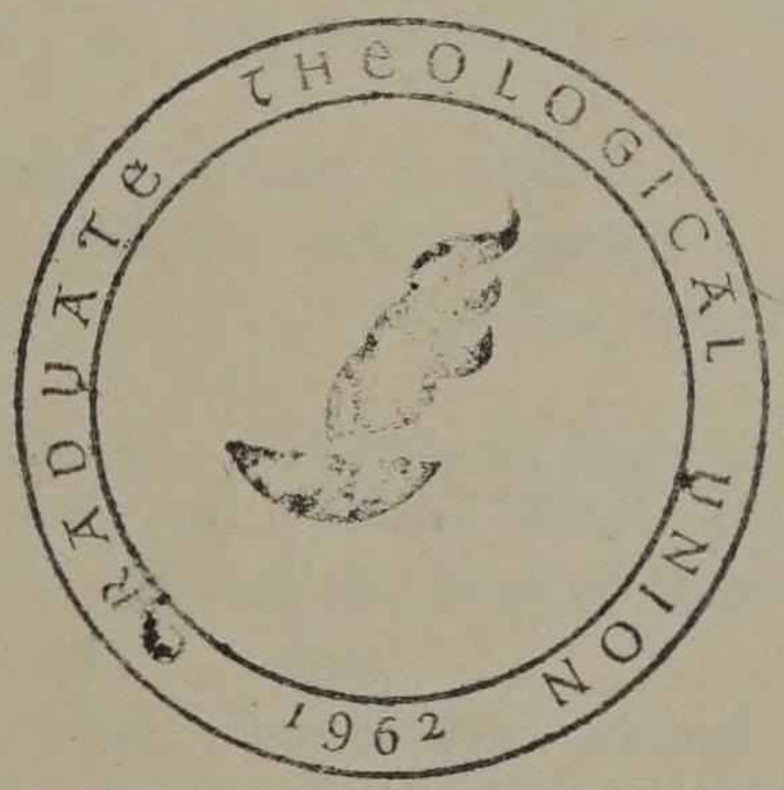
OMEGA

An International Journal for the Psychological Study of Dying,
Death, Bereavement, Suicide and Other Lethal Behaviors

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Welcome to the pages of OMEGA.

Or perhaps we should call ourselves OMEGA II, since we do have a history. In the early spring of 1966, Dr. Robert Kastenbaum and I produced and distributed about 400 copies of a purply, dittoed, awkward newsletter titled OMEGA. We wanted to provide information and stimulation for those with an academic or professional—or, in some instances, a personal—interest in death, bereavement, and time perception.

OMEGA continued through twelve quarterly issues in this fashion, with both funds and time being bootlegged from other projects. As it increased in circulation (to around 800) and in sophistication (we felt), we, as editors, began to desire something more professional. We realized that what was once a taboo topic, surrounded by anxiety and rejection, had become an almost respectable part of the academic and professional establishment. The trickle of articles and books became a stream; national publications began to quote our subscribers; universities and adult education programs used death and bereavement as topics for classes and programs. We eventually believed that interest was sufficient to merit a publication to draw together the best efforts of researchers, theoreticians, and practitioners who wished to expand knowledge and understanding of death and bereavement.

It was at this point that Robert Fulton joined with us as co-editor. And it was shortly thereafter that Greenwood Periodicals, Inc. of Westport, Connecticut, decided to include OMEGA as one of several new academic journals it would publish. We quickly agreed to extend OMEGA's boundaries to include suicide and other forms of lethal behavior. Then we suddenly found that, instead of fantasizing about how nice it would be to have a journal, we needed to work like fury to put out the first issue. (As an aside to aspiring editors: stick with the fantasizing—it's much easier.)

So began OMEGA: An international journal for the psychological study of dying, death, bereavement, suicide and other lethal behaviors. I remained as editor; Bob Fulton is now associate editor. And we are an official publication of the Center for the Study of Death, Dying, and Lethal Behavior, situated at Wayne State University, Detroit, under the directorship of Bob Kastenbaum.

All journals, when they begin, hope to offer new opportunities and innovative ideas for both authors and readers. So do we. We will try to do this by remaining open to any kind of article from any individual. Although our primary focus will be upon behavioral and psychiatric sciences and upon social and health services, we want to encourage papers from theologians, political scientists, art historians, librarians, musicologists, biochemists, police admin-

istrators, and any and all others who can add a meaningful increment to knowledge and understanding.

We are, thus interested in original research and theory, but we also intend to publish personal statements, literature reviews, blue sky speculations, and descriptions of programs. We might even publish a poem, a television script, or an essay. Our standards for acceptance will not be the academic credentials of the author, but the contribution that his writing makes. We will try to avoid any kind of restatement of familiar sentiments, no matter how sincere or well-phrased, but we will publish in a forthcoming issue an article beginning "I am going to die in 30 days . . ."

OMEGA will not be all things to all people. We expect that our audience will consist primarily of persons whose work brings them into personal or philosophic contact with the dying, the dead, and the suicidal. But if someone who has just suffered personal loss or someone who faces his own imminent death turns to our pages, we might contribute something to him as well.

One final thought. People often ask us why we selected this topic of study. The reasons are many, of course, but I would like to quote from a recent letter sent to me by an anthropologist: "I felt that we (speakers at a conference) at times verged on ministerially rubbing our audiences noses in it (death and dying). I also had moments of feeling, both of ourselves and our audience, that there was the hope that somehow this encounter might make death easier and that, in an odd sort of inversion, we were slipping into avoidance and denial by this confrontation." Thus, perhaps, we need to confront our own confrontations, not, of course with guilt or self-punishment, but with self-questioning.

Like the original OMEGA, the present OMEGA hopes to inform, stimulate, and provoke. We want you to send us your articles, your announcements, and your suggestions and complaints.

Once again, welcome to the pages of OMEGA.

Richard A. Kalish
Editor

PSYCHOTHERAPY FOR THE DYING: PRINCIPLES AND ILLUSTRATIVE CASES WITH SPECIAL REFERENCE TO THE USE OF LSD*

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It is time to introduce humanism into the American way of death. The recent sociological work of Glaser and Strauss (1965, 1968) on the sociology of death in American hospitals portrays with anguished precision the frightful manner in which the dying and death are handled. They are a very much discriminated-against group in our culture.

In America the living ignore death. This attitude prevails to the death bed, for death is ignored both by the dying and by those attending to the dying. Even when the dying person comes to the awareness of his dying, he is not allowed, much less aided, to work with the many conflicts that arise out of his impending death. Medical personnel vigilantly maintain massive denial and offer the dying little that is useful. The family of the dying, unless absolutely insistent on the physician sharing his prognosis with them, are treated with the same attitude. At best, they are given basic medical information. The physician who has difficulty with his patient's dying and/or working with the very intense emotionality elicited by impending death, protects himself by assuming the dying and the dying person's family really "do not want to know the facts;" he therefore does not divulge this information to the patient or family. The paramedical staff are essentially in the same position, having neither the skills, training, nor inclination to deal with the problems surrounding death. The result of this state of affairs is that the patient is most often left to himself to die, and the isolation imposed upon him makes it virtually impossible for him to deal with conflicts that emerge when he becomes aware he is dying.

ISSUES RAISED ON AWARENESS OF DYING

There are two basic types of issues that arise when the patient becomes aware that he is dying; one concerns his total conception of death reflected in his attitudes and beliefs, and the other concerns the nature of his relationships with his significant others. The first issue we shall call personal and the second, interpersonal.

Personal Issues

The personal issue encompasses a plethora of phenomena but centeral is the identity phenomenon. When the individual's identity is restricted to experiences emanating solely out of personal ego, the identity is, to borrow Allan Watts' phrase, a "skin encapsulated" one. When an individual with this type of identity

*This paper was read at the American Psychological Association meetings, Washington, D.C., September, 1969.

realizes he is dying, a crisis ensues and the crisis is essentially an identifying crisis. This identity crisis is no different from any other identity crisis he has experienced in his lifetime, but typically it is not recognized as such. Affective reactions of fear, panic, anxiety, anger and dependency are common. Unless the individual is permitted to explore the basis of these reactions, he does not comprehend that they are in response to the life constant: change.

> It seems obvious that the problem of the death of our physical self is a problem insofar as we identify the self with our physical body. When we do this and we see a person's dead body, then we assume that he is dead because we have identified 'him' with his body and its actions, its appearance, its smell, its sound, its color, and so on. Thus, when we see that these things are gone, we assume that he too is gone. Identifying ourselves with our bodies and others with their bodies then makes physical death a cessation of individuality and awareness. In one of the Buddhist sects, the novice must sit and watch the decomposition of the body of someone he has known well. This practice is to help cast some doubt on the assumption that body and individual being are one and the same thing. It would be difficult to go on believing that one's friend, after a couple of weeks of decomposing, was just that mess of maggots, worms and bone before one's eyes. The emphasis in Zen, of making an experience, of concreizing an abstraction, so that it becomes a felt reality, is meaningful and leads to knowing. Rather than abstractly thinking that man is more than his body, and rather than having an intellectualized concept of this possibility, as is Western man's inclination, the Zen approach has us experience it.
>
> The problem of physical death, then, has something to do with our identity and what is considered to be 'me.' When we identify ourselves with our 'skin encapsulated ego', we naturally face annihilation. When we can identify with something beyond our skin-self, death has a different face. The problem, of course, is a process of coming to know parts of ourselves that we do not already know. Or, stated differently, identifying with things that we do not now know and, therefore, have no identity with. The solution is to identify with the life process—to experience, for instance, our cellular consciousness (awareness of that fantastic neurophysiological activity) and to experience another's cellular consciousness, and on the other extreme, to experience (in Eastern religious terms) the 'void', the unmanifested energy (the absence of any thing), the source of all life (Fisher, 1969).

Interpersonal Issues

When an individual is not allowed to work out interpersonal conflicts before his death, he experiences his days of dying as burdensome, is often guilt-ridden and resentful, and suffers terrible loneliness from his isolation. As a result of his altered states of consciousness, he very often experiences new insights into his relationships and he wishes to share them with his significant others. Often these insights are laden with conflict resolution, and when he is unable to share this knowledge with his loved ones, he experiences sadness. Sometimes the individual experiences ego-free states prior to his physical demise and this experience of transcendence gives new meaning to his past personal life and his relationship with others. He develops a new perspective, as it were, of life, and this perspective typically has at its base a profound acceptance of the life constant, change. He experiences himself in a transitional state and welcomes a new state of equilibrium and consciousness. Sometimes this is interpreted specifically by the individual that his after-death consciousness will have specific characteristics. Sometimes the individual experiences himself simply as part of the life process, as being "at one", and for some that they again have touched the life source. We have found these experiences

to be very useful to the individual while he stays alive. These experiences become very pragmatic and functional.

First of all, he ceases to be concerned about his own physical demise—accepting it as a natural phenomenon of the cycling of life force. Second, this acceptance drastically alters his life style—he no longer reacts with panic, fear, pain and dependency to the changes that are occurring in him. Third, he is willing and eager to share his new knowledge with those he cares for—and often, this is a highly expanded group. He devotes his attention to the needs, anxieties and apprehension of his loved ones. He attempts to relate, talk and respond to them in ways which will enlighten them as to his state of consciousness. In current popular parlance, he attempts to "turn them on."

One of the very significant results of his having experienced a transcendental state of consciousness is his willingness to engage in the life process. No longer is death an excuse for not living. In American culture, the myth of death is in the service of denying the life process. At some level of consciousness, some of one's daily behavior is geared to a time when one does not have to engage in the life process and confront oneself. There is the myth that "someday I will die" and therefore if you just hold out long enough, you won't have to deal with basic issues such as "the condition of my humanity." The attitude is "business as usual", "nobody rock the boat" and this business of my consciousness will be over soon. An additional result of this myth is that one can get away with his destructiveness—i.e., death is a way out—I can get by with my own and other destructiveness because I will die and that will be the end of it. In western religion, most people don't consider the concepts of heaven and hell as seriously as eastern religionists take the concept of Karma. When a man experiences himself as life force and feels that the quality of his life force is vital to the human condition and trans-human consciousness, he begins to take his own destructiveness very seriously. He becomes a humanist. Now the persistent question as to whether one stays around forever in an identifiable (to himself, of course) form is perhaps unimportant. That one identifies with the human condition and craves for its perfection, i.e., of becoming human, is pragmatically useful, useful to himself and useful to those with whom he relates. That life becomes richer and fuller, with greater feeling, trusting and loving relationships for the patient and for his loved ones should certainly be sufficient for the severest of critics of aiding the patient in achieving a state of transcendence.

Achieving Transcendence

It has been my good fortune to have had the opportunity to utilize LSD in working with terminal cancer patients. LSD has been used extensively in psychotherapy with may psychopathologic types. This work continues outside of the United States, most notably in England, Czechoslovakia and Chile. Eric Kast of Chicago did the early work utilizing LSD in the management of pain in terminally ill patients.

Kast and Collins (1964) studied 50 gravely ill patients who were having difficulty in the management of pain. They compared LSD, dilauded and demerol for their analgesic effectiveness. The investigators found LSD to be

a much superior analgesic but were surprised that many of their patients did not want a second treatment. "Although the analgesic action of LSD was profound and the patients were relieved of the oppressive ideation accompanying grave illness, eight patients refused a second administration, 30 were indifferent, and 12 wished for it. An explanation for this peculiarity is difficult to conceive. It seems that the LSD experience required a great deal of psychic energy and represents hard work. This statement, which was frequent, probably reflects the heightened subconscious activity under lysergic acid which places strain on ego control and consequently is felt as a laborious task. If ego disintegration threatens, this experience may be felt as panic. In addition to pain relief, these patients displayed a peculiar disregard for the gravity of their situations and talked freely about their impending death with an affect considered inappropriate in our western civilization, but most beneficial to their own psychic states. This approach to their disease was noted usually for longer periods than the analgesic action lasted."

In a later study of 80 terminally ill patients in severe pain, Kast (1966) reported that three weeks after the administration of LSD, 90% of the patients felt they had gained insights through the experience and 85% were willing to repeat the experience. This was a marked increase in the number of patients favorably inclined to repeat the experience, and Kast believed this to be a product of terminating the sessions relatively early, before the patient became exhausted and began to have negative experiences. Again, Kast found considerable analgesic effectiveness from LSD; before the treatment the median amount of pain experienced by these patients was labelled between severe and intolerable, whereas ten days later the median amount of pain was between none and mild.

Kast also comments at some length on the psychological sequelae of the LSD experience, particularly in the change in mood and patient's acceptance of his disease. He states, "A definite lifting of the mood was noted for approximately two weeks, and a certain change in philosophic and religious approach to dying took place which is not reflected in the numerical data presented. During and after LSD administration, acceptance and surrender to the inevitable loss of control were noted and this control was anxiously maintained and fought for in non-drug patients. LSD administration apparently eases the blow which impending death deals to the fantasy of infant omnipotence not necessarily by augmenting the infantile process but by relieving the mental apparatus of the compelling need to maintain the infantile fantasy." He states in general the LSD experience "creates a new will to live and a zest for experience which against a background of dismal darkness and preoccupying fear produces an exciting and promising outlook. In human terms the short but profound impact upon the dying patient is impressive."

Pahnke (1969) and his associates in Baltimore extended this work using a psychedelic psychotherapeutic model to work not only with the management of pain but also with the psychological problems elicited by impending death. Their model was somewhat different from Kast's: (1) they did extensive preparation of the patients for the LSD experience, (2) they incorporated the family into the treatment plan, (3) they had a staff of thoroughly trained therapists in utilizing the LSD psychotherapeutically, (4) they gave ten to fourteen-hour treatment sessions, and (5) they also did extensive follow-up and support for their patients.

Reporting on six patients, their initial results are certainly very dramatic, both in terms of psychological sequelae and of psychological adjustment of the individuals and their life styles, as well as dramatic reduction in pain.

Our own work, although in its beginning phases, has been promising. We are administering LSD to terminally ill patients who have either one of two problems (a) intractable pain and (b) anxiety and fear over their impending death. We have primarily been treating terminal cancer patients where the medical and surgical management of the pain has been complicated and difficult. Other patients have been referred who have been difficult management patients in terms of their inability to cooperate medically with their treatment because of emotional instability.

One interesting aspect of our current work concerns the socio-political-psychological climate surrounding LSD. One of the major difficulties in the work has been obtaining the approval for the treatment by all those people involved with the patient. Our current project was set up as a double bind experiment testing the efficacy of LSD and an experimental analgesic in the management of the problems that were outlined. Patients referred were hospitalized and came through the Department of Nuclear Medicine and Radiation Therapy. Thus, they were initially screened by medical personnel. After the patient's approval was obtained, his private physician's approval became necessary. Next came our evaluation of the suitability of the patient for treatment in light of our general criteria developed over the years. This evaluation essentially involved the judgment as the patient's ability to utilize those markedly altered states of consciousness induced by the drug. We wanted some assurance that the patient was motivated toward psychotherapy, had sufficient ego strength to deal with heretofore repressed and traumatic historical events, was of sufficient intelligence and sophistication to integrate the uncovered material, and had the potential to work through and accept the fact of the fatal disease and resolve the problem of death.

We usually had one hour to do this evaluation, and, sometimes, an additional hour to prepare the patient. Parenthetically, we must mention that there was a 50% chance that, instead of LSD, the patient would receive the experimental analgesic, the possible psychic effects of which we had not personally experienced but had read about in professional literature.

After evaluating the suitability of the patient, the family members were approached and the nature of the experiment was explained. Because of the LSD publicity, a great deal of this conversation surrounded the possible risks involved.

After the relatives approved and signed releases of responsibility (which listed all the known possible untoward results of LSD, including psychosis and grand mal seizures), the patient was approached for his approval and signed release. As is obvious, the psychological state of the patient following all this was hardly optimum in creating a state of trust, relaxation and faith in the procedure. Making the situation still worse was the general attitude of the hospital staff toward subjecting the dying patient to the publicized horrors of the LSD "bummer" trip.

These negative attitudes run counter to the very encouraging results reported with LSD with a variety of psychiatric syndromes. In a literature review, Mogar (1966) states that, in spite of the great diversity in the conduct of the

research studies, "Impressive improvement rates have been almost uniformly reported with both adults and children, in groups as well as in individual psychotherapy—in patients representing the complete spectrum of the neurotic, psychosomatic and character disorders. Particularly noteworthy are the positive results obtained with cases highly resistant to conventional forms of therapy."

Hoffer (1965) in a long review of LSD research concluded, "So far there have been no therapeutic studies in which LSD was used as a psychedelic agent where similar success rates were not found. It is odd that there have been no negative papers."

Case History Material

The patient was a 65-year-old, married female who had had radical mastectomies for breast cancer and who was now in the terminal stages of lung cancer. The patient was rather suspicious of having this treatment as she had had negative attitudes towards psychiatry because her daughter-in-law had been unsuccessfully treated for a psychiatric condition by the Department of Psychiatry with which we were associated. However, because she did have confidence in her physician and he was most anxious for her to have these treatments, the patient agreed. She was a fairly verbal, bright woman, but was considered to be a difficult management patient because she was very demanding.

During the initial interview the patient spontaneously described dreams that she considered to be prophetic, two of which particularly related to her disease. The patient's elder sister had died of cancer of the lung. Two years after the sister died, the patient had a dream in which the sister wanted something. Although the patient did not know what the sister wanted, she kept telling the sister that she could not have it. In retaliation, the sister became very angry and placed her hand over the patient's right shoulder, touching her breast. As she did this, the patient felt an injury to her right breast and became aware that the sister was injuring her. She called out for help, whereupon a white winged object removed the sister from her. A year later the patient developed breast cancer.

Following this, another of the patient's sisters died of breast cancer. The patient claimed to have had a good relationship with this sister, who had in fact been the surrogate mother. After the sister's death, the patient dreamed that her sister came to her and demanded something of her; again when the patient would not comply with this unknown demand, the sister reached out and the patient felt a sharp pain surging through her chest and believed that she had been harmed. A few months following this dream, the patient started developing symptoms and was subsequently diagnosed as having lung cancer.

The patient spontaneously expressed concern about a possible relationship between these dreams and her cancerous condition. When the therapist inquired as to the specific nature of the relationship, the patient could not specify.

The patient was rather weak, depressed and apprehensive and was having difficulty with pain. She was taking percodan four times a day and also was taking valium as frequently but was having almost constant pain in spite of the medication.

The patient was administered 200 mcg. LSD orally and it took approximately one hour for psychological changes to occur. The materials that the patient became involved with was the relationship between her sister who had acted as a mother towards her. The patient's first comment was, "Why did my sister want to punish me? My sister made me walk out into the rain where I have been ever since." She began to complain of pain in the back of her head; at this point the therapist attempted to have her become totally in contact with her pain and to experience it completely. The patient began to experience pain in the chest and this pain increased in great intensity. As the patient experienced more pain, the therapist became more and more insistent that the patient go into her pain to see if there were messages in her pain for her.

This approach lasted for over two hours; then the patient sat up, looked the therapist straight in the eye, and said, "I am nauseated." When asked what was nauseating her, she said, "I finally accepted it. I finally have accepted the fact that I've got cancer and that's enough to make anybody sick." She made this statement with great meaning and with that touch of humor that acknowledged emotional acceptance. The patient then became relaxed and was able to discuss her relationships with her sister. For the first time she became aware that the sister had actually committed suicide by taking an overdose of barbiturates and that the sister had done this because she could not tolerate the pain from her cancer. The patient then said, "Well, it won't be necessary to do that now." When I inquired as to what it wouldn't be necessary to do, she replied that it wouldn't be necessary for her to commit suicide. She then said that she had been planning to commit suicide because she could not tolerate having cancer and suffering the pain. She also began to recognize that her sister had been a very controlling and dominating person, while making her think that she was a very loving, giving and martyred person. She recognized that the sister was selfish, that she was only interested in the patient performing the way she wanted her to perform, and that she was far from kind and giving. The patient was amazed that she had been duped for so long in such a relationship, even to the final controlling act expressed through her own planned suicide. She explained that she had been going to take her own life to absolve the sister of the sin of committing suicide. The patient stated that she had never been aware that her sister had actually committed suicide, but only became aware of this during her treatment as she reconstructed the events on the evening of her sister's death.

After four hours of treatment the patient became agitated because she felt she was losing control of herself and her thinking. She was very much concerned that she was going to "fall to pieces," complained of feeling helpless, and said that she could not maintain the kind of control psychologically that she wanted. Her agitation increased and finally, in response to the question as to what she was afraid of, answered, "That I will die." After some five hours of the treatment, the patient was given thorazine to decrease her agitation.

The following day the patient said she felt considerably better and that she felt a calmness and peace which was very new to her. She was not having any pain and she had not taken any analgesics. She was very much impressed with having understood the relationship with her sister and felt that she had finally been freed of the sister's domination. She also was convinced that she would

have committed suicide, had she not worked through these synamics regarding her sister. She was now perfectly assured within herself that she would not take her own life.

During the seven months she continued to live, she was seen a number of times and a marked change in her psychological state was evident. Previously, she had been a rather demanding, passive-aggressive woman who was a management problem; she now seemed a pleasant, outgoing individual who became involved in people and in activities. Staff members also commented upon the great improvement in her psychological attitude and now found her to be very different in relating to them.

What was most outstanding, however, was the lack of pain that this woman had subsequent to one LSD treatment. Three months later she was not having any pain and was not taking any analgesics. The pain only began to become a problem after the fifth month following the LSD treatment and never became unmanageable since she started to take codeine occasionally; apparently this controlled the pain. A month before she died, she became apprehensive about being left alone and was having separation anxiety. Her relationship with her husband was very much improved. Whereas it had previously been rather competitive and she had used her dependency in a controlling fashion, they now had a much more open and free and relaxed type of relationship. They seemed to enjoy each other a great deal more, in marked contrast to the strained and anxiety-ridden relationship when they had been seen initially. During the last two weeks she became afraid of being left alone and wanted him with her most of the time. She denied, however, that she was afraid of death *per se* and said that through her LSD experiences and her prophetic dreams that she was not apprehensive about dying.

The most meaningful aspect of the use of LSD in this case was the patient's ability to work through her relationship with her sister. She then gained a state of peacefulness and tolerance and understanding of other people which was new to her. The reduction in her pain was most remarkable. Certainly, the remaining months of the woman's life were very much influenced by this experience that made life much more meaningful and peaceful.

The second case is that of a 45-year-old female, who has terminal cancer of the bone, spine, and who had recently developed brain tumors. She was hospitalized because of inability to manage the pain and was suffering nausea and vomiting from the medication. She was being medicated with demerol, morphine and thorazine. The patient was a quiet, soft-spoken woman who was psychologically naive and unsophisticated. She knew she had cancer and knew that her disease was fatal but did not know how long she had to live. She was depressed but attempted to maintain control over depression. Her major defense mechanisms were massive denial and avoidance. This avoidance was so pervasive that she did not want her family to visit her while she was in the hospital. When questioned as to this attitude, she explained that their visits reminded her that she was hospitalized and if she was in the hospital then there must be something wrong with her and she did not want to think that there was anything wrong with her.

This woman had had a very unsatisfactory 20-year marriage with an alcoholic. Because of her strict Catholic faith, and at the insistence of her father, she

remained in this marriage. Finally, however, she was unable to tolerate the relationship and obtained a divorce. This action was very unacceptable to her father and to her church; when she remarried some four years later, her father disowned her, and she was refused her church sacraments. Five months following her marriage, she developed breast cancer and, subsequently, cancer in other organs. She had seen a priest and attempted to absolve her sins with relation to her marrying outside of the church. She tried to reassure herself that she was not living in sin but obviously had great difficulty believing it. She was able to state that she felt cheated because, for the first time in her life, she had a good marital relationship and had achieved some happiness, only to develop cancer.

It was impossible to prepare this patient for an LSD experience because her total attitude was one of avoidance and denial of feelings. We repeatedly told her that the LSD treatment was not for her cancer but rather an attempt to help her with her emotional problems. She was incapable of hearing this message and kept repeating that she would cooperate totally with any procedure that the doctors were recommending because "they are trying to do so much for me." She also told us that she had a great deal of difficulty in bearing any pain, relating this to the death of her child through leukemia. She had watched him die in great pain and she was not terrified of experiencing her pain in the terminal phase of her disease. Thus, this woman obviously met none of our established criteria for individuals suitable for LSD treatment. Understandably, we felt quite ambivalent about treating her, because she used denial so extensively, had poor ego strength, and was approaching the LSD experience, in our view, with totally wrong intent, i.e., that it would cure her cancerous condition. With trepidation, we gave her 200 mcg. of LSD. At the beginning of the session, the patient was in considerable pain and discomfort but did not have any specific anxiety about taking the LSD. Onset of psychological changes was quite rapid, occurring in approximately 20 minutes. She immediately started verbalizing her experiences. For the first three hours of the treatment there was a very intensive interchange between the therapist and the patient.

The patient was not given her usual medication on the morning of the treatment and was in considerable pain, writhing around, grimacing and beginning to cry because of the pain she was experiencing. An example of how the therapist tries to deal with that is as follows:

Therapist: "Let yourself feel the pain. Let yourself totally experience it."
Patient: "It hurts, it hurts. I don't want it."
Therapist: "I know you don't want it, but let yourself feel the pain. Let it become worse. Let yourself totally feel it. Either let the pain totally come to you or else you go to the pain, whichever you find easiest to do."
Patient: "No, no (patient writhed about to try getting away from the pain), I don't want it."
Therapist: "I know you don't want it, but see what the pain can tell you. See if there is any message in the pain. Let it overcome you, totally become your pain. Let it completely take over, don't try to stop it, just let it come. Let yourself become the pain."

Patient: (screaming) "No, no. I don't want it. Make it go away.
Therapist: "Let it come, let it come. Let yourself let it come. Give in to it completely. Let it come.
Patient: (crying) "It's my daddy, it's my daddy. He doesn't want me, he doesn't love me. He pushes me away. Oh, daddy, I just wanted you to love me. He's laughing at me. He wants me to suffer. Oh, daddy, shame on you. It's not fair. You have no right to treat me in such ways. (Patient starts showing anger) He doesn't want me to be happy. He's jealous because I have someone who loves me now."
Therapist: "How is your pain?"
Patient: "What pain?"
Therapist: "Do you feel any pain in your body?"
Patient: "No, I don't have any pain."

This particular sequence of the conversion of physical pain into psychological pain was repeated over and over again. When the patient would be experiencing severe pain, writhing around on the couch, the therapist would continue to insist that she totally experience the pain. Each time she did so, the pain represented rejection by her father; later, it extended into the rejection by her sisters and by her church. This was followed by her resentment and anger over the way her family members and her church treated her their rejecting judgment of her. At these times, whenever the patient was questioned as to her experiencing physical pain, she always said, "What pain? I don't have any pain."

Her first concern was her rejection by her church and her family over having divorced her husband. At this point the section of the Casals Montserrat choral where a chorus of males and females alternately sing was playing. To the female voices she verbalized, "They are pleading. It is depressing. They are pleading, but they won't let me in. They turn their backs on me. I am an outsider, that's why. They don't think I belong in the church. They think I am a bad girl because I didn't get married by the church. The family didn't like that. They didn't want me to get a divorce. They are pleading. They are pleading, but they won't let me in. Oh, I want in, I want in."

She then became involved with material concerning her father and the rejection of her by her father and by her sister. She experienced them as taunting her, laughing at her and pretending concern without really feeling it. She cried because they were angry at her, resented her for remarrying, and particularly resented her happiness in her new marriage. When she asked them why they were so cruel to her, they replied that they wanted her to stay and to suffer and remain married to a man whom she did not love and who did not love her. She felt them laughing and talking about her and now obtaining their revenge because she did not have a happy marriage because she was going to die.

She then started to go back earlier in her life and deal with her father's rejection of her as an infant. She apparently was dark skinned whereas the rest of the children were light skinned and she was taunted and rejected because of the skin color. She said, "The color of skin means nothing. Daddy, I just want you to love me. They said I came in a charcoal freight car because I'm black. He said I wasn't pretty like my big sister. My daddy never did love me, I just wanted him to love me. Oh, daddy, why don't you love me?" All this was said with a

great deal of affect, a great deal of crying, and a great deal of horror and surprise.

In the next sequence, she began to resolve her feelings of rejection by her father, by the extended family and then by the church. It appeared that she finally accepted her father the way he was, and this acceptance removed her anger and resentment toward him. As she began to accept her father and her family, her whole mood changed dramatically, and she became happy, radiant, very peaceful, in a tranquil state.

After working through this acceptance, she then very quietly put out her hand to the therapist and said, "I am going now. Please walk with me." The therapist took her hand and said, "Yes, I will go with you." The patient's face became illuminated and her nostrils started quivering and she began to sniff the air. The patient verbalized, "The smell of the trees is so fresh. They are so fragrant. The flowers, they smell so beautiful. The air is so clean and so fresh, this is the garden." The patient became ecstatic and verbalized her tremendous delight with this experience. She said, "Death is a place you go to rest. It's such a beautiful road. It smells so fresh. Look at the light shining through the trees. It is so beautiful. Everything is so beautiful. Everybody has such beautiful faces. No one is ugly. I can go there too. I am not ugly. My daddy loves me. He really does love me. He's not laughing at me any more."

We present this material to indicate that the patient had worked through her feelings of rejection by her father, her family, and the church, she had come to an acceptance of those individuals and their attitudes and still could maintain that their attitudes were not valid with respect to her own worthiness. Through discovering that she was acceptable, she could experience them as human beings and accept them and their limitations. By releasing herself from their attitudes she was able to have a transcendental experience and experience the beauty of love; her previous notion and fear that she would burn in the fires of hell no longer held any validity for her.

Near the end of this type of experience the same music was played that was played earlier when she was experiencing such agony of being an outcast. Her response to this music was as follows: "The monks have come back and they say everything is going to be all right. We are all together now. They are answering and they are saying that everything is all right."

Following the session the patient required considerably less medication for her pain. The pain became manageable and she was discharged home.

The following day the patient verbalized remembering positive emotional experiences she had had and stated that she found these to be very, very helpful. She said that for the first time she was able to feel that her father did care for her and that she was able to accept him and no longer had any conflict in her relationship with him. She also said that she did not want to go back into the past any more but wanted to look towards the future.

Some five weeks later the patient's physician was contacted by telephone. The patient's physician had been out of town during this period, but I assumed that he had known of the LSD treatment. When I inquired as to the patient's status, the physician said that he had just been discussing the patient's case with other medical personnel and that in his vast experience with patients dying of this particular type of brain cancer, he had never before witnessed a patient dying in this way. He stated that most such patients had great emotional

lability and were subject to fits of severe anger and rage and also to periods of despondency and apathy. This patient, however, seemed to be very much at peace and was showing none of the usual signs. He stated that she seemed to be reliving delightful and joyous events in her past life and that she seemed to be totally peaceful and at ease. He continued to talk about the perplexity of the case. Because I still assumed that he had known about the LSD treatment, I said, "Well, I attribute those changes to the fact that the patient was able to work out many of the conflictual relationships in the LSD treatment and that she is not troubled by them." He responded to that statement with, "What LSD treatment?" It is of value to have had this independent observation of the psychological sequelae of the LSD experience.

The last case was not conducted within our current project, but was done outside of the United States under the auspices of another research project involving the therapeutic use of LSD. The patient was an 83-year-old woman with terminal lung cancer. She was a small, physically frail and debilitated woman. Her mood is best described as being one of apathy and withdrawal. She complained of being tired most of the time and had little interest in her surroundings. Her husband at 81 was a small, wiry man full of anxiety, fear, and apprehension over his wife's impending death, after 56 years of marriage. He appeared to be very dependent on his wife and, although reluctant to admit it, he was very much concerned about how he was going to survive and fare after her demise. He was in a general high state of anxiety and could best be described as being distraught, depressed and agitated. The investigators decided that both the husband and wife should have the LSD experience at the same time. Consequently, each had one LSD session on the same day but were initially treated separately by two groups of therapists. The patients were thus physically separated, each having two to three therapists with them for approximately the first seven hours of the experience. Much of the husband's individual therapy work revolved around his dependency on his wife and his tremendous separation anxiety precipitated by her impending death. The wife basically worked through her defensive maneuver of withdrawing and of isolating herself from the emotional trauma of the separation and her fearfulness of dying.

After about seven hours of therapeutic work the couple were united and this was one of the most touching and dramatic scenes I have witnessed. Age had totally disappeared from both of them. He, the excited Romeo, approached his loved one with the ardour and anticipation of the innocent youth. She, Juliet, totally fascinated by her Romeo, opened her arms to him with that full acceptance so delicately needed by an unsure lover. It was as though their love for the first time was totally unencumbered. Each saw perfection in the other. They were young sweethearts, and as we discreetly left them in her boudoir, they became lost in each other's arms.

The sequelae to this treatment was most encouraging. She had again became involved with life because she had fallen in love again. His anxiety, fear and apprehension were gone. He became so enthralled with living life with his Juliet that fear became unknown to him. They lived a full and meaningful life for the next four months until she died. She had no fear of dying and he, no fear of her dying. He did not experience mourning because, as he said, he

did not feel that she was truly gone from him. His warmth, vivacity and ability to give remained, and he became involved with other human beings and lived in his "here and now." He was seen some three years later and still maintained this positive mood, a sense of fulfillment and an interest and involvement with life.

These cases dramatize the need for the establishment of some setting where people can come to do the work of dying—with dignity, nobility and an opportunity for fulfillment. Such a facility would be dedicated to the living—both for the individual who is in the process of dying and for those who care for and love him.

But what is it to die but to stand naked in the wind and to melt into the sun; and what is it to cease breathing but to free breath from its restless tide that it may rise and expand and seek God unencumbered; only when you drink from the river of silence shall you indeed sing; and when you have reached the mountain top you shall begin to climb; and when the earth shall claim your limbs, then shall you truly dance.—Gibran.

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ASSUMPTIONS ABOUT WAR AND THE NATURE OF MAN*

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WARS have been fought by groups of men living under a very wide range of social, economic and cultural conditions. It is easy enough in examining the history of each war to find the exact series of circumstances that led to it: the angers, the fears, the complaints, the clashing interests, the broken treaties. However as Thucydides warned us long ago (1954, p. 25), we must look beyond the specific events if we are to understand the real causes of even a single war. How much further, then, must we look behind the specific events if we are to understand the problem of war in general? Not to ask "What events led to the outbreak of this war or that one?", but rather to ask "What is there in man that makes him so ready to go to war almost no matter in what culture or under what economic conditions he lives?" The question we pose here concerns the readiness, the receptivity, the seed-bed on which the specific events fall and which, then nourished by it, flower into intergroup conflict.

The basic question set forth is thus that of wars in general. They are a fact of human behavior: very widespread, easily stimulated into being, terribly difficult to prevent or control. Whether raised in a tribe, a city, state or a nation, man frequently engages in this activity. Whether rich or poor, single or married, in democratic or authoritarian societies, in rigid or flexible cultures, he gathers in armies and fights other armies. What is there that gives the energy behind this behavior? Why does he do it?

The question appears either naive or overwhelming. Either we feel that it is ridiculously obvious and simple to answer or else that it is so complex that it is impossible to deal with in any useful manner. However, it is the faith of science that any event in the natural universe can be understood more deeply and clearly if enough intelligence, effort and methodological rigour is brought to bear. Perhaps we can gain by bringing them to bear on *this* question also.

Whether or not increased understanding can give us greater powers to prevent and control, is an open question that cannot be answered until we have gained the increased knowledge. An astronomer may comprehend in detail the causes of the explosion of a star, but be powerless to prevent or influence the nova. Few would doubt, however, that deeper comprehension of the causes of juvenile gang conflict would be likely to lead us to new methods of control. It may be that the problem of war lies somewhere between these two examples and it does not seem possible to predict whether or not new insights in this area would help us with prevention. It is, however, equally an article of the faith of science that we cannot know in advance what uses may be made out of new knowledge arising from basic research.

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It may be worthwhile to start by examining the answers our culture has given, historically and in the present, to this question. At the same time we will ask if these answers are in accord with the orientations and knowledge of the social sciences today. In this way we shall see if the reasons for man's, apparently almost universal, readiness to go to war are already known and, if so, what if anything, we can do with this knowledge. If the answers we have are *not* acceptable in the light of modern scientific knowledge, we shall have to look further and try to see more clearly.

There appear today to be three major groups of answers to our question. For purposes of discussion we shall label these: "Psychological Theories"; "Economic Theories"; and "Social Group Theories." Let us survey each one briefly.

PSYCHOLOGICAL THEORIES

"Psychological" theories as to man's readiness to go to war are very old. In the Graeco-Latin world it was widely believed that all men want power; that no matter how much power they have, they want more; and that this desire must inevitably lead to wars. The surprise with which classical authors report exceptions to this—see for example, Herodotus' discussion of Otanes who did not want to be king of Persia (Herodotus, 1954, p. 212) shows the strength of these beliefs. "Love of power," says Thucydides in his "The Peloponnesian Wars' (1954, p. 210), "operating through greed and through personal ambition was the cause of all these evils." Other forms which "psychological" theories have taken are that man is born evil or that he is genetically and basically a carnivore. The basic concept of man is akin to that of Hobbes. In this viewpoint there is something in man's nature which naturally leads to large scale, overtly aggressive action against his fellows.

On a much more complex and sophisticated level, Freud stated his belief that, because of an instinctual death drive which must be externalized if the individual is to avoid destroying himself, nothing can be done to stop war. The best we can do, said Freud, is to await the time when mankind progresses further in evolution. In an exchange of letters (1949), Einstein asked "Why war?" and Freud answered, in effect, "Because man is what he is."

Obviously if there is an inborn need in man to fight wars, there is little that the scientist can hope to do about prevention. He is helpless against an organic part of man's nature. Let us, however, first look at this concept and its relation to the present viewpoint of the social sciences. We may accept this view as children of our culture; do we also accept it as scientists?

Instinct theories of molar human behavior are not generally in good repute today. We would question the validity of an "instinct" for power, an "instinct" for aggression or murder. (Similarly, most social scientists would question the existence of a "Thanatos," a death instinct. Even in psychoanalytic circles, this concept has not gained wide acceptance.) Further, and more importantly, our *behavior* as social scientists clearly indicates that we do not believe in the "psychological" theories of war. An industrial psychologist acts to reduce hostility

within a business organization. A social worker attempts to prevent hostile activities among juvenile gangs. A psychotherapist helps an aggressive patient to find a way of living with other men without overt and violent conflict. None of these seems to believe that in so doing he is acting against the basic nature of man. It therefore becomes clear that as scientists, we do not believe that man has something within him that must lead to warlike activity or to war itself. We act in ways clearly opposed to psychological theories of war. Appealing then as the concept is that it is *inherent* in man to fight wars, we must reject it. It is in too clear contradiction to our behavior as social scientists.

ECONOMIC THEORIES

The "economic," the "corn and iron" theories of the basic causes of war are also very old. Livy (1960, p. 81) writes of Tarquins preparing for war against Ardea, "Their wealth was, indeed, the reason for Tarquin's preparations. He needed money." Thucydides (1954, p. 78) tells of the Corinthians urging their neighbors to join them as allies in a war to protect their import—export trade. In this view, man fights for wealth; he goes to war to obtain the goods and possessions of another.

It is obvious that since the industrial revolution at any rate, and beyond question since World War II, the economic theories of war make no sense at all. The bald and unmistakably clear fact is that war destroys more capital and personal goods than the victor can hope to take from the loser. To try to explain the present international political tension on the ground that those involved believe war will increase their wealth, is obvious nonsense.

(In a nomad culture, the economic theories may be valid. In a non-nomad culture, they are not. However, there have been no nomad cultures of importance for a long time.)

Shall we go further and hypothesize that wars once increased wealth (or seemed to) and that we continue to have them either out of "habit" or as a sort of "phantom limb", a left-over behavior pattern from the past? The "habit" hypothesis does not appear to be tenable. Our present knowledge assures us that habits, per se, do not continue in the absence of motivation.

The "phantom limb" hypothesis is a more difficult one. It assumes that men continue to believe what was once true because they have not successfully re-evaluated the problem. We know that this occurs in many situations. However, *this* error, the idea that war does bring profit, appears to have been clear to many leaders, both political and intellectual, at least in the last century. It has been repeatedly demonstrated to the public of the world. Where we might once have accepted economic gain as a possible motive behind war, we can do so no longer. This class of theory also must be rejected. When a man can produce so much more wealth as a worker than he can to gain as a soldier, it simply does not make sense to regard economic gain as a powerful force driving toward war. Whatever its effect in the past, it no longer is a reasonable explanation.

SOCIAL GROUP THEORIES

This group of theories all appear to contain three basic elements: First, that human beings exist in groups (a necessity of their "nature", "economics", "early conditioning" or for some other reason); second, that the behavior of groups is quite different from the behavior of individuals; and third, that inherent in the structure of human groups is overt intergroup hostility.

That human beings are "group-organisms" and that the behavior of groups may follow different laws than does the behavior of individuals, does not seem germaine to our brief inquiry. However the concept that groups are not only inevitably hostile to each other but must express this in open conflict, is another matter. We all know of too many established groups which are in contact with each other which do not seem to need to express hostility between them (i.e., the U. S. and Canada). More to the point however, is the difference with which we treat small and large groups. On the small group level we do not act as if we regard intergroup conflict as inevitable. On this level we act rather as if we believe that the prevention of overt conflicts and the solution of covert conflicts are legitimate and reasonable goals of social science. Active group work, psychotherapy, city planning and various techniques from industrial psychology are among the many tools we use in achieving these ends.

It is only on the international level that we seem to have regarded their overt aspects as inevitable and inexorable, and have not organized major research programs which might enable us to understand them more deeply and to ascertain whether through greater understanding some action could be taken towards control.

One is startled if one compares the time and energy expended by social scientists in research on understanding and reducing the aggressive components in juvenile gangs with the time and energy spent by social scientists in research on understanding and reducing the aggressive components of nations. The contrast, particularly at a time when the nations have atomic weapons and the juvenile gangs do not, is striking. We are forced to the conclusion that, in these theories, a non-verbalized assumption exists that aggression is *not* organic to members of small groups, but *is* to members of large ones. This assumption does not appear to be an acceptable one. Therefore we cannot, as scientists, accept this group of theories as the answer to our question. It would involve us in too fundamental a paradox.

These three groups of theories include the major answers which our culture has given to the problem of man's readiness to fight wars. On consideration we see that none of them are acceptable. They have formed part of our cultural assumptions about the basic causes, but either logic or our behavior as social scientists forces us to reject them as satisfactory solutions. We shall have to admit our ignorance of this tremendously important and basic problem and try to approach it with a fresh mind. What we have been doing in this survey is to examine our assumptions and have found that they need, at the very least, much further testing and refinement.

Very often in man's considerations of this problem, he has confused the stimuli, the specific events, which led to war with the problem of man's receptivity to these stimuli. Thus, for example, Herodotus reported the view

that the long-term, destructive Graeco-Persian conflict was caused by a series of kidnappings of women (Herodotus, 1954, p. 13ff). That specific events, or the drive for power of a leader, or a psychopath in a position of authority, or the psychological illness of a Hitler or Stalin may serve as the specific stimulus which sets a war in motion, is not questioned here. Rather we raise another, and what seems to be a more basic question: that of man's willingness and readiness to respond to these stimuli. It may be, that in this seemingly almost universal condition, we shall, if we can understand more about it, find the type of knowledge which will help clarify some of the forces behind our history of repeated armed, intergroup conflict.

Mankind has had many dreams. An end to war has been one of them. The fact that a dream has not been accomplished in the past does not mean that its accomplishment is impossible. But success in a dream has resulted only after the problem has been accepted as being accessible to scientific analysis. In the study of the causes of war, we must abandon the kind of thinking that says: "It has never been done and it never will. It's just not natural. I told Wilbur and I told Orville and I'm telling you. It will never work." When this orientation has been given up, then and only then, can the scientists of the particular area explore and find out whether man *can* fly.

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DEATH, GRIEF AND SOCIAL RECUPERATION*

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IT HAS been almost forty years since Thomas Eliot first called for the objective analysis and comparative study of grief (e.g. Eliot 1930, 1932). Although American anthropologists examined the exotic burial rites and funeral practices of other societies, and social workers explored the economic problems of widows and orphans, medical and behavioral scientists in this country, with few notable exceptions, were virtually silent on the subject of reaction to loss.† Freud (1959) and G. Stanley Hall had advanced their theories on the possible causes of melancholia and fear of death and, of course, theologicans discussed death within their different cosmogonies, but little was known in a systematic way about reactions to death. As recently as four decades ago, the social-psychological crisis of grief was not a recognized subject for serious scientific research.

It was not until the early nineteen-forties, with Lindemann's (1949) investigations into the reactions of the survivors of the Cocoanut Grove fire that the situation began to change. Lindemann's classic report, "Symptomatology and Management of Acute Grief," dramatically highlighted the medical, psychological, and sociological significance of loss. The study of grief was brought into still sharper focus by wartime studies such as those conducted by Anna Freud (1943) of children separated from their families and by the stark accounts of concentration life. Systematic research into grief, however, began to burgeon only after the appearance in 1959 of Herman Feifel's book, *The Meaning of Death*. From that time until the present, studies of grief and the exploration of responses to, and attitudes toward, death have appeared in ever increasing number in the

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†Illustrative of the former rites are the following: Bendann, E., *Death Customs: An Analytical Study of Burial Rites*, Knopf, New York, 1930; Hocart, A. M., Death customs. *Encyclopedia of the Social Sciences*, Vol. 5, Macmillan, New York, 1926, pp. 21-7; Lee, R. P., *Burial Customs, Ancient and Modern*, The Arya Co., Minneapolis, 1929; Murgoci, A., Customs connected with death and burial among the Roumanians. *Folklore*, **30**, 89-102, 1919; Paton, L. W., *Spiritism and the Cult of the Dead in Antiquity*, Macmillan, New York, 1921; Puckle, B. S., *Funeral Customs*, T. W. Laurie, London, 1926; Rivers, W. H. R., The primitive conception of death. In Smith, H. E., (Ed.), *Psychology and Ethnology*, Harcourt, Brace & Co., New York, 1926, pp. 36-50; Thompson, E. J., *Suttee: A Historical and Philosophical Inquiry into the Hindu Rite of Widow Burning*, Allen and Unwin, London, 1928; Vulliamy, C. E., *Immortal Man—A Study of Funeral Customs and of Beliefs in Regard to the Nature and Fate of the Soul*, Methuen, London, 1926.

A few notable exceptions include: Bromberg, W. and Schilder, P., Death and dying. *Psychoanalytic Review*, **20**, 133-85, 1933; Barry, H., Orphanhood as a factor in psychoses. *Journal of Abnormal and Social Psychology*, **30**, 431-8, 1936; Middleton, W. C., Some reactions toward death among college students. *Journal of Abnormal and Social Psychology*, **31**, 165-73, 1936; Schilder, P. and Wichsler, D., The attitudes of children toward death. *Pedagogical Seminary and the Journal of Genetic Psychology*, **45**, 406-51, 1934.

social and medical science literature. It is of interest to note that more material by professional researchers appeared on the subject of death, grief, and bereavement within five years following the publication of Feifel's book than had appeared in the previous 100 years.

How do we account for this increase in attention and concern today, in such a relatively short span of time, for the formerly avoided subject of grief? There is no succinct reply to that question. It can be suggested, however, that the development of interest in the problems associated with death parallels the changes in the character and social structure of American society that have occurred during the four decades since Eliot appealed for a social psychology of death. Of the myriad of social and cultural changes that could be mentioned, the following would appear to be among the most significant:

First, the change from a predominantly religious perspective in American society to an emerging secular viewpoint has contributed not only to the problems that death presents contemporary society today but also to the objective analysis of these problems. Second, the American family over the past two generations has been transformed froma large, extended family into a small, nuclear group. It is today more mobile, socially and geographically, than ever before. Today's family can be characterized as more child-centered than adult-centered, more democratic than communal and more individualized than integrated. The family, moreover, is less a part of a rural community than formerly while increasingly it tends toward being singular in an anonymous, urban environment.

In addition to these changes in the American value system and character of its family life, there is a third factor that needs to be mentioned to account for the new-found awareness of the problems associated with death and dying—and, it may be added, which helps to account for the problems themselves. Medical science technology, with its associated public health programs, has not only focused attention on death and the issues related to it, but has provided an environment in which the ideas of Eliot and his successors now find a growing receptiveness. These changes, produced by medical science and other social innovations over the past two generations, have brought about a fourth factor to consider: namely, the change in the time, place, and incidence of death itself.

In 1970, approximately one per cent of the United States' population, or almost two million persons, will die. Sixty-two per cent of these deaths will occur among persons 65 years of age or older.* In excess of sixty-one per cent of these deaths, moreover, will take place outside the home, that is, either in hospitals or in a nursing home.† The number of persons over the age of 65 is now 19,000,000 or nine per cent of the population. In contrast, 60,000,000 or twenty-nine per cent of the population are children under 15 years of age. They account,

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*National Center for Health Statistics, Monthly Vital Statistics Report, Provisional Statistics. Annual Summary for the United States, 1968, Vol. 17 No. 3 (August 15, 1969) Washington, D.C., Table 6, p. 16.

†This statement is based upon the fact that the trend is toward greater hospitalization and institutionalization of the chronically ill and dying patient and the data for 1960 which shows that 60.9% of all deaths occurred in hospital or institution. See *Vital Statistics of the United States, 1958*, Vol. II, Table 67, Public Health Service, Washington, U.S. Government Printing Office, 1960.

for only 5.5 per cent of all deaths.⁂ This is a dramatic reversal in mortality statistics, as compared to the 1920's when the mortality rate was highest for children. As a matter of fact, contemporary American youth could be called the first "death-free" generation in the history of the world. That is, it is now one generation or twenty years that a family in the United States can expect, statistically, not to have a death occur among its immediate members.‡ The implications of these statistics cannot be overlooked. They color our contemporary conception of death as well as our view of what constitutes an appropriate response to it.

Death in American society, it has been shown, is increasingly an experience of the aged. They are, generally, retired from work, free of parental obligations and frequently outside or absent from the main current of family life. The extension of medical service and the advances in medical science research, moreover, make possible not only the prolonging of life of the elderly, but also often cause extended separations of those hospitalized from their families. Familial and friendship commitments are made fewer by such separations, and emotional and social bonds are loosened. The disengagement of the aged from their families and friends, prior to their deaths, therefore, means that their dying will little effect the round of life. The death of a leader such as President Kennedy can seriously disrupt the functioning of modern society. The vacuum he left in the social and political life of the United States was sorely felt. For the average man, however, and for the typical family, it is the death of someone in the middle, productive years of life, or the death of a child, young and unfulfilled, that will have a comparable effect upon the familial group. The death of the elderly, becoming less relevant as they are to the functional ordering and working of modern, contemporary society, does not compel such attention.

That this is so is reflected in the changing attitudes toward the funeral as a meaningful rite for the dead and in the criticism and attacks that have been directed toward it in recent years. Increasingly, the funeral is for that member of a family least functionally relevant to it. He has been, as suggested previously, physically removed from his family, perhaps by a long illness or confinement. In a society in which only half of the population is church-affiliated and in which the spatial mobility of its citizens is one of its more remarkable characteristics, the religious, economic and emotional obligations that a funeral has traditionally imposed upon a family are seen today by many as burdensome and inappropriate.* Advocacy of memorial services with the body absent,

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⁂National Center for Health Statistics, Monthly Vital Statistics Report, Provisional Statistics, Annual Summary for the United States, 1968, Vol. 17 No. 3 (August 15, 1969) Washington, D.C., Table 6, p. 16, and U.S. Department of Commerce, Bureau of the Census, Population Estimates: July 1, 1968 Series, p. 25, No. 400 (August 13, 1968), Table 2, p. 2.

‡United States Bureau of the Census, 1960 Mortality Statistics and United States Bureau of the Census. *Current Population Reports,* Series P-20, no. 106 (January 9, 1969), table 3.

*In particular see Bowman, L., *The American Funeral,* Paperback Library, New York, 1959; Mitford, J., *The American Way of Death,* Simon and Schuster, New York, 1963; Harmer, R., *The High Cost of Death,* Crowell-Coller and Macmillan, New York, 1963.

simple cremation and/or the medical donation of the body or its parts, are various attempts within the context of emerging contemporary values to resolve the many problems associated with the traditional disposal of the dead.

It is apparent that changes in contemporary family life and in the emerging social, demographic and ecological patterns of the country are effecting a redefinition of what constitutes an appropriate response to death.

Edmond Volkart (Volkart and Michael, 1957) has already pointed out that how one reacts to the death of another is dependent upon societal beliefs and practices.† In some societies, Volkart observed, death is viewed as inevitable and as an improvement in one's prospects and status while in other societies it is not. Mourning or weeping over the loss of an individual, he points out, is not considered appropriate behavior everywhere. How one reacts to the death of another is dependent, rather, upon one's status and role in relation to the deceased.

In American society, who is "bereaved" or who has suffered the main "loss" generally includes the parents and siblings of the deceased as well as the spouse and children. The situation is confused in our society, however, by the fact that death normally is defined as "loss" with the result that "bereavement" and "grief" are, erroneously, considered comparable or interchangeable terms.

Grief, Volkart reminds us, is a psychological reaction to a loss or a separation. It is not synonymous with bereavement which is the experience of such a loss or separation. The expectation of our society is that a person will or should express grief if bereaved. We know clinically that this need not be so. Families are not only sources of gratification, affection and love; they can also be the origin of frustration, hostility and hate. The cultural emphasis on the idea of loss at the time of death tends to ignore the full panoply of emotions that may be experienced by the bereaved person. The possible result of such a contradiction, in many instances, is the inducement of guilt. The cultural directive to mourn, therefore, may be, paradoxically, disfunctional in that it can generate a set of discomforting feelings and attitudes when what is intended is the mitigation or amelioration of emotional stress.

The presence of guilt in a bereaved person should not be misinterpreted, however. Whereas guilt can be generated by the absence of feeling, or by a negative feeling for the deceased, it is often an integral part of a normal grief reaction. The direction of the grief reaction, however, and the manner in which a person finally adjusts to his loss depends upon the success of what Lindemann (1944) calls the "grief work," i.e., emancipation from the emotional bondage to the deceased and the formation of new relationships. Lindemann noted in his research considerable resistance on the part of his patients to accept the discomfort and distress of grief. In many instances the patient chose to avoid the intense pain connected with the grief experience and to avoid also, the expression of emotion necessary for it. Such a distortion of normal grief, Lindemann warns, may well be the prelude to a morbid grief reaction. Morbid grief reactions, they report, can run a gamut of responses. It is their opinion that psychosomatic conditions such as asthma, ulcerative colitis, and rheumatoid arthritis, as well as anti-social behavior, and possibly even psychosis, can be the by-product of unresolved grief.

For bereaved persons who are genuinely grieved, it is imperative in the light of growing evidence that they somehow find the opportunity to resolve their grief. They should be encouraged to mourn. For those who are simply bereaved, but not grieved, however, it would appear to be inappropriate and perhaps emotionally harmful to insist that they express feelings they do not, in fact, have. There are many levels or degrees of loss, rather than just one. These different responses to death can be observed in the varied and changing character of contemporary mourning rites and funeral practices.

Traditionally the funeral has performed several different functions at a time of death over and above the socially useful act of disposing of a corpse. It has served as a religious rite; as an acknowledgement of the loss of the deceased from his social group; as an occasion to reassert the family's solidarity and status; as a commemoration of the life of the deceased, as well as a ritual of disposal. Many people today, however, look for far less than that from a funeral. For them the death of an elderly relative is an occasion for the barest acknowledgement of his death and the most expeditious disposal of his body. In such an instance, the death of such a family member could be described, for the lack of a better expression, as a "low grief" death. With such a death, loss is slight and grief is muted. The death of a child or of a young husband, on the other hand, may be perceived as premature and unjust and may be resented or denied by the survivors. The social and emotional needs of the survivors in such instances are infinitely greater, and the survivors' problems are more extensive than in the case of which has been termed a "low grief" loss. It is for those who are professionally concerned, to recognize this potentially "high grief" death and to be alert to the special needs and problems that can be associated with it. With such a "high grief" death the continued attention of friends, clergy, and other members of the care-taking professions may be required well beyond the perceived normal period of mourning.

Care, therefore, must be taken not to define too narrowly what funeral rites or behaviors are appropriate for the bereaved. To do so can lead to confusion, tension, or anguish on the part of the survivors. For instance, when members of the clergy perceive the funeral as a rite of passage only and stress death as a joyful spiritual victory over temporal life; they ignore the fact that death is also the separation of a husband from a wife, or a father from a daughter, and like any irrevocable separation, there may be experienced a profound sense of loss.

Care must also be taken that the professional worker not attempt to substitute for the deceased or, as in the case of the dying patient, attempt to become a surrogate parent or friend. The absolute number of survivors on the one hand and the number of deaths or of dying patients on the other, mitigates against the general success of such a well intentioned policy. It appears to this writer that the caretaking role would be better served and more effectively utilized in this particular instance if the effort were primarily directed toward maintaining family involvement in the patient's life and death. To do so would allow the family the opportunity to remain involved or to become reinvolved in the patient's life. Such a practice, moreover, would prevent the nurse or

other professional workers from becoming overexposed emotionally in the life and with the death of the patient. On the other hand, the continued involvement of the family in the patient's life that has been encouraged would permit the family to accept the death with possibly less hostility or guilt than might otherwise be the case.

What is proposed, then, in the light of these observations and remarks, is a stronger recognition on the part of those whose task it is to work with the grief stricken and the bereaved, to acknowledge the important distinction between grief and bereavement and to take into account the changing social and intellectual environment in which death is experienced in America today. It must be recognized more fully that the attitude that is taken toward death and the manner in which we react to it will be reflected in the social and mental well being of this nation.

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DYING, DEATH, AND LETHAL BEHAVIOR: AN EXPERIENCE IN COMMUNITY EDUCATION

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DYING, death and lethal behavior: what kind of people would show up for a non-credit evening course on these topics? How many? Why? What instructional format and content would be appropriate?

These were among the questions that came to mind when the Center for Psychological Studies of Dying, Death, and Lethal Behavior agreed to offer a course under the auspices of the University Center for Adult Education. The latter organization is a joint enterprise of Wayne State University, The University of Michigan, and Eastern Michigan University. The gentlemen in the Business Office of UCAE had their own questions, principally, would the course prove to be a financial disaster?

This brief article reports upon this little experience in community education. Hopefully, it may be of some interest to those who are contemplating the development of their own educational programs.

I. ANNOUNCING THE COURSE

A formal announcement of the course offering was included in the Fall, 1969 Bulletin of the UCAE. This was a 72-page publication describing special events as well as a variety of course offerings. The announcement that is quoted below was based upon material prepared by the instructors, but revised by UCAE. (The Bulletin editors surprised us by enclosing the announcement in a conspicuous blackedged box. We had mixed feelings about this typographical stunt, but it did seem to increase reader attention.) *See following page.*

The course was formulated as a broadranging exploration of the topic. An attempt was made to orient the potential student to the opportunity of bringing his own personal thoughts and experiences into the classroom situation—while at the same time suggesting that it would not necessarily be a typical "classroomy" experience. Mention of "what we know" about the experience of dying and "what we can learn from recent research?" was intended partially as reassurance that some academic conventions would be respected. Right from the beginning it struck us that active interplay between personal and "objective" materials and techniques probably would be necessary if we were to reach our students at both cortical and visceral levels.

The course received additional publicity when a feature writer of the Detroit Free Press noticed the announcement. After speaking with the instructors she prepared a well written article that gently challenged the readers' willingness to confront the topic of death. The article was accompanied by a somewhat

"Whoever teaches people how to die, teaches them how to live"
Montaigne

This course offers an opportunity to think, talk, and learn about death as a personal experience, about death as a social event, about death as an idea that influences the quality of our daily lives, and about something that everybody does and nobody talks about.

The course considers such aspects of death as:

Violent and unnecessary deaths—can we prevent them?
The experience of dying—what we know about it
Changing definitions of death—religious practices
The folklore of death—the humorous side
Sex and death—a curious relationship
Death in American culture—mortuary science, medical science and legal practices
Coping with death, ours and others.
Prolonging life artificially—how long is it desirable?
Is the fear of death inevitable?
What can we learn from recent research?
Resources for further thought and action

An interdisciplinary approach to these topics—and to the personal interests of class members—will be taken by the staff member of the Center for Psychological Studies of Dying, Death, and Lethal Behavior. In addition to lecture and discussion, dramatization and other improvisation in methodology can be expected. The course will be conducted by the Director and Associate Director of the Center . . .

"cornball" but effective photograph of three heads conversing: the two instructors and an immpressionistic ceramic skull. There is no question but that this feature article greatly increased the visibility of the course, and of the Center itself.

II. THE STUDENTS

The class quickly outgrew the first and then the second room to which it had been assigned. The final complement of 72 men and women far exceeded the expectations of UCAE. By all reports it was one of the largest, if not the largest, non-credit course enrollment ever registered at UCAE.

During the third session each student was asked to provide a little information about himself. From these mini-biographies we were able to learn the following things:

(1) Most of the enrollees had some form of professional or career involvement that brought them into contact with the dying, the dead, or the death-troubled. Almost a third of the students were affiliated with a hospital. Nurses, operators of nursing homes, social workers, and funeral directors comprised the largest subgroups. Among the nurses there were several who had responsibility for training and supervising other nurses. This group included women who had conducted their own research on related topics, and who frequently were called upon to deliver "death lectures" in their daily work. Several teachers and school counselors were enrolled in the class, and there was a smattering of secretaries, college students, retired persons, and community volunteer workers.

Essentially, this proved to be a group of mature adults, predominantely women, most of whom already had a certain amount of exposure to the topics of dying, death, and lethal behavior.

Why did these people enroll?

(2) Many of the students did not hesitate to cite very personal reasons as primary. A hospital nurse stated that "I have a daughter who is going to marry a boy with a fatal disease. I'm trying to understand myself and my feelings, I guess." This same student was also concerned about how she could be of more value to three young nieces whose mother (her sister) had recently died.

A community volunteer answered, in part, that "I deeply regret my inability to talk about his approaching death with my husband and a couple of close friends. I would like to be able to help my friends in the future to explore the idea of death, if they wish, during their terminal illnesses." On an even more personal note, she added, "I suppose most of all I want to be able to die gracefully and with courage. I want to be able to do it alone—not to be a burden, worry, or embarrassment to my sons. I do not want to be afraid."

An experienced nursing instructor felt that "since my brother's accidental death recently my fears about it have come to the fore and roused anxieties in me which have played havoc with my mind."

Other personal reasons included a secretary's revelation that she had been stricken with a "near fatal" disease some years previously and has only recently been able to accept her condition and continue with life; a teacher who has been wondering for years about "the mystery of it"; and a "crisis of faith" on the part of another teacher who had just severed connections with a religious order.

These illustrations indicate the kind of personal reasons cited. Other personal motivations were also expressed during class sessions (examples below).

(3) Other enrollees seemed primarily concerned with their ability to perform death-related responsibilities in their current or future careers. An embalmer, for example, felt "it is my duty to help them overcome their grief, and at times I feel very inadequate." A chaplain reported it "difficult to talk with those about to die about their death, and sometimes difficult in preparing them to die." A nursing instructor had experienced problems "facing the patient who is terminal—later I feel guilty for avoiding the situation." A psychiatric orderly stated that "Occasionally I have to take bodies down to the morgue at work. This task has reinforced my curiosity concerning death. The thought of death is always with me and I think about it many times a day. I would like not to be bothered about these thoughts so much when I have to take the bodies down. I fear that my interests or thoughts are slightly neurotic." There were others who, along with the orderly, expressed a combination of work-oriented and personal reasons. Implicit in most of the work-oriented explanations was the admission that the student was also interested for personal reasons.

III. THE COURSE ITSELF

Reach the students right away, involve them personally in the course—but without scaring anybody off: that was our first goal. We decided to begin the

first session with the minimum of preamble. With the help of early-arriving students we re-arranged the chairs into two banks facing each other, separated by a narrow corridor. The instructors also separated themselves, each manning a position on an extreme end of the corridor.

Everybody who happened to be sitting on *this* side of the room was to be a subjectivist tonight. Speak only in the first person, discuss only your own personal thoughts, feelings, and experiences. Everybody who happened to be sitting on *that* side of the room was to be an objectivist. Be concerned with the general situation, with processes. Speak philosophically, scientifically, analytically.

As soon as these ground rules were announced to the class, one of the instructors initiated a broad, philosophically-tinged discourse on the topic of death. After he had been speaking for three or four minutes, the other instructor crudely interrupted him. Speaking in more simple language, using only a personal frame of reference, and conveying a tone of disappointment and exasperation, the interrupter challenged the value of this "high-flown talk. I'm still going to die, ain't I?" The battle was on.

The instructors built up this long-range artillery contest for a few minutes, then each began to invite support from "his" side. Students responded—and in their appropriate roles. Before long the subjectivists and objectivists were speaking directly to each other. Discussions flared up on several points, particularly the question of whether or not there is something worthwhile to be gained from a depth exploration of dying, death, and lethal behavior. After a while the discussion shaded into statements of both individual and social problems pertaining to death. The objectivists scored various aspects of American society for unrealistic or unhelpful attitudes toward death; the subjectivists brought forth their own personal experiences and difficulties.

Now that the initial structure of this session seemed to have had its effect, the instructors moved to introduce greater flexibility. Indicating that he had had enough of being a subjectivist for the moment, one of the instructors invited the other to change places with him. At the same time, the instructors invited the students to change sides also whenever the spirit so moved them. Animated discussion continued through the remainder of the two-hour session.

The first session seems to have had the following characteristics:

(1) A quicker than usual coming-together of classroom strangers;
(2) An assurance that discussion of death need not be turgid or depressing;
(3) The dawning discovery that the group was strong enough to survive the strong effect engendered by the topic.

The later point first became clear when one of the students introduced a knife-thrust of a comment. This attractive young woman had arrived a little late (the unexpectedly large number of students slowed down last-minute registration procedures, and some were still wandering about looking for the new room assignment). She brought the ongoing discussion to an abrupt halt when she spoke feelingly about the very recent death of her husband. It was clear that she was feeling this loss acutely. "Why did this have to happen to me? What are you supposed to do? Am I supposed to just forget about it? Is this

supposed to be fair?" This was the gist of her remarks, her words being underscored by high although held-in emotionality. There was a defiant, challenging ring to her remarks. It was as though she were somehow holding everybody in the class responsible for her predicament. What were they going to do about it? What bill of goods would they try to sell her? How could they possibly feel as she felt?

The class paused. Was this hesitation and insecurity? Apparently not—from the discussion that followed it seems more likely that the silence was simply in respect to her feelings. In a moment the young widow's challenge was met head-on by several other women. Each respondent pointed out that she had also experienced the untimely death of somebody very close to her. Perhaps the specific nature of their comments was less important than the fact that they were delivered with strength, conviction, and feeling. It was obvious they were not simply uttering conventional, hollow phrases. In general, the respondents acknowledged the widow's present state of mind, accepted it, but declined to go along with her implication that her husband's death had been "unfair," that she had been singled out for special misfortune, and, chiefly, that there was nothing within her power to do. The widow's responsibility to her infant child was emphasized. It was our impression that the respondents, answering with a level of emotional intensity only slightly below that of the young widow, were conveying the message: "We really do understand and accept how you *feel*, at least, how you feel right now. But we give you no encouragement or support for your apparent intention to use this tragedy as an excuse for moving to the sidelines of life as a bitter spectator."

In any event, the ability of the class to survive this unexpected encounter had the effect of improving group cohesion and, we think, making it clear that the group had enough strength to take on serious death-related challenges. It is also worth noting that the major response came from members of the class, not the instructors. This advanced our goal of broadening and deepening the students' own comprehension of death without in any way leading them to look to an external source (the instructors or some particular books) for the "answers."

For sake of brevity, we will summarize the following six sessions in outline fashion.

(1) The following two sessions were conducted as free-wheeling dialogues. Typically, the instructors would each begin with a short "lecturette" on some topic that had already been touched upon by the class. Students then joined in the discussion, raising questions or offering anecdotes from their personal experiences.

Part of the third session was given over to a special presentation by an invited guest. A local artist with a self-acknowledged fascination for death spoke quite candidly to the class about his own death feelings, and how he attempted to use these feelings to enrich his work. The design and creation of unusually expressive ceramic skulls was one of special interests. He brought in several examples of his work and discussed them with the class. It seemed to us that his appearance (a) offered another example of candor and openness on the subject of death, (b) made it clear that death is very relevant in the arts as

well as in the health sciences and professions, and (c) provided an illustration of how an individual could *use* his own special orientation toward death to good advantage.

(2) Feedback from several students indicated that at least a minority of the class longed for more in the way of structured lectures. For the fourth session, then, we invited one of our colleagues to make a guest presentation. Melvin Schwartz,* a neuropsychologist on the Wayne State University faculty, delivered a well-organized but informal lecture on "The Neurobiology of Death." He emphasized the problem of defining death: its history, current status, and possible future.

(3) The fifth session also featured a guest speaker. This time we invited a man who is intimately associated with the community's efforts to reduce untimely death. Bruce Danto, M.D., director of Detroit's Suicide Prevention Center, spoke to the class regarding both the practical and theoretical aspects of suicide prevention.*

(4) For the next-to-last session we decided to move back to the students' own personal relationships to death. There was no lecture material at all. One of the instructors began by recalling one of the most memorable death experiences in his life, and his subsequent reaction to the experience. The other instructor then commented upon his personal relationship to death. One of the instructors stepped into the middle of the class, drew up a chair, and asked the adjacent student to tell him about a death experience that was memorable in her life. Next, he invited two other students to join this little group—and left them to discuss personal death thoughts and experiences among themselves. Both instructors then wandered throughout the class, helping the students to align themselves into small discussion groups. An attempt was made to divide the students so that people who already had become fairly well acquainted with each other would be in different groups.

During his "eavesdropping" with one group, one of the instructors heard an intense discussion concerning the relationship between early and current experiences in the life of one of the participants. This intelligent and sensitive middleaged woman spoke about the death of her parents at the hands of the Nazis. Since that time she has never been able to cry or express any authentic emotions when confronted with death. In fact, she does not feel anything when another person dies. Furthermore, she really does not feel much for other people, period. Despite the fact that she is considered by her colleagues and friends as a "life of the party" type, she herself feels entirely distant and alienated, merely putting on a good act. Others in the small group interpreted this pattern of behavior as a defense against possible further loss of intimates by death. The woman readily admitted that she thought this was, indeed, the case.

The conversation then shifted to the situation of a younger woman in the group. The latter had a different problem with death that was very much on her

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*Both speakers are members of the Local Planning Committee of the Center for Psychological Studies of Dying, Death, and Lethal Behavior.

mind. She was, in a sense, "haunted." The man who wants to marry her is a widower, his wife having died not very long ago. The young woman felt uneasy about a sort of competition with the ghost of his dead wife—and with the question as to whether her suitor really knew and loved her or was instead trying to marry his first wife again. As the discussion unfolded it became clear that both this woman and her friend's dead wife had much in common. Again, the group provided the opportunity to explore her thoughts and feelings with no holds barred. A characteristic of these discussions may not be clear from what we have been able to convey in writing: there was nothing stilted or routinized about the "confessions." We had the impression that, by and large, people were expressing themselves directly on these matters for the first time.

(5) To round off this experience, we decided to attempt the integration of death-related thoughts and feelings through the medium of theatrics. Once again, we did not present a lengthy prologue about what was to happen—we simply began the last session by enacting a play (fortunately, this classroom possessed a raised platform which made a satisfactory stage).

The lights went out. Lighted candles appeared from several points around the room. The instructors, a "guest artist," and three early-arriving students who had been cornered for this assignment intoned by candlelight the lines of a short play entitled, "Welcome to All the Pleasures."* This play consitutes an intentionally ambiguous and abstract approach to the relationship between strivings for love and for death.

Next there followed a performance of Luigi Pirandello's memorable one-act play, "The Man With A Flower in His Mouth." This is essentially a two-person drama that moves from its casual and amusing beginning to a stark encounter with the prospect of death.

Finally, we offered our "production number." A play entitled, "Come Live With Me" incorporated a time-spanning technique (from the Renaissance to the present period). The admixture of love and death had its serious points to make, but was conveyed largely through what we hope was a spirit of humor. This play has a "happy ending," so permitted the course itself to end with the play.

IV. AFTERMATH

A few events that have transpired since the recent conclusion of this course seem to confirm the impression that it was a worthwhile effort. Several students have volunteered their services to work with the Center. Others have, in effect, volunteered their students or colleagues to serve as subjects in our research efforts. The University Center for Adult Education expressed strong interest in a repeat. We reached an agreement with UCAE to develop a somewhat more "far out" death presentation. We were also approached to offer the course (and the "far out" death special) by another academic institution a few miles outside the Detroit area, and agreed to do so.

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*Our guest performer was Miss Joan Rosenbaum, whose vivacious contribution was very much appreciated. The first and third plays were written by Robert Kastenbaum.

