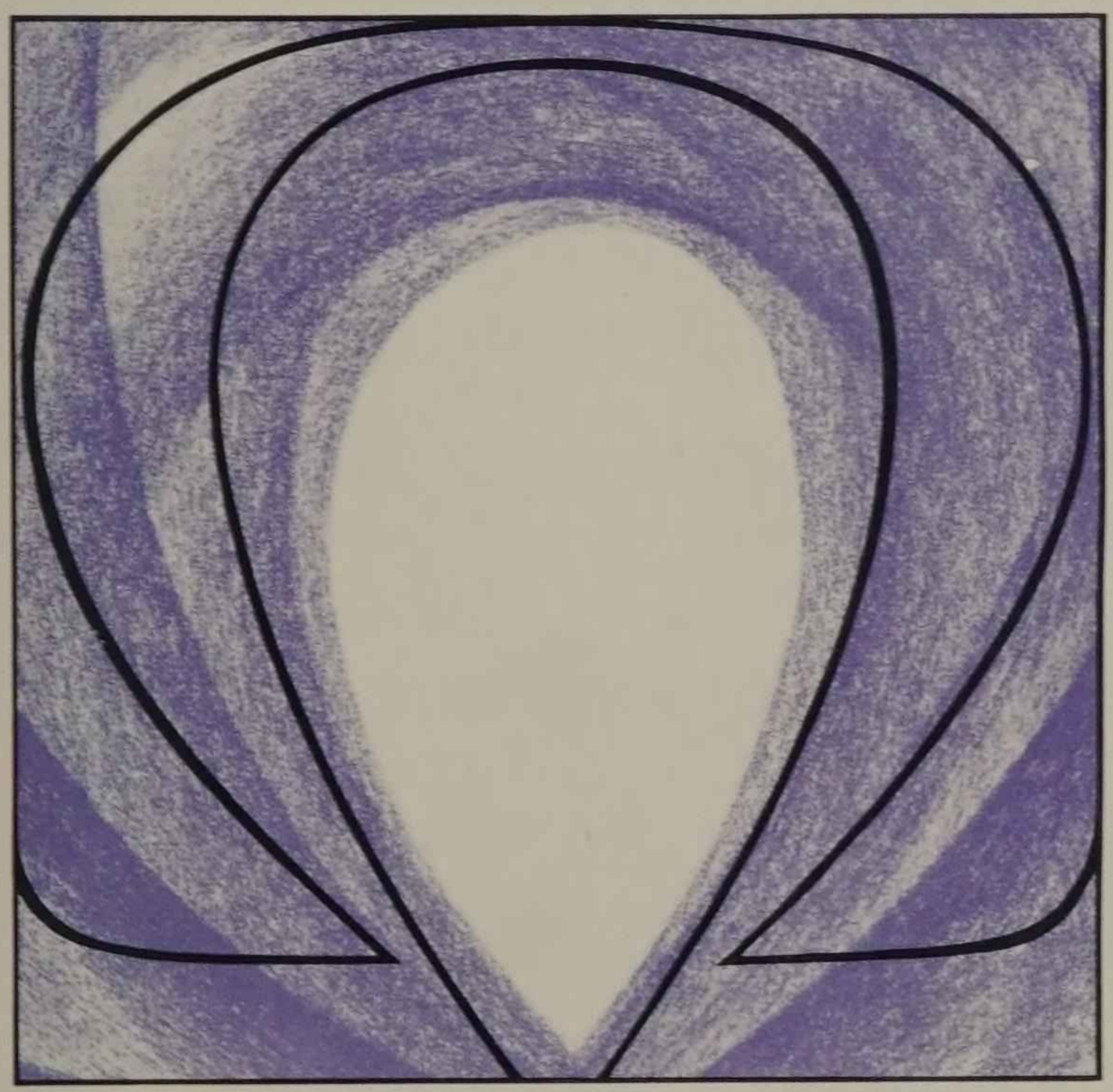
an international journal for the
psychological study of dying,
death, bereavement, suicide
and other lethal behaviors

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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CONTENTS

PHYSIOLOGICAL REACTIONS INDUCED BY GRIEF

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The increase in mortality reported in individuals undergoing the stress imposed by the grief situation, may be directly traced to the overstimulation of the pituitary resulting in the production of excess quantities of adrenocorticotropic hormone (ACTH), which in turn causes increased levels of corticosteroids to be produced by the adrenal cortex. The physiologic affects of these substances include the suppression of the inflammatory response. Since the inflammatory response is essential to the immune mechanism of the individual, the bereaved becomes more susceptible to common bacterial, fungal and viral pathogens. Indeed, because of the suppression of this response, the grief-stricken person may fall prey to overwhelming infections which are caused by "opportunistic" micro-organisms. It seems possible that the stress imposed by grief may be at the basis for the increase in death rates of individuals who are bereaved.

I tell you, hopeless grief is passionless;
That only men incredulous of despair
Half-taught in anguish, through the midnight air
Beat upward to God's throne in loud access
Of shrieking and reproach. Full desertness,
In souls as countries, lieth silent-bare
Under the blanching, vertical eye-glare
Of the absolute heavens.

"Grief" by Elizabeth Barrett Browning

The poem by Elizabeth Barrett Browning captures the several elements of the grief situation. It has been shown that "grief" encompasses rage, terror, profound sadness, helplessness, acute loneliness and despondency (Paul, 1967). These profound psychological elements undoubtedly combine to place the *physical* organism in a state of *stress.* Wolff (1953) has shown that the organism responds to psychological assault as if it were physical.

Certainly there is no need to review the many psychological implications of the grief situation. These have been adequately delineated in numerous studies. There is complete agreement with Bovard (1961) that reinforcing social stimuli such as affection and social approval inhibit the response to stress, and that the effect of the small group (such as the family) is all-important in sustaining the individual under severe emotional stress.

Rather, we would like to bring the *physiological* aspects of grief into focus. Specifically, the stress induced by the grief situation seems worthy of further, and intensified study. The recent study by Rees and Lutkins (1967) on the mortality of bereavement indicates that the psychological aspects of grief are invariably translated into physiological reactions, some of which contribute, if not lead directly, to the death of the bereaved. In this pioneering study, it was found that 4.76 percent of bereaved close

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relatives died within one year of bereavement as compared with 0.68 percent in a control group. This represents a seven-fold increase in mortality in a bereaved group It would appear that the increase is not coincidental.

In studying the case histories of patients with malignant disease, Greene (1966) found that leukemia developed preceeded by a recent loss or separation of a loved one. Muslin et al (1966) found that a "significant separation experience" was common in patients with malignant breast tumors, but not in patients whose breast lesions were benign.

The most recent article by Kutscher et al (1970) points out that the grief experience makes it more hazardous for the bereaved patient to undergo oral surgery and dental treatment. A recent survey indicates that 82.5 percent of internists, surgeons and general practitioners advise the postponement of all elective procedures during the period of bereavement (Schoenberg 1969). There is little doubt that the period of bereavement, of grief, is a most dangerous time for the individual. Physiologically, the bereaved is in a precarious health state.

