acute grief. New York: Columbia University Press, 1981.

Vander Lugt, H. Light in the valley. Victor Books, 1977.

Vargo, M. Relationship between the Templer death anxiety scale and the Collett-Lester fear of death scale. Psychological Reports, April 1980, 46, 561-562.

Vernon, G. The sociology of death: An analysis of death-related behavior. New York: Ronald Press, 1970.

Wahl, C. Bolstering the defenses of dying patients. Hospital Physician, March 1969, 5, 160ff.

Wahl, C. The differential diagnosis of normal and neurotic grief following bereavement. Psychosomatics, March-April 1970, 11, 104-106.

Wahl, C. Helping the dying patient and his family. Journal of Pastoral Care, June 1972, 26, 93-98.

Wass, H., et al. Death education: An annotated resource guide. Washington, D.C.: Hemisphere, 1980.

Weathers, D. & Hewit, B. Coping with life after death. Newsweek, May 1980, 95, 91.

Westberg, G. Good grief. Rock Island, Illinois: Augustana Press, 1962.

Willey, D. On death and doctors: An exploration of how medical students are trained to deal with the emotional needs of their dying patients. Advances in Thanatology, 1980, 4 (2), 61-68.

Wilson, D., Ajemian, I., & Mount, B. The Royal Victoria hospital palliative care service. Death Education, 1978, 2, 3-20.

Wood, J. The structure of concern: The ministry in death-related situations. In L.H. Lofland (Ed.), Toward a sociology of death and dying. Beverly Hills: Sage Publications, 1976.

Zilboorg, G. Fear of death. Psychoanalytic Quarterly, 1943, 12, 465-475.