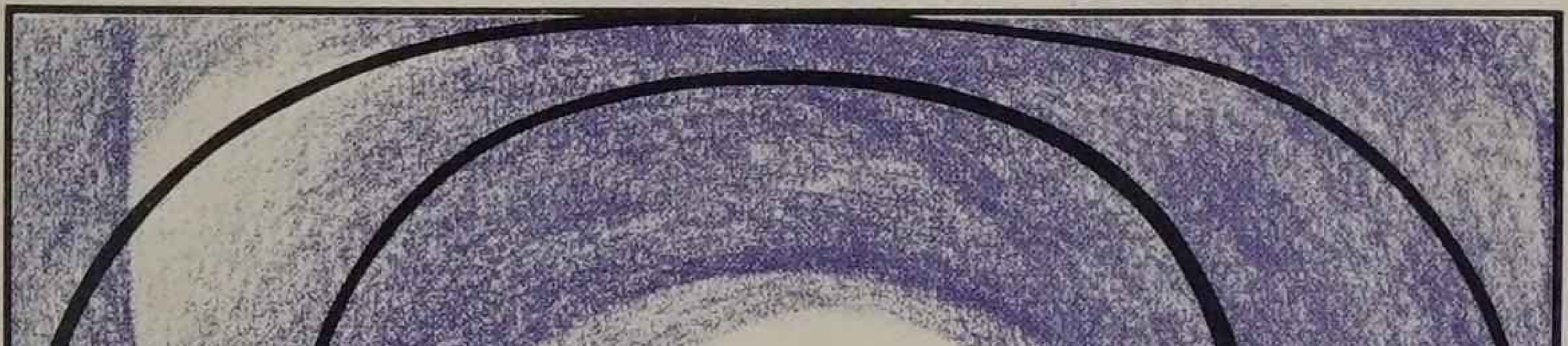
an international journal for the
psychological study of dying,
death, bereavement, suicide
and other lethal behaviors

OMEGA



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

Omega is concerned with the impact of death on the human being and on the human community. The journal is addressed to all professionals—from anthropologists, sociologists and philosophers to doctors, clergy, and police administrators—whose work brings them into personal or philosophical contact with the dead, dying, bereaved, and suicidal, as well as with victims of violence. Although the editors welcome contributions from persons in these and all related fields, they are primarily concerned with research investigations, theoretical developments, critical or integrative literature reviews, innovative and insightful speculations, and descriptions of health or social programs, as well as courses or academic offerings that formulate something new. A statement of style requirements for manuscript submission will be found on the inside back cover.

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THE NEED FOR THE PSYCHOLOGICAL STUDY OF CLINICAL DEATH

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> "Why dost thou not tell us what happened in the beyond?" And all grew silent, startled by the question. It was as if it occurred to them only now that for three days Lazarus had been dead, and they looked at him, anxiously awaiting his answer. But Lazarus kept silence.
>
> For three days had he been dead; thrice had the sun risen and set, but he had been dead; children had played, streams had murmured over pebbles, the wayfarer had stirred up the hot dust in the highroad . . . but he had been dead. And now he was again among them; he touched them, he looked at them . . . looked at them! And through the black discs of his pupils, as through darkened glass, stared the unknowable Beyond.

(From the short story "Lazarus" by L. N. Andreieve, 1871–1919)

The possibility of returning from the grave and learning the secrets of death has fascinated writers and their readers for almost as long as man has enjoyed literature. It is only within the last few decades, however, that "revival of the dead" has left the realm of fiction and become a reality. Our understanding of death and control over it have suddenly expanded to such a point that the religious and philosophical buttresses of our classical systems of human values as well as many time-honored scientific concepts have become antiquated. In time, "death" in the mind of the average citizen will mean something different than what it does today, and only that which will presently be defined as "biological death" will be "death." Meanwhile, those people whose pulse and respiration have ceased for some short interval (who have undergone "clinical death") frequently believe that they have been truly "dead" and returned to life. The psychological impact of this belief on these individuals must be considerable. Unfortunately, virtually no systematic attempt has been made to survey these effects.

In the future, when most people will experience clinical death perhaps several times before their final "death," the phenomenon of clinical death may be as irrelevant to personality dynamics as the use of antibiotics is today. For the present, however, the experience of clinical death probably involves major changes in the individual's ideas concerning his identity, life, death, and society. The reactions of the relatively few people living today who have undergone this experience will condition the course that future developments in this area will take. The attitudes of these people will both shape and predict coming changes in the attitudes of the populace, and the feelings they express may well represent the types of attitudes around which new social institutions will be built.

But it must be emphasized that research into the psychological effects of the experience of clinical death is needed for more immediate purposes than the adjustment of coming generations. In ever increasing numbers people *today* are undergoing this experience without the benefit of adequate psychological or social preparation.

That some psychological preparation is indeed necessary can be deduced from the as yet scanty accounts of the consequences of major organ transplants. For example, Lunde (1969) recently reported to the American Psychiatric Association that five of the thirteen persons receiving heart transplants up to that time at the Stanford University Medical Center had become psychotic. Three others exhibited more temporary emotional upsets. A man who had received the heart of a prominent citizen said he felt obligated to live up to the standards of the donor. Another man receiving the heart of a woman worried over possible loss of his masculinity. A third individual receiving the heart of a much younger person said he now felt young, born again.

Of course, organ transplants involve more than just the cessation of respiration and heartbeat. Besides the transplant patient's awareness of the precarious nature of his survival, he must incorporate the foreign organ into his self-identity. The idea that patients might also be traumatized by their dependence on machines is further suggested by Lunde's statement that many patients who have been "hooked up" to the heart-lung machine have experienced brief psychotic episodes. The point is that as in so many other areas of technological advancement, the possible socio-psychological consequences have not been fully explored.

CLINICAL DEATH AND RESUSCITATION

Before we can delve deeper into a discussion of the psychological implications of clinical death, a brief description of the phenomenon is in order. Formerly, a patient was diagnosed as dead if his breathing and pulse had stopped. Through the use of certain medical techniques (to be described below) called in combination **resuscitation**, breathing and circulation can be reinstituted in particular patients and eventually they may completely recover normal functioning. Because of this, many physicians are advocating that a diagnosis of death be based on electroencephalogram recordings. Schwab, a neurologist at the Massachusetts General Hospital, proposes that the criterion of death should be centered around the complete and permanent cessation of electrical activity in the brain (reported in *Time* Magazine, 1966). His measures of nervous system inactivity include a flat EEG for at least twenty-four hours, EEG remaining flat despite external stimuli such as loud noise, no muscular or pupillary reflexes, and no spontaneous and independent heartbeat or respiration. It probably need not be added that a more exact legal definition of death has been sought to provide some criterion as to when organs might be removed from a body for transplantation as well as to clarify matters concerning clinical death.

Experimental work on resuscitation has been going on continuously throughout this century. The impetus given medical science by World War II, notably the perfection of cardiac surgery, anesthesiology, artificial circulation apparatus, and electrical stimulation of the heart, brought much of this research to fruition. By the end of the war, the Russians under the leadership of Dr. V. A. Negovskii (1962) were successfully reviving "fatally" wounded soldiers. At that time (1945) it was reported that only those suffering premature death due to injuries to vital organs sustained in accidents or combat and given restorative operations within minutes of the onset of clinical death could recover. Today, the patient undergoing cardiac arrest and resuscitation in conjunction with longstanding disease processes and congenital defects stands almost as good a chance of being successfully revived as does the healthy accident victim.

The likelihood of being revived, however, still diminishes progressively as the time elapses from the onset of clinical death and the beginning of resuscitation. Revival attempts may be frustrated if the process causing death is prolonged and exhausting, if the cerebral cortex is subject to inhibition or extreme excitation, if the patient is older and generally unhealthy, and if the patient is deeply anesthetized.

Cardiac arrest on the operating table, even in the absence of cardiovascular disease, may take place at any age. Of 1,200 cases of cardiac arrest reported by Negovskii as taking place in seven countries, more than 20 percent of the total were children under 10 years of age. The incidence falls with age until 30 years, rises up until 60 or 70 years, and then declines again. If an average value of one case of cardiac arrest for each 2,000 or so operations under general anesthesia is accepted, it means that approximately 5,000 persons die each year during operations in the United States alone.

All 1,200 cases of cardiac arrest reported by Negovskii were given resuscitation treatment, and approximately 28 percent survived. In smaller, more select samples, significantly higher survival rates have been found. The survival rates do not differ between those patients with and those without cardiovascular disease. Cardiac arrest, therefore, cannot be ascribed to actual lesions in the heart muscle. Rather, it often results from loss of the ability of the specific conducting system of the heart's nervous system to produce the electrical stimulus which keeps the heart beating regularly.

Cessation of respiration and cardiac failure are the immediate causes of clinical death. To ensure the resuscitation of the patient, these factors must be corrected first. Naturally, the cause of the terminal state, whether it is shock, poisoning, loss of blood, or other factors, must also be treated. Swann (reported in Negovskii, p. 12) believes that the sequence of extinction of the various physiological functions depends on the mode of death. Therefore, resuscitation methods must be directed primarily toward the restoration of the function first inactivated. The order of precedence of the measures to be adopted will thus vary accordingly. In some cases, oxygenation of the brain must be instigated first since this most delicate and important organ may begin to suffer damage before the complete cessation of respiration and circulation has taken place.

Methods of resuscitation in general use are intraarterial and intravenous blood transfusions, cardiac massage, ventricular defibrillation (either chemical or electrical), artificial circulation by means of perfusion apparatus, electrical stimulation of heart muscle, artificial respiration, and injections of various stimulant and depressant drugs. The application of these methods must be suited to the individual case. No one can predict just what method will be the one to revive a patient, and usually resuscitation is successful only upon the simultaneous combination of several of them.

TERMINAL STATES

Negovskii views the process of dying as a series of terminal states which he defines as "the terminal stages of life which, if treatment is unsuccessful, are immediately followed by those irreversible processes of tissue destruction which constitute biological death" (p. 209). The terminal states he recognizes follow this temporal order:

1. Severe degrees of shock—the various forms of coma marked by many features representing the disturbance and extinction of vital functions.

2. Agony—characterized by the last series of compensatory and adaptive reactions of the body immediately preceding death. These involve a profound disturbance of the functions of the higher divisions of the brain and grossly distorted bodily activities. The duration of agony may vary from a few minutes to several hours.

3. Clinical death—the final, but in many cases still *reversible*, stage of dying. It is the interval of time during which the higher divisions of the brain may survive after cessation of cardiac activity and respiration. Life exists in the body but at an extremely low level. Negovskii describes this condition as:

> . . . qualitatively different from our usual ideas of life as applied to the complex organism. At this period we may speak of an isolated primitive life of individual tissues and organs, a life no longer subordinated to central nervous and humoral influences; of modifications to and abnormalities of metabolic processes in the tissue and organs, and finally of increasingly deep inhibition, gradually turning into a pathological, irreversible state of the higher divisions of the brain (p. 210).

At present, full cortical function can be restored after clinical death lasting no longer than five to six minutes. In individual instances where conditions are especially favorable (rapid onset of death, low environmental temperature), this interval may be increased to seven or eight minutes. Although resuscitation is possible after more prolonged intervals of clinical death, such patients remain mentally subnormal and without their cortical function.

4. Biological death—the state where no organ, even in isolation, retains its function. Biological death is not simply a cessation of the life processes but represents irreversible changes in living matter which disintegrates and decomposes.

R. C. W. Ettinger, a physicist and a leader in the cryonics movement, describes biological death somewhat differently (1965, p. 63). He defines it as "that degree of damage and disorganization from which the body *as a whole* cannot be revived by the present resources of medicine." Patients have been maintained for years in states like the one Ettinger describes with the aid of artificial devices and drugs.

To the four stages of terminal states proposed by Negovskii, Ettinger adds another:

5. Cellular death—irreversible degeneration or disorganization of the individual cells of the body. Cellular death is usually not complete throughout the body until at least two days after clinical death (1965, p. 63).

CONSCIOUSNESS IN CLINICAL DEATH

In his excellent and otherwise complete monograph, Negovskii almost entirely ignores the psychological effects of clinical death upon his resuscitated patients. He does casually mention a few cases in which total amnesia was experienced for the period of the operation and occasionally for different lengths of time prior to it. This retrograde amnesia gradually disappeared. He also mentions that upon regaining consciousness, frequently the patients' first words are something to the effect of "I must have been dreaming." Because of anesthetics and loss of circulation to the brain, the clinically dead person is always unconscious. Normally, consciousness has been lost before clinical death (Feifel, 1963, p. 428).

Since a person is not conscious during clinical death, any experiences he later reports as occurring during that time probably represent dreams, images, and thoughts he experienced during other stages of the operation or fantasies he creates upon regaining consciousness. These reported experiences reflect the patient's state of mind and his preconceptions of what has happened to him.

Some resuscitees have been quoted as saying that they feel sure that they had been dead. The writer could find no subjective reports of resuscitees who did not claim they had died, no doubt because their comments would arouse little sensational interest. A question arises, however, as to whether the patients who felt sure they had been dead were told they had undergone clinical death before they reported their feelings. The anecdotal form of the few available accounts leaves this question unanswered. It seems probable to the author that if the resuscitees were not told that their circulation and respiration had stopped, they would have no awareness of and would not be able to separate that period of time from the total time they were under general anesthesia.

A 27-year-old Catholic woman whose heart and respiration stopped during a heart operation reported that she had had a wonderful dream (Hockling, 1955), the contents of which have never come back to her. Meanwhile she says, "I'm sure that I was dead."

An older man relates (Ettinger, 1964): "Yes, I remember. My pain was gone, and I couldn't feel my body. I heard the most peaceful music. The most beautiful music. God was there, and I was floating away. The music was all around me. I knew I was dead, but I wasn't afraid. Then the music stopped and you [the doctor] were leaning over me. It wasn't a dream."

ATTITUDES TOWARDS THE EXPERIENCE OF CLINICAL DEATH

It is interesting that these patients claim so tenaciously that they were dead. Perhaps they were first told what had happened to them and then rapidly integrated the facts into their system of religious beliefs. Perhaps the exotic and mysterious quality of the experience attracted them. Then again, it is feasible that the idea of the body surviving at a lower level without the self or consciousness maintaining its customary control is so repellent to some people that they readily accept the idea that they have been dead (body and soul) over the alternative that they had lost control over their bodies or had become briefly something like biological machines. This explanation might explain the disturbances noted by Lunde occurring in some patients who have been treated with the heart-lung machine.

But as important as the patients' immediate reactions to the experience is the effect it will almost certainly have upon their attitudes towards the process of dying and their eventual final demise. Again, the extremely sparse information available on this subject is anecdotal. For example, Grant Allen, a British author who was resuscitated after drowning, writes:

> The knowledge that I have experienced death has had a great deal to do with my utter physical indifference to it. Dying is as painless as falling asleep. It was only the previous struggles, the sense of its approach, that was at all uncomfortable, but even that was not half as bad as breaking an arm or having a tooth drawn. There was a total absence of craven shrinking (in Perry, 1938).

In the future, when more people will have been revived from clinical death, their reactions to it may lose the mystical quality that one now senses. For the present, however, the experience of the resuscitees remains exceptional, and so they will more often conceptualize the experience in magical ways. Their reactions to it will also be more individualistic and revealing of the personality than when clinical death becomes a common, institutionalized event.

One could predict that upon questioning, resuscitated patients would express a variety of reactions to their experience, ranging from a belief that they were now invulnerable to death to intense fear that since they had been "fated" to die but had escaped, they would be called to die again, permanently, very soon. Some patients might feel a sense of depression and morbidness because of their close escape while others might feel a sense of gratefulness and renewed purpose. Until data are collected, we cannot be sure how many major attitudes toward the experience and toward death in general would result.

In some individuals, specifically certain types of psychiatric patients, actual experience of clinical death or the belief that one had experienced it might prove therapeutic. It has often been noted that disturbed patients sometimes rise to biological emergencies with reintegration of the personality. Some theoreticians think that the beneficial effects of electroshock therapy are due to this mechanism. Shaffer and Lazarus summarize this viewpoint:

> Shock therapies propel the patient's personality back in the direction of a primitive, relatively undifferentiated, biological state remotely comparable to that of the newborn child, or the child in utero. This gives impetus to the movement of opposite forces in the direction of redifferentiation of the personality which may carry with it a stronger tendency toward the normal than toward the pathological. This supplemented by the experience of shock treatment with its connotation of death and rebirth results in restorative trends (1952, p. 419).

Fenichel (1945) and Schilder (1939) believe that the salutary effects of electroconvulsive shock therapy stem not only from the creation of a neurological *tabula rasa*, but also from the patient's belief that he has died and been reborn. (This aspect of electroshock therapy is recognized, but not emphasized, by Shaffer and Lazarus.) The patient supposedly considers that since he has been justly punished for his sins (by dying), he is no longer required to punish himself with excessive guilt.

Fisher, *et al.* (1953) attempted to study the relationship between fear of death and shock therapy in an experimental study of the effects of shock treatment on thirty schizophrenic patients. They noted that fear of death associated with the treatment increased as the series of treatments progressed. Of the six patients who showed significant improvement, only one at any stage during the treatment perceived it as a potential death threat. Of those who did not improve or became worse, 58 percent expressed fear that shock might kill them. The authors concluded that improvement during electric shock treatment is significantly correlated with the absence of intense fear towards the treatment.

The results of this study are suggestive but do not in themselves negate Fenichel's and Schilder's hypothesis. An identifiable number of the patients studied feared death, but it is not possible to determine how many of them believed they did die during treatment and were reborn. As Grant Allen (in Perry, 1938) and others have said, fear of dying may be more terrible than the actual event. Clinical death may prove to be a powerful cathartic force, therapeutic for mental patients and stimulating to the well-adjusted.

HYPOTHERMIA, CRYOGENIC INTERMENT, AND HIBERNATION

In the early 1900s, the Russian scientist Bakhmet'ev first announced that if the body temperature of an insect were slowly reduced to within a biologically determined "critical range" specific to the animal, all the vital processes of the body would stop and the animal would appear dead. He called this death-like state "anabiosis." When the insect was gradually warmed to its normal temperature, all body functions spontaneously returned. Bakhmet'ev likened the phenomenon of anabiosis to a pendulum clock which has been manually stopped in mid-swing. It no longer operates and yet it will resume functioning as soon as the obstacle—the hand holding it—is removed (Negovskii, p. 152). Since Bakhmet'ev's time, the inducement of anabiosis has been found possible in a great variety of animals.

In this state, circulation and respiration are completely stopped just as they are in clinical death occurring on the operating table. In the small animals studied by Bakhmet'ev, these functions spontaneously appeared as the animal was warmed. In human patients whose hearts and respiration have ceased and in larger animals such as the dog which have been "killed" by induced hypothermia (lowered body temperature) these functions will only reappear if the specific resuscitation methods mentioned above are applied within very narrow time limits. Hypothermia and anabiosis as general phenomena, however, are definitely subclasses of clinical death.

Experimental work with laboratory animals and even actual application of incomplete or partial hypothermia (cooling, but not to within the critical range) with humans undergoing major surgery show that hypothermia can prolong the period of clinical death. Negovskii (p. 164) found that the proportion of animals surviving various neurological operations is increased five times over that achieved at normal body temperatures. It has also been claimed (p. 164) that the resistance of the nervous system to interference with the circulation during cardiac arrest is considerably increased during hypothermia. Some of Negovskii's extremely provocative but as yet unverified work (p. 158) suggests that during hypothermia the body might produce biogenic stimulants which increase the resistance of the cooled animal to pathogenic agents.