An excellent starting point for examining the physiology of grief, is the prophetic statement by Parkes (1965) that "Grief may prove to be as important to psychopathology as inflammation is to pathology." In essence the unintentional linking of *grief* and *inflammation* inherent in Parke's statement leads directly to the first observable "pathology" of the stress situation induced by grief. It has been found, for example, that the posterior region of the hypothalmus mediates the pituitary-adrenal cortex response to emotional or neurogenic stress (Bovard, 1961). Under the stress situation, the pituitary releases ACTH (adrenocorticotropic hormone) in quantities above "normal". This, in turn, will cause the release of corticosteroids from the adrenal cortex. Schayer (1967) has demonstrated that these compounds are directly involved in the prevention of development of the important later phases of the inflammatory reaction. If the level remains high, homeostasis cannot be maintained. The number of capillaries active in carrying blood is diminished if these levels are sustained. As a result, most tissues are undernourished (Schayer, 1967), and catabolic processes predominate.

Other physiological effects of stress include an increase in the proteolytic activity of the plasma, a breakdown of fibrotic tissue by the proteolytic enzymes (with possible release of pathogens in cases of arrested tuberculosis as demonstrated by McLean (1963), and the paralysis of the all-important reticuloendothelial system (so important in "resistance" to disease processes). The increased levels of even the end-products of this increased pituitary-adrenal response, for example, hydrocortisone (17-hydroxy-corticosterone), enter into the deteriorating health picture by inhibiting protein synthesis at the cellular level (Bovard 1961), so that replacement which is normal for worn-out tissue, does not occur.

The direct participation of the reticuloendothelial system in the immune reaction is suppressed by the high levels of corticosteroids. In animals under stress, there is a precipitous decrease in the number of circulating lymphocytes (Schayer, 1964). The continued dosing of normal animals with corticosteroids produces alterations in every aspect of the body economy; changes in intracellular concentrations of oxygen. Carbon dioxide, ions, hormones, metabolites, waste products and acid-base ratio undoubtedly profoundly alter cellular chemistry and cellular functions.

In this respect, it has been found that cortisone can cause the induction of glaucoma in Man by its alteration of the intraocular pressure (Boyd and McLeod, 1964). Diabetes, too has been traced to cortisone treatments in man; it seems to be directly induced by the

adrenal steroids and differs substantially from the pancreatic type in being insulin-resistant (Frawley 1955).

It is the inhibition of the inflammatory response which is the underlying mechanism with regard to resistance to bacterial (such as t.b.), fungal (Candida infections) and viral pathogens. Interestingly enough, resistance to pathogens alone is but one aspect of the immune-response suppression observed with corticosteroids. More ominous is the increase in cases observed, of infection with "opportunistic" organisms in cortisone treated men (Louria, 1962). For example, since 1950 there has been an increase in the incidence of infections with the once-thought "innocuous" fungus, *Aspergillus flavus*, directly related to corticosteroid usage (Louria 1962).

The actual mechanism for this increase in aspergillosis has been established using cortisone-treated mice by Merkow et al (1968). When control mice and those treated with cortisone were exposed to aerosols of viable spores of the fungus, it was found that the cortisone-treated animals exhibited a diminished lysosomal response in forming phagocytic vacuoles. This diminished "defense" reaction resulted in the development of hyphal bronchopneumonia in these treated mice.

Because of the abundance of pathogenic and opportunistic fungi in our urban environments, it is interesting to speculate that people undergoing stress induced by grief (with the concurrent increase in corticosteroid levels) may fall prey to these types of mycotic infection more readily than the non-grief-stressed individual. The possible increased susceptibility of people dosed with corticosteroids to the common pigeon-carried pathogenic yeast, *Cryptococcus neoformans*, may be extrapolated to include grief-stricken individuals. Certainly, if corticosteroids do indeed increase this susceptibility, as postualted by Louria (1962), then there is every reason to suspect that the bereaved with his increased load of corticosteroids may well be more susceptible than the nonbereaved individual.

That the inflammatory reaction is a necessary part of the body's immune machinery is beyond question (Kinsell and Jahn 1955). No doubt it is directly involved in preventing *clinical* cases of tuberculosis. McLean (1963) has indicated that corticosteroids in usual pharmocological doses impair Man's defence mechanism to t.b. and promote its dissemination. In light of the fact that persons in large urban areas undoubtedly encounter the Mycobacterium at some time during their life in such areas, but do not necessarily manifest clinical tuberculosis, it seems probable that such persons (with "sub-clinical" t.b.) undergoing the stress imposed by bereavement may subsequently exhibit clinically active tuberculosis.

The persistent observation that cortisone deprives the phagocytes of their innate capacity to inhibit the multiplication of tubercle bacilli in their cytoplasm, thus markedly lowering resistance to the disease (Lurie 1960), may well account for the increased susceptibility of these individuals to infection with tuberculosis and may explain, in part, the transformation of sub-clinical infections into fullblown infections.

In cases of the viral infection, herpetic keratitis, the causative agent of which is the common herpes simplex virus, it has been found by Hallett et al (1951) and by Ormsby et al (1951), that cortisone markedly increases the viremia. Undoubtedly the inflammatory reaction so necessary for antibody production, is affected by the cortisone. Moeschlin et al (1953) have shown that ACTH and cortisone precipitously decrease the ability of the reticulo-endothelial system to participate in experimental antibody production in animals.

Without reviewing the increasing and voluminous literature implicating viruses in malignant disease, it is possible to speculate that the same reticulo-endothelial system may be involved in the body's natural defensive reactions contra the malignant process. Korngold (1957) showed that antigenic materials were present in human tumors. It seems logical that the antigens would result normally in the production of antibodies. However, as Taliaferro (1957) observed, if large amounts of cortisone are given, the antibody-forming processes are definitely suppressed, much like the result of large doses of X-radiation. Berglund (1956) demonstrated that there is a cortisone-sensitive initial stage during antibody formation. In the light of these studies, there is ample qualification for postulating a definite link between the levels of corticosteroids and the levels of antibody production by the reticuloendothelial system.

The recent recognition of the *duality* of viral effects lends an ominous tone to these discussions. For example, the relatively benign disease, infectious mononucleosis, presents a blood picture which is quite similar to the malignant disease lymphocytic leukemia. Indeed, many of the gross pathological manifestations are identical. Suspicion that the same virus may be involved is rapidly growing (Scientific Research 1969). It has been found that human mononucleosis cells injected into hamsters, induce a fatal lymphoma in these animals. The speculation that mononucleosis may be a non-malignant manifestation of the leukemia virus, seems worthy of intensive investigation.

It seems possible that whether an individual exhibits the relatively benign disease or the highly malignant disease, may ultimately be found to be the result of his immunological "state of readiness". In this respect, the corticosteroids would definitely enter into the picture by suppression of this immune response. Hence, a person who is stressed by grief, with the resulting physiological picture of increased corticosteroid levels, might when undergoing the specific challenge imposed by the virus, not be in an immunological-readiness stage. The result may be that such a person will exhibit the malignancy rather than the benign form of the disease caused by the identical virus.

In summary therefore, the very response of the human organism conditioned through the many years of our evolutionary history, instead of being defensive, by virture of its *phasic* nature ("to be turned off after the wrong has been righted"), becomes under the stress imposed by unresolved grief, *continuous.* This ACTH-corticosteroid response, because of Man's highly developed and integrated nervous system, becomes over-adapted in cases of non-specific stress (such as grief) as contrasted to specific stresses represented by a damaging microbial or chemical force or irritant. Once this stage is reached, tissues are pressed beyond their limits and these devices that ordinarily would serve to protect or restore the body now lead to active disease states (Chapman and Goodell 1964).