There seems to have been at least one area in which we came quite short of meeting the needs of our students, at least, of some students. Those who were concerned about the relationship between religious belief and practices and one's personal orientation toward death pointed out that we had not dealt extensively with this topic. Although there are rationalizations we might offer concerning this underemphasis, the simple fact is probably that we did not sufficiently appreciate the extent of interest in this, as compared with other death-related topics.

Although this course did reach a relatively large number of people, and people who are in "sensitive" positions in the community, it cannot be said that it reached a representative sampling. Relevant as it may be to delve into death with nurses, funeral directors, teachers, social workers, etc., this hardly seems sufficient. We will have to find new ways of approaching community education if we hope to share experiences with a broader base of the population.

For what it was, then—a first attempt by the Center to explore the possibility of community education on these topics—we tend to consider the experience a successful one. But it by no means exhausts the type of approaches that should be tried, or the range of people we believe should be reached. Obviously, the potential of such courses for research on the one hand, or community action on the other, are likely to be far greater than what we attempted to explore in the present offering.

SOME PSYCHOLOGICAL PROBLEMS IN HEMODIALYSIS

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THE prospect of extending human existence with an artificial kidney is already a fact of current medical knowledge. However for the recipients, continued life if a mixed blessing due to incomplete knowledge of the physiological processes involved and the restrictions imposed by medical regimes. The patients maintained by continuous hemodialysis illustrate the range of human complications possible with all artificial organs, and consequently solutions with these patients will have wider implications. Typically, the public perceives the artificial kidney as requiring the same accommodations as the more familiar replacements, therapies seen in prospthetic devices, hearing aids, or dentures. However, as difficult as these may be they don't threaten life in any immediate sense. Successful substitution requires mainly patience and a willingness to accept some degree of limitation. An artificial kidney requires much more. Here the tail wags the dog. Continuous hemodialysis can absorb the major portion of a patient's waking life and dominate the interests, diets, and activities of the remainder.

The difference between the human kidney and the dialysis process available today is grotesque. The machine is non-portable, ugly, noisy, dirty, and costly. It does not clean the blood as well, as fast, or as conveniently as the kidney it is intended to replace. Most important of all, the human kidney requires no conscious effort while the machine becomes a mistress who demands constant care, is easily upset, and cannot be taken for granted.

There is no doubt that the state of the art and technology will improve, but in the meantime the patient's lot is an arduous one. The usual hemodialysis patient is a psychological position comparable to the old western pioneer. He lives on a knowledge frontier where survival is contingent upon his resourcefulness in coping with incomplete or superficial medical advice relative to changes in his chemical environment, (Husek, 1967). He is vulnerable to attacks from acute toximias and chronic deteriorations whose presence is typically recognized too late for prevention.

From this perspective a number of issues emerge as significant psychological factors having impact upon both staff and patients. Since the method used is participant-observer, it should be noted that the statements offered describe how people react to the dialysis process as a human experience, and is based upon their understanding of events occurring in dialysis units. Because hemodialysis is such a fast-changing field of medical knowledge, the statements written here in early 1968 may well be obsolescent by the time they appear in print.

1. Eating delinquency

In the context of living with artificial organs, it is not enough to postpone death. For the person on the verge of dying, continued life is the essential desideratum. However, once the crisis is over, the more profound question is continued life for what purpose? While this question is universal, it becomes acute for the person who has been rescued from premature death. A positive answer is not necessarily the physician's responsibility, yet a negative one impairs the effectiveness of the replacement organ. For patients on dialysis this philosophical default is most easily observed in terms of their ability to cooperate with dietary restrictions.

A universal complaint staff makes in all dialysis units is the failure of patients to maintain their diets, (Scribner, 1965). Given the kind of people selected for dialysis (Scribner, 1963), their maturity (despite exceptions) and apparent willingness to cooperate, the occurrence of eating misbehavior appears strange and irritating in an otherwise tractable patient. Clearly some unusual motivations are in effect. (Schreiner & Maher, 1961). But what these might be is more obscure. To explain them one has to ask the following questions:

What sort of activities are available to the patient maintained by hemodialysis which might make his life interesting, pleasurable, and meaningful? In reviewing the possibilities one is made aware of exclusions rather than positive alternatives, (Husek, 1967). However, one ubiquitos answer occurs in terms of eating. For people with extensive and continuous dietary restrictions, a meal with all the trimmings can become a peak experience.

Eating in most cultures is an affectively positive experience in which our most intimate associations are consummated. The strong family life of most dialysis patients would tend to load the dining experience with nostalgia and sentiment. It is to be anticipated that eating in general, and esoteric or forbidden food in particular, would be especially tempting. The potential dangers of promiscuous eating merely add to the seductive aspects of the experience. The fact that it is often a gamble with death is no deterrent and should not be construed as a suicidal impulse merely because it occurs. Eating delinquency may be motivated by self-transcending goals with death as a possible price tag, or more likely never recognized as an outcome at all.

The ward physician's naturally zealous attitude toward optimal functioning has also contributed a preoccupation with improper eating as a potential cause of all dialysis failures. This well-intentioned concern has induced a complementary concern on the part of patients which precludes a casual attitude towards diet. The consequent overemphasis on food functions seductively. Parenthetically, the same process could occur in terms of fluid delinquency and was actually reported in one dialysis unit.

Since the body's capacity to assimilate chemicals and nutrients in the absence of kidney function is not fully understood, there are a number of ambiguous items, both quantitatively and qualitatively. Some are clearly forbidden, and others clearly tolerable, but a great many are dangerous only in relation to internal conditions. This borderline area permits self-experimentation with foods of uncertain effects, and in the culture of the dialysis patient legitimatizes deviation from prescribed diet. Indeed, variations and improvements of diet

have occurred precisely because of these trial and error experiences which the patients subsequently report to the staff and each other.

To counteract the temptations of eating delinquency, one must ask if there is a medically legitimate experience appropriate for the dialysis patient which he can seek without endangering his health, and which will permit him to feel that he is "living", i.e., with satisfaction and significance. One answer is to retain the element of choice as much as possible. This requires giving management decisions to the patient in terms of how much protein he can have today versus tomorrow; encouraging him to work within the framework of his culture and family diets; providing alternative diets; and permitting him to participate in eating with his significant others. This last is more complicated than it appears since the significant other may be eating in restaurants, picnics, or particular kinds of food such as barbecues, clambakes and potlucks. However, there are ways of engineering choice in food intakes, at least at a token level sufficient to permit the patient to gain a sense of participation.

The freedom to choose a meal in itself is a kind of freedom that most people take for granted or default upon. The provision for these decisions with a dialysis patient adds a whole new dimension to the patient's hope of being self-sufficient and with salutary effects on morale and cooperation.

In the absence of adequate choice, cheating on a diet becomes a "peak" experience where high risk, monotony, and continuous restrictions converge to make the conventional pleasures of eating highly significant goals to be valued occasionally over life itself. The effects of such cheating is only heightened by staff exhortation beyond the routine admonitions.

The test of the observation that eating delinquency is motivated by a variety of irrational needs would be the reduction in complaints with the availability of other alternative modes for securing peak experiences. Some examples follow: participation in a group with a larger purpose than individual needs such as fund raising campaigns or legal rights of the dialysis patient; acting as counselors for new dialysis patients such as in AA or other self help groups; paid assistants in home dialysis of other patients or as professional subjects in testing life support equipment. These are activities which utilize the patient's special experiences for which they can earn money, recognition, or social status directly rather than irrationally through the self-defeating process of eating delinquency.

Another positive answer is employment and especially the kind of work the patient finds meaningful. For men in the American culture with the middle class ethics about the value of working, the loss of steady employment devalues them as people, let alone as males. In the context of being granted more life, this further denigration adds another increment of irrational pressure towards doing something more than existing. Regular employment in any degree is an effective prophylactic that minimizes some of these pressures towards eating delinquency. In the long run, medical staff need to face the issue of how much dietary cooperation a particular patient is capable of sustaining when the expectation is for a lifetime.

The patients on hemodialysis have developed techniques for coping with the psychological deprivations resulting from continuous and extensive dietary restrictions. Empirically, these patients have noticed that the ingestion of some forbiddens immediately before dialysis has no experimental consequences

as compared to the same items taken thereafter. Apparently these chemicals are removed before they can accumulate sufficiently to yield sensations. Simply increasing the number of dialyses from two to three times per week can increase the patient's tolerance for restricted items in the prescribed diet and thereby permit more variety and self-regulation. With increasing psychological sophistication, dialysis staffs have become more flexible in their dietary presecriptions. These two changes should permit a reduction in irrational motivation in the uncooperative patient and his diet. It will remain for future observers to document that these changes do, indeed, occur. If it is confirmed it may very well document the speculation that too little choice is as toxic to medical cooperativeness in the patient as increased urea to his life expectancies.

2. The Role of the Patient

Another significant psychological issue is the role of the patient in the medical context of the dialysis unit. By "role" is meant a package of expectations, more or less stereotyped, and analogous to a part in a play, which is imposed upon the person both by himself and others in the same setting. Thus, the traditional role of patient is one where he is expected to be a quiet, docile, passive, cooperative, unquestioning, long-suffering, object-of-scrutiny-by-incommunicative experts who know more but tell less. While there is ample evidence that this traditional role is obsolescent in such areas as mental illness, it is absolutely impossible in the area of continuous maintenance hemodialysis. What the ideal role of the hemodialysis patient may be is necessarily obscure and in transition. However, some of its qualities can be described on the basis of expectations which contribute to medical well-being. The patient in a dialysis unit is generally expected to act more like a colleague, who is equally knowledgeable in his specialized area of competence, namely, what it feels like to have the malady and receive the treatment. These people are expected to exercise their intelligence, wit, knowledge, and *savoir faire*, in participating, supervising and administering medical regime. Indeed, Scribner (1965), in his survey of nineteen investigators throughout the world, stresses that patient cooperation is the single most important factor in successful treatment.

Traditional doctor-patient and nurse-patient roles in this context are impediments to effective care. Like the paraplegic or orthopedic rehabilitation center, there is greater involvement simply on the basis of extended treatment. Over time, more social intimacy develops than is possible in an acute medical service. There is greater personal concern, and care is anything but routine. The attention received is from individuals to individuals; patients do not get lost nor is a dialysis unit the place for staff to withdraw emotionally. The atmosphere is as open as a fishbowl or group therapy. The patients ask for information, participate in certain decision making, and occasionally question procedures that conflict with their preconceptions. The patients are actively involved in their own management, and may be called upon to exercise good judgment in preventing changes in routine procedures by new or substitute staff, where they know these routines have inimical effects on dialysis.

The group of patients on chronic dialysis are a unique clinical group whose small number and total involvement in an esoteric and life-threatening venture

develops a sub-culture membership which can be a source of strength, especially where the colleague role has been emphasized. Much can be said about the content of humor in this group with the figurative imagery of urination dominating the punch lines. Also, the very tangible *rites de passage* is from the role of sickness to that of chosen people. The group as a whole tends to have a commitment to its members, and conversely, group expectations are imposed on the would-be deviants in terms of criticism, humor, or withholding of support. Some group expectations are neutral to negative to facilitating life on the machine. This same group influence is available as supplementary restraint against unnecessary risk taking. As home dialysis becomes more popular, the absence of group expectations permits a corresponding acceleration of uncooperativeness with medical regime unless steps are taken to incorporate self-regulation through persons working with the patient. Formal or informal group expectations can be built into any program of self-dialysis, since it is to be expected that the patient himself will be vulnerable to lapses in judgment and cooperativeness.

The colleague's role tends to enhance the value and self-respect of the dialysis patient and thus minimize irrational and self-destructive needs. An example of how this new role has both practical and psychological advantages is the possibility of asking one dialysis patient to help another in home dialysis. Whether to pay them or trade services in a buddy system could be resolved at an individual level, but regardless of which is utilized, each dialysis patient would enhance his social value and thereby increase his motivation and cooperativeness with medical regimes by rendering special services to his fellow patients. Again, this builds upon the colleague role for the patient. Experiences with self-help groups in all areas of medical practice offers ample precedence for using experience dialysis patients to orient and counsel new ones on how to live with the artificial kidney. Beyond these more parochial uses of knowledge and latent talent to the dialysis patient there is broader possibility in the sharing of experiences with patients involved in other kinds of artificial organs, i.e., common problems of living with the medical limitations of complicated equipment.

Another example of mobilizing dialysis patients to help medical staff is their contribution to the selection process. Clearly, patients who have lived through dialysis have some sensitivity to what it requires. Prospective candidates could be given a preliminary orientation by patients and the resulting discussion conveyed to screening boards for evaluation in final selection.

To date there have been minimal accommodations for the economic and legal rehabilitation of patients with artificial organs. These changes, which have impact on the continued well-being of hemodialysis patients, must wait for the collective efforts of self-help groups. The colleague role of the dialysis patient is an excellent preparation for such goals.

3. *The Influence of the Family*

For the patients with renal impairment, the most essential single factor in their willingness to cooperate with medical procedures, is the presence and kind of relation towards a spouse, (Sand, et al 1966, Brown, et al 1962). Ideally the mate shares the affective load of a life fraught with peril, acts as a conscience in assert-

ing agreed-upon standards when lapses occur, and provides a motive for the continuation of life, at the times the patient himself might tend to give up.

Does this imply that patients without spouses, or available significant others are a poorer risk for successful chronic dialysis than those with involvements? A patient living alone has fewer resources for absorbing the daily, cumulative, distress and sustaining his motivation for continuing life in the face of drab, discouraging circumstances. However, there are alternative resources for the patient without significant others, as there are for those who lose their intimate companions.

The patient group can compensate for and make up some of the deficiencies present in the interpersonal life of its individuals. The critical factor is the availability of someone who cares, which typically we find embodied in the concept of a spouse. Membership in a group could in part substitute for the missing significant other.

An important failing of chronic maintenance dialysis is the development of impotence and its persistence. While the impact of this psychophysiologic disability varies substantially from patient to patient, its overall importance in the matter of family interrelationships is significant. Undoubtedly the impotency of the chronic dialysis patient is in part related to the neurologic degeneration attending the uremic state. Yet it is frequent in patients who have no other reurological deficit and may worsen while overt neurologic disease is improving. Aside from the direct effects of reduced vitality on male sexuality, some other psychological factors may seem important.

The most obvious in the context of dialysis is the reduced secretion of urine. For men this means the absence of occasions to handle one's penis, and consequently the loss of physical feedback from this organ, which may reduce the sexual stimulation of these men. Sexual needs for males, at least, tends to be self-perpetuating in that the more orgasms experienced the more are sought. Extended absence tends to reinforce disinterest. The exceptions, of course, are those occasions where physical tension builds up and triggers the variety of release mechanisms open to men in the age, education and socio-economic subgroups to which dialysis patients belong.

A broader issue in America is the tendency to invest sexual experiences with far greater significance than the simple fact of reproduction ordinarily justifies. This overinvestment is easily documented by the emphasis on sexuality in entertainment and advertising. Since sexual encounters between people do represent moments-of-truth anyway, there is a small element of truth that justifies this overconcern. Sexual behavior is perceived as a measure of one's general capacity and subsequent value as a human being. For the patients on dialysis, whose reduced vitality limits their objective sexual performance anyway, there is a further tendency to denigrate their value as people in terms of sexual failure. Personal feelings of inadequacy, impaired sense of well-being, induced by renal failure and the social stigma of chronic unemployment, all tend to be externalized by the tangible failure to achieve erection, intromission, orgasm, or impregnation.

The sexual life of the dialysis patient represents a direct example of their residual capacity to live which can be scrutinized by the physician in evaluating overall response to chronic hemodialysis.

4. Selection of Candidates

There are far more suitable candidates than placed for chronic hemodialysis (Scribner 1965). In virtually all dialysis some type of selection occurs regardless of formal policy or position of the program (Husek 1967). The issue posed is between deliberate selection by some rational criteria relevant to optimal outcome versus selection by lot, default, expediency, or sentiment.

Superficially, the argument can be made that merely providing more equipment resolves the necessity for selection. However, experiences are accumulating which demonstrate individual differences in capacity to cooperate with chronic hemodialysis, and it seems likely that even if an infinite capability existed in terms of equipment and personnel to use it, all patients deemed medically suitable with terminal renal failure would not do equally well on dialysis. In the units where patients were admitted during initial phases, selection was made on the basis of medical and social expediency, willingness to accept dialysis, and the existence of empty beds. The consequences of this kind of choice are obscure, but undoubtably contribute to management problems in terms of uncooperativeness.

There is an inherent tendency of any selection process to favor patients who participate in the middle class morality that dominate American values, such as ethics of cleanliness, punctuality, gainful employment, payment of bills, regular church attendance, fidelity, monogamy and material achievement. However, there may be more specific, rational and relevant psychologic criteria for selection of candidates.

There is the question of what stage in renal disease should a patient be placed on dialysis? While this is clearly a medical question, it has a psychological implication in that part of the success of dialysis therapy is a function of residual health or vitality. Life with dialysis requires more social and medical resources currently than do other chronic conditions. If selective criteria require some emphasis on the patient's physical capacity to carry on meaningful or worthwhile activities, the patient who starts dialysis earlier in his renal disease will bring more resources to the problems of adapting to dialysis.

The orientation of medical boards to dialysis is critical. Is this procedure being used as a treatment, a palliative, or a substitute? By treatment is meant the assumption that dialysis is the preferred solution to a particular patient's degree of renal failure, and is embarked upon as a permanent solution in the light of existing medical knowledge. By palliative is meant the use of dialysis as a means of relieving the symptoms of renal failure as long as his vitality permits, but until termination occurs. By substitute is meant the use of dialysis as a holding action until kidney transplants are possible.

Aside from the medical implications of these three positions, the psychological impacts are profound. The patient will mobilize more enthusiasm and cooperation where he perceives dialysis as the treatment of choice. Probably the least cooperation will occur where dialysis is a holding action and perceived by the patient as second best to transplant. Of course, if transplant occurs immediately there will be no problem with cooperation. However, as is typical, if the search for a compatible donor takes several years, difficulties will certainly become apparent. The patient who is being symptomatically treated is more vulnerable to discouragement and depression but may be able to cooperate better than

the patient awaiting transplant. These are psychological implications for the patients on dialysis imposed by the approach of the physicians in their orientations towards dialysis, and which consequently have profound impact on the cooperation and motivation of all dialysis patients.

Obviously, the immediate goal of dialysis is the ubiquitous postponement of death. However, dialysis must aim for more than mere existence; consequently selection of patients must aim for full rehabilitation of pre-morbid functioning.

With women this usually means the ability to manage a household or carry on some meaningful activity; with men this must offer some promise of being able to work. If treatment itself becomes the full time occupation of a patient, there is an inherent double-bind that will impede the medical goals of the dialysis and actually reward the patient for uncooperative behavior. Less than this criteria is to expect more cooperation than a patient can mobilize and sustain over the long haul without additional rewards.

There is also the question of home dialysis versus hospital dialysis. Aside from economics, medical emergencies and the disruption of the home, self-dialysis poses two psychological issues. The first is the value of self regulation in attempting to approximate a normal life. This may or may not be an advantage. In the obvious effort to avoid medical dependency, home dialysis may foster a physical dependency on the spouse. This in itself may be quite contructive in some marriages, but in others may foster further symbiotic kinds of psychological dependency which can be exploited in a contest of marital conflict.

The second issue is psychological isolation of the patient from others undergoing the same experience. For people sharing an esoteric encounter with some legal and economic stigmas, it is demoralizing to be isolated. Hospital dialysis permits some sharing of these difficulties with others similarly affected. Dialysis Centers or a buddy system could resolve this aspect.

Another issue is the choice of fistula versus shunt methods of tapping the blood from the patient to the dialysis chambers. The fistula appears to be more convenient, sterile and safer, but is not as suitable for females, presents some technical problems in blood flow volume and is currently so esoteric surgically that it cannot be easily performed in many dialysis units. Yet again, the choice is important psychologically since it gives a man more freedom while affecting the body image for women.

Very similar to the fistula is the debate about choice of a site for a cannula (i.e., arm versus leg). The majority of patients receive arm cannulas which clearly limits the patient's capacity for readying himself for dialysis, and certain kinds of work. A leg cannula allows the patient to use both arms in the dialysis process and would be a clear advantage in home dialysis. It just may be that other issues have been found more important and thus the choice was left to tradition, since the first ones were in the arm. Patients' preferences in the location of this vital spigot were not in evidence in the observations reported here. It may well be than an effective site may depend on the patient's individual preferences since it will influence his capacity to adapt to dialysis.

5. The Prospect of Imminent Death

"Everyone knows they are going to die some day, but everybody acts as though it will never happen to them." However, there are some people, and occupations, in which it is impossible for the individual to avoid facing the prospect of his imminent end. The most obvious examples might be soldiers in the midst of fighting, policemen and professional pilots. Chronic hemodialysis is one of those situations where the frequency and continuous extent of physical distress force the patient to recognize the high probability of dying. However, even in this context the denial process is evident (Wright, et al, 1966). The insufficiency of medical rescue efforts prevents the patient from denying the prospect of his own termination and consequently forces him to face the imminent possibility of his own death. Schreiner and Maher (1965), describe two patients who voluntarily withdrew from dialysis and thus essentially committed suicide. However, these two are exceptions. More typically, the full emotional recognition that "today or tomorrow I will be dead, and my capacity to participate in all the things I value will cease." As self-evident as the preceding statement may seem most people make use of denial mechanisms to avoid facing the possibility of a world without them in it. The presence of this defense is most apparent after a person has a "close call." Subsequently, some of these individuals will reevaluate all their values and goals dramatically, in the light of a near death or dying experience. It's as though they suddenly realized for the first time that they might one day die.

The patients on chronic hemodialysis die every day — or more positively are "saved daily." While the novelty and subsequent drama may wear off, the dialysis patient is unable to deny, or rationalize, the possibility of his death completely. With no escape possible he is forced to consider the meaning of his life with the prospect of making his "every day count," since he never knows which one is his last.

In spite of the morbidity implied by these considerations, the patients consider the significance of their daily pursuits, relations and values, and reap the advantages of the Socratic dictum, "the unexamined life is not worth living." Paradoxically, a full acceptance of one's own mortality facilitates the patients capacity to follow regimes, since they are more able to translate specific hazards into life and death issues. The failure of patients with diabetes or obliterative vascular disease to follow medical restrictions is related to the delusion of immortality and associated with the universal denial mechanisms, (Farberow, et al, 1968). Accepting the prospect of imminent hazards to life helps the patient to cooperate with strict diets, avoid potentially hazardous exercise, follow medical procedures in caring for himself at home, and aids his morale in living with pain, impairment and diminished vitality.

Thus, a key psychological issue is the patient's capacity to accept the prospect of his imminent death which continuous distress makes more real than for the medically well person. All of the patients on chronic hemodialysis have had one or more experience with near dying and the prospect of sudden termination is ubiquitous. In such a context the usual benign delusion about one's immortality is untenable, and alternative thoughts occur. Psychological problems,

reactive depressions and suicidal behavior are often mentioned but do not seem to occur any more frequently than in other chronic termal conditions, (Husek, 1967). Instead, one finds examples of unusual optimism in conversation or group discussions.

Patients treated in dialysis units tend to be more accepting and matter of fact about their own termination than are the medical staffs who operate the units. While medical staff do handle death every day, their psychological skills are predicated on the premise of professional distance, uninvolvement and emotional neutrality. Coping with the death of a stranger, or even a client whose relationship is casual, does not challenge his personal philosophy or intimate reaction. In most medical wards, the transient nature of patients prevents involvement. In the dialysis units, however, the smaller number and continuing nature of treatment induces significant human commitments. Professional distance is reduced, and each member of the staff is touched by the people he serves. Death in this context takes on the impact of bereavement by friends, relatives or associates.

The death of someone close forces individuals to evaluate their own termination, a subject most seek to avoid.

The failure of specific staff members in dialysis units to work out answers to the prospect of their own death, impairs their effectiveness in helping patients cope with their own reactions. If the most staff can offer is a variation of their own denial mechanisms, then the patient must turn to other, necessarily non-medical, but informed sources for help. An immediate corrolary impairment in staff-patient relations occurs and increases in terms of obstacles to effective communication. The existence of taboo areas acts as conversation. One never knows what taboo will be violated if spontaniety is permitted in casual talk.

The differential quality of staff-patient coping with death is most apparent in terms of the grief reactions, disguised but observable, among staff when a specific patient dies.

There are many positive values possible in the direct acceptance of one's personal mortality. For the patients, the prospect of death leads ultimately to thoughts about utilizing the remaining time more fully and constructively. The specific answers are necessarily unique and personal, but typically involve here-and-now type effects that usually yield immediate pleasures. The experience of satisfaction is generally incompatible, and remains an effective prophylaxis against depression, especially in the context of termination.

A medical advantage deriving from the patient's acceptance of imminent death is his corresponding acceptance of limitations inposed by treatment or illness, the denial of which permits behavior that aggravates symptoms and reduces life expectancies. The more "normal delusion" of immortality ordinarily predisposes a patient to minimize the consequences of non-cooperation with a medical regime in terms of diet, activities and punctuality.

The dialysis patient's survival in the face of terminal kinds of impairment, the exotic medical procedures employed, the hot-house kind of existence that they tend to lead, emphasize their differentness from ordinary people or patients. Potentially, their differentiations as a unique group is positive in that it can facilitate joint action for valuable goals.

Individually, belonging to and participating in a significant shared experience permits self-transcending states to occur in which these people use their awareness of uniqueness as a springboard to greater understanding of where they fit in a society and how to solve some human dilemmas such as the necessity to accept physical restrictions to diet and activity.

The awareness of imminent death forces the individual to reconsider the ordinary, taken-for-granted kinds of things, such as eating, home, work, entertainment, family, etc. These mundane events become more appreciated and a better perspective on their value becomes possible. This potential and optimal result is more likely to occur if medical staff are oriented and sensitive to the issue of imminent death. The fact that positive life continues in a medically impaired group, where dramatic procedures postpone death, makes these people poignant examples of the effectiveness of artificial organs.

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SOME MEANINGS AND CORRELATES OF FUTURE TIME AND DEATH AMONG COLLEGE STUDENTS*

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A BODY of literature is growing in psychology which deals with how a person relates to the time dimension of life and the inevitability of his own demise. Through many centuries time and death have been of great concern to philosophers. In recent years, philosophical and physical conceptions of time and death have been joined by much psychological investigation and theory in those areas. Wallace and Rabin (1960), in their definitive bibliography, collected some 159 essay and research sources relating to time perception and perspective. With respect to the latter focus, Wallace (1954) introduced the concepts of future time extension (length of future time span) and coherence (degree of organization of future time and its contents) into his own work.

In 1959 Kastenbaum logically and factorially analyzed four dimensions of time: extension (future duration or range), coherence (degree of organization), density (number and frequency of anticipated future events) and directionality (sense and purposefulness of movement).

The problem of death has likewise received extensive religious and philosophical examination and recently has been the object of considerable psychological interest. At various times, Freud held three views about death. One was that fear of death was derived from castration anxiety (Freud, 1960). Second, he acknowledged that man, in a hypocritical way, suppresses the necessity to face death (Freud, 1915), and third he finally conceptualized the death instinct in man's psyche (Freud, 1960).

Another source of concern about death, both philosophically and psychologically, stems from existentialist writings. For example, Heidegger, Sartre, and Camus among others convey the impression that modern man is "rediscovering" death. Except for a few early studies (Bromberg and Schilder, 1933, 1936), empirical investigations into attitudes toward death have been quite recent in origin. Without doubt the most comprehensive treatise in the area is Feifel's (1959) *The Meaning of Death*, in which extensive theoretical, developmental, clinical, experimental, cultural and religious information and research are discussed. In his overview in this volume, Gardner Murphy notes at least seven different aspects of death attitudes: death merely as natural end, death as fear of loss of consciousness and mastery, plus fears of loneliness, of the unknown, of punishment, of failure, and finally death in terms of worry over the future of one's dependents.

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This scheme and that of Kastenbaum provided the basis for the present study which was directed toward determining possible patterns of relationships among perspectives on future time and death, and how these might relate to other behavioral and cognitive expressions. This is premised on the theory that one's current orientations, beliefs, and behaviors are consonant with his perspectives on future time and death.

Based upon this orientation, the following hypotheses were constructed.

1. An outlook which sees the distant future as clearly defined (extension), organized (coherent), filled with activities (density), moving in a consistent manner (directionality), will also be attractive (valence). Measures of these time perspectives will thus be interrelated along a dimension definable in positive and negative terms.
2. An affirmative orientation toward death will see dying as a natural end not necessarily involving pain, loss of mastery, loneliness, mystery, punishment, being forsaken, or as exemplifying failure. Such a view will relate death to courage and final reward, and thus measures of death perspectives designed to assess such outlooks will be positively related.
3. The affirmative perspectives on future time and death hypothesized above will tend to be positively correlated.
4. The hypothesized affirmative future time and death perspectives will be positively associated with intrinsic religious faith, perceived religiosity, and frequency of church attendance.
5. The hypothesized affirmative future time and death perspectives will be positively related to higher current productivity as represented in college grade-point-average and more constructive orientations toward the world and current affairs, less dogmatism and less need to respond in a socially desirable manner.
6. Because age, marital status, parental income, and political identification may be reflected in maturity of outlook, the acceptance of responsibility, and a basis for broader concern among college students, it was hypothesized that affirmative time and death perspectives would relate positively to age, marital status, being employed, and liberal political affilitation. A negative relationship to parental income is suggested since high parental income might serve to reduce burdens requiring more concern and responsibility in a college sample.
7. Because the method of the present study is factor-analytic in type, it was further hypothesized that additional dimensions which might be evidenced would be (a) tough-minded *vs.* tender-minded (Eysenck, 1953) (b) an affirmative *vs.* a negative world-outlook (Lewin, 1942; Schweitzer, 1950) (c) a courage-fear continuum, and (d) a liberal *vs.* a conservative outlook (Eysenck, 1953, 1954).

METHOD

Subjects: Two hundred and ninety college students from a wide variety of humanities, social sciences, and business administration courses served as Ss.

These were administered an extensive battery of tests, and 195 complete sets of data were obtained. The final sample represented 107 males and 88 females, the mean ages of which were respectively 21.8 and 21.0 years.

Materials: Fourteen 18-item, 4-point Likert scales were constructed. Five of these were designed to assess future time perspective while the remaining 9 dealt with different attitudes and views of death. Table 1 summarizes briefly the nature of these instruments. Those concerned with future time, except for the scale labeled, Valence, are based on Kastenbaum's analysis of time perspective. Seven of 9 death scales related to Murphy's theoretical breakdown. Death as relating to an afterlife of reward, and as an expression of courage and one's values were added to broaden coverage in this area.

TIME I

Brief Description of Time and Death Scales

Scale Description	Item Selection Criteria	Split-half Reliability (corrected for length)
Future Time Extension	duration; range	0.62
Future Time Density	number & frequency of events; changeableness; productivity	0.45
Future Time Directionality	purposefulness; continuity; speed of movement	0.37
Future Time Coherence	predictability; degree of organization; controllability	0.49
Future Time Valence	approach or avoidance or ambivalence	0.48
Death as Natural End	naturalness; simple conclusion	0.63
Death as Pain and Loss of Self-Mastery	fear of pain &/or loss of consciousness; prospect of violent end	0.76
Death as Loneliness	dying as lonely experience; abandonment; isolation	0.62
Death as Unknown	mystery; ambiguity & uncertainty	0.77
Death as Punishment	punishment by God; remorse & guilt feeling; retribution against others	0.83
Death as Forsaking Dependents	guilt over abandonment, or feeling abandoned; hostility and envy toward living	0.74
Death as Personal Failure	frustration; pessimism; defeatism; regrets over past mistakes	0.75
Death as Afterlife of Reward	faith in everlasting life; personal participation in eternity	0.89
Death as Expression of One's Values & Courage	sense of duty; secular optimism regarding dying as opportunity to express one's faith	0.67

Dogmatism was assessed by the Rikeach Dogmatism scale (Rokeach, 1954), while Social Desirability response tendencies were evaluated by the Edwards SD scale (Edwards, 1957). The Wilson Extrinsic Religious Values (Wilson, 1960) plus questions relating to extent of personal religiosity (perceived religiosity) and frequency of church attendance were employed as indicators of extrinsic religious values and the significance of religion in one's perrsonal life. In addition data were collected on sex, age, marital status, class level in college, parental income, whether employed or not, and political affilitation.

For purposes of botaining reliability estimates for the time and death scales, a simple split-half procedure was employed. The estimates of reliability presented in Table I are thus probably minimal.

RESULTS AND DISCUSSION

The data were subjected to a principal components factor analysis (Harman, 1960) which resulted in 12 factors that accounted for over 99 percent of the total factor variance. These were rotated orthogonally to the Varimax criterion of simple structure. A factor loading of approximately 0.30 was considered minimally indicative of significance in the final rotated matrix. Table 2 presents those loadings in the rotated matrix which met this criterion. Those variables which loaded only on one factor and in a manner unrelated to the hypotheses are not presented. Similarly those factors which both accounted for a negligible amount of the total variance and on which only one or two variables loaded weakly and were also unrelated to the hypotheses were eliminated from Table 2.† These are, however, briefly discussed in the following pages.

Hypothesis 1 which postulated a positive-negative future time perspective factor obtains support from Factor III on which the time perspective scales of directionality, coherence, and valence load in part. The direction of the loadings and the intercorrelations among these scales are all positive, suggesting that an attractive view of the future is associated with views of the future as being purposefully directed and organized. Factor V similarly shows a positive correspondence among the time extension, density and valence scales; thus a positive view of the future is related to one which is also active and interesting, and which further possesses extensity or in other words, is of a long-range nature. Factor VI, however, provides the strongest support for Hypothesis 1 in that time destiny, directionality, coherence, and valence are all loaded in the same direction, and reflect the consistently positive pattern of correlations among all of the time scales.

Hypothesis 2 which postulated an orientation towards death similar in nature to that suggested for time, gained strong support from Factor I. All of the negatively oriented death scales loaded in the same direction, and all correlations among those measures were positive. The two positively scored death scales, those relating to death as a rewarding afterlife and as an expression of courage and one's values, load together on Factor III, and correlate negatively with all of the other death scales. Factor I thus reveals a strong reaction to the idea of death as fearful, possibly violent, as punishment, loneliness, being defeated, and forsaking one's family. The puritanic and fatalistic strains evidenced here might reflect "death anxiety." Viewed from its opposite scoring possibility we see the consistency suggested in Hypothesis 2. The correspondence noted in

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†Because of the extensiveness of a 42 variable intercorrelation matrix and a 12 factor, 42 variable rotated factor matrix, this abbreviated matrix is presented here. All data and measures are available from the authors.

TABLE II
Rotated factor matrix[1,2]
(Loadings judged as significant are entered)

Variable	Factors I	II	III	IV	V	VI	VII	X	XI
1. Class (college)		79		81					
2. Church Attendance		79							
3. Reliogisity		72							
4. Extrinsic Religious values		72							
5. Employment				30				50	
6. Marital Status				74					
7. Conservative political Orientation								-72	
8. Parental income					-58(71)		38	45	
9. Time extension									31
10. Time density					41	73(44)			
11. Time Directionality			62			58			
12. Time Coherence			29			51(64)			
13. Time Valence	42(45)[3]		32		31	35			
14. Death; Natural End	32						-36		64(55)
15. Death Pain	75(81)								
16. Death Loneliness	73(71)								
17. Death Unknown	41		62(75)						
18. Death Punishment	73(74)								
19. Death Forsaking	51(64)		30				-29		
20. Death Failure	78(67)								
21. Death Reward		66(66)	55(51)						
22. Death Courage			68(62)						
23. Dogmatism						36			
24. Grade Point Average					-46				
Percent Variance Accounted for	33.4	15.0	9.0	6.1	5.6	5.3	5.0	4.1	3.8

[1]Factors VIII, IX and XII are not shown since only one or two variables load on the factors each of which account for about 4.10 of the total variance. None of the time or death scales are present in these factors.

[2]The variables of age, sex, social desirability and general knowledge are not shown since each loads on only one factor. All variables and factors not present here are discussed in the results and discussion section.

[3]Since all time and death scales were split in the analysis, where both halves load above .30 on a factor, the two loadings are presented.

Factor III also supports this hypothesis. Factors VII and XI show similar directional correspondence among various of the death scales.

The positive-negative dimensional relationship between perspectives on time and death presented in Hypothesis 3 is only tentatively supported. In Factor I valence or attractiveness of the future loads in the same direction as the negative death views. This would appear contradictory to the suggested relationship. The intercorrelations among the time and death scales appear to be low, but nevertheless are still positive. One might wonder about the existence of an acquiescent response set being present here. In Factor III a similar contradictory pattern is present among the time and death measures; however, this could represent an effort to find values outside the religious sphere, and thus might be opposed to the pattern observed on Factor II. Factor III could thus be interpreted as not including truly conflicting views

but a natural kind of ambivalence when contemplating both death and the future.

The relationship between future time and death perspectives and religious belief and behavior suggested in Hypothesis 4 is most closely evidenced in Factor II. Here religiosity, church attendance, and extrinsic religious values are associated with both positive and negative views of death. Accounting for some 15 percent of the total variance, this rather important factor could be depicting a traditional Christian "Bible-belt" set of beliefs. At the same time, it also seems to reflect a wavering kind of orthodoxy as suggested by the negative views of death. In the main it does appear to demonstrate a conventionalized extrinsic form of religion. Hypothesis 4 is thus only partially supported.

Hypothesis 5 postulated a correspondence among positive time and death perspectives, a broad worldly orientation and evidence of high intellectual motivation and accomplishment. No support is gained for this expectation. Factor IX which possessed loadings of significance only on Dogmatism (-518) and Social Desirability (819) simply reveals that the former measure seems highly contaminated with social desirability response tendencies. General knowledge loads only on Factor VIII which contains no other loadings above .30. Grade Point Average loads on Factor V in the same direction as does parental income and time extension. This pattern is opposite to an attractive and filled view of future time. In other words, good grades seem to go along with high parental income and the long range view of the future, but this does not mean that the future is viewed favorably. Hypothesis 5 thus remains without support.

As with the preceding hypothesis, Hypothesis 6 suggested that other behavioral and belief indices such as marital status, being employed, age, parental income, and political preference would be meaningfully associated with time and death perspectives. Such did not occur and no support was gained for this hypothesis. It was, however, observed on Factor IV that the longer one has been in college, the greater is the probability that he is married and employed. This combination is essentially independent of all time and death perspectives. Factor X also reveals a peripheral combination in that being employed is positively associated with parental income and negatively related to the possession of a conservative political viewpoint. This suggests a need to know more about the actual influence of parental income on belief and behavioral variables in the college situation. Level of education or intelligence may be an influence here, but this study fails to provide information for further interpretation.

The three rather general dimensions of tough and tendermindedness, positive-negative world outlook, a courage-fear continuum, and liberalism-conservatism are at the most very tentatively supported. Factors I and III in their combination of time and death scales could be interpreted as indicating differentially tough or tender views of life and the world outlook involving underlying fearful or courageous approach to these areas. No liberal-conservative dimension is evident and further inferences regarding such possible secondary factors would appear to be unwarranted.

In general, it is felt that some fairly distinct modes of believing and acting relative to the future and death have been suggested by this study. Though support is often tentative for various of the hypotheses offered, the principal factors observed here are suggestive of different life-views, somewhat after the manner of Charles Morris' theoretical "paths of life" (1942). It is believed that an approach such as employed here does offer a fruitful avenue into the study of different philosophies of life.

SUMMARY AND CONCLUSIONS

The present study was based upon the assumption that one's present beliefs and behaviors are a function of perspectives on time and death. In order to assess this approach, 9 scales of attitudes toward death and 5 of future time perspectives were constructed. One hundred and ninety-five college students completed these questionnaires along with measures of current status as to work and marriage, political affilitation, social desirability and dogmatism response tendencies. In addition, information was gained on general knowledge of the world and current affairs, plus actual collegiate grade-point-averages. A correlation matrix of the 28 variables was factored by the method of principal components, and the 12 factors extracted were rotated to the Varimax criterion for simple structure. The seven hypotheses constructed were evaluated by an examination of those loadings on the various factors which attained a cutoff criterion of about .30. In brief the following conclusions appear warranted.

1. A positive-negative dimension of time perspectives appears to exist. Positive views of future time are associated with long-range perception of the future as being organized, filled, and possessing direction.
2. A positive-negative dimension of perspectives on death was observed in which a consistent pattern of death as being a natural end is involved with expectations of pain, loneliness, encountering the unknown, punishment, failure, and the forsaking of loved ones. The perception of death as involving regard and the expression of courage and values was also found.
3. The positive-negative dimensions of time and death perspectives are weakly present.
4. A factor of extrinsic religion in which religious belief and behavior is associated with somewhat ambivalent views of future time and death was extracted; however, in the main, religiosity would seem to be negatively related to fear of the future and death.
5. In general, measures of knowledge, achievement in college, work and marital status, dogmatism, and social desirability tendencies, political affilitation and age and sex were unrelated to perspectives on future time and death.

In summary, the phenomenological existential premises on which the present study was undertaken achieved tentative support.

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THE ONSET OF THE DYING PROCESS*

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"Living is dying." "To be born is to begin to die." "Each time I breathe, I die a little." These statements, in spite of undeniable philosophic implications, are too often used as equivocations when we try to learn more about the actual process of dying. Yet they point up the difficulty in defining the onset of dying. Dwight Eisenhower died after a series of heart attacks dating back to his first term as president; Adlai Stevenson dropped on the street and died soon after; Robert Kennedy was shot and died in a matter of hours. We could, assuming sufficient medical information, plot what Glaser and Strauss (1968) have termed the dying trajectory for each of these men. But we must learn more than the objectively charted trajectory of dying. We must also consider the trajectory as seen by the person himself and by each important person in his environment.

Many people have some form of professional contact with the dying person: one administers to his medical needs, another is concerned with his social and psychological needs, a third applies himself to satisfying his religious needs, and perhaps a fourth is more interested in studying his needs so that the insights can be communicated to appropriate practitioners.

Also, each enters the picture at a different stage. We may enter before or after we are aware that the person is terminal; we may enter before or after *he* is aware that he is terminal. We may enter shortly before death, to administer the last rites, to meet the ambulance in the emergency ward, to comfort those about to become bereaved. We may enter long before the death, as a psychotherapist, a personal physician, or a minister. In each of these situations, the professional sees the dying process through his own eyes. But even professionals often lack information on the dying process as seen through the eyes of the person who is dying.

I would like to discuss first, the process of learning that dying is the outcome of a condition that is already under way; second, the tasks that the dying person must accomplish.

LEARNING OF DYING

Some people never learn that they are dying. They are homicide or accident victims; they die from an initial massive coronary; they die from a progressive disease that has been misdiagnosed, or they have been sufficiently sheltered from knowledge of their real conditions so that death is not anticipated. We can only estimate how many die in this fashion. More and more evidence has accumulated to suggest that the dying person is much more likely to

*Since this article was written, I have had the opportunity to read the very excellent book by Dr. Elizabeth Kubler-Ross, *On Death and Dying*. New York: Macmillan, 1969. It is unfortunate that my reading came too late to permit me to incorporate the insights from this book into the present article.—R.K.

be aware that he is dying than we have previously believed. However, the dying person is frequently unwilling or unable to share his knowledge with others, even though he recognizes that the others have access to the same knowledge. Again referring to Glaser and Strauss (1965), there is a mutual pretense situation.

Most often the fatally ill person has some recognition of his circumstances. To gain this awareness, there must be some sort of informational input. Such input may be categorized in several ways.

First, it may be explicit in varying degrees. The physician who informs his patient point blank of a terminal condition is providing highly explicit information. Data, however, indicate that relatively few physicians will take this frontal approach. More commonly only hints are given. In many instances, the physician conspires with a family member, while the dying person himself is told nothing; nonetheless, he learns—from overhearing conversations, from comparing symptoms to those of people he has known, from the bedside stage whispers of physicians, nurses, relatives, friends, and others, from worried looks on faces, from questions about wills and funerals. The clues are too numerous to mention. One dying woman went so far as to tell her son, her one confidante, that "Everyone must think I'm either stupid or deaf—they stand at the foot of the bed and talk about when I'm going to die, then they come up to the head of the bed and smile and tell me how well I'm looking and how quickly I'll be out of here." Since explicit information is frequently lacking, the terminal person must put together the available information like a puzzle.

Second, the input may be complete or incomplete. There might be the kind of information that permits the person to know, without doubt, that his condition is fatal. Or there might be enough to make a judgment, but without knowing for sure. Completeness and explicitness are related, but are far from identical. A physician might very explicitly tell a patient that his condition is serious, but not give enough information for the patient to determine whether the illness is fatal. An explicit but incomplete statement might be "You have a malignant turmor in your stomach, but it is possible that an operation would remove it." An example of a non-explicit and incomplete statement would be "You seem to have something seriously wrong with you, but we'll do some more tests and see if it isn't something we can take care of." Explicit and complete: "Your tests show that you have a malignancy that is—as far as I can now determine—inoperable." By definition, a complete but non-explicit statement would be impossible. However, the patient may obtain complete information without ever hearing an explicit statement, merely by putting together a variety of vague comments, behavioral nuances, and other clues into a coherent picture.

A third way of categorizing informational input is according to the source of information. The patient may learn from any one or combination of the following ways:

(1) *A direct statement from the physician.* Inevitably, this may occur in a variety of ways, ranging from gentle to abrupt, from lengthy to brief, from encouraging questions and other responses to shutting off discussion;

(2) *Overhearing comments made by the physician to others.* Patients are frequently discussed in their presence as though they were inanimate objects. Stage whispers at the foot of the bed, explanations from physician to nurses, and so forth;

(3) *Direct statements from other health care personnel, particularly nurses.* This would normally occur only in response to direct questioning on the part of the patient, although occasionally a nurse will feel that the physician has shirked his responsibility and she will find some method of eliciting the direct question so that she must answer it. This is a rare circumstance, however;

(4) *Overheard comments made by other health care personnel.* This parallels the statements of physicians;

(5) *Direct statements by others involved, such as a family member, a social worker, a clergyman, or the family lawyer.* This occurrence is also unusual, since for a variety of reasons the physician is normally the individual to take the responsibility for direct comments;

(6) *Overheard comments by others involved.* Again, this is similar to comments overheard from the physician;

(7) *Changes in behavior of others.* In some instances, the visits of the attending physician drop off after a terminal diagnosis is made. The interactions with nurses and other staff members become more abrupt. Friends and relatives who visit may exhibit additional strain through unduly forced cheerfulness, through sudden wires and telephone calls to out-of-town family who soon appear on the scene (after all, what would prompt a brother living 2000 miles away to drop by for a casual visit?), through badly masked tears, through tense admonitions that everything will be all right. Hushed voices or false joviality become more frequent, from both family and professional staff. And, of course, the behavior of the clergyman may show sudden and significant change;

(8) *Changes in medical care procedures.* Different medication is now given. Exploratory surgery produces neither report nor follow-up. The patient is given narcotics and other pain-killers more readily;

(9) *Changes in physical placement.* The patient is moved to another room or another ward. He is sent home or there is talk of sending him home. The physical location has great significance in terms of the progress of his illness;

(10) *Self-diagnosis.* Many patients learn a great deal about their own conditions and the conditions of others. Mixed in with confusion, ignorance, and distortion is a fair amount of truth. Through reading magazine and newspaper articles, through a careful search at the local library, through listening to the fatal symptoms of others, a reasonably valid self-diagnosis can often be made. Even if the diagnosis is incorrect, the degree to which the person accepts it and acts accordingly is extremely important. On several occasions, when my children have shown a particular symptom, I have gone to my wife's old pediatric nursing books to make certain that the symptoms were associated with relatively harmless illnesses. Sick people will frequently find such a source of information describing their own symptoms. One close friend of ours had just finished reading a *Newsweek* article that described her symptoms so accurately that only her own incredulity prevented an accurate self-diagnosis on the spot;

(11) *The signals from within the body.* As pain and discomfort increase, as curative and ameliorative efforts become progressively less successful, as sedation becomes more necessary, the fatally ill person often senses the changes within his own body and recognizes that his future is brief. Again, he may be totally wrong, but we are now concerned with subjective reality, not medical reality;

(12) *Altered responses to personal futurity.* Discussion of the future suddenly takes a new tack. Visitors and hospital staff become reluctant to talk about future plans. Queries about funerals, burial, wills, and so forth enter the conversation surreptitiously—or else are aggressively avoided. Slips of the tongue are made and corrected with great embarrassment.

The response of the dying person to these clues is a joint function of (1) the clues themselves, (2) himself as a person, i.e., his background, religious beliefs, personality structure, cognitive and sensorimotor capacities, etcetera, (3) his present life status, i.e., medical condition, age, financial status, etcetera and (4) the circumstances causing his death. Patient A learns of his coming death by overhearing a conversation between his physician and the floor nurse; the diagnosis is a broken hip complicated by pneumonia; he lives alone, does not attend church or have strong religious beliefs, has no performance decrement, and is a mild and passive person. Patient B is told of his condition by his physician while his wife is with him; he has suffered a series of increasingly serious strokes and is expected to receive another; he lives with his family, attends the Catholic church, has major psychomotor impairment but no cognitive change, and hates the idea of being dependent or inactive. Patient C has almost succeeded in a sincere suicide attempt; he overhears the ambulance driver telling the physician on duty in the emergency room that his respiration rate suggests a very high risk of death or permanent cognitive impairment; he is a depressed, self-deprecating person who has attended the Methodist church on occasion. Patient D's family and physician have done an excellent job of keeping her condition from her. Unfortunately they ignored the fact that Mrs. D.'s mother died of a similar form of cancer, and Mrs. D. diagnosed herself long before the physician was certain enough of the diagnosis to inform the family. Mrs. D. is a self-sacrificing person whose life has revolved around her family and her ability to protect them from any harshness.

These thumbnail sketches should suggest quite different responses to the informational input. As we learn more about each of the variables and their relationship to patient response, we can begin to make predictions about what the patient will do. To take a relatively simple example: assume that the physician has informed the patient directly, that the patient is a stable and emotionally healthy person, that he is elderly with no dependent survivors, that his condition indicates a relatively painless death—we could predict an effective coping response. I've obviously loaded the dice—most people are not so ideal.

A person can respond to the informational input in many ways. He may be able to absorb the information immediately and completely, even though it is totally unexpected. Or he may accept one clue, live with it a while, and learn to deal with the entering wedge of probability of impending death, then return

to consider another clue. Or he may vacillate, move back and forth between acceptance and denial, or both accepting and denying simultaneously. He may overtly express his knowledge that he will die, while not emotionally accepting it. Conversely, he may be able to accept his own dying, but be unwilling to verbalize his feelings and knowledge. And he may deny his circumstances completely. Many physicians have reported making a direct, explicit statement to a patient concerning his medical condition, only to have the patient deny ever having heard such a statement a month later. The patient, of course, can distort the information by seizing upon the thread of hope the physician holds out, by seeking other medical opinions or treatment, by visiting faith healers and others who offer pseudo-medical help, by redefining the probability of survival, by denying the existence of a particular symptom, and in other ways.

Each of the situations described above can be plotted on a subjective trajectory. The subjective trajectory of the person who learns, without prior hints, that he will die shortly and who accepts the information, would be a straight line function from upper left to lower right. For others, the trajectory will dip and jump up, will blur and become indistinct, will bounce rapidly up and down like a kymograph measuring a rapid heartbeat.

Plotting the subjective trajectory next to the objective trajectory would also have value. To what extent does the intellectual awareness and emotional acceptance of the fatally ill person parallel his dying process. To what extent might the subjective trajectory exert force upon the objective trajectory, i.e. to what extent does one's belief about his own survival possibilities influence the actual survival possiblities? The subjective trajectory may never reach the point of dying, regardless of the path of the objective trajectory. Conversely, the subjective trajectory, due to misinterpretation of non-explicit and incomplete input, may move to the point of dying, when the patient's medical condition is still reversible.

To translate the latter comment from jargonese to English: the patient may misinterpret clues and assume he is dying, when in actual fact he is not at all likely to die. In this context also, the family mutual pretense situation will prevent the patient from establishing an effective two-way communication system. He does not know how—or is unwilling—to send out the kind of signal that would elicit the feedback needed to give him appropriate answers. Knowing that the dying person is not told the truth (indeed, he has probably participated in the deception of others), the non-dying patient may ignore all the clues that tell him he is healthy and will recover, but will attend primarily to those clues that may be interpreted as suggesting a fatal illness. After all, it is very easy to re-interpret a sincere smile into a forced smile, a valid word of encouragement into an attempt to reduce anxieties, a conversation between doctor and nurse as to the outcome of the football pool into a conversation on a forthcoming rapid decline.

For the dying person—and equally for the person who suspects that he is dying—vague and otherwise meaningless events suddenly become Rorschach cards into which he projects his fears and hopes. If the psychological set is that dying is likely, the interpretation of the environment will reinforce the set. The more his circumstances, his past history, his symptoms, etcetera resemble

his concept of a fatal illness, the more likely he is to interpret whatever feedback occurs as signifying dying.

TASKS OF THE DYING PERSON

As the fatally ill person copes with the process of learning about his own coming death, he also undertakes a variety of added tasks. Until his acceptance of his own fatal condition is complete, his need to accomplish the related tasks may not be sufficient to produce action or at least to produce sustained action. As an example: a dying person might need to consider the financial circumstances of his survivors and plan for them. However, a non-dying person either is required to make other plans or is able to postpone the entire concern of planning. As the ill person is increasingly convinced that he is dying, he may be increasingly motivated (assuming physical and intellectual functioning is appropriate) to plan for the family. Very possibly he will pass through periods when dying seems impossible or improbable. At any given point in time, denial may be struggling with reality so that he simultaneously feels that he (a) must and (b) need not take immediate steps in this regard.

This may serve as the first example of a task of the dying person: he must contemplate arranging a variety of affairs. Inevitably he does not have to do anything concrete—but it is doubtful if he can avoid contemplation. Thus, he may wish to verify, alter, or initiate a will; he wants to have back debts paid off; he may have messages for friends, neighbors, relatives, co-workers. He wants to discuss funerals, burial, autopsy, tissue donation. As I write this, I am asking myself what I would wish to arrange if I had just learned I would be dead within six months. I would need to make arrangements for students, grades, exams, etcetera. I would see to it that a brief codicil was added to my will. I would make explicit my desire for cremation. I would try to pull together my insurance policies to make sure none of them would expire before me. I would talk to an insurance agent or other adviser about how much money my family would need to live on and how we could come closest to arranging for it. I would suggest to what institution I wished to donate my books and journals. I would make certain my wife understood the finances of caring for the house. There are undoubtedly other arrangements, including, of course, those that involve inter-personal relationships.

My previous comments presuppose, of course, that I am sufficiently intact mentally and physically to make the arrangements. Often pain and discomfort, fear and anxiety, or confusion and disability prevent the dying person from taking such a direct role in arranging his affairs. Of course, if denial has caused his personal trajectory to reject the possibility of dying in spite of his medical trajectory, he may refuse to make such arrangements because he would feel they were unnecessary.

In addition, if the dying person has received misleading input, he may make inappropriate decisions. Often the family is able to take over most decision-

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*For a totally different approach, see the excellent book *On Death and Dying* by Elizabeth Kuber-Ross, Macmillan, 1963.

making functions (and therein is a topic worthy of a paper on its own), while the ill person merely signs the papers. However, why should a sick person, intellectually intact and led to believe that his condition is reversible, suddenly add a codicil to his will, bring together his life insurance policies, and decide whether he wants to donate his eyes to an eye bank.

What occurs is obvious: either the person receives enough input to provide a reasonably clear picture of what is taking place, or else some tasks may be left undone. A mutual pretense situation does not permit the freedom to discuss the dying process, and those in his environment are unable or unwilling to provide the required information. In order to arrange his affairs properly, the dying person must have a reasonably accurate perception of his trajectory, i.e. his personal trajectory should not deviate too far from his medical trajectory. This means that three things must have occurred: first, he must have received sufficiently explicit information, or have been able to bring together information from various sources into an explicit understanding, so that he can recognize the extent of his potential for death; second, he must have received sufficiently complete information to enable him to be fully aware of his condition; third, he must be psychologically able to deal with the clues he receives without resorting to extreme denial or repression or other mechanisms that would permit him to turn aside the implications of the informational input.

The second task is that of dealing with loss, both the loss of the survivors and the loss of the dying person himself. The dying person is often deeply concerned with what his death will mean to his survivors in ways other than legal and financial. He will frequently consider their feelings, their grief, their vulnerability, their isolation, their coming need to establish replacement relationships. Mutual pretense prevents any discussion of these feelings; open awareness permits such discussion, at least in some instances. One woman commented that during her last year of marriage, when her husband was terminal, the mutual deceit placed so much stress on top of an already stressful situation that the year was robbed of the potential it did have for closeness and intimacy.

Similarly, the dying person must accommodate himself to his own loss, i.e. that he is going to lose the entire world that he has known and—at least temporarily—all the people in it. Dealing with impending loss, widely discussed in the literature, is one of the most difficult tasks for the dying person. In the final analysis, his tears are probably a combination of his own personal sorrow and his capacity to empathize with the sorrow of others.

Has he been able to help his family find new relationships quickly or has he left them so effectively tied to his memory that they cannot move away? This becomes an interesting value question: who is better (or better off)—the woman whose husband leaves her such rich memories and emotional ties that she never feels the need to remarry or the woman whose marriage relationship was directed at self-fulfillment in such a way that she was quickly able to find a subsequent happy marriage? Which of these two women is paying the greater tribute to her husband?

Task number three is arranging for future medical and other care needs. Often this task can be left to others, but the fatally ill person may wish to take

a more active role in the way in which he dies than is presently permitted. He may wish to consider alternate care arrangements: nursing home versus own home versus hospital, hiring a nurse versus utilizing family members, using narcotics or other pain-killers versus retaining as much self-awareness as possible. It is not that the individual need make final decisions, but that he may wish to participate in the decision-making process.

The fourth task is that of planning his future and allocating whatever time and energy (and financial) resources are available. Once again, it is not that each dying person should have a time-energy-money budget that he makes out the first of each month and tabulates on the thirty-first. Rather, the knowledge that death is imminent changes the meaning of time and futurity. The proper allocation of these resources becomes both more important and less important. Is this the time to take a trip? To go on an orgy of eating and drinking and other hedonistic activities or on an orgy of reading and listening to music? Are walks in the woods more important? Is there one final beau geste to be made? Does he want to give away his money while still alive, so that he sees it being enjoyed?

Fifth, the fatally ill person might have to anticipate future pain and discomfort. Additionally, he might be faced with various forms of motor, sensory, and cognitive decrements in performance. Neither of these are pleasant, and, fortunately, most terminal patients can avoid severe physical pain and extensive changes in functional effectiveness. Again, the realities of the situation are less important than the anticipations and the anxieties. We have little accurate (or even inaccurate) information on what the dying person fears in his impending death; we do not know to what extent fear of loss of faculties is felt; we know that fear of future pain is common, but we don't know how common. More important we don't know how to communicate with the dying person to reduce his fears. Suggestions range from LSD to psychotherapy to "never telling the patient the truth because then he will give up hope."

The fear of loss of performance capability is extremely great also. The reaction of horror many people express upon seeing an elderly relative or friend reduced to a semi-coherent, shuffling, forgetful figure is common. "I would rather be dead than end up that way" is a frequent statement. Yet, by the time the condition is far enough advanced to be serious, the person is no longer capable of influencing his own destiny.

Other physical changes can occur with equally disruptive effects. Fatal illnesses often produce changes in appearance that are very difficult for either the sick person or those in his environment to accept. Similarly, unpleasant odors can also occur. Accident victims and burn victims are particularly dramatic examples, but cancer and other diseases can have similar impact.

The loss of physical function, the fear of regression, the recognition of loss of control over physical and cognitive capacities, the coming destruction of the body, all these suggest a loss of self or a loss of identity. If the body is shortly to exist no longer, who is he? (Or, more cogently, who are *you* when your body ceases to function?) Is it sufficient to be a name in the record books, a memory among your friends, a statistic in the Bureau of the Census? The Western concepts of immortality do not require that the physical body be

present in corporeal form, but we associate ourselves so completely with our physical body that it is difficult to conceptualize our existence apart from the body.

The sixth task is closely related to the fifth: the dying person needs to cope effectively with his own death encounter. I have already mentioned that he must contend with his feelings of loss. Similarly, he must account for his fear of a *rite de passage* from which no one has returned with descriptions of the demands of the new role; he has to deal with the possibility of permanent extinction; he must consider becoming a non-person, a forgotten person, a person whose continuation resides only in memories, official documents, and a few temporary results of work and human relationships.

Coping with a death encounter inevitably brings up concern with immortality. Some people accept the traditional Christian immortality of abiding with God and Jesus in some self-aware state (with or without a physical body). Others look to living in memories, through artistic or industrial productivity, through children, or other accomplishments as sources of immortality. Whatever the beliefs along these lines, the imminence of death will usually elicit consideration of immortality.

Seventh, the dying person faces the task of making a decision: to the extent that it is in his power, should he attempt to slow down or to speed up the dying process. The will-to-live is far from established as an effective determinant of life and health; yet, in spite of the inadequacy of research literature, clinical literature and personal reports are filled with examples of the importance of the will-to-live. But the patient's attitude extends beyond the will-to-live. It affects his willingness to follow medical orders, to take medication, to restrict certain eating or drinking or smoking or other activities. It is doubtful whether many patients state to themselves that they want to die sooner or later than the physician has predicted and then set about doing something about it. However, the speeding up or slowing down of the dying process is undoubtedly part of a pervasive pattern of response to the entire sickness—dying role.

The last task to be discussed consists of dealing with the numerous psychosocial problems that might beset a dying person. For example, our society condemns dependency, but the dying person must often anticipate a future of increasing dependency. He is going to be a burden upon his family, regardless of whether he wants to or whether his family accepts him willingly. He may need financial help, personal care, housing, and emotional support. The dying person frequently loses mastery over his environment and, thereby, loses one of the major supports of an adequate self-concept. He must make some adjustment to the sick role or the dying role. In so doing, he must accept the idea that others are going to do for him many things that his own selfhood required he do for himself.

A related matter: our society rewards the person who contributes to it, but causes to feel guilty the person who extracts from it. The dying person, with few exceptions, is not going to make any additional contribution to the community or to his family and friends. He will only remove resources from the society. His lack of productivity may be distressing to himself, and he is likely to reject himself to some degree because of it.

THE ROLE OF THE PROFESSIONAL

Much writing and discussion have taken place regarding the needs and the rights of the dying person to learn of his own circumstances. There is little doubt in my mind that the informational input should be as explicit and as complete as the patient is able to accept, that the source of the information should be the physician or someone (family member, friend, minister, or nurse) delegated by him, and that the information provided should err on the side of being too explicit and too complete, rather than insufficiently explicit and complete. Thus, the present tendency is to state "The patient should be informed of his condition if it seems probable that he is emotionally stable and if there is evidence that such information would not rob him of hope." I would suggest the focus be as follows: "The patient should be informed of his condition unless it seems probable that he is emotionally unstable and unless there is good evidence that such information would rob him of hope *and* that such hope is more important than the benefits of an open awareness situation." Shifting the burden of proof would make an immense change in what actually takes place.

When the professional faces the needs of the dying person to accomplish the handful of tasks previously described, the problem becomes more difficult. Let me return to those tasks in this context.

First: Making arrangements, particularly financial arrangements. Someone is likely to have to help the dying person do this. One of the most persuasive reasons for an open awareness context is to enable the individual to realize the urgency that he make necessary arrangements. We may under-estimate the importance, particularly to middle-aged persons, of tying up the loose ends, of arranging for family finances, of feeling assured that things are in order and that the survivors will be able to carry on without him. This offers the dying person mastery over himself and over a portion of his phenomenal field, at least for the time being. It is his arrangements that will be executed, not those of subsequent advisers.

But it is just this time that people are least likely to discuss such matters openly. Fear of being seen as greedy or insensitive may impede such discussion. It is probably better for the subject to be opened by a person not closely involved with the family, e.g. the physician, the social worker, the minister. I can say about this task, as about all others: we need to learn much more about *how* important it is for *which* dying persons.

Second: Arranging for non-financial concerns of survivors and dealing with personal loss. In being effectively humanistic, we need to learn a lot more about how to help the dying person and his survivors to cope with the loss, both when impending and when past history. However, it is not necessary to wait for additional research in order to put into effect what we already know. Nursing school curricula are beginning to include materials on helping patients deal with loss. Medical, social work, and clinical psychology programs are

lagging behind. Strangely enough, even the ministers, who have for centuries been the guardians of the gates to existence after death, seem to say little in their training programs regarding the dying or the bereaved.

Three: Arranging for future medical and other care needs. Here again we need to learn about *what* kinds of decisions *what* kinds of patients can make with *what* kinds of effectiveness. It is his death—he should have as much to say about it as possible, even if it distresses the family, irritates the physician, and inconveniences the charge nurse. When a person is terminal, we are inclined to read him off as a non-person and do our planning in terms of those he leaves behind. It is his life as long as he has it, and it is his body after his earthly existence ceases.

Fourth: Allocating time, energy, and financial resources. Dr. Avery Weisman advocates that professionals working with the dying focus upon the time and opportunities that remain, rather than upon those that are lost. What can be done in such limited time? What can be done with a given organic condition? Planning for the future is part and parcel of middle-class America: just because the future is sharply reduced does not mean that planning should cease. Here is an area where all professionals can be helpful, if to do nothing more than help family members help the patient. Dr. Weisman commented that if a person dying of cancer has a hangnail that is getting better, concentrate on the hangnail. To attempt to bring this idea home more forcefully, everyone of us is going to die so that any medical condition we alleviate merely postpones the inevitable day. Therefore, you might contend that it is useless to worry about any painful hangnails you ever may have because you will eventually die. The only difference between you and the patient dying of lung cancer is that there is a very high statistical probability that you will outlive him. The probability is not, however, 1.00.

We all have a future, no matter how brief or how bleak. That future deserves attention. To draw another analogy: At what point do you stop repairing your house? A week before you expect to sell it? A month? A year? A decade? You will never be in that house permanently, so you might argue that any improvement is temporary and should not be worth bothering with. Now change your set and assume that this is the last house you will ever live in—now how do you feel about it? Your decisions probably waver—you are no longer so certain. Perhaps this will help you empathize with the dying person.

Fifth: Anticipation of future pain and performance decrement. As mentioned before, we should try to learn how important this is and to whom. Professionals can do a great deal to help in this regard. Sometimes the dissemination of accurate information is sufficient. In other instances, a good listener to attend to expressions of fear of pain is requisite.

Sixth: Dealing with the death encounter. The task here is similar to that outlined briefly above, except that the task may be more complex and difficult, partly because of the feelings of the professional.

Seventh: The decision to affect the rate of decline. The complexities of this concern are too great to deal with here.

Eighth: Psychosocial problems, including loss of independence, loss of mastery, and loss of productive roles. What does the dying person really fear he will miss most? Diggory and Rothman (1961) investigated seven consequences of one's own death, including (1) inability to have experiences, (2) uncertainty regarding after-life, (3) fear of what will happen to the body after death, (4) concern for survivors, in terms of caring for them, (5) concern for survivors in terms of their grief, (6) ending of plans and projects, and (7) pain. These authors began the investigation, but it has never been followed up. I think they omitted several important consequences. If we can learn what types of role change and capacity change are really the most destructive to the dying person, we might be able to structure his environment to make these losses less important. Again, we do not need to wait for more research before beginning—we have ample information to launch our efforts.

Pattison (1969) discusses the need to respond to the crisis or crises faced by the dying. "Here lies our opportunity to intervene, for although we cannot deal with the ultimate problem of death, we can help the person to deal with the various parts of the process of dying. By focussing on these part-problems, the dying person can cope with himself and with his dying, to some measure, to resolve the crisis in a rewarding fashion that enhances his self-esteem, dignity, and integrity. The dying person can take pride then in having faced his crisis of dying with hope and courage and come away having dealt successfully with the crisis. One might call this healthy dying!"

Pattison describes six ways in which practitioners and others in the phenomenal world of the dying person can assist in creating an appropriate death:

1. Sharing the responsibility for the crisis of dying . . . so that he has help in dealing with the first impact of anxiety and bewilderment.
2. Clarifying and redefining the realities of the day-to-day existence which can be dealt with by the patient.
3. Making continued human contact available and rewarding.
4. Assisting in the separation from and grief over the realistic losses of family, body image, and self control, while retaining communication and meaningful relationships with those who will be lost.
5. Assuming necessary body and ego functions for the person without incurring shame or depreciation, maintaining respect for the person, and helping him maintain his self respect.
6. Encouraging the person to work out an acceptance of his life situation with dignity and integrity so that gradual regression may occur without conflict or guilt.

This paper began with a discussion of the process of learning of dying; the latter half dealt with tasks facing the dying. It is customary to close an article by stating that we do not presently have enough information and that we need additional research. I agree with that thought. Nonetheless, I think we do have enough information to put certain changes into effect, since the knowledge we

have is superior to no knowledge at all. What we need is the ability to communicate our information in a sufficiently persuasive fashion to the decision-makers, i.e., every practitioner who works with the terminally ill. We need to communicate what we know about the ways in which people learn of their impending death and how they respond to this information; we need to communicate the significance of the tasks that face the dying and how to help them cope with the tasks. We need to persuade other practitioners that the dying person is as much a human being as he ever was and that he is entitled to the same consideration that was his due before the terminal diagnosis. And we need to become sufficiently comfortable with the inevitability of our own death so that we can help others learn to accept theirs.

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PREDICTING POST-RELEASE RISK AMONG HOSPITALIZED SUICIDE ATTEMPTERS

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With the emergence of suicide prevention centers and the establishment of the Federal Center for Studies of Suicide Prevention has gone a strong mandate for sanctioned officials to intervene in situations where suicide threat, gesture, or attempt is imminent or has occurred. In carrying out this mandate, would-be helpers are hampered by the dearth of techniques available in the praxis of suicidology.* This article attempts to further the goal of an adequate suicide prevention system by contributions in theory and in practice. We shall first present—in capsule form—the theoretical framework for the dynamics of suicide which has guided our explorations; we will then describe a clinical tool, generated from our theory, which has shown promise in predicting future attempts among those hospitalized for non-lethal suicide attempts.

Warren Breed (1967) categorizes traditional ways to study suicide along four dimensions: (1) the Durkheim focus on suicide rates as indices of societal integration, (2) the demographic concern with actuarial data on comparative rates for groups and strata within society, (3) the interpersonal approach to social relationships, and (4) the study of intrapsychic processes. As with Breed, our approach to suicide is in terms of his "dimension 3," more especially in the tradition of George Herbert Mead's school of symbolic interaction (1939). In the belief that a truly utilitarian theory—i.e., one which will enable prediction and control of the phenomenon at hand—must be grounded in real life situations, we turned to case studies and the comparative method for an understanding of the suicide process, rather than to the macro-structure of society and suicide rates. We saw the specific nature of self conceptions and the concrete interaction processes between individuals as of critical importance to suicide as a social act. Consequently, we reconstructed from case material the suicidal careers of twenty-five former state hospital patients who subsequently took their lives following release from the hospital; interviewed and tested thirty-five hospitalized suicide attempters, comparing them with thirty wife-murderers and with thirty suicide prevention workers; and, finally, studied sixteen suicide attempters who were admitted to a mental hospital, predicting on their release which were high and which were low suicide risks, and followed them for three months after release to check our predictions.† The particulars of this study will be discussed here; the others are reported elsewhere (Miller, 1967).

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*The excellent work being done at the Los Angeles Suicide Prevention Center is perhaps the single most significant source of experienced suggestions and strategies for handling suicidal persons. See, e.g., Farberow and Shneidman (1965).

† In his thorough critique of suicide theories, Jack Douglas (1967) notes the failure to use the strategy of grounded theory as the fundamental weakness of the traditional statistical-hypothetical, or positivistic, approach to suicide among sociologists.

A SYMBOLIC INTERACTION MODEL OF SUICIDE

The symbolic interaction orientation toward human behavior views the self—one's sense of identity and self-concept—as arising directly from his ability to take the role of the other and hence to look back upon and evaluate himself. One's self image and esteem reflect this evaluation. With this in mind, three social-psychological concepts were used to develop a model of suicide: *commitment*, *communication*, and *crisis*.

Commitment is a process of role-embracement in which the self is identified as a special kind of person, a person epitomized by a hero-image and concomitant personal ideology and value system. Over the course of time, an individual may become committed to such a self-concept to the exclusion of other self-roles. Erving Goffman (1966) describes the process whereby commitment to one's self-concept occurs. He notes that "An individual becomes committed to something when, because of the fixed and interdependent character of many institutional arrangements, his doing or being something irrevocably conditions other important possibilities in his life, forcing him to take courses of action, causing other persons to build up their activity on the basis of his continuing in his current undertaking and rendering him vulnerable to unanticipated consequences of these undertakings. He thus becomes locked into a position and coerced into living up to the promises and sacrifices built into it."

If the self-concept is a rigid, narrow and constrained one, then an individual may find himself at an impasse insofar as change or threat of change is concerned. If a person invests in a single or special hero-image, and if he then becomes less open to alternative images, he becomes *over-committed*. Goffman (1966) uses the term "embracement" to describe this total commitment state: "to embrace a role is to disappear completely into the virtual self available in the situation, to be fully seen in terms of the image, and to confirm expressively one's acceptance of it. To embrace a role is to be embraced by it." In this sense, commitment is both a social and psychological variable: the hero-image arises out of those roles and values to which a person is committed; it also creates an intense degree of psychological loyalty which accompanies the commitment to a specialized hero-image of the self.

The communication process—the symbolic interaction—which occurs between a person and others will nourish or starve the self-concept, even as it helped initially to create it. If the communication channels between the self and others are open and clear, then the processes of correction, validation, and innovation of the self-image can go on between the person and his significant others, and so nourish his self-concept. Communication between the person and others leaves him "open-ended": he is relatively free to play many roles, hold many statuses, relate to many significant others; his self-concept is a pluralistic one. Because a person belongs to many groups, plays many roles and ordinarily has several others who are significant to him, his commitment to his self-concept reflects these pluralistic loyalties. This flexibility means he is not susceptible to personal crises which might otherwise shatter his esteem.

As long as one interacts with and is supported by significant others, and is not in conflict with one's own personal ideology, life's ordinary turning points can be met in pragmatic ways. Change is only change—not disaster. The con-

cept of crisis is important in such an ordinary career only at times of accident or sudden trauma. Even then, a person with an open communication network, several significant others, and a continuous self-concept can utilize the many available social and structural resources without suffering irreparable damage to his self-esteem.

THE SUICIDE PROCESS

For the person who does not have ready access to reciprocal communication channels, life is full of dangers, traumas, and crises; any major turning point in life can become a time of despair. When a person is over-committed to a self-concept and when blockage or distortion of the correcting or validating processes occurs between the person and his significant others, suicide becomes a possible course of action.