In the greater number of studies of induced hypothermia and consequent clinical death in vertebrate animals, resuscitation has rarely been successful in as many as half the cases. Some of the animals which did survive died soon afterwards or were disabled in some respect. Even Ettinger, the most vocal proponent of cryogenic interment (freezing a person in a state of complete hypothermia), readily admits that no human being has ever been revived after complete hypothermia (1965). He also admits that most scientists say there is little chance of ever reviving anyone frozen by current methods.

Nevertheless, clubs exist in the United States today whose members carry "emergency freezing" cards in their wallets so that they may be frozen immediately if found dead. Ettinger (1964) has carefully worked out for them a step-by-step program of the technical and financial preparations which must be taken and the equipment which must be readied for the interment. The hope is that the frozen person can remain frozen until medicine has discovered a cure for the disease that killed him or until somehow his own immunological systems successfully combat the illness. How the immunological systems might recoup while the person is frozen is not made clear. Other advocates want to be frozen before they grow too old, until that day when science can prevent aging. They reason that with the metabolism suspended, the individual will not age. This belief, of course, is not supported at present by any scientific evidence.

What is of concern is that although Ettinger and his followers recognize the myriad of economic and legal problems that longterm anabiosis would entail, they fail to take seriously the psychological and social problems which would inevitably arise. With serene faith they believe that by the time resuscitation from cryogenic interment is perfected, science will be able to make a person happy and productive in any society into which he finds himself reborn. Obviously their great anxiety about death blinds them to the possibility that the human psyche might be incapable of making certain adjustments—at least, without adequate preparation. Legitimate medical science should not be as oblivious to this difficulty as Ettinger seems to be.

A less extreme procedure which will probably be possible sooner than cryogenic interment is chemically induced artificial hibernation. This process would be used when a person wishes to be interred for shorter periods of time up to five years. During chemically induced hibernation, metabolism may be reduced to one-fiftieth to one-two-hundredths of normal. In such states, the body temperature falls to near the environmental temperature and small amounts of nutrients must be circulated in the blood stream. Research on artificial hibernation is also proceeding apace.

CONCLUSION

Whether or not cryogenic interment and chemically induced hibernation become common will depend in part on how today's resuscitees report their experience of clinical death: as a peak experience, as terrifying, or as neutral. But more significantly, the growing influence of the concept of *degrees* of death spread by the presence of an increasing number of resuscitees (and transplantees) will ready the public to accept the question of interment in a more matter-of-fact manner.

Regardless of the acceptance or rejection of longterm freezing and hibernation, resuscitation as a medical technique will become increasingly common in the immediate future. Negovskii concludes that:

> In view of the rapid development of research in the field of the treatment of terminal states, we can confidently state that the time is near when failure of the doctor to take active resuscitation measures on persons dying from, for example, blood loss, general anesthesia, and so on will be regarded as a case for legal action. To take a more long-term view of this problem, we may prophesy that perhaps at the end of the 20th or beginning of the 21st century active and successful treatment will be given in any case of sudden death (p. 272).

If Negovskii's predictions are correct, and they probably are, it is obvious that research is urgently needed to investigate the psychological implications of resuscitation for the patient, his family, his doctor, and his society.

SUMMARY

Since World War II, tremendous advancements have been made in techniques to revive patients whose heartbeats and respiration have ceased but whose brain activity is still present, patients who are clinically dead. These techniques, pioneered by the Russians under Negovskii's leadership, include cardiac massage, ventricular defibrillation, artificial circulation, and special injections. Growing numbers of patients who "die" of cardiac arrest are being successfully resuscitated each year.

Recovery from clinical death and the need for organs for transplantation have necessitated new conceptualizations of death. Negovskii, for example, defines death as a series of terminal states of increasing irreversibility.

Although consciousness is lost to patients prior to actual clinical death, anecdotal reports show that some recovered patients believe they experienced certain mystical events during that period. The scarcity and subjectivity of these reports make it difficult to evaluate such experiences. One problem is that it is not often clear whether the patients were told that their hearts had stopped before or after they made their statements.

The author believes that the experience of clinical death would almost certainly have important psychological implications for the patient, his family, and eventually, society. It is hypothesized that clinical death might have effects similar to those thought by some to result from electroconvulsive shock therapy. The belief that one had died might relieve strong guilt feelings and subsequently offer a cathartic release. At any rate, it is conceivable that one's entire outlook towards life would be altered. Unfortunately, almost no research into the psychological consequences of clinical death has been undertaken or reported.

Other techniques besides the resuscitation of accident victims and surgical patients at present being explored also lead to altered states similar to clinical death. The possibility of chemically induced hibernation, freezing, or cryogenic interment, and the lowering of body temperatures to less extreme ranges (hypothermia) are increasingly being brought to the notice of the public.

If such practices as hibernation and repeated resuscitation of an individual ever become commonplace, massive changes will have to be made in the structure of society and the attitudes of its members. Very little attention has been paid by the expounders of these and less extreme techniques (such as organ transplants) to the psychological readjustments these changes would require.

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THE WIDOW AND WIDOWER AND REMARRIAGE: SELECTED FINDINGS

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Remarriage as a social institution has received little attention among family sociologists in North America. The available literature has been annotated by Schlesinger (1969, pp. 104-106), and a summary of findings related to remarriage in North America has been reviewed by the same author (1968). Berardo has described in detail the position of the widow in North America (1968) and that of the widower (1970). The studies of the widow and widower as a one-parent head of the family have been annotated by Schlesinger (1969, pp. 91-98).

Canada has not produced any studies related to remarriage until 1968 (Elkin, 1964; Vanier Institute of the Family, 1967).

THE SAMPLE

In 1968 we interviewed ninety-six couples in Metropolitan Toronto, Canada, by using a structured questionnaire, which also contained a limited number of open-ended questions. Each couple was interviewed by two investigators;[1] one queried the wife while the other questioned the husband. Table 1 contains the marital composition of our sample, and indicates that we only requested one partner of the second marriage to have had a previous marital union. Our total sample was preeminently white, middle-class, and Protestant.

The widowed population among our remarried population contained forty-three widows and widowers (twenty-three males, twenty females). On the average they had been remarried for a period of five years at the time of the study, and had been married for an average of eighteen years in their first marriage. The average time lapse between the first and second marriages was seven years for the women and three years for the men. Their average ages at remarriage were 45 years for the males and 37 years for the females. This average is lower than the average age of remarriage for widows in Canada, which is 56 years for males and 50.3 years for females. Their average age at first marriage was 24.2 years for the males and 22.1 years for the females (in 1950 the average age for brides was 25.3 years, for grooms 28.5 years). The widowed group brought 57 children,

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[1] Schlesinger and Macrae, 1970; the research team included the following: Judith Bamiling, Edyth Jacobson, Jewell Lanterman, Brenden Montgomery, Dee Osachoff, Elizabeth Smith, Eugene Stasiuk.

TABLE 1
Marital Composition of Couples Who Remarried
(N = 96 couples)

Male	Female	Total
Widowed	Widowed	6
Widowed	Divorced	5
Divorced	Widowed	6
Divorced	Divorced	20
Divorced	Single	16
Single	Divorced	23
Single	Widowed	8
Widowed	Single	12
	Total	96

consisting of 31 boys and 26 girls into their second union, and 32 children were born of the second union.

The major limitation of our study was the fact that we advertised for volunteers to take part in our study, and thus we may have obtained primarily a group whose second unions were stable.

When we view the marriage composition according to average ages, some interesting differences between the widows and widowers appear. Widowers who married single women averaged slightly less than 40 years of age at time of remarriage; the average age of the single spouse was 27.5 years. The average age of the widow who married a single man was 30.6 years, and that of the husband, 30.5. Thus when the combination was widowed male and single female, the former was older and the latter younger than their counterparts in the single male-widowed female combination. However, this disparity was not present in the marriage of widowers and divorced women. In this combination, the average age of the widower was 47.4 years and that of the divorced woman, 44 years. Widows who married divorced men averaged 37.5 years and their spouses 39.3 years.

Remarriage, one might hypothesize, involves establishing a new equilibrium in families who bring children into the new union. The newlyweds are now a different unit. They relate as a reconstituted family within a community of relatives, friends, and neighbors.

It could be expected that there would be an adjustment process between the remarried couple themselves, as well as within the family system. The fact that there was at least one former spouse and possibly two (if both were widowed), raises the question of the difference between the deceased and the second spouse.

Further, the presence of children, and the advent of children of the new union, are further factors involved in the establishment of the new family equilibrium. It also could be anticipated that a remarriage, where children are brought in, would be significantly different than a marriage where bride and groom enter into marriage for the first time. Normally, the adjustment process would begin initially with two. The additions to the family (ordinarily) come along one at a time. Again, in the background of a remarriage, there is a former parent, mother or father, who may or may not live in the memories of the children as well as in the memory of the surviving spouse.

The adjustment process was arbitrarily divided into three broad areas. First, the area of social relationships and contacts with the inlaws and friends of the remarried couple and the relatives of the deceased. Second, the dimension of personal relationships between the new spouses. Are there elements of the relationship with the former spouse, for example, which affect the adjustment process? Third, the rather complicated area of parent-child relationships. In some cases a child may be faced with a rather bewildering array of new relatives—aunts, uncles, and perhaps two new sets of grandparents—the whole area of the extended family. He may be faced with the fact of relating to new brothers and sisters, different family life style, difficulties in accepting a new type of discipline (if any). He must share his single parent with another adult, and possibly with other children.

Finally, the sample was asked to give their perception, in capsule form, of the similarities and differences between the two marriages; and whether they felt it was more difficult to be the previously married or previously unmarried person in a remarriage.

SOCIAL RELATIONSHIPS

In the area of social relationships the respondents were asked if their social life differed from that of the first marriage. Thirteen (57 percent) of the male and 13 (65 percent) of the female widowed replied in the affirmative. They noted that there was more socializing together because the children were older; "They could travel more." On the other hand, some noted that there was more family-focused life, less drinking, less "keeping up with the Joneses" than in the first marriage. The absence of children makes a significant difference in the social life. "There are no children now, we come and go as we please," one widower reported. Another said in the same vein, "The big difference is not having children around. I enjoyed them in the first marriage. Before, there were many activities with relatives, not now."

The tendency in the widowed remarriages is frequent socializing as couples. Ninety-five percent (thirty-five) reported this. Another finding indicated that 54 percent of the sample (thirteen widowers and ten widows) reported having close friends among other remarried couples.

The general picture of a close-knit family life is further emphasized by the data which indicates that 93 percent (forty) of the sample reported that they engaged "often" to "always" in various activities together.

Remarriage brings change. What is the case for the constellations of friends of the former marriage? The data shows the extent to which contact with friends of the former marriage has been retained. Ninety percent (eighteen) of the widows who answered this question reported "infrequent" to "none" in contact with former spouse's friends. Seventy-seven percent (seventeen) of the widowers indicated the same state of affairs.

Even contact with their own personal friends of the first marriage seems to have undergone a significant change. Sixty percent (twenty-six) of the sample reported "infrequent" to "none" in contact with these friends. It would seem that a major shift in social relationships occurs, at least in this sample, when the widowed remarry.

If there was any difference between the widows and widowers in this respect, it would seem that there was a greater tendency of the latter to retain contact with their own friends and those of the deceased spouse.

PERSONAL RELATIONSHIPS

Eighty-one percent of the sample reported that they socialized frequently together with their new spouse, while 92 percent reported that they engaged in activities together frequently as a family. This would be one indicator that the adjustment process had been successful.

What of the area of interpersonal communication? Do they talk freely to one another? Do they disagree? What do they disagree about? Do they discuss their former marriages?

A significant proportion of the sample, 60 percent (twenty-nine), replied that they can always talk freely with their spouses. There seemed to be near unanimity of response between the couples themselves which strengthens the replies.

Do they find topics which are difficult to discuss? Forty-nine percent of the sample reported that there was "none", 7 percent said that extended family relationships was a difficult topic. The next most difficult topics were children and money.

SEXUAL ADJUSTMENT

The widowed were also asked to rate their sexual adjustment in the remarriage according to whether it was very satisfactory, satisfactory, or unsatisfactory. Thirty-three of the sample answered this question, nineteen males and fourteen females. A total of twenty-three (nearly 70 percent) reported "very satisfactory sexual adjustment" in the remarriage. Thirty percent rated it as satisfactory, and none said unsatisfactory.

An interesting correlation to this finding can be seen in the replies of the six divorced men who married widows. All rated their adjustment as "very satisfactory." Three divorced women who married widowers reported "very satisfactory" adjustment, one divorced woman said it was unsatisfactory. A male widower remarried to a single female commented that "one in his position should be prepared to understand that the person married for the first time has different expectations than the previously married." Another in the same category advised that the couple should explore themselves and each other, and "know what each other's needs are and how to satisfy each other."

One widow married to a single male urged that the sexual relationship be spontaneous, and "scheduling should be avoided." Another in a similar marriage composition suggested that professional help should be sought "if you don't enjoy it." Her formula was "make love all day, and at night have sex."

Another widow married to a divorced man reflected the attitude of many of the widows when she said, "don't worry about it—if you love the person, there will be no problem." She felt that sex was just a physical projection of one's feelings. One widower married to a widow suggested that "it is important to know each other's attitudes toward sex and talk about it freely."

PARENT-CHILD RELATIONSHIPS

The third area of investigation in remarriage was that of the adjustment of children in remarriage. What are the problems that children encounter? They acquire a new parent and possibly new siblings, either from the previous marriage of their new parent, or born into the new union. They may acquire new grandparents, and perhaps a host of new uncles and aunts.

As we previously noted, in our sample of forty-three widowed persons, thirteen widows brought a total of eleven boys and sixteen girls into remarriage. Fifteen widowers brought twenty boys and ten girls into remarriage. Fifty-six children from bereaved families, then, were involved in the adjustment process. Added to this were thirty-two children born of remarriages involving the widowed.

In general, the widowed parent who brought children into remarriage felt that it was not difficult for the children to adjust to being a member of a new family. Twenty-five percent of the widowers and 35 percent of the widows felt it was difficult for the children. If there was any difficulty initially, the situation always improved with time.

Memories of a deceased parent or spouse would be revived by the children mentioning the previous mother or father. Twelve of the sample reported that children spoke often of the deceased. Twenty-two said that reference was "seldom" or "not at all". Would the physical resemblance of the child to the deceased parent create a problem of adjustment in the family either for the new spouse who may have known the deceased or for the previously married who faces a living reminder of a former partner? Twenty-seven (fourteen widowers and thirteen widows) replied that there was a physical resemblance. Of the total who noticed a physical resemblance, one widow reported that this presented some difficulty in the remarriage. Thus we can conclude that this presented no difficulty in the vast majority of cases.

Perhaps the most important element in the family adjustment of the children in a remarriage is the relationship of the child to the new spouse. Of the twenty-eight who brought children into the remarriage, only one, a widow, said she felt the children related unfavorably to the new spouse.

In an attempt to measure the quality of the relationship between the children and the new spouse, the sample was asked whether they felt the relationship was warm, casual, indifferent, or hostile toward the boys and girls. Twenty-two felt that the relationship with the boys was warm, one reported it as casual. Fifteen described the relationship with the girls as warm, two as casual, four as indifferent and one as hostile.

There were fifteen remarriages of the widowed where children were brought in, and children were also born of the new union. These were asked if they noticed any difference in the attitude of the new spouse to the children brought into the remarriage and the children born of the remarriage. Six of the widowed (three males and three females) replied in the affirmative; nine replied negatively.

ADJUSTMENT PROBLEMS

Although the data seem to argue for a successful adjustment in remarriage in terms of parent-child relationships, it is not surprising that the adjustment process involved problems to be solved. The sample was asked what they felt were the most difficult problems they faced with the children, as parents in the various roles referred to above, in the remarriage.

The most common problems reported by the widowers seem to have been connected with the question of discipline, whether it was teaching respect for the new parent, coping with children who attempted to "play off the old against the new," or getting the siblings of both families to cooperate. To a lesser extent the problem of sharing time between the new spouse and the children was mentioned by the widowers. Other problems mentioned included making the children feel loved and wanted, and conversely, coping with the fear of whether the parent would be accepted; helping children to adapt to different ways of housekeeping with the new mother; and general lack of communication.

The most common problem mentioned by the widows was also connected with discipline. Three mentioned the problem involved with adjusting the children to two-parent discipline after the single parent system. Two widows mentioned the problem of adjusting to "boys": their interests, their clothing, their language. Two also mentioned the problem of wanting more time with the new spouse—"the children, frankly, were in the way." This was allied with the problem the children had with sharing their parent with someone new. Two widows also noted that they were faced with the problem of the children feeling disloyal to the deceased father. Adjusting to new surroundings was also mentioned as a difficulty to be faced, in regard to the children. Apart from the question of discipline, which seemed most common, no particular problem seemed to be more prominent, and the range of problems themselves was quite wide.

There did not seem to be any difficulty in naming the new parent. What, in fact, did they call him or her? The vast majority replied that the children called the new parent by his/her role name, i.e., mother or father; nine said the children used the first name.

Two possible factors that might add stress to the children in a family which is undergoing the adjustment process of remarriage are moving from familiar surroundings and a change in community relationships. Seventeen of the sample moved into a new home after remarriage. Seven reported that this had an effect on the children and five of these seven were widows.

The sample was asked how many planned on having children when they remarried. Eleven widowers and seven widows replied in the affirmative. Out of the twenty-two who did not plan on having children or who did not respond to the question, only ten could be considered in the age-range for bearing children, i.e., either the wives of the widowers or the widows themselves. Consequently, 65 percent of those in the childbearing age-range planned to have more children after the remarriage.

ADJUSTMENT OF CHILDREN

The sample was asked their opinions on the three major difficulties children faced in a remarriage. "Being accepted by the new parent" and "adjusting to a new authority figure and discipline" were mentioned most often. The difficulty the child had in sharing his widowed parent with another person ranked close to these. If we add the problem of "accepting the change from single parent to two-parent family system," which would be related to the problem of "sharing," the largest proportion would seem to see this as *the* major difficulty.

Integrating children from two families, and becoming accustomed to a new family style with new rules and standards, were also mentioned by one widow and three widowers and by two widows and two widowers respectively. The mention of acceptance and discipline was equal among widowers and widows. However, six widows as opposed to only two widowers felt that "sharing" was a difficulty.

Other problems included the adjustment of the child who was cared for by doting grandparents during the interval between marriages; reduction in attention accorded the child; and the difficulty the child had in explaining why his name differed from that of his father. Only two widowers and one widow felt that the child had a problem in comparing the deceased parent with the new parent.

The sample reported on what they considered was most satisfying for children in remarriage. The male and female widowed replied almost equally that having a "complete," "normal," "ordinary," "two-parent," "proper," or "real" family life again was the most satisfying factor for a child (eleven widowers, nine widows). Economic security was mentioned by one widower and six widows. Six widowers mentioned having a mother in the home again, and three widows, "having a father." Other sources of satisfaction noted were having the parent who worked during the widowhood, "home more now"; children were able to boast to their peers about having a complete family, or new brothers and sisters. One widow remarked, "Life is more satisfying for the children as I no longer use them as an emotional crutch." A widower felt, "A wife for me is good for the child." "Two-parent discipline" was also mentioned.

SUCCESSFUL ADJUSTMENT

What is the key to successful adjustment in a remarriage? The sample was queried on what they considered to be the most important components of a remarriage.

