DEATH, SOCIETY, AND HUMAN EXPERIENCE

ROBERT J. KASTENBAUM
Why Do You Need This New Edition?

If you’re wondering why you should buy this new edition of *Death, Society, and Human Experience* here are 13 good reasons!

1. Terror management theory is re-examined in the light of recent studies.
2. The discussion of death legalization is updated, as it is approved in another state, and controversy rages in several others.
3. Death attitudes and practices through the centuries are discussed, including Aries’ stimulating perspective.
4. A discussion of how the human mind projects death thoughts into the universe—and yet often denies it in everyday life.
5. Exploration of selective attention and fatal errors in people who are in decision-making situations.
6. St. John Bosco’s version of stages of dying, radically different from those described by Elizabeth Kubler-Ross, is brought forward for consideration.
7. A discussion on troubling data indicates that pain and other symptom relief is still not provided for many terminally ill hospital patients.
8. New discussion of ethical and legal issues regarding the harvesting and merchandising of transplant organs from impoverished or imprisoned people to the more affluent.
10. Discussion of the effectiveness of the response to high suicide rates among active military personnel and veterans.
11. Discussion of child murders committed by desperate parents.
12. A review of the “stages of grief.” Are they a story made up to make sense of disturbing and chaotic events?
13. Discussion of the extent to which various nations and cultures agree on what is “the good death”.
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Death, Society, and Human Experience

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Arizona State University

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For Cynthia
and for those
you have loved . . .
## Preface

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We are not alone. We have more than 300 million compatriots if we live in the United States of America. There is no point in making this number more specific, because at least one infant will have made its debut before you finish reading this paragraph, and the total continues to rise day after month after year. On planet Earth, we are accompanied by nearly 7 billion of our carbon-based species. There are more humans alive today than at any previous time in history, and, as you may have noticed, far more competition for parking spaces. On numbers alone, the human project seems to be doing well but all these lives end.

The first business of life is to stay alive. Ask the blades of grass that struggle up to the sunlight through the hard surfaces of a city street. Ask our resourceful adversaries, the virus and the microorganism, who continue to reinvent themselves whenever we launch a new pharmacological assault. Ask the child of a devastated homeland who has already experienced massive loss, stress, and deprivation but is determined to survive, and does. Ask nurses, paramedics, and physicians who have seen people make remarkable recoveries, seemingly because they had such a strong will to live. Ask firefighters why they risk their own lives to save people they’ve never met.

Even at its most resourceful and fortunate, life does not succeed indefinitely. All those millions and billions of us have been given a limited time offer by life, and most will also experience the death of people who are precious to us. That is a pretty good reason for having a book such as this and courses focused on dying, death, and grief. For many years, society ignored death, the dying, and the grieving person. The rule of silence created more problems than it solved. There was little comfort for the dying or grieving person, and little counseling for the troubled mind of the suicidal person. Inadequate communication interfered with potentially supportive relationships. Health care professionals had their own share of misery: responsible for care of the “incurable” (as dying people often were known) yet not prepared to deal with mortality in their own thoughts and feelings.

Many people participated in the systematic avoidance of death. They paid the price in anxiety and burdensome defenses. Other people brooded alone, haunted by death-related anxieties. Still others challenged death by risky actions; these episodes turned passive anxiety into active thrills but, too often, resulted in serious injury or death. Few had the opportunity to reflect on mortality with the help of a sensitive instructor and knowledge-based writings. There was little peer support for the nurse who dared to “get involved” with dying patients by actually being with them, the teacher who allowed students to discuss their death fears and bereavement experiences, or the researcher who deviated from the mainstream to explore our response to mortality. Funny thing, though: let death come a little too close to one’s own life, and the same people who had looked askance at the local “death lady” now approached her for counsel and comfort.

The field of research and practice sometimes known as thanatology started to take shape in the 1960s, mostly in Western Europe and North America (Chapter 14). Like the other early “deathniks” back then, I had to learn almost everything on the go. Our professional training had not prepared us for encounters with mortality. The first time I stepped into a death and dying classroom was as the instructor, and the same held true for many other death educators who followed. It still seemed odd to be studying death. Eventually I figured out that thanatology was actually the study of life—but with death left in.

As the 1970s began, we had the emerging hospice movement, a scattering of classes and workshops, media attention, and Omega, the first peer-reviewed journal devoted to death and dying. We didn’t have a textbook, though, so I wrote one. I thought that we should call on experiences, knowledge, and insights from many perspectives. No field had all the answers, and most had been reluctant even to raise the questions. Easy generalizations had already appeared in public and professional discourse. Whoa! Let’s not become attached to hasty conclusions, especially those that satisfy our wish-fulfillment needs. This meant that the knots of uncertainty, inadequate evidence, and conflicting perspectives had to be identified and acknowledged, even if this posed a burden for reader and author.
I thought a lot about the people who would read this book. Some would be working toward or engaged in a human services career. Others would be following their curiosity. There would also be people—many—who had experienced traumatic death-related situations that continued to trouble them. For still other people, death-related issues would be ongoing: a roommate is suicidal; a family member is dying; they might themselves have a life-threatening condition. There is a give-and-take in the classroom that no book can accomplish on its own. Nevertheless, authors should respect the diverse life experiences and circumstances that people bring with them. It also seemed to me that authors should continue to be contributors to research, theory, and practice, and so the first and all succeeding editions include some sharings from my own work.

**ABOUT THE ELEVENTH EDITION**

This book is intended to contribute to your understanding of your relationship with death, both as an individual and as a member of society. For example, you will learn:

- How your personal attitudes and experiences compare with those of other people, as well as with the available research findings. This will be accomplished through self-inventory quizzes in several chapters.
- How our thoughts and feelings about death develop from early childhood and how we struggle with anxiety and denial as we move toward a mature and effective view of death.
- How mass media and computer-mediated programs can influence our attitudes, risk factors, and relationships.
- What very different ideas and meanings have been associated with death throughout the centuries.
- How and why the “Undead” have survived into our own times.
- How the ideas of “death” and “dead” have become and remained unsettled in our own time.
- How social forces and events affect the length of our lives, how we grieve, and how we die—in nations ravaged by disease, poverty, and violence, as well as in our own.
- How dying people are perceived and treated in our society, and what can be done to provide the best possible care.
- Why the “Good Death” is a difficult but valuable ideal.
- How hospice (palliative care) continues to change and develop.
- What choices and decisions we have about the way we are treated at the end of our lives.
- What stresses and risks caregivers to terminally ill people and their families experience.
- How people respond to the sorrow and anxiety of grief and the challenge of moving on with their lives.
- Why the funeral and memorialization process is still with us today after so many centuries, and how it is changing.
- Who is most at risk for suicide, and who is most likely to become either a killer or a victim of homicide.
- What is happening in the continuing controversy over euthanasia and physician-assisted death.
- What is becoming of faith and doubt about an afterlife.
- How we can help others cope with their death encounters.

**NEW TO THIS EDITION**

- Terror management theory is re-examined in the light of recent studies.
- Assisted death legalization is approved in another state, and controversy rages in several others.
- Death attitudes and practices through the centuries: Aries’ stimulating perspective.
- How the human mind projects death thoughts into the universe—and yet often denies it in everyday life.
- Explores selective attention and fatal errors in people who are in decision-making situations.
- St. John Bosco’s version of stages of dying, radically different from those described by Elizabeth Kubler-Ross, is brought forward for consideration.
- Troubling data indicates that pain and other symptom relief is still not provided for many terminally ill hospital patients.
- Ethical and legal issues regarding the harvesting and merchandising of transplant organs from impoverished or imprisoned people to the more affluent.
• How effective has been the response to high suicide rates among active military personnel and veterans?
• Child murders committed by desperate parents.
• Are “stages of grief” a kind of story made up to make sense of disturbing and chaotic events?
• To what extent do various nations and cultures agree on what is “the good death?”

These and other topics recognize interactions between individual and society. It is true that we live and die as individuals. However, it is also true that we live and die within a particular society during a particular time in world history. Preoccupation with our thoughts and feelings as individuals could lead us to lose sight of the larger picture in which social dynamics so often influence the timing, mode, and experience of dying as well as our basic interpretations of life and death.

We draw upon the best available scholarship and research as well as upon the words of people who have found themselves in the middle of death-related situations. We note the limitations of present knowledge and offer alternative interpretations. It is our intention to present information clearly but without undue simplification.

I welcome you personally to this book and to the course to which this book may contribute. Take advantage of your instructor’s expertise: Do not hesitate to ask questions and share your experiences. Explore the ever-growing literature on the human encounter with mortality. Discover what observers from many different perspectives can offer us. Now join us in one of humankind’s oldest—and newest—voyages of discovery.

I appreciate the comments offered by the following reviewers: Patrick Ashwood, Hawkeye Community College; J. Meredith Martin, University of New Mexico; and Allen Richardson, Cedar Crest College. It was also good to hear from other instructors and readers who had useful suggestions to make.

I hope you will find this book helpful in your explorations of death, society, and human experience.
Is death our greatest fear, as many observers have concluded? Perhaps they should have added, “That’s why it can be such a thrill to dance at the edge of existence.”
As We Think About Death

Union General John Sedgwick was killed during the battle of Spotsylvania on May 8, 1864, while watching Confederate troops. His last words were, “They couldn’t hit an elephant at this dist. . . .”


Chilling whistles preceded horrible booms, and Antonia found herself listening for each whistle to end, fearing the worst, then letting her breath out when she heard someone else’s life exploding.

—Diane Ackerman (2007, p. 58)

. . . we are taught not to contemplate the possibility that all being is ephemeral—including our own. But san men remind us of it every day: as our trash goes, so one day, go we. No wonder we need to hate them.

—Robin Nagel (2008)

I felt like we were going to get thrown out of the car numerous times, and I had zero control in anticipating which direction we were thrown next. I’m glad we hit it again before I could think about it or I might not have done her again.

—Anonymous rollercoaster enthusiast (2008)

One man was stretchered away after he was hit in the back by a bull with its horn and another man who had tripped had a lucky escape when the animal simply tripped over him. . . . “You’re not even thinking. You’re just sprinting. The elation at the end of it. You’re just ecstatic,” said a 23-year-old accountant from Adelaide, Australia, Jim Atkinson


“His brow was perfectly calm. No scowl disfigured his happy face, which signifies he died an easy death, no sins of this world to harrow his soul as it gently passed away to distant and far happier realms.”

Every year women arrive at the Herart Public Hospital in Afghanistan with burns so severe that they die. These are women who were killed for bringing "dishonor" to their families by violating a rule, or who failed to bring a suitable dowry when married.