As a result of communication blockage, interpersonal enjoyments atrophy, and role-taking and role-playing diminish. The greater the communication blockage, the greater a person's sense of isolation, and the more he withdraws from further contact with others. This process is circular, leading to ever greater distortions, greater distance separating the person from others, and ever greater degrees of isolation and withdrawal. As this process continues, the person increases his commitment to a self-image that affords him some sense of esteem in the face of increasing isolation and distortion of his relations with others. The self-concept is shaped by the person's inability to engage in numerous roles: it is framed, more and more, by idiosyncratic views of the world, telescoped and distorted by the blocked communication and the diminishing influence of significant others. Some persons become so incapsulated in this isolated "me and myself" role that no outside contact seems necessary for them. Every small town has its "hermit," every large city its recluse, every university its isolate—and every mental hospital its wards of catatonics. So long as no serious external threat or internal doubt develops and so long as there is social reinforcement and support available for such roles, it is possible for these isolated persons to live without serious concern.

One who diminishes his social world and develops an over-commitment to his self-image begins to be alone, to feel alone, and to turn inward upon himself. Maintenance of his "hero-image" becomes crucial, for it may be his sole source of self esteem. He must nurse this esteem, drawing upon his self-concept for the support he lacks from his significant others. This view of himself comes to occupy his thoughts, to govern his behavior; more and more doors close to him. Goffman relates potential threats to self-esteem and this pattern of "closing doors," wherein "Fear over possible loss of his face often prevents the person from initiating contacts in which important information can be transmitted and important relationships re-established; he may be led to seek the safety of solitude rather than the danger of social encounters" (1966, p 88-89).

At this stage of over-commitment, what would otherwise be seen as a turning point, if it serves to create doubt about one's self-image and validity as a person, can lead to suicide. The concept of over-commitment implies that what is worth living for is worth dying for. If we can learn what kind of a hero

a person is to himself—what "code of honor" he lives by—we can begin to predict the circumstances under which he might choose self-destruction as a response to crisis. For persons loosely committed to social roles, such intensity of self-threat is not likely to occur.

A suicidal crisis causes a person to see contradictions in his routine definitions and interpretations of his world. The work of Alfred Schuetz (1960, p. 102) is useful in understanding the social process whereby change can become crisis in the course of ordinary role playing. "Thinking-as-usual may be maintained as long as some basic assumptions hold true, namely: 1) that life and especially social life will continue to be the same as it has been so far . . . 2) that we may rely on the knowledge handed down to us by parents, teachers, governments, traditions, habits, etc. . . . 3) that in the ordinary course of affairs it is sufficient to know something *about* the general type of style of events we may encounter in our life-world in order to manage or control them; and 4) that neither the systems of recipes as schemes of interpretation and expression nor the underlying basic assumptions just mentioned are our private affair, but that they are likewise accepted and applied by our fellowmen. If only one of these assumptions ceases to stand the test, thinking-as-usual becomes unworkable . . . then a 'crisis' arises . . . it overthrows precipitously the actual system of relevances. The cultural pattern no longer functions as a system of tested recipes at hand; it reveals its applicability is restricted to a specific historical situation" (1960, p 102). When a situation contradicts the person's self-image, and with the corrective that might otherwise come from others being provided by the person himself, the situation may be defined by him as a crisis, a threat to the existence of the self. Situational changes which may become for the suicider devastating traumas are, as Anselm Strauss (1956) points out, continually occurring in the natural course of our lives.

> The strains in family and community life fall exactly at those points where the speed of transition gets out of alignment . . . In status-passage, transition periods are a necessity, for people often invest heavily of themselves in a position, come to possess it as it possesses them and it is no easy matter for them to sever themselves from it . . . we must note the frequent occurrence of misalignment-surprise, shock, chagrin, anxiety, tension, bafflement, self-questioning . . .

Breed (1967) conceptualizes the situation leading to suicidal crisis in terms of "loss" of position, person, or mutual social relationships. Depending upon the specific nature of the self at hand, these kinds of losses could indeed threaten that self.

Facing such a threat, the person may begin to feel he is worthless, that he cannot live up to his hero-image. A process of negative self-evaluation begins. He takes the negative-self role, accusing himself of his own unfitness, worthlessness, wickedness, and the like. Feelings of worthlessness and the like are universally noted among suicidal persons and typically result in their being psychiatrically diagnosed as "depressive." The link between a suicidal crisis threatening the self and these feelings is pinpointed by James C. Diggory (1967, p 320), who states, "The components of personal despair are precisely those conditions under which an individual's special *raisons d'etre* are rendered

nonexistent," Farberow (1967) makes the same connection, noting that "the suicidal patient will frequently display excessive preoccupation with self-identity," along with feelings of helplessness, rejection, and depression.

Efforts (among them suicidal threats, gestures, and attempts) may now be made to reach out to others to try to re-establish shattered communication lines—for the person cannot live without self-esteem. If he does not receive it from others, and if he feels he cannot measure up to his hero-self, then a suicidal crisis is upon him: one way out of ensuing shame, panic and despair is to end his own life.

Suicide develops in a social strand over time. Thoughts about suicide as a solution have a natural history in one's plans of action. In fact, suicide is inherent in the hero-image, in the over-commitment to the self-concept. As the suicidal career develops, the self-concept begins to incorporate suicidal actions as one of its hero-characteristics. The self-concept narrows and tightens as communication with others diminishes or becomes even more negative and distorted. But even between the self and others, suicidal threats, gestures, and suggestive acts begin to be sent out over the communication network. Thus, suicidal threats and actions *become* communications. Shneidman and Farberow's *The Cry for Help* (1965) reflects in its title the notion that suicide behavior is communicative. They explain in the preface, "The title . . . is meant to convey our feelings . . . about the messages of suffering and anguish and the pleas for response that are expressed by and contained within suicidal behavior."

It is at this point in a suicidal career that prevention and rescue can occur. If we can trace the development of a suicidal career, we can also outline the process of changing that career-line, of re-opening distorted or blocked communication channels, of re-aligning significant others, and hence, of revising the self-concept. "In suicide, the intervention of rescuers reassures the person; indicates he is not alone and reasserts his identity and worthwhileness" (Farberow, 1967). Suicidal actions *can* be functional if they serve to blast open jammed communication and revive interest from the person's significant others.

PREDICTING SUICIDE ATTEMPTS: METHOD

The typical pattern of events following a non-lethal suicide attempt involves intervention in the attempter's life situation by help-agents. Frequently the intervention is within the framework of one or another psychiatric setting, often the state mental hospital. One problem for those who would help is that of determining if they have, indeed, been any help at all. In the hospital this question is of vital import when the patient is being considered for discharge.

In most cases a suicide attempt is enough to save the day; most suicidal careers never proceed to an eventual end in suicide. Yet for some, like the child who called "wolf" too many times, even this "cry for help" comes to fall on deaf or indifferent ears. Consequently, persons who have previously attempted suicide and who find themselves again in a suicidal crisis, as might a patient released to an unchanged setting, are extremely high suicide risks. The problem for the hospital staff is in distinguishing between those attempters for whom

their action was an ultimately positive gesture resulting in an ameliorated situation, and those whose life situation was fundamentally unchanged and who thus continue to represent a high-risk group. It is estimated that of all persons who kill themselves, approximately three-fourths previously attempted to take their own lives. In addition, studies indicate that about one in eight attempters may ultimately go on to kill themselves (Shneidman, 1967).

Persons who attempt suicide have found themselves over-committed to a status or a position which seemed to offer them no escape route. In order to avert further suicidal actions, it would seem necessary to somehow change this "dead end" state—to change the self-definition to one offering more potential and different alternatives for action. In order to create a change from an inflexible *cul de sac*, fresh communication channels must be opened between the suicider and his significant others. He must begin to find a "new self," new or changed others, and a new view of his formerly hopeless world. Even when the immediate suicidal crisis has passed, a "healing process" would have to occur within a re-definitional framework. Suiciders must change their desperate view of themselves and the world to one which would afford a different and more hopeful perspective of their lives. Thus, some indication of a change in the self—a change that would indicate a more hopeful approach to their situation—would accompany a change in their suicidal career. If a suicide attempter brought to a state hospital saw the institution as a prison at the time of his admission, he would have to change this view to a more optimistic and less self-devastating one if he is to pick up his life without further depletion and despair. His self concept would have to change from a negative one—"prisoner" or "victim"—to a more positive one—"recovered patient."

A change in the self can occur with a change in reference groups or in the course of interaction between the self and significant others. Other persons can become "significant" by means of close or meaningful communication. Communication is inherent in the process of definition change: if the suicider holds a negative definition of the state hospital at the time of his admission, and if he is outside a communication system which would offer new or different definitions of the state hospital, he would not be expected to change that negative definition to a positive one.

The suicidal crisis offers possibilities for radical or dramatic change. It can "shock" the suicider's family or friends into new attempts at communication and can force the suicider to reassess situations and positions once viewed as fixed and immutable: crises can rearrange the world. Conversely, crisis, such as a suicidal act, can further alienate persons, further truncate communication channels, and lead to even more hopeless definitions of the self, as when loneliness and isolation leading to suicidal actions come to be defined as "insanity" or "mental illness." Thus, it becomes crucial in predictive studies to learn what definition of the situation is held by the suicider and his significant others.

In view of the effects of "total institutions" on their inmates, a reasonable means of getting at a hospitalized attempter's definition of his situation is through his description of the hospital (Goffman, 1961). The underlying assumption is that inherent in each descriptive phrase regarding the institution is the respondent's perception of his own status. If, for example, he perceives the state hospital as a school, he is a pupil; if he sees the state hospital as a prison,

he is a prisoner. His self-definition should vary directly with his definition of the hospital. If over the course of hospitalization an attempter's self-definition improves, his prognosis would be favorable; conversely, a change for the worse in one's self-definition would increase the possibility of suicide.

This predictive study of suicidal careers followed sixteen persons who were admitted to a state hospital because of a serious suicide attempt. They were tested at the time of their admission and then again at the time of their release. Each subject was his own "control;" the intervening variable was defined as the subject's attitude change toward the hospital during the period he spent in the state hospital.

The schedule used to determine change and its direction was included in a broad battery of tests aimed at operationalizing the symbolic interaction theory of suicide discussed above. This section was a check list item as follows:

Some people say that the state mental hospital is like:

1. A boarding school
2. A resort hotel
3. A hospital
4. A prison
5. A mental health clinic
6. A nursing home
7. A concentration camp
8. The Army
9. A college
10. A church camp
11. A friend's home
12. Other, specify:

Each subject was asked to check the item he agreed defined the state hospital. At the end of the list the instructions read: "Now go back to the above list and circle the one answer you feel *best* describes this state hospital."

At the time of each subject's release from the state hospital, his tests were scored and a prediction was made whether or not that person was a suicide risk. The prediction was based on each person's change in attitude toward the mental hospital as indicated by his definition of the institution. From these definitions of the state hospital we developed a four-fold predictive typology:

I. Those who defined the mental hospital negatively at the time of admission and at the time of release. These persons consistute a high suicide risk.
II. Those who defined the state hospital positively at the time of admision but who changed that definition to a negative one at the time of release. These subjects constitute a seriously dangerous suicide risk since they have lost even the original promise of positive self change.
III. Those who held a negative definition of the state hospital at the time of admission but who, by the time of release, redefined the institution in more positive terms. Such persons have a better potential for changing their suicidal career by virtue of their changed self concept, and are low risks.

IV. Those who held a positive definition both at time of admission and release. Such persons do not constitute a suicide risk, since they see their situation in the institution as a hopeful one.

PREDICTING SUICIDE ATTEMPTS: RESULTS

Each of these types suggests a hypothesis predicting future suicidal actions. The sixteen cases studied were classified into one of the four types on the basis of the before-and-after measure.

TABLE I
Typology and Predictions of Suicidal Risk

Types	Prediction	Number	Percent
I. Negative Negative	High Risk	5	31%
II. Positive Negative	Highest Risk	3	19%
III. Negative Positive	Low Risk	3	19%
IV. Positive Positive	Lowest Risk	5	31%
Total		16	100%

As can be seen in Table I, three persons would, according to type, have a very high suicidal potential at the time of release from the state hospital. These three changed their definition of the state hospital from a positive one at the time of admission to a negative one at the time of release: all changed the definition of "hospital" to "prison"—and went from "patient" to "prisoner." Such depletion of a hopeful outlook indicates a further weakening of self-esteem and undermines interest in continuing life. If these assumptions are correct, persons in Type II would remain suicidal after their release.

Five subjects continued at the time of release to hold to their original negative definition of the state hospital. This indicates continued difficulty in maintaining an adequate self-concept, and these subjects would remain suicidal risks. They had no favorable expectation of the state hospital when they entered and left with no positive change, and thus continue as suicide risks.

Three subjects who came to the hospital with a negative definition of the hospital went out with a more positive one. Their self-concept has improved and so Type III are predicted to be low suicide risks.

The five subjects in Type IV held a positive definition of the hospital both at the time of entry and the time of discharge. They are the best risks for release to the community.

Each of the sixteen* cases was followed for a three-month period after release from the state hospital. Two questions were asked: (1) Is the person alive, and if not, how did he die? and (2) If alive, has he engaged in any suicidal behavior during the three-month follow-up period?

Type IV consists of four women and one man, all of whom defined the state hospital in a positive way both at admission and discharge. Three months after their release, each of these persons was alive. Four of them were in the community; one was rehospitalized for a physical problem and was awaiting placement in a nursing home. None of the five had engaged in any further suicidal actions during their three months in the community.

Type III consists of two men and one woman. They had changed their initial negative definition of the state hospital to a positive one during their stay. Three months later, one was a patient at a Day Treatment Center, making a good adjustment in the community; one had received some further psychiatric evaluation at a VA hospital but had been released and was at home without having engaged in any further suicidal actions; and one was in the community without any further treatment or suicidal actions.

Type I consists of four women and one man, all of whom defined the hospital negatively at the time of admission and again at discharge. They were seen as having a high suicide potential. Of these, only one was at home without treatment, and seemingly doing well in the community. Another, also in the community, continued in outpatient treatment; her adjustment was precarious and she continued to be despondent and to engage in suicidal threats; her social worker was trying to persuade her to re-enter the state hospital at the time of the three month follow-up period. One woman was unlocatable after her release from the state hospital. Her family and friends had not seen her for six weeks and had filed a missing person's report; her community adjustment had been precarious at best. The other two women had been rehospitalized, one because of incoherent speech, hallucinations and generally bizarre actions, and the other in a comatose state after a serious suicide attempt.

Type II is that group of two men and one woman who, because they changed their initial positive definition of the state hospital to a negative one at the time of release, constituted the highest suicide potential. Of these, one woman had set fire to herself and was rehospitalized in serious condition within one month following her release. One man had made another suicide attempt and was also returned to the state hospital. The other, a twenty-seven year old husband and father, had shot himself in the head and was found dead in the hills near his parents' home in a midwestern state.

DISCUSSION

According to the symbolic interaction theory, subjects who rate as having a high suicide potential (Types I and II) should have more of the characteristics

*There was a serious attrition from the original sample of thirty-five originally tested cases in the "before" sample to only sixteen who were tested in the "after" sample; this was due to a breakdown in the researcher-hospital-staff data collection system; i.e., often subjects would be discharged before the second research form could be administered.

which indicate over-commitment, communication-blockage, and the presence of an unresolved crisis than those who do not rate high. The schedule, of which the prediction item was part, aimed at a systematic operationalizing of the concepts of commitment, communication, and crisis, and so data is available comparing the high and low risk groups along these dimensions. The Self Attitude Schedule, developed especially for this study, used a series of open-ended questions about the self and standard psychological tests of characteristics which reflect aspects of over-commitment. Measures and data were obtained for the following dimensions: self attitudes, positive and negative "symbolic others," significant others, ego strength, ideal self, compulsiveness, authoritarian aggression, authoritarian submission, conventionality, projectivity, romanticism, sense of victimization, over-commitment, communication-block, self-estrangement and crisis susceptibility.* The suicidal career involves a process; consequently an examination of the changes in the before-and-after SAS test scores of the two groups would have greater significance than the scores on each scale taken at the time of the subjects' release from the state hospital.

TABLE II
Outcome Findings: Suicidal Actions During Three Month Follow-Up Period

		Prediction	Percent
Type I —High Risk	5	1	(20%)
Type II —Highest Risk	3	3	(100%)
Type III—Low Risk	3	—	(100%)
Type IV—Lowest Risk	5	—	(100%)

Thus among the highest risk type, Type II, all had engaged in further suicidal acts (one ending in death) *as predicted.* Among those five typed as high suicide potential cases, Type I, one was known to have again attempted suicide, while one is missing and feared dead by her family and another had been rehospitalized. *Among Types III and IV, both low suicide risk groups, none had engaged in suicidal actions—a 100% prediction outcome.*

One would hypothesize that persons with a high suicidal potential will increase their rigidity as indicated by their test scores in the before-and-after SAS measure, while the low suicidal potential group will tend to change to less rigid, less authoritarian attitudes over their stay in a state hospital as reflected in lower scores. Analysis of test scores showed, however, that while the trend was in the expected direction, the difference between high and low types was not great enough to support the hypothesis.†

An indicator of self-esteem is the number and type of positive adjectives these two groups of suiciders used in describing "the kind of Person" they are.

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*In the interest of brevity, the logic and development of this schedule will not be gone into here. The reader is referred to Miller (1967). The scales were, in general, developed from items found to correlate highly with the California F Scale.

†Using the Mann-Whitney U Test, ranking each subject's mean change on the before-and-after psychological test scores by high and low suicide potential types, a U of 23 was obtained. Such a value, with a sample size of 8 high risk and 8 low risk group, results in a value of 0.191, a value of 0.193. This compares with the "normal" score of 0.185 which one might expect by chance.

Though an examination of the number of positive and negative adjectives revealed no differences between the two groups, the high risk group tended to increase the number of their negative evaluative statements, while the low risk group made the same or fewer number of negative self-statements at the time of their hospital release.

The low risk groups decreased the intensity of their attitudes toward "compulsivity," "romanticism," and "conventionality," during their hospital stay, while the high risk group increased their scores on these scales.‡ This finding supports the hypothesis that the high risk suicider will be more "over-committed" and less likely to change during hospitalization. There was a further and more suggestive difference between the two groups with regard to the type and the intensity of the adjectives used in describing negative aspects of the self: among the high risk group, subjects referred to their "bad temper," "short temper," or "destructive" tendencies. No low risk person used these adjectives in describing their negative aspects. High risk subjects also used adjectives such as "hateful" and "bad" while low risk subjects did not. Low risk persons tended to use milder condemnatory adjectives like "bossy," "boring," "lazy," "ungrateful"—all rather common, socially recognized, albeit annoying faults, but not traits beyond the pale of social acceptance.

Changes in relationships between the self and others reflected a difference in the communication patterns between the high and low risk groups of suiciders. An analysis of the list of significant others in the before-and-after schedules revealed changes in the significant others listed and in the assignment of symbolic positive and negative others. Among the high risk suicide group, five were married, but only one mentioned his spouse as his "positive other." Among the low risk suicide group, 50% of the married mentioned their spouses as their "positive other," while the rest mentioned "friends."

Among the suicidal risk groups, 87% of the low risk group was married, while 63% of the high risk group was married. Further, among married subjects 50% of the low risk group and 86% of the high risk group described some type of marital discord. Among the high risk group, the marital difficulty was seen as arising from the spouses' "cruelty," "meanness," or "infidelity." Among the low risk group, the problem was seen as "disappointment," or "family interference." It would seem that some communication routes remained open between the subject and the spouse among the low risk group; there still remained subjects open to discussion and negotiation. Among the high risk group, however, the spouses tended to be viewed as unreachable, unrelenting, or totally unforgiveable. These findings are only suggestive, and the concept of communication-blockage remains for further research investigation.

High suicide risks were more likely to have changed their "positive other" in the before-and-after test. Two-thirds of the high risk group mentioned a different positive other on the after test, while only one-third of the low risk group made a change. For example, in the case of the subject who later actually

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‡The overall change in the difference between the scores on all scales was marked: among the high risk group, the overall difference was +1, while in the low risk group the overall difference was –26. While the t test does show a significant difference between the two risk groups (t = 3.567, p. .05), its usefulness is limited by the size of the sample.

took his own life, the change was from "spouse" as positive other in the before test to "none" on the after test. Such changes, characteristic of the high risk group, would seem to indicate an increased blockage of communication between these subjects and their significant others. The high risk group were likely to list their family as "negative-other," while the low risk group were likely to list non-family members as their "negative-other." Since they had already attempted suicide, this further distortion in communication between the self and others would seem to make any change in the over-commitment stance highly unlikely.

In the responses which the two groups made on the significant other list the first person mentioned on the list was compared with the subject's actual family role position. It was found that the low risk group were more likely to mention their family role partner as their significant other than were the high risk subjects. Thus, the high risk subjects were likely to feel distant from the very persons with whom they might be expected to have the closest communication.

In a review of each subject's entire schedule, on the overall evidence of the presence or absence of communication-blockage, 87% of the high risk group evinced communicative difficulties between the self and others, while one-half of the low risk group showed such difficulties.

Subjects' report of their crises differed between the high and low risk cases in three ways: (1) high risk cases saw their crises in specific, personalized terms while low risk cases saw themselves as being caught in a diffuse, general state of confusion or change; (2) high risk cases reacted to perceived crises in terms of violent, angry actions or thoughts against their significant others, later turning this anger against themselves as partial retaliation against those who cared about them; low risk cases seemed to react to crisis with self pity and dependency feelings; (3) high risk cases seemed to feel actively involved in their crises, while low risk cases saw themselves as passive victims or innocent bystanders at their turning point.

SUMMARY

This symbolic interaction theory of the suicide process posits three key elements; over-commitment, communication-blockage, and crisis. On the basis of the significance of self-identity and self-esteem in this process, a means for predicting the likelihood of suicidal behavior among hospitalized attempters was developed and tested. It was hypothesized that the person who either defined the state hospital in consistently negative terms, or who changed his initial positive definition to a negative one, would continue to be a high suicide risk. One who held a positive definition of the state hospital at the time of his release would, on the other hand, be a low suicide risk. It was assumed that such definitional change does not occur in a vacuum, but has the support of the suicider's significant others; such changes are thus reflections of other, broader changes in the overall situation which had previously led the person to suicidal actions. As a result of the before-and-after measures of sixteen subjects' definitions of the state hospital, each subject was assigned to one of

four categories indicating the degree of suicidal risk from highest to lowest. There were eight subjects in the two high and eight subjects in the two low risk groups. Each of these subjects was followed for a three month period after his release from the state hospital.

At the end of the ninety days, one subject of the high risk group had taken his own life, three had re-attempted suicide and had been hospitalized, one was missing and feared dead by friends and family, and two had been returned to the state hospital because of poor psychiatric and social adjustment in the community. Only one person in the high risk group seemed to be making a reasonably adequate adjustment in the community.

Among the low risk group, one subject had been rehospitalized because of continued ill health due to old age, two attended sessions at a Day Treatment Center and were doing "well," and the others were all in the community. None had engaged in further suicidal action.

This method of predicting suicidal potential thus initially demonstrated its utility. The two groups were also studied in relation to a series of variables which were indicators of over-commitment, communication-blockage, and crisis. The comparative findings seem to support the theoretical orientation: persons in the high risk group are more likely to remain "over-committed" to a hero-image of the self, to have a continued communication vacuum between themselves and their significant others, and to define their crisis in a violent, unresolvable manner.

CONCLUSION

Though many clues for identifying and gauging self-destructive potential have been suggested, the most significant ones do not seem as yet to have been identified—certainly none exhibiting the predictive power initially displayed by the tool discussed here. We hope that our results will lead to further study, using different and larger populations, to test the implications of this typology and its theoretical basis, and to validate the associated findings. The symbolic interaction orientation to suicide shows promise for generating new and more powerful tools for those who would meaningfully respond to the suicider's cry for help.

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BOOK REVIEWS

Man's Concern With Death. By Arnold Toynbee et al., **McGraw Hill Co., New York, 1968, pp. xxi +279. $7.95.**

This book is a welcome addition to the growing literature on death. While recent contributions have been of interest primarily to the specialist, this volume addresses itself very largely to the lay public.

The contents are arranged in three parts: Part one, entitled, "Death and Dying" examines death from a medical and philosophical perspective. According to one of the authors, A. Keith Mant, death has taken on a new meaning for the medical profession. The traditional medical conception of death: stoppage of the heart beat, is, he believes, outmoded. The new definition of death is what has come to be known as "brain death" or more precise, medically, "cerebral death." Cerebral death occurs when the impulses from the brain make no impression on an electrocephalogram. The author however leaves off the discussion with the contemporary medical definition of death without confronting the ensuing moral, religious, legal, and ethical problems that may and do arise from such a conception of death. If this new criterion is increasingly to become a medical norm of determining death, one wonders which definition will take precedence in the case of a heart transplantation, the "organ death" of the recipient or the "cerebral death" of the donor.

The article by Simon Yudkin on "Death and the Young" calls attention to another timely problem: How does one explain death to children? Like a new pornography, death today is generally concealed from direct view and its possibility is often denied to children. While efforts are being made to educate children about such sexual matters as cohabitation and reproduction, knowledge about death and dying is kept from them. Empirical studies have shown that a child's involvement with death tends to vary with the stages in the development of his personality and with the progressive nature of his socialization. His involvement with death, therefore, is greater during early childhood and adolescence than during the pre-adolescent period. The author would have done extra service had he brought these empirical findings to the awareness of his readers because the literature which has related these fears to such disparate phenomena as separation, anxiety, sex-guilt, physical restraint, fear of the dark, sibling rivalry and the castration complex has many provocative ideas and insights to offer.

Part two entitled, "Attitudes Towards Death" takes up the major portion of the book. It contains nine articles, eight of which deal with religious perspectives on death. The ninth article, by the distinguished historian Arnold Toyn-

bee, provides historical depth for the others. With this group of essays the reader is invited to appreciate the fundamental difference between Eastern and Western religious attitudes towards death as well as towards life after death. In essence the burden of the difference rests upon two main points: first, for the East, the route to salvation tends to be either contemplative or mystical, while for the West, it tends to be ascetic and active. Second, the East views the ultimate outcome as an undifferentiated and impersonal 'oneness' with the universe, while the West perceives it as the continuation of the integrity of the personal self.

Part three entitled "Frontiers of Speculation" consists of four articles each of which takes knowledge of death as its central theme. Rosalind Heywood's article, for instance, 'Parapsychology and Death' provides the reader with much material for speculation concerning the existence of E.S.P. and the prospect of communication between the worlds of the quick and the dead.

The book ends in a fitting epilogue by historian Toynbee in which he shares some of his most candid thoughts about death with the reader. His often repeated statement "In the midst of life we are in death" is a bold and explicit reconciliation between the magnitude of his mind and his mortality.

This book is interesting reading especially for those with a sense of the historical. It is informative, and well executed in its style of presentation. It represents an interest in death among European historians, Psychiatrists, Pediatricians and Religious Specialists, which, it is hoped, will continue to flourish.

Vijay B. Gupta
University of Minnesota

On Death and Dying **by Elisabeth Kubler-Ross, M.D. The Macmillan Company, London, Collier-Macmillan Ltd., 1969. pp. VIII +260. $6.95.**

On Death and Dying is one of the most important human documents to be published on the subject of the terminally ill and dying patient. Following closely on Glaser and Strauss' two books, *Awareness of Dying* and *Time for Dying*, and on Sudnow's, *Passing On*, it would seem at first glance that Dr. Kubler-Ross' book would be redundant. Such is not the case. What Elisabeth Kubler-Ross has done in her book which distinguishes it from its predecessors is to encourage dying patients to speak for themselves. In doing so, she has produced a moving, personal testimony to the courage of these men and women who were willing to be interviewed about their own imminent deaths. Beyond this, she has provided the medical and other care-taking professions with invaluable clues to the proper treatment of the dying patient —clues made more persuasive by virtue of their source and poignancy.

On Death and Dying is the product of a seminar conducted by Dr. Kubler-Ross at the University of Chicago since 1965. For the past four years, chronically ill and dying patients have been invited to appear before her inter-dis-

ciplinary group of students to express freely and openly their fears, anxieties, hostilities and hopes in connection with their condition. These interviews have called attention to the many issues and questions that the patient confronts with the prospect of his own death. In addition, they have provided a level of communication and understanding which promises a period of enlightenment regarding the care and comfort of the dying patient never before experienced.

After interviewing hundreds of patients, Dr. Kubler-Ross proposes that there are five different psychological stages in the trajectory toward death. There is, she says, the first stage of denial when the patient cannot bring himself to believe that death could ever occur to him. At the second stage he rebels against his misfortune. In the third stage he attempts, by every contrivance, to bargain with God or the fates for his life. In the fourth stage it becomes clear to the patient that no amount of negotiating with transcendental forces will save him from death; hence, he becomes seriously depressed. Finally, in the fifth stage, acceptance is reached and the patient is prepared to die.

It is Dr. Kubler-Ross' conviction that the care-taking professions must come to appreciate the different stages of dying and deal with the patient in terms of the stage he is going through. Such an understanding is helpful not only to the patient himself but it also aids in the support, comfort, and guidance that can be offered the patient's family when the patient's emotional as well as physical condition is understood. Hospital personnel that must deal daily with hostile, irritable, raging or depressed patients can also benefit from this understanding.

Today in American society the majority of our citizens now die in hospitals. Their length of stay in those hospitals in all probability will continue to increase, given national programs of medical assistance and care. The prospect for the future, in the face of the contemporary character of urban existence, is that the burden of support, care, and concern for the almost 2 million persons who die every year in the United States will almost assuredly fall upon the nursing and other care-taking professions. *On Death and Dying,* like its predecessors, takes cognizance of these changes and asks the public to recognize the multifaceted problems that confront our society with regard to death as well as to consider the intimate personal problems that challenge the dying patient.

Like its companion volumes, *On Death and Dying* calls for a more realistic approach to the problems associated with death and dying in America but unlike these prior volumes it is the patient himself who is the most articulate advocate for a sound and intelligent approach to the problem of death. This is an important book that should be read particularly by those who must offer assistance to their fellow man during his last hours of consciousness.

Robert Fulton
University of Minnesota

ANNOUNCEMENTS

—**Hamline University, St. Paul, Minnesota.** A symposium, "Death Education: Preparation for Living," was held at Hamline University on February 20 and 21, 1970. Keynote speaker was Dr. Herman Feifel. Other speakers included Dr. John Brantner from the division of clinical psychology at the University of Minnesota School of Medical Sciences, and Dr. Dan Leviton, department of health education, University of Maryland.

—**University of Chicago, Chicago, Illinois.** The Center for Continuing Education presented a two-day conference, "A Seminar on Terminal Illness," last December 5 and 6, 1969.

—**University of Iowa, Iowa City, Iowa.** Professor David Belgum, coordinator for Clinical Pastoral Education conducted a seminar this fall, focussed upon dying and death. The seminar was co-sponsored by the School of Religion and the College of Medicine. In addition to Professor Belgum, speakers included physicians, clergymen, nurses, lawyers, and social workers. A guest appearance by Dr. Kubler-Ross produced an overflow crowd at the medical amphitheatre where the course was being conducted.

—**University of Minnesota, Minneapolis, Minnesota.** Dr. Roberta Simmons, Department of Sociology, will conduct a study of persons volunteering to be donors for organ transplants at the time of their deaths. Interviews will be conducted both with future donors and family members of those who have died and have been donors.

ANNOUNCEMENT

The Center for Thanatological Studies, in the Department of Sociology, received administrative approval to be established at the University of Minnesota in July, 1969.

The Center's primary concern is with the issues and problems surrounding mortality in contemporary society. The Center will sponsor original research into grief and bereavement as well as studies of attitudes toward, and responses, to death and dying. The Center, in addition, will serve as the repository for relevant materials and will serve as a focal point for the collection and dissemination of information to the professional community as well as to the lay public.

The Center will be interdisciplinary in scope and purpose, and a local advisory board of interested faculty members throughout the University will serve to guide the Center's projects and policies. In addition, nationally recognized experts will serve as consultants to the Center.

Activities that have led up to the formation of the Center include: a seminar on "Death, Grief, and Bereavement" offered in the Department of Sociology since 1963; a symposium entitled "Death, Grief, and Bereavement: An Interdisciplinary Evaluation" held at the University of Minnesota in May of 1967; a national survey of contemporary funeral practices conduced in 1967; and a cross-cultural survey of American and Indian attitudes toward death undertaken in 1968.

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COMMENT

Malcolm Muggeridge, the English author and critic, has said recently in discussing the rising tide of violence in the world, that the decade of the 70's may well be known as the decade of the death wish. We cannot predict, of course, whether this will be the case or not. Certainly, it gives every indication of being the decade in which the subject of death will become a major topic of discussion as well as an issue of public concern.

Death and death-related matters are no longer the taboo topics they were a few years ago when Feifel drew our attention afresh to the subject. (I say "afresh" because man has always been deeply concerned with death. See, for instance, Markusen's review of Brandon's book, *The Judgment of the Dead,* in this issue of OMEGA). Death, for the most part, has been the problem of the theologian or the philosopher. What we are observing presently, in the United States particularly, is the emergence of the social scientist as a participant in the dialogue on dying and death. Questions as to how, when, and where, and under what circumstances man will die are now within the purview of the social researcher. Death has become a subject for objective analysis.

Complementing this interest in death and dying on the part of the social scientist is, of course, the growing interest on the part of the public in the subject. Lectures, symposia, television programs, newspaper interviews and other expressions of attention and concern appear in an ever-increasing volume. Last month, for instance, a symposium at Hamline University in St. Paul, Minnesota, attracted upwards of one thousand people on a cold Friday evening to hear John Brantner of the University of Minnesota, Herman Feifel of the Veterans Administration and Daniel Leviton, of the University of Maryland, discuss the need for education for death. These expressions of professional and public interest in the problems of death and dying have been generated, I believe, by the stresses and strains placed upon our social relations and institutional facilities and by the particular problems that death presents to families. The excellent work of Strauss, Glaser, Quint and Sudnow, the recent attention given to the work of Kübler-Ross, as well as the continuing efforts of Kastenbaum, Kalish, Weisman, Lindemann, Jackson, Kutscher, and Grollman, to name but a few, has served not only to alert the public to the problems associated with death and dying but has served to give support and direction to the caretaking professions in an area long-considered beyond the realm of the social scientist.

This interest in death and concern for the dying is strengthened and promoted also by the fact that our society has progressively undergone significant changes with respect to the structure as well as to the values and goals of family life. Simply stated, the structural model that the American family has followed

until very recently could be described as a three-generation model. That is, a kinship system in which three generations of family members—parents, grandparents, and children—lived under the same roof. This model has undergone considerable modification over the past three or four decades so that today it is, if not unusual, at least infrequent that we will find these three generations living in the same household. Today the ideal American family is two-generational in form—that is, parents and children. (For a discussion of some of the factors associated with these cultural changes see the paper, "Death, Grief, and Social Recuperation," in the first issue of OMEGA).

Paradoxically, while the contemporary family structure is based upon a two-generational model, the demographic reality that is emerging is a four-generational society. The increase in life expectancy today and earlier marriages means in effect not only the prospect of more living grandparents than ever before, but, in more and more instances, of living great-grandparents as well. Inherent in these changes in values and structure are contradictions which promise to affect increasingly the young as well as the old.

One of the things that has been taking place quietly over the past decade or so is the removal of the chronically ill or sick person from his home. This development has a long history beginning with the funeral director who entered the home and removed the deceased member to prepare him for burial. In the course of time the medical practitioner came to provide the same service in the sense that he removed the chronically ill or sick person from his home to the hospital. More recently the nursing home functionary is doing the same thing. However he has taken the process one step further. He removes the elderly, but not necessarily ill, member of the family from the home. This person is often someone who is no longer competent to take care of himself or whose needs are deemed to be more than can be met by family members. The retirement city movement can be considered a corollary to these new social practices. In this case, the elderly member voluntarily or involuntarily removes himself from the family circle, oftentimes many thousands of miles distant.

What these several developments mean is that the younger members of our society have less and less opportunity to experience not only death in the immediate, visceral and physical sense, but they are unable also to witness or share in the process of growing old.

At the same time that these social changes have been taking place in American society, the present generation of young adults has been exposed, as possibly few other generations have, to all forms of violence and death. The mass media, particularly films and television, have provided an unending stream of brutality to the first generation in the history of the world that in a sense has been free of death in their own private lives. Again, the contradiction is this—the present youth-generation has grown up in a world that has promised them shelter, order, security and life, yet they find themselves exposed to death and violence presented without sentiment or emotion and they are bereft of any model against which to measure their fears and sentiments with regard to aging, dying, and death.

Dr. Konrad Lorenz, author of the book *On Aggression*, was quoted recently as saying that the large and stable family grouping is essential to the survival of

human society. "The father-mother family with two children, isolated in a city flat," he said, "is already insufficient." There is, he feels, a strong need to surround the child with enough people to make it feel secure, thus making "even" grandmothers desirable. "The young child must know more than two people that are friendly. Because if you have just two people who are your friends, that 'we' are only four and the rest are 'they,' then 'we' are in a frightening minority." Lorenz advocated artificial families of several young couples associated closely, if it were otherwise impossible for a child to have an intimate association with several adults in an extended family group.

It is here, I think, that social scientists have much to do. Their research is needed and their insights are necessary if we are to understand the wave of violence that is crashing not only across America but also across the world. It is here that the social scientist can make a contribution to the understanding of our fear as well as our obsession with death and violence.

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THE LAST WORDS OF A SUICIDE— A CASE REPORT

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As a member of one of several teams set up by the Los Angeles Suicide Prevention Center to interview next of kin of suicides, I called on Mrs. D. M. five months after her husband had shot himself through the mouth. When I asked her how he felt before he died, she said she had a tape recording of his thoughts voiced within a few hours of death. In the literature on suicide there is scant documentation of the feelings of patients immediately before they kill themselves. The fortuitous discovery of this recording and the suicide's history contribute to the understanding of the drives for self destruction.

CASE HISTORY

On the day of his death, D. M. at his office in a drunken state, dictated his thoughts to a tape recorder. The text is interspersed with episodes of drinking and dozing. Intelligible portions follow:

> I don't know what your account of me is, but you've got me. You've been nice, real nice. Now I've got one thing to do, and God give me strength, please give me strength. I can't take it. I'm a coward. I'm a live coward. *(Episode of drinking.)* It boils down to this. I have to kill myself. I hate myself; I have to kill myself. You don't feel sorry for me because I played a big trick on you, a real big trick on you. Just like for the other people—I always play big tricks, big tricks. Love—what the hell do I know about love? I live to hate. I live to hate, hate, hate. You're just a poor kid, just sucked in by me. You didn't get a chance, not a chance. I don't know how to live. There should be an easier way. Get drunk—then you can do it, then you can do it. I'll get drunk. I'll get drunk and then I'm going to kill me. I hate me. I'm going to destroy me. I'm going to do away with me. _____ I hate myself. Shit.

Thus ends the tape shortly before he shot himself.

Mrs. D. M. told me her husband was born in Burley, Idaho, first of three children. For unknown reasons, he was separated from home while his mother was carrying his sister, two years his junior. He remembered the separation and being angry about it. At that time, he vowed to get even with everybody. His brother is about ten years younger. Mrs. D. M. knew little else about his early background. She knows that he attended high school in Los Angeles where his parents had lived since he was four or five. His father and an uncle were in the plumbing business where he worked until he entered the armed forces. Although the family was linked to the Presbyterian faith, he had no church affiliation.

His first wife wished to live in Idaho so the children could grow up on a farm. He gave his business to his brother and moved there. When his marriage and stay in Idaho failed, he returned to Los Angeles and tried to take back the business, but was unable to get along with his brother and they split.

The first marriage, broken by divorce after four years, yielded a girl, now 14, and a boy, 12.

Relations between the patient's mother and his widow are strained. The widow says, "I'm not friendly with her because she never spoke to me before the divorce." At the time of the suicide, D.M. was about to be divorced a second time.

According to his widow, D. M. "had to do everything himself." She describes the deceased as curt, sharp, and brusque, very decisive, and totally unable to delegate anything because of his perfectionism.

D. M. had a history of several traffic accidents. It was during recovery from a traffic injury that he met his first wife, in the hospital where she was a nurse. His drinking record was known to her.

D. M. met his second wife as his attorney for the first divorce. During their 51 weeks of marriage, D. M. had been taking LSD, sometimes on his own initiative, sometimes under a physician's guidance. Here he began his custom of recording his expressions of feeling. Possibly at the suggestion of a therapist, he dictated while under influence of the hallucinogen.

DISCUSSION

The transcript of D. M.'s words on the afternoon of his suicide contains many elements: the need for strength or energy, the need to kill, the self hate, the guilt, the cowardice. All these elements have been noted in the literature. The alternation of his wife and himself as the object of hate is clear. His last words, "I hate me," split his concept of himself, so that a part of him can be the object of hatred and murderous impulses. It might be inferred that alcohol assisted the split. LSD, too, may have a role: other suicides have been precipitated by its use.

SUMMARY

A suicide's statement, recorded shortly before the fatal act, supports psychoanalytical views of the dynamics of suicide and clarifies elements which trigger the death.

ATTITUDES ON DEATH

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What does the general public think about death? From an attitudinal or psychological point of view, a number of facts can be added to the information already gathered over the last decade. These facts were obtained by asking some 14,000 people who visited the 1967 World's Fair in Montreal a number of direct and indirect questions concerning their attitudes on death.

THE METHOD

To collect data, we selected one in ten persons entering the compound of one of Expo's theme pavilions, "Man in the Community," and asked him to come to the nearest of the three Votomat machines where he could register his private and anonymous responses to four categories of questions:

(1) The visitor's profile (identifying variables).
(2) His mental health indices.
(3) His public opinions on socio-political issues.
(4) His response to the environment.

The sensory quotient perceptual test, which I devised, and a variety of ink blot tests were added. The questions were multiple choice, with one forced answer. The mean time taken in punching out the responses was three and a half minutes. Environmental data on the actual day, time, weather, and temperature were also available.

THE POPULATION

The subjects were very much a self-selected group, resembling the general population only in that half were male and half female, and perhaps in that 47% were under 29 years of age while the rest were over 30. They resembled some populations in that a third were Roman Catholics and a third, Protestant. However, somewhat less than one-third of the Roman Catholics were non-active, and no less than one-half of the Protestants were non-active. Twelve per cent of the subjects were Jewish, only half of them active.

In other respects, the population resembled theater-going audiences and, to an extent, adults going to museums in that 44% were university or college graduates and 36% were technical college and high school graduates; only 20% were drop-outs. Forty-eight per cent came from a metropolitan city of a million or more, and 30% came from towns with populations between 100,000 and a million.

But, in some major respects, the population was quite unique: 57% had never married; only 67% were unilingual (English), the rest were French speaking or bilingual; and the majority were students (27%), professionals (18%), or businessmen (16%). One may conclude that this was an elite population, and likely to present the most sophisticated views of a European or North American type of civilization.

ATTITUDINAL RESPONSES

I hypothesized that fears and phobias of physical disease, fear of death, and fear of insanity were on a continuous range, monitored by the *Ss* degree of sophistication. They each represented a primitive fear of the unknown in terms of a loss of self.

The responses on these three items are listed in a table along a range of frequency.

I THINK ABOUT LOSING MY . . .

	HEALTH	*LIFE*	*MIND*
1. Daily. It is my strongest preoccupation.	2.6	1.5	1.1
2. On or off, daily.	10.1	4.1	2.7
3. Weekly. It is a moderately strong preoccupation.	8.1	5.7	2.7
4. On or off more than monthly.	12.1	8.7	3.9
5. Monthly; it is a mild thought.	10.1	6.5	4.9
6. On or off more than yearly.	10.3	15.2	7.8
7. Rarely; it is a mild thought.	16.9	18.3	11.2
8. Very rarely and very vaguely.	10.7	16.8	13.3
9. I'm barely aware of such thoughts.	9.6	10.4	19.5
10. Never.	5.9	8.2	26.8
11. No response.	3.6	4.6	6.1
Total:	100%	100%	100%

The suggestion is confirmed that these three items were on a scale where the milder phobia of somatic disease is twice as frequent as the more severe phobia of death, which is in the middle ranges of frequency, and is, in turn, twice as frequent as that of insanity.

Altogether, it is remarkable how many persons, who are exceptionally intelligent, well-educated, and of a high socio-economic grouping, and probably superior in all aspects of health, are strongly preoccupied with these universal fears, (from 21% suffering hypochondriasis through 11% thanatophobia to 7% lyssophobics). Only 6% to 27% of persons claim absolute freedom from these phobias.

In a previous paper, I reported the comparative attitudes to death of the mentally ill and the suicidal, along with that of other sick and also normative population (Cappon, 1962). On that occasion, the criterion of suicidability was an actual attempt. In this study, I thought it would be useful for clinical psychiatrists, who are in the habit of asking patients, however gingerly, about their suicidal intention, to know what a possible baseline is for responses to the following direct question:

I THINK ABOUT ENDING MY LIFE . . .

1. Daily. This is my strongest preoccupation.	2.5
2. Daily.	2.5
3. Weekly. Strong preoccupation.	2.8
4. On and off more than monthly.	3.8
5. Monthly and mildly.	3.7
6. On and off yearly.	6.3
7. Rarely or mildly.	10.7
8. Rarely and vaguely.	13.9
9. Barely aware of such thoughts.	17.0
10. Never aware of such thoughts.	33.6
11. No response.	3.2
Total:	100%

I would call this a startling result. Five per cent of this population stated that suicide is nearly uppermost in their minds daily. For another 6.6%, it is a strong and frequent thought. Only one-third deny ever having such a thought. This indicates either that this population, which I regard as essentially very healthy, has a peculiarly high suicidal index, or, much more likely, that suicidal thoughts are very frequent in the general population. This makes the prediction of active suicide that much more difficult. A good clinician would need this sort of baseline from which to gauge the more threatening alarms.

To check, in a way, on the frequency of murderous impulses, including attacks on the self, the following question was asked:

THE SCARY THOUGHTS THAT COME MOST FREQUENTLY INTO MY MIND ARE ABOUT . . .

1. Throwing myself off heights.	9.9
2. Crashing my car.	14.3
3. Knifing or shooting someone.	2.3
4. Attacking an infant or young child.	1.2
5. Yelling or singing or attracting attention in a crowd.	7.0
6. Running naked out of doors.	2.5
7. Smashing a window and damaging property.	2.9
8. Jumping in deep and dangerous water.	4.1
9. Other thoughts just as scary.	14.3
10. I never had such thoughts.	38.1
11. No response.	3.4
Total:	100%

There may well be a relationship between the lack of such impulses and the lack of suidical thoughts in over a third of the respondents. There is a clear relationship between suicidability (in terms of frequency of thoughts) and two of the responses in terms of method: crashing one's car and throwing oneself off heights. There is, most of the time, an inverse relationship between suicide and homicide. At any rate, the following question was asked to establish a baseline for "death-wishes."

MY WISH FOR SOMEONE ELSE'S DEATH(S) IS . . .

1. My strongest and daily preoccupation.	2.4
2. Happens daily on and off.	2.6
3. Weekly, and is strong.	1.9

MY WISH FOR SOMEONE ELSE'S DEATH(S) IS . . . *(Continued)*

4. More than monthly on and off.	2.3
5. Yearly on and off.	5.2
6. Happens monthly and mildly.	3.6
7. Happens rarely and is mild.	8.2
8. Happens very rarely and is very vague.	17.0
9. I'm barely aware of such thoughts.	26.8
10. I have never had such thoughts.	26.8
11. No response.	3.6
Total:	100%

The reverse of this kind of thinking on death might be the hope for a long, if not an everlasting, life. As a test for this kind of optimistic futureness, the respondents were asked for how long they saw themselves living healthily and successfully.

1. 40-50 years.	41.4
2. 30-40 years.	9.7
3. 20-30 years.	7.1
4. 10-20 years.	7.4
5. Up to 10 years.	6.5
6. Ill and incapacitated within a few years.	1.6
7. Failing in strength and at work within a few years.	1.6
8. Dead within a few years.	1.7
9. No vision of future self.	16.0
10. No response.	7.0
Total:	100%

Considering the age distribution of this population, I'd say this was quite a realistic prediction, that nearly half the people (under 29) would live up to half a century.

There is a distinct suggestion on the part of the respondents that their death thoughts will not actually affect the length of their lives.

In the previous study, I used "Euthanasia" as an index of health in that the healthier the population, mentally and physically, the more they were in favor of "mercy killing." Even a sizable population of the dying (over one-third) believed in this act of mercy (Cappon, 1962).

Again, to get a baseline, from another normative population, the following question was asked:

MERCY KILLING SHOULD BE PERMITTED MOST IMPORTANTLY IN THE CASE OF . . .

1. Adults with incurable illness who request it.	25.4
2. The newly born with gross physical deformity.	11.5
3. The newly born with gross mental deficiency.	15.2
4. Adult mental defects with incurable anti-social behavior.	7.8
5. Never.	36.1
6. No response.	4.0
Total:	100%

Half the people believed in euthanasia for some condition or other. This corresponded with my previous finding, although it is somewhat more conservative.

Finally, in previous papers, I tried to relate attitudes to death and beliefs about "after life" and general faith in God.

It must be remembered that 32% of these *Ss* were Roman Catholics (and 10% more were non-active Roman Catholics), that 15% were active Protestants, and that another 6% were active Jews. Yet the following were their religious beliefs:

I BELIEVE THAT LIFE AFTER DEATH OCCURS IN . . .

1. Heaven, hell or purgatory.	30.7
2. Lying in a grave but not being able to communicate with the living.	3.3
3. A world of spirits.	8.5
4. Ghosts.	2.1
5. Reincarnation or being re-born in a new form.	12.0
6. Staying close to relatives or friends but being invisible.	5.5
7. There is no life after death.	33.0
8. No response.	4.9
Total:	100%

This corresponds fairly well with their "official" church affiliation and initial declaration of religious activism.

As for the meaning of God, the following is the description nearest to their personal faith:

1. God is with me, protecting me all the time.	24.5
2. God is supernatural, an all-powerful creator beyond my personal reach.	8.5
3. God is that part of each human being striving for good.	14.2
4. God is a core of human behavior stressing love and a commitment to one's fellow men.	19.3
5. God is the mathematics and the laws of the universe.	5.3
6. God has given up on our world, or has died.	1.3
7. There is no God, and never has been.	6.2
8. I don't know if there is a God.	11.9
9. No response.	8.8
Total:	100%

There we have it. Some 6.2% are dedicated atheists; another 11.9% are agnostics. But God is not dead except for 1.3% of respondents. For 5.3% He "personifies" science for another 19.9% He "personifies" ethics; and for some 14.2%, He is the humanitarian drive. No more believe in the dogma of "after-life," than believe in the more theistic and formal aspects of divinity.

DISCUSSION AND CONCLUSIONS

The majority of healthy, intelligent and educated persons are not excessively worried about their health, the loss of their lives or minds—which I suspect are the same types of escalating fears. Also, the majority do not wish to die. But, a surprising percentage does both, wish for death (11%) and worry about it (20%). Crashing a car they drive is probably the main and most technologically influenced means of impulsive suicide.

Also, the majority of respondents do not wish actively for anyone's death, but a surprising minority do (13%), and quite a few are violent in their homicidal impulsivity (2%).

The majority of these people believe in euthanasia, which thus requires consideration by more countries than the United Kingdom and by a wider cross-section of the population than the medical profession. A bare majority of these respondents do *not* believe in "life after death" and the ones who do are fewer than the number who declare themselves orthodox religionists.

Although God is not dead for these *Ss*, for the majority He does not exist in a formally religious way, but rather as the essence of humanity, ethics, or science.

Finally, I suggest that clinicians need baselines such as these on which to evaluate their particular clinical questions. And social scientists, philosophers, theologians and others are also well-advised to use similar normative data banks before they make ponderous pronouncements. There is no excuse for those in search of the truth, however soft and variable, for not making an effort at continuous approximation.

REFERENCE

Cappon, Daniel. Attitudes of and towards the dying. *Canadian Medical Association Journal*, 87, 13, 693-700, 1962.

ANNOUNCEMENT

THE NATIONAL CENTER FOR MENTAL HEALTH SERVICES, TRAINING, AND RESEARCH, National Institute of Mental Health: Now accepting applications for a new one-year interdisciplinary graduate training program in Suicidology, beginning September 1970; stipends range from $6,500 to $12,000, depending on academic preparation (master's degree, predoctoral, post-doctoral) and experience. In addition to full-year fellowships, there also will be stipends for a ten-week intensive training experience in one of the following areas in Suicidology: Community Services, Education and Training, Research, or Treatment. For application forms and more detailed information, write to:

Henry D. Lederer, M.D.
"Training in Suicidology"
National Center for Mental Health
Services, Training, and Research
National Institute of Mental Health
2700 Nichols Avenue, S.E.
Washington, D.C. 20032.

DEATH EDUCATION: ADULT EDUCATION IN THE FACE OF A TABOO

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THOSE who would offer death education are faced with a major dilemma: Will persons participate in death education? On the one hand, popular opinion, backed by research findings (Feifel, 1963), seems to consider death a taboo topic for conversation and investigation. It would appear that this taboo extends to educational consideration of death. On the other hand, based on both educational theory (Knox and Videbeck, 1966) and crisis theory (Caplan, 1964), death education can enable persons to increase their competency to deal with the critical event of death.

With considerable hesitation and some skepticism, one group of adult education programmers* decided to challenge the assumption that death education would not attract enough participants to justify offering it. They deliberately placed fear of death and the taboo about matters related to death on the curriculum agenda of a church-sponsored educative series entitled "On Meeting Death." In so doing, members of the committee hypothesized that the strength of the fear of death and the taboo of the topic would be outweighed by the desire to participate in an educative series on meeting death.

Previous educational series offered by this committee had dealt with more conventional topics such as the use of leisure time and economics for retired persons. These previous programs had averaged approximately 100 participants. For programming purposes, the committee which developed the "On Meeting Death" series hypothesized that an average of fifty or less adults would attend the five programs in the series.

A CURRICULUM OF DEATH EDUCATION

The "On Meeting Death" series was publicized in a manner similar to previous series. Announcements were made in organizational meetings in the church. Flyers were printed and distributed in the church and the community. A description of the series was placed in the church's weekly newsletter.

The series consisted of five evening sessions, each of two hours length. At the first session, the commercial film, "All the Way Home," based on James Agee's novel, *Death in the Family*, was shown. In the other four sessions, persons

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*The "On Meeting Death" series was developed and offered by the writer and by the members of the Plan Now, Retire Later Committee of the Riverside Church. The Riverside Church is an interdenominational, Protestant church in New York City.

from the community who give care to the dying and the bereaved were used as speakers and as resource persons. Those who participated in the series as speakers were: a surgeon, a pathologist, a funeral director, a representative of a burial society, a theologian, and a psychologist. Each participant was asked to make a 30 to 40 minute presentation. The purpose of the presentations was to assist participants to more effectively adapt to the altered circumstances which would be associated with the critical event of their own death or the death of persons close to them. Each presentation was followed by a question-and-answer period. Before each speaker began, blank cards and pencils were distributed to all present. Participants were asked to note questions on these cards during presentations. At the end of each presentation, these cards were gathered from the participants and given to the speaker who responded to these written questions as long as time permitted. This procedure was used to allow for anonymity in the questions addressed to the speakers and to prohibit potentially disruptive or psychologically damaging statements from those attending the session. In addition, the committee chose to use this "protective climate" for the question-and-answer part of each session because of the unknown aspects of programming for death education.

All presentations and responses to written questions were tape recorded. A content analysis of the tapes indicated that consideration of the following topics were included:

SESSION ONE: Film—*All the Way Home* (two hours)

SESSION TWO: *Presentation of a physician (a surgeon) and answers to questions.*

Topics:

1. Revealing or withholding the truth in terminal illness;
2. Decision-making with the family when the truth is not told;
3. The physician's role in protecting the individual and the family from "quacks" in terminal illness;
4. Pros and cons concerning euthenasia;
5. Do we prolong life?

Presentation of a funeral director and answers to questions.

Topics:

1. Traditional fear of undertakers and death;
2. The role of the funeral director as a helping agent;
3. The place of funeral rituals in grief work;
4. The importance of planning ahead;
5. State laws in reference to embalming, cremation, and transporting a body from one state to another;
6. Wills and letters of instruction;
7. Cost of funerals, death allowances, and Social Security;
8. Decisions to be made before dying;
9. Pre-planning arrangements.

SESSION THREE: *Presentation of a physician (a pathologist) and answers to questions:*

Topics:
1. Ways pathology aids the living;
2. Types of banks: Blood, bone, eye, blood vessels, pituitary gland extracts;
3. Willing the body;
4. Problems connected with disposition of a body;
5. Cost of willing your body;
6. Need for willed bodies.

Presentation of a representative of a burial society and answers to questions.

Topics:
1. The history and organization of burial societies;
2. Funeral costs and alternatives;
3. Pre-arrangements for funerals;
4. Procedures and problems in forming a burial society.

SESSION FOUR: *Presentation of a theologian and answers to questions.*

Topics:
1. Viewing death objectively and existentially;
2. Death as part of human nature;
3. Individual uniqueness and death;
4. Grounds for accepting death;
5. Why death is frightening;
6. The place of trust and faith in facing death.

SESSION FIVE: *Presentation of a psychologist and answers to questions.*

Topics:
1. Denial and avoidance of death;
2. Dread of death, the unknown and separation;
3. The demands of death;
4. Facing painful reality.

In short, the "curriculum" for the "On Meeting Death" series consisted primarily of those topics which care-giving agents of the dying and the bereaved believed would assist the aged and others from the community in educative coping behavior.

EXTENT OF PARTICIPATION IN DEATH EDUCATION SERIES

The range of attendance at each session was 210 to 250 persons. The number of different people who came to one or more sessions totaled approximately 550 adults. Participants for each session included both members of the sponsoring church and persons attracted from the community at large by publicity and by word of mouth about the series. While the average age of those attending was over 60 years, there were children, teen-agers, young adults and middle

age adults participating as well. Some came as families. One family group consisted of a grandparent, parents, and grandchildren. The largest category in attendance at the sessions was that of older, single women, including widows. The second largest category consisted of middle-aged and older married couples.

DISCUSSION

Two aspects of this death education series seem particularly significant: (1) the extent of participation; and (2) the number of requests for information about the series.

(1) The number of participants at each session was very much greater than the planning committee had anticipated. The willingness of the aging and others in the community to participate in death education of the type described is understandable from the viewpoint of preventive psychiatry, which has been engaged in developing crisis theory. It would appear that adults, and particularly aging adults, view their own death and that of those close to them as impending crises. According to Caplan (1964), when faced with such a crisis, an individual experiences a heightened desire for help.

A person is more susceptible to influence by others when involved with a crisis than during periods of stable functioning. "When the forces are, as it were, teetering in the balance, a relatively minor intervention may weigh them down to one side or the other. The resulting steady state will then be relatively stable. Crisis, therefore, presents care-giving persons with a remarkable opportunity to deploy their efforts to maximum advantage in influencing the mental health of others." (Caplan 1964, pp. 53-4.)

It would seem that, at least for the persons who attended the "On Meeting Death" series, the desire for help in coping with their own death or that of others close to them outweighed deterrents to participation such as fear of death and taboos related to the topic.

(2) After the "On Meeting Death" series had been completed, reports about the series were circulated spontaneously in private correspondence from participants to relatives and acquaintances. In addition, organizational publications made reference to the series. As a result, and unexpectedly, requests for more detailed information about the series were received by the writer from organizations and agencies in such nations as Israel, Australia and the Philippines. Similarly, requests for information were received from many different types of agencies and institutions throughout the United States such as: state commissions or departments on aging, extension and cooperative extension services of universities, metropolitan councils for community services, educational television stations, medical social services of hospitals, local community service councils, homes for the aged, local churches and synagogues, Y-organizations, and community mental health centers. Both from the point of view of this expressed interest and because of their positions in the community, such organizations and agencies, individually or in consortium, would seem to be logical ones to sponsor death education.

The number of persons willing to participate in the "On Meeting Death" series indicates that the fear that adults will not participate in death education

was unjustified. Those who wish to work in this area under the sponsorship of a wide variety of organizations and agencies should proceed to do so in the face of taboo.

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LONGEVITY AND ACHIEVEMENT IN EIGHTEENTH CENTURY SCOTLAND*

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THE correlation between age and achievement has received considerable attention from psychologists, sociologists, gerontologists, and historians. In general, it has been pointed out that there are earlier peak performances in mathematics, physics, and chemistry than in geology, biology, and the social sciences, and that there are different ages for peak performances in the several kinds of literary performances (Lehman, 1953). This has led to some concern among psychologists, as exemplified by Lewis M. Terman (Lehman, 1953, p. vi), that the increasing age at which positions of leadership are now attained as compared with earlier times might profoundly affect the "direction as well as the speed of our social, political, and industrial progress." This brief article is an attempt to indicate that Terman's fears in this respect were perhaps misplaced and to suggest another possible line of exploration, namely the correlation of longevity itself with intellectual achievement. This is not to dispute the conclusions of other investigators that basic innovative discoveries or acts or creativity are more likely to take place among those who are under 40 than those who are over 60 but to give emphasis to the concept that continual refinement and additions to an individual's accomplishments are probably as important to his long term reputation as his original contribution. This means that longevity itself, at least in the case of the productive writer, scholar, or scientist, is important.

These conclusions result from a study of intellectual achievement in eighteenth century Scotland. The study was focused on answering why so many intellectually eminent people appeared in Scotland during this period which has come to be known as the Golden Age of Scotland or sometimes as the Scottish Enlightenment. This was the time when Adam Smith, Sir Walter Scott, Robert Burns, James Watt, James Boswell, David Hume, James Mill, John Hunter, and numerous others still remembered today, were active. For the purpose of the study, eminent men were chosen because of their continuing influence today, although for the most part the individuals were also regarded as eminent by their contemporaries. To select the group a two-step methodology was used. First a comprehensive sample of eminent men born between 1685 and 1785 was selected through a survey of standard reference works in the history of

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science, medicine, engineering, literature, art, and so forth. This list was then compared with those included in the *Dictionary of National Biography* (1885-1901) who had achieved eminence in intellectual fields or whose fame was based on an innovative achievement in their field. The qualification that their eminence be based upon intellectual achievement eliminated most of the nobility as well as the military and political leaders whose accomplishment in reaching high office or being born into a high status position led to their being included in the *DNB*. In fact, the majority of Scottish figures of that time who were included in the *DNB* were excluded from the study since the editors of that collection tended to give a large proportion of their columns to nobles, military figures, and politicians. Such an exclusion was deliberate, based on the assumption that there had always been nobles or military and political leaders in Scotland, but there had not always been a significant number of men (and women) who achieved intellectual eminence. Moreover, not all those included in the *Dictionary of National Biography* for intellectual contributions were judged eminent enough to qualify for the sample. The result was a list of 375 individuals (364 men and 11 women).

People whose birth dates were between 1685 and 1785 were selected because it was hypothesized that schooling was important and those born after 1685 would most likely have received part of their education in the eighteenth century. Nicholas Hans (1951), in his study on English education over the same period, included a sample of 338 who had been educated in Scotland but he excluded surgeons, architects, musicians, painters, craftsman, and others who became famous through practical application of their natural talents alone. Such individuals were included in this study, and thus the total sample of 375 is somewhat comparable to that of Hans even though different standards were utilized.

Once the list of eminent individuals had been selected, biographical investigations were made into the lives of each of them. Part of this could be done through the *DNB* itself, but since the required information was not always given, and it was important that the information be thoroughly checked, there was a concerted effort to arrive at independent and individualized biographies from all available source material. Included in the biographical studies was information on the parish in which the subjects were born or went to school, their social class background, their level of education, their place in the family constellation, their age of achievement, their age at death, and other such data. This report is concerned only with the longevity of the subjects in the study.

In fact, longevity turned out to be a much more significant factor in the study than age of achievement. This was because it was difficult to determine just what age should be used in measuring achievements: the publication of the first book, the first mention of a discovery, or the decade in which the greatest achievement took place. Even using the criteria set down by Lehman (1953), there seemed to be considerable variation among the coders but not enough to argue with his historical findings. Much more significant, however, was the fact that eminent eighteenth century Scotsmen tended to live much longer than the norm, and that their reputation and achievement on the whole seemed to be cumulative rather than due to any one particular event. Obviously, no one in the study made his or her initial contribution when they were past 70, but many added to their reputation when they were past that age. The median age at

death, as indicated in Table I, of the achievers in the sample was in the 70-79 age group, although it was much closer to 70 than to 79. In the 1755 census compiled by Alexander Webster (Kyd, 1952), the median age of the population was between 21-30, centered at about 25 years of age.

TABLE 1.
Age at Death of Eminent Scottish Achievers (n=375)

Age Range	Number	Percentage
Unknown or uncertain	10	3
Under 30	3	1
30-39	8	2
40-49	29	8
50-59	46	12
60-69	93	25
70-79	107	28
80-89	69	19
90-99	9	3
Over 100	1	—
		101 *

*All percentages are rounded off.

Webster, who conducted his census in part to gather information for actuarial projections, estimated that 25% of those born within Scotland at that time died within their first year, and 50% had died before their tenth year. Only 25% survived their forty-eighth year. It is estimated that the median age at death of those who survived their first year was around 40 years. There were, of course, localized differences. In Torthworwald, in Dumfriesshire, it is calculated that there was a life expectancy at birth of 49.64 years and at age 5 of 54.69 years. In the larger cities, where infant mortality was higher, the average was lower. In 1791, Glasgow (which had a population of 77,385 in 1801) recorded 1,508 deaths of which 46% were children under two and 63% of all deaths were children under 10. The high death ratio in Scotland is further indicated by the epidemic nature of some diseases. In Edinburgh between 1740-1742, 2,700 out of a total population of 40,000 died from smallpox, of whom half were children under five. In the next two decades, 10% of all deaths were from smallpox, while in the last quarter of the eighteenth century the rate in Glasgow was 19% of all deaths.

The longevity of the eminent achievers is most evident when the age distribution of the Scottish population is considered (see Table 2). If all the population under 21 is excluded, the median age is between 31-40 years of age, much lower than the age of achievers at death. Approximately 1% of those who lived to be 80 or over in eighteenth century Scotland achieved eminence, and nearly one half of 1% of those who died between 70 and 79 did so. The ratios decline with each decreasing age group as Table 3 indicates.

From these data some conclusions can be drawn about achievement and longevity in eighteenth century Scotland. First, there is a high correlation between achievement and longevity and those who live longer lives are more likely to become eminent. Second, those who achieved eminence in eighteenth century Scotland were in better health and undoubtedly had less sickness than the

TABLE 2.
Age Distribution of Population in Scotland in 1755

Age Range°	Number	Percentage	Percentage if those under 21 excluded
10 and under	322,381	25%	
11-20	235,813	19%	
21-30	210,791	17%	30%
31-40	175,202	14%	25%
41-50	134,701	11%	19%
51-60	94,840	7%	12%
61-70	58,911	5%	8%
71-80	25,659	2%	4%
81-90	6,495	—	1%
91 and over	587	—	—
		100%	100%

°Unfortunately the decades in this table are not calculated exactly the same as in the other tables but it should be possible to compare with only a slight error.

TABLE 3.
Ratio of Longevity and Intellectual Achievement per 100,000 Population

Age at Death	Ratio
80 and over	1115
70-79	417
60-69	158
50-59	49
40-49	22
30-39	5
20-29	1

general run of the population. They probably were less likely to have any of the chronic debilitating diseases such as tuberculosis which tended to result in an early death. Third, it would seem that few people achieved real eminence who died before they were forty, in spite of the fact that they might have published a book or had other important achievements. Instead it seems that, except in rare instances, it is the weight of accumulated publication, research, invention, and other accomplishments that is most likely to be regarded by later generations as making a person intellectually eminent. This has some implications for today, since in a world where growing numbers of people live beyond the three score and ten most associated with eminence, there ought to be a rise in the number of eminent men, disproportionate to the general increase in population. It might well mean that the decrease in debilitating infectious diseases and the improvement of general health is an important factor in the intellectual achievement of twentieth century western man.

It is impossible to determine from these data whether eminent persons lived longer because their success enabled them to purchase the necessary health care and nutrition to sustain life or whether it requires a longer period of time to become well-known. Our information, however, suggests the latter as more probable. The median age at death of our sample approximates the median age at death of

contemporary Americans and is some thirty years later than the median age at death of those eighteenth century Scotsmen who were alive at age 21. Regardless of what age a person produces his major work, eminence apparently requires longevity. Perhaps historians or behavioral scientists of the 1990's might return to Lehman's original sample to learn whether the impact of those he selected are similarly related to longevity or whether the initial achievement that he cited is sufficient to include them as eminent men of twentieth century America.

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DEATH AND THE HEREAFTER: THE STRUCTURING OF IMMATERIAL REALITY

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INTRODUCTION

THE scientific rationale of Western man is that physical death is experienced only once and that those who have experienced it cannot return to describe what it was like. Yet in most cultures, including Western nations, men do speak of death and the hereafter with considerable knowledge and in great detail, and this is not limited to religious specialists such as shamans and priests. Under the premises of the Western man rationale, then, these persons literally "do not know what they are talking about."

This paper will take the position that in order to understand the meaning that death and the hereafter has for particular people, one must examine what it is to "know" something, and what ways people have of talking about and acting on a particular subject, in this case, death and the hereafter. The perspective taken will be (following Wittgenstein) that grammar tells us what kind of object anything is (Wittgenstein, 1958), and that the meaning of words is their use or their role in what Wittgenstein calls "language-games," that is, the language and the actions into which language is woven. Any concern with some reality behind the language-games is nonsense, for language-games put a limit on what we can know, experience, believe in, imagine, feel, etc.

The language-game that will be described is members' knowledgeability of death and the hereafter, that is to say, that prior to the time of physical death a person already "knows" about death and about the after-death state, can talk about it, and acts in particular ways based upon this "knowledge."

When persons speak of death and the after-death state, for them it seems as if they were talking of real feelings and experiences. It is one of the characteristics of language to make persons think that they are talking about "real" feelings or experiences that exist in some kind of ontological sense, when in fact, they are actually talking about the ways their language enables them to talk about things.

The perspective this paper takes is that persons "know" what they are talking about when speaking of death and the state after death in the sense that they have procedures for gaining this knowledge and are able to describe or give accounts of what they believe death and the after-death state to be like. "Knowing" does not imply knowing the "real" state of affairs, but it refers to talking and acting in particular ways. The meaning death and the after-death state have for persons does not refer to any real feelings or experiences at death, but to the language-games involved.

The description that follows will be of the language-games of Tibetans. The major contention is that Tibetans "know" what they are talking about when

speaking of death and the state after death because they have means available for describing what they believe to be death. In Tibetan language-games, physical death is only one of many ways of entering a particular realm which they believe to be void of physical matter and for which I have coined the term, *Immaterial Reality*. Physical death, in Tibetan language-games, falls into a larger category which I will label *Discarnation* and which refers to the Tibetan belief that the "spirit" or "soul" is able to separate from the body. Tibetans maintain that through discarnation a person enters Immaterial Reality and acts in it.*

For Tibetans being and acting in Immaterial Reality involves a particular language-game, or meaning, in terms of the uses which words have. The description of how, when and in what contexts Tibetans use words relating to a realm which they believe only the "spirit," is what I mean by Structuring Immaterial Reality. For Tibetans, their talk and activity concerning the phenomenon of death and the after-death state, form a complex of meaning which is continually being created and altered in different situations. Structuring Immaterial Reality refers to the actual use of concepts in living situations as though the concepts had known physical referents and is a process involving social time and space. How such structuring is accomplished by Tibetans will be this paper's main concern.

DEFINING THE SITUATION

The process of Structuring Immaterial Reality can be considered identical with that of Defining the Situation. Both Structuring Immaterial Reality and Defining the Situation refer to the process by which discrete events and other phenomena are defined as "real," according to people's distinctive social logic of time and space; that is, both refer to the means by which people through their language-games isolate units and accord them the status of "real" as opposed to "illusory" phenomenon. Hence, the terms Structuring Immaterial Reality and Defining the Situation can be considered equivalent for my purpose and they will be used interchangeably. The problem, then, is to ascertain how immaterial reality is structured or how situations are defined and hence become meaningful for members.

A few introductory characteristics of a definition of the situation can be mentioned. A definition of the situation can be considered an observable activity of members and is therefore available for analysis. It is a way of depicting the social experiences of members, and it is possible only when physical space and chronological time are transformed into social space and social time. Definition of the Situation is also a necessary component of orderly social interaction and it is based on mutual expectations.

McHugh (1968) gives a detailed discussion of Definition of the Situations. He maintains that persons "know" what they are doing in the sense that they are

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*It is not implied here that the "spirit" of a Tibetan enters a realm devoid of physical matter, or even that there is such a realm, but only that Tibetans claim to have sensations, feelings, etc. that they consider as "having died" i.e., having become discarnate.

describing and defining what they are doing in some situation. Two conditions that create and limit knowledge are Emergence and Relativity.

EMERGENCE

Emergence, as defined by Mead, refers to "the presence of things in two or more different systems, in such a fashion that its presence in the later system changes its character in the earlier system to which it belongs," (Mead, 1932). Those things can be an event, or memory, or idea, or attitude, or any symbolic definition of the present, if this definition is influenced by the past as well as by one's inferences about the future. Events in the future will also reconstruct one's definition of the past. Persons in their language-games are able to place themselves at a future time when a particular action *will* already *have been* accomplished. They can then reconstruct the single steps which *will have* brought forth this future condition (Schutz, 1962). Because people assume that future events will occur as they have in the past—Husserl's idealization of "I-can-do-it-again" (Husserl, 1929), the environment is routinized and order is made possible.

People's reconstructed past and future programs become part of the present and the present is the point at which all impingements on behavior contemporaneously intersect. Emergence, then, is the temporal dimension of activity where the past, present, and future are analytically distinct, yet not correspondingly distinct in their influence upon concrete behavior. In short, Definition of the Situation, in the chronological present, exists in the social past and future.

Members maintain temporal congruity in the environment and keep meaning extensive over time, by what Mannheim calls the "documentary method of interpretation" (Mannheim, 1952). It is a way to homogenize temporal events and invoke normative order across social time so that one still retains the feeling that one has derived a single common meaning from a wide range of objective and expressive meanings.

The following devices are used by members in creating temporal continuity in Defining the Situation (McHugh, 1968).

THEME. A pattern of meaning that actors assume they will discover in observed events. Both expectations of future occurrences and past events are used to describe the present. Theme is the past and future homology that informs the present.

ELABORATION. The theme is elaborated by locating its particulars over chronologically discrete events. Elaboration is the process by which identity of the interaction is achieved.

FIT. Members test the correspondence of particulars to the theme, and the applicability of a theme is assessed.

AUTHORSHIP. Members conduct active search for patterns and actively revise definitions.