One widower emphasized compatibility and motivation when he commented, "One needs a sense of humor; try to see the other person's point of view; try not to be too dogmatic about small issues; avoid comparisons between the first and second wife; one should not be marrying to get a housekeeper, but should want a wife "

A widow, in arguing that one has to work at a remarriage no less than at a first marriage, delineated certain important components: "Have a willingness to thrash things out before and after a remarriage—give and take; maintain an open mind especially re children and the new spouse's acceptance of these; know your own and the other's weaknesses and needs; understand and accept each other when disaster strikes, and utilize the knowledge you have of each other."

An interesting perspective can be gleaned from the comments of the single females who married widowers; one advised withholding "any comment about the first spouse; don't enter into remarriage in a hurry; have a firm attitude toward the widower's family regarding discussion of the first spouse."

In this marriage the wife claimed that the marriage was almost destroyed because "the relatives always compared me to my husband's first wife." She also recommended living at some distance, if possible, from relatives, especially early in the remarriage.

Another previously single female suggested that the remarriage is "new to both" so "treat it as if neither has been married before."

Twenty of the widowed married previously single spouses. These were asked what advice they would offer an unmarried person who is contemplating a marriage with a previously widowed spouse.

The single males who married widows with children urged that one should make sure he is prepared for a "ready-made family." The opinion was expressed that in such a marriage one avoids a lot of the problems of the newly married in terms of adjustment, housekeeping, handling of children. The previously married have "all the understanding of what a marriage is all about," and "this is the best type of marriage." The single males also counselled patience. One said, "Don't expect miracles, but with patience and understanding you may get to see them. Where there are children, don't force your ideas, go easy and things will work out."

The single females warned that marrying a previously married person means more problems which need to be worked out. They advised a reasonably long engagement, and suggested marriage was a good thing. In this connection one said, "Try to determine if talk of the former spouse would be upsetting, and settle this before the marriage. Further, forget everything you have been told of the former spouse (by others) and be yourself."

The consensus seems to be that the previous marriage may be a difficulty to overcome, but that it will fade. It is "just a problem to be lived through, if you feel the person is what you want."

ADVICE RELATED TO REMARRIAGE

Two dominant themes appear in the advice of widows to the widowed women contemplating remarriage: don't compare your second husband with your first, and proceed with caution in your decision to remarry. This does not mean you do not discuss your first spouse. However, if the second spouse finds it uncomfortable, avoid it. One widow emphasized the need for deliberation, and the reasons; "I think there are added risks to a second marriage, a tendency to carry over old hostilities and preconceived ideas developed in the first marriage. A second marriage should be given a long and careful consideration if it is to be a success."

Another explained the risks of comparing first and second spouses: "Never compare the second spouse with the first. It isn't healthy to do so mentally, but verbally it would be disastrous. The new spouse usually finds it harder to compete with a memory than a flesh and blood rival. Admit the deceased was not perfect, and do not try and fashion the second spouse into a pattern of the first. Get rid of guilt feelings over remarriage—if you have them, don't remarry until you are free of them."

Another theme in the advice of the widows is implicit in the above comments. This is an insistence on the fact that the widowed person is a different person from the bride of the first marriage: "You are quite a different person, older if not otherwise changed—and you can't start over again, so start where you are."

Another comments, "You are always making comparisons, but try to forget about it and make a new start." The problem of the resolution of guilt feelings about remarrying also appears in the advice. The consensus was that "the widow should sort out her feelings about death in general, and about her own widowhood in particular before she remarries." The widows, in general, did not stress love as an important element in remarriage.

The male widowed mentioned "love" more often than the female widowed as an important ingredient in remarriage. "Avoid marrying just because you are lonely, be sure it is a wife you want," was the considered advice of one. The main theme in the advice was "be sure you know the second wife well." A correlative to this was a pronounced insistence on marrying someone who shared your interests.

There was emphasis on making sure that the new spouse liked children. Equally important was the idea that the new spouse should understand and accept the fact of the first marriage. It was urged that she be given information about the first marriage.

Among the males, there was not the same caution against comparing first and second spouses. On the other hand, there was general agreement that "if you have ever been married it is only natural to want to enjoy and live this normal and pleasant experience again."

One respondent warned about the difficulties a widower may face in a community. "At first" he said, "recognize the natural reaction that people regard you as a disease. They want to help but they don't know how to accomplish that simple gesture." He urged "mingling in company; don't set as an objective remarriage; rather, associate with people and work like hell."

The widows generally differed from the widowers in their advice, by their insistence on taking time to decide to remarry, and avoiding comparisons of first and second spouses. The widowers were more sensitive to the question of the relationship between the children and the new spouse, and to the fact that love is important.

CONCLUSIONS

An exploratory study of ninety-six couples who had remarried contained forty-six persons who had been widowed. Selected findings related to social adjustment, parent-child relationships, and personal attitudes related to the second union have been presented. This is part of a first study on remarriages in Canada.

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The methods may change, but the quest remains. Salvation through belief or belief and good works has been replaced by immortality through biological means. The IMMORTALITY NEWSLETTER, established in conjunction with the various cryonics societies, was launched in October, 1970. Editor A. Stuart Otto states in the first issue that "The IMMORTALITY NEWSLETTER reports all known activity in the field of anti-death research and thought, the boldest and most challenging work ever undertaken by man." Information and subscriptions can be obtained through the Editor at P.O. Box 696, San Marcos, California 92069. Another publication of similar bent, this one published by the Cryonics Society of New York and appearing monthly, is entitled IMMORTALITY; write Saul Kent, 9 Holmes Court, Sayville, New York 11782.

SUB-GROUPINGS OF SUICIDAL PEOPLE[1]

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During the short history of clinical research with suicidal subjects, there has been an important, if gradual, development. Initially, studies proceeded as if suicide were a unitary phenomenon. The goal seemed to be to describe suicide as a single state or action, characteristic of a special group of people for which some one best treatment method might be devised. As an example, a number of studies have developed signs of general suicidality in projective testing (Martin, 1960; Costello, 1958; Shneidman and Farberow, 1958). In the area of treatment or intervention, specific suicide prevention services are in operation throughout this country and the world (Litman *et al.*, 1965; Farberow, 1968). Most of this service is based either implicitly or explicitly on a crisis model. Such a model conceives of suicide as a relatively homogeneous state, arising out of stress situations, requiring short-term intervention techniques applied generally to all in need.

There has been increasing recognition of the diversity of suicidal expressions and feeling states and the need for new therapeutic techniques based upon the appreciation of these diversities. New models of suicide are beginning to include classifications of sub-groups of suicidal people, as well as differences in the way suicidal problems present themselves in the community (Litman, 1970). This paper is a report of some efforts to develop sub-groups of suicidal people as they are seen at one type of community agency, The Los Angeles Suicide Prevention Center (SPC). We hope that the identification of sub-groups of suicidal people will have two major advantages. First, it should facilitate the prediction of suicide by improving measures of suicidal lethality, that is, a scale to measure the probability of a given person committing suicide. Second, new treatment methods should develop, tailored more closely to the identified characteristics and needs of a particular sub-group.

METHOD

In order to generate the descriptive sub-groups of our Center patients, we are employing three approaches: clinical, clustering, and factor analytic techniques. This report will discuss interim results of the clinical and clustering techniques, and indicate current and planned research with these methods. Factor analytic techniques with our data are under way, but there are no results to report at this time.

The clinical development of sub-groups or syndromes began informally (perhaps as early as 1960) as a result of suicide prevention services offered at the Center (Wold, 1970). Following contact with a large number of suicidal people (by the end of 1967, the staff had talked with over 26,000 suicidal people), impressionistic, clinical categories began to

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emerge.[3] These descriptive sub-groupings most often cut across other mental health taxonomies, focusing on the psychological and social contexts out of which suicidal concerns and actions arise. They include aspects of the person's character, feeling states, and current and past life situation.

As our research became more formal, reliable measures of our sub-groups were needed. As a result, some members of the staff[4] met weekly for five months, deciding on ten tentative, clinical sub-groups (Chart 1). For each sub-group, four to eight items were agreed upon. These items are clinical statements which describe the sub-group. We intended to formulate the items in such a way that raters could score them reliably from our case records of suicidal people.

The Sample

By 1967, we were ready to gather case file data to learn more about sub-groups. From approximately 26,000 files, each with a number, a sample of 1,000 was designated by a table of random numbers. When the actual case files were drawn, we were able to locate 984 of the 1,000 sought. The sixteen cases not used in the sample were either missing from the files, or, on closer inspection, proved to be duplicates of other files. These files varied considerably in the extent of information they contained. Some had one data form sheet filled out on an emergency basis at night, with the emphasis on quick action and a minimum of detailed information. At the other extreme, some files contained extensive therapeutic interviewing, some psychological testing, recorded staff conferences and follow-up correspondence covering many years. The sample included 500 of the more extensive files, which were used as the data source for our ratings. This sample of 500 cases will be referred to subsequently as SPC patients.

A separate sample of forty-two SPC patients who actually committed suicide was collected. These were people who had had some contact as patients with the Suicide Prevention Center prior to their suicide. The forty-two represented all known SPC patients at that time who went on to kill themselves, and for whom we had extensive file information. Subsequently, this sample will be referred to as patient-suicides.

The Ratings

A rating form was constructed which consisted of two sets of items. First, there was the pool of items referred to above, namely, descriptions of our clinically derived sub-groups. There are fifty-eight of these items covering the ten sub-groups. The second pool of items included seventy-three other descriptive statements in the following categories: demographic items, such as age and sex; details of the individual's suicidal history and current suicidal problem; prior and current professional help; and presenting symptoms and character descriptions.

Reliability of the ratings was studied by giving the same three case files to each of eight raters, and percent agreement among the raters on each item was determined. These raters included members of the professional staff, graduate students in training at the Center,

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[3] Robert E. Litman was instrumental in these formulations.

[4] Staff members included Rosita Alfaro, Janet Green, Sam Heilig, David Klugman, Michael Peck, and Paul Pretzel.

and trained, nonprofessional volunteers. The mean agreement for the pool of fifty-eight items was 80 percent. For the seventy-three-item pool, the mean agreement was 90 percent. The lower reliability of the fifty-eight items may be due to the fact they are generally less specific and more judgmental than the other items.

The patients were assigned to one clinical sub-group when indicated by "yes" scores on the items comprising that sub-group (c.f., Chart 1). In order to be assigned, at least 70 percent of that sub-group's items were rated "yes."

The Clustering of the Items

During the clinical development of sub-groups, we began with global notions based on clinical experiences and we then developed items to specify those sub-groupings. Conversely, we are beginning to cluster items themselves to construct meaningful sub-groupings. We want to identify groups of people who score the same way on a number of individual items. For this phase of the research, both item pools were combined into one series of 131 items.

With the aid of a computer, all 131 items were compared with each other, with chi-square as the test of statistical significance. For this segment of the research, a .02 level of significance was established. It must be recognized that calculating such a large number of chi-square comparisons will result in some extreme frequencies by chance alone. Nevertheless, this phase of the research is meant to generate sub-groupings to be validated by later studies using other samples.

Chart 1

Clinical Sub-Groups of SPC Patients

Discarded Women
- Pattern of divorce or repeatedly being discarded by a lover or husband.
- May discard a man prior to his rejection of her. (May provoke rejection.)
- Facade of femininity. (Being a lover, wife or mother is more a role than an identity.)
- Actual or perceived abandonment or rejection by parents. (Parents divorced, chaotic, dead, separated, or severely abusive.)
- Suicidal in response to break-up of a relationship with a man.
- Feels people don't take her seriously and feels like a failure as a woman.
- Hysterical, over-dramatic, and exaggerated emotional responses alternating with denial of any feeling.
- Frequent, highly sexualized responses.

Violent Men
- Periodic episodes of violent rage toward self and others. (May be associated with heavy drinking.)
- Strong guilt and remorse about these episodes.
- Poorly controlled, impulsive action discharge during these episodes. (To get away from overwhelming feelings of pressure, anxiety, anger, etc.)
- Job is important to him. (Often a good worker and well liked by employer.)
- Socially involved with others. (Not a loner, often a family man and may have close buddies.)

Middle-Age Depression
- Relatively stable life history
- Good to excellent resources.
- Age: 40-60.
- Actual or feared sexual impotence. (Heightened concern over sexual potency.)
- Resistant toward getting help.
- Tends to keep problems to himself.
- Achievements and goals have lost their meaning.
- Over-concern about physical health. (Vague physical complaints.)

Chart 1 (*Continued*)

Harlequin Syndrome
- Death is eroticized. (Fantasies of peaceful or pleasurable death.)
- Malignant, masochistic life-style. (Sensual pleasure through painful life experiences.)
- Suicidal feelings are omnipresent.
- Malignant self-image. (Feelings of rottenness.)
- Feels like a foreigner in life. (Alienation from others.)
- Facade of femininity. (Being a lover, wife, or mother is more a role than a basic identity.)

I Can't Live Without You
- Suicidal in response to the threat or actual break-up of an intense, symbiotic relationship. (Could be spouse, homosexual partner, parent, etc.)
- Passive-dependent personality. (Waits for others to make decisions, leans on others, submissive with others.)
- Patient feels that part of him has gone with loss of symbiotic other. Feelings of terror and overwhelming incompleteness.
- Unable to conceive of anyone ever replacing the lost partner.
- Relatively stable life style. (Long-term relationships, jobs, and residence.)

I Can't Live With You
- Both partners (man and wife, homosexual pair, parent and child) may be suicidal.
- Mutually destructive interdependence. (Partners accent each other's psychological weaknesses.)
- May have open death wishes toward symbiotic partner. (May provide suicide implements to partner, openly wishes the other dead.)
- Much overt, serious emotional disturbance.

Adolescent-Family Crisis
- Very poor interpersonal communication between family members.
- Suicidal in response to parental discord or disruption.
- One or both parents destructive toward the adolescent.
- Major problems with identity and independence. (Homosexual and/or heterosexual conflicts, delinquency, rebelliousness, over-dependence on parents, strong feelings of not being able to make it as a person, failure of optimism.)

Down and Out
- May use alcohol or drugs excessively.
- Man or woman in late 40s or older.
- Downhill life course in all areas of life.
- Exhausted personal and community resources.
- History of superficial relationships, may have moved around frequently.
- Damaged pride and self-esteem may be acute.
- Lost ability to make comeback by self.
- Poor physical health.

Old and Alone
- Age: 60 or over.
- Often debilitating illness.
- Alone, or feels alone.
- Depressed.
- Has outlived the meaningful people and activities in his life.
- Life is an effort; give-up attitude.

Chaotic
- Periodic states of severe confusion.
- Impulsive, suicidal acts in a state of confusion.
- Clearly psychotic. (Suspicious, inappropriate, withdrawn.)
- Chaotically disorganized at times.
- Suicidal acts may be bizarre.
- Panic states.

RESULTS

The Clinical Sub-Groupings

The results of the ratings will be discussed below under each of the sub-group headings. Most of the discussion and findings concern the SPC patient sample ($n = 500$). The patient-suicide group ($n = 42$) was not large enough to provide much meaningful data when spread over ten sub-groups. Sixty-four percent of the SPC patients were rated as a member of one of the ten clinical sub-groups. Of the patient-suicides, 92 percent were rated in one of the sub-groupings.

Discarded Women.[5] Discarded women made up 8 percent of our SPC patient sample. Half of this group of women were under thirty years of age and there was only one woman over fifty. About half of the group were in contact with the Suicide Prevention Center following a recent suicide attempt. Their suicidal problems tended to be chronic; that is, there was a history of prior suicidal episodes in two-thirds of the cases. Considering suicide potential, or the Staff members' ratings of the probability of that person committing suicide, almost all the "discarded women" were rated either low or moderate risks.

As to the symptom picture, three-quarters of this group were troubled by confusion, and among 17 percent it amounted to overt psychotic behavior and/or symptoms. About 20 percent used drugs abusively.

Although information about early family history was fragmentary, it was noted that 70 percent of the women in this group reported an early parental loss (before the young lady was 12 years of age). This loss may have been through the death, divorce, or separation of her parents.

Violent Men. It should be noted when discussing this sub-group that a change in the name is required. While all those classified by raters as "discarded women" turned out, in fact, to be women, among the group rated "violent men," only 55 percent were indeed men; 45 percent of those classified "violent men" turned out to be women. It seems we are measuring a category of "violence" distributed democratically according to sex. At any rate, the items included for rating in this sub-group are such that women were not excluded from the sample. This group of people was distributed by age as follows: one-third in their 20s; one-third in their 30s; and the last third in their 40s. Four percent of SPC patients and 10 percent of patient-suicides were classified "violent men."

Eighty-five percent presented a chronic suicide problem. Sixty percent had made a suicide attempt just before contact with the Suicide Prevention Center. For suicide potential, the Staff rated them as high risk (one-third of the cases). Twenty percent reported a history of multiple, highly lethal suicide attempts.

As to presenting symptoms, about two-thirds were confused, amounting to psychotic proportions in 17 percent. Sixteen percent used drugs abusively and about 20 percent could be considered alcoholic.

Of the patient-suicide sample ($n = 42$), there were four people, all males, rated "violent men." All four had chronic suicide problems and three of the four were rated as alcoholic.

Middle-Age Depression. Although 3 percent of the SPC patients were rated in this sub-group, 12 percent of patient-suicides were rated "middle-age depression." Among SPC patients in this sub-group, two-thirds were women; most were in their 40s or 50s. Very few had made a recent suicide attempt; rather, when seen at the Center they were threatening to kill themselves or troubled with suicidal thoughts and ideas. The majority were seen as moderate suicide risks and about 8 percent were high risks.

Although depression was the most frequent symptom, there were problems with confused thinking among 25 percent, yet this did not reach psychotic proportions. Alcoholism was not a problem, nor did they use drugs abusively.

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[5] Based in part on unpublished psychoanalytic research by Albert Schrut.

Harlequin. These people were all women and accounted for 4 percent of the SPC patient sample. Among patient-suicides, 5 percent were classified "harlequin." These SPC patients were in their 20s or 30s and 90 percent had chronic suicidal problems. Sixty percent had made a recent suicide attempt and two-thirds had a history of a suicide attempt sometime in the past. Ten percent of these women were rated as high suicide risks and the majority as moderate risks.

Over 90 percent were confused and disorganized in their thinking, and 40 percent were seen as psychotic. Alcohol was not a problem, but 15 percent used drugs abusively.

I Can't Live Without You. People classified in this sub-group accounted for 12 percent of SPC patients and 20 percent of patient-suicides. They are distributed rather widely in age from the 20s through the 50s. Among SPC patients in this group, two-thirds were women, while the patient-suicides were 4 men and 4 women.

Fifty percent suffered chronic suicidal episodes; all were suicidal in response to the breakup of a love relationship. As a group, they tended to be assigned a high suicide risk; in fact, two-thirds were rated either high or moderate.

About half of the group was seen as confused in their thinking; fewer among the patient-suicides in this group were rated as confused. Neither alcohol nor drugs was a problem.

I Can't Live With You. Seven percent of SPC patients were rated under this classification, while they accounted for about 10 percent of the patient-suicides. They range in age from 20 to 50 and two-thirds of the group were women.

Seventy-five percent of the people presented chronic suicide problems. Generally, they were high suicide risks; in fact, almost 90 percent were rated either high or moderate.

Most of these people were severely confused and disorganized in thinking and 35 percent were seen as psychotic. About 15 percent were rated as alcoholic and the same percentage used drugs abusively.

Adolescent-Family Crisis. This group accounted for 10 percent of the SPC patient sample and 8 percent of the patient-suicides. Somewhat over half of these SPC patients were female, while out of five people classified here among patient-suicides, four were male. Most of this group are in their teens or early 20s, yet two people in their 30s were classified as "adolescent-family crisis." In spite of their young age, two-thirds presented chronic suicidal problems and all five patient-suicides were rated chronic. Fourteen percent of this group was seen as a high suicide risk and 36 percent were rated a moderate risk.