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CHOICE OF METHOD FOR SUICIDE AND PERSONALITY: A STUDY OF SUICIDE NOTES[1]

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There has been occasional comment made concerning correlates of the choice of method for suicide. Hendin (1963) noted that schizophrenics tend to use bizarre methods and make attempts with multiple methods. Older people tend to use more active methods for suicide. For example, among the Tikopians (who live in the Pacific Basin) the young people usually attempt suicide by swimming out to sea, whereas the older people hang themselves (Firth, 1961). Lester (1969) noted that women tend to use passive methods of suicide, whereas men tend to use active methods.

However, there have been few intensive studies to examine correlates and causes of why a particular method for suicide is chosen by an individual. The choice of method is an important aspect of a suicide attempt and may provide important therapeutic cues to a therapist working with an attempted suicide; but research has neglected this aspect of the act. Lester (1970, 1970a) has reported two exploratory studies of personality correlates of the choice of method for suicide. In one study, he examined data on the aggression in the TAT themes of those using active and passive methods for suicide, and found no significant differences. In another study, he examined the MMPI profiles of those using active and passive methods for suicide, and of those shooting and hanging themselves, but again found no significant differences.

The present study is a further attempt to explore correlates of the choice of method for suicide. The data for the present study come from the suicide notes written by suicidal individuals. Since research into this aspect of suicidal behavior is at a preliminary stage, the present study explored a variety of measures obtainable from suicide notes. No specific hypotheses were tested. The study was conceived as an exploratory study to find whether any differences exist in the notes of those using different methods for suicide.

The important distinction made in this paper is between passive methods of suicide–use of gas, poisons, and pills–and active methods–cutting, hanging, jumping, and shooting. This distinction follows the one made by Capstick (1961) on intuitive grounds, and the one made by Darbonne (1967) who rated different methods of suicide for their activity or passivity in the sense of Adler's use of the terms (Ansbacher & Ansbacher, 1956). They agree on the division of methods into active and passive categories with the exception of suicide due to drowning, and suicide due to injection of drugs with a hypodermic needle. (It should be noted that death due to drowning, for example, can

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represent drowning in one's bath, or jumping into a river; both constitute very different kinds of acts. This distinguishing information is not always on the death certificates.) Accordingly, in this study, deaths due to drowning and injection of drugs were not included in the sample of suicides studied.

METHOD

The sample consists of 47 suicide notes retrieved from the records of the Medical Examiner and the Homicide Bureau of Erie County and the city of Buffalo over a 5 year period. The sample includes 43 notes from individuals who completed suicide and 4 notes from individuals who attempted suicide. In the sample, 23 individuals used passive methods for suicide and 24 individuals used active methods.[2]

RESULTS

Demographic Status

The active and passive suicides did not differ in sex ($X^2 = 0.53$, df = 1), age (t = 0.39, df = 42), whether living alone or with others ($X^2 = 0.09$, df = 1), or in marital status (X^2 0.00, df = 1). The mean age of the *S*s was 40.7 years (standard deviation 17.0, range 18–72).[3]

Length Of The Notes

The two groups of subjects did not differ with respect to the number of notes left (t = 1.07, df = 45), the total number of words written (t = 0.61, df = 45), the total number of thought units written[4] (t = 0.51, df = 45), the number of words per note (t = 0.49, df = 45), or in the number of words per thought unit (t = 0.06, df = 45).[5]

References To Self And Other

Tuckman and Ziegler (1966) suggested that the social maturity of the writer of a suicide note might be assessed by the use of self-referent pronouns and other-referent pronouns. Following the ontogenetic sequence noted by Piaget (1926), they argued that the more socially mature person uses more other-referent pronouns. The two groups of notes in this study did not differ in the proportion of other-referent pronouns used (t = 0.95, df = 41) or in the proportion of other-referent possessive adjectives (t = 0.51, df = 31).[6] The groups did not differ either in the number of self and other referent pronouns and possessive adjectives used.

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[2] Of the active suicides, 15 used a gun, 6 hanged themselves, 2 jumped, and one cut. Of the passive suicides, 16 used pills, 5 used carbon monoxide, one used gas, and one suffocation.
[3] The sample size is reduced in these comparisons due to missing information for some *S*s.
[4] The number of thought units were defined as outlined by Dollard and Mowrer (1947).
[5] Where a suicide had written more than one note, all the notes were combined together for the purposes of measuring the content of the note in the following analyses.
[6] The n is reduced in some comparisons due to the ratio for a subject being 0/0 and so not computable.

Degree Of Activity

Darbonne (1967) attempted to operationalize the concept of activity as used by Adler. He suggested that the following measures taken from suicide notes would assess the concept: the length of the note, the proportion of verbs of action as compared to verbs of thought and feeling, and the proportion of verbs as compared to adjectives.

The two groups of notes did not differ in their length, in the proportion of verbs of action as compared to explicit verbs of thought and feeling ($t = 1.26$, $df = 42$) or to explicit and implicit verbs of thought and feeling ($t = 0.66$, $df = 42$), or in the proportion of verbs to adjectives ($t = 0.77$, $df = 44$). The two groups did not differ in the absolute numbers of these categories either.

Discomfort-Relief Quotient

Dollard and Mowrer (1947) described a way of measuring the tension in written documents in which each thought-unit is categorized as indicating positive emotion, negative emotion, or neutral emotion. The ratio of negative to positive statements is the discomfort-relief quotient. This measure has been used to compare genuine and simulated suicide notes by Shneidman and Farberow (1957).

The two groups of notes did not differ in the proportion of neutral thought units ($t = 0.65$, $df = 45$) or in the discomfort-relief quotient ($t = 1.62$, $df = 39$, two-tailed $p > 0.20$). The two groups did not differ either in the number of each kind of thought unit.

The Predominant Motive

Menninger (1938) classified the three predominant motives found in suicidal individuals as follows: to die (escape from a painful situation), to kill (outward directed anger), and to be killed (inward directed anger). Each suicide note in the present sample was classified for the predominant motive shown in the note. Each note was rated by two judges and the agreement between the raters was 92 percent. Inspection of the data indicated no significant differences between the two groups of notes. A comparison of the categories "to die" versus the others by means of chi-square test gave $X^2 = 0.05$, $df = 1$.

Dread Evoked By Suicidal Intention

Spiegel and Neuringer (1963) hypothesized that people about to kill themselves will experience dread, and in order to kill themselves, this sense of dread must be inhibited. They hypothesized that the suicide notes would show evidence of this inhibitory process and they argued that indicators of this would be avoidance of thoughts related to suicide (for example, less explicitness in stating suicide as an intention, use of fewer words synonymous with suicide, concern with instructions and orders to others, and less drama in the notes), and disorganized thought processes which would protect the individual from realizing the implications of what he was about to do.

Two of the measures are objectively scored; the two groups did not differ in the use of terms synonymous with suicide (Fisher exact $p > 0.30$) or presence of instructions ($X^2 = 0.02$, $df = 1$). The other measures were less objective and so each note was rated on

a five-point scale for each of the three measures by two judges, independently. The agreement between the judges was 82 percent. For judge A, none of the measures differentiated the two groups significantly on a Kolmogorov-Smirnov two-sample test (Siegel, 1956), and the same was true for the ratings of judge B.

DISCUSSION

None of the measures investigated here significantly differentiated the two groups. These measures had all previously been successful in differentiating genuine suicide notes from simulated ones, and cover the range of possible measures that are obtainable from suicide notes. However, none of the measures investigated even came close to differentiating the notes of those who killed themselves using active methods from the notes of those who used passive methods.

