

Death and Dying

Epilogue Preview

Depending on an individual's age, experience, beliefs, and historical and cultural context, death can have many meanings. Death marks the end of the life span—an ending that individuals must come to terms with both for themselves and their loved ones. Indeed, an understanding and acceptance of death is crucial if life is to be lived to the fullest.

The first section of the Epilogue focuses on how dying is viewed throughout the life span, in different cultures and religions, and at different points in history.

The next section explores various issues regarding the dying person's wants and needs. Although the concept of an unvarying sequence of stages among the dying is not universally accepted, the pioneering work of Elisabeth Kübler-Ross was instrumental in revealing the emotional gamut of terminally ill patients, and the importance of honest communication. The section also discusses hospice and other forms of palliative care designed to help the terminally ill patient to die “a good death.”

The final section deals with changing expressions of bereavement and how people can be aided in the process of recovery.

What Have You Learned?

The “What Have You Learned?” questions at the end of the text chapter are reprinted here for your convenience in checking students' understanding of the chapter contents.

1. What do fatally ill children fear most?
2. What do children believe about death, according to the study with the puppet mouse?
3. How does terror management theory explain young people's risk taking?
4. What is the difference in attitudes about death between younger and older adults?
5. How does parenthood affect people's thoughts about their own death?
6. How is the trolley car dilemma an example of the illogic of people when they think about death?
7. What is the effect of religious faith on thoughts of death?
8. What is one example of contrasting rituals about death?
9. Why are near-death experiences controversial?
10. What is a good death?
11. What is a bad death?
12. Why doesn't everyone agree with Kübler-Ross's stages of death?
13. What are the guiding principles of hospice care?
14. Why is the double effect legal everywhere, even though it speeds death?
15. Why is the definition of death controversial?

16. What is the difference between a DNR order and euthanasia?
17. Why does Oregon use the phrase death with dignity instead of physician-assisted suicide?
18. Why do some people want to speed up their own dying process?
19. Why would a person who has a living will also need a health care proxy?
20. What is the difference between grief and mourning?
21. How do bereavement customs help people who are grieving?
22. How can a grieving person find meaning in death?
23. When are people not allowed to express their grief?
24. Who is expected to decide on the details of funerals, burial, cremation, and so on?
25. If a person still feels a loss six months after a death, is that pathological?

Chapter Guide

- “On Your Own” Activities: Developmental Fact or Myth?; Portfolio Assignment
- AV: Transitions Throughout the Life Span, Program 26: Death and Dying

I. Death and Hope

Instructional Objective: To help students understand the various meanings of death over the life span and in different religious and cultural contexts.

- AV: The Biology of Death; The Death Knell of Old Age: The Physical Aspects of Death
- Teaching Tips: Feelings About Death; Cultural Denial of Death
- Classroom Activity: The Day of the Dead
- “On Your Own” Activity: Death Anxiety Questionnaire

1. **Thanatology** is the study of death and dying.
2. (Table EP.1) Today, death occurs at a later age, takes longer, and more often occurs in hospitals. The major causes of death have also shifted, from infectious diseases to chronic illnesses such as cardiovascular disease and cancer.
3. Children as young as 2 years of age have some understanding of death. Dying children often fear that death means being abandoned by the ones they love. Because loss of companionship is a main concern of children, telling them that the deceased person is sleeping or in heaven is not helpful.
4. According to **terror management theory (TMT)**, people adopt cultural values and moral principles in order to cope with their fear of death.
5. Adolescents and emerging adults die in suicides, accidents, and homicides partly because they romanticize death in order to manage the fear of it.
6. A major shift in attitudes about death occurs when adults become responsible for work and family. Adults see death as something to be avoided or at least postponed. During late adulthood, anxiety about death decreases and hope rises. Many developmentalists view acceptance of one’s own mortality as a sign of good mental health.
7. The specific meanings attached to death vary from individual to individual, and according to their cultural and historical contexts.
8. Belief in life after death is directly related to people’s estimate of how close they themselves are to death. For this reason, the aged tend to be more religious than the young.
9. In all religions and cultures, death is considered a passage, not an endpoint.
10. Some people who survive a serious injury or illness report having had a *near-death experience* in which they left their body. These experiences often include religious elements.

II. Dying and Acceptance

Instructional Objective: To help students understand the meaning of a “good death” and to explore the controversy over whether to prolong life or hasten death in a terminally ill person.