—Leela Jacinto (2002)

In the land of the Uttarakurus grows the magic Jambu tree, whose fruit has the property of conferring immunity from illness and old age, and, by means of this fruit, they lengthen their lives to a thousand years or even, in some accounts, to eleven thousand years . . . among other things, their realm includes landscapes of precious stones and trees from whose branches grow beautiful maidens.

—Gerald J. Gruman (2003, p. 33)

Life is supposed to go on. Yes, there is death, but not here, not now, and surely not for us. We wake to a familiar world each day. We splash water on the same face we rinsed yesterday. We talk with people whose faces are familiar. We see so much of what we have seen many times before. It is so comforting . . . this ongoingness of daily life. Why disturb this pattern? Why think of death? Why make each other anxious? And why do anything that would increase our risk? Here are a few quick, if perhaps not entirely satisfying answers:

• General Sedgwick led an eventful life, but is remembered now for his inadvertently famous last words. Did he deny his immediate danger to set a bold example for his troops, to cover up his own fear, or perhaps just because he would not think of taking advice from a junior officer? Denial of vulnerability can be a fatal gesture.
• Death anxiety sometimes arises in a moment and passes almost as quickly when the threat evaporates. Not so for Antonia and her family in Warsaw, as the great city was first bombed extensively and then occupied by the Nazis, who used every method within their means to discover, torture, and kill anybody who might oppose their rule. Normal life had been replaced by 24/7 emergency alert. Death was no longer an abstraction or a remote and mysterious event: it was life that now seemed elusive, perhaps unattainable.
• We can’t help but think of death. It’s their fault, the sanitation workers who haul our garbage away. That is the considered opinion of New York City sanitation worker Robin Nagel, who is also a professor of anthropology. She notes that we live in a high-consuming, rapid-disposing culture that tries to keeps death and the dead at the farthest margins of our physical and emotional space. We are uneasy in the knowledge that there is no permanence in our lives. Today’s bargain purchase is tomorrow’s garbage. We, who have purchased, used, and discarded so much, will ourselves be hauled off some day, and then what? What will it all have meant? “Why Do We Love to Hate San Men?” (op. cit.). Well, Professor Nagel has just told us.
• Who can resist the opportunity to be scared out of our wits on a diabolical rollercoaster or gored and trampled by a bull? Each year so many people crowd into the northern Spanish town of Pamplona that they become almost as much a menace to each other as the six bulls who rush down cobblestone streets. (Fifteen have died and hundreds have been injured since the first bull run in 1911.) The “ecstasy” of outrunning death is hard to understand for those who organize themselves around the avoidance of mortal anxiety. Our friend “Anonymous” tries out the biggest and baddest rollercoasters, and does it over and over again. It’s the thrill of terror and the joy of survival. Not only do accidents
had died far from home, bereft of comfort and spiritual ministry, and possibly in a despairing state of mind. The Confederate soldier quoted by Faust (p. 21) was providing a welcome service when he described his cousin’s death in such positive terms in a condolence letter. It was best if his relatives could be made to believe that their young man had ended his life at peace with himself and God. How people died reflected on how they had lived and hinted at what would be their estate in the afterlife (see also the *good death* in Chapter 15).

*Young women, even girls as young as 11, have set themselves on fire, choosing extremely painful deaths over lives enslaved to men they did not want to marry. Such events are still occurring in Afghanistan, and other places where females are regarded as disposable property. Some of these deaths are finally coming to general attention, as when Shakiba, a 19-year-old Afghan woman, was interviewed by television from the hospital bed in which she would soon die. Shakiba’s family sold her to become a man’s second wife. “My family was selling me and I didn’t know what else to do.”* Women between 14 and 20 years of age who were desperately trying to escape marriages to older men have carried out most of the self-immolations. The daughters were being married off for a “bride price” intended to help the rest of the family survive. But families themselves have also been accused of killing daughters for being uncooperative or for having violated their society’s rigid sexist code of conduct. Not only death, then, but death in youth, and not only death, but death preceded by intense suffering—these were chosen over lives that seemed even worse.

*Through the centuries, most people died before what we now would consider to be midlife. Many did not even survive childhood. Perhaps this is one reason why the folklore of ancient times is filled with stories about fortunate people who lived so long that they hardly needed to think about death. The Uttarakurus were supposed to live in the far north of India, but similar tales flourished in Greek, Persian, Teutonic, Hindu, and Japanese lore, among others. One of the oldest Hebrew legends speaks of the River of Immortality, which some scholars believe provided the*
background for Christ being identified with the Fountain of Life. The idea that in a faraway place there were refreshing waters that could extend life and perhaps also renew youth was still credible enough to gain funding for Ponce de Leon’s expedition to Florida (although skeptics suggest it was gold lust all the way). Fear of dying could be attributed to the prevailing short life expectancy. If only we could do something about death, we wouldn’t have to be thinking about it so often!

Some families today cherish fading photographs of relatives who died years ago of pneumonia, tuberculosis, cholera, typhoid, scarlet fever, infantile paralysis, and other widespread diseases. One hoped to survive the diseases that threatened children and young adults. One hoped for the chance to realize personal dreams for a good life. Perspectives have changed about what to do when life isn’t good. There are now increasing demands for release from life when the quality of that life has been reduced by painful or incapacitating illness. Death, once the problem, is being regarded as the answer by a growing number of people.

In this chapter we begin our exploration of thoughts, knowledge, attitudes, and feelings about death. We will consider many world societies, although our focus is on the United States. It is not enough, though, to attend only to the way other people think about death; therefore, this chapter also provides the opportunity to take stock of our own dealings with mortality. First, we gather around the campfire and spare a few thoughts for our ancestors.

**A HISTORY OF DEATH?**

We have already touched a little on the history of death. In fact, one might grumble that all of history is just death warmed over. The people who did those things, or had those things done to them—their lives, no matter how lively, have been absorbed into yesteryear. Grumbles aside, the history of death is so interwoven with life that scholars have hesitated to take it on. Try to encompass life and death in the big picture, leaving nothing out and placing everything in balanced perspective? Good luck with that! Therefore, in this book we offer historical perspectives in many specific areas, e.g., hospice care, euthanasia, terrorism, and afterlife beliefs. One scholar stands out, however, for his effort to identify basic themes in attitudes toward death over an extended period. Phillipe Aries had already made substantial contributions to the history of family life (1987) and the social construction of childhood (1962). Aries’s influential work (1981) energized the study of death from a historical perspective. He attempted to reconstruct the history of European death attitudes, focusing on approximately a thousand years after the introduction of Christianity up to the present time. He drew most of his observations from burial practices and rituals surrounding the end of life. Aries’s book is a treasure of information regarding how our ancestors lived with death.

What does Aries extract from this daunting mass of observations? Four psychological themes and their variations: awareness of the individual; the defense of society against untamed nature; the belief in an afterlife; and belief in the existence of evil. These themes have unfolded through the centuries.

Death was primarily a community event in the earliest human societies. The community or tribe could be seriously weakened by the loss of its members, and the survivors feared even more for their lives. Nature was dangerous, so the death of the individual was relatively “tame.” How the community would keep itself strong and viable was the challenge.

Ritualization was a way of protecting fragile human society from the uncontrollable perils of nature and malevolent gods. Death and the dead had to be dealt with constantly. Much of the danger resided in potential harm from the dead, who might return with a vengeance. The dead as well as death were tamed by requiring them to return only under specified occasions and conditions. Mostly, the early Christian dead were assigned the role of peaceful sleepers. Speak not ill of them.

About a thousand years into the Christian era, a darker shadow fell over prevailing attitudes: the death of the self became the most intense concern.
People became more aware of themselves as individuals. This was associated with a heightened sense of vulnerability. It was their very own life, their very own soul that was at stake. And there was a lot more to life. The quality of life was improving, so people were reluctant to surrender the pleasures of earthly life unless postmortem bliss was assured. The hour of death became the most important hour of life. The Ave Maria became a fervent prayer for a good death. Death was no longer simply a natural part of life: it was make-or-break with individual destiny. This transformation became evidence in burial practices: the body and face were now covered and concealed, taken out of nature.

Next came what might be called twisted death. Rationalism and science were contributing to an increasingly progressive and sophisticated worldview; however, at the same time, death became more entwined with both violence and sexuality. In other words, death had become strange, alien, and sometimes perverted.

Furthermore, a specific dark fear becomes “viral” throughout the world: being buried alive. Horror is on the loose as people recoil but are fascinated at the image of life and death so closely mingled, perhaps with forbidden sexuality as a terrifying temptation. Sex and death would remain strange bedfellows as a cross-cultural theme still having its say.

Attitude change did not stop at this point. Next into prominence came the death of the other. This took place within the context of widespread technological advances and the growing importance of family life and privacy. People lived more as members of a tight-knit family than as cogs in the larger society. Death had become more personal—individual grief breaking through communal ritual. “What the survivors mourned was no longer the fact of dying but the physical separation from the deceased” (p. 610). Death now was neither tame nor wild. It could be viewed as a beautiful adventure. This social reconstruction of death was made possible by the dismissal of purgatory, Hell, and an eternity of suffering. Death was revisioned as a guilt-free trip. One could therefore contemplate the mysteries and wondrous transformations rather than tremble at the threshold of damnation. Best of all, death meant reunion with loved ones. Heaven had been improved with an extreme makeover that promised reunion with loved ones, a projection of the earthly good life into a forever space.

Next? The invisible death made its impact in the nineteenth century and continues its dominance today. It does not revoke the death of the other, but takes us to a different place in the mind. “Death became dirty, and then it became medicalized” (p. 612). Why? Because “success” had become everything. The opposite of absolute success was absolute failure, and that was the new role assigned to death. This meant that it was a kindness to protect people from knowledge of their imminent death: enter denial! Avoidance, misrepresentation, and denial had an effect that could hardly have been more unthinkable in earlier eras. It was spiritual deprivation—deprived of the opportunity for that transformative deathbed moment. Distracted from their own final passage and shorn of interpersonal support and communal ritual, people now died neither in grace nor in peril of damnation. If death were no longer an evil, it was no longer a sacred passage either. It was just, well, failure of the machine.

Aries offers many examples in support of his conclusions. His book is little short of a revelation for those who have never attended to the connection between our social constructions and how we live and die. Nevertheless, Aries’s conclusions have not escaped challenge. It is possible to read history in more than one way. Perhaps he emphasized one source of data too much while ignoring others. In any event, he does not delve into the history of death attitudes and practices in Africa, Asia, and the Pacific Islands. A fair assessment is that Aries has made a remarkable contribution for one scholar as he pioneered a vast and neglected realm of human experience.