This, is the third study that has failed to find any differences between those using varying methods for suicide. The present study examined the suicide notes of the completed suicides, whereas the previous studies examined the MMPI protocols of completed suicides and the TAT protocols of attempted suicides.

This failure to find differences between those using different methods of suicide is not in accordance with common sense. It seems reasonable to assume that the choice of method for suicide reflects something about an individual's personality or life-style. If people are asked which method they might use to kill themselves, the majority can quite decisively choose a particular method. (Whether they would just as decisively use this method were they ever to seriously consider killing themselves is debatable. However, the ease with which individuals can theoretically choose a method for suicide is remarkable.) The question remains, therefore, why has research failed to identify differences between the personalities of those using different methods.

There are two possiblities. First, the division of methods into active and passive may be a poor choice. In answer to this, all that can be said is that suicidologists have been unable to come up with any alternative suggestions. Furthermore, in a study of MMPI protocols, Lester (1970a) compared those hanging themselves with those shooting themselves–a distinction that is based simply on the method, and not on any "psychological" dimension hypothesized to underlie methods for suicide–and failed to find any differences.

A second possiblility is that the tests used so far to differentiate those using different methods for suicide have been unrelated to the basic variables that determine this difference. The only answer is that there is a dearth of hypotheses concerning determinants of the choice of method for suicide, and a scarcity of data from suicidal individuals.

At the moment, therefore, there are only three variables that have been found to be associated with the choice of method for suicide: sex (females use passive methods more often), age (older people in some countries tend to use active methods more often), and diagnosis (psychotics tend to use active methods more often). Aside from these three findings, we have no further cues as to the factors determining choice of method for suicide.

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AN IMPLEMENTATION OF SHNEIDMAN'S CLASSIFICATION OF ORIENTATIONS TOWARD DEATH

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In a 1963 publication, Shneidman proposed a classification of human orientations toward death. This system provides a schema for classifying suicidal persons relative to their expectations about the outcomes and consequences of their suicidal behavior. He indicated that most suicidal deaths fall into an *intentioned* category with respect to their orientations toward death or cessation. The author stated: "By intentioned, I refer to those cases in which the individual plays a direct and conscious role in his own demise." Four special subcategories were described. Three of these, the *psyde-seeker, psyde-initiator,* and *psyde-ignorer* are quite similar. All are consciously aware of their behavior and have fairly certain expectations of their physical demise. The psyde-initiator differs only in that he already faces death from other causes. The psyde-ignorer is a second special case of a psyde-seeker, the distinction being that the psyde-ignorer expects to survive in the hereafter. Psyde-seeker appears to be a superordinate category which includes the other two as special subcategories. In addition, Shneidman noted two other categories of persons that have relevance to suicidal behavior. One, the fourth of Shneidman's special subcategories, is the intentioned *psyde-darer*, persons who are ambivalent about their attitudes toward cessation and literally dare death, or gamble with their lives. The second is the *psyde-feigner*, a person who mocks death, but neither intends nor expects cessation to result from his activities.

The authors believed it important to determine the feasibility of assigning suicide cases into these categories. This goal was of particular importance to the Central Research Unit, a Veterans Administration research program located in Los Angeles and devoted to the study of suicide. It must be recalled that in order to implement the classification, the assignment had to be made on the basis of intention or expectation which may not be congruent with the observed consequences.

There were three primary objectives in testing this classification.

1. It afforded an opportunity to determine the reliability of the categories, using different judges.
2. It afforded the opportunity for estimating the percentage of Central Research Unit cases that could reliably be classified by this system.
3. It afforded the opportunity for estimating the percentage of Central Research Unit cases falling in each category.

METHOD

Fifty suicide cases were chosen randomly from the Central Research Unit files.[1] After a preliminary examination of the clinical data, seven cases (14 percent) were excluded

[1] These cases were chosen randomly from cases forwarded to CRU and labeled suicide by the forwarding Veterans Administration hospital.

from the sample due to insufficient data. Historical abstracts for the remaining 43 cases of the clinical records were prepared randomly by two research staff members.

These abstracts were then independently sorted by three research staff members into three categories according to Shneidman's outline. These were intentioned-psyde-seeker, intentioned-psyde-darer, and intentioned-psyde-feigner. (In general terms, a seeker was defined as a person expecting and intending cessation as a consequence of his suicidal behavior, a darer is a person who is ambivalent concerning cessation as a result of his suicidal behavior, and a feigner neither intends nor expects cessation as a consequence). Cases which could not be classified in these three categories were assigned to a fourth, or residual, group.

RESULTS

In 38 cases, the three judges were in complete agreement (86 percent agreement within the 43 cases rated). Of these, 36 were rated, with reference to the fatal attempt, as psyde-seekers. One case was rated by all judges as a psyde-darer, and one case was rated as equivocal between accident and suicide.

It is of primary interest that in 36 cases there was complete agreement that the suicidal person could be described as a psyde-seeker in the fatal suicide action. This represents 84 percent of the 43 cases rated, and 72 percent of the original random sample. It is of significance that in 28 percent of the original sample there is a question of whether the suicidal victim can be considered a genuine psyde-seeker. (This includes the 14 percent undetermined because of inadequate data, and the 14 percent uncategorized because the judges either disagreed about the classification, or they agreed that the case could not be classified as an example of psyde-seekers). Such a finding indicates that considerable care needs to be exercised in studies undertaken using existing clinical data. If the statistics are reliable, nearly one-third of the so-called suicide cases, at least in this center, may be unsuitable in investigations attempting to elucidate characteristics of persons who intentionally kill themselves. The attrition is largely a function of inadequate information, but regardless of the contributing factors, it must be recognized that many cases are unsuited to investigations because they are unreliable.

The high percentage of agreement in the 43 cases among the judges is most encouraging; however, it needs to be interpreted with great care. Of the 38 cases in which there was total agreement relative to the fatal attempt, 36 were cases judged as psyde-seekers. Two of the remaining seven cases were rated with complete agreement, one as equivocal between suicide and accident, and one as a psyde-darer. Five of the seven cases resulted in disagreement among the judges.

Among these 43 suicidal persons, there were several who made more than one known suicidal attempt. A total of 74 suicidal incidents were identified, although six of these resulted in disagreement among the judges as to their authenticity. The remaining 68 attempts were assessed according to the schema outlined above. In 47 cases there was complete agreement (including the 38 instances already described) and 21 disagreements. This resulted in overall agreement in 69 percent of the incidents.

However, in the nonlethal suicidal attempts, there was agreement in only 38 percent of the incidents. Among instances of disagreement, 52 percent of the variance occurred between the categories of psyde-darer and psyde-feigner, but only one disagreement involved categorization in the nonproximal categories of psyde-seeker and psyde-feigner.

It would appear that two primary factors are responsible for the diversity of judgement. First, the data were, especially in nonlethal cases, grossly inadequate and incomplete; and second, the descriptions of psyde-darer and psyde-feigner are too vague for high operational reliability. However, despite these marked disavantages, the results are encouraging and argue for further work utilizing this classification.

CONCLUSIONS

It would appear that five tentative conclusions may be justifiably entertained.

1. Many of the so-called suicide cases reposited in the Central Research Unit are so incomplete that they are wholly inadequate or unreliable for most research activities; this accounts for approximately 30 percent of all the cases.