About half the group were confused and disorganized in their thinking. Only 8 percent had a history of abusive use of drugs and none of the five patient-suicides gave such a history.

Down and Out. Accounting for only 3 percent of SPC patients, this group represented 22 percent of patient-suicides. Two-thirds of the SPC patients were men and almost all were in their 40s and 50s. Among the patient-suicides, there were nine people "down and out," all of whom were men.

Seventy-five percent of the SPC patients had chronic suicidal problems, while 90 percent were chronic among patient-suicides. Generally, they were rated as high suicide risks; in fact, only 25 percent were given a low rating. Although 85 percent of these people were in contact with the Center because of a suicide threat or suicidal ideas, only 7 percent had made a recent attempt.

Half the group experienced a problem with alcohol, two-thirds among patient-suicides.

Eighteen percent of SPC patients classified as "down and out" had a history of using drugs abusively, while 30 percent of patient-suicides gave such a history.

Old and Alone. These people accounted for 3 percent of SPC patients and 10 percent of patient-suicides. All were in their 50s and 60s and the sex ratio was fifty-fifty. About three-quarters of this group had no history of a prior suicide attempt. As to suicide potential rating, there was one-third in each classification: high, moderate, and low. Thirty-six percent had experienced the death of a loved one.

Two-thirds were not confused in their thinking, although depression was a common symptom. Fourteen percent used alcohol abusively, yet none misused drugs.

Chaotic. This sub-group accounted for 9 percent of SPC patients and 12 percent of patient-suicides. Eighty percent of the SPC patients were female. Ninety percent presented chronic suicidal and two-thirds had a history of multiple suicide attempts. Eighty-two percent were seen as either high or moderate suicide risks.

All the people in this group were rated as severely confused and disorganized in their thinking and two-thirds were seen as psychotic. Twenty percent abusively used alcohol, and 14 percent drugs.

Results of Clustering

Chart 2 shows some of the results of the clustering procedure. In the discussion below, these results will be considered in conjunction with the clinical sub-groupings. The three main items shown are age, sex, and chronic vs. acute suicide problem. The table lists all other items which are associated with each main item with greater frequency than would be expected by chance.

Chart 2

The Results of Clustering Using the Chi-Square Test Items Related to Each of Three Main Dimensions

THE AGE DIMENSION

Under 20	*20–39*	*40–59*	*60+*
Single	Acute stress, unstable life style	Divorced or widowed	Widowed
Living with family	Acting out sexually	Repeated marriages	Living alone
Single, low lethal, prior suicide attempt	Pattern of divorce or discard	Living alone	Acute stress, stable life style
Low lethal rating	Panic states	No prior suicide attempt	Death of a loved one
Family or professional called center (NOT patient himself)	Facade of femininity	High lethal rating	Recent serious medical problems
No prior inpatient Rx	Hysterical, overdramatic	Acute stress, stable life style	Chronic serious medical problems
NOT depressed	Impulsively suicidal	Recent serious medical problems	Downward job mobility
Unstable character		Chronic serious medical problems	Stable character
College student		Recent job loss	*NOT* chaotic
Significant other seen at SPC		Depressed (medical signs)	*NOT* impulsively suicidal

Chart 2 (*Continued*)

One or both parents destructive toward the patient	Overconcern about physical health (vague, physical complaints)	Outlived others in his life
Major problems with identity and independence	His job is important to him (a good worker)	Life is an effort; give up attitude
	Downhill life course	Lost the ability to make a comeback by himself
		Downhill life course

THE SEX DIMENSION

MEN	*WOMEN*
Single	Married or widowed
Low socio-economic status	Repeated marriages
Living alone	Recent, serious medical problems
High lethality rating	Recent contact with M.D.
Recent job loss	Abusive use of drugs
Downward job mobility	Malignant self-image
Depression (social withdrawal type)	Good resources
Excessive gambling	Impulsive suicidal acts
Homosexuality	Death is eroticized
Serious auto accident(s)	Hysterical, over-dramatic
Legal involvement	
Damaged pride and self-esteem	
Socially involved with others	
Keeps problems to himself	
Downhill life course	

ACUTE VS. CHRONIC SUICIDE PROBLEM

ACUTE SUICIDAL PROBLEM	*CHRONIC SUICIDAL PROBLEM*
No prior suicide attempt	Made prior suicide attempt
Low chronic suicide potential	High chronic suicide potential
Acute stress—stable life style	No acute stress
Break-up of a love relationship	Chronic, serious medical problem
Friend or professional called center (*NOT* patient himself)	Prior *POSITIVE* inpatient Rx
Stable character	Multiple outpatient therapies
Stable life history	Unstable character
Unable to conceive of anyone ever replacing the lost partner	Current alcoholism
Suicidal in response to the threat or actual break-up of an intense symbiotic relationship	Abusive use of drugs
Patient feels like part of him has gone with a loss of symbiotic other	Serious accidents (non-traffic)
	Malignant, masochistic life style
	Clearly psychotic
	Much overt, serious emotional disturbances
	Chaotically disorganized at times
	Pattern of divorce or repeatedly being discarded by a lover or husband
	Impulsive suicidal acts in a state of confusion
	Periodic states of severe confusion
	Suicidal feelings are omnipresent
	Death is eroticized

DISCUSSION

In this discussion, an attempt will be made to pull together current sub-groups under the three main dimensions presented in Chart 2. When possible, the pattern of interrelated items associated with that dimension will be compared with the clinical sub-groups and there will be some discussion of treatment implications.

Age

The under-20 age group seems to resemble the "adolescent-family crisis" clinical sub-group. These are young men and women, struggling with needs to be independent from difficult, if not destructive, family relationships on the one hand, and strong dependency needs and fantasies that things can be different at home on the other. Suicide arises as a cry for help; the young person feels trapped, with suicide the only viable exit. Most often he is living with his family and the young person has been trying to communicate to his parents how miserable and desperate he feels. The parents have been aware that the situation is desperate, yet they are immobilized, unable to take any action toward change. Often, confronted with an overtly suicidal young person, denial and repression remain the major coping mechanisms.

Crisis intervention is often a useful treatment technique with this sub-group. It seems particularly effective to involve the family from the start of treatment. This is facilitated by the fact that the call for help to a suicide prevention service most often comes from the family. Some of the more serious situations lead to separation of the adolescent from his family by hospitalization or alternate living arrangements.

Among young adults (20 through 39 years of age), suicidal problems arise in the context of love relationships and the definition of a job role. A number of people in this group may be classified as "discarded women." For these women, a pattern of repetitive failure in relationships with men, punctuated by recurrent suicidal episodes, has begun to be established. This pattern is related to character problems, and appropriate treatment should take this into account. Crisis intervention, although useful at the time of the suicidal episode, should help these people with an eye toward the repetitive pattern. Changes in living arrangement and job placement may help by providing a stable base. Often extended psychotherapy is indicated.

A small clinical sub-group, "harlequin," and the "chaotic" sub-group are also in the 20 through 39 age range. In contrast with the "discarded women," these two sub-groups are characterized by more severe psychopathology. Panic states occur with the "chaotic" group; the "harlequin" sub-group may act on omnipresent suicidal feelings without identifiable external stress.

Some of the men in this age group may be classified "I can't live without you." Apparently, they are few in number, since most of the items from Chart 2 at these ages apply to women. It should be noted that this 20 through 39 range is modal for suicide prevention center patients. Also, two-thirds of all SPC patients are women.

Inspection of the items under the age range 40 through 59 suggests that the dimension of acute vs. chronic suicide problem is important. Such items as acute stress, stable life style, no prior suicide attempt, depression, perhaps recent job loss, all suggest a group of people who were functioning adequately in life until they suffered an acute external stress. Some of these may be classified in the "I can't live without you" sub-group. There are other items relating to chronic suicide problems such as living alone, divorced, or widowed; and downhill life course. Some of these people could be included in the "down and out" clinical sub-group. Treatment implications in light of the acute vs. chronic dimension will be discussed below.

Among the items characteristic of the group 60 years of age and older, there are some which suggest the "down and out" sub-group; however, more prevalent are those items relating to an acute suicidal situation. The group is similar to the clinical sub-group of "old and alone." Such items as widowed, living alone, death of a loved one, outlived others in his life, life is an effort, give-up attitude, and stable character suggest a more rapid decompensation with prior history of adequate adjustment to life.

The Sex Dimension

The items associated differentially with men and women emphasize the fact that men are generally higher suicide risks than women. When seen at the Suicide Prevention Center, men were more often given a high lethality rating by the worker. Some of the components of a high lethality rating are present with men, particularly poorer resources. Such items as living alone, recent job loss, downward job mobility and downhill life course reflect the isolation and erosion of personal resources. For example, a number had had recent contact with a physician. The item "keeps problems to himself" associated with men supports clinical observations that it is more difficult for a man to turn to others and develop interpersonal resources.

As for treatment, a major focus of suicide prevention activity, based on a crisis model, involves mobilization of the person's resources. Often with men, there are few, if any, resources to mobilize. If the man is resistant or unable to establish an extended psychotherapy relationship, an appropriate treatment plan is hard to formulate.

Acute vs. Chronic Suicide Problems

From earlier discussion, it is apparent that the dimension of acute vs. chronic suicide problem is important. Chart 2 lists other items associated with this dimension which suggest its important components. People rated as acute suicide problems gave no history of prior suicidal episodes. Generally, their life had been fairly stable and the current suicidal crisis was often a response to some external stress. Most often, this stress was the loss of an important other, particularly the break-up or imminent disruption of a love relationship through divorce or separation. Undoubtedly, a number of the people represented here as acute suicide problem would also be rated in the "I can't live without you" clinical sub-group.

Suicide prevention services or any other crisis intervention techniques may be particularly successful with these acutely suicidal people. Although the risk of suicide is high during the crisis period, large amounts of outside support and activity may allow the person to weather the storm. When the crisis period is over, these people have some level of successful functioning to which they may return. It should be noted that often a friend or some professional in the community will call about such a person and the initial phase of help becomes important. Much of the therapeutic energy will be needed to establish the helping relationship with a sense of trust and mutual purpose. During the crisis period, there is a loss of perspective such that the suicidal person is unable to conceive of anyone ever replacing the lost love object, and the fact that there have been earlier love relationships is forgotten.

People with a history of chronic suicidal problems generally show more overt, serious emotional disturbance. Often their life has followed a downhill course, with repetitive failures in many areas. When you ask such a person why he is suicidal *at this time*, he is often unable to relate it to any specific external events. Character problems such as alcoholism and the abusive drugs complicate and interfere with help.

Such a chronic picture does not correspond with the crisis view of suicide. Crisis intervention focuses on current time and presumes the suicidal problem is in response to identifiable external circumstances. Some people with chronic suicidal problems have had a number of chances at psychotherapy which have failed. New treatment programs are called for to provide useful external resources currently unavailable in the community.

Current and Planned Research

At this stage of our research, these sub-groupings are presented tentatively with the understanding that major subsequent changes will be made. We are planning an extensive revision and re-assessment of the clinical sub-groups, and a new sample of 500 case files for clustering and factor analysis is now being drawn. We have expanded and refined our item pool through a series of lengthy reliability studies and many items have been added which should provide a reliable and valid measure of suicide potentiality. Moreover, we hope that later sub-groupings will result from a fusion of clinical, clustering, and factor analytic techniques.

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DEATH: A NEUROSCIENTIFIC ANALYSIS[1]

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The twentieth century has been witness to a series of advances in medical treatment techniques which are viewed by many with almost a sense of disbelief. Now, life can be prolonged for hours, days, or even weeks beyond that time when it would once have been given up for lost. This has led medicine to be less accepting of the inevitably terminal prognosis for patients with total or nearly total failure of one or a series of major bodily organs.

This new, cautious attitude has its heritage in a series of scientific advances which rest upon the initial hypothesis that man can exert considerable control over both his external and internal environment. One need only examine the recent rapid progress of organ transplantation to see a fruition of this scientific maturation which has resulted in potential modifications of the human life cycle. Certainly another prominent example lies in the technological progress which has enabled physicians to prolong life by such artificial means as resuscitators, pacemakers, etc. Those whose lives have spanned the nineteenth and twentieth centuries and even younger men must stand in awe of these developments.

As with technological advances occurring in any field, progress does not take place without some toll. The ability to modify the life cycle has raised a series of important issues which must ultimately be evaluated so as to reap the full bounty of knowledge. Organ transplantation, particularly with the heart, represents perhaps the major confrontation with progress. Here science is faced not only with a decision to prolong the life of the recipient, but also with deciding the conclusion of the life cycle of the donor. When artificial resuscitative devices do enable the continuation of basic life functions, the question arises as to the actual rehabilitative result which might be achieved by such intervention. For example, if the individual so revived would nevertheless be incapable of maintaining his existence at any level above that of a vegetable, why exert such effort?

THE BRAIN: ORGAN OF LIFE

The potential resolution of these issues, along with others to be raised shortly, has fallen to many, but most recently to the neuroscientist. It is certainly the prevailing viewpoint that the organ which provides the direction for the uniqueness of behavior denoted as an individual's "life," is his brain. The integrity of the brain, therefore, becomes the yardstick upon which to evaluate life. There are two hypothetical poles of brain function, namely the failure of brain maturation in the young organism (as seen in several varieties of mental retardation) and brain deterioration in the biologically mature individual. Beyond these poles is the possibility of existence at only vegetative levels, without human capacities such as consciousness, judgment, abstraction, etc. If life is the

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[1] The author gratefully acknowledges the consultation of Dr. Robert Kastenbaum in the preparation of this paper.

presence of these capacities, then their absence is death. And, if it is accepted that the brain is the ultimate mediator of these nonvegetative functions (as well as of such basic activities as respiration and circulation), then it follows that the brain represents the organ of human determination.

This definitional problem can also be examined from a more traditional vantage point. Prior to the current evolution of the neurosciences, the problem of defining death has been approached from a rather narrow "vegetative function" point of view. Boba (1965) has defined death as "a complete cessation of respiratory and circulatory functions occurring simultaneously in a patient for whatever reason" (p. 9). In a similar vein, death had been defined as a cessation of integrated life functions (ingestion, digestion, respiration, circulation, etc.) which occurs if any of these functions is much impaired or arrested (Collins, 1966). Such definitions are statements of clinically observable events, i.e., arrested activity in vital functions, which may be partially or even totally reversible. Hence they constitute what may be called "clinical death." Beyond this consideration, however, would be an attempt to define the biological reality of death. In fact, when no amount of resuscitation has the potential to restore the patient even to a vegetative existence, then the biological reality of death has been reached.

The implication that a biological reality of death does exist further implies that an empirical criterion could be specified to allow precise definition of a *moment* of death. Although this is a logically consistent derivation, there is little organic verification for the principle of a death moment. Certainly the rates of tissue decomposition vary widely across organs as well as across organisms such that some biological activities decline rather slowly whereas others deteriorate quite rapidly. For example, the growth of hair and nails may continue for days beyond the cessation of circulation and respiration; and kidneys may remain functional for a few hours after death. Hence the determination of death, unless the judge is prepared to wait long enough to evaluate the final deterioration of each and every organ system separately, is without specific criteria for a definition of *the* fatal moment. However, if it is accepted that the brain be allowed the status of arbitrator, then one must look to the knowledge provided by the neurosciences as a means of establishing some functional criteria of death.

Therefore, to proceed conservatively with a working definition of death, two preliminary criteria can be generated: (1) irreversible brain damage with total loss of cerebral function; and (2) cessation of spontaneous respiratory and circulatory function. Since the latter criterion has been invoked almost routinely, it is far more advantageous to examine the former, which is far from routine. The question then becomes: how can irreversible brain damage with total loss of cerebral function be determined?

A perusal of current neuroscience research yields two major sets of criteria for brain death, i.e., the findings based upon clinical neurological examination and the finding of electroencephalographic (EEG) examination. Considering the clinical neurological examination first, several indicators of the lack of evidence of neural activity have been enumerated by Walker (1969). These include (1) bilateral dilated and fixed pupils; (2) paralysis of self-maintained respiratory effort; (3) absence of corneal reflexes; (4) absence of tendon reflexes; (5) unresponsiveness to deep pain stimulation (e.g. pinpricks, compression of the Achilles tendon, or in the male, of the testes); and (6) lack of response to injection of ice water in the external auditory meatus.*[2]

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[2] Words marked in this fashion (*) will be defined in a brief glossary at the end of this article.

With respect to the electroencephalogram, the criteria for establishment of brain death are somewhat more complex. Specific efforts to establish criteria have evolved in part from surveys of electroencephalographers who have reported various cases of flat (isoelectric) EEGs. It is assumed that a flat-line tracing represents absence of neuronal activity. The Ad Hoc Committee of the American Electroencephalographic Society on EEG Criteria for Determination of Cerebral Death has reported on such effects (Silverman et al., 1969). A questionnaire sent to members of this society yielded reports of 1,665 cases of isoelectric EEGs and revealed only three cases with truly linear records who recovered some cerebral function. Of the three cases, two were barbiturate-induced comas and the third was a coma secondary to meprobamate* overdose. For this reason, death in patients under the influence of these varieties of drugs must be determined most cautiously, with evidence from techniques or examinations other than the EEG as the primary assessors of brain function. As cited in the American Electroencephalographic Society report, further complicating the issue is the fact that the number of isoelectric EEGs available for study has increased in recent years because of greater success of resuscitative efforts in hospital intensive care units.

The definitions of an isoelectric EEG may account for considerable variation in brain death determination. For example, it must be decided as to the length of time that an EEG is required to be flat. Also, some consensus as to the evaluation of specific EEG parameters (gain, or amplification, in particular) must be reached. Finally, the patient must not be in a hypothermic* state, for under such conditions brain dysfunction may be somewhat reversible.

Beyond the clinical neurological examination and the EEG, several more exotic criteria of brain death have been proposed. Walker (1969) notes that cerebral oxygen consumption (when less than 10 percent of normal) might be usable as an index. He further points out that "when the intracranial pressure reaches 67% of the systolic arterial pressure, the blood through the carotid artery does not enter the intracranial cavity and the entire brain becomes hypoxic* and undergoes necrobiotic* changes" (p. 12).

Gilroy (1969) has also noted some potential adjunctive methods for the determination. He cites a megimide* injection via the intracarotid route as a means of stimulating latent cerebral activity. This method has been in use for several years as a means of activating latent epileptogenic foci.* He also has mentioned the use of measures of cerebral circulation time (greater than fifteen seconds being equivalent to cerebral death) and determination of oxygen pressure levels in arterial and jugular systems. Still other potential methods which he cited include radioactive angiography* and enzyme level determinations in the cerebrospinal fluid.

For death determination, some institutions have adopted what has come to be known as the "Harvard criteria" as developed by an ad hoc interdisciplinary committee of that university (Ad hoc committee, 1968). These are: (1) no hypothermia or anesthetic drug levels; (2) no reflexes, spontaneous breathing or muscle activity; (3) a flat EEG at gains of 50 m^{V}, 5mm to 10mm through a ten-minute period of recording; (4) no clinical EEG response to noise or pinch; and (5) repeat of conditions of 1, 2, 3, and 4 twenty-four or forty-eight hours later. This report details a series of additional moral and ethical safeguards for the doctor in charge and for the electroencephalographers. Furthermore, there is at least consensus with respect to several of these criteria on the part of two of the world's prominent heart transplant surgeons (in Winter, 1969).