For a brief, intensive immersion in the history of death, a top recommendation is Barbara W. Tuchman’s (1978) authoritative and richly illustrated A Distant Mirror. The Calamitous 14th Century. Here we find death raw, up close and personal, and in command of town and country, crown and church. Another informative read is John R. Hall’s (2009) Apocalypse. He traces the history of doom-saying
from antiquity to the present. If you have ever wondered about the end of the world, here is the opportunity to catch up with what others have been imagining through the centuries. Many entries on specific historical developments are offered in the encyclopedias listed at the end of this chapter. And I wouldn’t mind it if you felt like reading my book, *On Our Way: The Final Passage Through Life and Death*.

Philosophers were most active in pondering death when abstract thought burst through with unprecedented enthusiasm during the Golden Age of Greek antiquity. What is the world made of? What is really real, and what is illusion? How do we know anything, and how do we know that we know it? What is the good? And what are we to make of this limited run on earth? In later centuries, philosophers mostly whistled past death, and it is only in recent years that a few have tried to pick up where the ancients left off. Jacque Choron (1973) offered a concise and reliable survey of *Death in Western Thought*, but good luck in snagging a copy! As a challenging sample of early philosophical thought, here is what one maverick passed along:

*So death, the most terrifying of ills, is nothing to us, since so long as we exist, death is not with us, but when death comes, then we do not exist. It does not then concern either the living or the dead, since for the former it is not and the latter are no more.* (Epicurus, Third century b.c.)

Neither the living nor the dead should be concerned about death. Instead, we should cultivate a pleasurable life of learning and friendship. Epicurus illustrated this approach by creating a garden community that welcomed people of all backgrounds who wanted to live here and now in a peaceful and friendly manner. It is said that, remarkably, this community endured for 500 years. Is that a philosophy we should live by—or we entitled and condemned to worry about our mortal endings?

The media also cooperated. Nobody died. Nobody had cancer. Lucky “Nobody”! Instead, people would “pass away” after a “long illness.” Deaths associated with crime and violence received lavish attention, then as now, but silence had settled over the deaths of everyday people. When a movie script called for a deathbed scene, Hollywood would offer a sentimental and sanitized version. A typical example occurs in *Till the Clouds Go By* (1946), a film that purported to be the biography of songwriter Jerome Kern. A dying man tries to communicate to a friend his realization that this will be the last time they see each other, but the visitor obeys the Hollywood dictum of avoidance and pretense. As a result, the friends never actually connect, never offer significant words of parting to each other. A physician then enters the room and nods gravely to the friend, who immediately departs. Another mortal lesson from Hollywood: The moment of death belongs to the doctor, not to the dying person and the bereaved. Audiences today see this scene as shallow and deceptive. One student spoke for many others in complaining, “It was as phony as can be—what a terrible way to end a relationship!” A new question has arisen, though: Does the fascination with grisly corpses...
and mangled body parts on television programs such as *CSI* literally depersonalize death? Is immersion in gory details just another maneuver to avoid emotional confrontation with the death of a person?

Not thinking about death was a failure. People continued to die, and how they died became an increasing source of concern. Survivors continued to grieve, often feeling a lack of understanding and support from others. Suicide rates doubled, then tripled, among the young, and remained exceptionally high among older adults. Scattered voices warned us that in attempting to evade the reality of death, we were falsifying the totality of our lives. Who were we kidding? Neither an individual nor a society could face its challenges wisely without coming to terms with mortality.

It is still difficult to think about death, especially when our own lives and relationships are involved. Nevertheless, enforced silence and frantic evasion seem to be less pervasive. There is an increasing readiness to listen and communicate.

### Listening and Communicating

More physicians are now listening and communicating. Patients and family members feel more empowered to express their concerns, needs, and wishes. Physicians feel more compelled to take these concerns, needs, and wishes into account.

Some people have a ready-made answer that dismisses open discussion of death: “There’s nothing to think about. When your number’s up, it’s up.” This idea goes back a long way. It is part of that general view of life known as *fatalism*. Outcomes are determined in advance. There’s nothing we can do to affect the outcomes so why bother? There is something to be said for respecting the limits of human knowledge and efficacy. But there is also something to be said for doing what we can to reduce suffering and risk within our limits. The person who is quick to introduce a fatalistic statement often is attempting to end the discussion before it really begins. It is what communication experts call a *silencer*.

Fatalistic attitudes in today’s world are perhaps more dangerous than ever. As we will see, many deaths in the United States can be attributed to lifestyle. Our attitudes, choices, and actions contribute to many other deaths across the entire life span. Ironically, it is the belief that there is no use in thinking about death and taking life-protective measures that increase the probability of an avoidable death.

### YOUR SELF-INVENTORY OF ATTITUDES, BELIEFS, AND FEELINGS

We have touched briefly on a few of the death-related questions and beliefs that are current in our society. Perhaps some of your own thoughts and feelings have come to mind. One of the most beneficial things you can do for yourself at this point is to take stock of your present experiences, attitudes, beliefs, and feelings. This will give you not only a personal data baseline but will also contribute further to your appreciation of the ways in which other people view death.

Before reading further, please begin sampling your personal experiences with death by completing Self-Inventories 1–4. Try to notice what thoughts and feelings come to mind as you answer these questions. Which questions make you angry? Which questions would you prefer not to answer? Which questions seem foolish, or make you want to laugh? Observing your own responses is part of the self-monitoring process that has been found invaluable by many of the people who work systematically with death-related issues.

Each of the inventories takes a distinctive perspective. We begin with your knowledge base, sampling the information you have acquired regarding various facets of death. This is followed by exploring your attitudes and beliefs. We then move on to your personal experiences with death. Finally, we look at the feelings that are stirred in you by dying, death, and grief. Our total view of death comprises knowledge, attitudes, experiences, and feelings—and it is useful to identify each of these components accurately. For example, if I fail to distinguish between my personal feelings and my actual knowledge of a death-related topic, I thereby reduce my ability to make wise decisions and take effective actions.

Please complete the self-inventories now.
Inventory 1

Your Knowledge Base

Fill in the blanks or select alternative answers as accurately as you can. If you are not sure of the answer, offer your best guess.

1. Your friend wants to live as long and possible—and would change species to do it. Which of the following species has the longest verified life-span?
   a. Bat ______  c. Lobster ______
   b. Cat ______  d. Queen termite ______

2. Most baby boomers:
   a. Do not believe in Heaven ______
   b. Believe in Heaven, but not in ghosts ______
   c. Believe in Heaven, but do not expect to go there ______
   d. Believe in Heaven, and expect to go there ______

3. How many deaths are there in the United States each year? ______

4. The leading cause of death for the population in general is ______

5. A person born in the United States a century ago had an average life expectancy (ALE) of about ______ years.

6. A person born in the United States today has an ALE of about ______ years.

7. In the nation of ______, ALE has dropped from 63 to only 34 years over the past quarter of a century. Why?

8. There is a new entry among the 10 leading causes of death in the United States. This is ______

9. What is the leading cause of fatal injuries in the United States? ______

10. A seriously ill person is in the hospital and not expected to recover. How much time is this person likely to spend alone each 24-hour day?

11. Homicide rates in the United States have been consistently highest in:
   New England ______
   Mountain states ______
   Southern states ______
   West north central states ______

12. Does your state recognize an advance directive for end-of-life medical care as a legal and enforceable document?
   Yes ______  No ______

13. A suicide attempt is most likely to result in death when made by a/an
   a. Young woman
   b. Young man
   c. Elderly woman
   d. Elderly man

14. Cryonic suspension is a technique that is intended to preserve a body in a hypothermic (low-temperature) state until a cure is discovered for the fatal condition. How many people have actually been placed in cryonic suspension, and how many revived?

15. The earliest childhood memory reported by most adults is an experience of ______

16. The two states that have legalized physician-assisted death are ______ and ______

17. Palliative care most often has relief from ______ as its top priority.

18. What was placed inside the chest of a royal Egyptian mummy, and why?

19. In the United States, cremation is now chosen by about one person in ______

20. Near-death experience reports have several key elements in common with G-LOC. What is G-LOC?
   ______

21. Jack Kevorkian, M.D., “assisted” in the death of more than 100 people. How many of these people were terminally ill?
   ______

22. “Periodic mass extinctions” have totally eliminated many species and taken a tremendous toll of life. The three most recent mass die-offs are thought to have been caused by ______

23. The Harvard Criteria offered an influential guide to the diagnosis of ______

24. ______ is the philosopher who turned down the opportunity to escape his unjust execution, and instead used the occasion to explain to his friends why death should not be feared.

25. PTSD has been receiving increased media attention lately. What is it?
   ______

Answers to self-inventory questions are found later in this chapter. Not going to peek, are you?
Inventory 2

My Attitudes and Beliefs

Select the answer that most accurately represents your belief.

1. I believe in some form of life after death:
   Yes, definitely ______
   Yes, but not quite sure ______
   No, but not quite sure ______
   No, definitely ______

2. I believe that you die when your number comes up. It’s in the hands of fate.
   Yes, definitely ______
   Yes, but not quite sure ______
   No, but not quite sure ______
   No, definitely ______

3. I believe that taking one’s own life is:
   Never justified ______
   Justified when terminally ill ______
   Justified whenever life no longer seems worth living ______

4. I believe that taking another person’s life is:
   Never justified ______
   Justified in defense of your own life ______
   Justified when that person has committed a terrible crime ______

5. I believe that dying people should be:
   Told the truth about their condition ______
   Kept hopeful by sparing them the facts ______
   Depends upon the person and the circumstances ______

6. In thinking about my own old age, I would prefer:
   To die before I grow old ______
   To live as long as I can ______
   To discover what challenges and opportunities old age will bring ______

7. To me, the possibility of nuclear weapon warfare or accidents that might destroy much of life on earth has been of:
   No concern ______
   Little concern ______
   Some concern ______
   Major concern ______

8. To me, the possibility of environmental catastrophes that might destroy much of life on earth has been of:
   No concern ______
   Little concern ______
   Some concern ______
   Major concern ______

9. Drivers and passengers should be required to wear seat belts.
   Yes, agree ______
   Tend to agree ______
   Tend to disagree ______
   No, disagree ______

10. The availability of handguns should be more tightly controlled to reduce accidental and impulsive shootings.
    Yes, agree ______
    Tend to agree ______
    Tend to disagree ______
    No, disagree ______

11. A person has been taken to the emergency room with internal bleeding that is likely to prove fatal. This person is 82 years of age and has an Alzheimer’s disease–type dementia. What type of response would you recommend from the ER staff?
   Comfort only ______
   Limited attempt at rescue ______
   All-out attempt at rescue ______

12. You have been taken to the emergency room with internal bleeding that is likely to prove fatal. You are now 82 years of age and have an Alzheimer’s disease–type dementia. What type of response would you hope you receive from the ER staff?
    Comfort only ______
    Limited attempt at rescue ______
    All-out attempt at rescue ______

13. Another round of chemotherapy has failed for a woman with advanced breast cancer. The doctor suggests a new round of experimental therapy. She replies, “I wish I were dead.” What do you think should be done—and why?
    __________________________________________
    __________________________________________
# Inventory 3

## My Experiences with Death

Fill in the blanks or select the most accurate alternative answers.