REVELATION. Events are connected with one another in such a way as to make each other intelligible and the recognition of the character of one event may call forth a transformation of the original understanding.

RELATIVITY

Whereas Emergence deals with Events and relationships between events across time, Relativity characterizes events and their relationships across space. When speaking of both Emergence and Relativity one is assuming that there is no absolute time and space in which an item can exist, nor is there an absolute judge existing outside the world as a final arbiter.* Events and relationships exist only by definition or by agreement, which is reached because members are able to interchange standpoints. In other words, meaning is assigned, decisions for action are made, and objects are characterized, that is, phenomena become "real" and are assigned factual status only within particular language-games (Wittgenstein, 1965).

Relativity, which deals with definition of the situation and its transformation across space, can be overcome by the interchangeability of standpoints. It is possible for persons to rehearse action *as if* they were in the other person's place. Both persons assume that if their positions were reversed they still would be "seeing" the same thing as the other person is now "seeing." Relativity in spacial perspectives is overcome because of what Garfinkel calls "perceived normality" which refers to the normative way in which persons classify their social environment and make the activity of others sensible so that standpoints are interchangeable (Garfinkel, 1962).

There are six devices that members use for assessing the behavior of others (McHugh, 1968).

TYPICALITY. Members infer whether or not the other's behavior is representative of some group or category membership.

LIKELIHOOD. Members assess the probability or improbability of the occurrence of behavior and hence are able to make predictions.

TECHNICAL EFFICIENCY. Members maintain that some means are more efficient than others and behavior is classified as appropriate or inappropriate.

CAUSAL TEXTURE. Some phenomena are seen as conditions under which others will occur.

MORAL REQUIREDNESS. Some actions are considered to be ontologically necessary regardless of personal circumstance.

SUBSTANTIVE CONGRUITY. Members assess whether other's substantive assessments of their environment are emperically right or wrong in terms of accurate judgment.

The five devices of the documentary method and the six devices that induce perceived normality together create the meaning of objects, events, etc., if meaning is used in Wittgenstein's terms, that is, how the objects, events, etc. are used by members in various language-games (Wittgenstein, 1958). No social object is intrinsically meaningful but the assignment of meaning is an accomplishment of members' activity and the meaning of objects, events, etc. influences the member's behavior towards them.

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*For the importance of context or purpose when describing something, see Wittgenstein's *Philosophical Investigations*, sec. 47.

IMMATERIAL REALITY

Since it is maintained in this paper that no object is intrinsically "real" or "meaningful"; that meaning is imputed into phenomena by members in their activity of structuring or defining; that definition of situations are possible because social time and space are involved; that discontinuity in time is overcome by the five devices of the Documentary Method, and relativity in space is overcome by the six devices of Perceived Normality; the language-games of Tibetans involving death and the after-death can be described.

Discarnation has been defined as the process believed in by Tibetans by which the "spirit" is separated from the body and hence enables a person to act in a specialized manner. For Tibetans a discarnate being is one who has "lost" his corporal essence and is believed to have entered Immaterial Reality. Physical death according to Tibetans is only one means by which discarnation can be accomplished. According to Tibetan language-games it is possible to speak of the transition from an incarnate existence to a discarnate one as being followed by:

1. A temporary transition back into an incarnate state
   a. Discarnation as being followed by incarnation into what Tibetans consider to be the same body *(rolang)*.
   b. Discarnation as being followed by incarnation into what Tibetans consider to be a different body (possession of mediums; *trong jug*).
2. The passage from an incarnate state to a discarnate one may be seen to be only temporary and may be viewed as being followed by a permanent transition back into an incarnate state.
   a. Discarnation is seen as being followed by incarnation into what Tibetans consider to be the same body (shaman's journey; *(delogs)*.
   b. Discarnation is seen as being followed by incarnation into what Tibetans consider to be a different body *(tulkus)*.

According to Tibetans ways of talking and acting, Discarnation is not necessarily a one-way process; it can be experienced by Tibetans in not only what Schutz (1962) calls the future perfect tense, but directly in the present. Expectations that Tibetans have of what it is like when one *will have been* dead, are believed by Tibetans to be corroborable by leaving one's body and entering Immaterial Reality.

It seems that Tibetans also "know" of discarnation and Immaterial Reality indirectly by observing others becoming what Tibetans consider to be discarnate; by being present during a shaman's "journey"; by hearing what is taken as a discarnate's voice through mediums; and so on.

By *Immaterial Reality* I mean a realm which Tibetans view as being devoid of physical matter or substance and which is believed to be the domain of the discarnate and other entities that supposedly have never known an incarnate existence.

Tibetans view physical death as a means of discarnation and in certain contexts do not distinguish between physical death and what we in our culture refer to as unconsciousness, trance states, dreaming, etc. This does not mean that Tibetans are unable to distinguish a sleeping person from a dead one, but merely that the accounts of what a Tibetan supposedly feels or sees when sleeping or unconscious

are sometimes treated as if the person was describing real feelings and sensations that are believed to accompany physical death. These sensations and experiences are considered by Tibetans to be "real" and are used in their language-games as proof that the person has actually entered Immaterial Reality. Thus, at the time of one's physical death, it is possible for people to believe that they have already experienced the sensations they believe accompany death and after-death states. Social time as well as chronological time merge at the time of one's physical death, and Tibetans make what they believe will be a transition into Immaterial Reality with a backlog of experiences and a definite program of future expectations.

STRUCTURING IMMATERIAL REALITY IN TIBET

I will first relate the activity of Tibetans when a person is dying or has died, then describe what Tibetans believe the dying or dead person supposedly experiences, and finally show how the entire phenomenon of dying and death is viewed by Tibetans as a transition into Immaterial Reality.

In Tibet, when a man is dying, his family sends for the high Lama who is considered to be qualified to perform the activities by which the "soul" is supposedly allowed to escape from the body. The Lama seats himself at the head of the man and pulls the man's hair. If he is not dead yet and opens his eyes, this is taken as a good sign because Tibetans consider consciousness while making the transition to a discarnate state to be extremely important. The Lama is careful to prevent the man from falling asleep or from fainting or falling into a coma. He constantly repeats in the ear of the dying man formulas that are believed to acquaint the dying with the proper manner of conducting himself on the road to his rebirth. The Lama describes for the man the nature of the beings and things which are believed to appear to the discarnate, and the Lama assures the man not to be afraid because he will guide him in the right direction (Habenstein & Lamers, 1963).

Then the Lama performs a ritual which Tibetans believe will make the spirit spring out of its envelope through the top of the head of the man. The Lama, believing he is concentrating his thoughts and identifying with the man, and shouts *hik!* in a prescribed tone, which Tibetans believe will produce a slight opening in the skull. The Lama then places a straw in the opening. The outcry *hik* is followed by shouting *phat!* which supposedly leads to the separation of body and spirit (discarnation), and it is considered that this has been accomplished when the straw stuck in the skull of the man stands up straight as long as desired (David-Neel, 1931).

Tibetans believe that only a lama can correctly liberate the spirit and if a lama is not available, a white cloth is thrown over the body to prevent the escape of the spirit until a lama can be found. If it is impossible to retrieve the body because the man has drowned or has suffered another accident, it is believed that the spirit can still be properly liberated by the lama, who performs the activities in what is considered to be a state of deep meditation. If the steps are not performed, Tibetans believe the soul leaves the body by some

other passage and the man's chance for a successful reincarnation is severely jeopardized (MacDonald, 1929).*

An astrologer lama casts a horoscope to determine who may touch the body; how it shall be disposed of; what prayers shall be said; and what god shall be made in effigy. When these matters have been decided the portrait of the god or holy person is painted on a banner and it is believed that this holy person will intercede at the Judgment time and ask that the soul be reborn into a higher human state.

Meanwhile the body is stripped of its clothes, its hands and feet are bound, and it is placed in a squatting position behind a cloth partition where it remains for three days while the spirit supposedly is asleep. During this time the lama continues addressing the spirit, signaling which roads he should take and which he should avoid. Food is placed before the body in the amount that the man would have required in life.

On the day that the body is to be taken for burial, an elaborate meal is placed before it and the spirit is presented with a long silken "scarf of honor." One end is tied to the body and the lama holding the other end asks the spirit to leave the house and proceed on the road to paradise and never to turn back and annoy the living. The lama addressing what he believes to be the discarnate says:†

> You now have received from your relatives all this good food and drink. Partake freely of its essence, as you shall not have any further opportunity of so doing. For you must understand that you have died and your spirit must be gone from here and never again come back to trouble and injure your relatives. Come this way. (Waddel, 1895).

The lama, holding one end of the scarf, begins to lead the funeral procession, chanting a liturgy to the accompaniment of a miniature hand drum, trumpets, and brass cymbals. He looks back from time to time, inviting the spirit to accompany the body and assuring the discarnate that the route is in the right direction (Evans-Wentz, 1960).

Then the body is disposed of in the manner prescribed by the astrologer lama. Four methods could be used, each it is believed is returning the body to one of the four basic elements: (1) Destruction by fire; (2) Burial by water, in which the body is cast into a river; (3) Earth burial in a grave lined with wooden planks; (4) Burial by air, in which the body is fed to the vultures and crows (Bell, 1928; Combe, 1926).

When a lama feels what he believes to be his own death approaching, Tibetans believe that he is capable of liberating his own spirit by shouting *hik!* and *phat!* and that he needs no assistance in making himself conscious of what path he is to take. Tibetans maintain that a lama has foreseen and experienced in life the sensations that are believed to accompany death. It is also believed that a lama will not be surprised or troubled when he dies, because he has supposedly made a careful study of the *Bardo's* map (the Tibetan term for what they believe to be the state between discarnation and reincarnation). Tibetans maintain that

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*Many sources for the paper date back several decades: We are less concerned with describing contemporary Tibetan practices than we are with describing the usage of language-games, including the dead and dying. Hence a reliance on the ethnographic present is justified.

†For a discussion of how a man's name does not lose its meaning when the man is destroyed, see Wittgenstein's *Philosophical Investigations*, sec. 55.

some of the very learned lamas are even capable of making the entire journey through the *Bardo* without losing a particular consciousness.

However, it is believed that when an uninitiated or lay person dies, his spirit is "asleep" until two hours before noon on the third day, and it is further maintained that after the spirit awakes,* it may roam around until forty nine days after death. The person does not at first know† that he is discarnate because it is believed that the first state of man after death is like his state in life. Tibetans talk of the after-death state in the following way:

> On the third day the spirit wakes up and says to himself: What is wrong with me? What have I done? Then he will think, Maybe I am dead! He imagines he has a body like a living man but is afraid. He goes into the room where the family is sitting at a meal and looks to see whether a place is left for him. He sees his *tsamba* bowl beside the lama and all the people are crying and are very sorry. He is afraid he is dead, and goes up to the roof to see whether he has a shadow. There is none. He goes down to the riverside and walks on the sand; he leaves no footprints.
>
> Then he knows for sure that he is dead, and he returns and tries to get into his body again but cannot; it is cold, like earth or stone (Combe, 1926).

It is believed that the spirit then searches for a husband and wife in conjugal embrace, and tries to enter the womb but cannot because he has not been purged of his sins. He then tries to find the way the lama spoke of and sets out along the *Bardo Trong*, the Tibetan road that lies between death and rebirth.

He follows a road bordered with trees and flowers which is leading nowhere. He comes back and wanders to many places and is chased by many terrifying men with animal heads, and all these creatures have swords and spears, bows and lassos. It is cold, dark, and dreadfully frightening. Tibetans believe that if the man was knowledgeable and good, he is not afraid; he will think it is all an illusion; he will know that he has no body and must find the way to be reborn.

The creatures with the lassos catch him and lead him to the King of Hell where he is judged, getting a white pebble for each good deed and a black one for each evil deed. If the black and white pebbles weigh about the same, it is believed that the spirit must go back to Man's Country and be reincarnated. With his rebirth in this or some other world (hell being possible for the very exceptional evil doer), it is believed that the after-death state comes to an end (Combe, 1926).

From the description of Tibetan activities and beliefs surrounding death, it is apparent that "death" for Tibetans is no surprise or accident, in the sense that the time or place of death might be considered accidental. The activities of the lama are all based on what Tibetans believe to be his intricate knowledge of the nature of death. The lama aids the uninitiated in what is considered to be the proper manner of dying. Instructions on how to proceed at the time of death

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*In our culture the terms "sleeping" and "awaking" are reserved for entities with some kind of consciousness. Tibetans however talk about non-living entities that are capable of such activity, but this does not mean that such spiritual entities actually exist, even though they are referred to.

†It may be argued that persons who have become discarnate cannot "know" anything; and I agree. The locus of this "knowing" lies in the accounts given by persons, who are believed by Tibetans to have returned from a discarnate state. The accounts of persons believed to have been discarnate are taken and used as evidence by *living* Tibetans to maintain that: (1) there is such a realm as Immaterial Reality; (2) the sensations of the discarnate must be very like those that supposedly accompany actual physical death.

are codified in the *Bardo Thodol*, the *Tibetan Book of the Dead*. Lamas spend their lives studying this work and having mastered its teachings, they believe that they are able to make the transition into Immaterial Reality without assistance. However, the commoner is also familiar with the *Bardo Thodol* which is not only addressed to those who think they see the end of their life approaching, but also to those who still have years of life before them. Thus, Tibetans become familiar with what they believe that the after-death state will be like while they are still alive. When a person is dying he is called upon by the lama to remember what he has learned of death and it is the lama's duty to see that the dying person is kept alert. The lama's aim is to restore what Tibetans believe to be the complete consciousness to the deceased after the three days of sleep that supposedly immediately follows death, and to accustom the spirit to the environment of the after-death state.

For the lama and for the dying, the entire transition to a discarnate state is made with knowledge, in the sense that they are able to describe what they are doing. Both the lama and the dying "know" what they are doing in that they are using the devices of the documentary method of interpretations and the devices of "perceived normality" in Defining the Situation and in Structuring Immaterial Reality. Past experiences, e.g., the lama's expertise in liberating spirits; the dying man's familiarity with death; and future expectations, which already have been experienced in the social past and present by both the lama and the dying man, fold into the chronological present to give meaning and definition to the activity of dying.

Dying is also seen in its normality and standpoints are easily interchanged. The dying man believes that any other person in his place would feel and experience the same thing he is supposedly experiencing. He also believes that the discarnate wander through the *Bardo* until they are reincarnated. He believes that the lama can point out to him the right direction because the lama supposedly has already made the journey himself. A Tibetan also believes that after he has died, he will be able to continue to listen to the lama's directions and will proceed as the lama himself would have proceeded if their roles were reversed.

From the account of what Tibetans believe to be the thoughts and activity of a spirit upon awaking from the three days of sleep, we see the supposedly newly discarnate proceeding to define the situation, and in doing so he recognizes what Tibetans believe to be the elements of Immaterial Reality.

The discarnate can be seen to use the five devices of the Documentary Method of interpretation (discussed on page 123) to construct a definition. The *theme* is a suspicion that he is dead and hence no longer in material reality. But since his query of "what's wrong with me?" could possibly be answered by being ill, having fainted, or dreaming, etc., the theme of dying needs to be *elaborated*. He tries to locate particulars, e.g., he looks to see if a place has been set for him; he sees his family weeping; he sees the lama present; he notices his bowl next to the lama. He knows from past experience that these are all occurrences associated with the death of a person. He has seen death before and *fits* these

particulars to the theme of dying. His first suspicions are becoming stronger; however, he needs more proof so he actively searches for patterns that may revise or confirm his theme. He *authors* a search for more evidence. He goes to the roof to look for a shadow, then to the river sand to see if he leaves footprints. He is able to make this search because he knows that persons who are dead don't leave footprints or have shadows. Finding none, he sees the previous events in their true character, that is, what they were in the first place. The true nature of his waking up and feeling strange is now revealed (*revelation*) by other events, e.g., no shadow or footprints and he knows now that he has been dead all along. He has defined the situation and this definition calls for appropriate action. He tries to get back into his body but cannot, yet another confirmation of the correctness of his definitional outcome.

Tibetans are able to define the situation because of their past experiences, e.g., the things the lama told them of death, their familiarity with the teachings of the *Bardo Thodol*, their eye witnessing of persons dying; and their future expectations and anticipations that they have in fantasy, dreams, "visions," etc.

Tibetans also assess their present situation not only by using the Documentary Method as described above, but also in terms of the six devices of Perceived Normality (discussed above). They believe that other persons in what they believe to be same situations would arrive at the same conclusions; for example, persons who have no shadows or footprints are dead, regardless of private past experiences. Persons not only assess a situation in its *typicality*, but also consider the *likelihood* of occurrence. For example, Tibetans believe that if a man were dead it would be very likely that the lama would be present and that his family would be weeping. These are not only typical behaviors under such circumstances but would also be likely to occur. However, they know that there is a more efficient way to check the suspicion of "being dead," such as looking for one's shadow or footprints (*technical efficiency*). If a person finds none, his suspicions are verified because he sees events in their *causal texture*. He knows one phenomenon is a condition under which others will occur. That is, being dead is a condition for the absence of a shadow and footprints. The entire investigation forces him to agree with the assessments of his family and the lama that he is, in fact, dead, *substantive congruity*. This being the case, a person knows that reincarnation cannot follow until one has been judged, *moral requiredness*.

In this manner Tibetans succeed in Structuring Immaterial Reality in which they manage to locate themselves. But much of the knowledge upon which persons rely in defining the situation has been accumulated in the social past, present, and future. How does a Tibetan gain such knowledge and experience of the afterdeath state so that the elements of Immaterial Reality are familiar to him?

I have already mentioned the teachings of the *Tibetan Book of the Dead* and how they are learned before physical death occurs, and how as death approaches, the Tibetan beliefs are repeated in the ear of the dying person by the lama who is assisting him. There are, however, other means of gaining "knowledge" and thereby structuring Immaterial Reality. I will briefly discuss six of them.

1. Tibetans believe that there is no one living person who has not returned

from death and all have "died" many deaths before coming into their present incarnation. The process from incarnation to discarnation and reincarnation is seen to be a continuous one; a journey that is believed to be sometimes made with a particular consciousness intact so that "remembering" is possible. Persons who are believed to be reincarnations of saintly or learned departed personalities and supposedly remember their previous lives are called *tulkus* (David-Neel, 1931).

Tibetans believe that at the time of death, very learned persons are capable of choosing and making known the place of their next birth and their future parents. The enlightened ones who are aware of the goal which they mean to reach and are well informed of the *Bardo's* map, its roads and byways, are supposed to remain undisturbed by the apparitions they encounter and are believed to retain their psychic energy intact. It is believed that this concentrated energy will provide itself with a new form or body, which Tibetans call a *tulku.*°

A lama at his death is supposed to be able to foretell the geographical area where he will be reborn and may add various particulars about his future parents and the situation of their house or the like. Two years after his death, investigations are made to find the child who is believed to be the *tulku.* This investigation takes the form of Defining the Situation. The *theme,* whether or not a child is the *tulku,* is *elaborated* by examining the particulars, e.g., the clues the lama left before he died, the actions of the child who is suspected of being the reincarnated holy one, the findings of the astrologer lama who conducts the investigation, etc. Various tests are actively conducted (*authorship*) to "prove" that a particular child is the reincarnation of the lama. For example, the child has to be able to pick out those objects which belonged to the lama. If the child succeeds, Tibetans interpret his success as showing that the child recognized which were *his* possessions in his previous life. Particulars are examined to see if they *fit* the theme, and behaviors of the child which may have appeared peculiar or strange are reinterpreted in the new light that the child was not an ordinary child but the *tulku (revelation).*

Typicality and *likelihood* of behavior are also assessed. Tibetans believe the child would be likely to pick out the correct objects if he were a *tulku,* and some tests or proofs are considered to be more efficient indicators then others *(technical efficiency).* The final outcome is agreed upon by Tibetans, that is, given the particular nature of the signs and the results of the tests, everyone would necessarily have to agree that this was indeed the *tulku (substantive congruity).* Beliefs as to what happens after death are then confirmed by all who are doing the Definition of the Situation.

2. Not only do Tibetans believe that everyone has already died, but they also maintain that one can in his present life go to see what the after-death state is like. Tibetans believe in an ethereal "double" that is closely united with the material body during life. Either involuntarily or through training of the will, persons are believed to be able to effect a separation and the double supposedly leaves the material body and shows itself in different places. Persons who are

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°Although by the word *tulku* Tibetans mean particular persons, I will mean by the word, not a person or object but the total number of contexts in which Tibetans use the word.

believed to be describing various places in which they have supposedly travelled in a discarnate state are called *delogs*, which means "one who has returned from the beyond." (David-Neel, 1931).

Some *delogs*, it is said, have only visited countries inhabited by men, while others claim they have traveled through the paradises, or in the *Bardo*, the intermediary region where it is believed that the discarnate wander after death while waiting to be reincarnated. *Delogs* describe their movements as light, agile, and incredibly swift. They say they need only will themselves in a particular place and they would be there. They maintain that they can penetrate walls, walk on water, and yet all the while still be able to see their material body lying in the room where they "left" it.

3. Another way Tibetans gain knowledge of the afterworld is through the activity of mediums. It is believed that the discarnate often becomes irritated at not being able to conduct his activities as he could when he had a material body. A discarnate is believed to be able to appear in dreams or "do" strange things to his former dwelling. These signs are interpreted by Tibetans as a "call for help" and a lama diviner is summoned to read holy books to comfort the discarnate. If this is not sufficient to quiet the spirit, a medium is consulted to lend his voice to the spirit who supposedly takes possession of the medium and speaks telling of his misfortunes.

4. Tibetans often view the spirit as being captured by a demon, and a shaman is called in to attempt to liberate the captive spirit. The shaman enters into what Tibetans believe to be a trance and his "double" visits the dwelling place of the demon.* He gives the demon a ransom and seizes the spirit to take him away. The demon, however, is characterized as usually not being willing to release the discarnate, even when he has received the agreed-upon ransom, and a struggle between the demon and shaman ensues. If the shaman is unsuccessful, he will have to make the entire journey over again (David-Neel, 1931).

Persons witnessing the medium and shaman claim they actually hear the discarnate's turmoil and thus they gain knowledge of the after-death state through the spirit's "complaints." The medium and shaman, on the other hand, believe they are experiencing Immaterial Reality directly. In either case, Immaterial Reality is defined by the devices of the Documentary Method and Perceived Normality. Members assume that if they were in the shaman's or medium's place, they would experience or see what they believe the shaman or medium is seeing and experiencing. They also are capable of identifying with the discarnate in the future perfect tense, and are able to see what may happen when they themselves *will have been* discarnated. Their experiences of the social past and future feed back into the present situation rendering the spirit's complaints and the entire shaman's "journey" meaningful.

5. There is also another method that Tibetans claim they could use. It is called *trong jug* (David-Neel, 1931), and by means of it a person's ethereal "double" is supposedly capable of entering another body whose original occupant has been recently discarnated. Through *trong jug*, it is believed a

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*Of course, the shaman never physically leaves the room, and the sensations he may have while in a "trance state" are irrelevant. His behavior and his account of his journey and the interpretations Tibetans make of his behavior and account are the components in definition of the situation.

person is also capable of absorbing the original occupant's knowledge and experience of the world. According to Tibetan beliefs, this, then, is a form of resurrection in which the body is animated by a different person. It is believed that one can use the body temporarily to acquire the knowledge of someone in different circumstances than oneself, and then withdraw into one's own body. While the ethereal self or "double" is translated into the new body, the body from which it withdrew supposedly remains inanimate. However, it is believed that if the inanimate body is destroyed, one will no longer be able to return to it.

When Schutz spoke of intersubjectivity or interchangeability of standpoints, of course, he was not referring to an actual transference into the other's body. However, Tibetans believe that such transference into another person's body is possible and this belief is used in their talk and activity and in their definitions of situations. When performing *trong jug*, Tibetans believe that they are actually experiencing what they think is another person's "knowledge" and think that they are seeing the world as that other person would see it.*

A weaker formulation of this notion of "getting inside other persons," can be seen in the practice of mental telepathy. Tibetans claim to send messages "on the wind" so to speak. Persons believe they are able to send and receive messages across great distances and they act upon their beliefs. They act not *as if* they know what the other person meant, but claim they can actually directly experience his thoughts.

6. The Tibetans speak of another form of gaining knowledge of the afterworld, which involves a kind of resurrection and which is called *rolang*. Whereas *trong jug* refers to the resurrection of the body by a different personality, *rolang* refers to the resurrection of the body by what is believed to be the original occupant. Under special conditions, it is believed that the discarnate re-enters his body and is capable of animating it. Usually this is done with the help of a shaman who has to remain in a dark room alone with the body. In order to "animate" it, he is supposed to lie on top of the body, mouth to mouth, and has to hold it in his arms. During the entire procedure he must continually repeat a magical formula. It is believed that after a while the corpse's eyes become bright and it gains "consciousness." The body is felt to be moving and it stands up and tries to escape. The shaman must continue to repeat the formulas and use all his strength to hold the body and to keep his mouth against that of the body. When he feels what he believes to be the "revived" person's tongue touching his lips he must bite it off. It is believed that a failure to do this would mean certain death for the shaman. When the shaman seizes the tongue with his teeth and bites it off, the body supposedly collapses (David-Neel, 1931).

SUMMARY AND CONCLUSION

The six procedures described above are some of the ways Tibetans claim they use to gain knowledge of what they believe death and the hereafter are like.

*According to Wittgenstein, it is not possible for persons to "know" they are feeling what another person is supposedly feeling because criteria for judgment are lacking. However, it is possible for persons to talk as if they knew what other persons felt, and "mean what they say." *Trong jug* is merely another way Tibetans have of talking about the sensations of others.

The perspective throughout this paper was to view these procedures and the Tibetan accounts and activities at the time of physical death as language-games. No "reality" beyond peoples' language and the activities surrounding it was implied. I have tried to give a description of the phenomenon of death and the after-death state as Tibetans, themselves, regard it. Death was viewed as an ongoing activity that for Tibetans is characterized by a particular reality, which was called Immaterial Reality, for the reason that the elements and the participants in it are conceptualized by Tibetans as lacking corporal essence. The process by which a person supposedly loses his corporality was called Discarnation. An attempt was made to show that Tibetans view physical death as a transition from an incarnate state to a discarnate one which is seen to be followed by alternative transitions back into an incarnate state.

It is apparent that Tibetans have definite knowledge about what they believe to be the nature of death, and what this "knowledge" consisted of, and how things can be experienced in social time and space was examined.

Parting from the premise that knowledge of the world lies in the language-games of people, it was found that in order for Tibetans to be familiar with Immaterial Reality, it had to be structured and this structuring was identical with Defining the Situation. Tibetans, in gaining knowledge, used and relied on the devices of the documentary method of interpretation and assessed phenomena on the basis of agreements arrived at through the interchange-ability of standpoints.

To illustrate this, a description of what transpires at death was presented. It was discovered that Tibetans, in order to act and proceed as they did at death, presumed and relied upon knowledge and experience gained in the social present, past, and future and assumed normality throughout the entire procedure.

Then I examined six of the ways, in social time and space, by which Tibetans acquired knowledge and at the same time structured Immaterial Reality. Tibetans had means at their disposal for entering Immaterial Reality and for recognizing its elements, and some Tibetans (shamans, lamas and mediums) had a particular expertise in that area and were able to inform others of its designs. That is, it was also possible to learn about Immaterial Reality without actually becoming discarnate and entering its domain.

The position taken was that an immaterial realm and "spirits" were real in so far as Tibetans talked about them, gave accounts of what they believed to be their experiences with them, in short, defined their reality through language and related activity.

The approach used in this paper, that of describing a people's belief system by giving an account of their language activities, seems to be justifiable because it may very well be the case (at least recent developments in philosophy indicate that it is so) that knowledge of the world is limited and perhaps identical with how we talk about things. Developments in philosophy suggest that to view people's statements as having real reference is some absolute sense, lacks epistemological sophistication. Rather it is how people talk and use words in specific situations that determine what is real. It has been an acceptable practice in anthropology to divorce statements from their contexts and, to theorize before having an adequate understanding of the data. Theories

constructed under such conditions may prove faulty as a deeper examination of the data is made.

In anthropology, where the elements of different cultures are apt to appear strange to the investigator, it is imperative that these elements are examined in the contexts in which they are found. As I have tried to show in this paper, the meaning of an item is intrinsically bound to the contexts in which it is used. Only after having examined how people speak of things, how words are used, what activities are involved, that is, what the meaning of an item is, should one proceed to generalize or incorporate elements of other cultures under some general behavioral scientific theory.

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ON CHARLES MOORE'S "THE SUBJECT OF SUICIDE"*

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CHARLES MOORE, eighteenth century minister and writer, summarizes his inquiry into suicide with twelve precautions as seem most efficacious to counteract all temptations to its commission. . . . In other words to prevent those cause which give it (self-murder) birth.

1. We should not think ourselves "too secure" that we may never be tempted to self-assassination. Security is the bane of virtue; and he who defies temptation is most likely to fall under it, when it comes in his way.
   . . . It is probably too late to begin reasoning against suicide when under actual temptation to commit.
2. Wherefore it behooves us in the days of full health and strength, of pleasure and enjoyment not to be backward in fortifying our minds against any future temptation, by impressing on them . . . all the general, forcible arguments that decide against its practice.
3. . . . We should not then suffer ourselves to forget the immediate and strong impression of disgust and abhorrence, which seize our souls when we first hear of the action in another . . . .
4. Again, let it be carefully remembered how anxious we are to preserve the life of a friend, or indeed of any one whom we suspect of this bloody minded purpose . . . . It is plain we esteem this to be an action of a very peculiar nature, since we trouble not our head, in general, with other men's follies or vices when they do not affect ourselves; . . . . We should always do well to bear in mind, what we think of the guilt and horror of suicide in others . . . . This plainly discovers, what our own "unprejudiced" thoughts on suicide, whilst under no temptation to commit it.
5. . . . The compassion we exhibit for the individual, in endeavoring to palliate his offence, insensibly diminishes the horror of the crime itself and thus without being useful to the deceased becomes highly pernicious to survivors . . . . Our tenderness and compassion should change its object and be solely employed in alleviating the distress of those whose affections and interests, he has thus cruelly deserted; while that distress itself, which we feel is so poignant in them, should still further rivet in ourselves a fixed horror of self-murder.

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*A *full inquiry into the Subject of Suicide*, Messrs. Rivington, London, 2 volumes, 1790.

6. . . . A person may be drawn into gambling by company, into dueling by fashion; but that self-murder is unsocial and solitary and in every shape selfish; that the intention must also be kept a perfect secret or everyone else will interpose to prevent it; . . . . But what cannot be justified ought never to be committed; and therefore this "necessary secrecy" should leave a strong impression on our minds of the great guilt of self-murder.
7. . . . Yet we should certainly shudder at the thoughts of engaging in a doubtful business which we know is incapable of any remedy; and the use we should make of this reflection is that therefore, all possible doubt or suspicion of its unlawfulness should be removed even to demonstration before we venture to encounter it. . . . But our not daring to enter into such communication with others is . . . a convincing proof that we stand single in our opinion and cannot make it appear good or justifiable in their sight.
8. But it is not sufficient to act on the defensive alone, by entrenching ourselves within the pale of general arguments (against) suicide, less we should be surprised and overcome in some unguarded moment . . . . Now our weapons of offence for this purpose are to be drawn both from our "principles" and our "practices"; by the former of which we shall be enabled to resist temptations to suicide should they attack us; by the latter we shall drive away the causes of temptation itself.
9. But if at any time we begin to feel weariness of life, from whatever causes it may arise, such a firm persuasion of the responsibility of our conduct will lead us to inquire how much of the trouble we endure have been brought on ourselves by our own misconduct? The reply will generally afford a weighty argument in behalf of a patient endurance. But if we cannot charge "ourselves" with having been the instrument of our own misery, the same patient suffering will be the most probable means of restoring us again to peace and tranquility . . . .

   . . . must lead to reflection before we think of departing—whether we have fulfilled all the duties incumbent on our station . . . . For there is no state or condition of life, in which there are not some duties still left to perform; —for instance that one of general benevolence or doing good to our fellow creatures, can never have an end; . . . .

   . . . All these considerations which are the genuine effects of virtuous principles are so many strong preservatives against the commission of self-murder.
10. . . . The effects of a virtuous education break forth in various stages of life; sometimes earlier, sometimes later; but it rarely happens that if life be continued to a moderate length these valuable impressions do not exert a powerful influence at some period or other . . . . Good principle naturally prepare and caution us to cultivate such a line of conduct, as will best secure us from all temptation to the commission of self-murder.
11. . . . an enervated body debilitates the power of understanding, or a gloomy turn of thoughts relaxes the hone of the corporeal organs; till the health and soundness of both being destroyed, that miserable lassitude and dejection of spirits ensues, which so frequently terminates in this bloody catastrophy . . . .

    . . . But while the body is in health and the mind in action, the man is

safe; . . . , Suffer it then to be repeated again, that temperance and employment are the great bulwarks of health, contentment and happiness; . . . But idleness and intemperances are alike the bane and destruction of both rich and poor. In the latter they have a strong tendency to shorten life by the hands of public justice, in the former by his own; and therefore may in both be rightly named the parents of self-murder . . . .

12. . . . . The employment of humanity will "demonstrate" to us that if at any time we be inclined to think our own lives miserable, we shall find there are others whose are more so; but whom not withstanding we should advise the live in hope and patient suffering . . . . In short, the spirit of practical benevolence is opposite in every respect to the spirit of suicide, as to be most efficacious in counteracting its baneful propensity—while the man of benevolence, conscious that he lives for the good of his fellow creatures and fulfill the most endearing and amiable duties of his station, is stored with inward peace, satisfaction and comfort. By these means, as he has a fore-taste of future happiness so he is unwilling to hazard its future enjoyment by any act of impatience.

DISCUSSION

This rather remarkable treatise first appeared in 1790 and while it has been cited many times (Motta, 1890; Rost, 1927; Fedden, 1938) its unique and precocious insight have not been apparent in modern works.

Consider the opening statement or principles numbers 1 and 2. Here is a call for positive public health education, before the "temptation." The same logic is used today for vaccination against small pox, immunization for the flu, and early detection for cancer. Yet, in suicide prevention the universal taboos forbid a positive approach while the subject is still in good spirits, in order to "fortify" his mind against this "temptation."

Moore has other perspicacious suggestions, ahead of his times and even our own current thinking. In principle number 4, he gives us a touchstone for an objective evaluation of the suicide impulse in our own moments of temptation. Here, he refers to the "horror of suicide" as it manifests in others. In principle number 6, he challenges the intellectual of today who defends the absolute right to commit suicide. The "necessary secrecy" documents that what cannot be justified in public ought never to be attempted in private.

Moore urges "the practice of benevolence," which is the "care of our fellows." He argues that it is an employment of the mind which strengthens the wish to live. In principle number 10 he anticipates the possibility of a potential victim, devoting himself to other potential victims in the now-modern tradition of self-help groups. For instance, we accept the self-help principle in work with alcoholism (AA), criminals (Synanon) and mental patients (Recovery, Inc.). Yet, the idea of two suicidal victims consorting with each other for a benevolent endeavor is viewed with alarm by suicidologists. The fear of a suicide pact is given as the justification. Yet, we know from abundant research that the wish to die fluctuates widely even in the same person, e.g., suicidal ambivalence. It is even less likely that two ambivalent, and unrelated people, would have the

same degree of wish to die at the same time. If we add a third and fourth potential victim to the benevolent endeavor of mutual aid, this minimal possibility is effectively prevented. It becomes reasonable to think of four or five potentially suicidal victims working with each other to prevent any one of them attempting a self-injury. Yet, such is the ubiquitous presence of taboos about death and dying that no one has ventured to use this approach with a suicidally identified group.

The biographical details are so minimal as to prevent an opinion about personal intimacy with suicidal behavior. We know the following: Charles Moore, M.A., Rector of Cuxton and Vicar of Bloughton-Blean, Kent, former Fellow of Trinity College, Cambridge. He is listed in the *Bibliographical Directory of Living Authors of Great Britain and Ireland for 1816* as one of six preachers of the Cathedral of Canterbury. He is also described as the eldest son of the late Archbishop Moore. This source also lists four other works; 1) A visitation sermon preached before his father in 1785; 2) *The good effects of the United Trust in the arm of the flesh and the arm of the Lord,* 1804; 3) *Female compassion illustrated,* 1806; 4) *personal reform, the only effectual basis of National Reform,* 1810. The British Museum lists his work and notes that his son, Capt. Charles Moore, has edited a three-volume work of selected sermons from the manuscripts of the late Rev. Charles Moore and published it in 1818. As of this writing that is all which published biography provides. Pending further research, we must assume he learned his wisdom from clinical practice as a minister, coupled with astute observation.

The further question occurs why were his insights effectively "lost" for 180 years? Since they were technically available and often cited in the older reviews, his lack of influence on moderns is even harder to explain. The failure of modern suicidologists to incorporate or at least react to the thinking of Charles Moore is another example of the pernicious tendency for Western and especially American culture to repress ideation concerning suicide. It is another documentation of the existence of a suicide taboo that operates as a conspiracy of silence to avoid the subject. What makes this avoidance tragic is that, it impairs the effectiveness of researchers and rescuers while making potential victims less able to call for help.

One wonders if the current increase in suicidal research and prevention is not also equally vulnerable to cultural rejection by a collective avoidance. The criteria that would reassure me is the universal acceptance of suicide prevention as everybody's business. The starting point would have to be the acceptance that all of us may be "tempted" someday, and that the life we save must indeed be our own.

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SHOULD I BEQUEATH MY CORPSE TO A TEACHING HOSPITAL?

Paul Rom, M.D.

SPENDING some time at a health resort, it happened that I talked to a number of interested guests on Adlerian dream interpretation (Ansbacher & Ansbacher, 1956). Whilst I gave numerous illustrations from my practice and from novels, I declined to interpret any dreams of those present; the heterogeneous gathering was not the right place for such an exercise.

The next day, a lady who had shown great interest in my talk, approached me in private and asked if I would be interested in a dream of hers. Assuming I should not say no, she had even come prepared with a written report, which we then discussed.

She was in her late forties and told me she had been living alone since her divorce. She had this extraordinary dream eight years ago, when she was a medical secretary.

She told the dream to a friend who recommended her to undergo psychoanalysis; but not thinking much of psychiatrists and such people, she declined this advice and soon forgot the dream. Due to my talk she recollected it again. Here is what she had written down:

> One night I awoke and noticed with astonishment that my pillow-case was quite wet. I realized that I must have been weeping. Suddenly I remembered my dream which I re-lived, now being fully awake.
>
> I had died. Something had to be done. As I live alone and it being rather warm, I was afraid that, as nobody knew about my death, I should decay and stink. So I wrapped myself in a bedcloth, added my knitting things and put myself over my shoulder as though it were a sack of potatoes. I went to my brother who does not live far from my house.
>
> My sister-in-law opened the door, was astonished but did not say anything. I asked her where my brother was. She said he had gone out. I was very much excited and asked her to fetch him as he would have to bury me. Thereupon I put 'the thing,' as I called it, in the kitchen, and when I got out my knitting things I was frightened when noticing how cold 'the thing' was. I went into the drawing room and sitting on the sofa I began knitting. I was alone; no sound was to be heard; I only thought 'they must bury me!'
>
> Suddenly I looked up and saw in the door 'the thing'! Standing upright and looking at me sadly and reproachfully, it said: 'Ann, why are you so bad to yourself?' Whereupon I awoke.

I told her that the dream revealed how over-anxious she was to do something her eagerness to be useful was expressed by the fact of knitting even in so strange circumstances.

She said that she was indeed a hard-working and serious person, perhaps a little pedantic, and not tender at all. It now occurred to her that people had sometimes criticised her exaggerated helpfulness; indeed, she had often rendered services which were not asked for and may even have been resented. Was not her love of neighbour perhaps an obsession?—Smiling, I left her to find the answer by herself.

She said that the sister-in-law who occurred in her dream was alien to her.

Did your brother know something of which his wife was ignorant?

Oh yes, she said, he was the only one who knew that in my last Will I have bequeathed my corpse for study purposes to a training hospital.—Have you changed your mind during the last eight years? No, not at all, she said.

Considering the corpse's question we understood the meaning of this dream: the dreamer had some doubt about her uncommon decision to consider her dead body only as useful matter for medical students. Should she not rather wish to be buried like other people?

In our present culture this doubt is perfectly normal. The objective quality of the dream suggests that the doubt was passing and not serious. The purpose of this dream was to strengthen her decision and to decline the imagined possibility of a change, for the dream was forgotten and the problem never bothered her again.

What people think and say about the possibility of bequeathing their corpse, as this dreamer had done, indicates the degree of their social interest, which in Adlerian conception is identical with that of their mental health.

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THE COFFIN

J. H., Ward 8
Class of '65

Prologue—Death

Now it was over. The big job. The one I had worked so hard to get. I knew I had done it well, but time had run out on me and now it was over. So what? Or rather, now what? Anything from here on would be anti-climax. Today I was a somebody; tomorrow a nobody. What price mediocrity?

I stared at the ceiling. The door. The wall. The ventilator grill. The ventilator grill? I had wondered about it before. Now I studied it seriously. Was it high enough? Could I shove something through the latticework? Would it support my weight? And if all these factors were favorable (or unfavorable—depending on the point of view), would I have guts enough to go through with it? I decided to find out.

The Coffin—Limbo

After my clothes had been removed, they opened the coffin and put me inside. Then they shut the coffin and went away. I lay there a long time trying to figure out what had happened before I realized I was dead. Having never died before, I didn't know what it would be like. I didn't know the rules. I got the feeling that I might have to create my own rules of unexistence—sort of play it by ear.

Then I began to take stock of my surroundings. It was a large coffin with nothing in it. Nothing, that is, except a wash basin, a commode, two windows, and a corpse. I thought about the wash basin. Do dead people wash? Unlikely. I would not use it. The commode. Do dead people excrete? Probably not, but I decided I would use it if I had to. The windows. A small one to be looked in; a large one to be looked out. Did I dare to look out their in-window? Did they dare to look in my out-window? There was no hurry. I would find out later when I got used to being dead.

The coffin was opened. There were three of them. One of them threw in a pallet, another a covering. The third one stared at my body, still and pale in death. They closed the coffin and went away. Do dead people use pallets? Of course. I placed my corpse on the pallet. And the covering? Yes. Keep the body warm.

I lay there a long time. I tried to figure out why I was dead. Had I died a natural death? Not likely. Had they killed me? That didn't seem to be the answer either. Had I killed myself? Probably. But why? I couldn't remember.

Then I began to wonder how long I would be dead. How long is long when you're dead? There is no way to measure time spent in death. There is no yester-

day, no today, no tomorrow. There is only the forever of the moment, the infinity of the now.

So I lay there a long time and then the coffin opened again and they gave me a tray of food, closed the coffin, and went away. I looked at the food. Do dead people eat? No. I would not eat. Days passed and they came again and took the tray away.

Again I tried not to think, but another question posed itself. Can dead people think? Probably not. I would stop thinking.

And so the days passed into weeks and the weeks into months. Once I looked out the in-window and saw one of them looking at me, so I didn't do it again.

And the months passed into years and the years into decades and they left the trays and took them away again. And then one day the coffin opened and with them stood the Creator. I felt the breath of his life flowing toward me and breaking my rules of death I dared to speak. "May I be born again?" His voice, rising from the depths of eternity, answered, "You have not yet earned the right to be born again." So they closed the coffin and went away. And I returned to the frustration, the agony, the hopeless limbo of my unlife.

And the decades passed into centuries and the centuries into eons and then one day someone looked in my out-window. It was a friend from countless ages in the past and his unspoken thoughts seeped into my dead mind, "Why did you do it? Why? Why? We all needed you so much." And I started to weep, but then I remembered that the dead don't cry and I tried to check myself, but couldn't hold it back. "To hell with the rules," I thought, and wept unashamedly.

And as I wept, the coffin opened and the Creator spoke to me in a gentle voice. "You may have your life back. Use it more wisely than you did before. Come out. You are born again."

Epilogue—Birth

I stood in the hall in my underwear, looking and feeling rather foolish. A friend came up and spoke to me. "Man, you sure look rocky. Anything I can do for you?" "Yeah, Dunc buddy," I answered, putting my hand on his shoulder, "You can score a couple of smokes for us. Then you can help me celebrate my rebirth."

He reached in his pocket, pulled out a cigarette, and lit it for me. Looking at me quizzically, he spoke again. "That sure was a goofy thing you did. You could have died, you know." "I did, buddy," I said, thinking over the last six days, "that's just exactly what I did."

SUICIDE: TOWARD A SYMBOLIC INTERACTION THEORY OF SELF-DESTRUCTION

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Suicide appears to contradict most current assumptions regarding the survival instinct of the human animal. Suicide is an affront to all who believe that life is sacred, meaningful, or purposeful. Why would a man kill himself? What is the true nature of man that he would turn upon his own life and destroy it?

Suicide involves the death of the self as the result of a direct act carried out by the self. Two central problems are thereby posed: (1) *what is the nature of a self which can, as one of its actions, render destruction upon its own self?* and (2) *under what conditions would a self prefer death to life?*

In order to answer these two questions, I propose to discuss the nature of the self in relation to suicide. I will propose a theory of suicide which will specify the conditions under which death is preferable to life. A symbolic interaction theory of suicide based on selected contributions from several psychiatric and social theories is developed from selected concepts such as "commitment," "crisis," and "retreatism."

These concepts, in a combination of propositions, appear to offer a fresh and fruitful frame of reference for a further investigation of suicide, specifically, and other critical decisive actions in general. In order to do this, I accept a view of man being a resident of a fictional world created by his own beliefs and by the beliefs and institutions of his society. These "fictions" commit man to a specific set of actions, under certain types of conditions, in time and space. *Man takes his own life, not alone because he is driven by guilt out of his past, but because he cannot accept the reality of his future.*

TOWARD A THEORY

From the works of Freud, Fenichel, and Menninger, two major concepts emerge—(1) that of "depression," and (2) that of "aggression." From the concept of aggression I wish to develop a condition leading to the development of a symbolic interaction theory of suicide:

> (1) *Persons who take their own lives are deeply emotionally involved with a discrepancy between their projected view of themselves in the eyes of their significant others and their self-view, with the self-view being more positive.*

That is, they see themselves as they think their significant others see them and find such a view to be negatively discrepant from the way they see themselves. Such a discrepancy generates great anxiety because of the fixed self-definition to which they are committed and which cannot change in response to the

imagined critical view of others. This discrepancy is seen by some students of suicide as evidence of "basic aggression."

If the self develops out of social relationships with others, and if it is capable of evaluating, judging, and acting *toward* itself as an object as well as toward others, then one might see that under certain types of situations the self might turn upon itself and suicide would be a logical resultant.

Inherent in this concept of the self is the concept of others-in-the-self. The self, in the process of carrying out relationships with others, involved itself in a delicate and highly precarious exchange.

> A person-object is a locus of causality, capable of introducing undreamed-of events into one's life . . . In the social encounter each member exposes for public scrutiny, and possible intolerable undermining, the one thing he needs most—the positive self-valuation he has so laboriously fashioned. With stakes of this magnitude there can be nothing routine about social life. Each social encounter is a hallowed event (Becker, 1962, p. 94).

The fact that man utilizes language in order to rehearse his future behavior is an obvious fact that has long been overlooked by social scientists. In order to develop a symbolic interaction theory of suicide, man must be viewed as a symbol-bearing animal, living with a sense of the past and the future by means of language.

A second condition of suicide hinges upon this understanding of man's use of symbols. That is:

(2) *Persons who take their own lives first rehearse the act symbolically and by means of such imaginative dramas they evaluate, judge, and act.*

Of course, only a very few of all suicide rehearsals reach completion in action. As the philosopher Neitzsche has written: "The thought of suicide is a great consolation; by means of it one gets successfully through many a bad night." Suicidal rehearsal is possible because man everywhere has developed suicide as one symbolic act always available to him.

In order for such suicidal rehearsals to occur and have importance for a subsequent action of self-destruction, it is necessary to understand the nature of the self as a symbol-directed entity.

Man is an animal, separated from other animals by only a flimsy barrier: that of man's ability to behave symbolically, to develop and use language. Many other animals engage in social behavior, the components of which are also common to man. Natural scientists have described the social life of the higher primates, including man, as having the qualities of territoriality, dominance, and in-group/out-group perspectives.* Man as a social animal differs, only in degree, from other primates along such "social" dimensions. The vast difference between man and beast lies in man's ability to bind time, space, and all other relationships by symbolic means, by the manipulation of language and, thus, transmit his culture through time. Man is a history of other men gone before, and each man is formed as a *person* by the manipulation of symbols.

In order for man to emerge from his animal state he must fix himself in time with a precise designation of himself. As Ernest Becker has put it:

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*See Richard Ardrey's dramatic presentation of the development of human life as derived from the natural scientist's perspective, *African Genesis;* also, the work of Konrad Lorenz and Washburn, among other cultural anthropologists and ethnologists.

> Man is the only animal—in the universe, for all we know—who sees himself as an object . . . The self, after all, is in a continued process of creation. The self is a linguistic, ideational system in a constant state of modification . . . Man is a social creator as well as a social creature. By the social exercise of linguistic power man creates his own identity and reinforces that of others (Becker, 1964, p. 32).

George Herbert Mead (1934) wrote that the human being can be the object of his own actions. He can act toward himself as he might act toward others. The self's ability to act is based on the taking-of-the-role of the other. The conversation that takes place between "I," the actor, and "me," the self-object, constitutes thinking. Such a dynamic process permits ordered, persistent, and socially acceptable behavior. The self is socially derived and is an organization of roles and attitudes gained from others about the self. As Cooley (1961) has stated:

> The thing that moves us to pride or shame is not the mere mechanical reflection of ourselves, but the imputed sentiment, the imagined effect of this reflection upon another's mind.

The self is the actor, and the world is the self's stage. If suicide is to be the self's destiny, we must then ask ourselves "what is the meaning of death?" to a person. Man is capable of suicide because man knows about a future; he knows that there is a tomorrow, because his symbols have told him so. Death cancels the tomorrows and transforms them into a heaven or a hell. Man is the only animal who has a future—i.e., who symbolically rehearses what will happen next. He does this because he has language—he can project himself into tomorrow by using the symbols of his yesterday and he can use this knowledge in the making of choices—even those involving his own death.

But, if the reality of death is glossed over or disguised, death remains a symbol available to all men. It is one type of "escape hatch" out of all untenable situations. The more romanticized and pleasant death is pictured as being, the less frightening will be the terrible fact of death as the ultimate *end of all life and living*.

Death then becomes a social role, visualized by the self in the same manner as other roles can be and, thus, death becomes symbolically available as a choice of action. According to Merton, a condition of anomie leading to the adaptation of retreatism is one in which the self seeks to "escape from the requirements of society." The ultimate retreat is death and, of all death, suicide is the most drastic retreat of all.

We must now examine how an individual is related to the social structure and how he experiences society's requirements within his own style of life. One of the social-psychological concepts I will use to conceptualize such a linkage is that of "status and role" as conceptualized by Ralph Linton (1936), who saw status as a position in a particular pattern—as a segment of society. Each status has a series of roles which represents the dynamic aspect of the acting out of the rights and duties of that status. The distinction between status and role has often been blurred.

Suicide may occur when *statuses* are destroyed, shaken, or threatened. An individual plays many roles and may change roles without major trauma—but, when statuses change, a whole world, a whole personal ideology is threatened and exposed. Every social status provides us with roles and role-recipes;

prescriptions for explicit behavior. Every status has a world view dangling from its end. All role playing is done on a status stage, generally a public one.

Depending on the type of play, the individual's part, the script, the plot, etc., one's performance is either conforming or deviant, fulfilling or frustrating, etc. (Goffman, 1959; 1963). As Peter Berger (1963) has put it—"One chooses one's gods by choosing one's playmates." Where do the scripts come from?—how are the statuses chosen?—and, how could it be that one becomes "locked into" a status in such a fashion that suicide would provide the preferable exit?

In order to understand the sélf and how it acts, one must develop a radically different notion about "motivation" than the one generally discussed in most psychology or psychiatric textbooks—*the self acts because it is alive in an action world.*

Anselm Strauss' article on identity transformation offers many provocative insights into the way the self changes and the directions these changes may take. He stated: "Critical incidents constitute turning-points in the onward movement of careers" (1962, p. 65).

Thus, in order to develop the self-in-action model, it is necessary to conceptualize a world of action, of significant others, and of institutional structures which influence and change the direction and destiny of the self.

An examination of crisis, of turning-points, leads to a clearer understanding of "motivation" for self-destruction. Crises and their solutions are both of the social fabric. Motivation becomes, then, a directional question in a symbolic interactional frame of reference. What incidents become "turning points" in a person's life, and how are these related to "motivation"? Such turning points, if they are sudden and if they occur in crucial periods and in areas which may involve a situation of threat to the "ideal self"—the embraced status—may then produce shock, chagrin, anxiety, and tension. If the turning point represents a favorable enhancement of the ideal self, then the feelings are those of victory, elation, happiness, and pleasure. Whatever they may arouse in self-feeling, these turning points necessitate action and movement into a new stance and require new alignments and new vocabularies.

Status consistency, however illusory, does provide social stability and makes possible ease of relationship between individuals. Many minor situational changes are accommodated without a serious rupture of the self concept. Over time, youth changes to maturity, and maturity to old age. The junction of a life occurs when the taken-for-granted world stands revealed as being only a smoke screen.

A third condition in a theory of suicide can now be stated:

(3) *Persons who take their own lives are confronted by a crisis which involves a radical and inconsistent change in their embraced status.*

There are turning points which lead to status-discontinuity or destruction and which violate the self's sense of honor, of worth, of value—so that self-destruction is preferable to other alternative actions at that point of time.

The importance of this "self-feeling," this "self-esteem," this sense of "face" is basic to a theoretical approach to suicide. Most of the language regarding the self is stilted and artifical, reflecting, I believe, our degree of ignorance about our "self." The Oriental term of "face" has been translated and discussed as having a somewhat shallow meaning in our language usage. The English term

"self-esteem" is now used to refer to everything from a cigarette ad to a promotion to a vice-presidency.

I would like to utilize an older English word, now out-of-date, to refer to this all important sense of self-love or self-respect. That word is *honor*. When a woman's "honor" was sullied, someone had to die. When a gentleman's "honor" was questioned, a duel was fought. When "honor" was questioned, when default of honor was revealed, shame erupted.

To trade one embraced status for another is to risk exposing the secret self to a loss of dignity, and, thence, to shame, to being a fool. According to Simmel (1950), the secret is a hiding of realities by negative or positive means and offers the possibility of a second world along side the manifest world. Secrecy is related to its logical opposite—betrayal. The secret is full of the consciousness that it can be betrayed and that such a betrayal may result in self destruction. The risk of exposing the secret self is the risk of being made a fool. As Orrin Klapp points out, "Life is a continual process of fool making . . . humor, derision and belittlement are constantly assigning this role . . . social relations are continually rendered unstable by foolmaking" (Klapp, 1949).

Helen Merrill Lynd (1961) has put it another way: "Coming suddenly upon us, experiences of shame throw a flooding light on what and who we are and what the world we live in is." Some psychoanalytic thinkers, such as Karen Horney (cited in DeRosis, 1961), also noted this process of self-shame, or the "range of the proud self" leading to suicide.

What is a crisis? How does change occur? It is in this very area that so many of the "stress" theories falter, for always it must be seen that "reality" is the fabric of dreams, hopes, and philosophies. When a disjuncture between the self and its embraced status occurs, a psychological state of "depression" may appear. If we examine "depression" from a symbolic-interaction framework, we can see its relationship to suicidal actions. The pain of seeming a fool, of being betrayed, of losing face, narrows the symbolic horizon. How can one satisfactorily explain such defeat to oneself and to others? Unless the individual feels worthwhile, and unless his action is considered worthwhile, life grinds to a halt.

If one is committed to a status in such a way that the world is *closed* to alternative moves, self-accusation may be seen as a search for a redefinition that would enable a new perspective of an old situation. Hence, if the world is *right* and others are *worthwhile*, but the individual cannot hold onto his committed status, then he must be *worthless*. This takes me back to Freud's observation about "guilt-language"—that while a person said he was worthless, he quite pointedly also referred in action to the basic worth of himself.

Ernest Becker (1904) noted three interlocking ingredients which lead to a depressive breakdown—uncritical perceptions, poor vocabularies in which to frame choices, and a narrow range of persons to support an identity. He felt that the guilt language served as a justification for personal failure, where that failure could not be otherwise understood. With this language the depressed individual takes cognitive command of a situation that is undermining him and with it he attempts to unblock his action. Given such a blockage of alternatives, suicide then looms prominently as an acceptable action.

In our vernacular we sometimes speak allegorically of suicide—that is, we

may say that Statesman X commits "political suicide" in espousing an unpopular cause. Yet, upon closer inspection, we may discover that a politician would rather face political defeat than betray his conviction about certain values or ideologies. There is a folk-saying that a person would "rather be right than President." Could this saying suggest that persons who choose suicide may really be choosing to remain "true" to a prior and more important value than life itself, and to be known later as having stood firm and true? I am suggesting a theme of "death before dishonor" as a symbolic interaction theory of suicide. Another condition necessary for a complete symbolic interaction theory of suicide is that of the thought of leaving behind a "statue" of the self.

A fourth condition leading to a symbolic interaction theory can now be drawn:

(4) *Persons who take their own lives envisage leaving behind, in the memories of others, an image of themselves as they were in a previous prestigeful role.*

They must see the possibility of leaving behind a symbolic "statue" of themselves. That is, by taking their own lives they may be setting up their own brand of immortality. Perhaps this can best be illustrated by the death of both Ernest Hemingway and Adolf Hitler. In another paper on suicide, I maintained that Hemingway chose to die and leave behind an image of himself as a brave, masculine, vital, and death-defying person rather than to live out his days as a weak, ill, old man (Miller, 1964).

Self-destruction involves a heightened awareness of the self, a sense of crisis, and a dearth of hope. All of these are dramatic components. To kill oneself is to choose drama over deterioration. Since suicide is a dramatic event, it also has the qualities of a gamble. It is one scripted ending to human drama. So, while man may contemplate his own death in his fantasy, and while his external condition may be one of extreme despair, a sense of gaming with death—of taking a wild and magical chance—must also have developed.

This leads me to a final condition:

(5) *Persons who take their own lives develop and play a gambling game, which offers the last chance hope of a magic solution in lieu of death.*

Such a gambling impulse may only occur briefly and if no powerful "hunch" or bluff pushes the self at that psychological moment, the suicidal fantasy may wither, and the daily despair of disillusion, change, and role accommodation can then continue, and other resolutions of "honor" be found. New insights regarding human behavior developed by game theorists offer considerable promise for the study of suicide.

If suicide is a game and a gamble, then it is one always available for playing. Shneidman (1963) reported that he found most patients were acutely suicidal for only a relatively short time and, even during that crisis period, they were extremely ambivalent about living and dying. Thus, as in all gambles, the laws of probability have to be taken into account.

These are the major conditions which form the basis for a symbolic interaction theory of suicide. All these conditions will occur for individual cases at different times and with varying degrees of intensity. For a suicidal action to take place, I maintain all five of these conditions must be in operation. Each condition may occur alone or in other combinations without resulting in suicidal action.

The above conditions develop in situations where a person has become "committed" to a status. Commitment to one specific status out of the many available in our society is a symbolic process of central importance for this suggested theory of suicide.

This "projected image" of oneself to others may be of such substance and become so institutionalized as to prevent a person from changing from one status to another—from one "self" to another—in response to a crisis. When a commitment to a status has been made by an individual, and when his significant others come to accept him in that given status, ratifying his right to perform it—it is "*validated,*" as K.T. Erikson (1957) has pointed out. In a sense, I am suggesting that an achieved role may become a committed status; i.e., a "job" may become a "life." But, when that validation is removed—by accident, misadventure, or betrayal, and when that status is radically threatened with tarnish, eradication or exposure, then one course of action left to the self might be self-destruction, rather than to move on to a new status, to become a "new person."

I suggest there are two major dramas prevalent in our society which provide script-statuses affording commitment possibilities; i.e., which allow a person to become a "hero" or to be made into a "fool" *One may become a hero by either over-embracing these statuses or by completely rejecting them.* These two scripts are the "rags to riches" myth (Wahl, 1953) and the romantic "one-and-only true love" myth (Volkart and Michael, 1957). Both provide major themes, major styles of life for persons in our society. Both are symbolically and systematically portrayed in our public mass media and in our literature.

Goffman (1959) developed a concept of "role distance" which has important bearing on the development of a symbolic interaction theory of suicide. By "role distance" he meant the "expressed pointed separateness between the individual and his putative role." But when the role and the player became one, he used the term "embracement" to describe this total commitment state—i.e., "to embrace a role is to disappear completely into the virtual self available in the situation, to be fully seen in terms of the image, and to confirm expressively one's acceptance of it. To embrace a role is to be embraced by it."

When statuses become so embraced as to involve the self in a trap, in case of disaster, the whole world of interaction may collapse around the self. What sorts of threats lead to the collapse of the "world" created by the self? For example, in a marital situation, one partner may build a life out of the life of the other. This, then, is a "vulnerable" world—a world of fabrication. If one partner has "embraced" that role, when that world is challenged by any major change in the world of the other, a dangerous game can begin which could end in the suicide of one on the doorstep of the other. Thus, one individual can introduce a change in the definition of the situation which would turn the world of the other into "unreality."

Most adults make a commitment, to some degree, to statuses stemming from both the work myth and the romantic love myth. Those persons who seem to make "inappropriate" connects to such statuses become overly-identified with one of these statuses to the point where it becomes a matter of honor, of debasement, of ego loss, should any change or modification occur. This "shock" occurs on a psychological, symbolic level, often not clearly visible from the "outside."

If we can learn what kind of a hero a person is to himself—what code of honor he lives by—we can begin to predict the circumstances under which he might choose self-destruction as one type of response to crisis. For persons who are loosely committed to social roles, such intensity of self-threat is not so likely to occur. In short, commitment, then, is the social-psychological stance that proposes what is worth living for, is worth dying for. A social status becomes a code of life and a reason for living or dying.

Both major myths in our society allow for the development of intense feelings of self-responsibility and, thus, leave the self vulnerable to many forms of misadventure beyond the control of an individual. *Given such a state of personal commitment, a hero can be turned into a fool by any number of sets of contingencies.*

The five conditions I have previously outlined as leading to suicide can then develop. The self and the significant others can become entangled in "fool-making." Such "loss of honor," of "face," can lead the self to its own destruction as a way of ending the pain and paying-off psychological debts at the same time.

Persons who have held a single role over a consistent time period and who have relationships only with groups who are also directly or indirectly connected with that special role may become over-committed to a special "hero" image of themselves in that status and, at a time of any major change which eliminates or threatens that role and that reference group, they choose one of five modes of adaptation to this condition of normlessness.

Four of the five adaptive modes require a change in some aspect or degree of the status commitment, either in the means or the ends, while, by adopting the "retreatism" mode, no definitional change in the situation is required and those individuals who have no other reference group or no other status available to them in their immediate situation will choose the retreatism mode of adaptation. Their view of their situation will become increasingly egocentric and they then have three possible patterns of action available to them: (1) that of "illness," (2) that of "alcoholism" or some other type of addiction and (3) that of "termination"—i.e., self-destruction.

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BOOK REVIEWS

Perspectives on Death, by Liston O. Mills, editor. Abington Press, New York, 1969, 283 pp., $6.50.

This volume of readings represents an attempt to survey, interpret, and assess the meaning of death for contemporary man. First given as a series of lectures at Vanderbilt University in the spring of 1967, *Perspectives on Death* brings together the collective ideas of a team of scholars representing such varied fields of interest as Biblical studies, theology, psychology, and sociology. In order to integrate these disparate offerings somewhat, editor Mills has written an introductory statement as well as brief notes to each of the contributions. These preliminary materials serve not only to identify the particular author and his viewpoint but also help the reader to relate more readily the part to the whole.

Given the theological auspices under which the essays were originally presented, it is to be expected that the readings are predominantly weighted toward religious issues and concerns. For instance, a long article by Milton Gatch traces theological reflections on death from the early days of the Christian Church through the Reformation and in so doing, describes how the idea of the "resurrection" gave way to the concept of immortality in Christian dogma. To any reader with an anthropological bent, this article provides an interesting case-study in selective diffusion and adaptation of cultural items from one society to another.

Counterbalancing Gatch's linear development of the emergence of the concept of immortality in Western thought, John Killinger, in his article, "Death and Transcendence in Contemporary Literature," attempts to trace its decline. For Killinger, contemporary literature gives testimony to the increasing loss of faith in traditional beliefs and values. In his view, the inspired optimism concerning man's goodness and potential happiness that the Enlightenment engendered gave way first to the skepticism of naturalism, then to the pessimism of existentialism and finally to the despair of the theater of the absurd. It is this reviewer's opinion, however, that the idea of immortality still possesses a powerful attraction for twentieth century man despite the presumed absence of any explicit notions of transcendence in contemporary literature. The emerging cryogenic movement, with its shibboleth of, "Freeze—Wait—Reanimate!", promises the restoration of life through medical science technology and would appear to be a new manifestation of the ubiquitous and resilient impulse to immortality.

William May, in his article "The Social Power of Death in Contemporary Experience," argues that the loss of the belief in the transcendence of death has led to an emphasis on life with a subsequent denial of death. Yet, excesses in the attempt to avoid or to deny death serve, he believes, to affirm its ultimate mystery and sacral power. It is May's contention that the Christian faith, even though shorn of its other-worldly speculations, nevertheless enables men to face death with its intrinsic threat to personal identity better than those who are without such a faith. At this point in time, the empirical literature cannot confirm

or deny with confidence this assumption.

The article by Lloyd D. Elam, *A Psychiatric Perspective on Death,* describes the place of death in man's psychological economy. He finds that interpretations of death usually reflect the meaning and maturity one has achieved in life. However the author does not tell us exactly what is "the" interpretation of death that will reflect one's maturity, or, for that matter, whether there are interpretations of death that can be associated with maturity.

Ernest Q. Campbell, in his essay, *Death as a Social Practice,* takes a functional view of social phenomena and holds that the rituals and ceremonies and prescribed behaviors of any society express its values and priorities. The funeral, he maintains, is a rite of passage that declares society's attitudes toward life and death. Thus, in his opinion, the funeral director as much as the clergyman serves as an agent of the larger society. Despite recent protests in the popular press and elsewhere, the author insists that these agents provide what people want. Their role is symbolic of the secular take-over of death. While this thesis has merit, it does not provide an answer as to why a certain culture expresses its values and priorities in the manner that it does. His "challenge-response" argument, however, is a very interesting interpretation of the present death scene in American society.

In his *Ethics and Death,* James T. Laney suggests that the "axiological presence" of death and a transcending faith must serve as the basis for ethical reflection. To fail to acknowledge their presence is to invite individual life to lose its uniqueness and daily decisions to forfeit their moral seriousness. Thus, Christian ethics, Laney concludes, requires an affirmation of both death and grace.

The last article in the book, "*Pastoral Care of the Dying and the Bereaved,*" by the editor, Mills, is written on the assumption that the pastor's ministry to the dying and the bereaved continues as an important aspect of his work. In his view, the needs of both the dying and the bereaved are neglected in society's tendency to eschew death. Such neglect, he warns, enhances the temptation to despair of love and meaning. It is Professor Mill's contention that by the pastor's willingness to be present with the dying patient, the pastor may participate in his quest to end life with dignity and with hope.

The book on the whole is a valuable source of information, speculation and commentary on an issue of significance to us all.

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The Judgment of the Dead, S.G.F. Brandon, Charles Scribner's Sons, New York, 1967, pp. viii-300, $6.95.

Man's persistent search for the meaning of death is the subject of this volume—a volume which should be of interest to the social scientist as well as to the theologian inasmuch as it is concerned with the meaning of death both for the living and for the dead.

Richly documented, *The Judgement of the Dead* examines the ideas about

death held by the major world religions. The historical ubiquity of eschatologies, i.e., systems of belief about life after death, leads the author to speculate about the consequences of the contemporary trend toward secularization: what does the progressive retrenchment of traditional religious dogma mean to modern man? Are conceptions about post-mortem judgment, which archaeological evidence indicates extend back to the Paleolithic era, no longer relevant?

The author maintains that these issues are as much the responsibility of the social scientist as the theologian. The need for knowledge about death in the face of its cultural denial or of its devious expression is as important to the laity as it is to the theologian. Contemporary America is a youth-oriented culture apparently oblivious to the inevitability of aging and dying. The burgeoning cryogenics movement promises scientifically to postpone death indefinitely yet at the same time the present popularity of spiritualism and psychical movements suggest that the irrepressible need to know about life after death is resurfacing in pseudoscientific terms.

Out of the array of eschatological conceptions held by the major world religions, Brandon finds that three broad patterns of belief about life after death emerge. Several religions—notably the ancient Mesopotamians, the early Jews, and the Homeric Greeks—depicted the hereafter as a bleak underground place to which everyone, regardless of his earthly merit, was consigned. Hence the issue of post-mortem judgment was irrelevant.

The second pattern appears in those religions whose dieties play an active part in man's ultimate fate. This pattern is found in the religions of the ancient Egyptians, later Jews, Christians, and Muslims. Conformity to dogma is the criterion which distinguishes the saved from the damned. Belief in post-mortem judgment is necessary for such theodicies in which the faithful suffer and often die unvindicated. Belief in a hereafter serves, for those religions, to reconcile man's experience with his hopes.

The third pattern of belief about life after death is seen in Hinduism and Buddhism, two religions without a strong theistic perspective. Instead of teaching, as the other religions do, that man has only one earthly life which death terminates, they teach that man undergoes a potentially endless series of reincarnations. Between reincarnations, the individual either goes to a place of reward or retribution, depending on his actions, or karma, in the previous life. Karma also determined the conditions of subsequent reincarnations. If his previous life was characterized by evil karma, he is reincarnated as a degraded human or in some sub-human form. In contrast to the theistic religions, karma, which determines post-mortem fate, is not conceived as an omniscient deity, but as an impersonal process, which no amount of ritual or intercession can influence.

Although there are diverse ideas regarding the fate of man after death and the nature of the judgment process, Brandon notes a remarkable uniformity in the imagery used to present ideas symbolically. The image of the judging of the soul after death for example, appears in the eschatological artifacts of the ancient Egyptians, Greeks, Christians, Muslims, Hindus, Buddhists, and Japanese. Depictions of heaven and hell in the various religions also show much in common. Whereas heaven is customarily depicted with relatively vague symbolic allusions, hell has inspired horrifically detailed descriptions and paintings,

ranging from the "Dooms" on Christian churches to the Japanese scrolls in which specific tortures for given crimes are painstakingly portrayed.

The Judgement of the Dead is a worthwhile book for the social scientist, both for its careful exposition of a vital area of human concern and for the stimulus it provides in considering the social and psychological importance of beliefs in life after death.

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ANNOUNCEMENT

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LOVE-PACT SUICIDE

K. Ohara, M.D. and D. Reynolds, Ph.D.

LOVE-PACT suicide can be considered to fall within a larger class of phenomena perhaps best called dual-suicide. Dual suicide commonly includes sub-categories such as parent-child suicide, murder-suicide, murder-suicide between lovers, suicide following the death of a spouse, and love-pact suicide proper. In its narrowest sense, love-pact suicide is perhaps most usefully defined as suicide involving two or more persons with similar purposes who by their own will commit suicide at the same time and place. Love-pact suicide in a wider sense can be considered to include murder suicide between lovers in which both persons agree to die at the same time and place but rather than a double suicide, one of them kills the other and then commits suicide.

Some attempts to compare the frequency of occurrence of love-pact suicides in the Western world with the occurrence of dual-suicides in Japan, have, quite understandably, found the figures much higher for Japan. This mixing of categories has generated a good deal of confusion, and whether Japan, in fact, has a higher rate of love-pact suicides than countries in the West is still an open question.

However, it seems fairly clear that Japanese literature, ranging from newspapers to novels, dwells on the theme of love-pact suicide far more than is the case in the West. Japanese scholars who have combed the literature for accounts of love-pact suicide offer us a picture of what perhaps may be taken as the general public conception of the act. Most often the literature portrays a pattern involving a young merchant craftsman and a young girl (generally a hostess or prostitute), who because of economic difficulties, poor living circumstances (such as pending criminal proceedings or inadaptability to rapid social change), and other problems preventing their marriage (such as their parents' or spouses' objections), one night during the spring or summer in the Tokyo-Osaka area, toward dawn stab themselves (occasionally hang or drown themselves) and almost never survive.

Probably this description closely approximates the picture conjured up in the minds of many Japanese whenever love-pact suicide is mentioned. It will be useful to keep this picture in mind for comparison with the data from recent investigations of actual cases in the Tokyo area.

From the examination of descriptions found in literature, Japanese scholars have hypothesized that certain characteristic norms and values underlie the occurrence of love-pact suicide in Japan and, we would suggest, also contribute to the Japanese people's interest in literature containing accounts of love-pact suicide. The complex norms and values surrounding female chastity and marriage restrictions appear to be fundamental in the rise of love-pact suicide.

As evidence, one can point to the earlier periods of Japanese history during which a value on chastity and rigid marriage restrictions seem not to have been so prominent. During these ancient periods, love-pact suicide was not a common feature.

It was not until the Edo period (ca. 1600-1868) that love-pact suicide became a characteristic theme of Japanese literature. The value upon female chastity, the *samurai* code placing loyalty over death, the religious belief that lovers are together after death, and the conflicting effects of *giri* (social responsibility) and *ninjo* (human emotion) all seem to have been influential factors in the rise of love-pact suicide. Also at this same time, the popular Kabuki drama picked up the theme and emphasized the romantic and idealistic aspects of love-pact suicide. The government made hopeless efforts to restrict the occurrence of such suicides by banning plays with the word *shinju* (love-pact suicide) in the title (Keene, 1961), by placing burial restrictions on those who committed suicide, and by considering a surviving partner in a love-pact suicide to be a murderer. But the motif had already been established in the minds of the Japanese people.

Perhaps the Japanese playwright most closely associated with the love-suicide theme is Chikamatsu. His popular Kabuki plays of the early 18th century were generally built around a standard plot outline involving love, obstructions to marriage, and idyllic death.

To give the reader some flavor of such plays, we quote here a brief passage from Keene's fine translation of Chikamatsu's plays.

OHATSU: I had this razor prepared in case we were overtaken on the way and separated. I was determined not to forfeit our name as lovers. How happy I am that we are to die together as we hoped!

TOKUBEI: How wonderful of you to have thought of that! I am so confident in our love that I have no fears even about death. And yet it would be unfortunate if because of the pain we are to suffer people said that we looked ugly in death. Let us secure our bodies to this twin-trunked tree and die immaculately! We will become an unparalleled example of a lovers' suicide.

OHATSU: Yes, let us do that.

NARRATOR: Alas! She little thought she thus would use her light blue undersash! She draws it taut, and with her razor slashes it through.