2. It is possible to get high agreement among independent judges concerning the intention of suicidal victims when they make fatal attempts. The degree to which these judgments are contaminated by assessments of the objective lethality of the suicide methods is unclear but appears to be marked. (It may be, however, that there is a high positive correlation between objective lethality of suicide method and the expectation of the victim. At present no method for independently assessing these variables is known).

3. Agreement among judges, using the Shneidman classification, in evaluating nonlethal suicidal attempts is substantially poor, but encouraging. At least three factors are responsible for the disagreement in these cases. First, more precise descriptive definitions must be made in order to improve reliability in identifying genuine suicidal attempts. Second, more precise descriptive-operational definitions must be made in order to improve the reliability of assigning persons to one of the categories described in Shneidman's classification. However, since these are not truly discrete categories, but rather points on a continuum, it is readily apparent that 100 percent interjudge reliability will never be possible. Third, existing clinical data, especially of nonlethal suicide attempts, seriously hampers reliable judgments. A truly fair test of the classification system should utilize more specific and extensive data.

4. Agreement is maximal in the assessment of psyde-seekers. This agreement is enhanced because the data are more complete, contaminated by a knowledge of the objective lethality of the suicide methods and the outcome. It is influenced, in an unknown extent, because the continuous dimension of intention is blunted as a result of irrevocable consequences. This unnatural artifact alters the probability of agreement in assessing psyde-seekers as compared to assessing psyde-feigners and psyde-darers.

5. Studies attempting a control for suicidal intention, need to be cautious in selecting and prejudging cases, since the extent of disagreement and uncertainty is so great in cases drawn randomly.

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WHAT MAN HAS TOLD CHILDREN ABOUT DEATH

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This article begins with the assumption that one can gather some picture of the history of man's attitude toward death by examining the literature he has written for children.

And so, it proceeds to survey death in children's literature from the early, anonymous works such as Mother Goose, to contemporary picture books like *The Dead Bird*. This literature is basically divided into four periods: Anonymous, Puritan, Intermediate and Contemporary. At least one representative example and further references follow the explanation of the values and principles of each period.

The conclusion points out that, aside from the merits of this survey as a literature study and an indication of man's attitudes towards death through history, it can serve the important role of challenging the reader to examine his own death attitudes.

It seems that at some level, every man has some perception of death. These levels might range from a complete denial of the reality of death, to an acute sense of what death means for him. A very interesting question that might emerge here is whether an individual's perception of death changes during his life. Making the plausible assumption that his perception does change, the curious might further ask: "how often and how fundamentally?"

These questions about death in relation to the individual man decidely deserve attention, but the possible answers must come from competent, psychological research of the longitudinal type with individual subjects. However, a more grandiose question can be asked about man in general (which cannot properly be answered through longitudinal research), in terms of his perceptions of death throughout history?

One may be able to handle this massive inquiry in the following way. It seems a reasonable assumption that some of the strongest beliefs a person holds, might well emerge as those he would want to pass on to children. It then follows that a man's perception of death might well be found in what he tells children of death. And since the concern here is with the perceptions of man in general through history, a look at children's literature on death seems most appropriate.

The look at the literature which follows does not purport to be a standardized measure of cultural, developmental perceptions of death. It attempts to point out some strikingly frequent themes that occur, and present them in a form that might make one think more about death, especially his own.

Survey of Children's Literature

In surveying children's literature through the gamut of its history, the attempt has been to confine the scope to literature intended for the young child, in order to define the bounds of the potentially limitless category of "children's literature." In this survey

"young child" means 4 or 5 years old. However, any student of children's literature knows that such a gamut would be a short one indeed, reaching back only to the beginnings of the 20th Century.

Nevertheless, this does not mean that young children never had contact with books until 1900. They certainly heard or overheard their older brothers and sisters talking about books they were reading, and these young children also had many stories read to them. Therefore, the perspective in surveying death in children's literature is precisely that of a 4 or 5 year old looking through the children's books of history, considering relevant only what he could understand. This survey will roughly follow a chronological sequence, in order to trace developmental growth from the early anonymous nursery rhymes to present-day picture books. In spite of the sparseness of material in this area, a thorough review of existing children's literature is beyond the linear space allowed for this article. Therefore, a discription of the period or category and a representative example will be given, with a simple enumeration of the rest of the works in that period.

This first era is a nebulous one, full of anonymity. Authors, as well as the time of writing, are unknown; schools of thought are not clear, creating a lack of definition for this Period. A familiar example is the very famous Mother Goose nursery rhymes. Talk of death dances coyly about in the rhyming and tumbling verses of "Old Mother Hubbard," and some stands out so boldly in the first three stanzas as to almost become lost in the playful rhyming:

Old Mother Hubbard,
Went to the cupboard,
  To get her poor Dog a bone,
But when she got there,
The cupboard was bare,
And so the poor Dog had none.

She went to the baker's
  To buy him some bread,
But when she came back
  The poor Dog was dead.

She went to the joiner's
  To buy him a coffin,
But when she came back
  The poor Dog was laughing.

It is interesting to see how the fact of death is negated.

Much less subtle is the short and lyrical life of Solomon Grundy (Anonymous):

Solomon Grundy,
Born on a Monday,
Christened on Tuesday,
Married on Wednesday,
Took ill on Thursday,
Worse on Friday,
Died on Saturday,
Buried on Sunday.
This is the end
Of Solomon Grundy.

Without presuming to completely encircle this undefined period by listing other works

in the category, two other pieces deserve mention: "The Courtship, Merry Marriage, and Feast of Cock Robin and Jenny Wren, to which is added the Doleful Death of Cock Robin" (Anonymous), whose very title gives an adequate one sentence abstract. The other is a very old sequence poem generally referred to as "The Song of the Little Goat" (Anonymous).

The next period stands a bit more solidly implanted in time, namely, the Puritan era in America. Several aspects of the Puritans' attitude toward death are revealed in their "children's literature." First of all, discussion of death certainly did not possess the taboo status it has had in other times and places. On the contrary, death was a frequent topic of books and sermons. Secondly, one simply cannot consider death in the time of Colonial America except in the context of religion. It was the Puritan view that the life of man on earth is a sinful one and he must be saved, but he *must* pass through death in order to reach salvation. Therefore, death should be welcomed, provided that it does not catch him while in disfavor with God, for then he shall be damned! Thirdly, one might say that they used the powerful and effective threat of death to scare children into good behavior; fear functions very effectively as an inner control when adults are not around.

During this time, *Pilgrim's Progress* by John Bunyan (1678) achieved great popularity among children in spite of the fact that Bunyan did not write primarily for adults. He had the religious motives of a preacher, but he employed the method of allegory. This allegory took the form of a Pilgrim on his journey to heaven, and the work strongly attracted children because of the adventures the Pilgrim became involved in.

At one point, Christian the protagonist, finds himself almost at the gates of the celestial city with only the river of death to cross. His fears of drowning are overcome by his companion, Hopeful, who tells him to have hope and believe in God. Other parts of the work add the implication that without this faith, death overwhelms the body and condemns the soul to hell. How well the children could travel the allegorical bridge is debatable, but that many parents helped the crossing is probable.

Bunyan also wrote *Divine Emblems, Or Temporal Things Spiritualized. Fitted for the Use of Boys and Girls* (1794, in Shipton, 1956), where he speaks of death directly in the form of two images, a candle and an hour glass. James Janeway wrote *A Token for Children, Being an Exact Account of the Conversion, Holy, and Exemplary Lives and Joyful Deaths of Several Young Children* (1728; in Shipton, 1956). And finally John Foxe compiled *The New and Complete Book of Martyrs* (1794; in Shipton, 1956).