1. A. I have had an animal companion who died.  
   Yes  No
B. How I felt when my pet died can be described by words such as __________ and __________.

2. The following people in my life have died:  
   Person  How Long Ago?  
   A. ____________________________  
   B. ____________________________  
   C. ____________________________  
   D. ____________________________  
   E. ____________________________

3. The death that affected me the most at the time was ________.

4. How I felt when this person died can be described by words such as _____ and _____.

5. This death was especially significant to me because ________.

6. In all the circumstances surrounding this person’s death, including what happened afterward, my most positive memory is of ________.

7. My most disturbing memory is of ________.

8. I have conversed with dying people:  
   Never  One person  Several people  Many people

9. I have provided care for a dying person.  
   Never  One person  Several people  Many people

10. I have known a person who attempted suicide.  
    Not to my knowledge ________  
    One person ________  
    Several people ________

11. I have known a person who committed suicide.  
    Not to my knowledge ________  
    One person ________  
    Several people ________

12. I have known a person who died in an accident.  
    Not to my knowledge ________  
    One person ________  
    Several people ________

13. I have known a person who was murdered.  
    Never ________  
    One person ________  
    Several people ________

14. I have known a person who died of AIDS-related disease.  
    Not to my knowledge ________  
    One person ________  
    Several people ________

15. I know a person who has tested positive for the AIDS virus.  
    Not to my knowledge ________  
    One person ________  
    Several people ________
Inventory 4

My Feelings

Select the answer that most closely represents your feelings.

1. I would feel comfortable in developing an intimate conversation with a dying person.
   Yes, agree ______  Tend to agree ______
   Tend to disagree ______  No, disagree ______
2. I would hesitate to touch someone who was dying.
   Yes, agree ______  Tend to agree ______
   Tend to disagree ______  No, disagree ______
3. My hands would tremble if I were talking to a dying person.
   Yes, agree ______  Tend to agree ______
   Tend to disagree ______  No, disagree ______
4. I would have more difficulty in talking if the dying person was about my age.
   Yes, agree ______  Tend to agree ______
   Tend to disagree ______  No, disagree ______
5. I would avoid talking about death and dying with a person who was terminally ill.
   Yes, agree ______  Tend to agree ______
   Tend to disagree ______  No, disagree ______
6. I would avoid talking with a dying person if possible.
   Yes, agree ______  Tend to agree ______
   Tend to disagree ______  No, disagree ______
7. I have had moments of anxiety in which I think of my own death.
   Never ______  Once ______  Several times ______  Often ______
8. I fear that I will die too soon.
   Yes, agree ______  Tend to agree ______
   Tend to disagree ______  No, disagree ______
9. I have no fear of death as such.
   Yes, agree ______  Tend to agree ______
   Tend to disagree ______  No, disagree ______
10. I have no fears associated with dying.
    Yes, agree ______  Tend to agree ______
    Tend to disagree ______  No, disagree ______
11. I feel good when I think about life after death.
    Yes, agree ______  Tend to agree ______
    Tend to disagree ______  No, disagree ______
12. I am anxious about the possible death of somebody I love.
    Yes, agree ______  Tend to agree ______
    Tend to disagree ______  No, disagree ______
13. I am grieving over somebody who has already died.
    Yes, agree ______  Tend to agree ______
    Tend to disagree ______  No, disagree ______
14. I have a hard time taking death seriously: It feels remote to me, and not really connected to my own life.
    Yes, agree ______  Tend to agree ______
    Tend to disagree ______  No, disagree ______
15. I have some strong, even urgent, feelings regarding death these days.
    Yes, agree ______  Tend to agree ______
    Tend to disagree ______  No, disagree ______

Note: Questions 1–6 are part of a scale introduced by Hayslip (1986–1987).
Here are the answers to Self-Inventory #1:

1. Lobster it is, at age 170. Bat, 30; cat 36; queen termite, 50 (Kirkwood, 2010). If lobstering does not satisfy your friend, suggest morphing into a bristlecone pine tree, some of which have survived for thousands of years. Perhaps you can outdo your friend as a hydra, which is (theoretically) immortal.

2. Most members of the baby boomer generation believe in ghosts and in their own acceptance into Heaven, though they judge that many other people will not make it (Chapter 13).

3. More than 2 million people die in the United States each year. The most recent data report lists 2,443,387 deaths (Chapter 3).

4. Heart disease continues to be the leading cause of death in the United States (Chapter 3).

5. A person born in the United States in 1900 had an ALE of 47 years (Chapter 3).

6. A person born in the United States today has an ALE of nearly 78 years (Chapter 3).

7. Zimbabwe, beset by AIDS, poverty, and societal disorder, has suffered a severe reduction in ALE (Chapter 3), after having previously achieved one of the highest levels ever in Africa.

8. Alzheimer’s disease has become the eighth leading cause of death in the United States, an unfortunate consequence of the aging of the population and the limited success so far in preventing or treating this condition (Chapter 3).

9. Motor vehicle accidents have long been the most common cause of fatal accidents in the United States. Among elderly people, falls are the second most common type of injury fatality (Chapter 3).

10. Seriously and terminally ill people were alone almost 19 hours a day, according to a hospital study (Chapter 4).

11. Homicide rates have been consistently the highest in Southern states (Chapter 9).

12. Yes—all states do! (Chapter 6).

13. A suicide attempt is most likely to be fatal when it is made by an elderly man (Chapter 7).

14. Fewer than 100 human bodies have been placed in cryonic suspension worldwide, and no known attempts have been made to resuscitate (Chapter 6).

15. A death or other loss experience is most often the earliest childhood memory recalled by adults (Chapter 10).

16. Oregon and, more recently, Washington (Chapter 9).

17. Relief from pain is most often the top priority for palliative care or hospice programs. Relief from other symptoms is also provided as much as possible (Chapter 5).

18. The royal physicians replaced the heart with a scarab, a carved stone that represented the dung beetle, whose mysterious work of helping to bring life back from death was regarded as intrinsic to the great cycle of being (Chapter 12).

19. About one person in four in the United States now chooses cremation. There is much variation in frequency of choosing cremation within the United States and among nations (Chapter 12).

20. G-LOC is a sudden loss of normal consciousness that is experienced by pilots under acceleration stress. Tunnel vision and bright lights are among the perceptual changes that resemble near-death experiences (Chapter 13).

21. Less than a third of the patients whose lives Kevorkian helped to end were actually terminally ill at the time (Chapter 9).

22. Scientists now believe that asteroids were responsible for the three most recent mass die-offs or extinctions (Chapter 15).

23. The Harvard criteria have been applied to determine whether a nonresponsive person should be considered brain-dead (Chapter 2).

24. Post-traumatic stress disorder is a disabling condition that is related to overwhelming experiences, such as warfare and disaster (Chapter 3).

25. Socrates (Chapter 15).

**Attitudes, Experiences, Beliefs, Feelings**

**Attitudes** refer to our action tendencies. I am ready or not ready to act. I am ready to approach or to avoid this situation. **Beliefs** refer to our worldview.
Fatalism, already mentioned, is one type of belief. Feelings provide us with qualitative information, a status report on our sense of being. I feel safe or endangered, happy or sorrowful, aroused or lethargic. Two people may hold identical beliefs and attitudes but differ greatly in their feelings. On Inventory 2, question 10, for example, these two people may answer, “Yes, agree: The availability of handguns should be more tightly controlled to reduce accidental and impulsive shootings.” However, one of these people may have relatively little feeling attached to this view. Perhaps this person thinks that it is risky to have a lot of handguns around on general principles. The other person might be the widow of a physician who was shot to death by an emotionally disturbed person who did not even know him. Her feelings could hardly be more intense. (This is a real person, the former owner of a home my wife and I purchased. Incredible as it may seem, the young widow herself became the recipient of death threats because she spoke up in favor of gun control.)

Personal experience influences our attitudes, beliefs, and feelings. For example, people who have had near-death experiences while in a life-threatening situation often develop a different perspective on life and death (Chapter 14). A paramedic who has responded to a thousand motor vehicle accidents is likely to have a stronger attitude and more intense feelings when noticing children without seat belts in a car. A person who has never suffered the death of a loved one may be more impatient with a bereaved colleague who does not seem to “snap back” right away.

*There is a profound experiential difference between people who have had a personally significant death and those for whom death has remained a distant topic, or even just a word.* Death stopped being just a word for a graduate student of social work when both her parents were killed in an automobile accident. She could not go on with her own life until she fully realized their deaths as well as her own mortality. “Before all this happened, it was just a word to me, death. I could hear death. I could say death. Really, though, it was just a word. Now it’s like something under my own skin, if you know what I mean.” Simply knowing intellectually that people die was not enough; she now had to connect death with life in a very personal way.

This challenge is ours as well. If we have experienced a death that “got” to us—whether the death of a person or an animal companion—then we are also more likely to realize what other people have been going through. This is one of the most powerful dynamics at work in community support groups. Organizations such as Compassionate Friends and Widow-to-Widow provide emotional support for bereaved persons from those who have already experienced the sorrow and stress of loss. New support groups continue to be formed to help people with specific types of death-related stress (for parents whose child has been killed by a drunk driver or for persons with AIDS). However, there are limits to the value of experience. Just because a person has had a particular kind of loss experience does not necessarily enhance his or her ability to support others. Furthermore, some people have proven helpful to the dying, the grieving, and the suicidal even if they have not had very similar experiences in their lives. The basic point to consider is whether at this time in your life you are someone who has experienced death in an undeniably personal way, or whether you still have something of an outsider’s perspective.

Some people have an inner relationship with death that goes beyond basic realization. The sense of being dominated or haunted by death can emerge from one critical experience or from a cluster of experiences. Perhaps you have mourned the deaths of so many people that you could not even list them in the space provided. Perhaps several people died unexpectedly at the same time. Perhaps you are still responding strongly to the death of one person who had been at the center of your life. The question of whether your life is being highly influenced by death-related experiences cannot be answered by examining a simple list. We would need to appreciate what these people meant to you, and what lingers in your mind regarding the deaths themselves, the funeral, and the memorialization process. Furthermore, we would need to examine your own involvement in the situation. Perhaps you have a vivid memory of your last visits with a person who was a very important part of your...
life. On the other hand, perhaps you were thousands of miles away when this person died and had no opportunity to be with your loved one. We may be much influenced by how a person has died as well as by the fact of death itself. A death by suicide, for example, has often been considered tainted, resulting in additional stress and social isolation for the bereaved family.

How Does State of Mind Affect Death-Related Behavior?