OHATSU: The sash is cut, but you and I will never be torn apart.

(Keene 1961, p. 55)

However, one need not look back 200 years into Japanese history to find evidence of the Japanese preoccupation with love-pact suicide. A recent special issue (July, 1968) of a respected literary magazine, *Dentoku to Gendai*, was devoted to love-pact suicide with sections on the etymology of the word "shinju," its psychoanalytic interpretations, its relation to social thought, its influence on art and literature, its psychological and philosophical implications, as well as analyses of several well-known cases.

RECENT CASES

Two cases have been selected from case histories of a series of recent attempts at love-pact suicide reported by Ohara (1965).

Case 1. The first case involves a 28-year-old man and a 24-year-old female. The male, oldest of seven children born to a man of lower-middle class means who worked as a fire lookout, is described as being quiet, asocial, withdrawn, and lazy.

The female member of the pair is described as being persistent, industrious, helpful, but also a poor loser, depressive and asocial. She was born out of wedlock in Tokyo, had never seen her father, and at about age 9, experienced the death of her mother. At the time of her mother's death from lung tuberculosis, she and her younger half-sister were placed in an orphanage. After much moving around from place to place and job to job, she found herself at age 21 in W. Hospital suffering from lung tuberculosis.

The male, after having graduated from junior high school, had worked with his father until at age 25 he also contracted lung tuberculosis. He was treated at home until age 26 at which time he was hospitalized for over 20 months. Upon being discharged from the hospital he squandered his money on women and gambling. This was particularly hard on his family because a few years earlier his father had suffered a brain hemorrhage and as a result his family was in financial difficulties. Finally, after a violent argument, the young man left home. He worked in a factory for 7 months until his condition worsened and he was forced to return to the hospital. This time he was also admitted to W. Hospital.

It was in the hospital that he met his suicide partner. The two patients promised to marry, but due to the man's family's economic problems and both being in poor health, as well as because of their youth, they decided to wait.

In March, 1960 the young man was discharged and obtained employment in a small factory. Two months later the young woman joined him. Then followed a series of quarrels between the young man and his family. It was finally agreed, however, that the family would allow the couple to live together if they would contribute about 30 dollars each month to the support of the family. The young couple agreed to this stipulation although they knew that it would be impossible to contribute that sum since together they made only about twice this amount at the small factory where they lived and worked. Actually, they sent only 8 or 10 dollars a month if they sent anything at all.

In March, 1961, the young man hemorrhaged and once more returned to W. Hospital. The female partner continued working at the factory but, because sexual advances were constantly made toward her, she soon quit her job. After seeking private and public assistance for a few months, and receiving only temporary housing and employment, she felt ready for suicide. On September 1st, she went to the hospital and aided her partner in an escape. They went to Shinjuku, a flashy entertainment section of Tokyo, and had a wild fling. On September 4th they returned to the hospital, with their money gone, and both considering suicide. They remained at the hospital long enough to take their valuables and flee, once again to Shinjuku. They had procured some sleeping pills but decided that if they were going to die it would be better to die in a more scenic spot. On the night of the 5th they started off for Ashinoko but on the way

they realized it was too late at night to reach their destination. They returned to Shinjuku. There they planned to die in an inn, but the maid seemed suspicious so they postponed their suicide attempt.

The next day, after some discussion, they decided to die at scenic Enoshima, an island about two hours' train ride from Tokyo. On September 6th at about 5 P.M., in the mountains of Kamakura near Enoshima, they attempted suicide with sleeping pills.

They had talked to no one after making their suicide pact. Together they wrote a note to the man's father asking his pardon for their misdeed. However, their suicide attempt was unsuccessful and they were rescued. Upon recovery their attitude was as follows: "We were saved but that doesn't mean his family will care one way or the other. It would have been better if we had died." They said that they had no plans for the future, and each confessed, weeping, that he felt it regretful that the partner had survived..

"I'm sure everyone in my family thinks this was a very foolish act," said the man.

In the hospital he wanted to see no one. And no one came to visit.

Case 2. In this case a 43-year-old married white-collar worker and a 21-year-old bar girl pledged a dual suicide.

The man had a 40-year-old wife and four children, the eldest in junior high school. The man was described as being industrious, quiet, somewhat introverted, and as enjoying a good reputation as a typical office worker.

The girl was the only daughter of a middle class iron-factory worker. She had an elder and two younger brothers. She was the first cousin of the wife of the male member of the suicide pair. In contrast to the man, she was described as being somewhat flashy, talkative, and outgoing with changeable moods. In 1960 she had suffered a nervous breakdown from which she recovered spontaneously in a few months.

These two people had grown up together in a small town in Niigata Prefecture and knew each other well. In the spring of 1960 the girl had taken employment in a local bar that the man frequented. In May, 1960, there was an unusually heavy snowfall in the area. On that night the man happened to be out drinking at the bar, and when he started for home, the girl decided to accompany him part of the way. However, the snow was so heavy that they agreed to stop at an inn; that night their physical relationship began.

They subsequently met about once a week at the inn and continued having sexual relations. The man never took their relationship seriously but the girl gradually built up dreams of marriage.

In May, 1961, at their meeting place, the girl made an individual suicide attempt by ingesting one hundred sleeping pills after the man had gone to sleep. She was unsuccessful, however, and following her recovery she often remarked that, since there was no hope for marriage, she wanted to die.

In early June, 1961, the man was drinking at the bar and began arguing with the girl about some trivial matter. He left abruptly. The girl, still upset, told both families of their relationship. This led to a family council meeting in which the man was warned to leave the girl alone or risk losing his wife and children. The girl simply could not accept this arrangement and tearfully asserted that parting was impossible.

About a week later the man received a call from the girl with the eventual result that their secret relationship was reinstated. From the 20th of June, the girl complained of insomnia, depression and death wishes. The man was distraught on hearing about her troubles and finally decided to clear up the tangled mess in which they had become involved.

On June 23rd the couple fled their homes and spent the next few days in various hotels until their money ran out. At around 7 P.M. on June 28th on the grounds of a temple in Kamakura, they took poison.

They were rescued and in the hospital the man was visited by his wife. Upon recovery he returned to his home and expressed a desire to try once more to live separately from the girl. The girl was visited by her elder brother, and her wish remained for the two lovers to go away and live together.

MODERN LOVE-PACT SUICIDE STATISTICS

We will now examine love-pact suicide from a statistical perspective. Within a fifteen year period (1946-1960), the Tokyo Coroner's Office reported 22,113 cases of suicide. Of this total, 796 persons (3.6 per cent) were involved in 474 incidents of love-pact suicides. This includes some 30 persons who died in murder-suicide love pacts. In slightly less than one-third of the suicide love-pacts one member of the pair failed to die. (See Diagram A).

The peak year for love-pact suicides was 1949, perhaps because of the post-war ideological conflicts. However, the peak year for all suicides in Japan was 1958. In Tokyo there was no significant difference in the numbers of love-pact suicides when compared by month. January had the highest number (11.6 percent), followed by March and November; the months with the least number of love-pact suicides were June, July, and October (6.8 per cent each). However, in the scenic spots that are associated with romantic death, such as Kamakura and Atami, the tourist seasons of spring and autumn showed considerably higher frequencies of love-pact suicide than did summer and winter.

Throughout Japan the areas with the highest frequencies of love-pact suicides were the scenic spots and the larger cities. Shizuoka Perfecture (with Atami hot springs) had the highest frequency, then Tokyo, Osaka, and Kanagawa Prefecture (with Yokohama and Kamakura). Of course, in urban areas of high population density, one expects to find a high frequency of not only love-pact suicide, but of all types of suicides. However, in the scenic spots, the high frequency of love-pact suicides is only understandable when viewed in terms of the Japanese theme of a romantic death with the performance of the act of self-destruction in an idyllic setting.

We have classified the Tokyo Coroners Office data on love-pact suicides within the 15 year period (1946-1960) into three categories. Group 1 (lovers) consists of love-pact suicides involving a male and a female who are not married to each other (73.6 per cent); Group 2 (spouses) consists of husband and wife love-pact suicides, including those living together in a common-law relationship for one year or more (21.5 per cent); and Group 3 (same sex), consists of love-pact suicides involving couples of the same sex (4.9 per cent). (See Diagram B).

Among the Group 1 (lovers) love-pact suicides, approximately 60 per cent

of the cases involved persons ranging in age from 20 to 30. Females below age 20 were much more common than males of that age group. The model case involved a female aged 20-24 and a male aged 20-29, however, the range included the following combinations: a 17-year-old male with a 29-year-old female; a male 19 with a female 38; and a male 59 with a female 21.

Many persons in Group 1 were unemployed, or the males were employed as factory workers and the females were employed as clerks. There were some students, geishas, and hostesses. Males under 20 often had students or hostesses as partners; males 20-29 often were fellow-workers of their partners (e.g., factory workers, clerks, cooks, and maids); males 30 and older were often involved in extramarital love relationships with their partners. Compared with cases of individual suicides, Group 1 of the love-pact suicides exhibited case histories with less stable job situations and less satisfying heterosexual relationships.

Dr. Komine (1938), attempting to determine suicide motivations, examined 6,234 cases of love-pact suicides reported in the newspapers between 1927 and 1936. He classified the precipitating factors into four main categories and one residual category: 1) inability to marry (3,258 cases); 2) non-marital sexual relationships (1,493 cases); 3) economic problems (254 cases); 4) family discord (158 cases); and 5) other (1,044 cases). These precipitating factors obtained from newspaper accounts can be viewed as socially credible statements of motivation, or, in C. W. Mills' terms, a vocabulary of motives (Mills 1940). Whatever other private motivations may have existed is, perhaps, not determinable. It is not surprising that these social motivations also appear in the recent data from the Tokyo Coroner's Office. For males under 20, parental opposition to a love-marriage was generally the precipitating factor. In the male 20-29 year age group the motivation was the same, but as age increased, other factors such as disease, finances, and legal problems entered the picture. Among the males aged 30 and older, difficulties centered around relationships with mistresses, geishas, and other men's wives.

Suicide methods in Group 1 have changed over the 15 year period from primarily potassium cyanide ingestion to sleeping pill ingestion. The use of gas remained constant over this period. The method of sleeping pill ingestion is especially appropriate in that the pills induce a dreamy state prior to unconsciousness, which is quite in keeping with the idealized, romantic conception of love-pact suicide. Almost always both partners used the same method. Despite this, in 18% of the cases one member of the pair survived.

Over one-half of the suicides in Group 1 took place in a *ryokan,* the traditional Japanese inn. Other places included apartments or dormitories, but only very rarely did the suicides occur in the private dwelling of one of the partners.

The murder-suicide love pacts, in which one partner kills the other and then himself, showed somewhat different characteristics. Many cases involved two different methods of inducing death. The most frequent methods of killing the other person were cutting, strangling, and poisoning with potassium cyanide. The place of the act was more varied than in mutual love-pact suicides, with the traditional inn accounting for only one-fourth of the cases. Interestingly, in 45 per cent of the cases the murderer failed to kill his partner, and in only 15 per cent of the cases he failed to kill himself. The murderer was much more often the male member of the pair than the female member.

In Group 2 (spouses) approximately one-quarter of the cases involved common-law marriage. The husbands ranged in age from 20 years to 75 years and the wives from 22 years to 69 years. In general, persons in this group were older than those in Group 1, with one-third of the spouses aged 55 or older.

Motivation within Group 2 reflected the basic age dichotomy within the group. The older couples were often weak or sick and faced economic problems such as unemployment. On the other hand, the younger couples looked much more like those in Group 1 in that those who were employed held the same type of jobs, and held similar motives.

The suicide methods employed by Group 2 were also similar to those of Group 1. However, there were relatively fewer cases involving sleeping pills, and there were four cases of murder-suicide pacts in which strangulation of the wife was followed by the murderer's hanging himself. This unromantic method of suicide did not occur at all in Group 1.

Group 3 (same sex) included 6 male pairs and 17 female pairs. Ages ranged from 16 to 24 years. The only blood relatives involved were two pairs of sisters. Although motivation was difficult to determine in many cases, there seemed to be quite a few problems stemming from homosexuality. Motivation also included illness, debts, and broken marriages. Although both members of each pair used the same method (most often sleeping pills), in some 13 per cent of these cases one member survived while the other died.

Having examined two recent cases and modern love-pact suicide statistics, it seems apparent that the traditional Japanese literature fails to portray the rich variety of motives, methods, and relationships that one actually finds connected with current love-pact suicides in Japan. In fact, despite the obvious standardizing effect of the popular literature in terms of setting forth acceptable attitudes toward love-pact suicide, establishing "proper" motives, methods, and settings, etc., our investigations show that real people in a variety of real circumstances have adapted love-pact suicide to their individual situations.

SUPPLEMENTARY COMPARATIVE DATA

At this point we should like to append a few brief comparisons between these love-pact data from Tokyo and those gathered by Cohen (1961) from England and Wales for the period 1955-1958.

Although statistical comparisons of this sort are exceedingly perilous due to differences in classification, record keeping, and interpretation, some gross similarities and differences emerge between the two countries that are worth noting.

First, the sheer frequency of love-pact suicide in Tokyo is, in raw numbers per year, about twice that of England and Wales, and proportionate to the respective populations, some ten times the rate of England and Wales combined. Although the data are not strictly comparable, since we are dealing with a single urban center on one hand and national totals on the other, it is likely that the frequency and rate of love-pact suicides is higher in Japan than in Britain.

There also seems to be differences within the love-pact suicide populations, with much higher proportions of lovers' suicides in Japan (Japan, 74% vs.

England, 9%), but on the other hand, there were higher proportions of husband-wife suicides (England, 72% vs. Japan, 22%), same-sex suicides (England, 12% vs. Japan, 5%), and family love-pact suicides (England, 14% vs. Japan, less than 1%) in England and Wales.

One gathers from Cohen's text that the motivations in Japanese and English love-pact suicides are remarkably similar. For young lovers, there is some imagery of being united in death; for older spouses, motivations cited are illness, unemployment and all the socio-psychological concomitants of aging. Methods also show great similarity between the two countries; poison, gas, and pills occur frequently.

A final pair of possibly related divergencies stand out. One is the relatively younger age of the Japanese suicide participant. Nearly forty per cent of Cohen's population was 60 years of age or older. Even the oldest subgroup in Japan, the married suicides, was younger in comparison.

The other divergence is the relatively rarity of survivors in love-pact suicides in England, whereas around 15% of the Japanese love-pact suicides involved one survivor. However, the differences in this last category may be a function of the difference in data collection techniques. It is not clear how Cohen arrived at his statements regarding the rarity of unsuccessful love-pact suicides since his population was provided on the basis of "the registration of two deaths from suicide and which, from the place and date of death, appeared to be connected" (Cohen 1961). Thus, those cases with one survivor would appear to fall through his data-gathering net. Of course, those suicide pacts in which both members survived were not picked up by either our or Cohen's data collecting procedures.

The relationship suggested between more youthful attempters and higher rates of single member survivors is similar to that found in individual suicidal behavior. Relative to committed suicide there are fewer attempters with increasing age groupings. One might suggest the impetuosity, inexperience, and the differing situational motivational pressures of youth as the cause for this difference.

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AN UNDERGRADUATE COURSE IN DEATH

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THIS is a brief description of an undergraduate course in death, established in the Pilot Program at The University of Michigan, and a presentation of student reactions to that class. In describing it, an attempt has been made not only to report the basic facts of the course, but also to convey its atmosphere as well. The author's training in anthropology, no doubt, strongly influenced the content of the class, but other fields of study were not ignored. Death is such an all-encompassing subject that it provides an excellent focal point from which the student of life may make a lastingly meaningful integration of the various academic disciplines. The author, speaking from personal experience, feels that there is a great potential demand for survey courses in death. Hopefully, the following may be of some use to educators who might be thinking about the formation of such a class.

DESCRIPTION

The Pilot Program, under the guidance of a standing committee, and sponsored jointly by the College of Literature, Science, and the Arts and by the Office of University Housing, is located in Alice Crocker Lloyd Residence Hall on The University of Michigan campus in Ann Arbor. The Program is engaged in a series of innovations designed to foster interaction between the student's academic and residential activities. One of its innovations is the hiring of residence hall staff members known as resident teaching fellows, who are graduate students selected for their interest in undergraduates and for their com-

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[1]I would like to thank Prof. Roy Rappaport of the Department of Anthropology for sponsoring the death course; the 1969-70 Pilot Program staff for their support and encouragement; and, most of all, my students, who were my teachers.

mitment to academic development. The relationship between resident fellows and Pilot students, primarily freshmen and sophomores, is one in which intellectual adventure is encouraged. Sometimes ideas are explored informally—through non-credit Free University courses, talks by guest speakers, or personal conversations. At other times, courses are offered in a more formal framework, and result in academic credit. During the 1969-70 season, Pilot's resident fellows and resident directors taught a large group of credit-bearing seminars. The general aim of these courses was to sharpen the student's ability to think logically and critically about himself, his values, and the larger society of which he is a part.

There is no official connection between Pilot courses and the various academic departments of the University, though each course has a sponsor from one of the departments of the College of Literature, Science, and the Arts, and each has been reviewed and accepted by the curriculum committee of that College. Each teaching fellow was also certified by his academic department as well able to teach his course in the Pilot Program. With few exceptions, the Pilot courses are of the seminar type, bearing two-hours credit, with enrollment limited to about twelve students, all of whom reside in Alice Lloyd Hall and are thus members of the Pilot Program

ORGANIZATION

During the summer of 1969, I was hired to be a resident teaching fellow and was to begin teaching in the fall. It occurred to me that, given our culture's preoccupation with the idea of youth, it might be interesting to explore the idea of death, since death is far removed from the thoughts and experience of many young people. The fact that death occurred to me as the subject of a course is another example of simultaneous but independent invention—of things "being in the air"—for it was not until October that I became aware of the increasing activity in death studies.

In early September, I initiated what was called the Free University Project on Death. In response to a small typed notice on the main bulletin board in the dormitory, an amazing total of 96 students, out of approximately 560 in the program, appeared for the first organizational meeting. The Project consisted primarily

of presentations by guest speakers, since I did not, by any means, consider myself an expert on death. Among many other guest speakers were Prof. Robert Hendrix of the School of Medicine, who lectured on the medical criteria of death, R. C. W. Ettinger, who came to talk about cryonics, and Prof. Clifton Olds of the History of Art Department, who spoke on the theme of death in Western art and illustrated his speech with color slides.

Meanwhile, my fame spread through Lloyd Hall as "death-man," "the grim reaper," and "D. K." (my initials, which, when spoken quickly, form the word "decay").

I was not in my room on the night before my birthday, in November. When I returned in the morning I found it had been completely transformed into a funeral parlor. The window was covered with black paper, and only a cross cut out of it admitted the gray early morning light, which illuminated a magnificent homemade coffin on a catafalque. A three-branched torchier burned at the head of the coffin, and lily incense suffused the room with a most deathly fragrance. The walls were hung with black bunting, and the telephone and lights were dead. Inside the coffin were some supplies for my journey to the land of the dead: a box of Wheaties, bread and peanut butter, a Tootsie roll, a grape lollipop, and a dead flower. Though not visible at the time, the underside of the coffin was painted with a life-size portrait of a man, an idea suggested by certain practices of Medieval art. Balanced on one corner of the coffin was the *Tibetan Book of the Dead,* opened to an appropriate passage. After all this, I was not surprised to see written above the pillow the words "DOUG IS DEAD." Nor was I surprised that, instead of candles, my birthday cake had miniature styrofoam gravestones on it.

The Free University Project on Death had met with such a favorable reception that I was urged to make it a credit course for the winter term of 1970. The end of November saw the conclusion of advance registration for winter classes, and "Death" had been the first among Pilot courses to be filled, even though two sections of it had been formed. This meant that there were twenty-four students, both men and women, enrolled in the course, with as many students on a waiting list in case of withdrawals.

SYLLABUS

The following course syllabus was posted during the registration period:

Pilot 127—Seminar on Death

Purpose: The purpose of this seminar is to widen the participants' understanding of human death, in its biological, psychological, and, primarily, socio-cultural dimensions. Our own culture's stance on death will be examined closely. However, the main thrust of the course will be to break through our ethnocentric views of death and try to see death as an event that can be dealt with and elaborated upon in sharply divergent ways by different cultures, with varying implications for the living.

Content:

I. Introduction—physiological characteristics and medical criteria of death

II. Psychological dimensions of death in the modern West
- A. The child's view of death
- B. Time and death, with respect to the adolescent
- C. Attitudes toward death in normal and mentally ill populations
- D. Attitudes of the dying toward death
- E. Animal behavior in the presence of death among animals or humans
- F. Freud and Jung

III. Beliefs and practices surrounding death in various cultures
- A. Death as a socio-cultural event
  1. Concepts of the elementary forms of magico-religious systems as regards life and death
  2. Some concepts of function
  3. Death as a rite of passage
- B. Death in selected non-literate "simple" societies
- C. In the United States
- D. In Great Britain
- E. Among some European gypsies
- F. In Mexico
- G. In China
- H. In India

IV. Death and the arts
- A. Literature and poetry
- B. Visual arts (including architecture)

V. Special topics—such as
- A. Suicide
- B. Murder
- C. Abortion and infanticide
- D. Euthanasia
- E. Capital punishment
- F. Voodoo death
- G. Sacrifice, assassination, and martyrdom
- H. Death in war
- I. Genocide
- J. Hara-kiri
- K. Death, demography, and death statistics
- L. Death and psychical research

Method: The class meetings will consist primarily of short presentations or lectures by the instructor and discussions of assigned readings. Individual term papers will be integrated into the course content by means of informal presentations by the students in the latter part of the semester. Also, there occasionally may be guest participants in the seminar sessions.

Since a major part of the course will consist of the discussion of assigned readings, it is expected that the assignments will be read. The quality and degree of participation in the discussions and the term papers will be the basis for the final grades.

Tentative Reading List:

Herman Feifel, ed., *The Meaning of Death*
Geoffrey Gorer, *Death, Grief, and Mourning in Contemporary Britain*
William A. Lessa and Evon Z. Vogt, *Reader in Comparative Religion*
Jessica Mitford, *The American Way of Death*
Cyrus Sulzberger, *My Brother Death*
Arnold Toynbee, et. al., *Man's Concern With Death*
Selections from the above, plus other readings.

Note: Oher readings during the semester included selections from—
Emile Durkheim, *The Elementary Forms of the Religious Life*
Robert Fulton, ed., *Death and Identity*
Clifford Geertz, *The Religion of Java*
Arnold van Gennep, *The Rites of Passage*
Jack Goody, *Death, Property, and the Ancestors*
Leo W. Simmons, *The Role of the Aged in Primitive Society*
Alan Watts, *Psychotherapy East and West*
Jan Yoors, *The Gypsies*
and—
Jules Romains, *The Death of a Nobody*
Richard Sterba, "On Halloween," in *American Imago* V (April, 1948)
Leo Tolstoy, *The Death of Ivan Ilyich*

The above syllabus was not strictly followed. At pleasure, we both added to and subtracted from it. I welcomed any and all suggestions from my students and considered myself *primus inter pares*. Each of the two sections met once a week for about two hours in the evening. The sessions were held in my apartment in the dormitory and were informal and relaxed.

SESSIONS

From the first sessions onward, we freely discussed personal feelings and experiences relating to death. A particularly successful meeting was one dealing with suicide. Mrs. Ruth Shelkun, formerly of the Ann Arbor Suicide Prevention Center, was the catalyst for some very stimulating and thought-provoking role-playing during this session.

As in the previous fall term, Prof. Olds' presentation on death in art was excellent. Many of the death themes in Medieval art

explored in his lecture were especially appropriate, since a campus film society was showing Ingmar Bergman's film, *The Seventh Seal,* which most of the students saw. Along with a reading of Tolstoy's *The Death of Ivan Ilyich* and of Jules Romains' *The Death of a Nobody,* works which present rather opposed views of death, these two events constituted the bulk of the section on death and the arts.

Some sessions were more successful than others, while the flavor of the meetings was always varied. After seeing a film about a dying cancer patient, the group was depressed and taciturn. At other times, the students were very talkative indeed. During one session, we were self-consciously talking about the "myth of objective consciousness" as presented in *The Making of a Counter Culture* by Theodore Roszak. We were considering what symptoms of alienation might be present in the very idea of having a need or place in our society for a course on death, when one girl suddenly doubled over. Her whole body convulsed, and when asked what the problem was, she made no reply. It immediately came to each person's mind that here, before our eyes, was a girl dying. I called an ambulance service, but no ambulances were available, and the service was going to connect me with the police, when the girl said that she was only fooling. As part of a sociology project, she had to break one of our society's norms, and so she broke one! She pretended that she was dying, though only in the setting of a course on death would her pretense have been so effective. With so much adrenalin in our bodies, we couldn't very well continue our discussion of alienation. So we turned instead to a very animated discussion of what had just happened.

The variability of our meetings demonstrates the great involvement the students felt with the topic of death. Their term projects ranged from scholarly treatments of euthanasia and capital punishment, to papers on death in the poetry of Dylan Thomas and the ancient burial mounds of Russia, from a project on death in music, to a children's story about death. One of the most unusual projects was one on death and the dance, complete with stunning demonstrations.

At the final meeting, I distributed a course evaluation sheet. The response to it was very helpful, containing equal amounts of positive and negative criticism. I have presented here some com-

ments particularly germane to the idea of death courses, and especially those comments which reveal the effect of this particular course on the students. Bear in mind that the students are representative of The University of Michigan as a whole, except for the fact that they chose to live in Alice Lloyd Hall. The twenty students responsible for the following comments are both freshmen and sophomores, male and female, "straights" and "freaks." There was no discernible correlation between which of the above categories the individual student fit into and the type of response he or she gave. Here, in conclusion then, are their comments.

Before this course I felt death was gruesome and morbid. Now I have no overt or morbid curiosity about death–I accept it as a fact . . . . When I mention this course to my family, my mother still cringes with disgust. However, I feel that they, too, now see that death is just a natural happening–sad but not overly gruesome.

. . . I don't think my attitudes have changed too much. I still am interested (fascinated even?) in death, but I have also retained a dislike for the permanence of death. It's funny, every week I left class a little shaken or at least with something to think about.

My thoughts have actually only begun on the subject of death. This to me was one of the best things that happened as a result of this class. I had never really thought about death, nor even talked about it with many people before. Now I see so many perspectives with which to view death, and I see that they all have some connections. I feel much better prepared I might say, for death, and also, for life. Thinking of death is thinking of life and what it really is and means to me. So often I lose sight of life in this society's routine existence. Just as it stifles thoughts and emotions of death, it also stifles life. . . . People only fear death because they fear life. I really think that by getting together with the world I can live fully and welcome death with wisdom and love. It is so silly to fear death because it is inevitable, but that is rationalizing I guess.

I think I've come to accept the event of death. This class had a lot of meaning to me as an individual because of my grandfather's death during the semester. I only wish I could express to the class the feelings I had then. . . . Everyone must die and it's good to know something about it before it happens.

After having this course I seem to feel more open-minded toward death and not so afraid to discuss it with someone or think about it. Before I kind of had the idea death was for old people or someone else, but now I realize death is real, it is here, and something I have to acknowledge and confront.

At times the topic seemed to drag.

The course turned out to be thinking sessions during many of the meetings. The subject of death inevitably lead to a discussion of life. . . . Many times the class was an interesting, relaxing thought session while at other times it was dull-boring. . . . An elaboration on drugs and their connection with death would have been interesting.

I think the best part of the course was the way in which it was basically non-structured. Death is not a structured thing, therefore it should be taught this

way. . . . I don't think death can be taught out of books. It has to be a learning process through interactions with other people. . . . I have never been familiar with death and I think the content of this course helped me realize what is going on. It was put forth as such a basic concept, one that you need not be afraid of. This is the way I look at it now.

Still don't know what death really is.

My attitudes have really been enlarged so as to include more questions about my present actions and general feelings about what kind of life I want to live, and what death must mean in the context of the life I want to lead. It is difficult to explain in words the subtleties of these kinds of changes. I can say how I believe death to be an extension of life, but this does not express the subtleties, the effect of that statement on the way I live, the relationships I have, how I see people, how I see myself.

The discussions were sometimes very stimulating, especially the ones involving personal experiences and feelings about death. . . . I have felt pretty cynical about death but feel a little less so now. Cynical? What the hell? I mean when you've gotta go, you've gotta go, and people die every day, and it shouldn't matter. But then, it really does matter if it's someone you care about, or if it's you. . . . I thought and was glad I did. Maybe I was even educated.

I have a deeper and more active working knowledge of death. . . . I say that I am eternally living a dying life and most satisfied with it. . . . growth is my game and I cannot negate that which is my essence. So when I reach the doors of death I will knock loudly.

. . .the conversation often became repetitious.

My attitudes toward death did not change so much as my attitudes toward life.

First of all, the idea of a course on death is very enticing. I doubt if the course turned out to be what anyone, including the instructor, expected. My interest in the Far Eastern philosophy of death lead me to an inquiry into the entire Eastern philosophy. After reading several books, hearing a few speeches and a lot of personal discussions, I began to form a very new outlook on life—an entirely new understanding and awareness which includes every aspect of life. . . . This is something that no course has ever come near doing. To me the course was well worth taking, but I say that in a very personal sense.

Before this class I had wondered at my and others' feelings that death was a separate, untouchable sort of thing. Now I feel I can treat death with somewhat less awe (or something), and when I study in the cemetery I wonder at others' expressions that I am doing a weird thing. To sum it up, I think this course has helped me put death in its proper place.

THE FEAR OF DEATH, THE FEAR OF DYING, AND THRESHOLD DIFFERENCES FOR DEATH WORDS AND NEUTRAL WORDS

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INVESTIGATORS of "perceptual defense" (for example, Cowen and Beier, 1954; McGinnies, 1949) have reported that recognition thresholds for sex-related words were higher than those for neutral words. Critics of these studies (see Howes and Solomon, 1950; Howes, 1954) argued that the perceptual defense effect might be due to differences in frequency with which the words appear in the spoken as opposed to the written language, or to a tendency for *S*s to suppress report of the sex-related words because of social pressures.

Two recent unpublished studies have investigated differences between recognition thresholds for neutral words and for death-related words. The emotional loading of death words is at least as great as that of sex words, but there is probably much less social pressure against public mention of death words. Since death words are socially acceptable, they are to be found in published material with a frequency which is probably comparable to their private oral use. Thus, control of word frequency is made possible. Golding *et al.* (1966) found a tendency for *S*s with high fear of death to have a higher threshold for tachistoscopically presented death words than *S*s with low death fear. Leviton (1968) compared the reactions of amateur sports car racing drivers and of bowlers to death and crash-word stimuli. He found a significantly lower threshold for death words than for neutral words in both groups.

The present study investigated differences between recognition thresholds for neutral and for death-oriented words. A fear of death scale was used to investigate the relation between perceptual defense to death words and the fear of death.

METHOD

Subjects

Twenty-five volunteer *S*s between the ages of twenty and thirty-one were used.

Apparatus and Procedure

The usual tachistoscopic presentation of words was not used. Instead, lists of stimulus words were typed with an electric typewriter. Nine carbon copies were made for each list, so that the lists varied from extreme clarity to almost complete illegibility. Each set of carbons was typed with the words listed in a different randomized order. The carbons were then interchanged to produce sets of word lists, ordered from legibility to illegibility, such that the same sequence of words did not appear on two successive pages.

The word list consisted of fifteen death-related words and fifteen neutral words. The death and neutral words were equated for number of letters and for frequency in the written language by means of the Thorndike-Lorge word count (Thorndike and Lorge, 1963). The words used were: cemetery, kill, tomb, suicide, die, corpse, coffin, strangle, bury, funeral, grave, hearse, morgue, death, and autopsy; eyelid, land, ear, sight, rank, invoke, delicacy, reed, babyish, inviting, poultry, ahead, delude, overcome, and tangle.

Each *S* was given the least legible word list first and was asked to write on a separate page his guess about each word. This was repeated with each page until *S* had identified every word correctly.

The Collett-Lester (1969) fear of death (*FOD*) scale was then administered to each *S*.

RESULTS

Recognition thresholds for death words were significantly lower than for neutral words. The sum of correct guesses for all nine trials on death words was greater than that on neutral words for 19 of 25 *S*s ($p = .007$ on a binomial test). Ten *S*s got all the death words correct first; one *S* got all neutral words correct first; and fourteen *S*s got all death and all neutral words correct on the same trial ($p = .006$ on a binomial test).

When the death words were divided into a group of four active words (die, strangle, kill, suicide) and a group of eleven passive words (all other words in the list), recognition thresholds as measured by sum of correct guesses were significantly lower for active words than for matched neutral words ($p = .007$ on a bionomial test), but there was no significant difference for passive words as compared to their matched neutral words ($p = .212$). In thirteen cases, *S* recognized all of the active words on an earlier trial than all of the neutral words; in one case all the neutral words were recognized first; and in eleven cases, the active death words and the matched neutral words were all recognized correctly on the same trial ($p = .001$ on a binomial test). In nine cases, all of the passive words were recognized before all of the matched neutral words; in one case, all neutral words were recognized first; and in fifteen cases, all of the passive words and the matched words were recognized correctly on the same trial ($p = .011$ on a binomial test).[1]

The relationships between word recognition performance for the active and passive groups of words and scores on the *FOD* test subscales were examined. The correlations (Spearman's rho) between recognition thresholds for active words and the *FOD* scales were: death of self (*DS*), $= +0.32$ ($p > .05$); death of others (*DO*), $= +0.16$ ($p > .05$); dying of self (*DyS*), $+0.28$ ($p > 05$); dying of others (*SyO*), $= +0.18$ ($p > .05$). The correlations between recognition performance for the passive words and the four subscales were: *DS*, -0.58 ($p < .01$); *DO*, -0.30 ($p > .05$); *DyS*, -0.08 ($p > .05$); *DyO*, -0.14 ($p > .05$). (It should be noted that a positive correlation indicates that high fear was associated with quick recognition of death words, while a negative correlation indicates that high fear was associated with a high threshold for death words.)

t-tests on differences between correlations of *FOD* subscales and active or passive words yielded the following results: cor-

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[1]In seventeen of the twenty-five cases, all of the active words were correctly identified before all of the passive words; in eight cases, active and passive words were all correctly named on the same trial; and in no case did correct identification of all passive words precede that of all active words ($p < .001$ on a binomial test). Since the active words tended to be of higher frequency than the passive words, this finding indicates that frequency effects were operating on thresholds for words within the death category at the same time that extra-frequency characteristics were producing differences between death and neutral words.

relation between *DS* and active words vs. *DS* and passive words, $t = 8.76$ ($p < .01$, two-tailed test); *DO* and active words vs.*DO* and passive words, $t = 2.65$ ($p < .02$); *DyS* and active words vs. *DyS* and passive words, $t = 2.42$ ($p < .05$); *DyO* and active words vs. *DyO* and passive words, $t = 1.77$ ($.10 > p > .05$).

DISCUSSION

Rather than perceptual defense (raised threshold for emotionally loaded words), the results of the present study showed perceptual facilitation since death words were recognized at a lower level of clarity than neutral words. This finding makes sense from an evolutionary viewpoint in a way that perceptual defense does not, since there would be survival value in heightened sensitivity to dangerous stimuli. Perceptual facilitation is also congruent with Leviton's results.

It appeared that recognition scores for active and passive death words were differentially associated with scores on the *FOD* subscales. *S*s who showed high *FOD* scores tended to have relatively low thresholds for active death words and relatively high thresholds for passive death words, while *S*s with low fear of death scores showed the opposite tendencies. People who feared death greatly were relatively sensitive to stimuli related to dying and being killed and relatively insensitive to the worldly concerns of disposing of the body.

The differences in results for active and passive words are relevant to interpretation of previous studies. Alexander and Adlerstein (1960), for example, in their study of galvanic skin response to death words, used words associated with the circumstances surrounding death (passive words) rather than the process of dying (active words). The results of the present study indicate that responses to active and passive death-related words may differ greatly.

SUMMARY

Twenty-five *S*s were tested for differences in recognition thresholds for death-related and neutral words, and were given a fear of death test. Significantly lower thresholds were found for death-related than for neutral words. *S*s with a high fear of death tended to have relatively low thresholds for words related to the active

process of dying, and relatively high thresholds for words related to the state of being dead. The reverse was true for *Ss* with low fear of death.

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RELIGIOUS BEHAVIOR AND THE FEAR OF DEATH

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A REVIEW of the research carried out on the association between religious behavior and attitudes toward death has found that the data were inconsistent and contradictory and these inconsistencies were attributed to the use of unreliable measures of both religiosity and attitudes toward death (Lester, 1967*a*).

The present study is part of a series designed to investigate more adequately the association. In order to measure attitudes toward death, three scales were used which have had some reliability or validity studies carried out on them. In order to assess religious behavior two dimensions were considered: religious denomination and religiosity. Attempts were made to disentangle the effects of each of these two dimensions of religious belief.

In addition to being an exploratory study of whether any associations can be discovered between religious behavior and attitudes toward death, new hypotheses were formulated for testing. It has been argued (Lester, 1967*c*) that very religious individuals, rather than having *either* a greater fear of death *or* a lower fear of death as compared to nonreligious individuals, may have extreme fears of death (very low and very high). Hitherto, research has focussed upon only differences in the average fear of death of groups of individuals and not into the variation within each group.

A second hypothesis was based on the suggestion of Feifel (1956) that individuals may resort to a religious outlook in order to cope with fears of death. Thus, we would expect there to be a greater discrepancy between the conscious and the unconscious fear of death for religious individuals than for nonreligious individuals. Religious individuals may also have more inconsistent conscious death attitudes than nonreligious individuals.

The use of the Collett-Lester fear of death scale, which measures four different specific fears of death, enabled the association between specific fears of death and religious behavior to be investigated. The Collett-Lester scale provides measures of the fear of death of self, fear of death of others, fear of dying of self, and fear of dying of others. It was considered possible that religious beliefs could affect some of these specific fears without affecting others.

METHOD

Subjects

The subjects were students in an Introductory Psychology course at a girl's college and participation in the research was a course requirement.

Procedure

Each girl completed a questionnaire which contained questions about her religious affiliation and that of both of her parents, the religiosity scale of Josey (1950), and the fear of death scale of Collett and Lester (1969).

From this sample, 25 were chosen with the highest and 26 with the lowest scores on the religiosity scale. Each of these girls was a Protestant with Protestant parents. Each student was seen individually and administered a word association test which contained words overtly referring to death (taken from Adlerstein, 1958) and words symbolic of death taken from Meissner (1958) together with neutral words matched for frequency of usage in the English language. The responses of the students to the test were recorded on tape played at a high speed and the latency of response of each word was measured by playing the tape back at a low speed. Each word related to death was compared to the neutral word and a decision was made as to whether the response latency to the death-related word was less than or greater than the response latency to the neutral word.

Each student was also given the fear of death scales of Boyar (1964), Lester (1967*b*), and Collett and Lester to complete. Each student also completed the Maudsley Personality Inventory (Jensen, 1958) which provides measures of neuroticism, extraversion, and a lie score.

RESULTS

Effects Of Religiosity With Denomination Held Constant

Scores on the scale of religiosity were correlated with scores on each of the subscales of the Collett-Lester fear of death scale for each of the denominations. The product-moment correlations all failed to reach significance (see Table 1).

TABLE 1

Product-Moment Correlations Between Religiosity and The Fear Of Death Of Students With Different Religious Denominations.

Religiosity and fear of	Catholics n=12	Jews n=14	Protestants n=83
death of self	–0.49	0.12	–0.14
death of others	0.35	0.37	0.19
dying of self	–0.50	–0.36	–0.09
dying of others	–0.30	0.09	0.10
Correlation needed for significance at the 5% level (two-tailed test)	0.58	0.53	0.22

Effects Of Denomination

Among the Protestants, the only sects with more than 10 members were the Episcopalians ($n = 25$) and the Presbyterians ($n = 20$). These two groups were compared for their scores on each of the subscales of the Collett-Lester fear of death scale and on the scale of religiosity.[1] No significant differences were found (see Table 2) but the Presbyterians did have higher fears on each of the four subscales.

TABLE 2

The Mean Fear Of Death Of Those With Different Religious Denominations.

	Episc. n=25	Presb. n=20	t df=43	Cath. n=12	Jews n=14	Prot. n=83	F df=1/106
Fear:							
death of self	5.4	8.3	0.87	2.2	8.8	4.6	2.03
death of others	5.4	6.2	0.44	5.0	5.8	5.5	0.05
dying of self	3.3	4.1	0.57	3.8	3.9	2.8	0.68
dying of others	–8.6	–6.8	0.66	–6.1	–3.4	–7.3	1.51
Religiosity	100.2	108.5	0.84	111.6	126.6	104.7	1.60

[1]The range of scores on the tests is as follows: religiosity 0 to 236, fear of death of self –27 to 27, fear of death of others –30 to 30, fear of dying of self –18 to 18, fear of dying of others –33 to 33, Lester fear of death scale 1 to 11, and the Boyar fear of death scale –54 to 54.

The Catholics, Jews, and Protestants (all sects combined) were also compared similarly and no significant differences were found (see Table 2). However, the Jews did have higher fears than the Protestants and the Catholics on each of the four subscales. Differences between those in different denominations still failed to reach significance when the groups were matched for their religiosity scores (the largest $f = 1.2$, $df = 14$, $p > 0.20$).

Effects Of Religiosity In Protestants: An Intensive Examination

The Effects Of Neuroticism. As a control for the degree of emotional disturbance of the two groups of Protestants (25 highly religious students and 26 minimally religious students), they were compared for their scores on the neuroticism subscale of the Maudsley Personality Inventory. The groups did not differ significantly ($t = 1.00$, $df = 49$).

Differences In Overall Fear Of Death. The two groups were compared for their scores on the fear of death scales with heterogeneous items. On the Boyar scale the students with low religiosity scores had the highest fear of death but the difference did not reach significance ($t = 0.55$, $df = 49$). On the Lester scale, however, the students with low religiosity had a significantly higher fear of death ($t = 2.09$, $df = 38$, two-tailed $p < 0.05$)[2].

Inconsistencies In Conscious Attitudes Toward Death. Lester (1967*d*) has shown how a measure of the inconsistencies in attitudes toward death may be obtained from the Lester fear of death scale. The two groups differed significantly in the degree of inconsistency in their death attitudes, with the students having low religiosity scores having significantly less inconsistency in their attitudes toward death ($t = 3.39$, $df = 38$, two-tailed $p < 0.01$).

Specific Fears Of Death. The two groups were compared for their scores on the Collett-Lester fear of death scale. They did not differ in their fear of death of others ($t = 1.00$, $df = 49$) or in their fear of dying of others ($t = 0.75$, $df = 49$), but the tendency was for those with low religiosity scores to have less fear. On the fear of death of self subscale, there were no significant differences ($t = 1.60$, $df = 49$) but the tendency was for those

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[2]The reduced sample size for some comparisons is due to some students not completing tests.

with low religiosity scores to have a greater fear. On the fear of dying of self subscale the students with low religiosity scores had a significantly greater fear ($t = 2.56$, $df = 49$), two-tailed $p < 0.02$).

The data were subjected to an analysis of variance (Kirk, 1968) which indicated that the two groups did not differ in their fear of death versus dying ($F = 0.25$, $df = 1/49$) but that they did differ in their fear for themselves versus others ($F = 13.57$, $df = 1/49$, $p < 0.01$). Those with low religiosity had a greater fear for themselves whereas those with high religiosity had a greater fear for others.

Extremeness In Scores. The two groups were compared for the variances of their scores on each of the fear of death scores. They did not differ on the Lester fear of death scale ($F = 1.32$, $df = 20/18$), on the Boyar scale ($F = 1.59$, $df = 25/24$), or on any of the four subscales of the Collett-Lester fear of death scale (the largest $F = 1.66$, $df = 24/25$).

Unconscious Attitudes Toward Death. The subjects in each group were compared for the proportion of death words for which the latency was longer than for the neutral words. For the four death words the two groups did not differ in the proportion for which the latency of response was longer ($X^2 = 0.07$, $df = 1$). For the twelve words symbolic of death the students with low religiosity scores had longer responses to the death words as compared to the neutral words less often than the students with high religiosity scores but the differences did not reach significance ($X^2 = 3.01$, $df = 1$, $p < 0.10$).

For all sixteen words, the students with low religiosity scores had longer response latencies to the death words less often than the students with high religiosity scores but again the difference was not significant ($X^2 = 2.53$, $df = 1$, $p < 0.20$).

There was, therefore, a tendency for the students with low religiosity scores to have less unconscious fear of death than those with high religiosity scores but the difference did not reach significance.

The Discrepancy Between Conscious And Unconscious Fear Of Death. Lester (1967*c*) argued that religious individuals should have a greater discrepancy between their conscious fear

of death and their unconscious fear of death. To test this hypothesis the scores of the students on the Boyar fear of death scale (which taps conscious fear) and on the response-latency measures to words symbolic of death (which taps unconscious fear) were compared. Words symbolic of death were used to test the hypothesis since the words directly referring to death were picked out by several students to be crucial to the experiment and so their reaction to them may be confounded by this increased attention to them.

The students were ranked in order of fear of death for both measures and the difference in rankings was noted. Of 25 students with high religiosity scores, 10 had a lower rank for their unconscious fear than for the conscious fear. Of 23 students with low religiosity scores 14 had a lower rank for their unconscious fear than for their conscious fear. This difference was in the predicted direction but it was not statistically significant ($X^2 = 1.33$, $df = 1$ on a median test).

The students were compared for the absolute size of the discrepancy and the students with low religiosity scores were found to have larger absolute discrepancies than those with high religiosity scores. However, the difference did not reach significance ($X^2 = 1.40$, $df = 1$ on a median test).

DISCUSSION

An examination of the effects of denomination upon the fear of death indicated that there were no associations. This remained true even when the variable of religiosity of the subjects was controlled for. There remains the possibility that there is an association which is very weak and which may appear in very large samples. For example, the Jews had consistently higher fears of death and dying than the Catholics and Protestants, though these differences did not reach significance in any separate comparison.

The effects of religiosity upon the fear of death appeared to be stronger than the effects of denomination. When students with extreme scores on the measures of religiosity were compared it was found that those with low religiosity had a greater fear for themselves whereas those with high religiosity had a greater fear for others. These results were in accord with the correlations based on the total sample of Protestants but these latter correla-

tions were not significant. Again, therefore, the association appears to be weak and manifest only in research designs that minimize confounding factors or which study extreme groups.

Comparison of the religious and nonreligious students who were Protestants on the fear of death scales produced unreliable results. The differences were significant on one scale but not on the other. The data from the use of the scale which differentiated between four separate fears of death indicated that the important dimension here was fear for oneself rather than others. The dimension of death as opposed to dying was not crucial. It is clear, that the use of a fear of death scale with heterogeneous items will miss discovering these associations and the scales will produce different results depending upon the orientation of their items (that is, are the items more concerned with death or dying or with death of oneself or death of others).

The results appear to indicate that, rather than reducing the fear of death and dying for individuals, religious belief shifts concern away from the self to others. Whether this shift is a result of the religious belief or whether the difference is part of the complex of attitudes and personality traits that help determine whether an individual will come to possess a strong religious belief is a question for further research.

The pattern of correlations between religiosity and fears of death and dying for Protestants was consistent with the data from the study of students with high and low religiosity scores. The patterns of correlations for the Jews and Catholics were very different from that for the Protestants and, if these patterns of correlation prove to be reliable and valid in future studies, this suggests the possibility of a religiosity/religious denomination interaction.

It was predicted and found that the more religious students should have more inconsistencies in their death fears than less religious students. No differences were found in the variation within each group of students in their death fears. Investigation of the unconscious death fears of students failed to reveal any significant differences. However, the method used was somewhat crude and effort must be made in the future to develop more satisfactory ways of tapping unconscious attitudes toward death.

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SUBJECTIVE LIFE EXPECTANCY AND FUTURE TIME PERSPECTIVE AS PREDICTORS OF JOB SUCCESS IN THE "HARD-CORE UNEMPLOYED"

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How long do I expect to live?/When do I expect to die?

No matter how we phrase this question, our thoughts are led in the same direction: futurity. There seems to be an intimate relationship between anticipation of death and future time perspective. It is difficult to conceive our own death without projecting our thoughts into the future—and how thoroughly can we scan our future without taking into account the prospect of death? Perhaps it is more than coincidence that research in both areas, future time perspective and the psychology of death, has been intensified since the end of World War II. Despite the natural affinity between these two sets of variables, relatively few studies have attempted to determine their mutual implications, or their combined relevance to behavioral outcomes.

Future time perspective has been characterized as having as one of its most important components the dimension of *extension* (Wallace, 1956; Wohlford, 1964). "How far ahead a person thinks" can serve as an approximate translation of this dimension. Many other dimensions of future time perspective have been distinguished and operationalized (Kastenbaum, 1964), but extension remains the most obvious and perhaps most potent single variable. This dimension has been found to be related to academic achievement and optimism (Teahan, 1958) and delinquency (Barndt and Johnson, 1955), and is affected by institutionalization (Fink, 1957), and the aging process (Kastenbaum, 1963). Significant reviews of the literature have been offered by Wallace and Rabin (1960), and Fraisse (1963).

On a broad theoretical plane, Werner (1957) has suggested that psychological futurity may be intimately bound up with the

ability to control tension, and to delay and postpone present gratifications. Hartmann (1958) has also emphasized the possible role of future perspective in ego development within a psychoanalytic frame of reference.

Thus, it appears reasonable to believe that future extension may reflect an ego function that is crucial for the sustained attention and action required of the productive individual. For this reason, an inquiry was made into the relationship between future time perspective and job success in men who have a chronic history of under-employment. A simple measure of subjective life expectancy (*SLE*) was also included. It was thought that *SLE* can be considered to be a specific form of the more general "thinking ahead" in which a person engages. We were interested in exploring the possible relationship between *SLE* and job success and the relationship between *SLE* and future extension in its more general form. The affective implications of future extension were also explored in a simple manner.

At the same time, this study provides an indirect opportunity to explore possible similarities in *SLE* and future extension between young adults who have not yet "connected" with the occupational side of The Establishment, and aged adults whose connections have been loosened or severed. Although only relatively young adults were involved in the present study, it was thought possible to learn something of value by comparing the data obtained here with observations reported in the gerontological literature.

METHOD

Procedure

The men involved in this study represent part of an initial sample of 49 "hard-core unemployed" males who participated in an attempted rehabilitation program under the auspices of a public utility company. All of the men were Negro. During the previous two-year period, none had held a single job for longer than ninety days, and none had worked for more than a total of six months during that two-year span. All of the data were collected on the University, rather than Company premises, and all

interviews were performed subsequent to the Company's training period.[1]

The men came on a voluntary basis for the interview and data collection after receiving a letter that described the study in general terms and offered a payment of ten dollars to those who made an appointment. There was the danger, of course, that volunteers might result in a biased sample. However, the men who eventually reported were almost equally divided between those who proved to be successful and unsuccessful employees (14 vs. 15). Thus, it does not appear that only the angry or disgruntled came to be heard. In addition, only one-half of the "leaves" (either "quits" or "fires") were interviewed following job termination. The others were seen while they were still employees in good standing. In most of these cases, the employees concerned did not feel that they were in danger of being terminated in the near future. The interviewer would have predicted that in some instances a particular man had now probably "made it." Thus, the obtained results do not appear to be merely a reaction to termination itself, since at least one-half of the interviews with "leaves" were carried out while these men still seemed to be doing an adequate job. In addition, inspection of the data revealed no differences between these two "leave" subgroups.

Subjects

The final sample comprised fourteen "stays," or successful employees, and fifteen "leaves," or unsuccessful employees. Their ages ranged from 21 to 44 years. Analysis of age differences between groups revealed that "leaves" had a mean age of 27.3 years, while "stays" had a mean age of 34.4 years. This difference was significant at the five percent level of confidence ($z = 2.05$). Thus, the successful employees were significantly older than the unsuccessful group.

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[1]This study represents part of a larger study dealing with the attempt to assist chronically underemployed men adjust to a new work situation. The training procedures and results of this project can be found in the final report on "A Group Orientation Approach for Facilitating the Work Adjustment of the Hard-Core Unemployed, Contract #81248824, H. Rosen, Principal Investigator; J. Teahan, Co-Investigator. Completed for the Manpower Administration, United States Department of Labor under authority of the Manpower Development and Training Act.

Instrument

The data with which this report is concerned were obtained by use of a Time Perspective Questionnaire prepared for this study by Kastenbaum, and subsequently employed in several further investigations (Figure 1). Its essential purpose was to determine life expectancy, perception of past and future in terms of positive or negative affect, and presence or absence of optimism regarding significant future goals. The *KTPQ* is more concerned with affectively-toned aspects of future orientation than with formal cognitive dimensions. This instrument was administered by Teahan as part of his total interview procedure with the *S*s. The data were obtained through individual interviews which were tape-recorded.

FIGURE 1

Time Perspective Questionnaire and Tabulation of Responses

	Leaves N=14	Stays N=15
1. How many good years do you feel you have ahead of you?	27.5	33.1
2. How long do you expect to live?	65.1	85.3
3. How has your life been up to now? (Circle one).		
Very rough	2	1
Kinda rough	8	6
Average	4	8
Kinda easy	0	0
Very easy	0	0
4. How do you expect your life to be from now on? (Circle one).		
A lot rougher	0	0
A little rougher	1	2
About the same	2	1
A little easier	6	4
A lot easier	5	8
5. What do you think is the most likely form of death for you?		
Old Age	5	10
Accident	1	2
Violent death	4	2
Sickness	3	1
No Response	1	0
6. As things stand now, how do you think your children's life will be as compared with your own? (Circle one).		
A lot rougher	0	0
A little rougher	0	0
About the same	0	0
A little better	7	3
A lot better	7	12

7. What has been the major turning point in your life?

Leaves		Stays	
This job	3	This job	5
Aware of race	2	Being on own	1
Knowing self	1	Losing last job	1
Getting married	1	Getting married	4
Service	2	Service	2
Quit School	2	Turing age 30	1
Bad Companions	1	Having no job	1
Stopping drugs	1		
Divorce	1		

8. What do you think is the biggest turning point ahead in your life?

Leaves		Stays	
Make foreman	1 (SA)	Get promoted	1 (SA)
Get own business	1 (SA)	Get own business	1 (SA)
Get equal status	1	Own my home	4 (SA)
Get married	2	Retire	4 (SA)
Accomplish something	2	Finish raising children	2 (SA)
Get new job	3 (SA)	Getting married	1
Go to jail	1	Getting more money	2 (SA)
Don't know	3		

9. How do you consider yourself age-wise?

(Circle one).

	Leaves	Stays
Young adult	8	6
Adult	3	5
Early middle-aged	3	2
Middle-aged	0	1
Late middle-aged	0	1
Old	0	0

10. Have you? (Check one).

	Leaves	Stays
Made positive plans for your future that you think have a good chance of working out?	3	5
Are you still planning and hoping for the future?	6	9
Are you becoming more pessimistic, although still planning and hoping for the future?	3	1
Do you still hope, but really don't expect much in your future?	2	0
Have you given up on the future?	0	0

RESULTS

A tabulation of responses to each question is given in Figure 1. In each instance where it appeared that statistically significant differences might be present, an analysis was made using non-parametric statistical procedures (Mann-Whitney U or Chi Square). These analyses are presented in Table 1.

TABLE 1

Comparisons Between Leaves and Stays on Critical Questions

Question #	Leaves	Stays	Statistic
	N=14	N=15	
1. Good Years	27.5	33.1	z=1.53
2. Expect to live	65.1	85.3	z=2.51*
5. Likely form of death			
Old Age	5	10	
Other	9	5	X^2=1.68
8. Major turning point ahead			
Specific Future Achievement	5	14	
Non-Specific Future Achievement	9	1	X^2=8.24**
10. Future plans			

*Significant at the .05 level or better
**Significant at the .01 level or better

Analysis of the first two questions (How many good years do you feel you have ahead of you? How long do you expect to live?) revealed that some differences did exist between successful and non-successful employees on these dimensions. "Stays" predicted more good years ahead for themselves (mean years = 33.0) than did "leaves" (mean years = 27.5). This trend is particularly interesting in view of the fact that the "stays" were chronologically about seven years *older* than the "leaves." From an external standpoint, they "should" have expected fewer good years ahead.

The trend mentioned above failed to meet the five percent level of significance. However, the importance of this trend is given support by the results obtained with Question 2. Here the "leaves" predicted a much shorter life span for themselves (mean years = 65.1) than did the "stays" (mean years = 85.3). This result was statistically significant at the two percent level. An "eyeball" analysis, reveals, of course, that the predicted life span of both groups differed by two full decades. Thus, unsuccessful employees predicted an earlier death for themselves than did successful men, and, when one considers the strong trend regarding the number of "good years" remaining, they would appear to see less ahead for themselves than do those men who stay on the job.

No differences appeared between groups in terms of cognition of the past (Question 3). All men seemed to agree that life, up to the present, had ranged from "average" to "rough." No one felt that it had been "easy" and most "leaves" felt that it had been more "rough" than "average." At the same time, both groups seemed to be hoping that the future would become easier (Question 4). The optimism of the "leaves" on this question appears to be contradicted by their responses to every other question dealing with this issue.

On Question 5, twice as many "stays" as "leaves" predicted death by old age which is, of course, in keeping with their higher predicted lifespans. However, this result did not reach the required level for statistical significance. It must be thought of as only suggestive since N was too small to result in significance even though the obtained proportion is indicative of a strong trend.

When it came to expectations regarding their children's lives (Question 6), all men felt (or hoped) that things would be better for their children in the future. There was still a slight trend, however for "stays" to feel, even more than "leaves," that their children's lives would be a great deal better than their own.

There did not seem to be a clearly analyzable trend in the answers given to Question 7 regarding major turning points in the past. However, it can be noted that more than twice as many "stays" made some reference to their job history.

The groups seemed to differ again in their prediction of a major turning point in their *future* (Question 8). The "stays" were more likely to cite a future turning point that represented a specific goal involving personal effort on their own part. The obtained chi square was significant well beyond the one percent level of confidence. (It should be noted that the response, "getting married" was not rated as a specific achievement. It was not felt that this represented an achievement involving great effort on the part of the subject. Since this response appeared only twice among "leaves" and once among "stays", scoring it would not have changed the obtained intergroup difference appreciably.)

No differences appeared in terms of how the men rated themselves on an adult-to-old-age scale (Question 9). The very slight trend among "stays" to identify themselves as older probably reflect the fact that they were in fact chronologically older than the "leave" group.

Question 10 again revealed strong trends which, however, failed to reach the required level for statistical significance. "Stays" were found to be more optimistic and plan-oriented, while "leaves" tended to be drifting into an even more helpless and pessimistic frame of mind. Again, however, because of the small numbers involved, this trend can only be thought of as strongly suggestive.

DISCUSSION

The results seem to indicate some clear differences between "leaves" and "stays" with respect to future time perspective. Successful employees predicted significantly longer lifespans for themselves. An examination of responses to the first two questions disclosed the somewhat surprising finding that four of the "leaves" predicted only ten or fewer "good years" (although they were actually younger than the "stays") left in their lives. In addition, two "leaves" predicted that they would be dead before age thirty. These responses, it should be emphasized, were made within the context of an intensive one-to-one interview, and not delivered as casual or "flip" comments. One can imagine the impact this expectation must have on every aspect of their lives. Is it any wonder that we find these young men setting fewer, less specific, and shorter-range goals?

The fact that "leaves" were found to be significantly younger than "stays" (mean age 27.3 vs. mean age 34.4 years) does not detract from the future time perspective findings. Chances of finding the obtained results should have been substantially reduced because of these age differences. Instead, we find that younger men see less ahead for themselves than older men. This suggestion that men over thirty may be better employees brings to mind Cleckley's (1941) observation regarding the tendency of psychopathic personalities to "burn themselves out" after age thirty. This specific age also seemed to represent an important

milestone in the minds of at least some of the "leaves." Two men in this group made explicit predictions that they would be dead before thirty.

One might also wonder how much of a self-fulfilling prophecy is reflected in the short lifespans which unsuccessful employees assign to themselves. The interviewer was impressed by the amount of inner rage present, especially in those men who foresaw death within a few years. In a group session, one of the men had to be restrained from attacking another member over a very minor issue. It is not difficult to imagine this person creating for himself many situations in which death may be imminent. The possibility of overt self-destructive behavior is worth pondering. Attack that invites formidable counter-attack may have a concealed self-destructive component. But as Hendin (1969) has recently suggested, young lower-class Negroes may also have a heightened vulnerability to direct suicidal attempts. Once beyond the early years of adulthood, the period of peak suicidal risk seems to be over.

It would, therefore, not be surprising to find some degree of reality reflected in the predictions of an early demise made by a number of the "leaves." Perhaps, then, those who "make it" over thirty do represent a different group, since living beyond this landmark may mean that certain changes and adjustments have been made. It would be valuable to learn under what conditions a person is most likely to make or fail to make these adjustments and what, precisely, these adjustments entail.

The relatively limited future extension demonstrated by the "leaves" implies that an ego deficiency in time binding, or the ability to bind tension, may characterize this group. As mentioned previously, Werner (1957) proposed that a direct relationship exists between time perspective and time binding in that the person who is bound in the present or the immediate future cannot conceptualize the possibility of postponing present gratification in anticipation of future gains. Retirement, owning one's home, seeing one's children grown and happy, promotions, etc., are empty words which simply have no relevance. Thus, the immediate pleasures—the camaraderie of the local bar or the luxury of a few more hours of sleep in the morning—are much more relevant

and meaningful experiences. Life has been dismal in the past and likely will not improve in the future. There is no way in which one can see his own efforts as substantially influencing the course of events for the better. Thus, one grasps the pleasures offered by the moment.

It remains for subsequent research to elucidate the basis of this hypothetical ego deficiency that seems to be manifested by limited future extension and *SLE*. A few possibilities might be noted here:

1. Insecurity during infancy and early childhood years forced the "failures-to-be" to become totally occupied with immediate experience. It required great effort simply to survive physically and psychologically; developing a concern for futurity would have been a luxury under those circumstances (or, perhaps, an unadaptive attempt at escape).

2. As a child and adolescent, the "leave" did not *learn* to use futurity as a tool for organizing his thoughts, impulses, and actions. Perhaps he lacked adequate social models from whom future-oriented modes of functioning could be learned. This interpretation is not completely independent of the previous one, but it does suggest a different level for analysis and pre- or inter-vention. It is not out of the question that one could learn to use psychological futurity, given appropriate opportunities.

3. Perception of his status as a person who has very limited access to the "good life" as defined by our society in general could be the most direct "cause" of foreshortened extension and *SLE*. It is not so much that the individual is unable to think ahead. Rather, he "decides" at some point early in his life that the future is *not worth* thinking about. Danger, frustration, humiliation and risk loom as more salient prospects than do fulfillment, achievement, etc. Again, this interpretation has something in common with those previously mentioned. But the emphasis would be upon the individual's response to the fairly realistic prospect of a barren future, rather than upon severe deficits in his own personal resources.

4. He actually does not want to live out a full life-span. Fron his perception of what becomes of people within his world who grow old, he may see nothing ahead but accumulated misery and degradation. "Life for the sake of life" may not seem to be a relevant sentiment. Implied in this interpretation is the possibility that reduction in *SLE* may be the most important factor in the total picture of future constriction. Basically, the "leave" neither expects nor desires a long life, and this orientation pervades many of his other thoughts and actions.

Finally, one is struck by the "premature oldness" of the future time perspective displayed by the "leaves." They see fewer good years ahead, and perceive death as closer. Is this a previously unrecognized form of precocious "disengagement"? (Cumming and Henry, 1961) Is it more properly regarded as a chronic depressive state? Or is it a passive "waiting for the end—and perhaps bringing the end a little closer" such as one sometimes observes with geriatric patients? Kastenbaum (1968, 1969) has proposed that the syndrome of "psychological aging" is *learned* and *developed,* rather than simply acquired as a side-effect of inevitable organic changes. It is further proposed that the old age syndrome could be *experimentally* induced in people who themselves are young in chronological age. Perhaps one of the implications in the present study is that our society serves as a "natural" pre-aging chamber for some of its more disadvantaged citizens.

SUMMARY AND CONCLUSIONS

Major consistent differences in subjective life expectancy and extensiveness of future time perspective were found between successful and unsuccessful employees who had participated in a project attempting to readjust the chronically unemployed to a new work situation. Employees who failed to stay on the job were found to have shorter lifespan predictions and fewer specific future goals than a group of successful employees. They also tended to be more pessimistic. These findings were discussed in terms of their relevance to several different theoretical perspectives on early development, as well as to the phenemonon of premature psychological aging.

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A CROSS-CULTURAL VIEW OF WIDOWHOOD

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THROUGHOUT man's span on earth he has been beset by numerous problems. Some have been unique to certain groups of people at specific times and places. Other problems are universal to all mankind throughout time and have been met and dealt with in some manner by the different societies of the world. Death is one such universal problem that, by its very mystery and finality, arouses deep feelings of despair and fear in all people. Cultural customs and rituals surrounding aspects of death are elaborate, dramatic and divergent. They represent man's varied ways of attempting to give meaning to the incomprehensible, to assuage fear, and to give solace and emotional catharsis to the living. Death involves broken personal and social relationships that are a part of the total of social organization. Therefore, most societies, in an effort to regain social equilibrium as quickly as possible, have established rules regarding the conduct of these closely associated with the deceased as well as for the society as a whole. The amount of this structure and regulation is not constant for all peoples. Sociologically it seems to be most important to non-technological groups in which there is much interdependence on a person-to-person basis. On an individual psychological level it is probably very important to all.

THE WIDOWED

The world over, widowed persons have been especially subject to many institutional controls. These are quite often as clearly stated as those controls governing the marriage in the first place, for marriage in whatever form it exists, is a union in which at least a segment of a society has a vested interest (Bernard, 1956). Of course, in its most basic aspect, it exists to meet biological needs

in an orderly manner and to assure care and enculturation of children. Beyond this, marriage exists in order to strengthen the central organizing forces of an aggregate of people. Thus, the actual choice of the martial partner is often based on some of the following considerations: to cement alliances between families, tribes and nations; for religious solidarity; and for economic advantage. The proscriptions and prescriptions to which the widowed person is subjected thus vary primarily in accordance with the society's view of the fundamental "raison d'être" of the marriage, as well as in accordance with the group's ideas of the causality of death, and the religious beliefs. Controls usually specify conduct for the period of mourning. They also may forbid a future remarriage, or at the other extreme end of the continuum, they may make remarriage mandatory and prescribe the partner (Bernard).

While the widower has his share of difficulties in adjustment to loss, it seems that in most cultures the widow has a far more difficult time in establishing a meaningful existence. She is usually subject to many more regulatory controls than a man. For this reason, and, also, because widows outnumber widowers throughout the world, this paper will be principally concerned with the widow's bereavement and her problems in reorganizing her life.

THE WIDOW

Bereavement

Bereavement is an integral part of the loss of a loved one. This is a universal three-part reaction of the species that is made up of shock, grief and readjustment (Keesing, 1962). Although the reaction is the same to all persons, the way in which it is handled and the time span vary enormously from culture to culture. The widow, as previously noted, usually has a more specific procedure to follow, for she is frequently seen as being more vulnerable to evil forces or to assault from the ghost of the departed if appropriate precautions are not taken (Howells, 1962). Bereavement and mourning customs seem to function as society's effort to protect itself, to alleviate shock, and to comfort and distract (Becker and Hill, 1955). It is a means by which the living psychologically detach themselves from the dead. Because of the intensity of the emotions involved, the rituals and customs always represent

unusual behavior. Almost universally a special mourning attire is required. Anger is a frequent component of bereavement and is often given expression in rituals (Bowlby, 1961). Cutting the hair and self-mutilation are other common symbolic cultural responses to the pain of bereavement. Mourning will be discussed in more detail further on in relationship to Western widows.

Role Loss

Widowhood always represents a sudden loss of a major institutional role for the woman (Clark and Anderson, 1967). Intertwined with this is the loss of an intimate relationship, sexual gratification, and very often economic uncertainty. The woman must learn to adapt at once to a new set of roles, which adds to the psychological stress of the death event. The age at which widowhood occurs has some bearing upon special problems faced by a widow, though the basic problem of role loss is the same for all. In the United States, widowhood commonly occurs to older women, and to them in greater numbers than to men. In underdeveloped countries where life is hard and medical care inadequate, a woman may experience widowhood while very young. In this instance, though, there may be a nearly equal number of widowers due to the same reasons, which is advantageous where remarriage is an allowable solution to widowhood.

Opposition to Remarriage

Opposition to remarriage of widows, though, is quite common in a number of cultures. Paradoxically, a widowed man is usually free to marry and often encouraged by public opinion to do so. This discontinuity probably arises from the role differences that have existed for the two sexes and from the patrilineal type of social organization that has been predominant in the world (Simmons, 1945). In the West, denial of remarriage to widows stemmed from teachings of the early Christian Church which held that a woman remained forever attached to her first husband. Remarriage was viewed as disrespectful to the deceased and even as a form of adultery (Habenstein and Lamers, 1955). Though this view is not supported to any extent in the Western world today, some other cultures still uphold forms of that tradition. Economically, remarriage may be opposed since a woman often

inherits property rights from her deceased husband that his family wishes to retain under their control.

WIDOWHOOD IN NON-WESTERN CULTURES

Detailed information on the sociopsychological aspects of widowhood and bereavement in non-western cultures is extremely sparse. Ethnographers have tended to treat this subject superficially with only descriptions of outward behavior and attire. However, I have found accounts of four societies—India, China, Manus, and Trobriand Islanders—which give enough material to be useful in viewing divergent solutions to the problem of widowhood, and for comparison to the widow's position in the United States.

India

In the East most marriages end with the death of a spouse rather than in divorce. Of the major Eastern societies, India is notable for its large number of widowed women, 19,000,000 at present, and for the extreme degradation in which they live out their lives (Mace and Mace, 1960). The lot of these women has been bleak,largely due to Hindu religious beliefs and the fact that India has a strong patrilineal social organization in which women are devalued. For almost 2,000 years the Hindu religion has decreed that a widow shall not remarry, although a widower is urged to remarry as soon as possible. This would be problematic at best. However, it is worsened by another Hindu custom in which girls are frequently betrothed while still infants or small children to a much older boy or even to a man. With the age differential and the death rate in India, it is not uncommon for a girl to become a widow before the marriage is even consummated. The rule of no remarriage for a widow has applied to these child brides as well as to adult women. In an overpopulated country with a staggering birth rate, this prohibition of marriage to a large number of women may serve the society functionally, but it is not helpful on an individual level.

Through history the life of a widow in India has been dismal. She can stay with her husband's family, but she is regarded as the menial of all the other persons in the household and the worst tasks are reserved for her (O'Malley, 1941). She is allowed

one meal a day. Often her head is shaved. She cannot attend ceremonies of rejoicing as her presence is considered a bad omen. If she has had a son, she maintains a slightly improved position in the household. If not, she is completely cut-off from the mainstream of family life and from life's pleasures. Many widows eventually drift back to their own families or live an austere existence at a place of pilgrimage such as Brindaban. The Indian widow in a sense spends the balance of her life in mourning.

At least a part of the rationale for the dehumanizing treatment of widows lies in the Hindu belief that in some mysterious way the husband's death has resulted from sins the wife committed in a past life. The widow herself tends to accept this as a valid belief and does not question her life of self-sacrifice. Through self-immolation she feels she will contribute to the deceased husband's spiritual welfare and win a place for herself in the next world at his side. This serves as an excellent example of the power of basic cultural beliefs that are imparted to, and accepted by, each generation of a society as unquestionable truths.

In much of the Eastern world suicide has been an acceptable response to widowhood. It is conceived as an expression of great devotion to the deceased, and reaches its most dramatic ritualization as the Indian suttee. This is the practice whereby the widow mounts the funeral pyre to be burned beside her dead husband. This was considered to be a supreme act of faith and spiritual devotion and, though there were some reluctant devotees of this solution to widowhood, most were said to have gone willingly to the fire. (Social pressure seems to have exerted quite an influence on the widow to take this step.) Reports suggest these public rituals were accompanied by all the excitement and fervor of the "Christians versus the Lions." The British banned the suttee in 1829, but as with most traditions of religious origin, it could not be stamped out in one blow, and it continued to be practiced surreptitiously into the twentieth century (Mace and Mace). For the most part, the Indian widow no longer undergoes physical death with her husband, but she does undergo a type of social death due to her poor status in the society.

Social reformers since the ninteenth century have been cognizant of the plight of the Indian widow and have attempted to alleviate some of the problems. The Widow's Remarriage Reform

Act was passed in the latter part of that century. It was thus legal for a widow to remarry, but again, religious convictions are slow to give way and remarriage is still not common and almost never occurs in the upper castes (Blunt, 1931). For example, in 1948, the ages of the approximate 19 million widows ranged from 8 years to 54 years with the average age being 20 years. Sixteen percent of these widows had had no married life as such, and fourteen percent had lived with their husbands less than one year (Mace and Mace).

One option that is theoretically open to Indian widows from both the religious and civil laws points of view is that of marrying the late husband's younger brother. This is known as the *levirate* and has been a popular practice in a number of cultures since biblical times. It has the advantage for a patrilineal group of keeping the wife, her children and her property in the husband's family. However this has not been a popular practice in India except among the Khasas and Coorgs (Hsu, 1963). If a widow does choose to marry other than her husband's brother, she must give up her children to her late husband's family, for the children are considered to belong only to the father's blood line.

Modern India is undergoing change with both increased education and job opportunities. Along with this, the government is making an active effort to train widows for social service, or gainful employment in such fields as teaching, nursing, secretarial work, administration, and politics. This is proving very helpful in giving the widow some expressive outlet and in liberating her from a life of humiliation. It also appears that opposition to remarriage is breaking down to some extent among better educated Indians (Kapadia 1966).

China

The Chinese, like the Indians, have traditionally prohibited remarriage of widows, and they also hold the view that the widow is somehow responsible for the death of her spouse. At this point the two cultures philosophically diverge, and the Chinese widow has not had to endure harsh social treatment. In fact, she has been venerated to a certain degree, and monuments to loyal widows, who remain faithful to their husbands, are seen throughout China (Hsu). The original marriage placed a mutual obligation upon

the husband's family and their daughter-in law which was not removed by the death of the husband. This acted to preserve the integrity of family life. The widow and her children had some degree of security and the extended family had the widow's domestic services and retained all the family property rights.

Among the very poor in China, economic considerations many times took precedence over the social ideal. The husband's family could not support the widow, and thus she would look for a new marriage partner. Traditionally, Chinese men have tended to reject marriage to a widow unless they themselves were quite poor. In this event they might be unable to arrange the "bride-price" for a virgin and would of necessity marry a widow since the latter went for bargain prices. Such an arrangement would not occur among the wealthy, and as in India, a widow that re-married lost her children and her property rights to her deceased husband's family.