Thus, it seems the Puritans established some rather firm guidelines for telling children about death. With various modifications this mind-set persisted into the 19th Century. In between lie the modifications which merit attention; the Intermediate Period.

Basically the writers of this middle period took various stands upon three fundamental aspects of the clear-cut Puritan attitute toward death: (1) religion, (2) threat and (3) didacticism. The Puritans' view of death stemmed from a very religious framework; the tone of the literature often boomed in damning threats, all to teach their children how to live this life.

In spite of some offensive passages, critics applaud the entrance of Isaac Watts for the vitality of his work and the easily understandable verse he wrote in. Again the title describes this very purpose: *Divine Songs Attempted in Easy Language for the Use of Children* (1773; in Shipton, 1956). Although easily understandable poetry may be regarded as a step toward modern literature for children, a religious didacticism still

shackeles the effort:

> There is an hour when I must die,
> Nor do I know how soon 'twill come;
> A thousand children young as I
> Are call'd by death to hear their doom.
>
> Let me improve the hours I have,
> Before the day of grace is fled;
> There's no repentance in the grave,
> Nor pardons offer'd to the dead.
>
> Just as a tree cut down that fell
> To north, or southward, there it lies;
> So Man departs to heaven or hell,
> Fixt in state wherein he dies.

The Taylor sisters do not speak the language of religious didacticism, but it seems they employ the threat of death for the sole purposes of reminding children of the fact of their mortality. The uniqueness of their style lies in the very descriptive nature of how they paint death, that is, with strokes of decay and worms. This selection comes from their *Original Poems for Infant Minds* (1804):

> You are not so healthy and gay
> So young, so active and bright,
> That death cannot snatch you away,
> Or some dread accident smite.
>
> Here lie both the young and the old,
> Confined in the coffin so small
> The earth covers over them cold,
> The grave-worms devour them all.

Another author is Anna Barbauld, who truly appreciates the sorrow that death causes, and does not hesitate to remind children of that. Without using the Puritanical threat, her approach presents salvation as the hope that will bear a person through death (1786; in Shipton, 1956):

> Mourn not therefore child of immortality!–
> for the spoiler, the cruel spoiler that
> laid waste the works of God is subdued:
> Jesus hath conquered death;–child of
> immortality! mourn no longer.

In her *Lessons for Children from Two to Four Years Old* (1788; in Shipton, 1956) one finds a condemnation of cruelty to animals, a theme which has not really appeared up to this point in time. Lastly, Anna Barbauld introduces still one more element; namely, death from the practical point of view. Observe her comparison between a fish and a child (1788, Part I, p. 49):

> "It has got fins to swim with; and it has got scales, and sharp teeth. It will be dead soon. It is going to die. It cannot stir anymore. Now it is quite dead. The fish dies because it is out of the water, and Charles would die if he was in the water."

The previous three writers of this Intermediate Periods (Watts, the Taylor sisters and Barbauld) were chosen because their works represent some of the themes developed

in between the Puritanical and Contemporary Periods. The following people and works, though not necessarily of lesser importance, will only be mentioned briefly.

Sarah Trimmer, a great admirer of Anna Barbauld, shared her feelings about cruelty to animals in *An Easy Introduction to the Knowledge of Nature* (1796; in Shipton, 1956). Mrs. Mary Sherwood achieved noteriety with her incident of the old corpse hanging from the gibbet with the children being forced to observe, in *The History of the Fairchild Family* (1818). The anonymous *Little Teacher, For Reading and Spelling Well* (1798) contains a piece typical of this period's concern with swimming accidents entitled "The Dangers of Swimming." Finally, in his book *The Affectionate Parent's Gift*, Sharpe (1828) stikes at guilt in "Death of a Father" and "Death of a Mother."

In a sense the next group of authors belong in an earlier chronological sequence, because many of their themes developed in earlier times. Neverthless, the two outstanding names who molded these themes into words are Hans Christian Andersen and Brothers Grimm of the 19th Century.

Andersen grapples with death in very many of his fairy tales. If death does not play the major role in the plot, It often functions in a fact-of-life manner. However, the frequent occurrence of death in these tales in no way implies a morbid obsession or a moralizing threat. On the contrary, Andersen puts death firmly in the Christian framework of life-death-life, where one does in order to live. The story of "The Little Match Girl" (Andersen, 1945), who lights all her matches to get warm and finds herself dead in the snow but alive with God, typifies this Andersen theme.

Andersen was chosen over the Brothers Grimm to represent this period because, although the Brothers Grimm repeated stores in which death often played an important part, Andersen had a tale to tell of death.

With the exception of the fairy tales, and especially Andersen, the Contemporary Period beings with it many new concepts in literature for children dealing with death. The theme of religions becomes quite secular; It does not threaten, and is not directly didactic. This literature falls into two fundamental styles the children's novel and the picture book.

Felix Salten, author of *Bambi* (1929), has a message to deliver much as Andersen did. Death permeates *Bambi*; the theme of the constant threat of death from the hunter threads through most of the pages and characters. Salten presents life as a constant struggle against death and a constant regeneration.

Anne and the Sand Dobbies by John Coburn (1964) tells of a very little girl who used to love to play in the sand at the seashore. One day she becomes sick and dies in the middle of the night. The family's decision to cremate her brings up questions about where Anne really is now that she is dead; and this is discussed by the family. Later on her brother's dog, Bonnie, dies and parallels are delicately drawn.

The Story of Babar by Jean de Brunhoff (1933) concerns an elephant who loses his mother and goes on to survive. Peal Buck puts death in an Oriental setting for children in *The Big Wave* (1947). E. B. White wrote *Charlotte's Web* (1952) about a pig and some of his life and death concerns.

Part of the 20th Century's novelty is it's new genre of children's literature. The picture book speaks directly to children, even if they cannot read. This, of course, means that now the illustrator plays an important role in what the book communicates.

Randolph Caldecott fits a bit enigmatically in this survey of books about death for children. Generally he illustrated texts that he did not write. This presents little

difficulty, except where the illustration does not exactly fit the text, as in "The Great Panjandrum Himself" (Caldecott,). It contains one line about death and it occurs in the midst of Mother Goose kind of nonsense:

> So she went into the garden to cut a cabbage leaf
> to make
> an apple pie;
> and at the same time a great she-bear
> coming down the street pops its head into the shop.
> What! no soap?
> So he died,
> and she very imprudently married the barber . . .

Alongside the line "So he died" the illustrator has drawn a man slumped over in a chair with a forlorn woman looking on. The next page finds a picture of a clown astride a grave with "Sacred" written on it.

Death does not feature importantly in this text, anymore than anything else does. And yet, Caldecott chose to illustrate the death, when one obviously cannot illustrate every element in the text. The casual subtlety of this absurdity occurs several times in Caldecott's work.

Finally, one must not overlook another, more contemporary picture book about death by Margaret Wise Brown called *The Dead Bird.* The story tells of children who find a bird, dead. They have a funeral for it, plant flowers and bury it. This book has an aura of gentleness and openness which graciously slash through the death taboo. The story emphasizes the fact that the children wanted to have the funeral, and that they very much wished to express themselves in this way. It ends rather realistically on the final page with the line: "And every day, until they forgot, they went and sang to their little dead bird and put fresh flowers on his grave."

Why Did He Die by Audrey Harris (1965) is a picture book that talks about death in the framework of a boy's grandfather who has died. *My Turtle Died Today* by Edith Stull (1964) is another picture book which deserves mention.