Much remains to be learned about the link between what goes on in our minds and how we actually behave in death-related situations. Here are a few studies that have addressed some of the questions:

- **The living will: why most of the living won’t.** The document known as the *living will* (Chapter 6) has been available since 1968. Although this document was designed to meet the growing public interest in controlling end-of-life decisions, most people did not choose to use it. Why? VandeCreek and Frankowski (1996) found that most people had not thought much about their own deaths and also believed that their last days were a long way off. The authors conclude that “completing living wills connotes personal death, and this appears to be a substantial barrier to completing the document” (1996, p. 80). Over the past few years there has been an increase in the number of people signing an advance health care directive (a successor to the living will) because this option is now part of established hospital policy—but many hospital personnel still have not gotten around to completing their own document because, well, they’d rather not think about it. Ask your favorite health care provider if he or she has completed a living will or other advance directive: it could be an interesting conversation.

- **Should I sign an organ donation card?** All states, as well as the District of Columbia, have enacted some version of the *Uniform Anatomical Gift Act* (Chapter 6). Despite the widespread availability of the organ donation option in association with the driver’s license, relatively few people sign and carry organ donor cards (Lock, 2002). Personal attitudes play a major role in this decision. Nondonors tend to be more anxious about death and to have the specific fear of being declared dead prematurely (Robbins, 1990). Additionally, people who think of themselves as effective and self-reliant are more likely to sign the donation cards. The decision to donate organs to save another person’s life seems closely related to the individual’s general attitude and personal fears and anxieties.

- **Stepping off the curb.**

  Is there a relationship between state of mind and risk-taking behavior in everyday life? Laura Briscoe and I (1975) observed 125 people as they crossed a busy street between the Detroit Art Institute and Wayne State University. There were equal numbers of

  “Briar Rose” (aka Sleeping Beauty) is only a kiss away from waking to Prince Charming’s love, and living happily ever after. Fantasy to the rescue when we don’t feel up to facing reality!
street crossers in five risk categories. People classified as Type A, the safest pedestrians, stood at the curb until the light changed in their favor, scanned traffic in both directions, entered the crosswalk, moved briskly across the street, and checked out traffic from the opposite direction lanes before reaching the halfway point. At the opposite extreme were Type E pedestrians who crossed in the middle of the block, stepped out from between parked cars with the traffic lights against them, and did not look at traffic in either direction (miraculously, all 25 in this study did survive their crossings). All street crossers were interviewed when they reached the other side. The observed street-crossing behavior was closely related to their general attitudes toward risk taking. For example, the high-risk pedestrians also classified themselves as high-risk drivers, and judged that they put their lives in jeopardy about 16 percent of the time in an average week, as compared with only 2 percent for Type A crossers. The Type E crossers were four times more likely than the Type A crossers to have contemplated or attempted suicide. They also reported a higher level of frustration with life. Within the limits of this study, it was clear that people’s general attitudes and feelings can be expressed in behavior choices that either increase or decrease the probability of death.

- In God they trust.

Cardiovascular surgery has come a long way in recent years. Many distressing symptoms have been relieved, many lives extended. Nevertheless, the recovery and rehabilitation process is effortful and sometimes punctuated by medical complications or episodes of discouragement. A thought-provoking study (Ai et al., 2007) followed patients through their postoperative period and found that those with “positive religious coping styles” experienced less pain and distress. These people were secure in their faith, trusting in a higher and benevolent power. They were also able to draw on social support from other people who shared their faith and helped to sustain their hope. Other studies have also hinted at improved health outcomes, including reduced mortality, for people with secure religious faith and peer support. Doubt and conflict in religious belief seems to have a negative effect on health outcomes, although more research is needed to firmly establish these findings.

**MAN IS MORTAL: BUT WHAT DOES THAT HAVE TO DO WITH ME?**

Our attitudes toward life and death are challenged when a person close to us dies. In *The Death of Ivan Ilych*, Leo Tolstoy provides an insightful portrait of the confusions and urgencies that can afflict everybody in the situation. Consider just one passage from a novel that has lost none of its pertinence and power over the last century:

*The thought of the sufferings of the man he had known so intimately, first as a schoolmate, and later as a grown-up colleague, suddenly struck Peter Ivanovich with horror . . . “Three days of frightful suffering, then death! Why, that might suddenly, at any moment, happen to me,” he thought, and for a moment felt terrified. But— he himself did not know how—the customary reflection at once occurred to him, that this had happened to Ivan Ilych and not to him. . . . After which reflection Peter Ivanovich felt reassured, and began to ask with interest about the details of Ivan Ilych’s death, as though death were an accident natural to Ivan Ilych, but certainly not to himself (pp. 101–102).*

Peter Ivanovich knows that we are all called mortals for a good reason. Yet he is playing a desperate game of evasion. Consider some of the elements in Peter Ivanovich’s response:

1. He already knows of Ivan Ilych’s death, but it is only on viewing the corpse that the realization of death strikes him. There is a powerful difference between intellectual knowledge and emotional realization. For one panicked moment, Peter feels that he himself is vulnerable. How could that be?
2. Peter Ivanovich immediately becomes concerned for Peter Ivanovich. His feelings do not center on the man who has lost his life or the woman who has lost her husband.
3. Yet he cannot admit that his outer line of defenses has been penetrated. He is supposed to show concern for others, not let them see his own distress. Furthermore, he hopes to leave this house of death with the confidence that death has been left safely behind.

4. Peter Ivanovich’s basic strategy here is to differentiate himself from Ivan Ilych. Yes, some people really do die, but not people like himself. The proof was in the fact that Peter was the vertical and mobile man while Ivan (that luckless, inferior specimen) was horizontal and immobile. We witness Peter Ivanovich, then, stretching and tormenting his logic in the hope of arriving at an anxiety-reducing conclusion.

5. Once Peter Ivanovich has quelled his momentary panic, he is able to discuss Ivan Ilych’s death. Even so, he is more interested in factual details than in feelings and meanings. He has started to rebuild the barriers between himself and death. Whatever he learns about how his friend died will strengthen this barrier: all that was true of Ivan obviously is not applicable to him.

These evasive strategies, and others, are not confined to the pages of a Russian novel. You might see them in operation when people in your life are confronted by what researchers today refer to as mortality salience. How will you deal with these situations?

ANXIETY, DENIAL, AND ACCEPTANCE: THREE CORE CONCEPTS

Three concepts that are central to understanding death attitudes are interwoven through this excerpt from Tolstoy’s masterpiece. Peter Ivanovich felt tense, distressed, unwell, and apprehensive. Death anxiety is the term most often applied to such
responses. Anxiety is a condition that seeks its own relief. To reduce the painful tension, a person might try many different actions—taking drugs or alcohol, for example, or fleeing from the situation. One form of avoiding death anxiety has received most of the attention from counselors and researchers: denial. This is a response that rejects certain key features of reality in the attempt to avoid or reduce anxiety. Peter Ivanovich denies the basic fact that he is as mortal as Ivan Ilych in order to distance himself from the death.

Many writers have urged that we should accept death. However, it is not always clear what they mean by acceptance: How does this response differ from resignation or depression? Precisely what should we accept—and on whose authority? And what is it that makes acceptance the most desirable response? Does a “good death” (Chapter 15) require acceptance? In Tolstoy’s novel, Ivan Ilych eventually does achieve a sense of acceptance, but Peter Ivanovich seems to be as self-deceived and befuddled as ever.

Anxiety, denial, and acceptance are not the only death attitudes that we encounter, although most research has concentrated on these concepts. People often experience depression and a sense of loss when death is near. Although sorrow and anxiety are both distressing states of being, neither can be reduced to the other, although both can be co-experienced (Kastenbaum & Heflick, in press). Sorrow is oriented toward the past, anxiety toward the future. Furthermore, neuroscientists (Izard, 2009; Mobbs et al., 2007) are finding that strong emotional states have differential pathways of operation. Still another strategy is to identify with death: Some people attempt to reduce their own death anxieties by joining forces with death and killing others, whether in reality or in games and fantasies. How much harm have people done to each other when they have tried to control their own anxiety by becoming instruments of death?

acquaint ourselves with the theories and their implications.

Self-report questionnaires are widely used in studies of death anxiety. Self-report instruments have the advantage of brevity, convenience, and simple quantitative results. There are limitations to what we can learn from them, however (Kastenbaum, 2000b):

1. Low scores on death anxiety scales are difficult to interpret. Do they mean low anxiety or high denial?
2. How high is high anxiety, and what is a “normal” level? Little has been learned about the level of death anxiety that is most adaptive in various situations because little information is acquired about how the questionnaire responses relate to real life behavior.
3. Respondents often are selected opportunistically. College students continue to be over-represented, and members of ethnic and racial minorities continue to be underrepresented.
4. The typical study is a one-shot affair. How the same respondents might express their attitudes at another time or in another situation is seldom explored.

Despite these limitations, some findings have been obtained repeatedly and are worth our attention. Death anxiety research has also become somewhat more sophisticated in recent years.

### Major Findings from Self-Reports of Death Anxiety

Several patterns have emerged from self-report studies of death anxiety.

**How Much Do We Fear Death?**

Self-report studies consistently find a low to moderate level of death anxiety. Should we take these results at face value? Or should we suspect that most people are trying to convince themselves and others that death holds no terror? However we interpret the results, it appears that most people do not consider themselves to be very anxious about death as they go about their everyday lives. I am inclined to believe that the self-report instruments
measure death anxiety only when the scores are very high: when the respondent is in a genuine state of alarm—and that seldom is the situation when the questionnaire is presented.

The few studies that have used laboratory experiments find that people could be cool, calm, and collected on the verbal level while at the same time experiencing a strong emotional response on the neurophysiological level (e.g., Feifel & Branscomb, 1973). Most often, though, we can only speculate about what the respondents were feeling when they were providing their moderate replies.

Are There Gender Differences in Death Anxiety?

Women tend to have higher death anxiety scores on self-report scales. This pattern is confirmed by a survey of studies conducted in 15 nations (Lester et al., 2006–2007). Does this mean that women tend to be “too” anxious? Probably not. Women are more comfortable than men in dealing openly with their thoughts and feelings on many emotionally intense subjects, not only on those that are death-related.

Over the years, I have observed that women almost always outnumber men decisively in seminars and workshops that deal with dying, death, and grief. I have met many more women than men in hospice and other care-giving situations as well (also see Chapter 5). If this is anxiety, perhaps we should be grateful for it, since relatively few “low death anxiety” men have responded to these challenges. In any event, research findings reveal a gender difference, but do not demonstrate that women are “too” anxious. Most nurses reported a higher level of death anxiety than the general population, yet they also accepted death as an integral part of life. Furthermore, some of the anxiety could be attributed to their limited training in caring for people with life-threatening or terminal conditions (Brisley & Wood, 2004). Level of death anxiety tells us something, but not everything, about the way a person interprets and responds to death-related situations.