In this vein, it is of considerable interest to look at the world medical community and its views on cerebral death. Publication of existing legislation by the World Health Organization, as summarized in Medical Tribune (Hirsch, 1969), reveals some significant international variation. France, for example, requires that potential donors must be evaluated for proof of irreversible lesions incompatible with life. This evaluation is based upon the circumstances under which the lesion occurred, absence of unassisted respiration, complete absence of all reflexes, and disappearance of all electroencephalographic indicators for a prolonged period (details of last criterion not given). Negre, a French transplant surgeon, notes in a personal communication cited by Winter (1969) merely that the EEG must be flat, with no time limits, gains or other subvariables specified. The other extreme is represented in Denmark's legislation which leaves determination of death entirely to the physician's judgment, without specific criteria being imposed. Similarly, in Australia, it is only required that a qualified practitioner decide that "life is extinct." Specifically with regard to organ removal, Czechoslovakia and Luxembourg have set specific time limits of two and twenty-four hours respectively (after certification of death) before organ removal. In fact, attempts to develop uniform international standards have been made. Debates at the World Medical Assembly Meeting in Australia during 1968 (Silverman et al., 1969) resulted in the following conference resolution:

> "The determination of the time of death in most countries is the legal responsibility of the physician and should remain so . . . . A complication is that death is a gradual process at the cellular level, with tissues varying in their ability to withstand deprivation of oxygen. But clinical interest lies not in the state of preservation of isolated cells, but in the fate of a person. Here the point of death of the different cells and organs is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation that may be employed.
>
> This determination will be based on clinical judgment supplemented if necessary by a number of diagnostic aids, of which the electroencephalograph is currently the most helpful . . . ."

However, it appears that one must be somewhat pessimistic concerning the development of specific uniform international standards in that the issue seems to have its roots not only in science but latently in law, politics, economics, and religion as well.

IMPLICATIONS OF DEFINITIONS OF DEATH

The entire definition of the state of death and its given moment is not without important legal consequences. That the determination of the exact moment may be crucial is of obvious significance in situations which now are probably hypothetical, but which may not remain that way. For example, one need only face the situation of a patient whose term life insurance benefits expire coincidentally, or almost so, with his impending death. This situation and several other hypothetical problems have been cited by B. D. Hirsh (1969), general counsel of the American Medical Association. In the legal vein, the Attorney General of the State of New Jersey, A. J. Sills (1969), has succinctly summarized some major legal topics with respect to death determination prior to organ donation. Among the most relevant for the present discussion are the scope and intent of criminal liability of the medical profession, the demands of science, and the conflict between the need for organs and the public interest in the causes of death.

Also in the legal arena, a coroner, E. H. Albano (1969), has summarized his experiences with the course of neurophysiologic events following cardiac arrest and culminating in brain death. He reports that in the first post-arrest minute the brain relinquishes control of sensory and neuromuscular systems; even earlier, after four seconds, EEG changes can be seen and often cease after thirty seconds. Four to six minutes later, irreversible brain damage occurs. In this last datum lies the very brief grace period during which resuscitation must be accomplished.

Despite increasing neuroscientific sophistication, there still persist the "miracles," or more precisely, the scientifically misunderstood, unexpected, or low probability occurrences that remind the "determinor" to maintain a cautious attitude. One example of the necessity for caution lies in a case report (May and Kaelbling, 1968) illustrating a patient with coma of one year duration who, after three years, regained nearly normal physical and mental functions. As documentation of the degree of restoration, this patient achieved an IQ of 96 on the Wechsler Adult Intelligence Scale at the end of this period of time. Of course the severity of the coma may have been judged too harshly; however, it is nevertheless striking that brain dysfunction of a seemingly permanent variety as might be suspected from the clinical findings reported by the authors would be reversible to a significant extent.

Certainly the medico-legal area may be strongly influenced by the new definitions of death. The situation of a murder, for example, poses an interesting hypothetical problem. If the victim could be kept even vegetatively alive by means of artificial resuscitative devices, then a corpse could not be presented and a charge of murder could not be proposed. If the victim were adjudged "dead" with the use of EEG, then perhaps the attorney for the accused could appeal that his client was being unjustly tried in that sufficient effort to prolong "life" had not been made. In this situation, even a vegetative existence is of great import, for the life of the accused hangs in the balance. Therefore, the term "death," in the legal vocabulary, might ultimately require some modification or even replacement by a term such as "termination of human life function." On the other hand, if such a replacement definition were employed, many persons who are presently being convicted of crimes such as assault with intent to kill, with their victims lying in chronic coma, would, in this sense, actually be guilty of murder!

From the standpoint of implications for the socio-behavioral sciences, it would be interesting to study attitudes toward death in the light of these new criteria. Perhaps the new definitions will spark a broadening of such attitudes to the degree that even vegetating schizophrenics will be attitudinally perceived as "dead," rather than ill. In fact, has it not been society's desire to assign such patients to intermediate cemeteries whose sole function becomes one of waiting for and then establishing the biological signs of death? Relatives of such chronically hospitalized patients frequently report the patient as dead as a means of denying his hospital existence, denying their own guilt, or for other psychodynamic purposes. Of course, defining the vegetative state as synonymous with death may be just the excuse that eugenics would be seeking. In fact, very close to the eugenic issue is the issue of euthanasia, with which the newer definitions and technology of death might force confrontation.

CONCLUSION

There has certainly been a rapid acceleration in the interest expressed by the scientific community in the role of the brain in determination of death. This interest has extended to the legal, medico-legal, religious and even political fronts. Certainly the current stimulus for the interest lies in the advances in human transplantation surgery. In a sincere attempt to help clear any potential confusion, the neurosciences have begun to dissect and reevaluate their own criteria of death. Ultimately, the neuroscientist must somehow improvise so that an empirical test can be made of each of the sets of criteria noted above. On the other hand, the hope that a single pathognomonic sign of brain death could ever be determined, or that a precise moment of brain death could be established seems unrealistic if the possibility is measured against biological fact and the prevailing quasi-empirical knowledge of brain deterioration. Perhaps cerebral death may be represented by a multivariate equation, containing differential weightings of clinical neurological signs and the characteristics of electrocerebral silence.

Certainly of major import is the fact that a double standard of death must be avoided at all costs. There must not be one standard accommodating the transplant teams alternating with the prevalent definition which rests solely upon heartbeat and respiration. The public will question a variation in standards—in fact, one could ultimately become apprehensive about euthanasia, were there such a double standard. Perhaps the neurosciences will eventually provide the rapprochement.

GLOSSARY

epileptogenic focus i)—the abnormal electrical activity, of an epileptic type, generated at a particular site (or sites) in the brain
external auditory meatus—the external auditory canal
hypothermic—very low temperature
hypoxic—of low oxygen content
megimide—a drug often used to activate latent electrical abnormalities of the brain
meprobamate—a tranquilizer and muscle relaxant usually marketed as "Miltown" or "Equanil"
necrobiotic—the physiologic degeneration and death of tissue
radioactive angiography—an investigative technique allowing the visualization of blood vessels (cerebral, in this case) employing radioactive substances

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THE TREATMENT OF DEATH IN CHILDREN'S BOOKS

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In a recently published compendium of essays by sociologists, psychologists, and theologians, *Explaining Death to Children*, a contribution entitled "Children's Books Relating to Death: A Discussion" was made by Eulalie Steinmetz Ross. Earl Grollman, editor of the volume, obviously felt that the literary medium had or could have a significant function in explaining death to children, but Ross' discussion of children's books appears to be based upon personal professional experience as a librarian rather than on empirical data and scholarly interpretation. This paper will use Ross' essay as a critical base in an attempt to present a documented study of the treatment of death in children's books,[1] the ultimate purpose of this discussion being to determine to what extent children's books support the developmental needs of children as they work towards a mature concept and acceptance of death.[2]

CHANGES IN ATTITUDE TOWARDS DEATH

An examination of present-day societal attitudes towards death and their historical counterparts provides a useful beginning to the analysis. In her book, *On Death and Dying*, Elisabeth Kubler-Ross states: "The more we are making advancements in science, the more we seem to fear and deny the reality of death" (1969, pp. 6-7). She supports this statement by showing how we use euphemisms to describe death; embalm the dead so that they appear to be asleep; and send children away supposedly to "protect" them from the emotional upheaval which accompanies the death of a family member. Death for the individual has become a lonely and dehumanizing experience which takes place in the sterile surroundings of a modern hospital (Kubler-Ross, 1969). In Louisa May Alcott's *Little Women*, there is a touching scene in which Beth dies peacefully in her own home surrounded by her loving family, but it is hard to imagine a similar occurrence today. There seems to have been a shift in emphasis away from satisfying psychological needs of the dying person to satisfying his physiological needs.

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[1] We wish to thank Professor Mary Gaver of Rutgers—The State University for her helpful suggestions and comments on an earlier draft.

[2] While this study has of necessity restricted its analysis of children's literature to books and a few outstanding short stories, it is recognized that there are many sensitively written children's poems dealing with death that deserve attention.

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Contrary to common belief, the reluctance of parents in western cultures to share the experience of death with their children is a recent phenomenon. Since the infant mortality rate was significantly higher in the eighteenth and nineteenth centuries than it is today, death came within the experience of almost everyone, rich and poor alike, at an early age. In response to this, the populace maintained a pattern of grief which could cope with the frequency of such experiences. Parents were generally less attached to their offspring when young than parents are today (Yudkin, 1968, p. 46). In addition, children were exposed to a great deal more physical violence in the forms of fights, murders, and public hangings. Death was an everyday occurrence, and hence an everyday topic of conversation and this was reflected in the literature of the period.

The eighteenth and nineteenth centuries marked the beginning of an age which accepted the uniqueness of childhood. At last children were not always expected to be "little adults" in manner and dress, and they began to have their own stories written for them. The death of a child by some violent means was a common theme in these stories, a theme completely unheard of in modern children's literature. The attitude of the Victorians towards children was, however, characterized by a mixture of authoritarianism and sentimentality. Death was often used as a threat to naughty children, and the death of a child posed the opportunity for displays of melodramatic remorse on the part of the parents. Children's literature, as well as that of adults, made frequent use of the dramatic possibilities inherent in these themes (Yudkin, 1968). Religiously oriented books were among the worst offenders as far as using death as a threat to children. The good child was given some comfort by religious teachings, but the terrible fate which awaited the bad child after death stood as a constant disciplinary reminder for those who misbehaved (Yudkin, 1968).

DEVELOPMENT OF THE CHILD'S CONCEPTION OF DEATH: PSYCHOLOGICAL FINDINGS

In her essay, Ross posits that the young child has no need of reading materials which consciously relate to the subject of death. Instead, she recommends a variety of titles which treat such themes as family, friendship, and religion. This position, however, contradicts the findings of child psychologists. The first major study in the area of how children perceive death was made by Sylvia Anthony and reported in her book, *The Child's Discovery of Death*, published in 1940. Anthony based her interpretation on that of Freud, who had said that death meant little more than departure or disappearance to a child. Anthony went on to establish the notion that consciousness of death develops in this individual as his intellect advances, rather than purely on the basis of his chronological age. This being the case, we could expect children to develop a mature view of death earlier today than in the past, considering the effect of their greater exposure to the media at the pre-school level, as well as the new learning techniques being employed in schools.

Jean Piaget has estimated that children begin to develop a realistic concept of death around the age of six. This is followed by a critical period of development between the ages of seven and eight, and is completed by eleven or twelve. At this point the finality of death is recognized and the child has formed many of the concepts which he will carry into adulthood (Anthony 1940).

In 1948, Maria Nagy constructed three major stages of development in the child's view of death on the basis of her research. The first stage, which she assigned to children aged three to five, involved the denial of death as a final occurrence. Children at this stage consistently state that the dead will come back to life or are not really dead at all. Between five and nine, Nagy found that children tend to personify death. They often speak of a "bogey man" or "death man" and, in addition, they begin to construct fantasies which include death as a theme. While the child realizes the eventuality of death at this age, he has not yet recognized it as an event which will affect him personally. In the final stage, at the age of nine or ten, the child does accept his own mortality and associates death with the dissolution of the body (Nagy, 1959).

More recently, Gregory Rochlin has challenged the conventional view that the very young child does not know about death. This psychologist points to the death games that children play from an early age as proof of this awareness (Rochlin, 1967). In Louise Fitzhugh's latest book, *Bang, Bang You're Dead*, we have an example of such a game. The story, which is really a denunciation of war, tells of a group of boys playing on a hill who are always "shooting each other dead." At the end of the day, the boys return home, happy and quite alive, despite the heavy casualties. Rochlin contends that children perceive death—the absence of life—very early in life and quickly develop defenses against the insecurity that this knowledge presents. Fitzhugh's book can be interpreted in this light as well; the children are using the denial of death principle in their game. Although Rochlin (1967) does not claim that there is any pragmatic acceptance of death by young children, he does emphasize that the subject is of great concern to them. In response to this concern, the child creates fantasies, repeats rhymes to ward off evil spirits after seeing a dead animal, and often pretends to be dead, only to come miraculously alive again.[3]

The children in Rochlin's study were aged three to five and the development of many of the death consciousness characteristics previously noted by Anthony, Piaget, and Nagy in older children was found in his sample. Rochlin also found that throughout life, individuals not only retain some of their childhood beliefs about death, but that they readily revert to more of them in response to their personal encounters with the death of friends or relatives in later life.

A comparatively recent analysis of children's fantasy reinforces Rochlin's position by showing an awareness of and a preoccupation with death at an early age. The psychologists Pitcher and Prelinger collected stories told by children aged two to five. While only one two-year-old boy mentioned death in his story, it was a popular theme with three-year-olds. These themes, which included the dead coming back to life, and death as a punishment for some wrongdoing, continued at age four accompanied by a growing ability on the part of the child to distinguish between the real and the unreal or imaginary (Pitcher and Prelinger, 1963). The children often referred to sleep interchangeably with death, sleep representing the ultimate finality for the very young child. The children also expressed an interest in the problem of whether or not it was possible to kill witches, ghosts, and goblins. By the age of five, the children's fantasies revealed a more "final" interpretation of death, especially among boys. It is particularly significant that the children did not seem threatened by the notion that death was final, at least as interpreted in their own fantasy world. This finding is in contrast to some of the

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[3] The subject of children's verses and games is treated at length in Iona and Peter Opie, *The Lore and Language of School Children* (Oxford: Clarendon Press, 1959).

views of earlier psychologists, especially Freud and Anthony, who stated that the discovery of the finality of death by a child was accompanied by feelings of loneliness, fear, and insecurity (Anthony, 1940).

We might speculate at this point as to whether or not a fear of death is more of a socialized fear than a natural one—a premise which would be shared by most psychologists other than the psychoanalytically inclined. Pitcher and Prelinger note that the idea of burial and the other physical consequences of death do not concern the child until he is older. This is also true of the notion of the ongoingness of life—of new life springing from the old.

It is interesting to consider some of the differences that were found between boys and girls in their attitudes towards death at different ages. In their fantasies, boys not only have more thematic references to death than girls, but they also are more curious about the possibility of death for superhuman characters. The deaths which the boy describes are often violent and horrible, but they never happen to the child himself or to "real" people (Pitcher and Prelinger, 1963). Girls are less likely to associate death with violence, and are more likely to deal with the personal implications of death. They cling to the notion of reversibility of death much longer than boys, and do not develop abstract concepts, such as reincarnation, as quickly. Of the 360 stories collected by these two psychologists, 57 used death as a theme. This is a significant proportion, especially since they were dealing with a two to five age group.

A brief summation of the findings that have been cited in this paper on how children view death shows that, contrary to Eulalie Steinmetz Ross' point of view, very young children are indeed concerned with death, and hence do have a need for reading materials which deal with the subject. The development of a child's perception of death takes place between the ages of two and twelve, and, according to Rochlin, the child's ideas are well-developed by the time he is five. Furthermore, Anthony's finding that this development is related to intellectual growth, coupled with the tendency of modern education to speed up this growth, points to a continuation of the trend we have noted towards a concern with death at an earlier age.

Clearly, more psychological research is needed to identify the developmental stages of the child's conception of death. But the existing literature allows us to be certain on one point—the important stages in such development occur at the very least before age twelve. And, moreover, the most recent findings suggest the the critical period of development occurs at an earlier age than had heretofore been realized.

IMPLICATIONS FOR CHILDREN'S BOOKS

A search of children's books reveals serious inadequacies in the treatment of death. The findings here presented are based on a thorough search of all bibliographies that were subject-indexed in the field of children's literature and held in the children's collection of the New York Public Library; and, for the ages up to seven, an additional search was made of the children's literature collection of Rutgers—the State University. It is symptomatic of the neglect of this field that no comprehensive bibliography of children's literature concerning death could be found. However, the appended list of all applicable titles discovered by this method might probably be taken as reasonably representative of the general picture.

On the basis of the most recent psychological evidence, the largest number of titles dealing with death carried by the ideal library would be in the pre-school to seven age group—the age span which covers the critical period in the child's formation of his concept of death. However, if we examine the number of titles in the listing at the end of this paper, we will find the number in this age group sadly lacking. Of the nine titles in the list, four can be included in the category of fantasy and five in realistic fiction. It is immediately obvious that a division must be made between these two categories since, as Pitcher and Prelinger have found, by the age of four the child is starting to distinguish between the real and the imaginary. Hence, in Andersen's, *The Steadfast Tin Soldier*, the child would not relate the deaths of the tin soldier and the little dancer to the death of a human being.

Of the five realistic fiction titles, two, Margaret Wise Brown's *The Dead Bird* and Warburg's *Growing Up*, deal with the death of animals. While this as an experience that most children have, Yudkin questions the extent to which the death of an animal or pet will help the child to understand the death of a human being. For one thing, the death of an animal is treated much differently by a parent than the death of a relative, and this is apt to confuse the child. When a person dies, we even use different terminology, saying that the deceased has "passed on" or "gone up to heaven". This is not to say that such stories are not beneficial to a child's development, but rather they are not the total answer to providing for the child's understanding of death.

Pearl Buck's *The Beech Tree* and Jean Fassler's *My Grandpa Died Today* are the only two books that deal with the death of "real" people. Both of the stories are about the death of a grandfather, and thus relate to a situation which is often encountered by the young child. Miss Buck turns to another culture in her book to tell the story of a wise old grandfather who used the beech tree as an example of how every living thing must serve its purpose and then die, leaving those who come after. *My Grandpa Died Today* is part of a new series of scientifically prepared children's books that have recently become available. This volume and the one listed under the eight to eleven age group by Zim and Bleeker entitled *Life and Death*, are in the forefront of a new trend in children's book publishing which involves treating troublesome subjects such as death from a psychologically supportive point of view.

Life and Death takes a straightforward look at death and covers the life functions, the difference between sleep and death, as well as the physical characteristics of death. The various rites that constitute funeral and burial procedures are described and compared with those of other cultures. This is obviously the type of publication which will solve for the child many of the mysteries surrounding death, and in view of the findings of this paper, we would hope that a similar volume will be made available for the younger age group. Rabbi Grollman's very recent *Talking About Death* (1970) is a welcome addition to this sparse literature. A brief volume, illustrated with mood-reflecting abstractions, this book is to be read to children of almost any age. It deals gently but directly with the meaning of death.

Ross cites a number of titles which relate to death that are suitable for more mature readers, but, as we have already noted, after the age of eight the child is *past* the critical period in his development of a concept of death. Children's literature has an opportunity which it has only begun to exploit: to play a unique role in providing developmentally sound reading materials to children as they learn about death. A gap exists today between the conventional view of how children perceive death and psychologist's findings on the subject. This gap, combined with the generally repressive attitude towards death which characterizes our technological culture, is making it increasingly difficult for parents to discuss the subject with their children. In order to fulfill the potential of the literary medium to counteract this problem, children's authors and librarians must combine their efforts to make books available which convey a sensitive and realistic picture of death.