CONCLUSION

And so, this study began in the Anonymous Period where man talked to children about death in works of nonsense, as well as tragedy. Puritan man chose to accent the fearful side of death from a religious framework. Writers of the Intermediate Period emphasized both the practical aspect of how to avoid death, as well as the religious concerns of salvation. The Contemporary Period generally speaks from a secular regard for the world, emphasizing the fact of death with the need to talk about it and grieve.

And now where does this analysis of death in children's literature leave one? It certainly stands as a study of one aspect of a particular type children's literature. However, its potential meaning lies beyond that, since all studies of literature has further ramifications. For example, it is certainly useful to discover trends in the past to make more sense of what is going on in the present. Also, one often discovers meanings in past literature, apparently unrealized at the time. Finally, one should have the opportunity to experience literature that approaches a certain universality, regardless of when it was created, as is the case with many classics. This particular study of death in children's literature certainly has some of these broader meanings.

However, I would like to say boldly that it can go even one step further: by looking at what men in the past have thought children should know about death, one is thrown in the face of what he himself thinks of death—especially his own.

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A PSYCHOSOCIAL ASPECT OF TERMINAL CARE: ANTICIPATORY GRIEF[1]

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Death in contemporary society is increasingly an experience of the aged. Of the 2 million persons who will die in the United States this year, almost two-thirds of them (62 percent) will be 65 years of age or over, although this age group represents only 9 percent of the total population. Children under the age of 15, on the other hand, account for 29 percent of the total United States population but only 5.5 percent of the total deaths.[2] This is in sharp contrast to the mortality statistics in 1900, for instance, when proportionally, far more children died. At that time, children under the age of 15 accounted for 34 percent of the population–approximately the same proportion as today–but this age group accounted for 53 percent of the total deaths. In the same year, persons age 65 and over accounted for 4 percent of the total population, and 17 percent of all deaths.[3] These changes in mortality statistics are further reflected in life-expectancy figures. A person born in 1900 had a life-expectancy of 47.3 years, whereas a person born in 1967 could expect to live 70.5 years.[4]

The context in which dying and death are experienced in the United States has also undergone a significant change. Of the two million deaths estimated for 1970, almost two-thirds (64 percent) will take place outside the home in either a hospital or a nursing home.[5] The number of persons who will go to such a setting eventually to die can be expected to increase with the prospect of Medicare, more sophisticated medical technology, and the progressive segregation of the aged from families. Medical science, with its associated public health programs, has reduced the mortality rate and prolonged the life-expectancy of millions of our citizens. The extension and bureaucratization of medical health services, therefore, not only has changed the age at which a person can expect to die, but, in addition, has changed the time and place of his death.

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[1] Prepared for the symposium, *Psychosocial Aspects of Terminal Care,* Columbia University, November 6 and 7, 1970.

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

[3] U.S. Department of Commerce, U.S. Bureau of the Census, *Special Report: Mortality Statistics 1900-04.* (Washington, D. C., Government Printing Office, 1906), Table 2, p. 22; and U.S. Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1957,* a Statistical Abstract Supplement, Washington, D.C., 1960, Table: Series A 71-85, p.10.

[4] U.S. Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1957,* a Statistical Abstract Supplement, Washington, D.C., 1960, Table: Series B 92-100, p. 25; and U.S. Bureau of Census, *Statistical Abstracts of the United States: 1970* (91st edition), Washington, D.C., 1970, Table 65, p.53.

[5] This statement is based upon the fact that the trend is toward greater hospitalization and institutionalization of the chronically ill and dying patient. The data for 1960 show that 60% of all deaths occurred in hospitals or institutions. See *Vital Statistics of the United States*, 1958, Vol. II, Table 67, Public Health Service, Washington, D.C., U.S. Government Printing Office, 1960.

The place to which the elderly go to die has recently drawn the attention of medical and social science investigators. Glaser and Strauss (1965, 1968) 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 Kübler-Ross (1969) has interviewed the dying patient in an attempt to understand more fully the many issues and questions that he must confront with the prospect of imminent death.

These and other investigators have directed their attention to the experience of the dying patient and the major problems he presents the institution and the staff responsible for his care. Little attention, however, has been paid to his survivors. Blauner (1966), giving a possible reason for this, points out that the reversal in mortality statistics over the past few decades has given dying and death a different meaning for the survivors. The change in mortality statistics has directly affected family relations. Blauner observes that the death of an elderly person today need not touch the emotional life of his family nor the social life of a community to the same degree that it once might have. The elderly in contemporary society are increasingly retired from gainful employment and other social activities, and they are frequently less central to the lives of their families than were the elderly in the past. The greater life-expectancy today, and the sense of having lived out one's life in full, permit the dying person, as well as his survivors, to accept his death more readily. With the sudden death of a young child or of a husband or wife in the middle years, there is a sense of the deceased having been cheated out of life and of the survivors having suffered a great loss. In contrast to this reaction, Blauner feels that the quality of a person's death in an institutional setting, particularly the death of an elderly person, does not evoke the same kinds of responses that we have traditionally expected of the bereaved. Medical technology not only makes possible the prolongation of life, it is also the basis for repeated and often extended separations of the chronically ill or dying person from his family. Such separations reduce familial and friendship contacts and also serve to weaken social and emotional commitments. The disengagement of the aged from their families prior to their death, therefore, means that their death will little affect the life of the family. As Blauner (1966) has observed, the death of an important social leader, such as President Kennedy, can seriously disrupt the equilibrium of a modern community. The death of the elderly, on the other hand, less relevant as they are to the life of their families and to the functioning of modern society, does not cause such a rupture.

This is not to say that there is no grief felt at the loss of an elderly parent or relative. Rather it is to point out that the degree or intensity of one's grief at the time of the death is a function of the kind of death experienced. A distinction must be made, in other words, between what can be termed a "high-grief-potential" death and a "low-grief-potential" death. A high-grief-potential death can be occasioned by the sudden accidental death of a man or woman upon whom others depend for their physical and/or psychological well-being. Such a death usually will precipitate a series of intense reactions, which Erich Lindemann (1944) has characterized as "normal grief."

According to Lindemann, normal grief can give rise to such symptoms as sensations of somatic distress, choking with shortness of breath, a need for sighing, an empty feeling in the abdomen, a feeling of tightness in the throat, lack of muscular power, and intense distress described as tension or mental pain. In addition to these somatic reactions,

Lindemann noted that the bereaved must contend with other grief related symptoms. The bereaved person will evince a preoccupation with the image of the deceased. He will also feel guilt, and in certain instances, show extreme hostility. Moreover, he may be unable to execute his normal patterns of conduct. The duration of the grief reaction depends upon the success with which a person does what Lindemann refers to as the "grief work"—emancipating himself from his emotional bondage to the deceased and developing new emotional attachments.

When grief symptoms are seemingly absent, on the other hand, it may mean one of two things: either the survivor is suppressing his feelings of intense grief—which is an important but separate issue in and of itself—or, the death did not evoke the emotional reactions Lindemann (1944) has described. A death in which these reactions are indeed absent and are not merely suppressed is a low-grief-potential death. For many people today, the death of an elderly relative occasions only the barest acknowledgement, and such a death might properly be designated as a "low-grief" death. There are many factors which might generate such a response, but one of the most important, we believe, is the phenomenon of "anticipatory grief."