Are There Age Differences in Death Anxiety?

Do we become more anxious as the years pass and the distance from death decreases? If so, then elderly adults might be expected to express a higher level of death anxiety. Not so. Studies show either no age differences or somewhat lower death anxiety for elders. Having seen and learned much from life, many people have come to terms with death as they move through their later years. The fear of becoming helpless and dependent on others may increase, but with death itself regarded as a natural ending to their lives. Elderly participants in a cardiac fitness program were totally aware of their continuing risk, but had found their own individual ways to experience a meaningful life without the sharp edge of death anxiety (Kastenbaum, 2010).

Episodes of intense death anxiety in elderly people often are related to relationship loss, increased health concerns, or uncertainties and also often can be relieved when the person is helped to feel safe again (Kastenbaum, 2000a). There is still another side to death anxiety in the later adult years: Some people experience so much distress from bereavement, social isolation, financial concern, and physical ailments that they feel ready to have their lives come to an end (Kastenbaum, 2009). This attitude is also reflected in the high completed suicide rates for elderly white men. Low death anxiety might then be related to dissatisfaction with the quality and prospects of life.

Death anxiety tends to be relatively high in adolescence and early adulthood (Twelker, 2004). The younger respondents also had more specific worries about dying before they could do everything they wanted to do, dying alone, not being remembered, and what to expect after death. It is possible that such concerns are moderated as one’s life becomes more settled and predictable. On the other hand, it is also possible that death anxiety goes underground through much of the adult life course, not so much overcome as sent back to the closet. Death anxiety is apt to rise again in later middle age, perhaps occasioned by the death of friends and family and signs of one’s own aging. After this rise, there is a decline to a new low in death anxiety for people in their 70s.

A study by Russac et al. (2007) gives us something else to think about. Death anxiety peaked at around age 20 for both men and women. It was also found that women—but not men—experienced a secondary peak in death anxiety as they entered their fifties. Death anxiety decreases for women as they enter their sixties, and continues relatively low for men. Why? The researchers
suggest that for women the age 50 spike is related to the end of their reproductive careers and therefore as a depressing reminder that they are growing older. They also note that the peak of death anxiety occurs at the same time that men and women reach the height of their reproductive capabilities. These are the researchers’ speculations. What do you think?

Here Come the Boomers

Most of the studies reviewed here are cross-sectional. In the Russac et al. study, for example, they were not able to wait for 20-year-old respondents to become 50 or 80 years old. It is probable, that there are generational as well as age differences at work. The baby boomer generation is a case in point. The term has usually been applied to people in the United States and the United Kingdom who were born between 1946 and 1964. Experts, however, see two population waves with significantly different cultural experiences (e.g., Gillon, 2004). Those born soon after the end of World War II are the true boomers because there are so many of them, the product of a spike in the birthrate (roughly, 1945–1955). They became the first television-from-the-cradle and rock-and-roll generations and came of age during the Vietnam War era, with its tensions and dissensions. By the mid-1960s, the population increase had subsided, coincident with the newly available birth control pills.

Babies no more, boomers are becoming eligible for Social Security. Many have earned the right to be called the sandwich generation because they have had the challenge of caring for their long-lived parents as well as their children. Aging is not popular with this active and achieving generation. They are not the first generation with the preference to stay young and live forever (Grollman, 2000), but perhaps the most dynamic in trying to accomplish this feat.

Boomers are falling into the many nets laid about by researchers. Benton et al. (2007) have found a close connection between aging anxiety and existential death anxiety (see also below). Retirement can reduce social status and amputate part of one’s identity. Other losses include the death of family members and friends and physical changes that the mirror impudently reports. There will be more research and more insights from the boomers themselves, but it is clear that belonging to a particular generation influences our view of death as well as our style of life.

Is Death Anxiety Related to Mental Health and Illness?

Death anxiety that is high enough to be disabling may warrant the attention of professional caregivers. Generally, self-reported death anxiety is higher in people with diagnosed psychiatric conditions. Death anxiety can rush to the surface when a person’s ego defenses are weakened and can no longer inhibit the impulses, fears, and fantasies that are ordinarily suppressed. However, death concern is not limited to people who are emotionally disturbed. For example, it is not unusual to experience an upsurge of death anxiety when we realize how close we have come to being killed in a motor vehicle accident. The sudden, unexpected death of another person can have a similar effect. Situations in which people feel alone and unprotected can also arouse a passing sense of separation anxiety, which often is indistinguishable from death anxiety.

There are reasons to be both anxious about death and to keep our anxiety within bounds. People with a sound mental health status have learned to avoid the extremes of too much anxiety and too heavy a reliance on defenses against anxiety. It has also been found that people with a knack for regulating their thoughts in general are less likely to have anxious and defensive responses to death-related situations (Gailliot et al., 2006).

Does Religious Belief Lower or Raise Death Anxiety?

The influence of religion in death anxiety has been a subject of controversy for many years. Bronislaw Malinowski (1948), a pioneering anthropologist, concluded that religion has the basic function of reducing the individual’s intense fear of death. A fellow anthropologist, A. R. Radcliffe-Brown (1952) came to just the opposite conclusion: Religion gives rise to fear of evil spirits, punishment, torment, and hell. Both sets of observations were based primarily on an outsider’s observations of preliterate societies, and leave untouched the question of whether or not religion serves the same function in societies at a higher level of general development.
People who firmly believe or firmly disbelieve in religion and an afterlife report less anxiety than those with doubts or “moderate belief.”

Religion seems to enter into our death orientations in a complex manner. From a practical perspective, we would probably be more effective by learning how religion and death are associated for a particular person or family. We would also become aware of the many ways in which people in the United States construct distinctive religious ideas and practices from a variety of sources instead of accepting one traditional view.

“High anxiety” has two meanings: fear of heights and a general state of elevated apprehension and dread. This steel worker 750 feet above New York City’s famous Broadway district seems well equipped, mentally and equipment-wise to cope with at least the first type of high anxiety.

There are substantial differences in religious belief and practices. In many tribal societies, death is believed to be followed by a life similar to the one that has just been concluded (Chapter 13). There may be anxiety about the journey through death to the next life (Kastenbaum, 2004), but the outcome is neither annihilation nor some frightening new state of being. By contrast, spirit possession is a major component in some religions, so interactions between the living and the dead are vital concerns. Fear of the dead may be more intense than fear of death (Frazer (1933/1966)). People in one society may fear eternal damnation, while in another there might be an intense taboo against contact with a dead body.

A longitudinal study in the United States (Wink & Scott, 2005) found no support for the assumption that highly religious people would report the lowest level of death anxiety in their later adult years. Strong religious belief did not provide an effective buffer against fear of dying and death.

People who firmly believe or firmly disbelieve in religion and an afterlife report less anxiety than those with doubts or “moderate belief.”

Religion seems to enter into our death orientations in a complex manner. From a practical perspective, we would probably be more effective by learning how religion and death are associated for a particular person or family. We would also become aware of the many ways in which people in the United States construct distinctive religious ideas and practices from a variety of sources instead of accepting one traditional view.

Situational Death Anxiety

The apprehension and restlessness we carry around with us in everyday life is sometimes called trait anxiety. Some of us are more “antsy” than others. However, there are also situations that tend to make most people more anxious. We are gradually
learning more about situational factors in death anxiety (Kastenbaum, 2009).

Transitional situations often lead to a spike in death anxiety. A list of transitional situations might well begin with separation, divorce, and other types of relationship loss. Even the exercise of imagining separation from a relationship partner can lead to more death-related thoughts (Mikulincer, Florian, Birnbaum, & Malishkevich, 2002). Feeling abandoned increases our sense of vulnerability, which, on the emotional map, is not far from fear of mortality. Heightened death anxiety might pervade society during periods of financial distress, violent episodes, family separation because of military action, and whatever else can shake a society’s confidence in its values and competence.

Exposure to death might seem to be a situation that will increase our anxiety. Often, though, we seal off such episodes before they can penetrate awareness. Most of us have strategies for limiting the impact of an exposure to death. For example, it’s too bad about the neighbor who died of pulmonary disease, but we don’t smoke the same brand of cigarettes, so, no worry. However, a delayed stress reaction often arises some time after the brush with death. We might have nightmares or sudden moments of distress without quite knowing why. Often, this is the death-related experience getting through to us. A severe response of this type is now recognized as post-traumatic stress disorder (PTSD).

The death of another person sometimes becomes the wake-up call that reminds us of our own mortality. Often it is the death of a parent, or some other significant person in our life, whom we had let ourselves assume always would be there. “When my father died, it was like Death had me next on his list,” a colleague confided. The “pecking order of death” phenomenon is perhaps more common than realized.

Life-threatening illness can persist for weeks, months, even years. During this extended period, people are likely to have a variety of thoughts and feelings about their situations. The first jolt often occurs when people discover that illnesses are life-threatening or terminal. Suicidal thoughts might occur at this time. A second period of anxiety arousal may occur later, accompanied by depression, as a result of continuing physical decline and fatigue. At this point the anxiety may be focused more on the fear of abandonment and suffering, rather than on death itself. Other moments of anxiety can develop when a new complication arises or a new treatment is proposed. Nevertheless, drawing upon their own resources and support from family and friends, many people can cope with a life-threatening situation without experiencing intense anxiety. Effective communication, symptom relief, and a positive worldview contribute much to anxiety reduction.

THEORETICAL PERSPECTIVES ON DEATH ANXIETY

There are two classic theories of death anxiety, and they could hardly be more opposed to each other. Which one seems more convincing to you?

Early Psychoanalytic Theory

Sigmund Freud reasoned that we could not really be anxious about death:

“Our own death is indeed quite unimaginable, and whenever we make the attempt to imagine it we can perceive that we really survive as spectators... at bottom nobody believes in his own death, or to put the same thing in a different way, in the unconscious everyone of us is convinced of his own immortality (1913/1953, p. 304).

Our “unconscious system” does not respond to the passage of time, so the end of personal time through death would just not register. Again, on the unconscious level, we do not have the concept of negation, so there is no death to cancel out life. Furthermore, we have not actually experienced death. When we express death anxiety it is only a cover story. For many years psychoanalysts spoke of thanatophobia as the expressed fear of death that serves as a disguise for the actual source of discomfort. Their mission was to dig, dig, dig until unearthing the underlying fear.