The trend towards psychologically oriented children's titles has been noted in this paper, but it is still in its infancy. Librarians have the responsibility of interpreting this new trend to parents and to the children themselves, as well as providing bibliographic access to titles which relate to death. Social scientists have provided the children's librarian with a new resource, but the utilization of this resource demands a critical awareness of scholarship and an inquiring scientific mind.

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ANNOTATED BIBLIOGRAPHY: A SELECTED LIST OF CHILDREN'S BOOKS RELATING TO DEATH

Compiled by Joanne Gard Marshall

The compilation of this bibliography was based on three sources: (1) As many already existing bibliographies of children's books relating to death as could be found; (2) A thorough search of general bibliographies in the field of children's literature which were subject indexed; and (3) A survey of books relating to death in the children's literature collection at Rutgers—The State University.

The limited bibliographic access provided by the first two sources has already been noted, but should be emphasized. In addition, these two sources only provided titles which present death as the major theme of the story rather than as a sub-theme. One of the purposes of the survey conducted at Rutgers was to add titles which did treat death as a sub-theme in the belief that there were many valuable titles in this category to which there was no bibliographic access whatsoever. A great deal more first-hand analysis of children's literature is needed to provide the adequate bibliographic treatment which this subject deserves.

An effort was made to select titles in the area of realistic fiction rather than fantasy, as children seem to develop their more mature attitudes towards death from the former.

It should be pointed out that the age categories into which the bibliography has been divided are meant to serve only as a general guide, the primary purpose being to show the inadequate number of titles suitable for the younger reader.

PRE-SCHOOL TO AGE 7

Andersen, Hans Christian. *The Steadfast Tin Soldier.* Ed. by Marcia Brown. New York: Scribner, 1953. After the tin soldier and the little dancer, whom he loves, are thrown into the fire, a tin heart and a spangle are found in the ashes.

Brown, Margaret Wise. *The Dead Bird.* Illus. by Remy Charlip. New York: Scott, 1958. A child finds a dead bird and she and her friends join in giving it a funeral and burial.

Buck, Pearl. *The Beech Tree.* Illus. by K. Werth. New York: John Day, 1955. Grandfather uses the beech tree as a simile to help his family to accept his impending death.

Fitzhugh, Louise and Sandra Scoppettone. *Bang, Bang, You're Dead.* New York: Harper and Row, 1969. Children decide that it is much better to "play dead" than to have a real war where they get hurt.

Fassler, Joan. *My Grandpa Died Today.* New York: Behavioral Publications, Forthcoming. A young boy encounters death for the first time.

Godden, Rumer. *The Doll's House.* Illus. by Tasha Tudor. New York: Viking Press, 1962. Birdie saves the baby from the burning candle, but burns himself up in the process.

Warburg, Sandol Stoddard. *Growing Time.* Illus. by Leonard Weisgard. Boston: Houghton Mifflin, 1969. King, Jamie's dog, dies and Jamie must learn to accept the loss of his old companion.

White, E. B. *Charlotte's Web.* Illus. by Garth Williams. New York: Harper and Row, 1952. When Charlotte, the spider, dies at the fair grounds, her friends Templeton, the rat, and Wilbur, the pig, manage to take her eggs back to the farm where they can safely hatch.

Wilde, Oscar. *The Selfish Giant.* Illus. by Herbert Danska. New York: Quist, 1964. A fairy tale with religious overtones about a small boy's adventures in a giant's garden.

AGES 8 TO 11

Alcott, Louisa May. *Little Men.* New York: Macmillan, 1963. The story of the founding of the school at Plumfield, during which Meg's husband, John Brooke, dies.

Alcott, Louisa May. *Little Women.* Illus. by Tasha Tudor. New York: World, 1969. In this classic story of New England life, Beth, one of the four March sisters, dies surrounded by her loving family.

Andersen, Hans Christian. *The Little Mermaid and Other Fairy Tales.* New York: Platt, 1963. A little mermaid gains immortality by conquering witchcraft and gaining the love of a mortal prince.

Baker, Laura Nelson. *Cousin Tryg.* Illus. by Paul E. Kennedy. Philadelphia: Lippincott, 1966. When a Scandinavian-American family living in the midwest loses their father, Cousin Tryg comes to help run the farm. Young Noris has a difficult time adjusting to this new situation.

Beim, Jerrold. *With Dad Alone.* Illus. by Don Sibley. New York: Harcourt, Brace and World, 1954. Life in the Madison house changes when Bruce's mother dies and he must help care for his younger brothers.

Buck, Pearl. *The Big Wave.* New York: John Day, 1948. After the death of Jiya's parents in a tidal wave, his foster father helps him to accept the tragedy. Illustrates the Japanese philosophy of life, which is to enjoy life and not to fear death.

Coatsworth, Elizabeth. *The Cat Who Went to Heaven.* Illus. by Lynd Ward. New York: Macmillan, 1967. A poor painter who has been commissioned to do a painting of the death of Buddha, gains entry for his devoted little white cat into heaven by including him in his work.

Courlander, Harold. *Terrapin's Pot of Sense.* Illus. by Elton Fax. New York: Holt, 1957. Contains an American Negro folk tale called "Death and the Old Man".

French, Harry W. *The Lance of Kanana.* New York: Lothrop, 1932. A young Arabian boy sacrifices his life to save his country from a fourth-century Roman invasion.

Freuchen, Pipaluk. *Eskimo Boy.* Illus. by Ingrid Vang Nyman. New York: Lothrop, 1951. When Ivik's father is killed on a hunting expedition, the boy must fill his father's role of providing for the family.

Hosford, Dorothy. *By His Own Might: The Battle of Beowulf.* New York: Holt, Rinehart and Winston, 1947. The tale of the hero Beowulf, who has no fear of death.

Johnson, James Weldon. *God's Trombones: Seven Negro Sermons in Verse.* New York: Viking, 1966 (c. 1955). Contains a touchingly beautiful funeral sermon for Sister Caroline entitled "Go Down Death."

Little, Jean. *Home From Far.* Illus. by Jerry Lazare. Boston: Little, Brown, 1965. Jennie's twin brother is killed and she must adjust to the presence of two foster children that her parents take into their home.

Kim, Yong-Ik. *The Happy Days.* Illus. by Artur Marokvia. Boston: Little, Brown, 1960. A Korean orphan boy comes to live with his grandfather and uncle, but another tragedy befalls him when his cousin Kao is killed hauling logs for a school which they are struggling to build.

Macdonald, George. *At the Back of the North Wind.* Illus. by E. H. Shephard. New York: Dutton, 1957. When the hero Diarmaid dies, it seems right that he should have reached the end of his life and gone to the back of the North Wind.

O'Faolain, Eileen. *Irish Sagas and Folk Tales.* Illus. by Joan Kiddell-Monroe. New York: Walck, 1954. Contains the legend of the death of the Irish folk hero, Cuchullin.

Saint-Exupery, Antoine de. *The Little Prince.* Illus. by the author. Tr. by Katherine Woods. New York: Harcourt, Brace and World, 1943. When the author's plane is downed in the Sahara desert, a little princeling appears to tell him of life's mysteries.

Sandburg, Carl. *Rootabaga Stories.* Illus. by Maud Petersham and Miska Petersham. New York: Harcourt, Brace and World, 1956. Contains the short story "Blue Silver" which beautifully describes a child's funeral.

Sawyer, Ruth. *Roller Skates.* Illus. by Valenti Angelo. New York: Viking Press, 1936. The story includes the death of fragile Trinket, whom Lucinda Wyman "borrowed" from time to time.

Sperry, Armstrong. *Call It Courage.* New York: Macmillan, 1940. After Mafatu's mother is killed in a storm at sea, the Polynesian boy must overcome his fear of the sea by embarking on a harrowing adventure.

Thiele, Colin. *Storm Boy.* Illus. by John Baily. Chicago: Rand McNally, 1963. Storm Boy whose mother has died, lives with his father on a lonely coast in Australia where he befriends a baby pelican.

Wilson, Barbara Ker. *Scottish Folk Tales and Legends.* Illus. by Joan Kiddell-Monroe. New York: Walck, 1954. Contains the legend of the death of Diarmaid, the Scottish folk hero.

Zim, Herbert S. and Sonia Bleeker. *Life and Death.* Illus. by Rene Martin. New York: Morrow, 1970. A clear and concise statement of the facts of life and death.

Age 12 and Over

Ball, Zachary. *Bristle Face.* New York: Holiday, 1962. A young boy is heartbroken when his hound dog has to be killed after being blinded in a fight.

Barnwell, Robinson. *Head Into the Wind.* New York: McKay, 1966. Toby Butler's father dies and he must learn to adjust to a new life when he goes to live with his grandfather on the cotton-growing land of North Carolina.

Behn, Harry. *The Faraway Lurs.* New York: World, 1963. A struggle between the pre-historic Sun people and Forest people culminates in the sacrifice of a young maiden of the Forest people.

Coburn, John B. *Anne and the Sand Dobbies: A Story about Death for Children and*

Their Parents. New York: Seabury, 1964. In this story, Danny's father tries to answer questions about death after the boy's little sister, Anne, and his dog are killed.

Commager, Evan. *Valentine.* New York: Harper and Row, 1961. A young Vermont girl is aided in her adjustment to a new life in Georgia by a dying woman and her family.

Dooley, Tom. *Doctor Tom Dooley, My Story.* New York: New American Library, 1965. The story of the courage of a young doctor who died of cancer at the age of 34.

Frank, Anne. *Anne Frank: The Diary of a Young Girl.* New York: Doubleday, 1967. A brave young Jewish girl keeps a diary of her experiences hiding from the Nazis during World War II. Anne died shortly before the Germans were defeated.

Gunther, John. *Death Be Not Proud; A Memoir.* New York: Harper, 1949. The author writes of the courage with which his son faced a premature death from a brain tumor at the age of 17.

Harnden, Ruth. *The High Pasture.* Illus. by Vee Gunthrie. Boston: Houghton Mifflin, 1964. A new pet helps ease Tim's grief after the death of his mother.

Harris, Joel Chandler. *The Complete Tales of Uncle Remus.* Comp. by Richard Chase. Illus. by Arthur Burdett Frost and others. Boston: Houghton, Mifflin, 1955. Includes the Negro folk tale "Death and the Negro Man."

Hawthorne, Nathaniel. *Great Stone Face and Other Tales of the White Mountains.* Boston: Houghton Mifflin. Contains the short story, "The Ambitious Guest."

Hunt, Irene. *Up a Road Slowly.* Chicago: Follett, 1966. After her mother's death, Julie goes to live with her Aunt Cordelia and learns to appreciate her strict ways.

Kelly, Eric P. *The Trumpeter of Krakow.* New York: Macmillan, 1966. A brave young trumpeter is killed by an arrow in the throat when he plays the Heynal, or hymn to Mary, to warn of a Tartar invasion in Poland in the 13th century.

Kipling, Rudyard. *The Jungle Books.* Garden City: Doubleday, 1964. The stories illustrate the fact that death is the penalty when jungle laws are broken.

L'Engle, Madeleine. *Meet the Austins.* New York: Vanguard, 1960. A spoiled child whose father was killed in a plane crash comes to live with the Austins.

L'Engle, Madeleine. *A Wrinkle in Time.* New York: Farrar, Strauss and Giroux, 1962. A story of good versus evil and life versus death. Three children pass through time to another planet and defeat "It" with their chant of love.

Lewis, C. S. *The Lion, the Witch and the Wardrobe.* New York: Macmillan, 1950. Another tale of good versus evil. The lion, Aslan, is killed by the White Witch, but, because he is innocent, death starts working backwards and he comes back to life. In the final battle, the White Witch is killed by Aslan.

Medearis, Mary. *Big Doc's Girl.* Philadelphia: Lippincott, 1950. The death of Mary's father, who has been a doctor in the backwoods of Arkansas, changes her career plans.

Musgrave, Florence. *Marged: A Story of a Welsh Girl in America.* Illus. by Arlene K. Thomson. New York: Ariel, 1956. After Marged's parents are killed in a flood on the Ohio River, she blames her grandmother for their deaths. Only after realizing how her grandmother feels about the tragedy is Marged able to accept it.

O'Dell, Scott. *Island of the Blue Dolphins.* Boston: Houghton Mifflin, 1960. An Indian tribe is evacuated from their island, but Karana jumps off the boat to go back and save her brother. The brother was killed, but Karana managed to survive on the island alone for 8 years.

Rawlings, Marjorie Kinnan. *The Yearling.* Illus. by Edward Shenton. N. Y.: Scribner, 1938. The Baxter family is forced to kill a fawn as a matter of survival when the animal threatens their food supply.

Sawyer, Ruth. *The Year of Jubilo.* Illus. by Edward Shenton. New York: Viking Press, 1940. When a father dies, his family is forced into a different way of life.

Sutcliff, Rosemary. *Knight's Fee.* Illus. by Charles Keeping. New York: Walck, 1960. A young serf rises to become knight of the castle when his Norman lord dies.

Speare, Elizabeth George. *The Bronze Bow.* Boston: Houghton Mifflin, 1961. A young Jewish boy seeks revenge when his parents are crucified by the Romans.

Wier, Ester. *The Loner.* Illus. by Christine Price. New York: McKay, 1963. The only friend of a homeless, nameless boy is killed in a potato-digging machine.

EXPLAINING DEATH TO CHILDREN

Child Study Association of America. *Recommended Reading About Childhood and Family Life.* New York: Child Study Association of America, 1969.

Fargues, Marie. *The Child and the Mystery of Death.* Paramus: Paulist/Newman Press, 1969. $.75.

Grollman, Earl A. *Explaining Death to Children.* Boston: Beacon, 1967. Paperback, $2.95; hardback, $4.95.

Grollman, Earl A. *Talking About Death.* Illustrated by Gisela Heau. Boston: Beacon, 1970, $6.00.

Jackson, Edgar N. *Telling a Child About Death.* New York: Channel, 1965. $2.95.

Mitchell, Majorie. E. *The Child's Attitude Towards Death.* New York: Schocken, 1967. $4.95.

White, Dorothy. *From Two to Five.* Illustrated by Joan Smith. New York: Oxford University Press, 1954.

Wolf, Anna W. M. *Helping Your Child to Understand Death.* New York: Child Study Association of America, 1958. $.85.

It is not usual for academic journals to publish accounts of how various instructors teach their classes, yet we have continued to do that with the hope that we may not only communicate what is being done, but that we may encourage others to consider teaching such classes. During the 1970-71 academic year, we know that two different departments will offer courses on death at U.C.L.A., that two more courses will be offered at the University of California's San Francisco Medical School campus, and that other courses will be taught at the University of Oregon and Portland State University. Vic Marshall, sociologist at McMaster University in Hamilton, Ontario, informed us that his class on death has drawn 108 registrants and was not even listed in the catalogue. We gave the matter some thought and decided to toss out an estimate: between thirty and seventy courses focused upon death will be taught this academic year in the United States and Canada—and if I were in a pool, I would pick sixty.

CANCER AND THE PSYCHE[1]

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INTRODUCTION

Should a patient suffering from cancer be informed as to the true nature of his illness by the physician? This is an old question, but it is still topical. According to the ethical rules accepted by Finnish physicians, the patient should be informed about the character of his illness. A great deal has been written about this issue, but there are comparatively few psychiatric studies approaching the question from the patient's standpoint.

The writers investigated a series of cancer patients and sought answers to the following questions: Were the patients aware of the nature of their illness? How did they come to know about it? What were the patients' reactions on learning the nature of their illness? What types of psychic symptom were observable in cancer patients?

The question of how far psychic factors may affect prognosis in malignant illnesses has particularly interested the representatives of psychosomatic medicine for a long time. In the present study, the writers paid attention to the following points related to this question: Does the patient's awareness of the true nature of his illness have a bearing on the prognosis? How far does the patient's attitudes towards illness and recovery affect the progress of the illness? And to what degree do the psychic symptoms exhibited by the patient correlate with prognosis?

A SURVEY OF THE LITERATURE

Informing the Patient about the Diagnosis

According to Litin (1960), most patients want to know whether or not they have cancer, and each patient has a legal right to know the truth. Where the patient's past history includes recurrent depressions, paranoid, schizophrenic, or psychotic episodes, it would be best, Litin feels, not to tell him the truth. It has often been observed, however, that even a rather neurotic person may unexpectedly behave quite maturely in such a situation, and show a great deal of strength.

In Hoerr's (1963) opinion, truthfulness in the long run is almost always preferable to deception, no matter how kind are the motives prompting the deception. According to him, callousness or brutality in telling a patient is always avoidable, since it is not synonymous with truthfulness. If the lesion is hopeless and rapidly progressive, there will

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[1] Adapted from *Psychiatrica Fennica* (Finnish Psychiatry), 1970, p.117-126.

be patients, in Hoerr's opinion, who should not be told unless they specifically ask, or have responsibilities to others which may be directly affected.

Desjardins (1960) writes as follows: "What the patient is told and how this information is conveyed to him seems to depend largely, if not wholly, on the temperment of the physician himself. Unfortunately, owing to a variety of factors, many physicians seem unable to appreciate the horror and discouragement that the word 'cancer' implants in the minds of most patients when they are told that they are affected by any forms of malignancy." In his opinion, the physician ought to have enough time to discuss the matter with the patient, and he should be able to advance some encouraging points of view. Perhaps the most important point is to avoid using the word "cancer", but to use the word "tumor" instead. For most patients this has a much less sinister connotation.

Wyrsch (1962) felt that the quality and quantity of the patient's spiritual resources were the decisive considerations. Emotionally balanced and intelligent persons could be informed of the malignant nature of their illness with less hesitation than could those lacking these characteristics. Wyrsch also considered it advisable to use the word "tumor" instead of "cancer".

Oken (1961) emphasized the importance of encouraging the patient, listening to what the patient wants to say, and letting this determine the approach. A "nothing can be done for you" attitude should be avoided. The physician's own emotions associated with death often make the matter difficult for him.

Erkkilä (1966) stressed the importance of a listening attitude in the physician caring for a patient with cancer. In his opinion, the physician must answer the patient's direct questions frankly; it would not be compatible with medical ethics to keep any essential fact secret from the patient.

Many other authors have also discussed the question how far a patient should be informed about the malignant nature of his illness and what points should be taken into consideration.

The Risk of Suicide

Achté, Apo, & Haapaniemi (1963) made a study of all the suicides committed in Finland in the years 1954 to 1958. Judging from the death certificates, 0.8 per cent of the people concerned were affected by cancer. Achté & Vauhkonen (1967) published a paper on the 32 suicides committed in the nonpsychiatric hospitals of Helsinki in 1953 to 1963. Three of these patients had cancer.

Farberow et al. (1963) noted that, irrespective of localization and age, the following findings correlated with the risk of suicide among cancer patients: (1) Emotional stress over and above the physiological aspects of the disease process itself; (2) low tolerance for pain and discomfort; (3) excessively demanding and complaining behavior, with a strong need for attention and reassurance; (4) controlling and directing activity (e.g., insistent request for, or directing of, treatment and medications); (5) relative alertness and orientation; (6) exhaustion of resources, physical and emotional, including a feeling of a lack of support and attention from family or hospital; and (7) prior and present suicidal threats or attempts.

Litin (1960) held that the suicide rate for cancer patients was not higher than normal.

LeShan and LeShan (1961), on the other hand, were of the opinion that the interrelation between suicide and cancer was quite complicated and in need of further study.

According to the survey published by Baltrusch et al. (1964), suicide rates were lower for cancer patients than for the general population.