- AV: Hospice; Letting Go: A Hospice Journey; “Doctor Death”: Medical Ethics and Doctor-Assisted Suicide; Living Wills; Dying Wish; Medicine and Mercy
 - Classroom Activities: The High Cost of Dying; The Chronosystem in Operation: Baby Boomers Avoid Talking About End-of-Life Issues; Hospices and a “Good Death”; Euthanasia; *Classroom Debate*: “Resolved: Euthanasia and Physician-Assisted Suicide Should Be Legalized”
1. A good death is one that is at the end of a long life; is peaceful, swift, painless, and dignified; and occurs at home surrounded by friends and family. Because of modern medical techniques, a swift and peaceful death is more difficult to ensure today than in the past.
 2. A major factor in our understanding of the psychological needs of the dying was the pioneering work of Elisabeth Kübler-Ross. Kübler-Ross’s research led her to propose that the dying go through five emotional stages: denial, anger, bargaining, depression, and finally acceptance. Another set of stages is based on Maslow’s hierarchy of needs.
 3. Other researchers have found that Kübler-Ross’s stages, when they occur, do not always follow the sequence she proposed. More typically, denial, anger, and depression disappear and reappear during the dying process; bargaining is brief because it is fruitless; and acceptance may never occur.
 4. The **hospice** is an alternative to hospital care that seeks to minimize suffering and to make the last days of life filled with love and meaning. To help more of the terminally ill die a good death, Cecily Saunders opened the first hospice in London during the 1950s.
 5. Hospices provide the dying with skilled medical care but avoid death-defying interventions. The hospice setting respects patients’ dignity.
 6. Medical care that is designed not to treat an illness but to relieve pain and suffering is called **palliative care**.
 7. Physicians once worried about causing addiction if pain relievers such as morphine were given too freely, but increasingly realized that pain destroys vitality faster than almost any infection. Pain medication for dying patients may have the **double effect** of reducing pain while speeding up death by suppressing respiration.
 8. (Thinking Critically) Historically, death was determined by listening to the heart. In the late 1970s, physicians decided that death occurred when brain waves ceased.
 9. In **passive euthanasia**, a seriously ill person is allowed to die naturally, through the cessation of medical interventions. The dying person’s chart may read **DNR (do not resuscitate)**. In **active euthanasia**, someone intentionally acts to terminate the life of a suffering person.
 10. Active euthanasia is illegal in most parts of the world. Especially controversial are issues concerning **physician-assisted suicide**, in which someone provides the means for a person to end his or her life.
 11. In the United States, the state of Oregon has allowed physician-assisted suicide since 1994 but under very strict guidelines. Since that time, concerns that physician-assisted suicide might create a **slippery slope**, hastening the deaths of the poor and the old, have not been proven to be well-founded.
 12. Some people make a **living will** to indicate what medical intervention they want if they become incapable of expressing those wishes. To avoid complications, many also designate a **health care proxy**, who can make decisions for them on the spot if needed.

III. Bereavement

Instructional Objective: To help students understand grief and how it differs from mourning, as well as historical and cultural views of bereavement.

- AV: Death: Coping with Loss; Grieving: Suddenly Alone; Saying Goodbye
- Teaching Tip: Rituals of Death
- “On Your Own” Activity: Coping with Death and Dying
- Critical Thinking Activity: Grief

1. **Bereavement** refers to the complicated and multifaceted feelings of loss following a death, and **grief** refers to an individual’s emotional response to this sense of loss. **Mourning** refers to the ceremonies and behaviors that a religion or culture prescribes for bereaved people.
2. A crucial factor in mourning is people’s tendency to assess blame and their search for meaning in death. The individual may engage in *grief work*, experiencing and expressing strong emotions and then moving toward wholeness.
3. In recent times, mourning has become more private, less emotional, and less religious. Small memorial services after cremation have generally replaced the large funeral. As rituals diminish, problems such as **absent grief** may become more common. Another problem is **incomplete grief**, in which circumstances interfere with the grief process.
4. About 10 percent of all mourners experience **complicated grief**, a type of grief that impedes the person’s future life because of lingering sorrow or contradictory emotions.
5. The practice of excluding unmarried partners, ex-spouses, and other people from mourning may create **disenfranchised grief**.
6. Bereaved persons are comforted by social support: a friend who listens, sympathizes, and does not ignore the real pain and complicated emotions involved in the recovery process.
7. Those who would comfort the bereaved should be aware that powerful, complicated, and unexpected emotions are likely.