What, then, do we fear, if it is not death? Freud’s answer was not exactly his finest moment: thanatophobia derives from the castration anxiety experienced during our normally abnormal psychosexual development. Boy loves mother and fears that father will cut him down to size. Freud’s description of the Oedipus complex has enjoyed
a flourishing career in fiction, drama, and popular psychology, but not so much in the behavioral and social sciences. If people have not been dead before, it is also the case that very few have been castrated, so, to use Freud’s own reasoning, how could they be afraid of this calamity? Castration anxiety is even more a stretch when applied to females. The assertion that girls feel they have already been castrated because they don’t have what boys have deserves all the ridicule it has reaped.

However, Freud’s castration–death anxiety theory could be interpreted more generously. He admitted to making up little stories as a way of getting new ideas across. Freud might have been suggesting that the source of death anxiety is the fear of losing value, love, and security by being less than a whole person. People who are losing their sense of security in the world might experience this generalized confusion and fear as death anxiety. This is an interpretation that does ring true with clinical observations. People who feel they cannot control the frightening things that are happening (or might happen) to them often do experience an upsurge in death anxiety (Kastenbaum, 2000a).

The bottom line for the early psychoanalytic position is clear, even if the explanation is open to question: Way down deep, we just cannot comprehend our own annihilation; therefore, our anxieties can only seem to be about death.

The Existential Challenge

The existential position takes the opposite approach. Awareness of our mortality is the basic source of anxiety. Our fears take many forms but can be traced back to our sense of vulnerability to death. Ernest Becker (1973) believed that people with schizophrenia suffer because they do not have enough insulation from the fear of death. The rest of us might share the schizophrenic’s panic if our society did not work so hard to protect us from the ontological confrontation—the awareness that we are always and acutely mortal.

Society’s primary function is to help us to maintain the illusion of continuity—that life will just go on and on. This is accomplished by a belief system supported by rituals and symbols that produce a sense of coherence, predictability, and meaning. It is a comforting illusion in which most of us are willing to participate. We feel that we are part of something bigger, more powerful, and more durable than ourselves. Monumental edifices contribute to the illusion of invulnerability. The destruction of the World Trade Center towers would be thought to have had a profound, unsettling effect on all of us, allowing our death anxiety to break through the cracks in society’s protective posture.

Becker’s writings stimulated the development of terror management theory (Tomer, 2002), which suggests that we try to control our death anxiety by socially sanctioned evasions and fantasies. There are two facets to this strategy: Keep up our own self-esteem, and become an integral part of an entity greater than ourselves. Religious belief and practice can go a long way to meet this need. However, faith can be undermined by disasters that overtake society (e.g., virulent epidemics, famine) as well as by radically changing circumstances (e.g., the rise of science and technology). Fortunately, we have an alternative strategy available: let’s feel so confident and competent that we can master death threats through our own strengths. We are doubly protected when we feel strong personally in a strong society. If one of these foundations is shaken, then it is time to make the most of the other.

A productive series of studies has refined and supported terror management theory (Pyszczynski et al., 2004 for a review of the pioneering research). Helping to strengthen people’s self-esteem seems to decrease death anxiety. Other studies have found that people tend to become more defensive when reminded of their mortality and then try to control their anxiety by focusing on the worldviews from which they draw comfort (Schmeichel & Martens, 2005). Cultural worldviews buffer us from fearful preoccupation with our own impermanence, vulnerability, and mortality (p. 658).

Terror management theory has shown the flexibility to modify its working hypotheses as the results come in. There are several concerns, however (Kastenbaum, 2009). Are these studies actually tapping into the depths of existential terror—or just arousing a little discomfort in the usual suspects (college students) who are responding to the research cues within the relatively safe academic environment? It seems a long way from the anguish and despair of mortal terror to the controlled
setting and circumstances of the research. Another concern is the assumption that society is devoted 100 percent to the amelioration of death anxiety. This proposition has been contradicted repeatedly by societies that have deliberately pumped up death anxiety, the better to incite the population into violence against a supposed demonic enemy, or for other power-control purpose. Terror management can be a tool either to raise or lower anxiety level.

Recent findings open a new chapter in understanding the relationship between terror and other responses to the prospect of personal death. Terror management studies have routinely asked their college student respondents to describe their thoughts and feelings at the time of their death. This probe was intended to arouse mortal terror, but the brief essays themselves were not analyzed. Working with more than 200 such narratives, Kastenbaum & Heflick (2010–2011) discovered a broad range of responses in addition to or instead of anxiety. Of these, none were more intense and pervasive than sorrow. And many of the sorrow responses focused on the feelings of family and friends, rather than self, e.g.:

“I’m not afraid of death. If I was to die, then it was my time to go. I would never commit suicide because that’s just selfish. So absolutely no feelings about me dying. I’d miss everyone and feel sorry for the people who have to live with me gone.”

“The first thing that comes to mind is the feelings of my friends & families. Honestly the thought of death doesn’t scare me but knowing how hard it would be on my family scares me.”

“Sorrow. I would most of all feel terrible for my family & friends. That would hurt the most.”

The insights pursued by terror management theory will be more useful when integrated into a broader understanding of how we respond to death threats. Even within the limits of the brief narratives, many respondents were already testing out and developing more effective ways of relating to their mortality.

**Edge Theory**

Both the Freudian and existential positions make basic assumptions that seem beyond empirical investigation. How can we know with any degree of certainty what the “unconscious system” knows or does not know? How can we prove all anxieties have their roots in the fear of nonbeing? Why is it that most people do not report a high and disabling level of death anxiety, but also do not completely deny such feelings? The typical report of a moderate level of death anxiety supports neither the psychoanalytic nor the existential positions. There are many useful observations in the writings of insightful psychoanalysts and existentialists, but their propositions remain open to question.

There is room for other theories as well. I have proposed an edge theory that distinguishes between our everyday low level of death anxiety and the vigilant state that is aroused when we encounter danger (Kastenbaum, 2000b). The experience of death anxiety is the self-awareness side of a complex organismic response to danger. Anxiety has its survival function; it is not always something to be sedated or rebuked. We feel ourselves to be at the very edge of the safe and known, perhaps just one step away from disaster. Edge theory emphasizes our survival and adaptation functions—the ability
to detect sources of potential harm both through built-in biomechanisms and through the development of cognitive and social skills. There is no need to be anxious all the time; in fact, this would be an exhausting and ineffective way to function. However, there are dangerous situations in this world, and we might save our own or somebody else’s life by moving quickly to an emergency footing when confronted by a significant threat.

The first responders to the World Trade Center attacks showed a remarkable blend of alarm and control. They neither ignored nor faltered in the face of an overwhelming threat to life. Most of us do not have their training and experience to cope with emergent disasters, but we can hone our own danger response systems to provide enough anxiety to provoke our attention but also exercise enough control and balance to see the situation through.

Whatever reduces our everyday stress level is likely to improve our ability to detect and respond to actual threats. A relaxed attitude is also more likely to free us to discover opportunities for adventure, creativity, and more rewarding relationships. Despite their differences, all the theories mentioned here agree that feeling at peace with ourselves and secure—but not overconfident—in our abilities can reduce death anxiety without compromising our ability to cope with threats.

**ACCEPTING AND DENYING DEATH**

What about death-related feelings, attitudes, and actions within our everyday lives?

*"Sitting in his favorite chair after dinner, the man suddenly went pale. He felt severe pain in his chest, and had to gasp for breath. His wife was by his side in a moment. ‘What’s wrong? Oh! I’ll get the doctor, the hospital.’ The man struggled for control and waved his hand feebly in a dismissive gesture. ‘It’s nothing—really. . . . I’ll just lie down till it goes away.’*"

This scene, with variations, has become familiar to health care professionals. The concept of denial comes to mind when a person has delayed seeking diagnosis and treatment for a life-threatening condition. Accepting the reality of serious illness can increase anxiety but also increase the chances of survival. There is often a subtle interplay between our impulses to accept and deny death-related events.

**Is It Really Denial?**

“Acceptance” and “denial” are used in a variety of ways. Their meanings can become blurred and misleading. From a psychiatric standpoint, denial is regarded as a primitive defense. Denial rejects the existence of threat. This strategy may be effective for a short period of time and for situations in which there is an overwhelming threat. However, denial becomes increasingly ineffective when prolonged or used repeatedly. We do not survive long in this world when we ignore crucial aspects of reality. Denial is often associated with a psychotic reaction, or as any person’s first response to crisis and catastrophe.

Denial in this fundamental sense is not usually part of our everyday repertoire of coping strategies. But we do engage in a number of behaviors that have some resemblance to denial. “Oh, she’s just in denial!” people say, when the individual in question has only engaged in a strategic evasive action. By using this term as a buzzword, we often come to glib and premature conclusions. People may be coping with difficult situations in the most resourceful ways they can discover at the moment. This will become clearer as we distinguish among several processes, all of which can be mistaken for denial (Box 1-1):

1. **Selective attention.** Imagine a situation in which many stimuli and events are competing for our attention. We cannot give equal attention to everything that is going on. This often happens with children. The individual is not “in denial,” but simply directing his or her attention to whatever seems most novel or salient in the immediate situation.

2. **Selective response.** A person exhibiting this behavior may have judged that this is not the time or place to express personal thoughts and feelings about death. The person may think, I’m not going to open up to this young doctor who looks more scared than I am, or, there is nothing effective I can do about the situation at this moment, so I will talk about something else, or just keep quiet. The person may also decide there is something very important
I must accomplish while I still have the opportunity, and it must take priority. Therefore, the person who may seem to be denying death might actually be working very hard at completing tasks in full awareness that time is running out.

3. **Compartmentalizing.** The individual is aware of being in a life-threatening situation, and is responding to some of its aspects. But something is missing: the connection, the drawing of the line of realization between the scattered dots of information. For example, the person may know that the prognosis is poor, discuss the situation rationally, and cooperate with treatment, and yet may make future plans that involve travel or vigorous exercise, as if expecting to be around and in good health for years to come. In compartmentalizing, much of the dying and death reality is acknowledged, but the person stops just short of realizing the situation. All the pieces are there, but the individual resists putting them together to complete the whole picture.

4. **Deception.** People sometimes deliberately give false information to others. This can occur during the turmoil of a death-related situation. When people are telling each other lies (for whatever purpose), it makes sense to acknowledge this deceptive action for what it is and not confuse the issue with the buzzword denial.

5. **Resistance.** People who are in stressful situations may recognize their danger but decide not to “give in” to it. Some people in war-torn Bosnia, for example, decided to go about their daily rounds of shopping and visiting, although these activities increased their vulnerability to snipers. They were not denying the death risk. Rather, they had resolved to defy the war and keep their spirits up by not becoming prisoners to fear. A person who has been diagnosed with an incurable medical condition might become angry instead of anxious. (“I’ll show them!”) And sometimes, as we all know, a person with an apparently terminal condition does recover. There is a significant difference between the person who cannot accept the reality of his or her jeopardy and the person who comprehends the reality but decides to fight for life as long as possible.