On Emotional Problems in Cancer Patients

Senescu (1963) writes: "Cancer presents a real, and at times most serious, threat to the welfare and survival of the human being, one which may overtax the adaptive resources of any or all concerned with the treatment and care of the patient. This threat, however, we regard as being considerably magnified by the fear with which the disease is viewed, a reaction which is by no means confined to the patient alone".

Almost every patient, when he discovers that he has cancer, reacts more or less intensely to this knowledge, depending on his psychic structure and past experiences (Renneker, 1957). According to Litin (1960), three phases are distinguishable in this reaction. First, there is the phase of initial shock with acute feelings of fear and depression. This fortunately is relatively short-lived, and sometimes not seen at all because the patient has been strongly suspicious or aware of the fact that he has cancer. This initial-shock phase passes relatively rapidly to a second phase which contains early measures dealing with stress and threat to life. This phase is marked by the usage of a common and somewhat protective psychological defence: that of denial. The usual form of denial also lasts for a relatively short period, only to be quickly brushed aside by reality. In this third phase, the patient has gradually attained a new picture of himself with altered perspectives, goals, behavior and appearance. This means a long-term successful adjustment to the new realities.

Cobb (1959) classified the emotional problems peculiar to persons with cancer into three groups: (1) anxieties associated with the meaning of cancer for the individual; (2) conflicts arising from the precipitation of a productive adult into an unfamiliar and barren hospital world; and (3) the emotional components of separation from the family, either temporarily through hospitalization or permanently through death.

According to Senescu (1963) it depends upon the doctor's words and attitudes whether emotional complications will be avoided or whether such complications will develop.

The psychic symptoms of patients suffering from malignancy have also been described by many other scientists. Most of them emphasize the importance of the physician's attitude. A warm protective relationship between doctor and patient minimizes many of the emotional problems.

On Psychic Factors Possibly Influencing the Prognosis in Malignant Diseases

Blumberg, West, & Ellis (1954) compared the personality traits of cancer patients whose illness progressed fast, with those of patients whose illness progressed very slowly. They discovering significant differences, ascertainable through tests, between the two groups. They found that the patients' anxiety potential was substantially greater, and their ability to discharge and to control inward tensions was substantially less, in cases where the illness progressed rapidly. They also discovered that prolonged and powerful psychic stress clearly affected the course of the illness.

Herberger (1963) found that difficult psychic stresses during the illness—including the patient's awareness that he was affected by cancer—could considerably shorten the course of the illness. It also appeared that the progress of the illness was hastened particularly in cases where the patient was—owing to the difficulties facing him, and to his strongly neurotic personality development—unable to handle the burden of his illness adequately and to compensate for it.

Baltrusch et al. (1963, 1964, 1969) have considered the influence of psychic factors on the course of illness, and listed a number of psychic traits that appear to correlate with prognosis.

Several other authors have also discussed the bearing of psychic factors on the course of cancerous illnesses.

PROCEDURES

The Series of Patients and the Methods Employed

The series of patients consisted of 100 persons affected by cancer and born during this century. All patients had been under treatment either at the Radiological clinic, Out-patient clinic or Surgical clinic of the University of Helsinki Central Hospital. Elderly patients were not included, because the possible changes caused by senility or arteriosclerosis were expected to complicate the study of the interrelationships between cancer and the psyche. Employing figures obtained from the Cancer Register, the authors attempted to form a series, comprising various types of cancer in proportions corresponding to the annual incidence figures, computed for men and women separately. Cases on benign cancer of the skin and the lip were, however, to be excluded from the series. It turned out that inclusion of a sufficient number of surgical cases caused such great technical difficulty that these patients were only included in limited numbers, and other patients, suffering from other common types of cancer, were included in correspondingly larger numbers. The patients were investigated between June 1, 1965, and September 30, 1966.A follow-up study of the series was carried out in October 1968.

The distribution of the series by location of the cancer was as follows:

Cancer of the respiratory system	38 cases
Cancer of the genito-urinary system	30 cases
Cancer of the breast	17 cases
Cancer of the digestive system	15 cases
Total	100 cases

The sex distribution of the series was as follows: men, 47; women 53. The age distribution was as follows: under 40 years, 7; 40-49 years, 23; 50-59 years, 47; and over 60 years, 23. At the time of the follow-up, in October 1968, 24 of the patients were alive: 7 men and 17 women.

The patients were classified into four groups according to the degree of the spread of the cancer as follows: Grade I, the cancer was confined to the tissue of origin; Grade II, the cancer had invaded contiguous structures; Grade III, the cancer had metastasized to regional lymph nodes; and Grade IV, the cancer had metastasized to other parts of the body. Distribution of patients according to this classification was as follows: Grades I-II: 48 cases; Grade III; 28 cases; and Grade IV: 24 cases.

The Psychiatric Interview

The method employed by the authors was the psychiatric interview. In each case, the personal interview took place with no other person present; the authors made a point of proceeding discreetly and tactfully, and we were particularly careful not to injure the patient, or—where the patient did not realize the character of his illness—not to inform him about it.

Observing due caution, an effort was made to find out whether the patient was aware of the nature of his illness. This was not always easy. We preferred to obtain incomplete information, rather than risk upsetting the patient or increasing his anxiety.

The case records of each patient were scrutinized. Moreover, in the case of each patient, the staff of the hospital, and particularly the nurse in charge of the hospital department in question, were interviewed, with the intention of obtaining supplementary information concerning the points listed in the Introduction. Two questions in particular were concentrated on: Was the patient aware of the nature of his illness? What did his behavior in the ward reveal in this respect?

The follow-up took place at least two years after the first examination. The intent was to secure information on the course of the patient's illness and his present condition, in the light of the clinical records concerning him. Additional information was acquired from the physicians who had later cared for the patient, and from the population register authorities.

RESULTS

Informing the Patient about the Diagnosis

Diagnosis spontaneously revealed to the patient by the physician. Forty percent of the patients in the total series belonged in this category. In most cases, the doctor had told the patient that he was suffering from "cancer" or from a "malignant neoplasm". None of the patients criticized the doctor's frankness per se, but five patients (12 percent) openly criticized the way in which the doctor had conveyed the information. In two other cases, the patient also censured the doctor, though less strongly or openly. Thus, a total of seven patients (17 percent) found the doctor's way of conveying the information more or less inappropriate. Many patients expressed the view that the doctor should have revealed the diagnosis gradually, giving the patient an opportunity to ask for it. Another point which the patients criticized was the doctor's habit of neither encouraging the patients sufficiently, nor giving them hope. There were cases where the patient had been told that his life was drawing to an end, or that he would die within a specific length of time. There were also cases where the doctor had stated that the illness was intractable and the situation hopeless. Statements of this kind had been particularly difficult to bear. As the authors saw it, the doctor's tactless way of disclosing the information was criticized in almost every case. Another impression was that generally, it was not considered a doctor's self-evident duty to inform the patient about a cancer diagnosis spontaneously, if the patient did not ask.

Four of the patients (10 percent) whom the doctor had spontaneously informed about the true nature of their illness, displayed a reluctant attitude toward this study. The proportion of the reluctant patients was 16 percent in the total series.

Three patients (7 percent) felt dissatisfied and somewhat bitter because the diagnosis had been established too late. The corresponding figure for the total series was 5 percent.

The group included five patients (12 percent) who did not realize, at the time of the study, that they were suffering from cancer or a malignant neoplasm, even though they had been told by the doctor. The proportion of patients in the total series who were unaware of the nature of their illness was 31 percent. In most cases this was due to repression, resorted to by the patient in order to avoid seeing the naked anxiety-evoking truth.

Six patients (15 percent) denied having reacted in any particular way when they learned of the diagnosis. Apparently, at least three of these patients had resorted to repression from the outset, or had interpreted the doctor's words in a way agreeable to them. The proportion of such patients in the total series was also 15 percent.

Judging from the interviews, a majority of the patients in this group (83 percent) were satisfied with the doctor's frankness; at least they did not censure it in any way.

A majority of the patients in this group (85 percent) had felt fear and anxiety when they learned they had cancer. In many cases, however, these feelings were mitigated in a few days or in a few weeks; this was particularly noticeable when the active treatment had begun. Most patients seemed to trust their doctors and the prescribed treatments quite strongly. Almost all of them were inclined to interpret something the doctor had said, or at least the tone in which it had been said, as a sign of a favorable prognosis, which alleviated their anxiety and depression. Many a patient spontaneously stated how important it was for a doctor to give hope even to a seriously ill patient. A vast majority of the patients expected they would be cured under therapy.

Diagnosis Frankly Revealed in Response to the Patient's Request. Twenty-nine patients in our series (29 percent) asked to be told the nature of their illness. None of them criticized the doctor for telling them; and all regarded it as important and correct for a doctor to reveal the truth, even where the illness was serious, if the patient inquired.

Only two of the patients in this group (7 percent) had a reluctant attitude toward the study; the corresponding ratio for the total series was 16 percent. Taking this group as a whole, the patients seemed to relate more naturally to the investigation and the investigator than the rest of the patients did.

Eight patients (28 percent) denied reacting in any particular way to the information about the nature of their illness. The corresponding ratio for the total series was 15 percent. The rest of the patients in this group had experienced more or less intense anxiety, had felt depressed or had manifested some other psychic symptoms.

One patient was dissatisfied because the correct diagnosis had been established at too late a stage, which diminished the probability of cure.

Revelation of Diagnosis Unrequested and Apparently Undesired by Patient. Thirty percent of the patients had never asked the doctor about the nature of their illness, nor had the doctor told them. Six of them (20 percent) revealed that they, nevertheless, knew they had cancer. On the other hand, it is very probable that the remaining 80 percent did not know the nature of their illness, although in certain cases it was impossible to establish beyond doubt whether they did or not. A majority of these patients knew they had some kind of tumor; but apparently, they did not realize the malignant nature of their illness, or at least they did not reveal that they knew. A reluctant attitude toward the study was characteristic of the patients in this group; more or less distinct signs of such an attitude were exhibited by as many as nine (30 percent) of them, wheas the corresponding proportion for the total series was only 16 per cent. Underlying this attitude was, apparently, fear and anxiety; these patients were afraid of becoming aware of the true nature of their illness. By warding off, or assuming an aggressive attitude toward discussing the matter, these patients were, perhaps, able to relieve their anxiety.

One patient in this group (3 percent) expressed dissatisfaction at the diagnosis being too late; the corresponding ratio for the total series was 5 per cent.

Patients Apparently Unaware of the Nature of Their Illness. In the total series, thirty-one percent of the patients were unaware of their condition. Apparently most of them knew they had some kind of tumor, but none used the terms "malignancy" or "cancer" during the interview. All seemed to be hopeful of recovery, although this was not absolutely certain in every case. Two had asked the doctor about the nature of their illness and had been answered frankly. But either they had repressed the fact, or they had been unable to understand the actual nature of the situation. Of the patients who had not asked their doctors about the diagnosis and had not been told by their doctors, 24, or 80 per cent did not know that they had cancer. Five of the patients whom the doctor had informed spontaneously were nevertheless unaware of the situation; they were either convinced that the doctor was mistaken, or they had repressed the matter altogether.

There was one case in which it was impossible to find out whether the patient knew the nature of his illness, or how he had been informed by the doctor. This case is not included in the group above.

Other Points on Which Physicians Were Criticized. Two per cent of the patients in the total series were dissatisfied, because the physicians they first consulted did not inform them about the actual diagnosis. These were the only patients who were dissatisfied with not learning of the cancer diagnosis early.

Psychopathological Symptoms Observed in the Patients

Tenseness, depression and anxiety were the psychic symptoms that were discovered to be the most frequent in the series. They were found to be present in more than a half of the total patients. Aggressiveness and paranoid attitudes were also a common occurrence. A fear of death was present in half of the patients in the series.

Phobic, obsessive or neurotic reactions were not very common. Moreover, where such symptoms were observed, it was discovered that the patients had been neurotic previously, and merely continued to display neurotic symptoms while they were suffering from a malignancy. Obviously, neurotic reaction formation of a type encountered in other contexts is not meaningful for the ego here.

It is interesting to note that a few patients experienced cancer as socially humiliating or "disgraceful". On the other hand, many patients realized the malignant nature of their illness completely; they knew that they were likely to die in the near future, and reported that they had not suffered from any subjective psychic complaints either before illness, or during it.

None of the patients expressed suicidal thoughts, although one of the male patients later did commit suicide.

Psychic Factors Possibly Influencing the Prognosis of Malignant Diseases

In the follow-up study, an attempt was made to devote attention to the influence that psychic factors possibly exerted on the course of the patient's illness. To this end, the data were treated statistically using regression analysis. The results will be published separately. Although the sample was comparatively small—only 100 cases—the findings can be regarded as symptomatic of certain tendencies. The results were, to a great extent, similar to those previously reported by Baltrusch et al. (1964), using a larger sample.

Two subgroups of patients were subjected to closer investigation: those who were alive at the time of the follow-up, and those whose illness had lasted for less than a year. Each of the two subgroups included 24 patients.

The two subgroups differed clearly in respect to the degree of illness: Grade IV tumors were definitely more frequent among the patients who had died (17 percent), as opposed to those who were alive (4 percent). However, the corresponding figure for the total series was 24 percent. The subgroups did not differ significantly regarding treatment, nor did they differ in this respect from the total series.

The two subgroups differed substantially in regard to the manner in which patients had been informed about their illness, as well as the extent of their awareness of the true nature of their illness. Forty-two percent of the patients in the subgroup of those who had died had not asked the doctor about the nature of their illness, nor had they been informed about it at any stage. Of those who were alive, no more than 17 percent belonged to this category. The corresponding proportion in the total series was 30 percent. Of the patients who died, 50 percent were not aware of the nature of their illness. The corresponding proportion of the subgroup that were alive was only 17 percent. These findings suggest that the patients whose illness progressed rapidly, leading to death in a short length of time, tended to repress the anxiety-evoking reality of their illness more actively than the other patients, either by refusing to acquire information about their illness, or by repressing the truth revealed to them.

All of the patients in both subgroups had apparently had "enough of life". Nevertheless, it was clearly observed that patients in the subgroup where the illness shortly led to death were not clinging to life as strongly as the patients in the other subgroup, or those within the total sample. It is hard to believe that this difference would have solely been due to a variation in the degree of gravity of the illness. Instead, it appears likely that as the patient loses his will to live, his general ability to resist illness diminishes, and tends to shorten his life.

Depression, anxiety, and tension were discovered to be a more frequent occurrence in the subgroup of patients who died soon, than in the subgroup of those who were alive. Only in the case of depression, however, was the difference between the two subgroups statistically significant.

The patients whose illness was progressing rapidly appeared to be more passive and dependent than those in the subgroup alive at the time of the follow-up, or those in the total series. Abuse of alcohol and/or drugs was definitely more frequent in the first (17 percent) than in the second subgroup (4 percent). The proportion of abusers in the total series was 9 percent. The lack of self-esteem was evident in the first subgroup more frequently (33 percent) than in the second subgroup (21 percent). Paranoid trends, on the other hand, occurred equally in both.

Thirty-eight percent of the patients in the total series had exhibited psychiatric symptoms prior to the development of the malignant tumor. The proportion was the same for the patients who died within a year. In contrast, the corresponding figure for the subgroup of those who were alive at the time of the follow-up was 54 percent. Thus it seems obvious that the occurrence of psychic symptoms prior to the development of a malignant tumor is a prognostically favorable factor.

A very interesting finding was the frequent occurrence of aggressiveness in the subgroup where the illness terminated quickly. Of the patients in the total series, 39 percent displayed aggressiveness. The corresponding figure for the subgroup of those alive at the time of the follow-up was 17 percent. However, the proportion of aggressive patients in the first subgroup was 58 percent. The differences were highly significant statistically. The degree to which aggressiveness can be regarded as a prognostically unfavourable factor cannot be ascertained within the framework of this study. It seems obvious, however, that patients in the first subgroup resort to aggressiveness as a means to repress the anxiety caused by the illness more often than other patients.

Patients whose illness progressed rapidly were clearly more hopeless regarding recovery than were the patients in the other subgroup. A fear of death was also a more common finding in the first subgroup than in the second. Obviously, hopelessness and a fear of death are factors associated with an unfavorable prognosis. It would seem that their frequent occurrence in the first subgroup was not explicable solely on the basis of the gravity of the illness; on the contrary, it appears likely that hopelessness is a factor that tends to reduce the patient's capacity to resist the illness.

DISCUSSION

It is doubtful whether a physician is right to invariably follow an "either-or" principle. Telling the truth presupposes both ability to listen to the patient and psychological insight. It is hardly advisable to hasten to tell the patient that he has cancer, if unasked. Even when the patient inquires about the diagnosis, it may be preferable to speak of a "tumor" or, if the patient wants to have more detailed information, of a "malignant tumor" rather than cancer. However, professional ethics oblige the physician to answer the patient's question.

None of the patients in the present series actually criticized the physicians adversely for their frankness. Instead, the patients criticized the doctors who did not give them any hope or informed them of the nature of the illness sadistically. Therapeutic nihilism–no matter how realistic–increases the patient's anxiety, makes him aggressive toward the physician, and perhaps makes his attitudes toward further treatment negativistic. It depends upon the physician's attitude whether the patient develops emotional complication; the physician's attitude can increase or diminish such complications.

The defence mechanism that cancer patients most frequently employ to repress the idea of death is denial. In so far as denial fails, other defence mechanisms are resorted to increasingly. Denial may sometimes assume psychotic forms.

Paranoid symptoms and aggressive or hypomanic traits work for the avoidance and channeling of anxiety. The frequent occurrence of aggressiveness in the subgroup where the illness shortly led to death was an interesting finding. How far aggressiveness can be considered a prognostically unfavorable factor cannot be ascertained within the framework of the present study.

Death, as an absolute end of life, transcends our experience. Investigations concerning death and opinions about it, contain a great deal of knowledge about what death is not. We can accept death as a fact, but it is hardly likely that anybody can see his own death as an absolute end-point of all that exists. Freud (1915) states that, in our unconscious, our attitude toward death is the same as that of pre-historic man; in our unconscious, we do not believe in our own death but act as if we were immortal.

SUMMARY

The series of patients consisted of 100 persons suffering from cancer. The writers interviewed the patients personally in 1965-1966, and a follow-up was carried out in 1968.

In 40 percent of the cases, the physician had spontaneously informed the patient of the cancer diagnosis. None of the patients actually criticized the act of informing the patient about the diagnosis, but 17 percent felt that the manner of communicating the serious diagnosis—without preparation, too soon, or tactlessly—was open to criticism. The latter group of patients also considered that it was not self-evident that the doctor should invariably inform the patient, spontaneously and immediately, about the correct diagnosis. It was discovered, however, that five of these patients (12 percent) were not aware of the nature of their illness.

Twenty-nine percent of the patients had inquired about the diagnosis and had obtained a frank answer; none of them criticized the doctor. These patients seemed to have the most favourable attitude toward the study.

Thirty percent of the patients had never inquired about the diagnosis and were apparently unwilling to know it. Six of them (20 percent), revealed, however, that they knew they had cancer. A reluctant attitude toward the study was characteristic of these patients. This attitude probably reflected the fear and anxiety that an awareness of the diagnosis would have aroused in them.

Fifteen percent of the patients stated that they had felt no particular anxiety on learning the true nature of their illness. The remaining 85 percent reported more or less intense anxiety, depression, and other psychic symptoms concomitant with these. In most cases the anxiety and depression were mitigated within a few days or weeks, particularly where active treatment had been started.