Traditions, whether they derive from religious or philosophical beliefs, tend to resist change through the years. However, the political upheaval that took place in China in 1949 did bring about rapid social reform. The Communist regime took over and implemented a number of laws affecting widows. Among them were the following: Widows are allowed to remarry, but they cannot under any circumstances be sold, and in remarriage the custody of the children is now based on what is deemed to be in their best interest, rather than having them go unquestionably to the paternal family. A widow also now retains her property rights (Yang, 1959). It would seem that the modern Chinese widow has gained in certain aspects of human rights, although family solidarity and security may be adversely affected.

Both India and China are extremely large countries with somewhat heterogeneous populations in which widows have rather anomalous positions in relation to the organization of the rest of the society. For contrast, widowhood in two small homogenous societies will be considered.

Manus of New Guinea

The Manus of New Guinea are a patrilineal society in which the fate of the widow is governed largely by magical beliefs and economic considerations. The widowed Manus woman will almost

certainly eventually remarry. There are no taboos associated with this, and women do not outnumber men and are needed as helpmates. It is furthermore considered most desirable for a man to be married in this culture. Therefore, widows find themselves eagerly sought after. The only stipulation made is that a widow must observe a four-month waiting period after her husband's death. Specifically, four menstrual periods must pass. This is to assure that she is not pregnant by her first husband when she remarries (Fortune, 1935). During the interim between marriages, a widow remains with her first husband's family and works for them. The family usually tries to forestall a remarriage as long as possible so as to retain her services.

There is an element of risk involved in remarriage, for the Manus believe that the ghosts of dead husbands are very jealous and vengeful and will attempt to inflict illness upon the wife and her new husband (ghosts seem to practice a certain amount of discrimination for they are not vengeful toward widowed men). The fear of the ghost, however is not sufficiently strong to prevent a widow's remarriage. The accepted cultural solution is for the couple to elope to another village, thus eluding the wrathful ghost. As in other patrilineal groups, a widow that remarries must relinquish her children to the paternal family since they are perceived as being only of the father's lineage.

Trobriand Islands

The Trobriand Islanders maintain a matrilineal social organization in which women occupy a more prestigious position than in the societies previously discussed. They also provide a highly structured role for the widow to fulfill during her bereavement which seems to serve as an effective emotional release. During the several days of the funeral rites, the widow is required to mourn ostentatiously and dramatically (Service, 1963). She must shave her head and howl loudly with grief. After this she enters a small cage built into her home, and remains in the dark for a period of six months to two years, depending upon the rank of her deceased husband. This is to keep the husband's ghost from finding her. Kinsmen are with her at all times. Once the period of mourning is terminated, she is ceremonially washed and dressed in a gaily decorated grass skirt. She is then considered to be immediately

available for remarriage. Women in this culture are an economic asset to a man, as they control material goods through the matrilineal descent system. Thus remarriage is most likely.

To the Western mind, Trobriand customs regarding the widow may seem strange and primitive, but actually they probably provide a mentally healthy situation. The widow has the comfort and security of a highly structured period of mourning in which she knows exactly what response society expects of her. She is given a socially accepted way to express grief openly. Though she has lost one role, she is supplied with another very formal role to play out for a definite period of time. She then can look forward to assuming a role of wife again with the approval of her kinsmen and peers.

WESTERN NATIONS

Of the conjugal pair in the United States, the woman is most apt to be left alone through the death of the spouse. Medical care has increased the life expectancy of both sexes in this country, but the woman's has been increased by four more years than the man's. The fact that in the United States men tend to marry women younger than themselves adds to the likelihood of the woman being the surviving partner. The most common age for a woman in the United States to experience widowhood is between 57 and 68 years.

At present there are an estimated 10,225,000 older women (over 65) in the United States and of that number, 54.4 percent are widowed. Of the 7,931,000 older men, only 19.5 percent are widowers, and if they remarry they again tend to choose younger women (U.S. Dept. HEW, 1966). Clearly this indicates that many older women, once widowed, will remain so the remainder of their lives. In gerontological work it should be an area of concern to help these women find and fulfill new and meaningful roles at a time in life when this type of adjustment is probably most difficult. However, gerontological literature of Western societies contains a surprisingly small number of references to the sociopsychological problems of the widowed person. This seems strange given the percentage of older widows and the generally introspective nature we have adapted toward social problems. Perhaps, as suggested by Clark (1968), problems associated with

death are culturally repellent to the laity, as well as to the social scientist, so that they are glossed over or ignored. Some writers, such as Cumming and Henry (1961), discuss the subject briefly, but do not see widowhood as problematical for the majority of middle-class older women. They claim these women have a ready-made peer group of other widows which they happily join. These groups are alleged to be so socially desirable that they arouse pangs of envy in some married women. Cumming and Henry also view widowhood in the United States as an honored state in which the woman retains her husband's prestige. I have not found much support among other writers for the "merry widow" syndrome to which they allude. Whatever validity there may be to it, it would seem to be somewhat dependent upon the age of the widow, for until age seventy widows are still a minority when compared to older married couples. By age seventy-five, seventy percent of women are widows (Koller, 1968). Apparently widows in that age-range can dominate the social scene by force of numbers, but one wonders how much the physical and mental decrements of their age may preclude much activity.

Psychosocial and Sociomedical Aspects

Studies done by Blau (1967) of older widows in New York State show that, for the majority, widowhood definitely has an adverse effect on friendships. There is a loss of contact with some friends and a change of the quality of relationships with others. This can be quite traumatic, for the aging person needs stable friendships: the aging widow doubly so.

There are other indications, also, that all is not bliss for the older widowed person. Among both sexes there is a higher incidence of suicide and mental illness and a shorter life expectancy than among married persons of the same age (Bernard). The high risk period for suicide is from six weeks to six months after loss of the spouse (Blachly, 1969). Mental and physical illnesses, too, are most apt to have their inception during the second stage of mourning. This is a period of intense grief that produces both great physical and mental stress. The older person's body cannot physiologically respond successfully to this stress nearly so well as can a younger person's. Parkes (1967) did several studies in London that are relevant. One showed that three-fourths of older

widows usually require medical help during the first six months following the death of the spouse. It is interesting that this study also showed that the type of illness the widows demonstrated was different for different age groups. Those wodows under sixty-five suffered mainly psychologically, and their consumption of sedatives increased seven-fold during the year and one-half following their loss. In contrast, widows over sixty-five manifested physical conditions. The most frequent were ulcerative colitis, rheumatoid arthritis, and asthma. These women did not increase their intake of sedatives. Parkes (1964) also studied psychiatric patients in a London hospital. He determined that the number of patients whose illness followed the loss of a spouse was six times greater than expected. Women over forty were preponderant among the bereaved mentally ill.

As noted, the second state of bereavement is painful and precarious, and must be worked through in order to reintegrate the self. However, Gorer (1964) claims that many widows over fifty remain in the second stage, never returning to a normal expression of life. Assuming the role of martyr and chronic complainer is not uncommon among older widows.

Psychologically during this second stage all of the individual's response systems are still focused upon the lost love object. The desire to recover the deceased spouse, and the knowledge that the loss is irretrievable, results in anxiety, frustration, despair and anger (Bowlby, 1969). A disorganization of personality is always present. This may be especially acute for the aging widow, for she has lost not only companionship, but a crucial long-standing life role of wife. This comes at a period in her life cycle when age may be already causing self doubt and a feeling of uselessness. Marriage represents a unit of interesting roles and relationships from which a woman derives much of her self-concept. Death of the husband can be a devastating blow to the self-image, and this according to Caven (1968) is the crux of the problem of readjustment. Normally with time, a reorganization of the self will take place and the widow will establish new inter-personal relationships, new interests, and new goals. Unfortunately, the aged are prone to suffer from abnomral prolongation of grief, melancholia, or inhibition of grief to the point of developing somatic symptoms (Bowlby, 1969). Western culture has no clearly defined

time length for mourning which may contribute to the cause of the widow clinging to her grief. Parkes (1967) found it sometimes beneficial to indicate to the bereaved widow that it is normal to show grief, but that this should not be interminable and that there is definitely a time to stop. An interesting note to the subject of mourning is that it can sometimes occur before the death of the spouse. This is a phenomenon seen in Western society where the aged frequently go through a long and torturous terminal illness. Mourning may take place when it is perceived that the spouse will never recover. When the actual death does occur, there is a sense of relief.

Havighurst and Albrecht (1953) consider loss of a spouse to be such a common experience among the aged that they include dealing with this eventuality as one of the developmental tasks of old age. However, Solomon (1969) takes the view that, "whether or not a task is developmental depends upon whether or not the individual has been conditioned by his culture to expect the event, and if so there should be learned behavior and environmental supports that assist the accomplishment of the task. If not, it will come as an unexpected blow and will be treated as an 'accidental hazard'."

If one accepts this definition, then it would not seem appropriate to include death of a spouse as a developmental task in Western culture. We appear to be getting further and further away from providing structure and support for the bereaved. Anthropologist Geoffrey Gorer laments this, saying that mourning in the West has been deritualized, and that there is no socially sanctioned release for grief. This causes the bereaved to hold his feelings within, which results in adverse reactions. He notes that the Orthodox Jews, Irish Catholics, and the Church of Scotland are the only Western groups still maintaining highly ritualized burial and mourning procedures. Gorer claims that these people adapt well to the loss of a loved one.

Aside from the stress naturally inherent in the grief experience, there are other matters of a more objective nature that complicate widowhood. Economic crisis is frequent. The husband's death may eliminate a portion or all of the income. Despite insurance and social security, it is often not possible for a non-working widow to maintain the same standard of living she previously

had. Since the major causes of death among older people are associated with lengthy and costly medical and hospital care, even once adequate savings can be depleted during the husband's final illness. If the older woman is not prepared by previous experience to assume sudden management of financial affairs, she can easily lose whatever security she had through the machinations of "con-artists."

For a widow in good health and with a marketable skill, a job might be an advantageous solution to several problems. It could help her economically and socially, as well as aid her in establishing a new self-image. However, there is not a great demand for older women workers in most fields of endeavor. Unskilled women or women with obsolete skills that wish to obtain work training are, of course, in a less enviable position. The Manpower Development and Training Act does have provision for training a very limited number of persons over the age of forty-five (Belbin and Belbin, 1968). Business and technology divisions of various colleges offer courses in commercial skills.

Loneliness and the need to love and be loved are multifarious issues which are mentioned in a number of reports on the older widow (Streib and Thompson, 1960). Financial strata, social class, health, personality type, and proximity of family and friends all exert influences on the degree of loneliness experienced. Some loneliness probably stems from the non-supportive nature of our society toward widows and from the fact that American social life is geared to couples. When a woman does not fit into the conventional one-man-to-one-woman arrangement due to her loss of spouse, she may suddenly find herself excluded from many social affairs. A partial reason for this may be our society's general uncertainty as to how to deal with the whole topic of widowhood. Therefore, the social situation is ignored or avoided. Also, there may be a tendency by married women to view a widow as a possible competitor for their husband's affections.

Feelings of loneliness are to some extent dependent upon housing arrangements and availability of family and friends. A much higher percentage of widows live alone than do widowers (Tunstull, 1966). Living alone does not unequivocably indicate loneliness, but it does increase chances of social isolation for many women. However, an active, healthy woman with many friends

and adequate transportation may be quite content to live alone after an initial period of adjustment. Townsend's studies (1957) showed that most widows felt lonely at first, but that this gradually subsided if affectionate family and friends were frequently present. Lowenthal and Haven (1968) published research results showing that in the aging population, widowed persons who had confidants had higher morale and life satisfaction despite living alone, than married women without confidants. The indication here is that an intimate and emotionally supportive relationship with someone is the crucial element for any aging person.

Some widows attempt to solve loneliness and housing by living with their children. This is often a delicate situation that may create more problems than it solves. Children, consciously or subconsciously, convey the message to their aging parent that she is in a subservient position and a burden. Obviously this is a devastating blow to the widow's self-esteem. Also, if living with children means that the widow must uproot herself and move to another city away from friends, it may be ill-advised.

Another possible solution to the loneliness and housing dilemma for a certain segment of financially solvent widows is the retirement community. Leisure World in Laguna Hills has a population of approximately 12,000. They have no records as to the exact numbers of unmarried men and women, but their operations officer, Mr. Hal Jones, estimates that there are about ten marriages a year between persons who met while living there. He stated that an unmarried woman can have an active social life as there are many clubs, classes, hobbies, and sports going on at all times. However, he added that he found a reluctance on the part of single women to attend dances or "couples" activities, even though they are permitted to do so.

At the other end of the social and financial scale is the widow living alone for whom even bus fare to activities or to visit friends may pose an insurmountable obstacle to social contact. Their loneliness is apt to be acute and difficult to remedy in current social organization.

In a study of widows done by Clark and Anderson most older widows claimed they felt restricted in their social life. There were many places they did not feel they could enjoy going unescorted. Most said they would like a man for a platonic rather

than for a sexual relationship. Very few in this study had been able to find a gentleman friend.

With regard to the pursuit of the elusive male, Champagne (1964) has written a very practical book concerning widowhood. In it she includes several chapters on how to meet men and establish whatever type relationship may be desired. Her main thesis is that if a widow wants to meet men, she must arrange to be where there are some. For instance, if she decides to take extension courses, then real estate and public speaking courses will undoubtedly have more men enrolled than home economics courses. The same applies if the widow decides to work. Being a saleswoman in a men's store will afford more opportunities than in ladies ready-to-wear. Champagne recommends volunteer work at political headquarters as excellent hunting grounds for the older widow. She advises avoiding cruise ships and resort hotels since both usually abound with single women.

How much of a problem loss of the sexual relationship is to the aging widow is not really clear at this point. Research is not abundant and contains much conflicting information. Kinsey *et al.*'s work (1953) showed most women become less inhibited and develop increased interest in sexual relations with age and maintain this interest into their sixties. Along the same line, a Duke University research group found that both men and women who maintained good health and had available partners were sexually active into their nineties (Solomon). The "good health" stipulation undoubtedly eliminates the majority from sexual enjoyment at that age. Conflicting data came from Peterson's studies (1969) at Laguna Hills. He found a high loss of sexual contact among older married persons. The degree of loss was directly related to the number of years married. Despite this it is probably safe to assume that a number of older widows do have a strong sexual urge which is not easily sublimated through flower arranging and volunteer work.

In the United States we have no cultural prohibitions against remarriage of a widow as long as a "suitable" length of time has elapsed (Bohannan, 1963). However, as previously mentioned, remarriage is not likely. Probability decreases sharply from age forty-five onward (Bernard). However, when remarriage does occur it is apt to be as successful or more successful than the first

marriage (Champagne). Remarriage usually involves a change in social grouping, and there also may be stresses in the form of disapproving children. Another pitfall is the possibility of the deceased spouse becoming so deified in memory that he becomes a rival to the second spouse. Awareness of these possible problem areas can minimize their impact. However, the widow considering remarriage should contemplate it carefully to make certain that she does not choose an unsuitable mate in an effort to avoid loneliness and recreate the past.

CONCLUSION

In all cultures widowhood involves a break in family structure and other social relationships, as well as a crisis in self-identity for the remaining spouse. The resultant social disequilibrium is dealt with in a variety of ways throughout the world. A cross-cultural view of a problem common to humanity can be especially helpful to those persons working in social services. The work of the social scientist involves contacts with people of varied cultural or subcultural backgrounds. It is important to realize that responses to stressful human situations such as death must be understood in the cultural context in which they appear. Cross-cultural studies point to the interrelatness of the response to other facets of the social structure. We need increased understanding of these interrelations in dealing with human problems.

Whether the societal solution to widowhood serves the individual functionally and offers an opportunity for self-fulfillment is dependent upon a number of variables within the culture. These include such forces as economic and technological development, religious and magical beliefs, status of women, ratio of men to women, structural patterns of family relationships, and housing patterns.

In non-Western cultures widows tend to receive better treatment in matrilineal societies where women enjoy more rights and higher rank than in patrilineal societies (Simmons, 1947). However, all the non-Western socities examined do seem to offer a more structured ritualized role for the widow than is found in the United States. This gives a certain degree of security to the individual and probably aids in favorable adjustment to the loss of a loved one. Even though the status of the Indian widow

seems deplorable, she nevertheless has a religious and philosophical view point that make it possible for her to accept loneliness and lowered status more tolerably than the Western widow. A strong extended family structure is common in non-Western civilizations which serve to preserve family continuity and offer material protection to the widow and her children. She usually has a useful function to continue to fulfill within the family.

In contrast the United States widow has little ritual or structured societal support to guide her. She occupies a rather anomolous position in which she and the society are equally uncertain as to what her response to the loss should be. She is generally older than her non-Western counterpart and the decrements of age, both physically and mentally, make the adjustment to loss more problematic than for a younger person. For the aging American widow remarriage is unlikely, jobs are scarce, and family and social life is often restricted.

Despite the statistical likelihood that the majority of older married United States women will have to face widowhood, few make any realistic plans for it, and so it comes many times as an overwhelming blow, emotionally, as well as from a material standpoint. This occurs in spite of the "rehearsal for widowhood" that is evident in a substantial number of women—over half of one sample of women in their twenties and thirties—indicating this anticipatory role behavior (Kalish in press). These women are a challenge to geriatic workers as they need help and counseling in strengthening their independence, autonomy, and self-concept.

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WAITING FOR WEDNESDAY

I've done with Wednesday,
Wednesday is finished; along
with all the rest of all the Tuesdays,
Mondays and next come
the Fridays and Thursdays
to be done with
One on one after the other.
Petals plucked from daisy weeks
I love thee
I love thee not
Ending always
I love thee not.
Now is Thursday.

Editor's Note

When a person selects death as the major focus of a publication he edits, he must be able to remain flexible in the kind of materials he includes. To be restricted solely to academic articles would be to deny the affective reality that is death. We are pleased to be able to publish materials such as that which follows, since we feel that poetry and introspection have much to offer students of death and suicide. The opening poem was written by Rip Hansen just prior to entering the hospital for surgery. The materials here were brought together into a small booklet by Mr. Hansen's widow, and they have been republished through her cooperation.

AUTHOR RIP HANSEN DIES AT 53[1]

Robert P. (Rip) Hansen, well-known author and Cal Poly lecturer, died early this morning in a [local] hospital.

He was 53.

Hansen underwent surgery last week. He suffered a setback Monday and was unable to recover from a second operation that day.

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[1]Reprinted with permission from the *San Luis Obispo County Telegram-Tribune*, Dec. 3, 1969.

A resident of Arroyo Grande for 12 years, Hansen was the author of numerous short stories, mysteries, novels and television plays.

His novel, "Rites of Summer," was nominated for a Pulitzer Prize in 1961. His latest work, "A Glimpse of Canaan," was published two years ago.

Hansen had been a creative writing lecturer at Cal Poly since 1963, and before that taught adult school classes in San Luis Obispo. A former newspaperman, he had been on the staffs of the Nassau (N.Y.) Daily Star and the Los Angeles Independent. Hansen worked during the summer of 1965 for the Telegram-Tribune and submitted occasional pieces to this newspaper since then.

He was a member of the Screenwriters Guild and the Authors League and, between 1951 and 1953, wrote movie scripts for North American Aviation, several of which won awards.

He was born on Feb. 5, 1916, in Hempstead, Lond Island, crewed aboard sailing vessels as a young man, and began his writing career early.

A World War II glider pilot, Hansen participated in the invasion of Holland. After the war, he had resided in Vermont before moving his family to Southern California.

Survivors include the widow, Helen; two sons, Peter and Erik; a daughter, Kristin, and mother, Mrs. Robert Hansen, Sr., all of Arroyo Grande, and a brother, Clayton, of Santa Monica.

According to Hansen's wishes, the family announced that there will be no funeral service.

The family has requested that donations to a fund for Arroyo Grande Valley Boys League, in which Hansen was active as a coach, be sent to Mid-State Bank in Arroyo Grande.

WAITING FOR WEDNESDAY

A Journal

By Robert P. (Rip) Hansen

Monday, Nov. 24, 1969

The cliche operates here: "a nightmarish quality"—but nothing outlandish, garish, brutal or beyond reason, nothing that does not follow logically and in good credible sequence. It is all en-

tirely believable, just as in the case of the finest nightmare. But of course from the nightmare there is the safe waking moment and if not then, in a brief time, reality is imposed and the premise of the dream destroyed—or at least it is thrust back to its secret corner of the mind where it burrows away out of all ken until it finds its opening again in dream and for awhile prevails absolutely.

But this, now, today, my prevailing moments passing, past, and coming on, are not to be shaken by any imposition of other reality. *They are*. There is no way to shake the premise of this living succession of logical acts piling neatly, properly, one on the other toward a time ordained last Thursday by telephone from the Danish Modern office, the long clean walnut plank desk, his medical tomes in serried, similar cover color sequence on the logical shelves, soft secure carpeting and the luxurious black pleated leather chairs, subdued light. His one hand made quick neat notes in a memo pad and his other held the phone. Small hands, tan, silky black hairs on the backs of the fingers, short shaped nails. A surgeon's hands, although I would not have guessed this for it seemed the fingers were too short. But watching them and being terribly aware of who and what he was, I could believe them and gave them the qualities that I believed they must possess to belong to the surgeon who, yesterday, with these very hands, had played golf with my friend, the dentist.

The two of them in the best tradition of American medical men playing that American game of Wednesday golf at the country club, had discussed me, I learned the next day, and the surgeon had told the dentist that he thought there might be enough room, if, indeed, he did have about six inches of bowel above the rectum to leave me in a normal state after the operation—said this to the dentist as with these hands that now made notes and held a telephone, he had gripped a golf club and made long straight drives, according to the dentist, and made careful chip shots and putted very well.

Very deliberate, the dentist told me, "takes his time and he's strong. You wouldn't think that because he's so small, but he's damn strong and in great shape. Takes care of himself y'know. Top shape like an athlete and y'know, you stop and think of it and that's what a good surgeon's got to be. Got to perform. Steady. Gotta be steady and strong. And he is. You can depend on that.

You can depend on him. I'd depend on him. I would. I had to have anybody cut on me, I'd take him.

"One of those intense little guys y'know that can concentrate and loves his work, was always tops in his class. The best. He is. He's the best you can get around here, this county, the state? Maybe anyplace, yes sir. A Jew y'know. Boston I think. Plays a helluva game of golf, too."

The dentist was a talkative man, like a barber and maybe there is a kind of connection there what with a similar kind of chair they use and the way the patient or customer is mostly at their mercy; it's hard to disagree with a dentist or a barber when he's working on you. Or when you're talking to a doctor. Listening to a doctor, how do you disagree? Listen. You simply listen to a doctor.

Listen to him order into the telephone a time and the place and the conditions and the people he wanted—only a fugitive trace of a Boston accent. As though he never really had one strong inimitable, like, say, the Massachusetts Kennedys, or else he had worked to attain the noninimitableness of the Californian, had tried to blend by lack of distinctive sound into the liberated sameness of the West Coast man.

But he had come not quite far enough for the sensibilities of the dentist—still a highly recognizable Okie—who could call the surgeon a Jew and guess accurately that he was from Boston. This Boston Jew held (with delicate fingers that apparently were long enough) the phone to his ear and ordered the apogee of my nightmare for the next Wednesday.

It was the logical thing to have done, the next inevitable move in a reasonable series of actions since the other doctor had performed his proctoscopy and from his viewing end of the stainless steel table saw at the electric-lit end, my end within my end, inserted up there within the bowel, exploring, something, saw what he said was "something." "Yes, there is something here," he said, and had with biopsy tool snipped a piece of something and that very moment, dreading, I knew that this was the start of it, the recognizable start of what had unrecognized evolved and grown within me fibrously, "a tumor," he said when I had been lowered from my absurdly ignominious position on his examining table—for God's sake, with head down and my ass in the air,

kneeling head down and held against the angled table, helpless there as he explored with light-tipped periscope tube of sleek steel into my recently enema-ed bowel.

I knew. I would not believe but I know and suspected and tried to recall how and when I had known before coming here to subject myself like this, but I could not.

I could only think that I had known before he told me that it was not just some trival thing. But no matter, because this moment had become, this was, the starting place, the premise for what had then logically to occur. The nightmare—with this premise.

No logic to the premise. There is logic only when the premise is accepted. Then a procedure is made from there. *Then,* logic. All logic then and deliberately reasoned events, coming inexorably one on the other. Now it is all clean logical step following medical step toward the time on Wednesday.

And as I say, there is no logic at all to what has been given to me as the premise for this. It is brain-consuming to try to think any logic into the absolute presence of the growing fibrous patch upon the smooth muscled sheath of lower bowel, this tumor growing, thrusting long filament roots out into flesh, mushroom growth within the stinking convulsive dark (dark as a barrel of assholes, they say; dark as the inside of a cow). What logic selected this bowel? Mine? One out of three? It that right? Isn't this what the voice on TV says as it sells health insurance? The voice: "You say it couldn't be me. You say these things do not happen to me but to someone else. Not to me. But one out of three American homes are . . ."

The voice is talking about cancer. I am inescapably by some mystery lottery selected as one out of three; my American home has been chosen to fulfill the statistic.

But there is logic. Honest logic. Truly.

Here is the logic. Simple irreversible logic. It is simply the fact of being. I am. I do not know why I am. But here I am.

Not knowing this is excuse enough for not knowing why.

I am one out of three, why the fibrous thing chose the interior of my bowel. Absurd logic. Yes.

But I am. It is. We are presently within the tediously careful charm of other logic that carries me toward Wednesday morning

and what the surgeon's hands, directly by the clean logic of his mind and supported by his strong and steady capabilities—like a fine athlete making quick conditioned responses—will do, those hands that will do to me logically what logically must be done.

There is no saving myself from this. I am its prisoner. I can only attempt, with what I hazily and mostly in an intuitive way understand as my sense of life, to deal with my imprisonment and my captors. We are in a powerful sense antagonists.

I know they will attempt to save my life. This is their righteous end. But it is their means that threaten me.

Within this absurdity, trapped here, I am helpless except in the way I am still able, perhaps, to deal with myself. I am long past dealing with them; they are in command and will act upon me. But I may still have the capacity to decide how much of myself I will expose. I need to preserve as much as possible of the man I must once more become when this is finished. I am a product. I want to control as much as possible the kind of product that will emerge from here. I will not, I will resist becoming a result, a complete product of the bad logic that is taking me along toward Wednesday and the hands of the surgeon.

Antagonists?

Partners?

Both. For we are brothers on our way together toward an end that is pure tragedy. Just as I am acted upon, so is he, for he is as mortal is I; he is as bewildered by the sheer fact of being as I and both of us attempt to repair one another, to give hope to one another in the midst of this absurdity, he with the skill of his hands and his eye and brain, fighting back the inevitable tragedy —even with the hope that he will one day triumph over it—and I as whatever artist I am, attempting to suggest to all who will listen to me that man possesses a vast quantity of hidden greatness and we must find it and use it on our way through this absurdity—and perhaps even triumph over the tragedy that waits within all experience.

Monday, Nov. 24, 1969

On my right an old man; on my left a young man.

The old man I have seen before in Arroyo Grande. I have never known his name but I've noticed him at Little League and Babe

Ruth ball games. He is an ugly old man, hairless and pink and he walks with his head twisted grotesquely to one side and down. He is here because he has fallen and hurt his side.

He told the nurse he is 77 years old.

When I came to this ward this morning, he was in bed behind thick glasses sucking at a cigar. He could not see me. The cigar was in an amber holder circled by a thick gold ring and he sucked at it and moved it and rubbed it about his mouth like a child would a pacifier or sugar tit.

He also smokes a pipe and seems to take as much pleasure from sucking and gumming the stem as he does actually smoking. He smokes one cigarette a day, in the morning, an "eye opener," he says, and that's all. Started to smoke, he told an aide, when he was 16. He told the young man who cleans the floor that cigarettes are "deadly poison."

He has emphysema. He cracked a rib in his last fall. He has double hernias and hardening of the arteries and arthritis and a helluva good appetite and although I believed when I first saw him in his bed that he was a dying man, I now understand that he is an indomitable old coot, very much alive and alert and as keen as many a young man I've known.

His range is limited, as I suppose it must be for an old man, to sports and simplistic and emotional views of politics. But he's pretty well informed on baseball and football and track, enough anyhow, to be ahead of me and the young man who is a college football player and wrestler. The old man is sharper in his way than the young man. First of all he understands who he is in relation to those around him and in a humorous way he is humble; he knows how to kid himself. I believe he knows how younger people see him and what their initial reactions are and so he disarms them with his candor.

He is out of his bed this morning and is using a walker, moving painfully on arthritic legs that seem nothing more than straight up and down bone, devoid of muscle, knobbed at knees and ankles. He is smoking his cigar. He is grotesque. This is the only word—bald and pink and almost blind and skinny and twisted and as he pushes along and out into the hall he says, "Look out for the old Gila monster."

Yesterday, he told the young Mexican janitor that old people like himself ought to be "taken out and shot. I used to be a pretty good man," he said, "but now I'm nothing but trouble."

"I bet you used to be pretty good with the women, eh pop?" And the janitor grinned over at the young man.

But the young man was having gas pains and was entirely to himself.

"Yeah I bet," said the janitor. "I can just see you, man, in the old days. Bigtime Charlie with the women."

"I was a good dancer," the old man said, speaking in the way the blind do, not looking at the young janitor, speaking into the distance toward the wall. "The old style foxtrot and waltz. I was a good waltzer."

"Waltzin' those gals around, eh pop?"

"Nothing like that now-a-days. The new style these days. Twist and all the rest. Entirely different. I wish we danced like that in the old days."

"Lots of belly rubbin' in the old style dancing," the janitor said. "Up tight against an' rub bellies." Again he failed to catch the attention of the college football player whose preoccupation was the gas which he was attempting to pass. The janitor wet-mopped his way out the door and left and for a little while the old man continued to talk as though he were still there. And this he would do again and again as nurses and aides and orderlies walked away from him, leaving him talking into space, on and on until finally he would sense that no one was listening and he would trail off vaguely and with indeterminate gesture and stare, squinting behind the lenses that were like the bottoms of 7-Up bottles, and then he would duck his head to the right and down almost to his chest muttering a little before he fell silent in that position and would seem to doze.

But he was seldom asleep. He would raise up and address some kind of statement and question in the general direction of whatever sound or motion he identified as belonging to the close presence of another person, and if there was no response he would return to his chin down somnolent position.

He could be turned on and off by a simple reply or even a grunt in answer to what he said.

Curious as a child. Eager to communicate. Like a small chirping bird, a marmoset of a man, monkeylike, birdlike attention to whatever comes within his spectrum and then he will hang on and hang on until he feels he is alone again. Alone. Lonesome within his small arc of sound and sight, a tiny, shriveled pink babylike dome and cheek and toothless shrunken chin, grotesque, a mind isolated but with antenna out testing for contact, testing, feeling, ever seeking out for attention.

Tuesday, Nov. 25, 1969

The young man is gone. He left this afternoon. He wished me good luck. He meant it. I think he felt sorry for me and I know he was glad to be out of this hospital and on his way to the health clinic at the college where he will finish his recuperation along with young people in another atmosphere that is not charged and shot through with tragedy. He was here with the old man, who is a tragic figure and a reminder to anyone with sensibilities of what mere humanness can do to us, and I was here to remind him that one does not have to be ancient to be touched, to be selected as the "one out of three." He did not, naturally enough, want to be reminded.

He had brushed against this and he wanted to be shut out of it and away into his proper atmosphere, insulated from the reality of this place. Which is not to put him down or to comment on his youth because we all of us insulate ourselves against the realities of this place; we do not want to be reminded.

It must be painful for my children to be thrust into close awareness of human fragility like this. Certainly they can find no reasons for this fragility, no conditions that they, upon becoming aware, could avoid and thus save themselves.

And so the young man wanted nothing more than to take his young invincible strength away into the secure company of other young invincibles.

Unhappily, my children cannot escape this thing of me and what is happening to me. I so regret this because it seems such an unnecessary pain to inflict upon them.

But the old man is something else where I am concerned. He knows of course that he cannot escape the way the college football player did. There is no escape for him, only a respite, an

interval that he can come close to measuring before the final tragedy of himself. So he has a different attitude toward me. He can identify with what is happening and what will happen tomorrow to me.

He attempts to cheer me.

"They will give you poached eggs tomorrow night," he told me. And I said I thought that perhaps it would not be until the next day that I would be treated to such luxury—or maybe even a day or two later. But no. "Eggs," he said. "Poached or boiled. Protein to rebuild your strength." He insisted it would be eggs for me "and meat on the second day. Chicken or veal. Something delicate and easy to digest. Protein. You'll need protein."

He has powerful hopes for me, I know, and strong confidence.

Tuesday, Nov. 25, 1969

I have been able all day long not to think about what will happen Wednesday, except in little passing intervals.

Kris brought me a potted plant. She came in with Terry this afternoon and the dog Rufus had eaten some of the blossoms. We all sat and talked and laughed and it was a pleasant visit without thinking specifically of why they had come. Kris is able to think of this in her young and, I think, frightened way because she doesn't want anything to happen to me. She loves me.

So then I thought about tomorrow in those terms, in terms of the love of all of my children and Helen. This was a good way to think of it and I have briefly, and with more comfort than I could have done without them.

Then Helen and Pete and Erik brought another plant for me. It is significant that these are growing plants and they intend to plant them at home and for all of us to watch them grow.

There was so much love present and a little pain in Helen's eyes when she left. She has had to go through this business twice before and here we are again. She will be here tomorrow morning and will hurt more than I do and when I think of this, I think of the time in Vermont when it was she who was hurt and sick and I was waiting for her. I've tried to write about those hours in Vermont and I'll have to go back and look at that copy.

All this, the last pages, are not what I wanted to write here. I wanted to catch something else and I don't think I have. It is so

elusive and it has to do with fears and love and absurdity and logic and a sense of life and continuity. I think I catch it best not by talking about it, that is, telling about it, but by showing it in scene, trying to catch it in narrative and dialogue and focus rather than in exposition or essay or journal. I do best with the fictional form but it's so hard to develop an illusion of this reality that will truly be the reality.

MY WEDNESDAY WAITS[2]

By Mel Gauntz

". . . It is all entirely believable, just as in the case of the finest nightmare. But of course, from the nightmare there is the safe waking moment and if not then, in a brief time, reality is imposed and the premise of the dream destroyed.

"But this, now, today, my prevailing moments passing, past, and coming on, are not to be shaken by any imposition of other reality. They are. There is no way to shake the premise of this living succession of logical acts piling neatly, properly, one on the other toward a time ordained (when the doctor) held, with delicate fingers that apparently were long enough, the phone to his ear and ordered the apogee of my nightmare for the next Wednesday. . . ."

Those are a few of the last words written by author Rip Hansen from a hospital bed while he waited for the operations from which he would not recover.

Rip did not survive what he called the final "absurdity," but it is obvious from reading those pages he wrote before the first operation that Rip did prevail.

Rip knew he was going to die, the words say, and in those last pages several times he seems to allude in an amazingly prophetic way to the end that was to come in that click-clack quiet that flows in from the dark shiny hallways of all hospitals.

". . . There is no saving myself from this. I am its prisoner," he wrote. ". . . I know they will attempt to save my life. This is their righteous end. But it is their means that threaten me."

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[2]Reprinted with permission from the *San Luis Obispo County Telegram-Tribune*, Dec. 9, 1969.

Time and again it comes back in those last pages.

". . . Within this absurdity, trapped here, I am helpless except in the way I am still able, perhaps, to deal with myself."

And again, of his surgeon, whom he admired, Rip writes:

". . . Antagonists? Partners? Both. For we are brothers on our way together toward an end that is pure tragedy."

I sat in Rip's tiny office—his writing room—late one night last week and read his journal.

His old-fashioned chair was too high for me, but then Rip was a much bigger man. A clam shell full of pennies sat in front of me—right next to some letters Rip won't answer, two cigars he won't smoke, and surrounded by books he won't read. And a clock on the desk that has stopped.

I never knew Rip saved pennies, and he was a friend of mine. He probably didn't know that I save pennies, too.

So I read his pages and remembered my friend who collected pennies but didn't have time to get around to mentioning it.

In addition to being my friend, Rip Hansen was a writer, a teacher and a newspaperman too good for newspapers.

He also was a sailor who sailed instead of steered, a combat glider pilot, an athlete, a pretty fair country beer drinker, a lover of words and books, dogs and cats and all sorts of people, including kids, a father who treated his like real people and the lover of a lady from Kentucky who spells courage with four letters. Rip was also the worst bluffer in the history of poker.

A big man with a big house and a big poker table that is necessary for someone with so many friends, Rip somehow confused winning at poker with being a bad host.

And no one ever accused Rip of being a bad host.

He played as if he thought it somehow inhospitable for the host to drop out of a hand just because he held lousy cards. Of course, you knowing this, he'd snooker you good those times when his cards were actually better than they appeared.

So I sat in the late-night stillness of his writing room and read his words and remembered my friend.

"All this, the last pages," he wrote in his final entry, "are not what I wanted to write here. I wanted to catch something else and I don't think I have. It is so elusive and it has to do with fear and love and absurdity and logic and a sense of life and continu-

ity. I think I catch it best not by talking about it, that is, telling about it, but by showing it in scene, trying to catch it in narrative and dialogue and focus rather than in exposition or essay or journal. I do best with the fictional form but it's so hard to develop an illusion of this reality that will truly be the reality. . . ."

When the phone rings at three o'clock in the morning you know what it means; but you answer it anyway.

It was "Doc"—another of Rip's friends. (In addition to doctors, there also were newspapermen, students, old codgers, kids, their folks, and even a dentist he described in his journal as a "highly recognizable Okie.")

The worst that could happen had.

Rip Hansen died last Wednesday in that 2 a.m. click-clack hospital quiet.

Before he died, Doc said, Rip instructed Helen: "Tell Mel I want him to write my obit."

Doc's voice sneaks out of the telephone line into the dark kitchen and clutches your throat so that you can't answer and you weep in the face of "this reality that will truly be the reality."

And I wrote my friend's obituary. The most terrible thing a newspaperman can be asked to do. But the nicest thing a newspaperman can ask a friend to do for him.

I wrote about his writing, about jobs and accolades, a Pullitzer Prize nomination, a career, a war record, a family. But obits are for libraries and files and records. Frozen and lost within the hack formula are the real people, the warm realities of the writer and the written.

So I sat in his little office and read his journal and remembered a friend.

And wondered who, when come my Wednesday, will write my obituary. Because the worst bluffer in the history of poker had snookered me again: I wanted him to do it.

Newspapermen can't resist writing about their friends, but Rip said it for me on the last page of his last pages: "I wanted to catch something else and I don't think I have."

Except that he did.

The apogee of Rip's nightmare is past; my Wednesday waits.

HANSEN'S DEATH WAS 'ACCIDENTAL'[3]

Cal Poly lecturer and author Robert P. (Rip) Hansen died in [a local hospital] last month as a result of an enema mistakenly administered by an orderly, a corner's jury ruled Thursday.

The jury decided, however, that the orderly had not been negligent when he gave the enema to the wrong patient.

The inquest verdict said death was caused by heart failure brought on by peritonitis which resulted from the accidental treatment. The enema actually was ordered for another patient in another room.

Hansen, 53, died Dec. 3 following surgery at [a local hospital], where he was recovering from an earlier operation for cancer of the abdominal tract.

According to medical testimony presented at the hearing, the patient had been in excellent postoperative condition until he was given an enema by a hospital orderly.

Dr. Robert Karger, who performed the surgery on Hansen, testified that death resulted from generalized peritonitis caused when sutures in the intestine were pulled apart, apparently because of the introduction of water into the intestinal tract.

This allowed bacteria to escape and infect the abdominal cavity to such an extent that countermeasures to combat it failed.

The jury's verdict Thursday said that death resulted from "heart failure due to generalized peritonitis and said failure was accidentally induced."

The jury had been presented with an alternative verdict which would have ruled that death had resulted from negligence—either ordinary or criminal—on the part of [the orderly].

Krager testified that his operation apparently had been successful but on the day after the enema had been administered, Hansen showed every symptom of internal infection. An instrumental examination of the intestinal tract proved that the sutures had, indeed, been pulled apart.

His only alternative then, Karger said, was to perform a colostomy and stop further drainage into the lower tract and lessen the infection seeping from the point of the break.

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[3]Reprinted with permission from the *San Luis Obispo County Telegram-Tribune,* Jan. 16, 1970.

The second operation was futile, however, because of the bacterial invasion of the abdominal cavity which caused a gradual degeneration in the functions of the various organs, the surgeon testified. This degeneration finally led to heart failure.

The nurse on duty at the time the "accidental" enema was given testified she had directed [the orderly]—in a written order—to administer an enema to a patient named Wilson, not Hansen. Wilson was in another room in the same ward.

[The orderly] admitted giving the enema to Hansen.

He said that when the nurse, Mrs. Diane C. Colson, confronted him subsequently with the written order he still held bearing Wilson's name, he said:

"I gave the wrong patient an enema. How could I have done that?"

[The orderly] said he did not check the order after it was given him nor did he check the wrist band on Hansen to make certain he was treating the right person. He said it was hospital policy to do so only when the orderly or other employe did not know the patient.

Dr. Karger's testimony that Hansen was recovering from the first surgery was backed up by that of Dr. Marie Barrows, a pathologist who performed the autopsy on Hansen. She said about three-quarters of the round intestine had healed but the remainder had been pulled apart.

She admitted under questioning by some jurors that the pressure from an enema could have induced the sutures to part.

Thomas Phillips, a Cal Poly student who was Hansen's roommate at the time the enema was given, testified Hansen expressed "opposition" to the administration of the enema, although he could not remember his exact words.

He quoted Hansen as saying: "What are you doing . . . am I supposed to have that?" when [the orderly] informed him what he intended to do.

A postmortem examination showed that the operation had been successful and that all cancerous tissue had been removed in the original surgery.

BOOK REVIEWS

Petrie, Asenath. *Individuality in Pain and Suffering*. Chicago: University of Chicago Press, 1967, pp. 153. (No price indicated).

This book presents a theory of perceptual reactance concerning the modulation of sensory experience. According to Asenath Petrie, there are three types of persons distinguishable from one another in their ways of processing their experience of the sensory environment. The "reducer" tends to subjectively decrease what is perceived, the "augmenter" to increase what is perceived, and the "moderate" to do neither. Augmenters make up about 10 percent of the population and reducers make up about the same percentage.

A series of clinical and laboratory studies are presented in which subjects estimate the size of various standardized stimulus objects and are then presented with one of several pain-inducing stimuli. Subjects who had increased the size estimates often are those with a high pain tolerance, and those who had decreased the size estimates are often those with a low tolerance for pain. Alcoholics tend to be augmenters. Juvenile delinquents and schizophrenics tend to be reducers. A dearth of reducers is found among subjects deaf since birth. Considerable detail is devoted to the techniques for distinguishing between augmenters, reducers, and moderates.

Although of interest, particularly because the research sheds light on some characteristics which may have side implications concerning patterns of adjustment to life situations, a number of issues and questions are raised that the research *as conducted* cannot answer. For example, while it is contended that a person's reaction to pain is only part of the individuality of his response to the total sensory environment, the data pertain solely to pain and suffering. Consequently, the extent to which different modes of perceptual reactance generalize to other dimensions of sensory experience is yet unknown. Moreover, Petri is not reticent to dis-

claim a culture/personality interpretating of her findings. (Perhaps, this prejudice accounts for her failure to (1) present tables showing responsiveness to pain by personal and social characteristics of respondents and (2) to integrate the findings with the literature on the sociology of pain and illness.) Instead, it is claimed that the results suggest a neurological/physiological basis for variations in the tolerance for pain. Because the investigatory techniques are solely phenomenal (experiential), there is no empirical evidence either to validate or to invalidate this assumption. However, if this claim is intuitively correct, by Petries' own admission, this work has only peripheral relevance for the behavioral scientist.

Stephen Spitzer, Ph.D.
University of Minnesota

Black Suicide by Herbert Hendin, Basic Books, Inc., 1969, 176 pages, $5.95.

Black Suicide is an interesting example of social psychiatry, in the tradition of Kardiner and Oversey's *Mark of Oppression.* Although most people have assumed that the black suicide rate is lower than the white rate, Hendin shows that in New York City, among males of age 20 to 35, the black rate is significantly higher than the white. Having identified suicide as a problem for young urban blacks, Hendin attempts to gain some understanding of the way the black experience, particularly the lower class black experience, impinges on the suicidal individual. By intensive psychiatric interviews of 25 blacks who were hospitalized after suicide attempts, Hendin arrives at many interesting insights. A common element in most of the case histories of younger blacks is the severe rejection and neglect of the patient by his mother during his childhood. Exposure to violence in the home, and a tendency to be violent toward others also characterizes these individuals. He discusses several cases of homosexuals in an attempt to illustrate the way in which the pressures of the black family can operate to handicap the male and cause him to hate his race, his sex, and himself. There are separate chapters on the female, the older male, and the adolescent who attempt suicide.

One of the most suggestive findings challenges the Henry and Short hypothesis of an inverse relationship between suicide and homocide. These patients are filled with rage and experience violent impulses toward specific others as well as toward themselves. The psychiatrist feels it would be impossible to predict whether these individuals would be more likely to commit homocide or suicide.

Roberta G. Simmons, Ph.D.
University of Minnesota

COMMENT

INTEREST in the issues and problems that death raises continues to grow in the United States. Over the past few months professional groups, newspaper columnists, radio personalties and television programs, as well as voluntary associations among the public, have addressed themselves to the general topic of death, grief and bereavement. Notable among these was the Eighth Annual Symposium of the International Academy of Law and Science, which was held in Clearwater, Florida, February 5th through the 11th. It chose as its theme for the entire week, "Matters of Life and Death." Among the stimulating papers presented were: "Legal Determination of Death," by Alfred Halpern and Stanley Wolder; "Medical Experimentation and Who's to Stop the Life Machine," by George Balla and Virginia Ann Church; "Come Now Sweet Death," by Albert S. Davis; "The Law and the Right to Grief," by Edgar Jackson; "Suicide Prevention as a Contribution to the Re-evaluation of Human Life," by Edward Ringel. The papers and reports of this important symposium will be available for distribution. Persons interested in obtaining a copy of the proceedings may contact the program chairman: Virginia Ann Church, 932 South Myrtle Avenue, Clearwater, Florida, U.S.A.

On May 22nd and 23rd, a symposium entitled, *Death and the Child,* was held at the University of Minnesota under the auspices of the Center for Thanatological Studies.

An audience of upwards of 150 professional and pre-professional persons heard a panel of distinguished speakers discuss death as it concerns the child.

The Friday afternoon session consisted of the presentation of four papers followed by a question and answer period. In the evening a major address by William Lamers, Jr., M.D., ended the first day's session.

On Saturday morning five different workshops were conducted by the Friday speakers. The summation address was given by Dr. Edgar Jackson.

A major theme in the Friday paper of Dr. Hella Moller, Child Psychologist, Arlington, Massachusetts, was the pervasiveness of children's concern with death. Using case histories to illustrate her

points, Dr. Moller emphasized that all children are curious about death but, depending upon their age, they are able to absorb only so much of death's reality. Very young children are convinced that death is not irreversible and are puzzled by a permanent absence; they are also unable to conceive of their own deaths. Children learn only slowly that they will die and have as a result many questions about what happens to a person after death. Dr. Moller insisted that parents should deal honestly with a child's questions about death and added that the parent should be guided by the child's own questions as to his level of understanding. Dr. Moller outlined the general capabilities of children in different age groups and cautioned that the child should not be pushed in a discussion of death beyond his intellectual and emotional capacity.

Dr. Carl Malmquist, Child Psychiatrist, University of Minnesota, concurred with Dr. Moller that honesty and the child's comfort were essential elements in dealing not only with the average child's questions about death but also in clinically treating children who are experiencing problems over a particular death. It is important, he said, to encourage a child to talk about death because this is an integral part of normal grief work. On the other hand, it is a mistake to push a child in his confrontation with death until he is ready and trusting enough to do so on his own. What is needed now, Dr. Malmquist felt, is a far-reaching, long-range study of as many children as possible who have experienced a death. In this way, a normal pattern of accommodation may be described. At present, most studies of so-called pathological grief reactions are based on institutional or referral populations of children whose problems are severe enough and obvious enough to merit professional attention. A more general sample would permit more reliable statements to be made with regard to what is in fact a normal or abnormal grief reaction.

A parent's as well as a professional's viewpoint was presented by Mrs. Delphie Fredlund, University of Minnesota Public Health Nursing Department. In a poignant personal story she related the experiences of her children to three deaths within their immediate family. One son was convinced that the glass of lemonade he had fixed his grandmother on the night she died was the cause of her death. He experienced great personal torment

for many years until he was able to talk to his mother about his feelings. Mrs. Fredlund subsequently conducted a study of middle class parents in Boston, examining their needs and abilities with respect to handling children's questions about death. She found that their needs were great but their abilities limited—despite the high level of education of the parents. Many parents in her study were at a loss as to how best to tell their children about death and expressed concern over the lack of public guidance in this sensitive area.

Complimenting Mrs. Fredlund's paper was Dr. Albert Cain's research conducted at the University of Michigan. He and his colleagues have studied numerous cases of pathological reaction to death. They have found that severe over-identification with the deceased, age and anniversary reactions as well as other pathological reactions afflict those who do not have the proper environment or opportunity to mourn. In one case of over-identification he cited, the bereaved child affected not only the manners and personality of his deceased father, but also incorporated him so realistically into his own being that he suffered intense pain and the other disease symptoms that had been experienced by the father. Such a reaction as this, Cain reported, may be experienced at all times by the bereaved or it may occur only at specific times such as on the anniversary of the death, or when the child reaches the age at which the deceased died.

Dr. William Lamers, Child Psychiatrist, Ross Clinic, San Francisco, picked up this theme in his after dinner speech and talking in an anecdotal and informal manner related personal instances as well as case histories of such grief reactions.

In his summary address, Dr. Edgar Jackson, Psychologist, Royalton, Vermont, related the general problems a child has with death to the larger social problems that presently afflict our country. He speculated that the current campus riots and demonstrations may well reflect an attitude among the young that life as well as death is both meaningless and absurd. He called upon the audience to address themselves more conscientiously to these issues with the intent to promote a needed program of death education.

One such program as Dr. Jackson called for in his address was held June 23rd through July 1st at the University of Maryland,

College Park, Maryland. Dr. Daniel Leviton of the Department of Health Education and Mrs. Stella Spear, R.N., conducted a symposium entitled, "Death Education and Suicide Prevention."

The purpose of the symposium was to examine the subject matter of death with the idea of 1) establishing the need for an understanding of one's eventual death as a legitimate concern of health education, 2) pointing out the possibilities of research in the field, and 3) recognizing the need for intervention and counseling when people are faced with crises of personal death, bereavement and suicidal intent. The speakers included: Dr. Frank S. Caprio, Dr. Jacques Choron, Dr. Calvin Frederick, Dr. Robert Fulton, Dr. Edgar Jackson, Mr. John Jagodinski, Dr. Warren R. Johnson, Dr. Daniel Leviton, Dr. Seymour Perlin, Dr. E. Lakin Phillips, Mr. Howard C. Raether, and Dr. Robert Yanowitch.

Robert Fulton
Center for Thanatological Studies
University of Minnesota

ANNOUNCEMENTS

OMEGA has not considered taking a stand on some of the more controversial issues involving death, dying, and suicide, but we hope to provide space for intelligent articles and, upon occasion, intelligent polemics on such matters as the meaning of contemporary funerary practices, the right of a person to die or to commit suicide, the potential future value of cryogenics, and so forth. At this point, now that we have seemingly copped out from having any convictions at all, we want to mention that the Euthanasia Educational Fund, Inc., has published a brief booklet entitled "The Right to Die with Dignity." There is no charge for the booklet, available through their offices at 250 West 57th Street, New York 10019, but a contribution is encouraged.

There is a constant risk in a publication of this sort that the editors, the authors, and the readers come to form a small in-group, well-known to each other and totally unknown to anyone else. The disproportionate number of articles from California reflects the simple fact that the editor is in a better position to remind these people that OMEGA exists and that their contributions are welcome. Everyone's contribution is extremely welcome. We are eager for submissions from anywhere in the world; indeed, we are eager to become in fact what we claim to be in theory: an international journal.

* * * *

At UCLA's School of Public Health, anthropologist David K. Reynolds and psychologist Richard A. Kalish are studying death and bereavement in a cross-ethnic context. As part of their research, and also as a community service, they have held two one-day conferences. The first focussed on death and bereavement in the Mexican-American community, and the second was directed to the Japanese-American community. Participants were primarily representatives from the appropriate ethnic community, including physicians, social workers, nurses, funeral directors, students, nursing home directors, and so forth. A final conference concerned with Black Americans will be held later in the year. It is the hope of the project's directors to meet again with these people at the completion of the study, so that the results and insights can be

communicated to, and evaluated by, these individuals. (This project is supported by NIMH grant MH 16537, under the auspices of the Center for Studies of Suicide Prevention).

* * * *

The Proceedings of the IVth International Conference for Suicide Prevention, held in 1967, are still available. The volume, in soft cover, consists of all the papers presented at the Conference, covering topics on certification of suicide, research in suicide, theoretical explorations, and so forth. Copies may be ordered through Dr. Norman L. Farberow, International Association for Suicide Prevention, 2521 West Pico Boulevard, Los Angeles, California 90006. The cost is $4.95, plus $0.25, for handling, if within the United States, and $0.35 for handling outside the United States. If you order one or more copies, please print or type your name, street address, and other necessary information with your order.

* * * *

The Center for Studies of Suicide Prevention, NIMH, is sponsoring three programs that might interest OMEGA readers: (1) a Winter Institute of Suicidology in Los Angeles, January 25 through February 5, 1971, in conjunction with the Los Angeles Suicide Prevention Center; (2) a series of ten-week study programs in Washington, D.C.; and (3) one-year fellowships in suicidology. The Center has stipends available for the second and third of these programs. Please contact Elmer F. Bertsch, Coordinator of Training Programs in Suicidology, NIMH, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015, for further information. Or telephone Mr. Bertsch at (301) 657-2944.

CONTRIBUTORS

Robert P. (Rip) Hansen was a journalist, living in San Luis Obispo, California.

Robert Kastenbaum wrote his first article on death for Herman Feifel's THE MEANING OF DEATH. Since then, he has written too many others to count.

David Lester, following his Ph.D. in psychology from Brandeis and a brief stint teaching at Wellesley, became research director for the Suicide Prevention and Crisis Service, Buffalo.

Gene Lester, the distaff side of David, is on the faculty at the State University College of New York at Buffalo.

Jean Mathison is one of the legions of mothers-who-returned-to-school-after. She has her bachelor's degree in anthropology, and has just completed her Master of Public Health degree at UCLA, with special focus upon social gerontology.

Kenshiro Ohara is a psychiatrist at the Jikei University School of Medicine in Tokyo who has a long-standing interest in suicide.

David K. Reynolds is a recent Ph.D. in Anthropology from UCLA who is project director of their School of Public Health study of death and bereavement in a cross-ethnic context.

John Teahan received his doctorate in psychology at Michigan State University. He is now on the faculty of the Department of Psychology, Wayne State University.

Douglas K. White is in the doctoral program in anthropology at the University of Michigan, where he recently completed his master's degree. His article was written as the result of his experiences as Resident Director for Students Affairs in the pilot program of the College of Literature, Science and the Arts.

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COMMENT

Our commentator this issue is David K. Reynolds, an anthropologist now teaching and directing a research project at the UCLA School of Public Health. His paper, "A Position Paper—A Credo," was not written initially for publication; rather it evolved because of his own desire to bring together his personal thoughts as to why research on death and bereavement is important. Specifically, the precipitating factor for this paper was the demand by more militant students, especially students from some of the ethnic communities, to justify expenditure of time, energy, and money for research on such a topic as ethnic aspects of death and bereavement, when this effort could be chaneled into providing services directly to the ethnic communities. Almost everyone doing research today has met with similar challenges. We feel that Dr. Reynolds has done a fine job of explaining the importance of death-related research and of research in general, as well as making a statement regarding the responsibilities of the research investigator to the communities and individuals he studies.

A POSITION PAPER—A CREDO

David K. Reynolds

UCLA School of Public Health

This paper concerns itself with my personal justification for the work I am doing. In it I say nothing of whether or not such justification would be acceptable to granting agencies, to the informants who share their insight and experience with me, or to the questioning students who motivated me into making my position explicit. If what follows makes sense to others, I am pleased, but I am not engaged in proselyting.

I study death, dying and bereavement. I seek to learn how people face death—their own and others' deaths. I believe that our awareness that you and I will someday die affects the way we live and die. Why is it important to know about this? Let me try to explain.

There are strategies for trying to help mankind. One major sort of strategy involves changing his environment. It includes action against pollution, hunger, overpopulation. It seeks to obtain legislation (or power) that will protect men from each other. It aims at clothing and sheltering the needy, providing proper medical care and job opportunities. Such strategy is useful, I think, and important. And I will concede that there are some secondary effects from this sort of "community action" in terms of changed attitudes, morality, and humanistic goals.

There is another strategy, however, one with a very long and respected history that has been undervalued in recent times. It aims at understanding man and changing him from the inside. It contends that no matter how one improves man's environment, if he is frightened and selfish and hate-filled, there will always be exploitation and discontent, and the need for new laws to plug new loopholes.

My interests, my ultimate hope for man, lie in this second strategy. I fully realize that it is difficult to change the inner man when his body is hungry (difficult mind you, not impossible). And I do not seek to invoke my strategy in lieu of community action. On the other hand, I ask that my strategy be given its chance to work as well. How, specifically?

I think that most men for most of their lives are frightened of death. I think that fear motivates them to avoid the topic of death, to accumulate property (and, perhaps, to accumulate people) as a buffer against death, and to elevate any person or profession that seems to demonstrate some control over death (as the medical profession is elevated currently, and the clergy not so long ago). I believe the fear of death produces much direct and indirect suffering for mankind.

But there are ways of reducing that suffering. There are people of many cultural backgrounds who have come to accept their imminent death; people who have individually and collectively developed ways of minimizing the grief of a survivor; people who are dying nobly, freely, even gratefully. I know this; I have seen it; I am studying it. Personally, this has been a richly significant task.

I believe it is not enough simply for a researcher to accumulate knowledge and experience for himself. He has the further re-

sponsibility of communicating what he has learned. He must be an educator as well. But what he has to teach must be firmly grounded in what he knows. He must collect information painstakingly, carefully crosschecking it against his knowledge and experience so that he can provide his source and level of confidence as well as the facts and their interpretation. Good research is work, as anyone who has done it knows well.

In my research, my task of educating begins during the period of community fieldwork. As I interview people and as I talk with them informally, I ask questions that serve not only to provide me with data but questions that cause my informants to see their job, their world, in new ways. I notice things that they have long grown accustomed to and forgotten. I ask "Why?" a lot and wonder aloud about alternatives. My informants are learning, too. I believe my presence at Keiro Nursing Care Facility, the V.A. death wards, and Fukui Mortuary has already had some small but positive influence on the quality of care provided.

There is also a cathartic value in offering people a chance to talk about death, about how others' deaths have been meaningful and how their own can be made so. It is not infrequently that people thank *me* for talking with them—for listening, for understanding, and, sometimes, for comforting.

Communicating what I've learned continues in the all-day conferences for each ethnic group sponsored by our project. It continues in lectures in various places to a wide variety of audiences including my students at U.C.L.A.

And it finds printed form in scholarly and "popular" articles and books. We have ethnic research assistants on the project not only to help gather and interpret information but also to help disseminate what we learn back to the communities, translated into useful forms of both strategies—both for changing the environment (e.g., what are the special needs of grieving Chicanos at L. A. County General Hospital?) and the inner self (e.g., what psychological price must an elderly Issei pay for controlling her expression of emotion at her husband's funeral? How does she achieve her calm acceptance of death?).

Of course, I won't knowingly communicate anything that would be harmful to the communities in which I study—either during my interviews or in my publications or lectures. Why

should I? These people are my friends. There is much to learn about dying—for their sake, for humanity, for myself.

As for money, I am fairly well paid for my work. I don't object to that; money is useful. I could get more money for less meaningful endeavors outside the University (or so I am told). If necessary, I would do the same project for lower wages, but the salary I receive is one reward that society offers to insure that men will be willing to undergo the long training that enables them to learn in reasonably efficient, creative ways.

Finally, some will ask why I, and not a Japanese–American or Chicano or Black, am directing the project. First, from the ethnic communities' standpoint, I think they will benefit more by cooperating with a person who has an appreciation for their culture and who has their interests at heart whatever his skin color than by making ethnicity the prime criterion for cooperation. We all know some Japanese–Americans who have no stake or interest in their ethnic group—the same is true of some Blacks and some Chicanos. I think it's not how a guy looks but "where his head and heart are" that really matters. And from the standpoint of mankind—and this *is* a project studying *man,* not a single ethnic group—we are better off investing research money in persons who are well trained and care about what comes out of their research than in anyone else. I *know* where I'm at. Frankly, there aren't many people with training or the desire or the vision to work in this research area.

Death is something every man must face; we have something to learn from every man.

Manuscript received July 30, 1970

A FUNERAL IN MEXICO: DESCRIPTION AND ANALYSIS

Patricia Osuna and David K. Reynolds
UCLA School of Public Health

EDITOR'S NOTE—Several months after becoming research assistant on a project studying cross-ethnic aspects of death and bereavement, Miss Osuna's aunt died and was buried near her home in Mexico. Miss Osuna was able to fly to Mexico to attend the funeral and burial services. After returning to Los Angeles, she described her observations and her feelings during the time in Mexico to Dr. Reynolds and other members of the research team. Subsequently she wrote of her experiences. This pair of articles consists of Miss Osuna's description of what took place in Mexico and Dr. Reynold's evaluation and analysis of this description and of his prior interviews with Miss Osuna.

EL FUNERAL DE MI TIA ELENA

Patricia Osuna

I HAVE recently returned from a trip to a small town in Northern Mexico, where I attended the funeral of my maternal aunt, my Tia Elena. My purpose for giving this descriptive account is to relate my experiences and sentiments as a Mexican–American to a Mexican funeral.

Tia Elena was in her late fifties when she died, the mother of three boys and one girl, ranging in age from 19 to 29 years. Her dying was prolonged and painful, but I will describe that later, in keeping with the way I learned of the circumstances.

ARRIVAL IN MEXICO

I left the Los Angeles International Airport Tuesday evening, flying directly to Tucson. From there I was driven to the small town near Hermosillo where my aunt had lived most of her life and where she was to be buried. My thoughts were very much upon my aunt and her children, but they also encompassed my

other relatives, some of whom I had never seen and others whom I would see for the first time in many years. I couldn't help but be a little curious as to what lay ahead. I had already been cautioned by other relatives here in the States, "Mexican funerals are much different than the ones here. They are longer and more of an emotional strain."

As is customary in Mexico, a wake was held prior to the burial. In most deaths, the body is brought to the home of the deceased for viewing by relatives and friends for a period of 24 hours. In this instance, however, the wake was held in the home of my Uncle Jaime, my Tia's oldest brother. This occurred because my aunt had expressed her wishes to be buried in her small hometown, where she had lived most of her life and where her parents are buried, rather than in Hermosillo, a large city in Sonora where she had resided with her husband and children for the previous ten years. After Tia Elena's death in a Guadalajara hospital, where she had been undergoing medical treatment for cancer, her body was transported by private hearse to her hometown for burial.

I arrived at my Uncle Jaime's home the morning before the burial and a few hours before my aunt's body was to arrive for the wake. I noticed that the immediate family was not yet present, but that my Tia Laura (Uncle Jaime's wife) and a few relatives and friends of my deceased aunt (all female) were there, and were all dressed traditionally in black mourning clothes. I had worn a navy blue dress for the trip, but I also made sure I had packed a black dress, just in case. . . . My relatives later assured me when I asked, that the navy blue dress I was wearing was perfectly appropriate, explaining that since I was from "the other side" (U.S.A.), I was not expected to follow strict customs. I remained in the navy blue dress for that day and wore the black one the following day for the burial service.

PREPARING THE WAKE

Preparations for the wake were well under way. The living room furniture had been rearranged. All the tables, chairs and couches had been placed along these walls, while the area along the fourth wall was occupied by a piano upon which the floral

wreaths were to be arranged. Two chrome stands upon which the casket would be set were in the center of the room.

Women were busy taking care of last-minute arrangements. Most of my Tia's friends and relatives were in the kitchen helping to prepare the food that would be eaten during the wake. A few women were busy setting up more chairs in the living room, while two others were dusting the four tall silver candlesticks borrowed from the town's casket maker. These would be placed alongside the four corners of the casket.

Although I don't recall ever making the decision to participate in the arrangements, I soon found myself helping place large white candles into the silver holders; these would be lit the moment the body arrived and would remain burning until the end of the wake. I did what seemed natural and what I felt was part of my duty as a member of the bereaved family and a Latin woman. My Tia's four sisters were present at this time, but they did not help with these menial tasks, nor were they expected to do so, since it was implicitly assumed that their sorrow was greater than that of the other women and, therefore, they should be absolved of these duties.

During this time there was a constant flow of people entering and leaving the house. Most of them were neighbors who were coming to bring some food or to offer their assistance. Since this was such a small town, both immediate and distant members of my deceased aunt's family were fairly well known to most of these people. It was not unusual for neighbors to come and offer their condolences to my aunt's four sisters, and to take the opportunity for saying hello and briefly catch up on what had occurred over the years since they had last met.

Approximately an hour or so before the body arrived, a few men started coming to the house. They were my Tia's two brothers and a few of her nephews. Like the rest of the people, the nephews would first go over to their four aunts and uncles and offer their condolences and then mingle with the rest of the people.

The general trend of conversation centered around the cause of my Tia's death and the shock it had been. The immediate family had only learned of the gravity of my aunt's illness on the day before she died, while other relatives were unsuspecting of her condition until her death was announced. Although the

general tenor of these discussions were sad, I couldn't help feeling that those who had learned a little earlier of my Tia's death or those who had a particularly appropriate and recent anecdote to tell about her gained a little prestige in so doing.

Since my job had given me a little bit of expertise on death, I was more sensitive and aware of people's behavior than I otherwise might have been. Attending the funeral provided me with the opportunity of being alternately both an observer and a participant.

THE WAKE BEGINS

Emotions were beginning to mount as the hour approached for the arrival of the body. I was in the kitchen conversing with some of my relatives when someone came into the room announcing, "Ya llego." ("She's here.") Immediately everyone went into the living room.

The first person I remember seeing upon entering the room was one of my Tia's sons. Up to this time I had not been upset seeing my relatives or even my mother crying, but now that I saw my aunt's immediate family, I felt quite apprehensive. This was because I feel relatively close to my aunt's children since we are more or less the same age. I did not quite know what I would say to them, except, perhaps, that I was sorry for their loss; however, this seemed so inadequate.

One by one, my Tia's four children entered the room. They were greeted by their aunts, uncles, cousins and other relatives. Soon they started asking for my uncle, my Tia's husband, and were told by one of the sons that he was too upset to come over now. No one questioned or criticized my uncle's behavior. The sound of muffled crying and voices saying, "I'm so sorry," seemed to echo through the rooms.

Within minutes the house began to fill with even more people. Several of them were friends and ex-business acquaintances of my widowed uncle. The men, including my Tia's three sons, were not dressed in black. They were, however, all dressed in suits and, perhaps, the only sign of mourning apparel was an occasional black tie.

I recall leaving the living room and going into the kitchen with one of my cousins. When I returned to the living room a few min-

utes later, the casket was being placed on the chrome stand in the center of the room. It was smoky gray in color with silver handles. The casket, made in the United States, had been selected in Guadalajara by my Tia's four children. As I approached the casket, I noticed two of my aunts dusting it off.

There was a man standing near the casket whom I assumed was the driver of the private hearse. He was talking with Tia Laura, and then he slowly opened the lid of the casket. The casket was lined in white satin and there was a glass cover shielding the body. He then unscrewed the frame of the glass cover so that Tia Laura could reposition the body which had slid down a little toward the foot of the casket. My aunt performed this task because she had had some experience in handling the sick and the dead.

The body which had been embalmed in Guadalajara was covered by a white satin shroud, and according to custom, only the face could be seen. After the corpse had been repositioned, the glass cover was put in place again, and thereafter never removed. Only that part of the casket lid covering the upper half of the body was left opened. On the closed part of the casket a wreath was placed with a banner reading, "From your loving children and husband."

On first seeing my Tia Elena, I was struck by surprise and sadness. I was suprised at how the illness had caused her body to become thin and frail and how her face looked worn and aged. It was as if the sickness had consumed all life from within. I felt sad and almost regretted that I had looked at her because what I saw was not my Tia as I knew her, but a body worn away by disease. I spent the next few minutes recalling the way she looked before the illness because I didn't want to remember her the way she looked lying in the casket.

Almost everyone present in the room went past the casket to view the body. The women often cried softly while the men were more restrained. Afterwards, they gathered in small groups in the living room and exchanged comments.

Frequently, I heard remarks concerning what a shock her death was, how fast the cancer had caused her death, or how almost unrecognizable she looked. Inevitably, nearly everyone at one time or another commented on their last living experience with my Tia. Another interesting remark made by various relatives was

how she seemed to resemble my deceased grandmother (my Tia's mother) who had died six years ago.

MY UNCLE ARRIVES

A short time later, my Tia's husband arrived. Again, everyone came to him and paid their condolences. Emotions seemed to rise again and some of my aunts and relatives started to cry when they saw my uncle. Uncle Jaime then took my Tia's husband into the dining room and gave him a small glass of straight liquor.

The people then began to settle themselves in various rooms. A handful stayed in the living room while nearly all the older men went into the dining room, where they remained throughout most of the wake. A few of my aunts went into one of the three bedrooms with other women who were consoling them. The majority of the women went into the kitchen and took charge of serving coffee and food. When I entered the kitchen, there was a group of women sitting around the table with my Tia's children, while Tia Laura was giving the driver of the hearse something to eat.

Conversation centered around finding out as much as possible about my Tia's illness. "What had the doctors said?" "Had she suffered?" Other questions were directed to the circumstances surrounding her last moments in the hospital. "Had she known she had cancer?" "Did she know she was dying?" For the next few hours my Tia's four children sat at the kitchen table, surrounded by relatives, answering such questions.

My Tia's husband spent most of the time in the dining room with the other men. Once in a while, he entered the kitchen, but when he did, all conversation regarding my Tia's illness, death and funeral arrangements stopped so as not to upset him further. Since I did not spend much time in the dining room, I have no information as to the topics of the men's conversation. They did, however, seem to be spending a great deal of time talking, eating and drinking. Unlike the women, the men drank mostly liquor, which was provided by Uncle Jaime. The liquor included everything from tequila to cognac to "Johnny Walker". Although there was quite a bit of heavy drinking, no one seemed to lose control.

In the course of the time I spent in the kitchen, I learned many things regarding my Tia's sickness and death. I found out that

she never confided to anyone in the family that she knew she was going to die. It was not until after her death that her children were informed by the nun who had nursed her in the hospital, that my Tia had confided in her and had made requests for funeral arrangements. She had also asked for the last rites, five days before her death. As my cousin so aptly put it, "All that time we tried so hard to keep the fact that she was going to die a secret from her and instead of us fooling her, she ended up fooling us." There had even been times when her pain had been so great that she had had to ask her son to leave her bedside, so that he would not become aware of her agony.

Another point of interest, which was revealed in the talk in the kitchen, was that the immediate family, after leaving Guadalapara, stopped off at their home in Hermosillo where they awaited the arrival of the casket. While the family waited, neighbors and friends dropped in to pay their condolences and await the casket, too. Late that afternoon, when the casket finally arrived, the family opened the casket for viewing upon the request of the neighbors. This allowed those people who were unable to attend the burial the opportunity for a last farewell. At that time, the immediate family accompanied by neighbors and a few friends kept an all-night vigil. The following morning the family left with the casket for the place of burial.

At different intervals throughout the course of the wake, friends and relatives would go into the living room and view the body. They would sit or stand by the casket for as long as they desired. Usually there was a member of my Tia's family already present since it is the responsibility of family members to see to it that the body is never left unattended. During the twenty four hours that the body was present in my uncle's home, it was never left alone. On various occasions, I, too, walked into the living room, not always to view the body but just to sit by the casket. I found this very comforting since it gave me an opportunity to withdraw from social interaction and spend as much time as I wished reminiscing on past experiences with my Tia.

THE ROSARY

Later that evening the priest arrived at my uncle's home and said the Rosary. This event took place in the living room and

was attended mostly by women. However, I did notice three or four men in the back of the room. After the Rosary, the priest was invited to dinner, and as was the case with the driver of the hearse, he promptly accepted.

As the early hours of the morning approached, people became less tense and more relaxed. There was even a moment when someone started telling jokes in the kitchen, but this was quickly criticized and discontinued. The trend of conversation drifted from things connected with my Tia's illness or death to more general topics. People who had not seen each other, perhaps in many years, began recounting past experiences.

By this time most of the friends had already gone, and only family members remained. My Tia's husband had left also and did not return even for the Requiem Mass or for the burial. My Tia's four children took this opportunity to slip out and get a few hours of sleep. For this my cousins were criticized by some of the relatives who remained in the house. It was felt that they would at least have taken turns standing guard over the body as is customary; the fact that they were very tired was no excuse because it was their duty to watch the body. This criticism was made despite the fact that one of my Tia's sisters had remained in the living room all night watching over the body until the casket was removed for burial.

THE DAY OF BURIAL

For the day of the burial all preparations were made exactly as my Tia had requested. Neighbors, friends and relatives began to gather again at my uncle's home. Again, the women were all dressed in black but this time they wore mantillas. As soon as the immediate family arrived, the atmosphere again became tense and strained, for this was the sign that the end of the wake was almost near. Once again people walked past to view the body and once more many tears were shed. I saw my two uncles' eyes filled with tears as they both took one last look at their youngest sister. Suddenly, I felt sadness, not so much for my deceased aunt, but for my uncles. It seemed to me that it must be especially hard for an elderly person to see his friends and relatives die. This can't help but serve as a reminder that they, too, will perhaps soon die.

The floral wreaths sent by families, friends and business ac-

quaintances had been removed so that they could be placed in the church and at the grave site. Then the casket was taken to the Church in the fashion my Tia had requested.

She did not want her body to be taken to the church in a hearse but instead asked that the casket be carried on men's shoulders down the streets of her hometown. Tia Elena did not care to have a pompous, lavish funeral even though economically she could have well afferded one. Hers was a well-to-do family, even by North American standards. She had explicitly stated that she preferred to be buried as her father and mother had been, in a simple, humble manner.

The nine men stood ready to carry the heavy casket. They included my Tia's sons, nephews and son-in-law. As the men walked out of my uncle's home and on to the street, I heard the bells of the church tolling in the distance. Men, women and children came out of their homes and stood in their doorways as the procession slowly passed. Most of the young men walked behind the casket while a few women walked along the sidewalk to the church. The other people followed in cars.