6. **Denial (the real thing).** This is the basic defensive process that was defined earlier. The individual is not just selecting among possible perceptions and responses, limiting the logical connections between one phenomenon and the other, or engaging in conscious deception. Rather, the self appears to be totally organized
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among the deniers. The reverse also happens. Consider a woman who grew up learning how to deny death, especially the deeper emotions that it evokes. Suppose she becomes a patient in a health care establishment where the staff relentlessly practices its belief that we must be open and sharing with each other. Here, then, is the denier confronted by the accepters. It is useful to be aware of the forces operating in the present situation and the individual’s previous life pattern in order to understand what is taking place between the dying person and the caregiver.

Weisman has observed that a person does not usually deny everything about death to everybody. More often, a selective process is involved. We must go beyond the question, “Is this person denying death?” It is more useful to ask instead, “What aspects of dying or death are being shared with what other people, under what circumstances, and why?” The same questions could be asked about acceptance—a person might “deny” with one friend and “accept” with another. Apparent denial on the part of the patient may derive from a lack of responsive people in the environment.

Temporary denial responses can be experienced by anybody who is under extreme stress. Denial responses are often seen in the wake of overwhelming catastrophes. For example, a woman was discovered intently sweeping the floor of her home after a tornado had passed through the city; the floor was practically all that was left of her home. Another woman was so debilitated by her long illness that she could no longer take nourishment by mouth or carry out other basic activities of everyday life. She had participated actively in decisions about her impending death: cremation, a simple memorial service, gifts to her church’s youth program in lieu of flowers, and so forth. One morning, though, she astonished her visitors by showing them a set of travel brochures and her new sunglasses. She spoke of feeling so much better and was as eager as could be to take a long-delayed vacation. Two days later she was dead.

The Interpersonal Side of Acceptance and Denial

The purpose of denial, writes Weisman (1972), is not simply to avoid a danger, but to prevent the loss of a significant relationship. All of the adaptive processes that have been described here might be used, then, to help the other person feel comfortable enough to maintain a vitally needed relationship. The individual faced with death may have to struggle as much with the other person’s anxiety as with his or her own. Instead of placing the negative label of denial upon these adaptive efforts, we might instead appreciate the care and sensitivity with which they are carried out.

One person may come from an ethnic background that treats dying and death in a straightforward manner (e.g., the traditional Amish). But suppose that person becomes enmeshed with a medical establishment where death is still a taboo topic. Here is a potential death accepter trapped against recognizing death-laden reality. Such an orientation can be bizarre and may accompany a psychotic reaction. It does not have to be that extreme, however. There is also a more subtle denial process that weaves in and out of the individual’s other ways of coping.

Anxiety, Denial, and Acceptance: How Should We Respond?

Anxiety is an uncomfortable, at times almost unbearable, condition. Yet it has a function. Small doses of anxiety can alert us to danger: “Something’s wrong here, what?” Anxiety can also prepare us for action: “I’ve been on stage a thousand times and a bundle of nerves a thousand times—but that’s just how I want to feel before the curtain goes up!”

The response strategies of acceptance and denial likewise are not necessarily good or bad in themselves. We must examine the contexts in which these processes are used and the purposes they serve. An individual might be making a desperate stand against catastrophe. The person has been forced to fall back on a primitive defense process that rejects important aspects of reality. This individual needs psychological help and, quite possibly, other types of help as well.

On the other hand, the person may not be denying so much as selectively perceiving, linking, and responding to what is taking place.
The coping pattern might include evasion, but there is also method, judgment, and purpose at work. Even flashes of pure denial may contribute to overall adaptation, as when challenges come too swiftly, last too long, or are too overwhelming to meet in other ways. Later, the individual may find another way to deal with the challenge, once the first impact has been partially deflected and partially absorbed.

Consider the following set of premises:

1. Most of us have both acceptance and denial-type strategies that are available for coping with stressful situations. These strategies may operate within or outside our clear awareness, and one strategy or the other may dominate at various times.

2. States of total acceptance and total denial of death do occur, but usually in extreme circumstances: when the individual is letting go of life after achieving a sense of completion and having struggled as long as struggling seemed worthwhile, or when the individual is resisting the first onslaught of catastrophic reality. These experiences can have a profound spiritual resonance.

3. Much that is loosely called denial can be understood more adequately as adaptive processes through which the person responds selectively to various aspects of a difficult situation.

4. Our pattern of adaptation should be considered within the context of our interpersonal network. Do we interact mostly with people who share and listen, or who avoid conversations on difficult issues and are quick to pass judgment? Family, friends, and colleagues can make it either easier or more difficult to find our way through the anxiety of life-threatening situations.

5. Acceptance and denial can be evaluated only when we are in a position to understand what the person is trying to accomplish and what he or she is up against.

In the Shade of the Jambu Tree

At the start of this chapter, we made a brief visit to the exotic land of the Uttarakurus, where the magic Jambu tree grows and people live 1,000 or, perhaps, 11,000 years. Attempts to remove the sting from the prospect of death have stimulated more than beguiling legends. Influential world-views have been formed around the core issue of what should be done with death. A significant example is Taoism, a major philosophical-religious system that developed in ancient and medieval China and continues to contribute to world thought and culture. Our eyes see a diversity of forms and activities as well as a relentless process of change. It is up to our minds to comprehend what cannot be so easily perceived: the basic unity of nature. Tao (pronounced “dow”) is translated as The Way. It is the force that both moves and unites all that exists. We may be in the habit of separating mind from matter, for example, but both are in the flow of the Tao.

What we call life and what we call death are also facets of the Tao. The same reality underlies both. This sense of an affinity or communion between life and death is part of the Taoist answer to death. There is also a more activist dimension, though. Life can be prolonged by drawing upon the power of the Tao. In practical terms, this philosophy led to exercise, diet, and use of natural substances (such as herbs) that were thought to strengthen health and preserve life. Present-day fitness regimes were prefigured in Taoist philosophy and practice.

Chemistry, biology, pharmacology, metallurgy, and other sciences and technologies also were given impetus by Taoist philosophy (Gruman, 2003). Nature has secrets that might be divined by patient study and moments of inspired observation. We can live longer and better and therefore keep the simmering pot of death anxiety from boiling over. Chinese alchemy devoted much of its attention to life prolongation, and this also became one of the prime goals of alchemy when it developed in Western culture. Transforming base metals into precious metals was also an ardent pursuit, but a life free from death anxiety was the true gold standard.

Thinking of life, we are also at least implicitly thinking of death. Thinking of death, we are attracted to the idea of a life that somehow flourishes, continues, and renews despite a universe that seems to have other plans. Perhaps each of us can find our own comfort zone in which life can be enjoyed while death is given its due.
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Not thinking about death has been a failed experiment. Listening and communicating are far more helpful approaches. You monitored your own knowledge, attitudes, beliefs, and feelings about death in a series of self-inventories. These exercises provided you with a stronger base for looking at the way other people think about death and how state of mind can affect death-related behavior.

After a brief introduction to the history of death drawing largely on the work of Phillipe Aries, we reminded ourselves that our personal orientations toward death are far from simple. For example, although the survival motive is powerful, sometimes we delight in risk-taking behaviors. The dynamics of accepting and denying death were explored with the help of characters in Leo Tolstoy’s probing novel The Death of Ivan Ilych. We then looked carefully at the core concepts of anxiety, denial, and acceptance. Freudian and existential theories offer competing ideas about death anxiety and its place in our lives. A series of studies has supported terror management theory, derived from Ernst Becker’s existential approach. Cultural worldviews and personal self-esteem seem to be important buffers against the experience of intense death anxiety, but both sources of support are subject to breakdown. A recent study finds that anxiety is not always the dominant response, however, with sorrow about the anticipated grief of others often the primary concern. We respond differently when reminded of death (mortality salience), and even more so when our vulnerability to death is exposed by a threatening situation. Most people report themselves to have a low to moderate level of death anxiety, with women having somewhat higher scores.

The baby boomer generation is experiencing the challenges of aging and the prospect of death. It is probable that generational influences on the ways we negotiate life and death will become more evident from now on. We also saw that denial is a term that is often used too loosely in regards to death. Some responses that are misinterpreted as denial are better understood as selective attention, selective response, compartmentalizing, deception, or resistance. Attention was also given to the kind of interactions we have with each other in death-related situations, and some suggestions were offered. The ancient philosophical–religious system of Taoism provides an influential example of thinking about life and death as unified in the reality underlying all that exists.

REFERENCES


**GLOSSARY**

**Uniform Anatomical Gift Act** A law that permits people, upon their own deaths, to designate their bodily organs for transplantation to other people.

**Death anxiety** Emotional distress and insecurity aroused by encounters with dead bodies, grieving people, or other reminders of mortality, including one’s own thoughts.

**Denial** An extreme response in which one attempts to cope with danger or loss by ignoring important features of reality.

**Edge theory** A theoretical approach that emphasizes the survival function of death-related anxiety.

**Fatalism** The belief that future events have already been determined; therefore, one is powerless to affect the future.

**Living will** A document that instructs medical personnel on an individual’s wishes should a situation arise in which that person cannot communicate directly. Often involves the request for limiting the type of medical interventions. The living will is one of a class of documents known as advance directives (Chapter 6).

**Mortality salience** A situation that is likely to bring thoughts of death to mind. Related to ontological confrontation, but often not as threatening.

**Ontological confrontation** A situation that sharply reminds people of their personal vulnerabilities to death.

**Post-traumatic stress disorder** A delayed response to a death or other disturbing experience that has occurred under extremely stressful conditions. The traumatic event is reexperienced repeatedly, and other disturbances of feeling, thought, and behavior are also likely to occur.

**Schizophrenia** A form of mental, and perhaps biomedical, illness in which a person is out of contact with reality and emotionally alienated from others.

**Taoism** Chinese philosophical–religious system that sees life and death as linked in a fundamental reality that underlies the apparent diversity, change, and disorder of the observable world.

**Thanatophobia** Fear of death.

**Terror management theory** A theory based on the proposition that many of our sociocultural beliefs, symbols, and practices are intended to reduce our sense of vulnerability and helplessness in prospect of death.
■ ON FURTHER THOUGHT . . .

What of your generation? How would you describe the prevailing attitudes toward life and death among people of your age?

Useful Reference Books for Exploring Death-Related Topics


Scholarly and Professional Journals

Death Studies
www.tandf.co.uk

Illness, Crisis, and Loss
www.baywood.com

Mortality
www.tandf.co.uk

Omega, Journal of Death and Dying
www.baywood.com

Suicide and Life-Threatening Behavior
www.guilford.com
Is this a brilliant meteor display, or the restless dead at play? Perhaps both. “Death” is attributed to stars in the far reaches of time-space by people who are less enthusiastic about confronting mortality in their own lives.