In the follow-up, particular attention was paid to the possible bearing of psychic factors on the course of the illness. The results suggest that patients who have rapidly deteriorating conditions, display a tendency toward actively warding off the anxiety-evoking reality of their illness; they do not want to be informed about the nature of the illness, and tend to repress the truth if they are informed. These patients clearly seemed to be more passive and dependent, in comparison with those who were alive at the time of the follow-up, as well as with the total sample. Aggressiveness occurred more frequently among the patients whose illness rapidly ended in death, than among the rest of the patients.

It appears likely that prior occurrence of psychic symptoms are a prognostically favourable factor in cases of malignant illnesses.

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BOOK REVIEWS

DEATH AND ITS MYSTERIES. By *Ignace Lepp.* New York: Macmillan, 1968. Paperback, $1.95

In 1964 Ignace Lepp attended a conference of those whose life and thought had been influenced by Teilhard de Chardin. Here the impact of de Chardin's theories on various disciplines was brought into focus. Lepp was aware of the fact that such innovative thinking about the nature of man and his evolutionary development must have some bearing on his theory of death and its relation to life. Because the area had been largely ignored, Lepp decided to make it the focal point of his thinking. For the next two years he read, thought, and wrote ceaselessly on the subject of death and its mysteries. Significantly, he died in 1966. This book is the result of his two years of special concentration.

Three important ingredients have gone into the structure of this book. Lepp was a priest of the Roman Catholic Church; he was a well-trained and competent psychotherapist; and he was aware of the special ways in which twentieth-century man had expressed his death anxiety through denials. These three starting points, plus his determination to explore in depth the thinking of de Chardin as it related to death, produce the special characteristics of this book.

The book will be of interest to American readers because Lepp draws on a variety of references that are not generally familiar to those who read extensively in the literature of death. He also draws on a wealth of case material which he interprets in a rather unique manner because of his all pervading life-view. Also, his exalted concept of the nature of man is applied not in terms of orthodox and dogmatic theology but rather in existential terms that are rooted in man's anthropological quest for meaning rather than in the church's historical quest for internal security.

Lepp says that man can have no experience of death individually because the blotting out of consciousness destroys the capacity for experience; he is therefore thrown back on the need to conceptualize. Lepp explores Freud's concepts of libido and death instinct and finds that Freud's despair is more prominent than a valid interpretation of the clinical material he employs. Lepp speaks of "radical separation" and its impact on personal experience. With a rather novel view, he says that the suicide is already dead to life at one level of his being, the overt act merely bringing the physical event and the psychic state into accord. His theories of martyrdom are less satisfying, for he tends to overlook the psychodynamics of martyrdom. And though he tries to write as a psychologist, his moral judgment tends to creep in and relate itself to the anti-individualistic concept of the mystical body of the individual as the extension of the mystical body of the church, to which the individual's responsibility is constant and final.

In his effort to explore death and the ultimates of man's spiritual evolution, Lepp looks at theories of immortality and implied communication with the dead. He finds the data here inconclusive at the evidential level, but highly important as indications of the need of individuals to create the evidence that can sustain their theories concerning the undying quality of the spirit. His own concept seems to be summed up in the words of de Chardin, quoted on p. 189, "From the very heart of my indifference to immortality springs its necessity".

In a manner comparable to Victor Frankl, Lepp sees therapy as a quest for meaning which must illuminate the concept of the unique and developing self. But from the point of view of his priestly assumptions he claims that mere meaning is never enough—it must be meaning adequate to sustain the highest aspirations of the human spirit. When life is lived with a concern to discover its most exalted meaning, death becomes an accomplishment rather than an event. The soul or spirit emerges as a product of the living encounter of man's endowment with his quest for ultimate meaning. In this way the spirit is not so much an entity as a relationship, and immortality would be a relationship with the beyond life as biologically conceived. It would be as though in both life and death man could shift gears and function in terms of a fourth dimension. Immortality would then be, to use Lepp's words, a "postulate of consciousness."

This book is an interesting and unique addition to the literature on death. My guess is that many American readers would find it a stimulus for new and provocative moods and modes of thought.

EDGAR N. JACKSON

ANGUISH: A CASE HISTORY OF A DYING TRAJECTORY. By *Anselm L. Strauss and Barney G. Glaser.* Mill Valley, California: The Sociology Press, 1970. 193 pp., paperback, $4.95

The authors of this intriguing little book must be complimented for a painstaking account of a dying trajectory.

Anguish is a strange book, painful to read, difficult, if not impossible to put aside, and one which stirs up many unpleasant emotions. Yet it is one of the rare books that does not embellish things, that does not even attempt to apologize for the often inhuman approach to patient care, and that, strangely, does not even try to have the answers.

Anguish is the story of the last few months of life of Mrs. Abel, a troubled, lonely, angry woman who does not behave as a patient should behave in order to be liked. She is judged and isolated, rejected, and lonely; she ultimately dies after surgery which she chose to hasten her death.

The heroine of the story is Shizu, the nurse who tries to understand rather than to judge her. But she, too, abandons her patient at the very end as did the many other staff people who tried in vain to be truly members of the helping profession.

The value of this book lies in its honest truth, in its long accounts of the little things that make the life of the dying patient and the staff bearable or unbearable. It lends itself beautifully to the training in sensitivity and to the better preparation of future nurses and professionals in the care of the terminally ill. I have used this valuable contribution on several college campuses and asked the students to respond to it. They have all gained from Mrs. Abel's communications and will hopefully be able to prevent future tragedies such as the one she had to endure.

Anguish gives an excellent account of the complicated communication system in our modern hospitals and should be read by anybody in a hospital's teaching or supervisory position. The last chapter on case histories and case studies would have better been published separately.

If someone cares enough to read this unique history, he should be assisted to synthesize the material in an instructive manner in order to learn from the mistakes and prevent them in the future. When the reader is on the last page of Mrs. Abel's story, he may not be in the mood for theoretical comments, but rather may search for some practical answers.

I truly hope that this remarkable contribution will find its way into many nursing schools, hospital libraries, and onto the desk of every hospital chaplain, social worker, and administrator of hospitals and nursing homes.

This book may not give the answers, but it certainly stimulates thinking and ultimately might serve to make our hospitals a better place for the final moments of our lives.

ELISABETH KUBLER-ROSS

TALKING ABOUT DEATH. *By Earl A. Grollman,* Boston: Beacon Press, 1970, $6.00.

Earl A. Grollman wrote *Talking About Death* to be read aloud to children who were touched by the death of someone dear to them. The author has managed to deal effectively with an orientation towards reality and the elimination of destructive fantasies.

Even without the guide for the lay reader which follows the text, the book is handled in a clear but delicate manner. It is an effective and concise book, superbly conceived and executed. Death, rather than the denial of it, is made into a real part of everyday life. Expressions of emotion, including crying, are encouraged. Feelings of guilt, which might occur if a child believes he somehow caused the death, are dealt with. Acknowledgement is made that even adults don't know all of the answers.

I read *Talking About Death* to two boys, aged 5 and 6, a month after their mother's death. When I first described the book, the 5-year-old was interested enough to want it read to him. The 6-year-old did not wish to hear it. Only after I half coaxed and half insisted, was I able to get him to agree to listen. But after one reading the 6-year-old said that he liked the book and requested that it be read again. Thus, *Talking About Death* passed its first test.

The next question was: would there be any discernable effects? There are too many uncertainties for a clear answer; but although the 6-year-old had been depressed for a year (withdrawn, quiet, slow to learn) he returned promptly to his former personality (outgoing, talkative, eager to learn). These changes were not only noticed by me, but they were called to my attention independently by his school teacher.

Briefly, I have found *Talking About Death* to be excellent when used as a mechanism for introducing a dialogue between parent and child about death. After the first reading, both children requested that it be re-read several times. (As a surviving parent, I have found it to be helpful to me also.) I was particularly impressed by the simple and direct language used to explain the reality of death to children. *Talking About Death* gives a brief but factual description of the roles relatives and friends play after the death of a loved one. Earl Grollman expects the reader to extemporize on the specifics of a situation during several readings with affected children. I found the book to be short enough, so that it appeared to be an effective tool with or without pauses for personal reflections.

The printing of the text and visual phrasing by Gisela Héau were certainly carefully handled. The art illustrations by Miss Heau were interesting and appropriate, but I am not convinced that the illustrations should have been rendered in a monotone. Grey may reflect an adult feeling about death, but if the book had any purpose in its creation, it should be to present things in a realistic manner. And this, in my opinion, includes colors such as are found in nature. In any event, Miss Héau's style did catch my eye and hold my mind to the subject.

A minor flaw in an otherwise sparking gem is that the parent's guide references to page numbers in the text begin with Page 1, whereas the text starts with Page 8.

I urge all who are faced with the necessity of dealing with a child who has suffered from the death of a loved one to get *Talking About Death*.

BYRON BACKLAR

THE DYING PATIENT. *By Orville G. Brim, Howard E. Freeman, Sol Levine, and Norman A. Scotch,* (eds). New York: Russell Sage Foundation, 1970. 390 pages, $10.00.

Drawing on the perspectives and experiences primarily of physicians and social scientists, this book is yet another effort to focus attention on the personal and social issues associated with human death in a technologically-oriented, rapidly changing society. It is an important book principally because the particular combination of articles helps to clarify the significantly different problems that death and dying pose for the individual, the family, health professionals, and society as a whole.

Divided into three major parts, the book opens with three chapters describing the social context of dying. These introductory discussions are concerned with how historical, social, and cultural forces have led to the special meaning of dying in today's world. Specifically they deal with three areas of concern—when, where and why people die; what the public thinks about death; and how attitudes toward death and dying are created and shaped.

The second section of seven articles ("the heart of the matter" according to the editors), deals with the impact and meaning that death and terminal illness carry for doctors, nurses, and hospitals. Three essays focus on the complex and problematic aspects of death as it affects the choices and decisions faced by the physician in his work. One essay considers the multiplicity of circumstances that affect the prognosis of death. Another describes the physician's behavior toward the patient, and a third discusses the special problems that technical innovation and heroic acts in prolonging life have brought to medical practice. A fourth chapter looks at the consequences of death for physicians, nurses, and hospitals from a more generalized orientation, showing how the medical profession's emphasis on recovery operates in a selective way to make some activities associated with death, (e.g. the post mortem examination); important, and others of little interest.

The remaining essays in this central section reflect a very different orientation toward dying. Two are written from a sociological viewpoint, emphasizing the institutional consequences of death for patients and staff. One describes patterns of dying as they were observed in hospitals and other terminal-care institutions. The other offers a lucid if somewhat depressing picture of what it means to die in a public hospital, a care-setting that is often the only one available to persons from lower-class circumstances. The third article is written by a psychiatrist and, somewhat ironically considering the title of the book, provides the *only* explicit discussion of the dying patient's responses and reactions to his own forthcoming death.

The theme that brings cohesion to this volume of essays is a concern about the effects of new medical technology and changing social values on the prolongation and termination of life. Part Three examines some of the serious social, ethical, legal, and economic questions that have arisen in connection with the development of extraordinary capabilities to influence when and how individuals may die. The articles in this section focus on the complex problems that have appeared in association with these changes. The first of these describes the emergence of dying as a major social problem. Then follows a discussion that points to the complicated and difficult matter of controlling medical conduct and of enforcing regulations at a variety of levels—in a society that has placed a premium on the power of self-regulation.

The influence and importance of values and priorities is clearly evident in the next two chapters. The first of these examines some legal and policy issues that are provoked by these new capabilities, not the least of which concerns basic decisions about the allocation of economic and social resources to the enterprise of life prolongation and termination, and the distribution of such services among the different segments of society. The other chapter describes the economic and social costs of death both for the individual and for society. The author suggests that traditional methods of cost-analysis may have to give way to new approaches for assessing the allocation of health services, and for determining priorities of distribution among the populace. A final chapter discusses the need for additional research about the process of dying and identifies some of the dilemmas involved in bringing such activity into being. The section closes with a brief, annotated bibliography of articles about death and dying.

For those who are familiar with previous writings about death and dying, Parts One and Two may not offer much new information. Part three, however, brings into sharp focus the many and diverse problems associated with the process of dying in our time. It provides thoughtful discussion of the moral issues involved in decisions affecting who is to live and who is to die. In a very real sense, the book is concerned with the power of new technology to bring about change that threatens not only the quality of human dying but, perhaps of more critical importance for mankind, the quality of human living. It is not comfortable reading, but it is timely.

JEANNE QUINT BENOLIEL

COMMENT

The place to which the majority of the elderly now go to die has, in recent years, drawn the attention of medical and social science investigators. For example, Glaser and Strauss (1965) have studied the interaction between hospital staffs and chronically ill and dying patients. Quint (1967) has explored the occupational problems that dying and death present the student nurse. Sudnow (1967) has focused his research on the manner of treatment accorded dying and dead patients in a public, as opposed to a private, hospital, while Kubler-Ross (1969) has interviewed the dying patient himself in an attempt to understand more fully the many issues and questions that he must confront with the prospect of his imminent death.

These and other investigators have directed their attention to the experience of the dying patient and/or the major problems he presents to the institution and the staff responsible for his care. Little attention has been paid to his survivors. Yet they may well deserve it. Over the past several years a number of persons have brought to my attention the fact that the visits of family members to chronically ill or dying patients in hospitals or nursing homes is observed to diminish in frequency and length soon after their relative is placed in an institution. While empirical confirmation of these limited observations is lacking at this time, they do permit a basis for some speculation about information that does have empirical support. Riley and Foner (1968) for instance, in their recent compendium, *Aging and Society*, report that different studies show that a disproportionate number of deaths occur among elderly patients soon after commitment to an institution. While it is, of course, possible that the time of placement in institutions may be due to the severity of the illness of the patient, nonetheless it is possible also that the precipitous rise in patients' deaths immediately following their commitment to the institution may be a response to their removal from their own homes and families and to what the patients perceive as abandonment by their families. Lieberman (1961), for example, reports that death rates among residents in an old-age home during the first year after admission were more than twice as high as for the same population while on the waiting list. He concludes, moreover, that early mortality did not appear to be clearly associated either with poor physical health or with age at first admission. Such a finding suggests that still unexplored factors may account for the increase in the death rate.

One such factor that I would suggest may be operative in this situation is the phenomenon of anticipatory grief. Anticipatory grief as defined by Lindemann occurs when family members are so concerned with their adjustment in the face of the potential loss that they slowly experience all the phases of normal grief as they cope with the illness or endure the separation prior to the death. Over an extended period of time, therefore, the family members may (1) experience depression; (2) feel a heightened concern for the ill member; (3) rehearse his death; and finally (4) attempt to adjust to the various consequences of it. Prior to the actual occurrence of the death itself the family will, to the extent that they have "anticipated" the death or dissipated their grief, display little or no emotion.

The phenomenon of anticipatory grief, at the same time, has immediate and profound implications for the chronically ill or dying patient himself. He, along with his survivors, must come to *accept* his illness and his death. It is a problematical thing for him to know, given the manner in which anticipatory grief appears to function, whether his survivors are in fact concerned or grieved at his dying. For as the family comes to accept the death, its emotional involvement in him diminishes or becomes intellectualized and diffuse. Thus, the family's diminished attention, absence of tears or other expressions of concern, may compel the patient to grieve not only for his own death but also for the seeming loss of his family's love. The turning-away of the family at this critical time, in a psychological as well as a physical sense, could deliver a shock to the patient's self-esteem from which he is not able to recover.

While the answer to the question of the role of anticipatory grief in the early death of institutionalized patients can only be found within the context of a specific case, there are indications that suggest that this question—and the need for careful study—will loom larger in the immediate future as more and more elderly people in our society are removed to nursing homes or terminal hospitals.

ROBERT FULTON
Associate Editor

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ANNOUNCEMENTS

The Center for Thanatological Studies at the University of Minnesota, known popularly among the more curious and alert of the student body as the Center for WHAT? Studies, will be known henceforth as the Center for Death Education and Research. It is earnestly hoped that this change in name will be duly noted by all and that our endeavors to communicate with the quick will now show some marked advantage over the success we have had heretofore with the moribund.

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Death education received significant support and a strong stimulus to move ahead recently with the annual meeting of the National Council of Family Relations held in Chicago this past October. For the first time, the Council, under the general conference theme of "Violence and the Family," systematically addressed itself to different questions dealing with the impact of death upon the American family. Five sessions were conducted during the meeting in which a total of fifteen papers were presented. In addition, four round-table luncheons were held at which a specific topic was formally presented and discussed.

For the convenience of *Omega* readers, the several session topics and their respective papers are listed here. It is hoped that some of these papers will be published in an early issue of Omega.

Theme I: *Death and Survivorship: Modes of Adaptation*
- "The Widow and Widower and Remarriage"—Benjamin Schlesinger
- "The Management of Death among Middle-Class American Families"—Vidal S. Clay
- "Death and Dying: Some Social Psychological Dimensions and Aging"—James T. Mathieu and James A. Peterson

Theme II: *Death as a Family Crisis: War and Missing Persons*
- "A Study of Thirty-two Wives of Prisoners of War or Missing in Action Men"—Sharon Price Bonham
- "War and the Family: The Psychology of Anti-Grief"—E. James Lieberman
- "Crisis of a Missing Person: A Family Search"—Kathryn Jordan
- "The Grief Process as Social Systems Disturbance"—Amy Ganzert, W. Vail Williams, Lewis Picher, Rita Vollman

Theme III: *Consequences of Early Parental Death and Father Absence*
- "Some Facts about Sex Role Development, Homosexuality and the Child Who Grows Up in the Father-Absent Home"—Jane Burgess
- "Relationship of Father-Absence to Attitudes and Behavior in Adolescents"—Leda A. Wilson
- "Problems Associated With Childhood Bereavement"—Robert Fulton and Eric Markusen
- "Early Parental Loss by Death as a Contributing Factor in Neurotic Marital Interaction"—Ida F. Davidoff

Theme IV: *Death Education and Research through Modern Literature*
- "Death, the Family, Modern Literature, and the Classroom"—Rose M. Somerville

"Death in the Family; Insights through Contemporary Creative Literature"–Laurence E. Smardan
"The Death Theme: Research and Poetry"–William P. Hawkinson
"Death Education"–Donald P. Irish

Information regarding the papers may be obtained by writing to:

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ROBERT FULTON is Professor of Sociology at the University of Minnesota. His activities include associate editorship of this journal.

EDGAR N. JACKSON is a minister with a long history of involvement in the concerns of death and bereavement. He has written several books addressed to the bereaved and is well known as a lecturer on this and related topics. He is now in active retirement in Corinth, Vermont.

ELISABETH KUBLER-ROSS has recently gained considerable national and international fame as the author of *On Death and Dying*, a book based upon her experiences as a psychiatrist working with theology and other students in talking with the dying. She has recently been appointed director of the Family Service and South Suburban Mental Health Center in Chicago Heights, Illinois.

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EDITORIAL

With a year's experience under our belts, we have decided to institute some changes of concern to those who anticipate submitting articles to us for publication. Some of these changes are based upon necessity, others upon personal prejudice.

From now on, we will use the reference citation style of the journals of the American Psychological Association. For those who do not have ready access to the APA style manual, there should be enough examples in this issue to help out. We are preparing a brief descriptive outline for distribution.

We need three copies of every article that we publish, one for the publisher, one for the printer, and one for the editor. Also, three copies enable the refereeing task to move more quickly.

If you are uncertain as to whether your article meets our requirements, you may query the editor or you may send a final draft for preliminary consideration. However, we usually cannot make a final decision until we receive a final copy (or, to be consistent with the previous paragraph, three final copies).

For the first year of publication, we gave twenty-five free reprints to every author. Unfortunately we cannot continue that procedure. However, we will give fifty free reprints with every purchase of fifty or more copies, and we will continue to give one copy of the entire issue of the journal in which the article appeared.

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