When we arrived at the church, the men carried the casket inside. In the church the priest dressed in black vestments was waiting to say Requiem Mass. The immediate family sat in the front pews of the church near the casket. The other women generally sat a few rows behind the immediate family while the men sat in the back of the church. During the mass the casket remained closed.

After mass the priest came down the altar to the casket. He walked around the casket twice, first sprinkling it with holy water and then incensing it. Finishing this, the priest nodded to the pall bearers. This was their cue that the religious ceremony had ended and that they were to remove the body.

By the time the people filed out of the church, the body had already been placed in a white hearse. From there the body was taken to the cemetery. The procession to the cemetery was somewhat different. The hearse led the way to the cemetery but this time a group of men both young and old followed along on foot. No women joined this group, instead they followed behind in cars.

THE INTERMENT

By the time I reached the cemetery, the casket had already been placed by the grave. My Tia's open grave was completely visible. It was approximately six feet deep, eight feet long and four feet wide. The lower half of the grave had been lined with bricks while the upper half was unlined. The grave had been dug to accommodate two coffins. One space would be occupied by my Tia's coffin and the remaining space will be given to the next person in the family who dies and wishes to be buried in that town. The grave site is located near other family graves.

After everyone had arrived at the grave site the casket was once again opened. My Tia's three sons stood near the casket and walked over to view the body for the last time. Then my Tia's youngest son, 19 years old, bent over and kissed the coffin. Her two other sons only paused briefly. They were followed by three of my aunts. For me this was the most emotionally draining time of the entire service. My tears were now flowing as were those of the others; they were, however, tears for the living, not for the dead.

The casket was then closed and lowered with straps into the grave. Everyone stood watching while two workmen placed wooden boards over the brick-lined portion of the grave. A workman then proceeded to step down into the grave. Then another workman handed him one pail of cement after another til he had completely sealed off the lower portion of the grave. Finishing this, the workmen left and were soon followed by the immediate family and other relatives.

The next evening, as I was flying back to Los Angeles, I thought about the intimacy with death that had been expressed in the wake and in the funeral and burial ceremonies. Emotions were expressed honestly and without embarrassment, yet the life-oriented tasks of eating, drinking and relating to other people went on.

Manuscript received April 6, 1970

A FUNERAL IN MEXICO

David K. Reynolds, Ph.D.
UCLA School of Public Health

THE FOLLOWING analysis is drawn from an account of the funeral of a 50-year-old woman in a small town in northern Mexico. She was survived by four children (three sons and a daughter, aged 19 to 29), an ailing husband, four sisters and two brothers, and numerous other relatives. The death came somewhat sooner than expected although at the time Tia Elena was in the hospital in Guadalajara undergoing treatment for cancer. Her condition was recognized as ultimately terminal.

A chronological account of the events following the death of Tia Elena may be found elsewhere. (Osuna 1970).[1] Some of the details of Tia Elena's funeral are presented in this paper for the first time. Here I focus on three key elements of the post-death period: relations between the survivors and the deceased; relations among the survivors; and the psycho-philosophical orientation of the survivors.

RELATIONS BETWEEN SURVIVORS AND THE DECEASED

I shall argue here that social relationships with the deceased continue, in a sense, even after one dies. The relationships express themselves in several ways, among which are the treatment of the body, the recollection of the past that included the living Tia Elena, and the carrying out of the deceased's wishes and intents.

Of course, according to Catholic belief and according to the folk understandings of Mexican culture, the *person* who died must be distinguished from the corpse of the deceased (Habenstein and Lamers 1963). There is something crucial that is lacking, that has departed when someone has died. This something may be called soul, mind, personality, life, or whatever. Nevertheless, the body remains *a symbol* of the deceased person. It is treated with respect, it is spoken of as "she" (i.e., in terms usually reserved for living

[1] See page 249 of this journal.

creatures or those we endow with imaginary life, like dolls, ships, and cars), and it is even kissed as one might kiss a loved *person* farewell.

Throughout the ceremonial period following death, the body remains a central object of attention. The three peaks of emotional expression by the group all focused on the body—when it arrived at the home, when it left the home following the wake, and when it was lowered into the grave. It was expected that the immediate family be present at the time the body arrived for the wake; it was expected that the immediate family be present before the body could be removed from the house and, again, at the graveside. The immediate family was also given the final opportunity to make farwells at the graveside (this included the kissing of the glass coffin cover by one of the sons of the dead woman). Here, again, the rights and responsibilities of the immediate family to *the person who once lived* are reflected in their rights and responsibilities toward the *corpse.*

The wake itself may be described as a series of reunions—reunions among survivors, and between survivors and the deceased. The coffin was "center stage." It was placed in a conspicuous place in the living room of the house in which the wake was held. Some attention was given to the proper positioning of the coffin since, with the hinged lid open, there was a natural "front" and "back." Chairs and sofas around the room were arranged to face the body. Persons who entered the living room were expected to face the body and not turn their backs to it. Voices were lowered as one approached and entered the living room. Throughout the wake people would socialize together, then slip in for a period of prayer, meditation, or recollection, then back to the kitchen chores, chatting, or sleeping and, again, back to the body, and so forth. Thus, the body was treated with symbolic respect in some ways even greater than that accorded a living person. It, too, was a focal point for reunion.

Various other symbolic behaviors were directed toward showing respect to the body. Throughout the night of the wake some family members remained with the corpse by turns. It would have been truly disgraceful to have left the body unattended for even a moment during the wake.

The procession on the following day to the church and to the

cemetery also focused on the body as the central object of respectful attention. An important part of the conversation among the survivors dealt with the condition of the body—how "she" looked, how wasted by the illness "she" appeared, how "she" reminded some family members of other deceased family members' bodies, and how much "she" looked like a saint.

A second way in which the survivors interacted with the deceased was through selective recollection. There was much talk of the time when each person had last seen her alive and what they had done together. Her life style was discussed with great emphasis on her positive qualities, her kindness, the care she took of her family. It was as if one must end one's relationships with the deceased on a positive note. It was noted that she had donated some of the money that she had taken to the hospital so that operations could be performed on a couple of other patients there. She had also given away some of her money to a nun who had become a nursing companion through the final hospitalization. It was told how she sent her son from the room sometimes so that he wouldn't be present while she moaned softly from the pain, and how she would stop when he re-entered the room. Finally, there was much expressed concern to know what were her final words, who she asked for near the end, whether or not she realized that death was close at hand, and what were her final wishes. It became clear from her behavior as well as from what she had told the nun who nursed her that she and her immediate family had practiced mutual deception with regard to her awareness of the approaching death. Everyone had recognized its inevitability but all had acted as if recovery were the expected outcome. Thus, interactions occurring in the final days of life were recollected and, in this manner, revived (in a favorable light).

We find that in carrying out the wishes of the deceased the survivors were able to participate in yet a third form of interaction with the dead. The wishes and perceived intents of Tia Elena were binding on the survivors. She had told the nun of certain special arrangements she wished for the funeral. For example, she wished her coffin to be carried on the shoulders of male family members from the house to the church rather than being transported by hearse. As soon as her wishes were made known to the

larger family, any discussion on the subject ceased—the matter was closed.

Similarly, some informal arrangements for distribution of her personal effects had been made by Tia Elena. Her wishes in this regard were also binding.

Thus, one sort of interaction begun during the life of Tia Elena could be concluded only following her death.

INTERACTION AMONG SURVIVORS

Although in one sense the above-mentioned customs involved a kind of interaction between the living and the dead, they also involved interactions among the survivors themselves. Temporally, death-related interactions began during the period preceding termination; they included notification of all appropriate persons that the death had occurred. There were interactions resulting from the coming together of survivors during the post-death period, and they extended on as results of the arrangements made for the temporary care of Tia Elena's husband and sons during the period following the funeral.

These interactions were to some degree restricted and predetermined by expectations regarding what was "appropriate" behavior under the circumstances. However, those closest to the deceased were afforded a certain degree of freedom from normative limitations due to their special temporary status as mourners. In addition, even in the midst of the collective funeral efforts, there seemed to be a value placed on independent action which permits non-conformity at the expense of some predictability and organization. I have selected for discussion three aspects of interaction among survivors; sex-differentiated limits on behavior; selected rule-breaking privileges and their consequences; and some evidence for the results of the valuing of independent activity in the midst of collective endeavor.

Perhaps most obvious among sex-differentiated expectations of behavior is the territorial dispersal of the sexes during the wake. The males congregated in the dining room and the females, in the kitchen. As in most rule-governed behavior, situational exigencies permitted some flexibility in practice and so sometimes women could be found in the men's area serving and chatting briefly, and men could be found in the kitchen eating. It also

seemed to be true that younger people and the immediate family wer permitted more freedom in their choice of location than were others. Nevertheless, in general, although it would not be considered so strange for a male to spend much time in the kitchen, for a female to "hang around" the dining room would be quite inappropriate. It is for this reason that we know much more about the events occurring in the kitchen than those occurring in the dining room (our research assistant was female and felt too uncomfortable to spend long periods of time in the male-designated area).

Expectations regarding the expression of grief also seemed to be divided into distinct male and female categories. Females were permitted free expression of their grief. In fact, there was some indication that females who were unable to cry were upset by this "lack" and felt they would be considered cold and unfeeling by others. In other words, I am suggesting that tears are not only acceptable but expected. Some Mexican American funeral directors indicate that this expectation is so strong that in some Mexican American families the females closely related to the dead may respond to social pressures to express grief by deliberately feigning a swoon.

On the other hand, the expressions of grief by shedding tears was socially acceptable but not required for males. Two instances of men crying are cited here. In the first instance Tia Elena's brother wept. It was remarked that since he was the youngest of Tia Elena's siblings (although now in his forties), such weeping was understandable. In the second instance Tia Elena's son finally wept, during the graveside ceremony. Presumably, the relationship, youth, and the immediate circumstances further justified the tears. The reader should bear in mind that in no case have I encountered in the Mexican or Mexican-American communities criticism of a male for crying following the death of a close loved one. He is not necessarily considered less "*macho*" for doing so. His behavior is seen as the natural expression of deep feelings.

If, however, the male can exhibit control over his emotions, if he can refrain from crying or otherwise show he is making efforts to spare those around him from observing the full depths of his feelings, he may be considered exceptionally strong and self-controlled. Strength and non-expression are valued traits for males,

and inexpressiveness apparently carries none of the negative implications for males that it may for females.

The proper methods of escaping from the immediate situation by chemical ingestion seemed also to be sex differentiated. Males found relief in several varieties of alcohol. Although no one seemed highly intoxicated, a great deal of liquor was consumed by the men. The women, however, were much less likely to drink and the few who did drink consumed only a little alcohol. In this particular case, however, a Mexican American woman had brought Librium which was passed out one to a person. The recipients were, with one exception, females. (It may be the case, generally, in the Mexican–American subculture that alcohol is seen as the masculine avenue and tranquilizers, the feminine avenue of relief during the immediate period of grieving.)

A final, quite visible, area of sex distinction was in appropriate dress. In Mexican culture, black (secondarily, white) is the color associated with mourning. The women felt constrained to wear black during the funeral ceremonies. Although exceptions were recognized and permitted the assumptions were that women would wear dark, preferably black, clothing. Males, on the contrary, actually wore very little black and this was restricted primarily to accessories such as neckties.

Thus, we find in the matters of dress, tranquilization, expression of grief and spatial location examples of sex-differentiated limits on behavior. But limits on behavior usually involve some flexibility permitting one to overstep the boundaries under unusual circumstances. Grieving is one such circumstance.

What kinds of deviations were permitted mourners? One sort involved the relinquishing of responsibilities to others. Those women in the immediate family as well as those who appeared acutely upset were not expected to participate in the food preparation and serving that absorbed so much of the attention and efforts of the rest of the women. A related sort of special dispensation involved participation in the rites themselves. The husband of the deceased was allowed to absent himself from the funeral mass and from the graveside ceremony because of his grief and age. Not only was the husband of Tia Elena allowed to evade participation in the planning of the funeral, but, furthermore, such plans were not discussed in his presence and even conversations concerning

the deceased stopped when he entered the room so as not to upset him further.

Although overindulgence in alcohol was not observed, it was the understanding of our researcher (as well as our findings in other funerals) that intoxication and some loss of self-control would have been excused, especially for males of the immediate family (see Robinson 1963).

In passing, it is worth noting that although some rules may be transgressed during mourning, others may not. For example, there was an expectation among some who attended the ceremonies that the immediate family should post themselves by turns one at each corner of the casket throughout the night of the wake. Despite their having been up the night before, despite their later claims of having "forgotten," and despite their status as mourners, they were subsequently criticized for having failed to carry out this responsibility.

Rule-breaking privileges, however, can be used as a kind of social currency as the following situation indicates. Our research assistant discovered that since she was from the United States, some people considered her exempt from the rule about women wearing black during the funeral ceremonies. However, she felt that if she indulged in this rule breaking, she would simultaneously be setting herself off from (i.e., isolating herself from) the group of mourning relatives and friends. Thus, in order to assert her identity as a group member, she refrained from this socially permissible overstepping of limits. Although social sanctions for wearing colors other than black might not have been directly forthcoming, unpleasant secondary consequences resulting from her being considered an "outsider" might have cost her something in terms of warmth, acceptance and openness by the in-group.

Interactions within any group are structured by their shared expectations and limitations on behavior. The Mexican people have been described as a communal, group-oriented people with relative congruence and conformity in attitudes and behavior within the family group (Romano 1968). Although it does seem to be the case that this funeral ceremony drew participation and cooperation from a large social group, it also provided for a great deal of independent, individualistic activity that ought not be overlooked. A group pays the price of a certain amount of dis-

organization and unpredictability when it permits individualistic variation. It is to the valued independence in human interaction and its consequences for these Mexican people that we turn briefly now.

One of the striking features of this funeral complex was its formality. There were few rules that were formalized and rigid. When decisions regarding the funeral details were to be made, there was neither a formalized set of persons to make them nor a regular means for arriving at them (with the exception of the binding wishes of the deceased). Instead, general discussion by those present, those interested, and those affected was necessary to arrive at some group consensus. Similarly, the timing of the beginning and ending of the ceremonies was generally unformalized. That is, the rosary was not set for a specific time but rather began when it seemed that enough people had congregated. In the same way, the graveside ceremony had neither formal beginning nor formal ending—the priest having arrived and gone before most of the procession reached the cemetery and people arriving and leaving at various times (though many waited to leave until some members of the immediate family had gone). The point I wish to emphasize is that the ceremonial events were not time-scheduled nor were there, in general, specific events that formally markd the beginning and end of the ceremonies so that a participant could say at a point in time, "Now the ceremony has begun; now it has ended." Nor could all the people turn away simultaneously with the sense that a particular ceremonial element was finished. Rather, arriving and leaving was timed within broad limits according to the convenience of the individuals and subgroups of participants.

In this light it is interesting to note that there was no fixed procession route from the cathedral to the cemetery. And, in fact, cars were scattered along several routes, some taking short cuts and arriving before the family.

THE PSYCHOPHILOSOPHICAL ORIENTATION OF THE BEREAVED

Some of the bereaved voiced their thoughts on death during the funeral ceremonies. I have consolidated and arranged their

philosophies under four headings: the force of the loss; the acceptance of the inevitable; the consolations involved; and the comparative response. Before describing these orientations, I should perhaps remark to the readers that I find them typically human rather than peculiarly Mexican. That is, some version of the thoughts discussed below could come from many, perhaps all, cultures around the world and are not, I feel, restricted to Mexican traditional ways of thought.

The Force of the Loss

For some, it seemed the emotional impact of the loss had spent itself during the period of terminal illness. "My mother died for me a long time ago" remarked one son. In other words, much of the "grief work" had already been accomplished by the time his mother actually died. The final event then drew less on the emotional reserves of some survivors than others.

In direct contrast to the pre-death grieving is the recognition expressed by some that the true extent of the loss will be realized later. The daily reminders of the deceased and the unfulfilled expectations that accompany changes in everyday routines of life will impress the survivors with the gap that has been creeated by death. "You don't really feel the loss *now* as much as you will as time passes and you're left alone, (i.e., as the funeral ends and relatives and friends leave). Now you feel sorrow, but later you will realize the extent of your loss."

The Acceptance of the Inevitable

"When death comes, it comes. These people were well off, but their money didn't help them any." This statement reflects a value that pervaded the funeral event (and seems common throughout much of Mexican culture). The participants in general seemed to feel that a mature life philosophy must include a resignation toward the inevitability of death. Here, as elsewhere (Reynolds 1969), I must emphasize that such acceptance does *not* imply passivity. Illness may be combatted by all means available. Nevertheless, death, illness and suffering are inevitable (at the level of even the most technologically-advanced cultures) and their occurrence must not be allowed to incapacitate the living and well for long. The experience must be incorporated and utilized for personal growth.

"You can't just forget. You must learn to live with what's

happened. That's maturity—to live with what life brings you."

The Consolations Involved

One way of dealing with one's grief was by emphasizing the positive elements of the death, i.e., the ways in which Tia Elena's death was better than other deaths.

As noted above, the positive aspects of Tia Elena's character were emphasized during the funeral. She was a good woman, kind, compassionate, loyal to her family, and generous. She was more ready than many others in terms of her virtuous character to face the judgment of death.

Related to this, she was lucky to know of her impending death and thus prepare for it. She died with a rosary in her hands. These reflections provided much comfort to the devout. Relatively speaking, this death had some positive elements, too.

The Comparative Response

When one experiences the loss through death of another, a very common response is to reflect upon one's own death and that of others in one's life space.

One young lady reflected that her parents were still alive though her cousin's mother was dead. Why was *she* lucky? When would she lose *her* parents?

There was some feeling in the group attending the funeral that the husband of the deceased would be the family member most likely to die next.

Accompanying these thoughts about one's own and others' deaths were related thoughts on the quality of one's current life style, one's preparedness for death, and the necessity for kindness to others while they are yet alive.

SUMMARY

We have examined some of the relationships, symbols and values incorporated in the funeral of a middle-aged woman in northern Mexico.

We have noted the respectful treatment of the body as symbol of the person, the existence of special rules and rule-breaking privileges which influence interactions during the period of mourning, the allowance for the expression of individuality, and the broadly human philosophical reactions elicited by the experience of loss.

We feel certain that funerals held in other parts of Mexico, for other classes of people, in different sorts of urban and rural settings, in memory of deceased persons of different age and sex, and so forth, will show some divergence from that discussed here (Habenstein and Lamers 1963). We look forward to the publication of detailed information on other Mexican funerals so that fruitful comparative studies may be possible in the future.

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THE DEATH CULTURE OF MEXICO AND MEXICAN–AMERICANS[1]

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A CENTRAL concern with death has been recurrent in western philosophy: it has certainly not been so in western social science. As Gouldner comments, "Plato sees that death. . . is overwhelmingly and uniquely important throughout the entire life of man, which, it must be said, is still something that few social scientists as yet grasp" (1965, p. 363). The existentialists saw that it is in the knowledge of death that man defines his existence: this insight has not been picked up by cultural analysis.[2] Logically, one should be rather surprised by this neglect. Anthropological and sociological theorists have continuously sought to define human universals: whether these be functional prerequisites of social systems (à la Radcliffe-Brown and Parsons) or universal "basic questions" (à la Florence Kluckhohn), social theorists have tended to focus on how cultures relate to the natural environment, to sex, to dependent children—but rarely to death.

This is unfortunate. Death is the ultimate human weakness, the ultimate limitation, and every culture must conceptualize weakness and limitation. Gouldner's analysis of classic Greek culture, in which death was recognized but bitterly resented, illuminates both the major themes and the strains within Greek society. A similar analysis of American culture, in which death is also resented but is *not* recognized—rather is suppressed, or denied—might be extremely useful. Suppression of death in American and northern European cultures has been repeatedly discussed (see, for example, Gorer 1967; Kalish 1969). Occasionally it has been suggested that this suppression has a functional

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[2] See Choron, 1963, pp. 222 ff, for the existentialists' views of death.

relationship to other elements of American culture. In particular, it is a logical concomitant of the American faith in the ability to master the environment. The conviction that the physical, social, and psychological environments *can* be controlled and manipulated to man's purposes is seriously challenged by man's failure to master his own fate.[3] The fact that every man must die is thus perhaps best managed in a culture like ours by denial. Particularly interesting is the notion that we must protect children from death. Children, who are most sensitive to learning the cultural priorities, must be shielded from the fact of human mortality. American children, who must grow up to transcend human limitations, must not be permitted even to become aware of the ultimate human limitation. The avoidance of death by social scientists is just part of the overall cultural pattern.

The contemporary American treatment of death, like the ancient Greek, appears to relate to core concerns of those two cultures, in both cases, achievement and power. The handling of death in any American minority sub-culture, therefore, must be of particular interest. American minorities have been the victims of the American emphasis on achievement; American minorities have been characterized by their powerlessness. How then, would a stigmatized, low-achieving, powerless segment of an achievement-oriented, power-oriented society face death? Would they resent it as much? Would they deny it as much? Or would one of the adaptations to their status be to recognize the pervasiveness of death and cope with it—or accept it? What would be the variations within the group? For example, would "achievers" be more—or less—likely than the middle-class Anglo to deny death? Once attitudes toward death are put into a broader context, somewhat more interesting sociological questions can be raised. And these questions, in turn, relate to psychological issues of personal adjustment to bereavement and to the individual's own death.

THE DEATH CULTURE OF MEXICO

The minority discussed in this paper—the Mexican-Americans—

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[3] The incompatibility between death and an achievement-oriented culture is perhaps illuminated in Greek culture by the bitter resentment of death—and also by the allied notion that "to wish for immortality is *hybris,* " (Gouldner 1965, p. 116). In contemporary terms, a doctor insightfully relates the normal medical man's avoidance of death to his sense of outrage and disillusionment at his dying patient's "betrayal" (Kasper 1959).

offers complications when we try to answer these questions. This is largely because the "home" culture—Mexico—has such an elaborate concern with death. Fifteenth century Spain had its own death culture, but with the Aztecs the Spanish encountered what Eric Wolf (1959, p. 145) calls a "fanatic obsession with blood and death." Wolf echoes the reactions of hundreds of European observers when he goes on to call the extent of human sacrifice "unique," in that "no other people on earth has felt it necessary to immolate thousands of victims annually to assure the balance of the heavens."[4] The Europeans not only observed death, but also brought death on a massive scale, with a devastating series of plagues shortly after the Conquest. It may well be that the very high death rate in the early years of Spanish occupation of Mexico facilitated the blending of Indian and Spanish death cultures. Whatever the cause, there is little doubt that contemporary Mexican rituals represent a continuity with Indian rituals: Indian food, incense, and flowers are, for example, presented to the dead on the Catholic holiday of All Saints Day (see Fergusson 1934; Green 1969). There is also little doubt that contemporary observers of Mexican life reiterate the early Spaniards' observation that death, per se, remains important in Mexican culture as a whole. For example, Serge Eisenstein focuses an important section of his Mexican films, *Day in the Sun,* on death. He moves from the funeral of a peon to a playful look at the Day of the Dead; sugar skulls become a grim commentary on the misery of the peons. A commentator on death's treatment in Western art is disturbed by contemporary Mexican depiction of death in art. She finds the work of the great revolutionary artist Posada "macabre," and chooses not to discuss his work; the preoccupation of Siqueiros and Orozco with Death symbols is noted in passing (Gottlieb 1959, p. 168). A contemporary Mexican art historian comments that Mexican art of the twentieth century has been preoccupied with two themes: revolution and death.[5] The Mexican literateur, Octavio Paz, generalizes: "We are seduced by death . . . . Our relations with death are intimate—more intimate, perhaps, than those of any other people" (1961, p. 58, 59).

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[4] "Assuring the balance of the heavens" by sacrifice surely betrays an uncertainty about man's capacity to master nature.

[5] Francisco Gaona, in his lecture on Contemporary Mexican Art presented at The University of California, Riverside, February 26, 1970.

We made the statement that the "home culture" of Mexico confounds the question of how a powerless American minority would cope subculturally with death in a dominant system whose denial and resentment of death is linked with a cultural emphasis on mastery of the environment. There is considerable evidence from Mexicans themselves that the home culture of Mexico is far from sure of its capacity to master the environment. Anthropologists like Kluckhohn may see this in a positive light, as a cultural value on being in "harmony with the environment." The Mexican philosopher Ramos, like Paz, has a more depressing view: he attempts to "psychoanalyze" his culture, in Adlerian fashion. His general thesis is that the Mexican "*feels* inferior . . . . for the majority of Mexicans it constitutes a collective illusion which results from measuring man against the very high scales of values corresponding to highly developed countries" (1962, p. 57). Ramos argues that Mexicans of all class levels continuously struggle with a sense of impotence. For the lower class person, referred to by Ramos as the *pelado* (or peeled person), "his real position in life . . . is a nullity" (p. 59). The *pelado* is aware of this, and his style of life is an attempt to conceal his self-defined weakness from himself and others. "Mexican distrust" of self and others, Ramos argues, is such that "the future is a preoccupation which he has banished from his consciousness. . . . He has therefore suppressed from his life one of its most important dimensions—the future" (p. 65).

Thus the culture of Mexico may not only be characterized by an interest in death which strongly contrasts with denial and rejection in American culture, but also may be characterized by a pervasive anxiety about man's capacity to dominate and control his environment—again, in sharp contrast with the United States. Unfortunately, there is little in the social science literature on Mexico to confirm or deny the generalizations of writers like Paz and Ramos. The most significant work on the topic is the recent book by Oscar Lewis, *A Death in the Sanchez Family*. But Lewis' work, like his other books, is designed to show how one person's "life and death reflected the culture of poverty in which she lived" (1969). Thus, though Lewis' participants recount the experiences attending Guadalupe's death, wake, and burial, the underlying thread unifying the book is less on the norms and the

extent to which a particular death reflects those norms, and more on the struggling, exaltations, and degradations involved in burying this woman. To be sure, the informants continually bewail the pains of being Mexican and the pains of being poor—in somewhat the fashion of a Victorian novel. However the book as a whole does not help much in the task of cultural analysis; nor does it present very much systematic evidence on the question of how heavily the culture of Mexico emphasizes individual achievement and the attainment of control over the environment. Thus the proposition that Mexican culture recognizes and is concerned with death and that this culture does not insist on mastery of the environment must remain at the level of hypothesis.

The general point made earlier stands, however. It is in fact amplified by this speculation about Mexican culture. Death will be a special issue in a deprived subsegment of a society in which denial and rejection of death in the larger system are associated with a drive toward power and mastery. It will be particularly interesting for a subsegment of a culture as different as that of Mexico. How this issue is resolved subculturally is a question for research; variation in the mode of resolution *within* the subculture is another major question. How one minority (Mexicans) compares with another (Blacks) is yet another question, when the two minorities may have a common factor in their position in the United States but may differ drastically with regard to "home culture." The remainder of this paper is addressed to a task that may be conceived as preparatory to research on such issues. It is a compilation of data and observations on death among Mexican–Americans. Even this analysis must be considered preliminary, since it is based on rather scanty evidence.

NEGLECT OF DEATH IN LITERATURE ON MEXICAN–AMERICANS

There is very little in literature on Mexican–Americans relating specifically to what might be termed the "death culture," either in the very poor, almost totally impotent past, or in the more recent, less desperate present. One difficulty has been that Mexican–Americans have produced few visual or verbal cultural

artifacts that lend themselves to analysis, with the exclusion of New Mexico, with its dying tradition of folk art. The present art and literature being produced in the Chicano movement provides an opportunity for analysis of how often and in what manner death themes are managed. An interesting and manageable research project, for example, would be a comparison of death themes in Chicano and in counterpart Black literature. But on the whole, the cultural artifacts of Mexican-Americans have been remarkable in their absence. This means that the phenomenological significance of death in the Mexican-American culture cannot be presented to the observer apart from the perceptual screens of his own conceptual apparatus.

One would expect that even Anglo observers would have looked at the Mexican-American death culture. In a poor, Catholic, large-family group like the Mexicans, death is a crisis for both family and community. In fact, observers of earlier immigrant groups in the East noted the burial societies as among the earliest ethnic voluntary associations. In some groups they have been significant in capital accumulation. There is almost no mention in the literature of burial societies among Mexican-Americans. Even superficial questioning among elderly Mexican-Americans today will reveal their importance, particularly in the past. They had little impact on capital accumulation. They were not investment clubs like the Christmas clubs; rather, they were like an office pool for a girl getting married. When a Mexican member died, each member was assessed for a funeral. In substance, these old Mexican-American mutualistas formalized the procedure outlined by Lewis during Guadalupe's funeral, when a collection bowl was placed near the coffin during the long wake. These groups still survive, and may still be significant in poorer areas of the Southwest as well as among today's old people.[6] There is little question that such associations would have been a major feature of communal self-help for Mexican immigrants in a hostile new society. The death of a member of a Mexican immigrant community appears

[6] In 1970, a young student at the University of California, Riverside, told me of a mutualista that his wife belonged to until she married. The group at that time consisted of about 600 members, descendants of a colony of Mexican immigrants who had settled in San Gabriel, California. There were two classes of funeral; 60 cents and $1.60. Even in 1970, that was enough to amplify family funds and provide for "a decent funeral." This student was surprised to find that "mutualistas are alive and well": he had not heard of any such groups in his own community in Los Angeles.

in fact to have been defined as a community problem, not only as a problem for the bereaved family. The burial societies, as in other immigrant groups, were apparently a collective mode of meeting what initially appeared to be an economic crisis, but which was actually a crisis in community solidarity. Certainly the burial society and its functions for contemporary aging Mexican–Americans is a topic of considerable interest; one wonders why it has been neglected in past research.

The burial society is mentioned here because it has been found significant in counterpart groups studied by Anglo social scientists and is significant in a wide variety of contexts, ranging from economic to communal. One's curiosity about the neglect of death in past literature on Mexican–Americans becomes even greater after even the most superficial interviewing about the topic.[7] Uniformly, one meets the flat assertion that the funeral is the single most significant family ceremony among Mexican–Americans. It far outstrips marriage, baptism, or any other family or church-related rite of passage—and there are many accounts of the latter in the literature. Family members from remote points make a special effort to come together for a funeral, particularly for that of an old person. The effort is far greater than for other family ceremonies. At a recent funeral, one out-of-town relative is quoted as remarking "Why do we always have to wait for a funeral to get together: why don't we kill a goat?" While an elaborate symbolic analysis might be made of just that statement, even a superficial analysis indicates the recognized importance of funerals as occasions for family solidarity. One begins to conceive of the neglect of death in the study of Mexican–Americans as yet another indicator of the American cultural denial and rejection of death, especially in recent decades.

In addition to the importance of death and funerary behavior to an understanding of family and communial bonds, there is another strong reason for the study of death. Patterns of behavior about death and bereavement are among areas that are most conservative and most resistant to change of any culture or subculture. For this reason, its study should have high priority among

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[7] I am indebted to Lorenzo Campbell and Benjamin Gonzales, in particular, for their observations, on which I have drawn heavily in this paper. In addition, David Leon, Norma Leon, and Jose Tapia offered valuable insights.

social scientists interested in persistence and change in ethnic subcultures in this country.

The conservatism of funerary behavior can be illustrated in Mexico itself. Indian customs were incorporated into the Spanish Catholic rites—both on the Day of the Dead and at the normal funeral. Candles, water, flowers, food, and incense are provided for the dead in the villages on the Day of the Dead. The particular artifacts demonstrate continuity with ancient times. These observances survive in the order listed as people move to the cities. For example, Lewis describes Guadalupe's celebrations on the Day of the Dead as including candles, water, and flowers: food and incense had disappeared. Why should these survive? Partly because of the intensity of emotions aroused by even such an apparently remote gesture as the visit to the cemetery on the Day of the Dead. Though most published accounts of those celebrations in Mexico emphasize the quiet cheerfulness of the occasion, one of my Mexican-born colleagues has a very different memory. He left Mexico when he was a child, and one of his most intense memories is of the terror inspired by the ceremonies on the Day of the Dead. The Day meant a terrifying visit with his mother to feed his ancestors—he remembers them as mummified, ancient, and awe-inspiring. These ancestors were *not* those of the "normal American"—grandparents or great-grandparents—but remote in time. They had been there for centuries, according to him. This is another reason for the conservatism of this area of life—particularly in "the old country." We in this nation have only a few generations behind us at the most; to the Mexican a visit to the graveyard is potentially a visit to his personal antiquity and his connection with the land. To a Mexican-American, the cultural artifacts of death in Mexico may have a very special place in his memories of his homeland, profoundly affecting his view of death in this society. Full knowledge of the "homeland" death culture does not give more than a remote knowledge of what that effect may be: he was not fully socialized in the culture of Mexico, and his partial socialization may have, as in this case, intensified certain aspects of the death culture in his memory.

Another important reason for the conservatism of customs connected with death is that it is generally the old people who die, and conscious efforts are made by their surviving young relatives to

"do what they would have wanted." Among the young Mexican–Americans I talked with, funeral ceremonies given for grandparents often violated the belief of the survivors. For example, one old man with a Protestant wife and non-practicing children was given a conservative Catholic burial. In another family, the atheistic sons of an old man not only buried him in the most conservative Mexican church in Los Angeles, but his male relatives went fully through the ritual—against their own principles. There is thus a strong element of truth in the Catholic clerical cliché that "they always come back to the Church to die." However, far from being a reconversion of the straying Catholic, I believe that this "return to the Church" is part of the complex of general cultural retentiveness around death and bereavement.

THE DEATH OF AN OLD MAN: THE MEXICAN-AMERICAN NORM

What follows here is the result of a preliminary exploration into the "normal funeral" in a Mexican–American family of a metropolitan area. In a very real sense, this is a description of norms: what *ought* to happen with the death of a person who *ought* to die—an old person. Following this, the discussion will turn to departures from these norms. The departures may be of several types: the wrong kind of person may die—a young person—or the death may occur in the wrong kind of setting—accidentally, for example. From this, we may raise questions about variations on the norms—the effect of mobility, intermarriage, and so on.

As far as I can gather, the crisis periods—the death, wake, funeral mass, and burial—are essentially more emotional and more participant variants of the standard American Catholic ritual. (By "more participant" I simply mean that everybody participates publicly.) Or, to put it the other way around, they are sterilized and tidied-up versions of what Lewis describes in his book on Guadalupe's death. After the death and its certification, the body is moved to the funeral home. This, an intrusion of state law into family customs, removes the most emotional scenes into the impersonal setting of the funeral home. In most Anglo funerals the immediate family is not visible; in the Mexican–American funeral they sit in front. In most Anglo funerals children do not participate; apparently this is not the case in Mexican–American

funerals. There is greater participation by all ages and degrees of involvement with the dead person than in the normal American funeral.

The rosary is said in Spanish and sets the tone for the rest of the ceremony. In Los Angeles, it is only the old people who know the Spanish rosary, and it is the old people, particularly the old women, who come into their own during the funeral and the succeeding events. The old women wail. According to one young informant, they sound much like the little old ladies in Mexican churches who wail during their private devotions. A young man from New Mexico states that in the rural areas of that state there are still professional wailers—lloronas—and apparently the possibility of such a practice is not altogether remote even in Los Angeles. One young Angeleno said that his grandfather's funeral was invaded by a total stranger wailing; it was assumed that she would want money.

After the rosary we progress to the viewing—and touching, and kissing—of the body. At least the older people touch; the younger informants protested this action. Condolences are then shifted from the dead person to his family and the wake moves to the home, for talking, eating and drinking. During this period it appears that the most immediately bereaved persons are the targets of the strongest reintegrative efforts: old friends talk endlessly about old times, though not necessarily about the dead person.

The funeral mass the next day begins to shift the focus to the whole family and community. Segregation by sex continues, with the men often on the porch of the church, women inside. On the porch a frequent topic of the conversation may be the meaning of the dead person to the family's position in the community. Pallbearers reflect this communal linkage—not only sons and grandsons, but fellow members of the Knights of Columbus or of the G. I. Forum or other civic associations are involved. Family reintegration also continues to be important in the postburial activities.

The days and weeks after the burial are in some respects the most interesting. An Anglo might expect that the deceased would have been adequately honored by traditional funeral and burial and that the family would then "modernize" and do nothing.

This was not the case among the people I talked with. Novenas, grave visits, and so on, punctuate the family's life for several months after the death. One young anti-religious boy got up with his mother and sister every Sunday at 5 A.M. for early mass, a visit to his aunt's grave, and back to church again. He made no protest, and felt full respect.

It is during this post-burial period that the controls of the older over the younger generation are reasserted. As previously mentioned, children are active participants in all events. They are expected to be affected. For a period after the burial the family lives quietly; social activities are sharply reduced. In some families, radio and television are turned off. Girls are kept from dating. (One young woman was devastated because her grandfather died the day of her senior prom.) Though dates are also proscribed for boys, they manage to evade some of the more stringent controls—as they do, and are expected to do, with other areas alike. In general, however, for several months after the death of an old person, family controls are reasserted over all members. Demand for observance of the controls is made in the name of respect. There is no reference at all to a religious rational, e.g., that behavior after the funeral could affect the fate of the dead soul. In general, the value placed on respect in the Mexican–American culture has probably been greatly underestimated as a conservative force. Respect for elders, for tradition, for authority, for religion, has been the basis of appeals by parents with school-aged children, by politicians attempting to control militancy, by even such a militant as Ceasar Chavez in his union's relations with the Catholic church. It is in the name of "respect" that Mexican–American men temporarily relinquish their anti-religious behavior. "Respect" thus involves a test of maturity and a behavioral statement about priority of values. One "abandons" principle in favor of alleviating the discomfort of other human beings—most importantly, of one's grieving female relatives—and one does so in the name of traditional respect.

There are, of course, many features of this account common to other Americans, particularly to Catholics of southern European descent. But there are some that are distinctive. Family reintegration at the funeral depends on the sacrifices made by the large-family to be present at the ceremony. The family spends money it

can ill afford in order to get a child or grandchild home. It notifies cousins who have been invisible for years: the entire family must rally. Of course, for this to occur one must have a large family. Familism is reaffirmed at the funeral of an old head or spouse of one of the subfamilies. Though not specifically "Mexican," familism of this sort is characteristically "Mexican."

Just as the family must rally, so must the community rally. This means both the community of the past (brought in for some through the mechanism of the mutualista) and the present day community. The family's link to the past—its historical status in the community—is reaffirmed. Its linkage in the present day is re-established. In this fashion, the funeral helps maintain ethnic cohesiveness. Rallying of family and community revives the sense of historical identity, which is the core of ethnic identity. Men and women who are otherwise assimilated, who live and work with Anglos, "return," at least temporarily, for the funeral.

REQUISITES OF THE "NORMAL" FUNERAL

Wake, funeral mass, burial, and mourning for the old man thus may function to revive both family and ethnic feelings. In this sense, the funeral is "Mexican," no matter what may be shared with other Catholic ceremonies. However, this normal ceremony, even for the old person, has some important requisites, and it is with the consideration of such requisites that we begin to approach the topic of variations upon the normative theme.

The normal ceremony as described requires a large family with a "normal" age–sex distribution, in a reasonably meaningful relationship to a community of the past or the present. Today, for many old people in Los Angeles, much of the meaningful relationship to the community of the past depends on the shared problems of the immigrant generation. The work groups of the 1920s and 1930s, the mutualistas, are aspects of life for the generation born around the turn of the century and migrating from Mexico to the United States. Many Mexican–Americans, even in Los Angeles, did not have the experience of immigration, and the "community of the past" for most Mexican–Americans in New Mexico, with its predominantly "charter-member" contingence, would be entirely different. So also would the community

of the past in Texas, where the generational experiences have been quite different from those in California.

Community solidarity may be a requisite for attaining the kinds of reintegrative functions, on the personal and family level, that have been discussed here. But the bases for community solidarity—both present and past—may differ widely from one area to another of the Southwest, or even within Los Angeles. Sampling for community values is a difficult problem in the study of Mexican–Americans.

Another requisite for a normal funeral is the capacity to muster enough money to bury the person decently. The meaning of "enough money" or of "decent burial" is an interesting topic of research. Clearly, a certain level of expense and a certain number of people are necessary for a socially effective funerary drama. There must also be permissible variations in the scale of expense for people of varying means, but at any given level of expectations, it would appear that the funeral expenses represent a financial strain. (In fact, it may be that financial strain is part of the expectations.) The funeral costs entail not only the direct costs of coffin, burial plot, funeral home, and mass, but also expenditures in assembling the family from distant points, housing and feeding family and guests, and so on.

There is an important research question involved in the matter of expenditures. Raising money is the most essential of the behind-the-scene actions that may be lumped together as the non-ceremonial aspects of behavior around death. What are the norms about family member's contributions? Who should bear the major burden? Are loan companies involved? If so, who manages the financial negotiations? In Oscar Lewis' study of a funeral in Mexico City, money is a paramount theme: there is no surviving spouse, and the male relatives are too indigent to take complete charge. The negative feelings between survivors in Guadalupe's family were exacerbated by the financial problems of the burial. In such destitute families, which also exist among Mexican–Americans, is there still an attempt to meet some "normal" funeral ideal? Or is the funeral ceremony attenuated and shrunken? Do mutualistas survive in such poverty-level families as a way of meeting the financial crisis?

In addition to family, community, and money as necessary con-

ditions for a "good funeral," there is one final point to be mentioned. That is, people have to be prepared to play their roles in the funeral and its aftermath. "Preparation" may mean several things. First, of course, there is socialization to the funeral roles. Mexican-American children attend funerals frequently, as a rule, and they learn the behavior appropriate to men and women of different ages and relationships to the deceased. In a brief pilot study, young Mexican-American children were asked to tell a story about a picture of an old dead woman laid out with no coffin: responses were entirely on the factual level: "that must be Mexico"; "they must be very poor if they can't afford a coffin"; and so on—suggesting a relatively easy familiarity with the facts of death.[8] Thus, not only is funerary role behavior subject to socialization, but so also is the general capacity to deal with human death and funerals on the cognitive level. This general capacity may in the past (and for today's middle-aged Mexican-American) have been related to the rural background from which this population is largely derived. Experience with animal death on the farm may have been frequent and have served some kind of preparatory function denied to children who were as products of urban socialization.

We may speculate about a more subtle kind of "preparation" as well. The accounts of a normal funeral note the prominence of women. Unlike the secular socially-oriented party, women rather than men are the focus of interest and emotion. To be sure, there are similarities between the normative role of women in funerals and their traditional roles elsewhere. They are segregated, they are expected to be emotional. But women's prominence in the funeral suggests that they are in some way especially "prepared" for this role, that death may be in some way a special confirmation of some aspect of their normal role. This revives the question discussed at the outset of this paper—namely, the question of the recognition and concern with death in the Mexican-American subculture. In this context, there was a suggestive theme recurrent in interviews with young men, all of whom remembered aunts and grandmothers shaking their forefingers and warning, "you'll be sorry when I'm dead!" Although the words are hackneyed, it is rather unlikely that most Anglo children have actually heard

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[8] I am indebted to Jennifer Hurstfield for this observation.

them from women of the older generation. More often, in the larger culture, it is children who warn their parents. It is, of course, dangerous to generalize from a few anecdotes, but it is generally acknowledged that suppression of women is not unknown among Mexican–Americans. Could it not be that women's "preparation" for prominence during the funeral is related to their suppression in everyday life? Certainly such an interpretation would be consonant with the macro-cultural interpretation initally made in this paper. If funerary roles are related to everyday suppression, this is a topic well worth investigating in any study of adjustments to death and bereavement.

VARIATIONS ON THE NORMATIVE PATTERN

When any of the requisites for the "normal" funeral are lacking (those suggested here, or others), presumably the funeral and its aftermath are variant, or perhaps even deviant in failing to fulfill the functions suggested. However, there are variations within the "norm," i.e., there are circumstances under which the ceremonial and nonceremonial aspects of death can serve reintegrative functions on personal, familial and communal levels, but which are quite different from those described as "normal."

As an illustration, the death of an old woman is normatively quite different from that of an old man. To the extent that the family structure represented traditional roles, the old woman is more likely to have played a more supportive, more sympathetic role vis-á-vis survivors than is the old man. The death of an old woman is more likely than that of an old man to evoke more straightforward grief. Old men are likely to evoke ambivalence. They may have been family founders, and in their old age no longer possessed of much power to cause pain. But given the facts of life for most Mexicans in the 1920s, '30s and '40s, many if not most old men are likely to have been poor economic providers, often to have generated family problems during the search for work. Moreover, most were probably relatively impotent in their dealings with American institutions, and hence provided weak role models for their sons and grandsons. In short, there were many marital and parental problems around the behavior of men in traditional Mexican–American families of the past generation, and

the death of an old man is different for all concerned than the death of an old woman.

Another illustration of a variant pattern may be seen in the generational problem raised earlier in the discussion of requisites for communal solidarity. While most of today's old dying Mexican-Americans in Los Angeles represent a specifiable generational experience, many do not. Some may have immigrated from Mexico just a few years ago, following their recently immigrated children. Some may be fifth or sixth generation Angelenos. Los Angeles presents some real challenges to the student of Mexican-Americans. As a magnet for immigration from the entire Southwest and Mexico, the dying old people are very likely to have come from a wide range of places, and to have been in Los Angeles a widely varying length of time. The nature of observances around the funeral and after, and the degree to which community and ethnic solidarity can be reasserted is obviously related to the family's history in the area. Also, many subtleties in the observances vary with the cultural "distance" from Mexico. Variations can thus be expected in Los Angeles itself with respect to these matters.

A final point may be made concerning variations around the norm. The funeral described as normal is a Catholic funeral. Clearly there will be variations within Catholicism: for example, not all old people are buried from the conservative sanctuario of Guadalupe. Religiosity—or intensity of practice—within the family is another basis of variation: in the post-funeral period, novenas are an important vehicle by which family authority and family solidarity are reasserted. Obviously, the degree of religiosity in the family will affect the extent to which such traditional modes of behavior can be comfortably utilized. Finally, some 10 percent of the Mexican-American population is not Catholic at all, but Protestant.

DEPARTURES FROM THE NORM

Whether the death of an upwardly mobile or relatively assimilated man or woman represents a departure from the Mexican American norm or a variation on it is a question involving values. Statistically, it may not in itself be a very important question, at

least for today's oldsters, because so few have achieved occupational mobility or any degree of assimilation. There are questions related to both social class and ethnic mobility in the middle-aged generation, however, that are relevant. What, for example, is the upwardly mobile man to do about his father's death? Following the model of Yankee City, described by Lloyd Warner (1959), he may well use his father's funeral to establish his own status symbolically—perhaps a burial at Forest Lawn rather than at Calvary Cemetery, perhaps an "Anglo" service rather than a Mexican one. Superficially such status-oriented burials might be seen as a special symbol of "respect" for the dead—an especially "decent" burial. On the other hand, they might well be seen as betrayals of family and ethnic custom, and sources of conflict among the survivors. Status mobility and death are profoundly important issues, as Warner has shown, and well worth a special investigation, even in a relatively non-mobile population such as the Mexican–Americans.

On the other extreme, we must raise the question of poverty again, in the context of deviance. The only person interviewed from a "multi-problem" slum family remembered funerals as times of family tension and fights—not as times of family integration. Mutual accusations of neglect of the deceased, other charges and countercharges, guilt and hostility, were not resolved during the funerary observances. Obviously this is not a problem of lack of money alone, but perhaps, of the accumulated tensions that attend slum living. One of the norms during the funeral and its aftermath is that conflict is suppressed. If poverty life and, perhaps, other sources of family tension can produce a violation of that extremely strong norm, how are such tensions and conflicts resolved or, alternatively, acted out?

Obviously, both poverty and mobility may affect the capacity of the family to reassert its integration—both internally and with the ethnic community—thus impairing the functions of the funeral and its aftermath. So also may other sources of family divisivness, such as migration, mixed marriage, and so on.

The final question relating to deviant patterns are those which occur when the "wrong" person dies, or dies in the "wrong" way or in the "wrong" place. Most cultures have some tradition about the special fate of the "wrong" people. Pregnant women have a

special malice toward women who died in childbirth; men who die in battle have a special niche; children, especially infants, go to a special fate after death. Both standard Christian mythology and archaic Mexican mythology provide special fates for such "wrong" people. And, in a poor population—in all minority populations in the United States—such wrong people die more frequently than in the larger population.

Little more will be done here than raise this question. Only one point will be pursued: the death of a man killed in Vietnam. Such deaths have a very special meaning in a minority population. In pro-war areas or families, commonly in south Texas, for example, the high death rate among chicanos is taken as evidence of the collective virtues of the Mexican-American people—their machismo, their willingness to sacrifice for their country, and so on. Community definition of such a death will affect the way in which the bereaved family becomes reintegrated in the community. In a macabre sense, a dead soldier can become a piece of family "capital," a contribution to the enhancement of the family's standing in the community. Alternatively, in a community with a different definition of the war and which defined the high chicano death rate as genocide, a funeral of a Vietnam casualty can become an occasion for violent alienation from the larger society.

In the cases of the Vietnam or other "wrong" person's death, there is no problem with the person himself, just with his status at the manner of his death. A very serious question arises in the case of a death which occurs in pursuit of some illegal action. Thirty-nine Mexican-Americans in Los Angeles County died in 1969 of narcotics overdoses; an unknown, though small, number died in prison or were killed by police. Though this is statistically negligible, and though it is probably not researchable, speculation about such deaths might be fruitful. The family must cope with a member labelled as a wrongdoer. What factors would be associated with, for example, the family's decision to conceal or, alternatively, to confront that legal label? An ostensible suicide in a sheriff's lockup may reintegrate the family and the community by uniting them against officialdom, for example, as apparently occurred recently. In several instances, deaths at the hands of police have become occasions for community organization and, thus, for ethnic militancy. This is a very meaningful departure

from the normal pattern of reintegration of family and community. Suicides and homicides represent another version of this problem of "deviant deaths."

A final point may be made with regard to the death of a "normal," i.e., old, person in an abnormal place. Death in the county hospital may be a matter for deep family bitterness. One young man remembers the death of his beloved grandmother with great anger. Children under sixteen were not allowed to visit her. He was the only one of some ten grandchildren old enough to go. This was a deep violation of emotional and family norms, with an ensuing resentment against the bureaucratic norms. Minority group members often mount guard over hospitalized relatives to ensure their adequate care and to keep them company. In the case of this young man, moving the family in for a twenty-four hour watch during her dying days meant a prolonged battle with the institution. Few Mexican–American families would have the emotional resources or the persistence to accomplish such a victory, though it is highly probable that many share this family's sense of outrage that their loved member was left by the agency to die inhumanely. Nursing and convalsecent home deaths may entail similar violations of normal expectations for managing both death and funeral. In these two illustrations the institutional quality of the place of death has been emphasized; death by street accident, for example, probably has little special meaning because there is no organized influence countering the operation of family norms.

GENERAL COMMENTS

Deviant, variant, or normal death and funerary practice all raise questions about how the reintegrative functions operate among Mexican–Americans. The point has been made that the "normal" funeral of an old man and its aftermath reintegrates the family and its special history with community and ultimately with ethnic history. However, the consideration of variant and especially of deviant funerals raises another aspect of this question: will such integration be hostile to the larger society? Will the reaffirmation of past ethnic identity generate pride—or yet more ambivalence about the past of the group? Research into the funeral customs must not blind the researcher to the fact that this

is a minority in this society—a relatively powerless segment, whose powerlessness is nowhere more evident than in its troubles and private ceremonies.

The point was also made that the normal funeral and later observances reinforces general norms. This raises an important methodological issue: in the interviews conducted for this paper there was almost total consensus on the norms. The individual, private, feelings of discomfort, or of disapproval for the practices, e.g., religious practices, were overwhelmed into insignificance. Thus one might conclude that the function of the funeral is *general* norm reinforcement which operates by resolving the discrepancy between the individual's feelings and the group norm. This resolution is accomplished by both the highly charged emotional atmosphere and by the prevailing altruism, in which "principles" take second place to comforting the most grief-stricken relatives. But this, of course, is *not* resolution, and the norms that are being reinforced are of the most general kind—humanitarian, for example, rather than specifically ethnic. Religion is not strengthened, but family bonds are, if things go well, reinforced. Perhaps most important, human needs are openly expressed, acknowledged, and met.

Death is the ultimate human limitation. Subcultural as well as individual adaptations to this limit on human potential reflect group status as well as group tradition. They reflect group and individual strengths, accomplishments, failures, and needs, as they are expressed and managed through a rapidly changing and increasingly heterogeneous tradition.

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THE LAW ENFORCEMENT PROFESSION: AN INCIDENT OF HIGH SUICIDE

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THE GENERAL hazards accompanying police work have been widely publicized and few would refute the claim that officers daily "put their lives on the line." Surely the very nature of their work implies certain inherent physical dangers. In this paper, though, we focus attention on the high suicide rate among policemen, something seldom acknowledged as a possible product of police work, and try to consider it in light of our contemporary society. Certain conditions and situations which are central to the law enforcement profession seem conducive to a disproprotionately high suicide rate.

THEORETICAL ORIENTATION

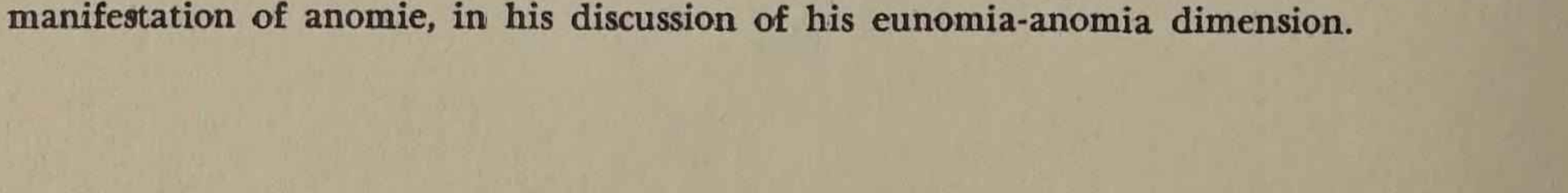
The orientation of the paper is sociological and, as such, the noetic frame will be of a social nature. Emile Durkheim's social integration theory is widely accepted as the classical sociological explanation of suicide in which the "social" factor is represented as the major determiner of human behavior (Durkheim, 1966).

Durkheimian theory is based upon three primary assumptions from which numerous hypotheses were derived and, in a fashion, tested. These assumptions are that suicide rates vary inversely with the degrees of social integration present in the domestic, political and religious societies.[1] Two types of integration are proposed by Durkheim: integration in sense of the normative structures (normative integration), and integration in reference to participation and feelings of mergence in collective activities or groups (col-

[1] It would be clarified that "altruistic suicide", apparently rarely manifested in modern societies, maintains a direct rather than inverse relationship with social integration. When it is detected, it is usually combined with one of the other types of suicide and, therefore, resulting in only a permutation rather than pure type.

lective integration). Concerning these two forms of integration, extreme conditions, notedly "ideal or pure" conditions, were discussed as situations conducive to high suicide rates or at least potentially high rates. Anomie and fatalism were considered as polar extremes of collective integration. Anomie is a condition in a society in which confusion, disgust, and disenchantment with the prevailing normative system exists because normative contradiction, attenuation, and atrophy persist. Fatalism, on the other end of the continuum from anomie, is a condition of hyperregulation rather than deregulation and arises out of conditions which provide for little or no personal autonomy, resulting in excesses of conventionality. Egoism and altruism are the subtended conditions which isolate, estrange, and alienate certain individuals from given activities, causing them to be "marginal members," and altruism being a condition in which the individual tends to lack uniqueness because the social system has made him so much a part of it that he has little or no individuality.

From the proceding discussions we can arrive at a type of classifactory system with emphasis upon the two types of integrations: normative and collective. The following crossed continua may help to visualize what is meant. At the four extremes social factors would be such that individuals experiencing them would have high suicide potential, naturally for different reasons in each case. Life-enhancing social conditions would be found where the continua cross or at least near the center, resulting in a type of balanced or stable situation.[2]



METHODS AND FINDINGS

The major source of empirical information for this report is a research study concerning the conspicuously high suicide rates which the State of Wyoming has experienced for several years (Nelson 1969). The study involved 64 in-depth case studies of

[2] Leo Srole (1956) described the absence of anomia, the personal rather than social manifestation of anomie, in his discussion of his eunomia-anomia dimension.

suicides and the examination of 535 death certificates. The certificates included only certified suicides during the nine-year period from 1960 to 1968. These certificates were analyzed in terms of age, sex, marital status, recorded cause of death, location and time of the suicide, and occupation. Because of the sociological orientation of the research and the concern for social class as a major variable, occupation was of central concern to the research. Through utilization of census materials avaliable on occupations the number of people employed in the particular occupation was acquired, and known suicide rates per 100,000 were computed.

Of the occupations listed, the law enforcement category had the highest rate of suicide at 203.66 per 100,000. Tables I and II show such a rate to be far above that for any other occupational group (In Table I, law enforcement officers are included in the service worker category). In fact, the rate is nearly twice that of the next highest occupational group (physicians) and much higher than any single occupation; rates ranging from 11.1 to 32.53 per 100,000.[3]

Related information concerning this high incidence group shows that all of the officers in Wyoming who committed suicide did so with firearms. Nearly one third of them (28.6 percent) were reportedly unmarried because of either divorce or separation. Other variables such as age, time of injury, race, and place of residence were considered and controls attempted; however, no trends appeared.

DISCUSSION

In light of these findings, along with the theoretical framework already presented, some possible clues to the central question of high suicide among police officers may be suggested.

First, the law enforcement profession is dominated by the male sex which has usually demonstrated suicide rates three to four times higher than those of females. This fact, however, hardly

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[3] Since this rate was established upon a frequency of only seven cases, it is not statistically conclusive, but at least it provides some indication as to the suicide potential of this group.

Similar results were also reported by Labovitz and Hagedorn (1968) in their study of suicide rates for different occupational categories. The law enforcement occupational group had next to the highest suicide rate (47.6 per 100,000). The highest group was the managers, officials and proprietors group.

TABLE 1

A Comparison of Suicide Rates for Wyoming Residents
by Types of Occupations, 1960–1968*

	MALES			FEMALES			COMBINED		
Type of Occupation	Number	Percentage	Rates per 100,000	Number	Percentage	Rates per 100,000	Number	Percentage	Rates per 100,000
Professional, technical	17	5.21	20.49	5	21.74	10.32	22	6.31	16.75
Managers, Officials, Proprietors	16	4.90	16.39	1	4.34	5.42	17	4.88	14.64
Clerical	12	3.68	33.00	9	39.13	9.67	21	6.01	16.27
Sales	12	3.68	33.00	0	0.00		12	3.43	19.45
Craftsmen, Foremen	66	20.26	41.93	0	0.00		66	18.91	41.37
Operatives	55	16.87	40.27	0	0.00		55	15.76	36.35
Service Workers	44	13.50	105.93	7	30.43	9.67	51	14.62	44.76
Laborers	44	13.50	77.55	1	4.35	268.38	45	12.89	77.71
Farm	60	18.40	44.52	0	0.00		60	17.19	42.06
TOTALS	326	100.00	$X^2 = 157.745$ $p < .001$ $C = .696$	23	100.00	$X^2 = 8,476.920$ $p < .001$ $C = .99$	349	100.00	$X^2 = 102.107$ $p < .001$ $C = .472$

* NOTE: Some frequencies are less than five, thus rendering the tests unreliable.

TABLE 2

Suicide Rates for Selected Occupations, 1960–1968

Occupations	Numbers	Rates Per 100,000
Physicians	3	132.53
Pharmacists	1	11.1
Lawyers	1	11.1
Students	30	*N.A.
Armed Services	19	*N.A.
Truck Drivers	27	*N.A.
Bartenders	5	105.66
Herders	6	*N.A.
Police Officers	7	203.66
Miners	11	36.51
Barbers	4	15.27

*N.A. means not available because demographic data concerning population size were not available for conversion to rates.

seems to answer the question concerning such extremely high rates in that other occupations are also dominated by males. Second, the fact that males employ firearms, probably the most positive and lethal means of self-destructive methods commonly employed, more often than females, may in part explain this difference. Further, the fact that policemen usually have much greater access to firearms and an adequate knowledge of their use may be a particularly relevant factor partly explaining the high incidence.

However, availability of and familiarity with firearms is not enough in itself to explain why the suicides are so high for this profession. There are undoubtedly numerous other, and seemingly more important, factors involved in the explanation. A third factor may be the physical and psychological demands upon the policemen which are not common to most "conventional" occupations. His constant confrontation with potential death, in reference to his own life as well as that of others, may have unusual psychological repercussions. Fourth, his long and usually irregular working hours may result in strained family relationships and may also make it difficult for him to participate in community and collective activities in which he can develop lasting friendships with others, leaving him, therefore, the victim of relationships which are all too often tenuous and cursory. Fifth, the officer's experiences with others, because of the very nature of his

work, are often in situations which may be considered unfavorable to "good human relations."

As voluminously reported in contemporary literature (Wilson 1967; Peterson 1957; Stern 1962; Westley 1956), the policeman in our society faces great public criticism, punctuated with violence and public apathy, and there is much evidence that dislike for "cops" is common. In such a setting the policeman becomes increasingly cognizant that the public does not care and that he is considered an "outsider" to a system that considers him only a "necessary evil."

In view of Durkheimian theory, the preceding would indicate excesses of anomie and egoism. Not only must the officer cope with the anomie and obvious contradictions of the average individual,[4] but also that of a society which, although needing him, does not want him.

A sixth source of frustration and confusion (anomie) to him is the legal system. People involved in the law enforcement are continually expressing feelings of weariness over what to them are evident contradictions, injustices and seemingly absurd decisions of the courts. It often seems that police stand as antagonists to those who act as proprietors of our legal system, and vice versa.

Whatever the arguments, it appears that law enforcement officers often become alienated from others because of their particular work situations and social exclusion from those who want nothing to do with police and seem to bear almost a hatred for them (egoism). If this be so, the presence of suicide potential in an occupational group of this orientation may be understandable.

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[4] Our society has been considered by some to be anomie-producing. (Merton 1938; Cohen 1965).

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CHANGES IN ATTITUDES TOWARDS LIFE AND DEATH DURING RECOVERY FROM A SERIOUS SUICIDE ATTEMPT

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VERY little research in the area of suicide has addressed itself to the problem of the changing meaning of life and death to the self-destructive individual. The bulk of investigation has focused on epidemiological factors (for example, Cavan 1926; Farberow and Shneidman 1955; Neuringer 1961; Schmid and Von Arsdol 1955), personality characteristics (see Farberow 1950; Hendin 1951; Neuringer 1964; Spiegel and Neuringer 1963), and to the discovery of prodromal clues to suicide (for example, Fisher 1951; Kaphan and Litman 1962; Shneidman and Farberow 1957). Much of this research has been illuminating and the prodromal clue research has been of practical importance in preventing suicide in hospital and clinical settings.

One of the most basic questions (and one of the most difficult to study) about self-destruction involves the suicide's attitudes towards life and death. This variable seems crucial for understanding of the emergence or non-emergence of a "suicidal" decision. Yet little is empirically known about these attitudes. Generally, suicide researchers' strategies have focused on establishing what kind of individual kills himself; what were the signs or clues that could have predicted the behaviors; what socioeconomic class is most prone to suicidal behavior; and so on. The present study represents a first step towards assessing the suicide attempter's attitudes towards life and death, and linking these to his self-destructive behavior. It was also hoped that some information might be gained about changes in these attitudes during the post-attempt period. The investigation of these changes may shed light on the variables influencing the prognosis for future suicidal attempts. In addition, the present investigation attempted to investigate an interesting piece of suicidal folklore. There exists a general underlying assumption among many researchers and clinicians interested in the psychodynamics of suicide that life has to be experienced negatively (i.e., burdensome, intolerable, full of anguish, and so on) and that death as an expectancy will bring about a

neutral state (cessation of consciousness) or some positive "existence" (peace, rest, after-life, and so on) in order for death to be chosen over life. This study attempted objectively to evaluate this assumption as well as studying the changes in attitudes towards life and death during recovery from a serious suicide attempt.

METHOD

The semantic Differential method, developed by Osgood *et al.* (1957), was selected as the means for quantifiably measuring attitudes towards life and death. The Semantic Differential is a measurement of meaning technique that is composed of three series of seven step bi-polar measurement scales. The first series of scales measures an Evaluative meaning factor (e.g., good–bad); the second set assesses a Potency meaning factor (e.g., strong–weak); and the third measures an Activity meaning factor (e.g., active–passive).

Consistent with Osgood's suggestions concerning the use of the Semantic Differential, only those scales possessing high factor analytic loadings on the Evaluative, Activity and Potency factors were utilized. In this study nine Evaluative scales (good–bad, dirty–clean, nice–awful, unpleasant–pleasant, fair–unfair, worthless–valuable, happy–sad, dishonest–honest, and beautiful–ugly) were used. The Activity factor scales utilized were passive–active, fast–slow, cold–hot, and sharp–dull. The Potency factor scales used were strong–weak, small–large, hard–soft, light–heavy, and rugged–delicate.

The subjects (described below) in this study were asked to rate what the concepts of *life* and *death* meant for them personally at the time of testing on the Semantic Differential. Half of the subjects received the test approximately one and a half days after their suicide attempt,[1] while the others were evaluated two weeks after their suicide attempt.

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[1] It would have been preferable to study changes in attitudes towards life and death through the use of a longitudinal research design (i.e., to retest the same post suicide attempt patients two weeks later). However, a cross sectional design was substituted, because the suicidal patients were quickly discharged and they could not be induced to come back for retesting either because of the stigma attached to their behavior, or because their goals had been achieved (i.e., manipulation of other people) by the attempt. The cross-sectional design, if the sampling has been rigorous, may serve the same purpose as does longitudinal research.

Scoring

Each seven step scale can be scored from +3 (very positive) to —3 (very negative). The ratings for the Evaluative, Activity and Potency subsets were summed for each individual and three individual mean factor scores were calculated for each subject. The group means for the three factors made by the subject assessed immediately after the suicide attempt were compared statistically with those scores of the subjects who were studied two weeks after their attempt.

Subjects

Ten subjects were gathered from five Veterans Administration hospitals and one large metropolitan general hospital. Four of the hospitals were in the southern California area and two were in the Missouri–Kansas area. Four of the hospitals were general medical and surgical and two were neuropsychiatric hospitals. All of the subjects were native-born, Caucasian males between the ages of 21 and 55. They were of average intelligence as defined by the Wechsler–Bellevue Intelligence Scale, Form I (1944). None of the subjects were psychotic and they were all in good enough mental and physical shape to partake in the research. All of the subjects were hospitalized at the time of the Semantic Differential administrations. None of the subjects received any kind of psychiatric or psychological treatment prior to partaking in the research project. Care was taken to select subjects who had no electroshock, ataractic drugs, individual or group psychotherapy.

Besides their general characteristics the subjects were chosen on the basis of their having made a *bona fide* serious suicide attempt. The establishment of the presence of the suicide attempt itself was made by (a) the verbal admission of the patient, and (b) the presence of some objective evidence of self-destruction such as a high barbituate level in the blood, noxious chemical substances lavaged from the stomach or deep surgical wounds on the body. The seriousness of the attempt was evaluated by a method developed by Tabachnick and Farberow (1961). They developed a six-step ordinal scale from which the lethality of a suicide attempt could be rated. In their six-step ordinal scale, "zero" lethability represents no chance of death occurring from the attempt (e.g., ingesting colored water), whereas a rating of

"five" represents a maximal lethal attempt (e.g., gunshot wound to the head). The possibility of rescue after the attempt may raise or lower the score. An individual who ingests a large number of barbituates and then immediately calls his physician receives a lower rating than the person who ingests an equal amount sitting in his car on an isolated mountain road. Gunshot wounds to the head or jumping from high places automatically receive a maximum rating because the possibilities for resuscitative intervention are almost absent. Accounts of the suicide attempt (in terms of method, place, time conditions of rescue) made by the subjects in the present study were submitted for ratings.[2] The combined mean rating for the subjects was 3.80 ($SD = 1.90$) indicating an appreciably high level of seriousness of the suicidal intention.

In addition, all of these suicidal subjects carried neurotic reaction diagnoses as defined by the American Psychiatric Association diagnostic and statistical manual (1952). Care was taken to screen out psychotic individuals because it was feared that their thought disorders and confusion might contaminate the data by interfering with their ability to comprehend the nature of the task.

While the impact of suicidal behavior on family and society is great, the occurrence of suicidal behavior, in comparison to other morbid events, is rather low, as Rosen (1954) and Neuringer and Kolstoe (1966) have indicated. This situation is reflected in research designs in which small sample sizes are the rule rather than the exception in suicide investigations. Research methodologists have pointed out the dangers inherent in drawing inferences from small sample size research. There are two general solutions to this problem. One may compensate for the small number of subjects either by statistical means or pay very careful attention to the subject selection procedures. The author has attempted the latter. The sample sizes for the two groups of suicide attempters is small ($N = 5$ for each group) in comparison to the numbers of subjects usually used in research, but it was felt that the vigorous criteria for selection described above partially compensate for the small sample size.

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[2] The author wishes to thank Drs. Norman L. Farberow and Norman Tabachnick for contributing their time and interest in order to make the ratings from the criteria of their scale.

RESULTS

The results of this study indicate that the general assumption that the attitudes towards life and death must be negative and positive respectively, in order for suicide to occur was not substantiated. It was found that, although the attitudes towards death were somewhat positive, the feelings about life were even more positive. The study of changes of these feelings over time indicated that the attitude towards death shifted from somewhat positive to clearly negative, but that the attitude toward life remained stable.

The average Semantic Differential Ratings of Life and Death made by the suicide attempters tested 1.6 days after the attempt and those evaluated 15.6 days after the attempt along the three meaning dimensions are found in Table 1. The two groups of subject's mean ratings of life along the three meaning dimensions are very similar. The disparities between the ratings of death made

TABLE 1

Average Semantic Differential Ratings of Attitudes Towards Life and Death Made by the 1.6 and 15.6 Day Post Suicide Attempt Groups Along the Evaluative, Activity and Potency Meaning Factors

	Meaning Factors		1.6 Day Group	15.6 Day Group
LIFE	Evaluative	*AV.*	+2.57	+2.29
		SD.	.43	.99
	Activity	*AV.*	+1.80	+1.05
		SD.	1.34	1.25
	Potency	*AV.*	+1.20	+1.04
		SD.	1.19	1.10
	Meaning Factors		**1.6 Day Group**	**15.6 Day Group**
DEATH	Evaluative	*AV.*	— .70	—1.34
		SD.	.93	1.53
	Activity	*AV.*	+ .05	—1.40
		SD.	.44	1.51
	Potency	*AV.*	+1.16	—1.00
		SD.	1.21	1.84

by the two sets of suicide attempters is much greater than those made for life. These relationships are more clearly and graphically displayed in Figure 1.

FIGURE I.

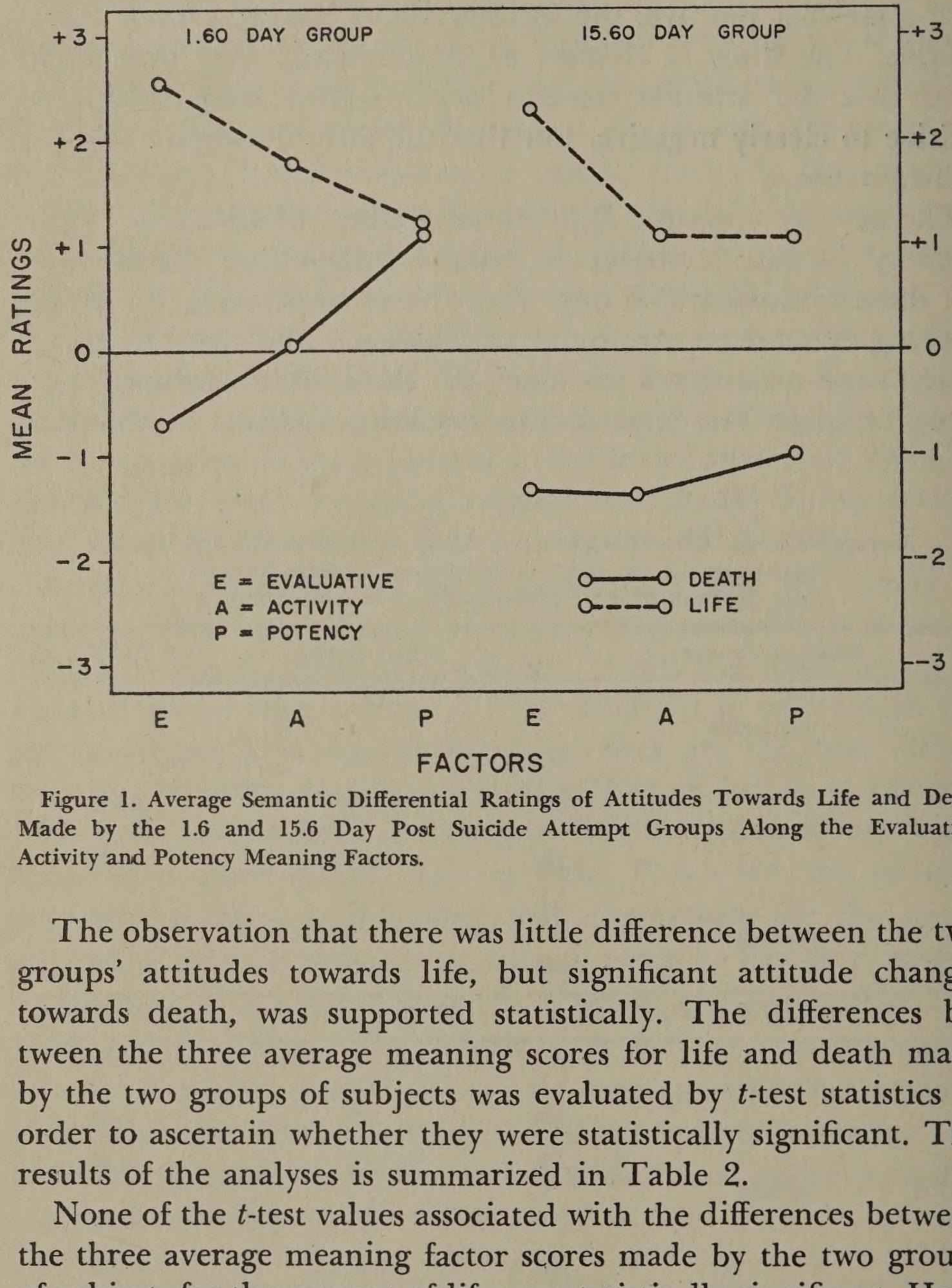


Figure 1. Average Semantic Differential Ratings of Attitudes Towards Life and Death Made by the 1.6 and 15.6 Day Post Suicide Attempt Groups Along the Evaluative, Activity and Potency Meaning Factors.

The observation that there was little difference between the two groups' attitudes towards life, but significant attitude changes towards death, was supported statistically. The differences between the three average meaning scores for life and death made by the two groups of subjects was evaluated by *t*-test statistics in order to ascertain whether they were statistically significant. The results of the analyses is summarized in Table 2.

None of the *t*-test values associated with the differences between the three average meaning factor scores made by the two groups of subjects for the concept of life was statistically significant. However, two of the *t*-test values (those associated with the differences

TABLE 2

t-test Values of the Differences Between the Average Semantic Differential Ratings of Attitudes Towards Life and Death Made by the 1.6 and 15.6 Day Post Suicide Attempt Groups Along the Evaluative, Activity and Potency Meaning Factors

	Evaluative	Activity	Potency
LIFE	.58	.91	.21
DEATH	.80	2.07*	2.20**

* Significant at .032 level of confidence
** Significant at .026 level of confidence

between the Activity and Potency meaning factor scores for death made by the two groups of subjects) were statistically significant. While the average Evaluative meaning factor score was more negative for the 15.6 days group as compared with the 1.6 days group of subjects, the difference was not statistically significant.

DISCUSSION

The data indicate that the certain assumptions about the attitudes towards life and death necessary for suicide to occur were not empirically substantiated. Life is perceived by both groups of subjects as highly valuable, active and potent and generally as a positive state of affairs. The 1.6 day group (if we assume that they are the most suicidal inasmuch as they are closer in time to the attempt) did view death as having a somewhat mildly negative character and as being quiescent. But also they did see death as being a very potent and strong force in their lives. The 15.6 day subjects (considered to be the recovery group because they are further in time from the attempt) showed evidence of change in their attitudes towards death. Although the Evaluative attitude towards death becomes only slightly more negative, they felt that it was a much less potent force in their lives and that it was definitely not an active aspect of their existence. It is possible that if the attitudes towards death could have been measured moments after the attempt, the Evaluative meaning factor rating may have been found to be much less negative or even positive. If this were the state of affairs during the suicide attempt or immediately afterwards, then the ratings that occurred two weeks after the attempt would be significantly different. There is experimental evidence that the rate of change of the Evaluative factor is more negatively accelerated (i.e., rate of change is initial-

ly very fast and then slows down) than those of the other factors (Osgood *et al.*, p. 134).

The findings in this study are illuminating in several different ways. The accepted assumption that life is a negative state of affairs and that death has definite positive overtones needs to be revised. It appears that the attitude towards death seem to be the crucial aspect of the suicidal "decision." It may well be that self-destructive thoughts and behavior occurs because death loses much of its negative character. The results of this study indicate that it is perceived as a mildly negative state but also as a condition of powerfully attractive quiescence. It may be feasible to hypothesize that suicide is most possible when death loses its fearful aspects. Spiegel and Neuringer (1963) after analyzing suicide notes reported that the lack of the dread of death seemed to be one of the necessary conditions for the occurrence of suicide. Menninger (1938) may have been making the same observation when he intimated that suicide was partly determined by the ascendence of Thanatos over Eros. The seemingly small inhibitory influence of positive attitudes towards life on suicide may explain the puzzling paradox of why people who seem to acknowledge that they had everything to live for suddenly committed suicide. This paradox has interested many writers, the best example being E. A. Robinson's *Richard Cory*.

It appears that death grows more abhorrent to the suicide attempter as he begins to recover. It is hoped that this negation can act as a deterrant to future self-destructive activity at least for a whole. The present measurement technique used for the assessment of attitudes towards death, while being of theoretical importance for the understanding of self-destructive ideation and behavior, may possibly be utilized also as a diagnostic sign for the resurgence of self-destructive tendencies and therefore have importance for the prevention of suicide. Repeated measurement of these attitudes may be a technique by which the threat of suicide may be quickly recognized and the suicide therefore avoided.

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MONTAIGNE ON DEATH

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MICHEL DE MONTAIGNE, the Renaissance essayist and student of human nature, showed a particular fondness for the subject of death. The rich treatment he gave it in his essays revealed the influence of his own experiences with death, as well as his critical self-examination and self-discovery. His *Essays* contain no detached metaphysical speculation on the subject, but treat instead the human experience of dying with all of its pain, grief, and courage. His view of dying contrasted sharply with that which prevailed during the Middle Ages. During that period dying represented a prelude to life in the next world. If accomplished according to explicit rules, it insured one's place in heaven. Montaigne saw men dying as a part of their human condition. He believed that the act should be accomplished simply, quietly, naturally, and in accord with each man's character. In the three volumes of his *Essays* he dealt extensively with various aspects of the subject, including the fear of death, the means of combating that fear, the preparation for dying, and, finally, the way to die. As his thought developed and as he was influenced by his experiences with death and advancing age, his early ideas gradually changed. From an obsessional and fearful preoccupation with death in his youth, he came to regard dying as an entirely natural and human end, not one to be prepared for or feared. His views seem especially worthy of reexamination during a time when dying for most persons has little continuity with the remainder of life and when we find ourselves concerned, as Montaigne was, with helping men to die appropriately and with dignity.

LIFE AND WORKS

It was only during the final third of his life that Montaigne wrote his essays. Several events may have influenced him in the

direction of scholarly endeavor. He was born in 1533 and was married in 1568; soon thereafter his father died leaving him a title and an estate. Dissatisfied with his employment in the courts and Parliament, he retired in 1571 at the age of 38 years. His adjustment to idleness and solitude was not easy, but at this time he began to write and develop his original idea of the essay. In 1578, when he was 45 years old, he fell ill with kidney disease productive of frequent stones. This painful condition, partly because it had killed his father, filled him with dread. Life remained bearable, however, and in addition to his writing, he traveled, and in 1581 was elected mayor of Bordeaux. Finally, in 1592, in his sixtieth year, he completed his third book of *Essays,* before dying of a throat inflammation.

Montaigne's approach to death and dying reflected his thinking on man and nature (Frame 1955). In his earliest essays his thought was derivative and he took the pose of a classical stoic. He was obsessed with meeting pain and death bravely, looked to will and reason for support, and tried to learn by premeditation to play his part well. Among the ancient sages he admired Cato the Younger, whose death influenced him as strongly as did his philosophy. Death was for Montaigne the goal of a life in which there was little to hope for but much to fear. In a few early essays, however, he began to criticize the heroics of the ancients. He felt their virtue could not be sustained and their expectation of the human will was extreme. Suicide, their panacea, seemed neither natural nor Christian. In his "Apology for Raymond Sebond" (Montaigne 1948, pp. 318–457), he revealed a skeptical crisis in which he finally rejected the humanistic attitude which he had admired. He argued that man, without divine grace, was distinguished from animals only by his presumption. Reason on which he prided himself had not found certain truth; nor was it likely to do so in the future. Wisdom, it followed, could come only from awareness of man's ignorance.

Montaigne's skepticism led him to recognize the importance of self-examination and self-knowledge. His subject became man and he presented himself as an example about which he revealed a great deal in his essays. As he gained confidence in himself and mankind, his early view "That to Philosophize is to Learn to Die" (p. 22), was replaced by a belief that "it is philosophy that

teaches us to live" (p. 120). He argued that man's greatest and most dangerous error was his attempt to reject the human condition, for within it he saw great resources for wisdom and happiness. His greatest achievement was to live appropriately and in harmony with that human condition and with nature.

EXPERIENCE WITH DEATH

Montaigne's interest in death was no doubt stimulated by his own experiences. Because few of us today are exposed to death in early years, we feel distant from it. This was not the case for Montaigne. When 30 years of age he lost his beloved friend, La Boetie. Five years later his father died and then a brother. His first child died in infancy. Not long thereafter he said, "With such frequent and ordinary examples passing before our eyes, how can we possibly rid ourselves of the thought of death and of the idea that at every moment it is gripping us by the throat?" (p. 59). As he looked among both men of renown and acquaintances, he estimated that as many died before age 35 as afterwards. While he sensed death's nearness and felt its sting, he also lacked faith in physicians and consequently derived no comfort from that source. He bitterly accused them of La Boetie's death and believed that they caused as much suffering as they allayed.

It was perhaps Montaigne's own experience of dying which most influenced his thought on the subject. In his essay "Of Practice" (1948), he gave an account of a riding accident in which he was struck from his horse and rendered unconscious. Gradually regaining consciousness he saw himself covered with blood and believed that he way dying. "The first though that came to me," he said, "was that I had gotten . . . shot in the head; . . . It seemed to me that my life was hanging only by the tips of my lips" (p. 269). This experience, from which he fully recovered, left with him an impression of what it must be like to die. Even so, he said, when it comes to "dying, which is the greatest task we have to perform, practice cannot help us . . . we can try it only once: we are all apprentices when we come to it" (p. 267).

The experiences of illness and old age were to further influence Montaigne's attitude. Painful bouts of colic related to the passage of kidney stones commenced in 1578 and contributed to this death. He said in "Of the Resemblance of Children to Fathers,"

"It was precisely, of all the accidents of old age, the one I feared the most" (p. 575). Shortly after the onset of this suffering, however, he reported growing reconciled to it and finding in it food for consolation and hope; and he found it useful in the preparation of death. In his *Travel Journal,* which he had not intended for publication, he remarked, after passing an unusually large stone, "There would be too much weakness and cowardice on my part if, finding myself every day in a position to die in this manner and with every hour bringing death nearer, I did not make every effort toward being able to bear death lightly as soon as it surprises me (p 1018). In old age he found another potent natural resource for putting himself in a state of readiness for death. Toward the last he said, using a typically vivid metaphor, "I am nearing the bottom of the cask, which begins to taste of sediment and lees" (Lowenthal 1935, p. 361).

Montaigne was profoundly influenced by the plague which killed nearly half of the inhabitants of Bordeaux during his mayoralty and later spread to his home. In one of his last essays, "Of Physiognomy" (Montaigne, 1948), he leaves an unforgettable account of the public death he witnessed. He felt that he learned from it and felt fortunate to have been a witness. Of this way of dying he said, "It is a kind of death that does not seem to me one of the worst: it is generally quick, numbed, painless, and consoled by the public situation, without ceremony, without mourning, without a crowd around" (p. 802). The quiet bravery shown by the unpolished mob as it met death impressed him especially.

FEAR OF DEATH

The nearness of death which Montaigne experienced caused him to be fearful. By his own admission he became obsessed with the subject in an effort to comfort himself. If it were not for doing this, "I should," he said, "be in continual fright and frenzy; for never did a man . . . . set less faith in his duration" (p. 61). Through an anecodote he left us a picture of his fear. Once when returning to his home and only a league distant he wrote a memorandum about something he wished done after his death. He had hastened to write it there, being uncertain of reaching his destination.

As Montaigne examined the fear of death he observed that dying more than death itself was a cause of distress. "Death," he quotes Ovid as saying, "holds less pain than does the wait for death" (p. 37). With respect to pain, the customary accompaniment of dying, he felt we make false excuses. "I find by experience that it is rather our inability to stand the idea of death that makes us unable to stand pain, and that we feel pain doubly painful because it threatens us with death'" (p. 38); but if dying seemed horrible, it was the dreadful faces and trappings which surrounded it that were probably responsible:

> . . . an entirely new way of living; the cries of mothers, wives, and children; the visits of people dazed and benumbed by grief; the presence of a number of pale and weeping servants; a darkened room; lighted candles; our bedside besieged by doctors and preachers; in short, everything horror and fright around us (p. 68).

The inclusion of physicians in this unsavory scene was no matter of chance. Montaigne found in medical men a source of fear of illness and death. He not only held no confidence in their prescriptions but viewed them even as causes of suffering and illness. The longevity of his ancestors who has avoided doctors was to him evidence that avoidance was the wisest course. He said:

> I see no group of people so soon sick and so late cured as those who are under the jurisdiction of medicine. Their very health is impaired and corrupted by the constraint of their regimens. The doctors are not content with having control over the sickness; they make health itself sick, in order to prevent people from being able at any time to escape their authority (p. 581).

Montaigne pointed to one advantage of fearing death. He claimed that such fear adds zest to life. Life, since it is made up of contrary things, is enlivened by the possiblity that at anytime it may be lost. As a consequence, he constantly told himself, "Whatever can be done another day can be done today" (p. 61). This thought, touched upon in his first essay on death, reappeared in his last one when, as an old man, he said:

> Especially at this moment, when I preceive that my life is so brief in time, I try to increase it in weight; I try to arrest the speed of its flight by the speed with which I grasp it, and to compensate for the haste of its ebb by my vigor in using it. The shorter my possenssion of life, the deeper and fuller I must make it (p. 853).

Knowing the fear of death, Montaigne viewed it as supremely important to conquer this fear of fears. ". . . all the wisdom and reasoning in the world boils down finally to this point," he asserted, "to teach us not to be afraid to die" (p. 56). He recom-

mended in his early writings ridding death of its strangeness by coming to know it and getting used to it. "Let us have nothing on our minds as often as death," he advised. "At every moment let us picture it in our imagination in all its aspects" (p. 60). Montaigne saw getting acquainted with death as important; should we be fearful of death, then we must fear life. "What shall we not fear," he tells us, "if we fear what cowardice itself has chosen for its refuge?" (p. 36). On the other hand, if a man gains assurance against it, he becomes immune to torment. Echoing Seneca, as he did in his early essays, he said that the premeditation of death was the premeditation of freedom.

PREPARATION

As he began to write, Montaigne urged the men of his time to prepare for death. "Be familiar with it," he said, "and it will never surprise you." With advancing age and increasing experience, however, he no longer called fearfully for premeditation. He discovered that studied preparation for death was practically unnecessary and perhaps even harmful. Early he turned to stoic philosophizing and reason as aids in preparation; later he drew upon personal experience and Nature. He urged men simply to follow Nature and, by accepting their human condition, allow her to supply the necessary resources. Thus as aids in preparation, he looked first to philosophy and later to experience and Nature.

Montaigne borrowed from the ancients in his early philosophy. He at first favored the benefits of virtue which seemed to offer disdain for death and coverage in dying. A man might even put an end to his life and suffering whenever he chose just as Cato, the Younger, had done. That statesman's suicide was one of the foremost examples of noble deaths among the ancients. Montaigne admired Cato. He also followed Seneca in saying that the man who had learned how to die had escaped from slavery. At one point he joined Cicero in saying that a philosopher's detachment from life readies a man for death. ". . . my farewells," he said, "are already half made to everyone except myself. Never did a man prepare to leave the world more utterly and completely, nor detach himself from it more universally, than I propose to do" (p. 61).

He presented several arguments in support of his call for men to accept gracefully what reason and nature urged. He argued that it is stupidity to torment oneself over what in reality is a passing from all torment. Some men may even be better off dying and avoiding great miseries. He asked how a thing that happened only once could be grievous; and he pointed out, "Your death is a part of the order of the universe; it is a part of the life of the world" (p. 65). For those who would bemoan their lot, Montaigne recalled the myth in which Chiron refused Saturn's gift of immortality when informed of its conditions. The advantages of living were measured in use, not length, he said: and if one has made profit of it then he can go his way satisfied. In doing so, he makes room for others just as others have for him.

Experience, which teaches and prepares one for action, taught Montaigne about dying. There seemed to him to be ways of familiarizing ourselves with death and trying it out to some extent. Sleep might be Nature's way of acquainting us with what it is like to be dead. He suggested also that those who fainted came close to seeing death's natural face. Thrown from his horse, Montaigne experienced a gradual return from a state of unconsciousness. As he began to revive, he tells us that he felt his life hanging by a thread and then, "I closed my eyes in order, it seemed to me, to help push it out, and took pleasure in growing lanquid and letting myself go. . . . It would, in truth, have been a very happy death; for the weakness of my understanding kept me from any judgment of it, and that of my body from having any feeling of it (p. 272). Thus, he found the experience of dying not so difficult and he felt that it somewhat reconciled him to death. It is of passing interest that Montaigne suggested a bit of research that remains to be done. He could not say whether persons suffering accidents such as his had similar experiences, but if so, he thought this information would be useful.

Concerning the preparation for death that nature provides, Montaigne was most eloquent. The resources of nature appeared to him to be abundant. She lends us her hand, he said, and gives us courage. "I notice that in proportion as I sink into sickness, I naturally enter into a certain distain for life. I find that I have much more trouble digesting this resolution to die when I am in health than when I have a fever" (p. 63). Just as he found a

gentle aid in the discomforts and weakness of illness, he also found one in aging. In one of his most consoling passages, he said:

> . . . when we are led by Nature's hand down a gentle and virtually imperceptible slope, bit by bit, one step at a time, she rolls us into this wretched state and makes us familiar with it; so that we feel no shock when youth dies within us, which in essence and in truth, is a harder death than the complete death of a languishing life or the death of old age; inasmuch as the leap is not so cruel from a painful life to no life, as from a sweet and flourishing life to a grievous and painful one (p. 63).

When he himself reached old age, he reiterated his belief that nature provides ample resources for meeting death. He reckoned that at his age death might take only a quarter or, at most, a half of the life that had once been there.

Observing the plague Montaigne saw nature at work. By this time (1584) he had rejected his former belief in the virtues of the ancients. He now looked upon Cato's suicide as agonizingly overdone and the suicide proposed by Seneca as impulsive but not necessarily courageous. With increasing frequency, he spoke of Socrates as his hero. What impressed him about this philosopher's death was its ease and naturalness. The same was true for the masses he saw dying of the plague. In his early essays he commented upon the calm resignation of the common people toward death. At that time he attributed this demeanor to brutish stupidity but now he spoke of a quiet courage and simple naturalness that he admired. A vivid passage pictures the scene which so moved him:

> Each man universally gave up caring for his life. The grapes remained hanging on the vines, the principal produce of the country, as all prepared themselves indifferently, and awaited death that evening or the next day with face and voice so little frightened that it seemed that they had made their peace with this necessity and that they were under a universal and inevitable sentence of death . . . . I saw some who feared to remain behind, as in a horrible solitude; and found them generally to be concerned only about their burial. It pained them to see the bodies scattered amid the fields, at the mercy of the animals that promptly appeared in swarms . . . . Here a man, healthy, was already digging his grave; others lay down in them while still alive. And one of my laborers, with his hands and feet, pulled the earth over him as he was dying (p. 802).

Montaigne felt that these common men, though benefited by ignorance, had learned well the lessons of nature. In resolutness and courage he saw his countrymen show, as if by habit, examples conceding nothing in firmness to any studied or premeditated fortitude. As he reflected, he seemed to reject the notion of laboring to prepare for death. "If you don't know how to die, don't

worry," he said, "Nature will tell you what to do on the spot, fully and adequately. She will do this job perfectly for you; don't bother your head about it" (p. 804).

The whole matter seemed to fall into perspective for Montaigne and he spoke again, as he so often had, of the many ways we torment ourselves by our powers of anticipation and imagination:

> We trouble our life by concern about death, and death by concern about life. One torments us, the other frightens us. It is not against death that we prepare ourselves, but against the preparations for death (p. 804).

No longer did he urge philosophy upon men so that they might learn how to die. To stimulate their forethought in that way would cause them fear, which would in turn require treatment. He likened the situation to one which would exist if a doctor made his patient ill in order that the patient might then respond to his drugs. It seemed inconsistant to him to teach a man how to die who had not learned how to live. This seemed especially true since, if a man had known how to live steadfastly and tranquilly, he would certainly know how to die in the same way.

HOW TO DIE

Finding himself prepared for death, Montaigne reflected in his final essays on how men should die. One of the important things in this world, he believed, was belonging to oneself, that is, knowing oneself and acting in accord with that knowledge. Not only was this important but, in dying, unavoidable. There he saw no choice for us but to face ourselves:

> In everything else there may be a shame: the fine reasonings of philosophy may be a mere pose in us . . . . But in the last scene, between death and ourselves, **there is no more pretending; we must talk plain French, we must show what there** is that is good and clean at the bottom of the pot (p. 55).

He hoped that, as he died, he would be true to his deepest self and be in harmony with the whole of his life. Accordingly, this man who recommended a "gliding, obscure, and quiet life" (p. 782), favored a death of like kind:

> It is not my idea to prove or display my fortitude in this act of dying. For whom? Then will end all my right to reputation and my interest in it. I am content with a collected, calm, and solitary death, all my own, in keeping with my retired and private life (p. 748).

In contrast to the demeanor he recommended he believed that many men attempted to be courageous and stiffened their coun-

tenance in order to acquire a reputation they hoped to enjoy while yet alive. He wished that his death would say nothing that his life had not already said; but he would not object if it went right on talking. "Even my death," said the essayist, "if I should find it garrulous, as others do, I would willingly give an account to the public on my way out" (p. 809).

If he were to be given a choice, Montaigne favored a sudden death in the midst of everyday life. "I would always have a man active to the last," he said. "But let Death take me while I am planting my cabbages, indifferent to him and still more indifferent to my unfinished garden" (p. 62). Where one's lot was not particularly happy, he believed that the resources to meet death were to be found within each man—he needed seek no further; and his emotions in that dying state might be expressed freely. He felt it unduly formal and unnatural to maintain a good countenance and composed bearing in enduring pain:

> . . . it is cruelty to require of us so composed a bearing. If we play a good game, it is a small matter that we make a bad face. If the body finds relief in complaining, let it do so. If it likes agitation, let it tumble and toss at its pleasure. If it thinks that the pain evaporates somewhat for crying out more violently, or if that distracts its torment, let it shout right out (p. 577).

Montaigne, though he favored dying by degrees, at the same time recognized certain hazards to the death occurring in old age. He recognized them because he experienced them himself. He reported, as he looked upon his own situation, that decrepitude prior to death is only tolerated within certain limits by family and friends. Chronic illness and dependency, he realized, do not evoke the same sympathetic responses that acute illnesses do. He concluded that dying persons may with time make themselves annoying and unbearable to others. It did not seem right to him for a dying man to inflict his suffering and helplessness upon his family to their detriment. Thus, seeing his life grow burdensome to those about him, he chose to withdraw. Decrepitude he saw as a solitary quality:

> . . . . it seems reasonable to me that henceforth I should withdraw my troublesome self from the sight of the world and brood on it by myself, that I should shrink back and retire into my shell like a tortoise. I am learning to see men without clinging to them; that would be an outrage in so steep a pass. It is time to turn my back on company (p. 750).

He arrived, finally, at what in his imagination was an easy and comparatively desirable form of death:

> How easy fortune makes it for me to trade in my life, having placed it in such a position that henceforth it is neither necessary, nor a hindrance to anyone! It is a condition that I would have accepted at any season of my life, but now that it is time to pack up my odds and ends and strap my bags, I take most particular pleasure in giving scarcely any pleasure or displeasure to anyone by dying (p. 753).

Montaigne believed the deadest deaths are the best. The one of which he spoke was provided by Nature, not wisdom, and appropriate, neither to fools nor wise men but to persons in between.

MONTAIGNE TODAY

What Montaigne teaches us is perhaps best examined by looking at its opposing sides. The essayist saw life as made up of contrary things and many of his ideas, if not viewed in this light, seem contradictary. First of all, he tells us, the fear of death influences life and we must face it. Our society has denied death as a part of its belief in control over nature. This denial has been expensive. It has resulted in rejection of old age, an unwelcome reminder of death. It has robbed us of a spur to intense and zestful living that an awareness of death may afford. The current reexamination of man's relationship to nature accompanied by a diminishing confidence in science offers less support for the past denial. We have seen that Montaigne was, for a time, an example of an opposite extreme. Because he looked death so squarely in the face, he forced himself into a philosophical detachment from life in at attempt to find security. When he said good-byes in early life, he must have died by several degrees in the process.

Montaigne tells us that old age provides adequate preparation for death. He allows us to feel in one eloquent passage after another the gentleness and ease with which we are led to life's end. He also comforts us by helping us to picture how old age and illness actually put us in a state of readiness for death. For us especially the salve of old age is available. The seeming contradiction is that the salve may be abrasive. "Old age," said Montaigne, "is a powerful malady." He attributed to it "a foolish and decrepit pride, a wearisome quality, an unsocial and snapping temper, and an idiotic pother over money, even when the power to use it is gone."

Montaigne points out that we have grown abusive of nature by our practice of coaxing life to its extremity. He said we "tease her along so far that she is forced to quit us, and leave our teeth,

eyes, limbs, and upkeep to the mercy of aid we must beg from others" (p. 846). This practice is, of course, one manifestation of the denial of death. Old age is prolonged for many so that it and the death that ends it bears little resemblence to the life that gave it birth. The process is a dehumanizing one. Montaigne would doubtless have disapproved any practice which preserved physical life when psychological life, in the human sense, had ceased to exist.

Montaigne said we should die naturally and in harmony with our lives. He rejected, as inappropriate for dying, that which he came to see as false and unnatural in his day; namely, the attitudes of Seneca and Cato. Today we expose dying individuals to the artificial surroundings of hospitals filled with their life maintaining aids. There we support their beliefs that life will be unending. To see equipment, drugs, and technicians all about maintains for them an illusion of continuing life. If dying in this manner is more palatable, it is less in keeping with everyday life and with the death Montaigne recommended. Such dying, however, is in harmony with our age and is fostered by a tremendous faith in science and a belief in our ability to control nature. It is consistent with this unrealistic belief that dying persons, rather than accept death, seek miraculous cures.

In another sense Montaigne might have recommended the hospital as a place to die. He favored going away to die in solitude to spare himself the agony of seeing his family grieving and to spare his family the pain of witnessing his death. ". . . there is no great evil in dying far off and alone. Indeed we think it a duty to retire for natural actions less unsightly and less hideous than this. But besides, those who are reduced to dragging out a long, lingering life ought perhaps not to wish to involve a large family in their misery" (p. 750). Hoping for a solitary death consistent with his private and retired life, he spoke of dying under the care of paid strangers:

> Dying is not a role for society; it is an act for one single character. Let us live and laugh among our friends, let us go die and look sour among strangers. You will find, if you pay, someone who will turn your head, rub your feet, who will not trouble you anymore than you want, showing you an indifferent face, letting you reflect and lament as you like (p. 748).

Finally, Montaigne advises us to be wary of the doctor's authority. He referred to the dangers to be encountered and spoke of

instances where the drugs and rules administered were more difficult to bear than the illness. Doctors sometimes become more dogmatic and inflexible when confronted with dying patients. Their more authoritarian approach, while allaying their anxiety and that of their patients, may also have a dehumanizing effect. A patient may not have an opportunity to talk about his death, even when he desires it, or to share in decisions regarding his treatment—decisions such as who may visit him, where he will stay, even decisions regarding life prolonging procedures. If a man is to maintain his dignity, he must continue to use those faculties which make him human to manage his life to best advantage.

There can be no single formula for how men are to die so long as they remain unique individuals. Montaigne taught each man to be true to himself and die accordingly. He was one man who in the process of self-discovery examined his relationship to dying and gave a truthful account. It is a deeply human one and allows us to share his fear, his struggle, and finally, his acceptance of death. Those who today, four centuries later, seek to identify an appropriate death would profit from turning to the essays of Michel de Montaigne.

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THE THREE-DIMENSION FACTORIAL MODEL AND DEATH

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IF LIFE has three aspects, biological, social, and psychological, so, too, does its termination, death. But none of the aspects of death is adequately understood. In the process of living, people develop drives, hopes, and expectations. Endeavoring to satisfy these desires, they become so attached to tangible, worldly things and involved in everyday events that they do not want to see, hear, or think about death. This is one of the several reasons why, until very recently, death as the subject of scientific investigation was considered "taboo" and why so few scholarly papers have been written about it.

But times have changed, and possibly because of the expansion of clinical knowledge, a growing emphasis on the problems of aging, and an increased willingness to look at death objectively, the amount of research is accelerating in this area, some of it providing guidelines for future explorations. However, there is no scientific literature on death education, i.e., the instruction and less formalized training in the reality, meaning, and acceptance of death so as to enable persons to develop positive attitudes rather than responding to it with despair or denial. In these days of psychological stress, death education is as necessary as vocational or sex education. The special problems of older persons such as the loss of personal identity are also of urgent importance. To these ends, that is, providing meaningful death education for all and counseling the aged, psychological investigators should address themselves not only to the study of children and adults, but also to the study of older and dying persons. They must focus attention on death, even though many would rather ignore it.

Many different techniques have been used to measure the in-

fluence of attitudes toward death upon the cognitive and affective lives of individuals. (See Lester 1967, for overview.) But no investigation has used a factorial model such as Guilford's (1967) "Structure-of-Intellect" which would systematically generate areas of inquiry.

The purpose of this paper is to present a model which could do just that, in other words, generate research topics, guide methodology, require better instruments, demand sophisticated statistical treatments, furnish scientific inferences and predictions about attitudes concerning death, and thereby, enrich the field of death education.

A backward glance into another field, intelligence, will show the benefits of this type of factorial model. Early theories of intelligence utilized several kinds of models. Thorndike developed a multifactor theory in which intelligence was constituted of a multitude of separate factors, each of them a minute element of the total ability. Spearman, to the contrary, statistically validated only *g* (general) and *s* (specific) factors. Thurstone tried to bridge the gap between these two different views by demonstrating the primary mental abilities of number facility, word fluency, verbal meaning, spatial perception, rote memory, and reasoning. Vernon applied an hierarchical approach to organizing intellectual factors, but his theory was based primarily upon Spearman's concepts.

Guilford has developed a factorial model of intelligence utilizing three axes: operations, contents, and products. "Operation" refers to what the respondent does, "content" to the nature of the materials or information on which the operations are performed, and "product" refers to the form in which the information occurs or is conceived by the subject. There are 5 x 4 x 6 or 120 separate categories or cells in this theory, each cell representing at least one intellectual ability or factor which is described in terms of its three dimensions. The present author believes that Guilford's structure-of-intellect (*SI*) systematically simplifies, organizes, and encompasses all the basic intellectual and related personality factors more satisfactorily than any of the preceding schemata. It is logical and complete but still more detailed and specific than any of the earlier theories, and it is capable of future modification. Heuristically, it can be simply understood by analogy to the computer's input, internal operation, and output.

A model similar to the *SI* model could provide the framework for a comprehensive, factor analytic study of death. The axes, of course, would have to be changed, but the basic structure would remain the same. The need for and applicability of a three-dimensional model for death research is based on the fact that the termination of life can be understood in terms of biological, psychological, and social aspects. Moreover, the individual receives information about it through his various senses, thinks consciously and unconsciously about it, and, finally, reacts to it in a variety of ways.

The proposed tri-dimensional factorial design presented below would help isolate the components of a factor and attach psychological meaning of each of them. The dimensions of this model, analogous to Guilford's operations, contents, and products are: research approaches, types of death, and psychological variables. Death can be classified most basically as natural or accidental or suicidal, and so these three classes have been chosen as the predominant types. The life sciences (biology, biochemistry, anatomy, and physiology), sociology, and psychology have definite and different viewpoints, and therefore these disciplines have been chosen as the major approaches. The sociologist might investigate the effects of death and/or beliefs about death upon group interaction, traditions, and values while the psychologist would study its influence upon the individmual's needs, perception, motivation, thinking, memory, evaluation, and imagination. How a biologist might investigate factors concerning the fear of accidental death will be illustrated below.

This tentative *PRT* model has 3 x 3 x 16 or 144 cells. Each cell contains at least one element that can be factorially described. The number of cells would probably increase as future studies further catabolize each dimension into its major subcomponents. For example, to the "types of death" dimension might be added abortion, homicide, euthanasia, and demise early in life versus late in life. In the same way, research approaches and psychological variables could be broken down into several more specific elements. In addition, each individual cell could be studied in many ways, The sociological study of the fear of natural death (*SNG*), for example, could mean both fear of natural death in different societies and classes or the effects of fear of natural death upon

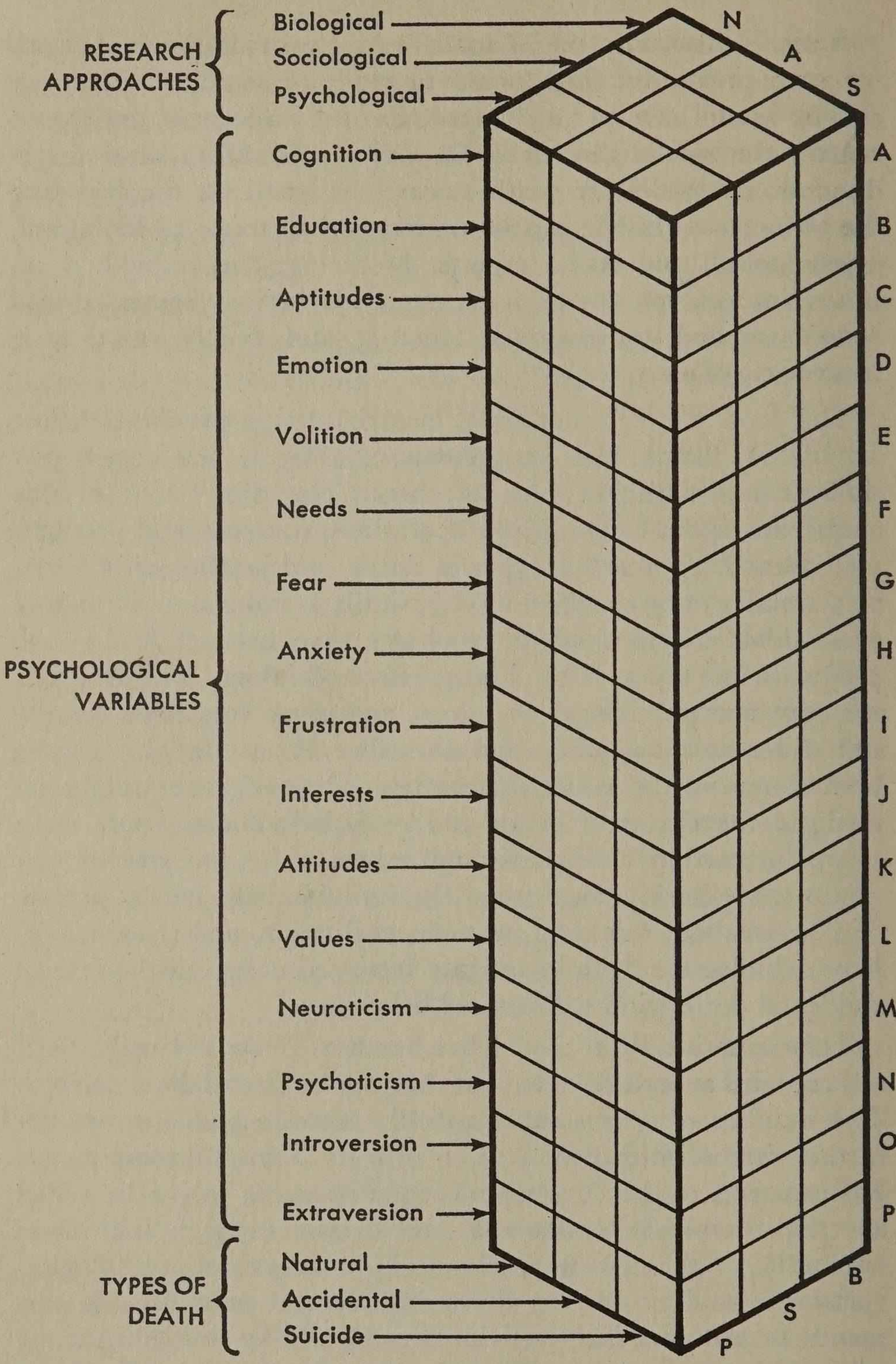


FIGURE 1

The *PRT* Model of Death Study

societal institutions. All the elements of a factor are of equal importance, and the functional relation can go in either direction.

The model can be read as follows. First, find the desired research approach along the top. Second, read down to the type of death along the bottom axis. Lastly, find the psychological variable of concern which is written along the side. Each factor is identified in this order.

In brief, a combination of one element of each dimension should be used in developing a research topic. If a person scans the cells or factors, he will find several problems commensurate with his research inclinations. Examples of individual cells include the influence of the biological aspects of approaching natural death upon cognitive functioning (*BNA*), the sociological investigation of the emotions concerning accidental death (*SAD*) such as the effect of the death of a leader upon his group's stabil-

FIGURE 2

The Biological Submodel of the *PRT*
Biological Approach

		Natural Death	Accidental Death	Suicidal Death
Psychological Variables	A	BNA	BAA	BSA
	B	BNB	BAB	BSB
	C	BNC	BAC	BSC
	D	BND	BAD	BSD
	E	BNE	BAE	BSE
	F	BNF	BAF	BSF
	G	BNG	BAG	BSG
	H	BNH	BAH	BSH
	I	BNI	BAI	BSI
	J	BNJ	BAJ	BSJ
	K	BNK	BAK	BSK
	L	BNL	BAL	BSL
	M	BNM	BAM	BSM
	N	BNN	BAN	BSN
	O	BNO	BAO	BSO
	P	BNP	BAP	BSP

A = Cognition
B = Education
C = Aptitudes
D = Emotion
E = Volition
F = Need
G = Fear
H = Anxiety
I = Frustration
J = Interest
K = Attitudes
L = Values
M = Neuroticism
N = Psychoticism
O = Introversion
P = Extraversion

ity, and the relationship between the psychological needs of an individual and his fear of accidental death (*PAG*).

An investigator who wishes to confine his work to one approach can locate individual factors of interest to him by dividing the model into submodels such as the one presented below which might be useful to a physiologist.

Let us illustrate how one biologically oriented scientist might go about studying a single factor, for example, *BAG,* the interaction of biological conditions and the fear of accidental death. He will first choose one or several specific biological conditions, e.g., health versus types of illness, suspecting that a sick peron will have an atypical type or amount of fear. The next step is to analyze the fear into its several components: fear of punishment, separation, being forgotten, pain, and loss of identity. After finalizing the biological and psychological variables he will study, he then must direct his attention to accidental death, which can occur early or late in life, in the home, street, hospital, penitentiary, or space. In short, he must be very careful in scrutinizing the dimensions of his study. Then he formulates an hypothesis and decides upon an experimental design, knowing that different designs furnish different sorts of information.

In summary, the proposed *PRT* model will help generate research problems. It will encourage researchers to develop new tests and scales to explore the many uninvestigated areas surrounding death. It will bring to light many unknown factors which affect the fear of death and dying. It will tend to eliminate vague statements about "attitudes toward death" and force investigators to focus on more specific operationally defined concepts. It will not only answer the question of refinement of instruments, but will also solve different methodological problems involved in the design of experiments. Finally, it will bring the biological, psychological, and sociological disciplines into close interaction on a problem of significance to all of them.

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FIREARM HOMICIDE IN THE HOME SETTING

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GENERAL INTRODUCTION

When compared to illnesses such as heart, stroke, and cancer, or to accidents and suicides, homicide is not a major cause of death in this country. The actual numbers are relatively small. For at least three reasons, however, the impact of homicide is far disproportionate to its actual numerical effect. First, the victim of a homicide almost always suffers a sudden and unexpected death. This is much more likely to be disruptive of the social fabric than the slower and more predictable deaths caused by chronic illness. Second, homicides are not distributed equally throughout the population but occur far disproportionately among certain age, ethnic, sex, social class, and geographical categories. Therefore, although the homicide rate for the entire country is very low compared to other causes of death, the homicide rate for certain sub-categories of the population is high enough to be a matter of great concern. Third, a homicide virtually always involves many persons other than the victim. There is, in addition to the survivors, the perpetrator of the homicide and his family members, the courts, the police, and so forth.

It is widely recognized that the homicide rate for the United States has risen drastically in the past decade. It is also widely recognized that the number of firearms available among the general population has had an even more drastic increase. Whether or not there is a cause-and-effect relationship between these two observations can only be speculated upon. The purpose of the present study is to obtain some basic epidemiological data about firearm homicide in an urban community. We selected Detroit for obvious reasons of convenience.

James Treloar (1969) in a recent newspaper article referred to Detroit as an "armed camp," one in which its citizens have been

consistently arming themselves since 1965. Observed since then has been a jump in the homicide rate from 232 in 1966 to 488 for 1969. According to the Wayne County Medical Examiner's 1967 report concerning firearms, the latter method accounted for 21 percent of non-natural types of death (suicide, homicide, and/or accidental) and was the leading method of death due to homicide and suicide. With regards to accidental death, firearms ranked ninth among the most common methods out of the total of 21 general method categories. Robert Pavich (1969) observed that most homicides in Detroit occur at home, involve Negro perpetrators as well as victims by 3 to 1 over white, affect the age range in the 21 to 30 bracket, and in order of frequency, involve hand guns, knives, rifles, and shotguns. Tanay (1969) in his study of homicide found that 58 percent of his cases involved a gun as a homicidal weapon; a decade ago Wolfgang (1958) found the gun used in 33 percent. According to Bensing and Schroeder (1960) firearms were involved in 55 percent of all homicides occurring in Cuyahoga County, Ohio, from 1947 to 1953. Tanay (1969) and Berkovitz and Le Page (1967) agree that the availability of a firearm is materially related to the prediction of a potential homicide.

Aside from the research-oriented professional, numerous politicians and lay people have observed the relationship between the method by which people discharge aggressive impulses and death resulting to their victims. Some have further postulated that death might be prevented if certain methods for such aggressive discharge were controlled or abolished. An example of one such proposal was the 13-man commission headed by Dr. Milton S. Eisenhower, of whom 9 of the members expressed the opinion that all hand guns should be purchased by the Federal Government and that there should be "a gradual strangulation of private hand gun ownership" (Detroit *Free Press* July 29, 1969). On the popular publication level, both *Newsweek* (June 21, 1968) and *Time* (June 21, 1969) magazines devoted considerable space to define the statistics of the problem and various people's reactions to problems regarding guns, and have made a very dramatic appeal for the control and possible abolition of the right to bear arms.

Social scientists have expressed interest concerning Detroit and the question of guns ever since the riot of July 23, 1967. Un-

known to the non-resident social scientist researchers was the fact that the arms race and the development of an image like that of Dodge City in the days of the roaring West began in 1965 for reasons which had no racial overtones. According to James Treloar, the year 1965 for the City of Detroit was the first special year for crime. Violent crimes such as rape, armed robbery, and murder began to climb "right off the charts." The homicide rate was staggering. "In the 25 years from 1940 to 1965 there were an average of 122 murders a year in Detroit. Then in 1965 there were 204; 1966, 232; 1967, 332; 1968, 423. Some observers are convinced that 1965 was the year in which the public decided they could no longer rely on the protection of the police."

Some members of the Prosecuting Attorney's Office for Wayne County, Michigan, estimate that 90 percent of the guns being carried or available to Detroiters are unregistered. If they were listed, it would mean that there would be more than one gun for every man, woman and child in Detroit. Despite the high incidence of unregistered hand guns, if we use the registered guns as an example, we would find, according to Treloar, that in 1965 there were 4,807 registered hand guns, but in 1968 there were 16,167 with a projection for 1969 of an added 13,000. Licenses to carry concealed weapons in Wayne County are approved at the rate of nearly 2,000 a year now, but in 1960, only 549 were granted. To be emphasized is the fact that many Detroiters carry pistols without a license.

It was out of the above background of information and concern that a modest research project was undertaken to ascertain what kind of data would be forthcoming during a selected time sample.

SPECIFIC RESEARCH ISSUES AND GOALS

Sought after were data pertaining to gunshot deaths in homes in Wayne County, Michigan. Demographic data involved age, sex, race, marital status, residence, occupation, and place of origin, of both the killer and his victim. The occupation of the head of the household and the relation of the owner of the firearm to the victim were also studied. Circumstances were researched; the shooting was classified accidental, suicidal, or homicidal. Specific

time, day of the week, position and number of people present in the room, and reason for the firearm's presence in the home were recorded, as was use of drugs or intoxicants by either the victim or killer. An attempt was made to determine the number of guns owned, their availability and accessibility, whether the guns were registered, and whether the owner had a concealed weapons permit.

Particulars of the killer–victim relationship were incorporated into the data schedule. Previous known histories of all gun incidents which involved the killer or victim were also noted: reckless use of firearms or any violent behavior, psychiatric treatment or hospitalization, suicidal or homicidal behavior, e.g., reckless operation of an automobile, or explicit perference as to mode of own death, and acts of violence resulting in confinement—jail, hospital—or in police incursion. Data were compiled on the victim's and killer's express or covert interest in guns: gun training, membership in a gun club, favorite television shows, and accessibility of any firearm in sleeping quarters.

Accessibility of firearms in the home was of primary consideration among possibly precipitating factors in the homicide. Differences in personality and in situation (circumstances of the homicide) were also considered in relation to the type of firearm, i.e., hand gun versus rifle and shotgun. Further, it was postulated that differences between owners of unregistered firearms as opposed to registered would reflect in a high incidence of unregistered handguns employed in homicidal deaths.

METHODOLOGY

The time of study was July–September 1969. This period was designated partly because of the outbreaks of violence during the summer of 1967. In addition, summer heat traditionally has precipitated flaring tempers: the school year hiatus allows freedom for youths; warmer weather promotes more group activity and proximity.

The data were collected by two reasearch assistants who were graduate students in the School of Social Work at Wayne State University. Working in cooperation with the Wayne County Medical Examiner's Office, the research assistants attended daily

medical examiner hearings. Additional information was obtained from the Homicide Bureau of the Detroit Police Department as well as the Wayne County Prosecuting Attorney's Office. No friends, peers, or relatives of the deceased were contacted for information by the research assistants: this project was restricted to information gathered by the above agencies. Non-recorded data was listed as "unknown."

Before the study began, a meeting was held among the author, research assistants, and medical examiner's staff. The data collection schedule, designed by the author, was discussed; terms and areas of information were agreed upon in order to familiarize persons involved with data sought and its proper categorization. Reliability of coding was achieved by comparing notes taken by the medical examiner with the copy obtained by the research assistant recorder.

It became apparent as the study progressed that the law enforcement and medical examiner's agencies conduct a type of investigation which is strictly limited to the legal issues of the death. However, neither they nor anybody else reading their reports would have a real understanding of how the deaths occurred. Since such data contained only superficial and vague information, this source was of limited value.

HOMICIDE DATA

Three sets of findings were of particular interest. First, homicide victims were predominately young, 67 percent being 40 or under. Second, most victims were male (over 70 percent). Third, nearly 90 percent of the victims were Negroes, although only 20 percent of Wayne County and 64 percent of the City of Detroit residents are Negro. Thus the typical homicide victim is a young, black male. Subsequently we will see that the typical killer is similarly a young, black male. The juxtapositioning of these two findings immediately suggests some of the circumstances under which Detroit homicides occur (See Table 1.).

The relationship of the victim to the owner of the firearm was that of family member on only 11 occasions (less than 20 percent). Seventeen times the victim was either a friend (other than romantic), a neighbor, or a stranger (30 percent). On 6 occasions (10

TABLE 1

Demographic Data on 57 Homicide Victims, Weapon-Owners, and Killers

	Victim		Weapon Owner		Killer	
AGE	No.	Percentage	No.	Percentage	No.	Percentage
11–20	9	16%	4	7%	7	13%
21–30	14	25%	5	8%	7	13%
31–40	15	26%	12	21%	13	23%
41–50	9	16%	8	14%	9	16%
51–60	7	13%	9	16%	8	14%
61+	3	4%	3	4%	3	4%
Unknown			16	30%	10	17%
SEX						
Male	41	70%	37	63%	35	61%
Female	16	30%	4	7%	12	21%
Unknown			16	30%	10	17%
RACE						
Negro	51	90%	36	62%	41	72%
White	6	10%	5	8%	6	10%
Unknown			16	30%	10	17%

percent), the victim was unrelated to the owner of the gun, but had a romantic involvement, and 8 of the victims were also the owners of the gun with which they were killed. The remaining 26 percent were unknown relationships. Since these data were limited to homicides occurring in the home or on adjacent areas, it seems remarkable that such a small proportion of the victims were related to the owner of the weapon.

That most of the victims were either unemployed or employed in unskilled jobs certainly reflects the job situation of Negroes in the Wayne County area. Noted were 20 unskilled laborers and 10 unemployed laborers which combined to a total of 53 percent of the victims. Added to this figure are 7 housewives, 7 unknown and 1 retired. Thus only 12 victims were employed which represents 9 percent of the sample. The degree to which being unemployed produces the conditions conducive to homicide cannot be directly evaluated from these data, but it is apparent that homicide victims are far over-represented among the low income segment of the city's population.

Another matter of interest is the time duration these victims had lived in Wayne County. Although 45 percent were born in southern states, only 3 out of the 29 whose length of residence was known had lived less than 10 years in Wayne County, Michigan.

Thus the homicide victim is rarely a recent migrant or a transient.

To be observed in Table 1 is the fact that the age of the firearm owner seems a little older than that of the victim, although the 30 percent unknowns in this set of findings places some question about such an interpretation. However, male Negroes did predominate in this category as well.

In Table 1 information concerning the killer reveals that the age distribution is heaviest between 15 and 45 years of age with 14 of the killers under the age of 30. The majority of killers were Negro and male, figures which were reflected in terms of 41 Negroes to 6 whites with 10 unknown and 35 male to 12 female with 10 unknown. The unknowns in the latter area concern the fact that the killer's identity had not been established at the time of the study.

It would appear that revolvers and shotguns are the most common types of guns in the home, at least insomuch as they were widely used in these homicides. This supports the hypothesis that the major purpose behind the original gun purchase was family and personal protection, since automatic hand guns are known to be unreliable due to frequent jamming. In addition, shotguns spray more than rifles and, thus, do not require the same degree of accuracy or marksmanship.

Firearms were brought into the home in 17 known cases by the owner, 4 cases by the killer and in 1 case by a son. Highly suggestive was the impression that such firearms were brought into the home for purposes of personal or family protection.

Of the 27 instances for which information was available, only 5 had 2 or more guns in the home (only one of these had 3), leading to the judgment that these firearm owners were neither sportsmen nor collectors and suggesting the possibility, untestable with our data, that many were inexperienced in the use and care of firearms. The impression exists that these people purchased a single gun for the purpose of personal or family protection.

In 33 of the 57 cases information was available regarding the type of gun kept in the home. Very clearly the revolver with 18 and shotgun with 11 were the more common types of firearms and perhaps were chosen as they lend themselves more suitably to personal protection.

Data concerning the owner of the firearm does not indicate any

clear trend because in 28 percent of the cases information was unknown; however, of the remaining 72 percent known, romantic friend occurred in 22 percent, husband in 10 percent and the rest were scattered among nonprimary (parents, child or siblings) relationships such as neighbors or strangers and in 2 cases the police. Data would suggest that nonprimary family members were more commonly victims than what has been observed by most researchers, namely, that firearms are hazardous to primary family members.

Location of guns in the home was unclear as there appeared to be an inordinately high number of unknowns, namely, 39. This might suggest that the respondents refused to admit or offer information about this fact. Perhaps in an effort to protect the killer, the family member did not want to make this information available. It is possible, but not very likely, that family members were unaware of the location of the gun and that when it was pulled out, it came as a surprise to the family as well as the victim.

Additional evidence giving weight to the idea of guns being kept in the home for personal and family protection is seen in Table 2 by the fact that despite the obvious large number of unknown responses, 10 of those that were known revealed that the firearm was kept in the bedroom and 4 revealed that the firearm was kept on the person of the killer.

In Table 2 there are some conflicting and interesting patterns in the choice of caliber of the firearm. Despite the fact that both the .357 and .38 caliber revolver are the largest caliber, there were an equal number of small calibers used, .22 and .32 caliber. The same basic range was found in the rifle category in which .22 caliber rifles amounted to 3 which was equal in number to the largest caliber of 30/30. In the pistol category all 3 calibers of .22, .25 and .32 are usually considered small caliber. Assuming that the owner was in a position to make a choice regarding the caliber of the firearm based on his knowledge of caliber, the data in this table appears to show no clear-cut pattern regarding old concepts concerning masculinity and size. In the shotgun category, there was a definite preference for large caliber in terms of three 16 gauge and seven 12 gauge versus the smallest caliber of one 20 gauge and one 410 gauge. This might have something to do with the popularity and availability of 12 gauge shotguns and

TABLE 2

Type of Firearm Used in 57 Homicide Cases

	No.	Percentage
REVOLVER		
38 Caliber	13	23%
22 Caliber	8	15%
32 Caliber	5	8%
357 Caliber	1	3%
SHOTGUN		
12 Gauge	7	12%
16 Gauge	3	5%
20 Gauge	1	2%
410 Gauge	1	2%
RIFLE		
22 Caliber	3	5%
30/30 Caliber	2	4%
PISTOL		
22 Caliber	2	3%
25 Caliber	3	5%
32 Caliber	2	3%
Unknown	6	10%
KINDS OF GUNS IN THE HOME		
Revolver	18	32%
Shotgun	11	20%
Rifle	3	6%
Pistol	1	2%
Unknown	24	40%

the fact that ammunition is easier to get; their spray advantage is fairly apparent.

With respect to the registration of hand guns, only 16 of the 36 hand guns involved in the study were registered. The total of 28 hand guns in this category does not equal the total of hand guns reported in the above section under type of firearm, and that is because the police were able to identify the caliber and type of gun even when the presence of the gun could not be located. This accounts for the discrepancy in figures. It would seem reasonable to add to the figure of 20 unregistered hand guns the 8 unknown, thus giving us a total of 28 unregistered versus 8 known registered.

The place of gun registry is clearly unknown, but among the known registered, most were by family members. None of the firearms owners who were of the 13 who were known had a

TABLE 3
Time and Place of Shooting

	No.	Percentage
DAY OF WEEK		
Saturday	15	26%
Sunday	8	14%
Monday	6	10%
Tuesday	8	14%
Wednesday	2	3%
Thursday	6	10%
Friday	12	21%
TIME OF DAY		
9:00 p.m.–11:59 p.m.	15	26%
3:00 a.m.– 5:59 a.m.	11	19%
6:00 p.m.– 8:59 p.m.	10	17%
12:00 a.m.– 2:59 a.m.	8	14%
12:00 p.m.– 2:59 p.m.	5	8%
6:00 a.m.– 8:59 a.m.	4	7%
3:00 p.m.– 5:59 a.m.	4	7%
LOCATION		
In House	46	80%
Porch	7	13%
Yard	4	7%
PEOPLE PRESENT IN ROOM		
Two	24	40%
Three, four or "several"	19	30%
Five or more	9	16%

concealed weapons permit legally authorizing them to carry a gun.

With respect to the time and place of shooting, the data in Table 3 show that over 50 percent occurred on weekends and that 27 of the killings, or about 48 percent, occurred from 6:00 p.m. to 6:00 a.m., which would appear to be consistent with weekend drinking and socialization patterns as generally reflected in traumatic injuries seen in the emergency room by the author over the past several years. Further, automobile fatalities in the county always increase over weekends and holidays and are associated with the same time period and alcohol intake during that period.

Forty-six shootings occurred in the house, which seems to be the most predominant location. In 34 cases, 2 to 3 people were present at the time of the homicidal shooting and 1 case involved 9 people as witnesses. It would appear that homicides occur in small crowds according to this sample.

A total of 45 unknown responses were recorded as to whether the gun was stored securely. The data reveal that there were 9

"no's" and definitely no "yes's." In the same unknown area are 45 for whether or not ammunition was kept separate from the gun versus 10 definite "no's" and 2 "yes's." The high proportion of unknowns in this area would seem to be an attempt to conceal the truth: the investigators during the process of the hearings did not observe any cases of homicide where killers had to load the gun, and thus obtain ammunition from any possible cache. It would appear that relatives of the known killer wanted to protect him for personal reasons and employed denial in both areas.

Data concerning the length of time that the gun was kept in the home have been unknown in some instances, but in this study it would be unreasonable that in 54 out of 57 cases this information would have been unknown. It may have been that because the experience was traumatic, repression of such a detail occurred, but it is difficult to see how a killer could have hidden a rifle or shotgun. An estimate of the length of time the gun was kept in the home, should have been feasible. Again, it would seem that this area of data reflects the need of the survivors to deny the fact that the loved one was the killer by attempting to deny the gun's presence in the home from the standpoint of remembering how long it was there and its condition. This conclusion would seem to be most significant in the aspect concerning length of time the gun was in the home, and it would seem to be predominantly supported by the observation that in 2 of the 3 known cases, the length of time was indicated to be 10 years and 30 years, respectively.

The vast majority of responses regarding the use of intoxicants or drugs was clearly unknown, and it would be difficult to make any definitive statement from the data as to what role these factors played in the homicide. However, with the vast majority of such shootings occurring on weekends and in the late hours, and the fact that a discussion of other data has shown relatives and informants to be suppressing information about the killer and, to some extent, the victim, we would have to say on the basis of empirical experience that these factors play a much more significant role than the data reveal. Further, such data impressions have been well established in other studies of not only homicide but violence in general.

Table 4 reveals the most important precipitating stress in homi-

TABLE 4
Killer–Victim Relationship

	No.	Percentage
Marital Conflict	21	36%
Interfamilial Conflict	12	21%
Parent–Child Conflict	7	12%
Strangers	7	12%
Intrafamilial Conflict	5	8%
No apparent Conflict	4	7%

cide to be marital conflict with slightly less than 50 percent of the cases involving this stress. Marital conflict refers to problems arising out of the relationships between spouses within the same family. Interfamilial conflict is used to designate problems arising between families. Interfamilial conflict with 12 cases appears to be second, be followed by items of lesser significance in terms of parent-child conflict, and intrafamilial conflict. Intrafamilial conflict refers to emotional problems concerning other relatives within a family group such as aunts, uncles, siblings, grandparents and so on, all of whom are members in the same family unit. Equal in stress to parent-child conflict were relationships involving strangers; it is presumed that this category concerns holdup attempts, either real or imagined. The remaining vast majority of responses concerning killer, victim, or other family member are in the unknown category. Possible significance of such responses may be attached to the fact that the informant was a relative or was being protective.

Both the killer and victim were involved in 4 occurrences each of previous gun incidents and were involvel in 10 cases involving previous history of violent behavior. Such data, although small in number, would seem to suggest a life style of violence and aggressive impulse-control difficulty as part of the background of both the killer and victim.

Despite the high proportion of unknowns for history of psychiatric problems of both killer and victim, there was a slight difference in history between the killer where 6 were known to have a psychiatric problem and/or history versus only 1 for the victim. The data concerning history of suicidal and/or homicidal thinking or behavior clearly reflect the most frequent observation—that all parties concerned have no knowledge of the fantasy productions of most killers. Acts of violence for which only 3 for the

victim and 2 for the killer were reported would seem to serve as a better measure of prediction for the results of this study rather than utilizing fantasy production, unless proportion of victims or killers are in treatment with psychiatrists who record the fantasies.

The unknown responses would seem to hide the true incidence of gun training on the part of both killer and victim, but in terms of available data, it would appear that the victim had had slightly more training with 4 cases reported, than the killer for whom 3 were reported.

Data regarding anatomical site of the wound would seem to be consistent with the usual report one sees from pathologists in most studies and does not reflect any special significance as it is not known what injuries went with what caliber. For example, if a shotgun were employed, there could have been wounds in the head, neck and chest, and the marksmanship or selection of a particular anatomic site would not have been possible. This information was collected to see whether anything significant might be elicited, but no results were apparent.

TABLE 5

Anatomical Site of Wound

	No.	Percentage
Chest	21	36%
Head	13	22%
Abdomen, neck	6 each	10% each
Back, side, stomach, unknown	2 each	3% each
Mouth, face, upper leg	1 each	1% each

DISCUSSION

The data from our study of homicide produced some interesting results. Few immediate primary family members were victims. The homicide victims were different from those of suicide (Danto, unpublished paper) in that they were under 30 years of age, Negro, poor, unemployed, primarily from Detroit instead of suburban areas of Wayne County, uneducated and frequently Southern born. Such demographic features are consistent with the findings of MacDonald (1968), Wolfgang (1969), and government

vital statistics (1967). It would appear that guns in the hands of the killers were more hazardous to others than to family members and that firearms were kept at home for family protection. It was of interest that, except for shotguns, there were as many small caliber guns used as large caliber, suggesting that large firearms do not necessarily compensate for feelings of masculine inadequacy. The homicide victims were more often killed by unregistered hand guns than were suicide victims (Danto, unpublished paper). Other differences were seen in the size of the crowd in the immediate area of the shooting as well as the time of the shooting, which for homicides was found to be in a 12-hour block from 6 p.m. to 6 a.m. on weekends. It was suggested that a pattern of violence was seen in the life style of the killer and victim and that conflict produced by a variety of interpersonal relations was important in precipitating stress.

The data from the study reveal that factors such as race, sex, age, emotional status and degree of education all play a role in determining which particular persons in a social situation will discharge aggression in a homicidal manner. It would appear that the increased homicide rate is more directly connected with violence of the black male youth than to the increasing availability of guns in the home. Violence was expressed in arguments at the neighborhood or community level and involved numerous methods; it demonstrates a need to understand this particular group. It would seem that gun control is not an appropriate change-producing intervention. Methods of reducing the acting out of violence among young blacks and ways of eliminating the conditions which give rise to such rage are vitally needed. It was pointed out by Havinghurst (1969) that lower status people have less effective control over aggressive impulses than middle class people. The expression of this fact is seen in increased homicide rates.

Data from this study would seem to force one to recognize the limits of Freud's concept of suicide and homicide. In "Mourning and Melancholia" (1953), he reflected that suicide would appear to involve the aggression of ambivalence toward a subject being turned inward as a form of murder of the self, a substitute for the hated object. He saw murder as an expression of hatred directed to the object outside the ego. The data from this study would

suggest that there are many factors which determine the direction of that aggression besides an intra- or extra-involvement of ego processes.

Perhaps one of the most important findings of the study was an indirect one. The research method employed failed to record data pertaining to the more intimate aspects of the killers and victims. Information pertaining to their history of violence prior to the final act of homicide was unknown. Equally unavailable from the informants was any information pertaining to drinking style, drug habituation, true ownership of the firearm and the behavior of the owner toward the firearm itself with respect to its location in the home and whether the ammunition was kept separately. Personal knowledge and experience with firearm users has taught the author that it is indeed a rare occurrence when a family is unaware of the presence of a firearm, particularly if that firearm is either a rifle or shotgun. Empirical experience would seem to suggest that the informants were withhoulding a great deal of information for personal reasons.

It would seem significant in light of the above that the police have displayed minimal interest in learning more about homicidal behavior, the behavior of the perpetrator's and those who are related to the victim. The traditional medical examiner's and police investigation of a homicide is strictly limited to the legal issues involved, and such investigations offer little insight or understanding of how and why the crime occurred and what society can do to prevent a repetition of homicide.

Law enforcement agencies and researchers who wish to study homicide should not only investigate these areas more thoroughly, but should also work toward the re-orientation of the police, medical examiner's office, and prosecuting attorney's office. The latter agencies are more important in themselves and might also offer interesting research areas in terms of the general taboos that accompany investigations of death regardless of the cause, but particularly in terms of homicide and suicide.

SUMMARY

All gunshot deaths determined to be homicides were studied in Wayne County, Michigan over a 3-month period during the

summer of 1969. Only gunshot deaths in the home setting were included in the study. Data were gathered by attendance at medical examiner hearings as well as conferences with local police and the prosecuting attorney's office. The obtained sample involved 57 homicides.

The homicide group was found to involve people who were predominately black, under 30 years of age, unemployed, poorly educated, reacting to interrelationship conflicts as precipitating stress and having an extremely low incidence of registration of hand guns. Forty-five percent of the victims were born in the South and fewer of the victims were primary members of the family than usually seen in other homicide studies. Limitations of the research method were discussed both in terms of the large number of "unknown" responses as well as the shortsightedness of both police and medical examiner investigations of homicide. It would be helpful if such public agencies were to expand the nature of their investigations to provide insight and understanding about homicide.

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the Wayne State University School of Social Work, were Mrs. Carol Becker and Mr. James Line, without whose help obviously the study could not have been done.

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LETTER TO MY FRIENDS

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EDITOR'S NOTE—The following letter from a psychologist concerning his innermost thoughts and feelings regarding his own death should be of interest to the readers of OMEGA. He is dying, perhaps, only in the sense that we are all dying. What his circumstances were when the letter was written are unknown and, we feel, irrelevant.

Dear Friends,

I AM going to die shortly. I don't know exactly when, but I am certain it will be within 30 days. Most of you have an opposite belief. You act as though you will live forever. No matter what dire mortal circumstances you encounter, some escape from death will be possible; and even when you do concede that death will some day come, you still expect to continue your awareness of human existence. Yours is the normal delusion; mine is merely atypical. By persisting in the belief that my death is imminent, I can reexamine the choices I have made so far, and perhaps live the rest of my life more prudently.

Nobody reading this has ever experienced death. Dead people don't read nor do other things we live people do. Because we have never died before, our notions of death are intellectual or the products of fantasy. The nearest experience to death are interruption states such as going to sleep, and awakening; fainting and recovering; being anesthetized and revived. From these we get the notion that death is a transition, or temporary, cessation of our awareness. We expect to continue in some other form, thus anticipate immortality. As a result, our own death is something we deny, and which always comes as a surprise. Indeed, most Americans prefer not to know the exact time of their approaching death. It's more comforting to make believe that our own death

will never come, and to deny that anything could kill us, really dead.

I am going to die shortly and I want to prepare for it. Prepare what? Me! I mean the way I am living; the choices I am making. If I really am going to die shortly, I don't have much time left, I'll never be able to get all those things done that I have been putting off. And, indeed, I never did have time for everything. Only immortals have infinite time. I should have made these choices long ago, when I had more time. Ah, but in those days, I thought I had infinite time. Of all the things I want to do, which three do I value most, which are the least expedient, and which must I act on today? The very idea that I must choose requires examination of alternatives, which alone can yield the satisfaction of a meaningful life. Of course, I can avoid choice and not examine my courses of action, which is likely to occur when I deny my imminent death. Such a default means in effect that I have surrendered to the absurd life; where my best efforts yield only random consequences rather than the positive results I anticipate. Connections between present choices and future consequences imply meaning, and therefore offer the satisfaction of having prepared myself. I am going to die shortly. I am talking about the very real possibility that I am mortal and many forces are operative today which can lead to my unpredicted death. So what else is new? Rather than shrugging my shoulders and surrendering to the various possible kinds of evasion, I want to face the prospect of my death without denial, euphemism, or begging the question of my personal continuation. OK. So I am going to die. The only real question is when, and for most of us, time becomes an issue only after a physical crisis reminds us of our mortality. The truly healthy man has little stimulus to consider the issue of his death. He can function secure in his delusion of infinite time. Others less fortunate with imperfect physiology have increasingly frequent and intense reminders of temporal limitations. There isn't much to be done for or with these sensations. Traditionally, we deny their significance by stereotyped thoughts about aging, lack of exercise, or diet. We use analgesics, intoxicants and psychedelics so long as we deny the threat of imminent death. Many people keep this denial up even after their first cardiac, surgery, stroke or sudden catastrophe. This

lack of cooperation with medical regime, or acceptance of impairment, represents a suicidal equivalent, since there is a reduction of life expectancy beyond that of the specific illness precisely because the patient fails to act prudently.

While there is nothing new about irrational motivation such as the delusion of immortality, and especially in the context of suicidal behavior, the connection between the specific denial of death and self-destructive activities offers a prophylactic angle. The universal inability to translate death into sensations we can experience predisposes all of us to use denial as a protection against the apprehension which the prospect of death tends to induce. But for some people, this denial facilitates carelessness, disregard, or actual risk-taking that leads to a variety of self-destructive behavior. A genuine acceptance of our vulnerability to imminent death can serve preventive functions in terms of minimizing, accident proneness, risk-taking, or suicide. This can be applied to known groups with high risk of suicide or accidental death. Policemen and physicians are exposed to death frequently in our culture. Both tend to handle this confrontation with denial as do most people. But the hazardous nature of police work demands more caution which an appropriate fear of death can foster. The physician's work is hazardous psychologically since the constant exposure to dying threatens his denial of death. When this defense is pierced, the physician is more vulnerable to depression and suicide, than are most people. Similarly, a policeman is also highly vulnerable, and especially because of his familiarity with firearms.

Another high risk group is the motorist. The driver with excessive citations, accidents or even all those who operate in an urban area like Los Angeles and San Francisco, could be exposed to a sensitizing experience with the imminence of their own death. The recent Forest Lawn Radio Commercials urging certain kinds of reckless motorists to purchase their own undertaking first before driving is a superficial illustration of what I mean. Instead of exhortation for safety, the driver needs reminders of how imminent and permanent his personal death really is.

Life consists of activities; usually aimed at attaining goals. In these we employ consistent approaches, methods, plans and efforts to attain a job, a promotion, an education, a girl, a prize, or

winning a game. In all these goal-seeking activities we can see evolving but consistent qualities. Your prior experiences are a preparation for your later ones and eventually for the kind of death you will die. The moment of death is an anticlimax to the thousand little deaths you have suffered in your prior choices; those little crossroads where a turn to the left defaulted on all the things to the right.

I am going to die shortly and I want to face my death in my own inimitable way. Isn't this really suicide? Many people kill themselves in the process of achieving significant goals. Our heroes, martyrs and philosophers who chose to die in the course of seeking an end, imposing a belief or expressing a value, are admirable people. Their choices represent preferences at the cost of their lives. This kind of suicide has to be admired, cannot be prevented and has little in common with clinical suicide.

The psychiatric patients who kill themselves are pathetic and self-defeating people whose life styles represent a psychological self-murder many times over, before they incidentally happen to do away with themselves in an anticlimax to a lifetime of psychological suicide. They are indeed the appropriate objects of suicide prevention, sympathy and psychological study. In hindsight, their death is always avoidable, their intentions always increasingly less ambivalent, their goals compulsively more interpersonal and paradoxically more alienating from significant others. These are people whose life or death serve no cause, no belief, no value.

There is another group of suicides whose number is increasing and the relative frequency of which was always high. Their self-termination is neither good nor bad. I am referring to suicide in the aged which occurs in healthy, intellectually competent, senior citizens. As medical science extends their life further, suicide seems to become merely another way of dying. In the older age group suicide occurs more often as a cause of death with increasing age. These are not altruistic deaths such as the voluntary death of the aged to maintain a marginal ecology. Nor do I mean to include the irrational self-elimination on the basis of depression, involution, or other clinical motives. I am discussing people whose advancing age induces a loss of vitality, whose significant others are gone, whose life work is meaningless or formally over,

and who may be terminally ill. However, this latter tends to be a red herring. Their suicide often provokes the romantic notion of a man's right to kill himself when a rational evaluation permits the conclusion that his life is absurd. However, the ones who argue this case most successfully are the ones least likely to commit suicide under any circumstances because their problem-solving capacity is so effective that the need for self-destruction as an alternative never becomes a real choice for them.

I make these three distinctions because our attitude towards suicide must necessarily be different in each. The altruistic suicide cannot be prevented. The clinical can, and must, be stopped because it is so expressive of self-defeating life styles. The elderly is more obscure. Perhaps, if social practices change enough to minimize clinical suicide, the self-destruction of senior citizens might also be minimized because both reflect social deficiencies that maximize alienation, purposelessness and denial of death.

If my contemplation of death is suicidal in any degree, I hope it is in terms of the altruistic kind. Of all the ways to risk my life I would prefer to do so in the cause of a value or belief rather than as a victim of my own efforts to secure goals by self-defeating choices. But the simple observation that I do take risks is not enough to support any conclusion since all human choices expose you to risks. The riskless life doesn't exist, except as a reciprocal definition of death.

All of which reminds me of an old fashioned idea. Whatever happened to natural death, or *mors ipse*? Well, of course, the explosion in medical knowledge has changed all that. Natural death is now regarded as a state of ignorance. Modern medicine has moved us to the point where death itself is a shame if not quite a crime. Correspondingly, the quality of death in the United States during the last twenty years has evolved from mainly random, impersonal and external catastrophes (disease, war, earthquake) to highly unique events in which the victim participates in his own demise (car accidents, homicide, suicide). Even heart disease, cancer and circulatory fatalities permit the victims to influence the quality of dying by the way they follow medical regimes. All of this allows the quality of dying to express our unique life styles as projectively as inkblot reactions.

But my original question still stands. Is there a kind of death

that we could call natural, in which we could agree that a life had been lived, and to linger on was less than a blessing? The extremes are easy. Clearly the prolonging of vegetative functioning without the recovery of consciousness is not a significant achievement, but what about less extreme examples. How about a man in his sixties, who is alone, healthy, economically secure. At what point is his psychological life over, such that termination could be construed as natural regardless of the pathologists' findings? If all his activities are devoted to the biological processes of existence, he can be described as killing time, and he will do this until time kills him. If he no longer engages in activities that capture his imagination, motivate his best efforts and give him a kick, he is ready to die. He will be a latent fatality waiting for a morbid process to terminate his life. In the days before modern medicine was able to intervene, a death at this point would have been called natural. No stigma would have accrued to the memory of the man nor his survivors. Today, the absence of natural death prolongs life promiscuously, often as a curse rather than as a blessing, and is a factor in the increased suicidal percentage of deaths in the elderly. All of which demonstrates the harmful consequences of a little immortality.

I am going to doe shortly and I want to die naturally and positively. What can I say about the end of everything I like. My first thoughts are regret, not only for the things I do but for the ones I care about. I am sorry to be leaving, and sorrier for the distress my absence will cause. These sentiments are universal and inevitable. They are even desirable since they force those who survive to reconcile themselves to loss, grief, and the inevitability of their own death, but beyond this immediate feeling I want to look for the positive aspects of dying.

I know now that I will die in a month. I want to give my last thirty days the best I have, and make them as meaningful as the first 15,695. What can I do that's special?

Absolutely nothing! At least nothing different than what went before. To reach for something special during these last days makes a lie out of the preceding life. If there are special things I want to do before I die, they must be started long before the end is in sight.

Your last days do not prmit any process that has not been ex-

perienced earlier. We are all victims of the habits we live by and crisis freezes these even more rigidly. Imminent death, especially if denied, is too traumatic a crisis to allow for creative innovations such as the special act implies! And so, to the degree that your approaching death evokes special things to do; to that same degree have you failed to live the full or meaningful life, even on your own terms.

If a positive death is choosing to die the way you have lived, what is the value of knowing when death is imminent? What's so good about deciding to do nothing different? Why not maintain the delusion of immortality and the comfort of being surprised by your own death? Either way, you die the way you live. The difference comes from the element of choice. Facing the prospect of your imminent end permits you to start making the choices now that you truly value because you can anticipate the consequences more vividly. By making these choices before termination is in sight you are choosing how you will die because of the manner in which you elect to live. And choice is what saves your existence from becoming absurd. You either choose alternatives that make for a meaningful life or absurdities get you by default. To have a choice and fail to make it, is the ultimate absurdity of all.

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ANNOUNCEMENT

JUST in case you haven't yet been informed by one of your previously-cynical friends that PSYCHOLOGY TODAY devoted an issue to death and suicide, we would like to offer you that belated information. The issue came out last August and contained articles by George Harris, Richard H. Seiden, Edwin Shneidman, and Sam Keen as well as a questionnaire constructed by Ed Shneidman. It is too late for you to fill the questionnaire out and thus become a PSYCHOLOGY TODAY statistic, but the survey results are to be published in a future issue and you might see how your views compare with others.

CONTRIBUTORS

Fred Cutter is appearing for the third time in this fourth issue of OMEGA. His job as Research Psychologist at the Central Research Unit at the Veterans Administration Center in Los Angeles requires that he do research and consultation regarding suicide. He is also a consultant for the Suicide Prevention Center in Los Angeles; otherwise he might spend full time writing for us.

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