The remainder of this paper, then, will be a discussion of anticipatory grief, and the reasons for both its increasing presence and increasing importance in contemporary society.

As has been pointed out, the death that a family experiences today is most frequently the death of one of its elderly members. Moreover, prior to his death, the elderly member may have been removed from the inner family circle. He may have spent several periods in a hospital or a nursing home prior to his admission to a terminal hospital. In any event, his family has experienced periods of separation from him due to his incapacity or illness. The low-grief response expressed by family members at the time of his death may be due to what has been termed by Lindemann (1944) as anticipatory grief. That is, the 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 (4) attempt to adjust to the various consequences of it. By the time the death occurs the family will, to the extent that they have anticipated the death or dissipated their grief, display little or no emotion.

ANTICIPATORY GRIEF

Anticipatory grief is not a recent psychic phenomenon, nor is it necessarily associated only with death. Both Lindemann (1944) and Rosenbaum (1944) have found what they would describe as genuine grief reactions in persons who had experienced separation due to the demands of military duty. Lindemann cites the case of a soldier recently returned from combat who complained that his wife no longer loved him and that she was seeking a divorce. It was Lindemann's opinion, following a review of the facts in the case, that the soldier's wife had so effectively worked through her grief over his separation and possible death that, emotionally, she had completely emancipated herself from her husband. While this reaction may well form a safeguard against the impact of the eventuality of death or a permanent separation, it is apparent that it has important as well as unforeseen

consequences for survivors. It has been found, for instance, that a great many of those who are released from military service, from jail, or from hospitals cannot be reintegrated into their families; in their absence, their families have established new role relationships which no longer include them. It may well be, for instance, that a significant variable in the poor adjustment of men released from prison, as suggested by their high rate of recidivism, is the fact that their significant others are no longer emotionally capable of incorporating them into the family or friendship circle; they are incapable of giving them the kind of emotional support they need to make a satisfactory readjustment to the outside world (see Glaser, 1964, for a fuller discussion of recidivism).

In each of the examples of anticipatory grief, family members have worked through their grief without a death actually having occurred. Appropriate responses and outward expressions of one's emotions in instances of this sort are at best vague and ill-defined. That is, in our society, it is considered appropriate either to laugh or to cry—or even to behave casually—when greeting a returning serviceman or someone who has been separated for a long time from the family. The only inappropriate response would be to show a lack of pleasure at this return. At death, however, there is a cultural directive for the bereaved to mourn. Joyful, casual, or business-as-usual behavior is considered both inappropriate and disrespectful.

Culturally, as Volkart (1957) has pointed out, we tend to perceive the death of a person as a loss, particularly the death of a close family member. Moreover, we expect the survivors as bereaved individuals, to show grief. We expect this because culturally we feel it is natural, proper, and desirable: natural to grieve, proper to show respect, and desirable to purge ourselves of the grief. The question of whether grieving is internally motivated or externally induced is generally not an issue with us. We assume that any observed behavior and the feelings that we impute to that behavior express the relationship between the deceased and his survivors. Regardless of the actual relationship that might have existed prior to the death, we tend to idealize the relationship once death has occurred, and to expect expressions of normal grief.

This is an expectation held not only by the average man, but it is held also by members of the medical profession. They have accepted and internalized these conventional categories of thought long before they became nurses or doctors. There is growing evidence that medical personnel who have attended the deceased patient are highly critical of his family members and friends whose behavior appears to be inappropriate, incongruous, or callous; they are responding negatively to family members who display such seeming disregard for their dead relatives.[6] To the extent, however, that such behavior is due to anticipatory grief, it is important for medical personnel and other social caretakers to temper their reactions and withhold their judgment of the survivors. To respond angrily, or in any other way show disapproval of the behavior of the

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[6] At a recent symposium on the terminal care of the dying, a hospital staff member expressed strong objections to what she described as the callous behavior of family members upon the death of an elderly relative. She found their behavior so characteristically indifferent to the deceased, particularly at the funeral, that she publicly called for their exclusion from the funeral. Moreover, she proposed that the funeral itself should be conducted from the hospital in order to allow for attendance of the hospital staff members, who according to her, were usually more concerned over the death of one of their patients than was the bereaved family.

This observation has been increasingly echoed in comments directed to the senior author by nurses and hospital staff members as well as by nursing home attendants and funeral directors over the past few years.

survivors, is to act in a lay rather than a professional manner, possibly aggravating an already troubled situation. What must be appreciated here is that the survivors themselves can be just as surprised and just as disturbed by their lack of response at the death of a close relative or friend as are the medical personnel. The absence of any feeling for the death can be very disturbing to the bereaved, and in the face of the cultural directive to mourn, can be conducive to a sense of guilt or a feeling of shame.

Lifton (1963) documents a similar guilt reaction in his study of the survivors of the atomic bomb in Hiroshima. In recounting the life history of the *hibakusha*, as the Hiroshima survivors are called, a significant aspect of their psychological reaction to the horror and chaos that they experienced was a closing-off of their capacity to feel or to respond to the condition of others. While, as Lifton points out–and it is a point to be stressed–psychological closure permitted the survivors to function in the situation and to do what they could for themselves as well as for the injured and dying, it was, Lifton believes, nevertheless an element in the shame and guilt that swept over these survivors afterwards. Their failure to respond to an event as profoundly tragic as Hiroshima was for them a mystifying as well as a demoralizing experience. How could anyone continue to live, eat, and sleep in the face of such a cataclysm? How could anyone go about the daily task of disposing of corpses, comforting the dying, or rendering assistance to the injured without shedding a tear? The psychological closure that Lifton discusses in his essay appears to mirror the protective function of anticipatory grief, as well as to reflect its similar consequences. That is, the *hibakusha* were unable to feel any grief at the time it was expected of them, and in reflecting upon this, they suffered an extreme sense of guilt. In situations in which grieving is considered appropriate, we not only expect it of others, but they also expect it of themselves. The *hibakusha* responded with guilt and shame at having gone through the death experiences of others with little or no feeling.

One of the unanticipated consequences of anticipatory grief, therefore, is the undeserved critical judgment by others, as well as the critical judgment of one's self.

That such psychological factors are at work is illustrated in the research of Natterson and Knudson (1960) in which the responses of 33 mothers of fatally ill children were studied. They reported:

> Initially, most mothers (25 of 33) were tense, anxious, withdrawn and readily inclined to weep. They reacted in a disbelieving manner, tending to deny either the diagnosis of the disease or its fatal outcome. They wanted to be with their children as much as possible, often tending to cling to them physically. This staying with the child was sometimes without much regard for the needs of the remainder of the family. Hope for the child was stressed, but in a nonspecific way–"Something will be discovered." They wanted, often in an irrational manner, to try anything in the way of new treatment that might offer hope for a cure (p 459).

After a period of more than four months, 16 out of 19 mothers whose children subsequently died showed calm acceptance of the child's anticipated death. As Natterson and Knudson describe it:

> These mothers gradually became less tense and anxious. They stopped denying the diagnosis or its prognosis. Their hope for the child became more specific, often related to particular scientific efforts. A considerable interest in the investigative program often developed at this time. There was a tendency to see the medical problem in its broader aspects, with the beginning of an expressed desire to help all children. Mothers during this period tended to cling less to their own children, encouraging them to participate in school or occupational therapy activities. They often helped in the care of other children on the ward and were generally more social. They spoke

> more about fulfilling family obligations. In most instances, this reaction gradually gave rise to (a) calm terminal reaction . . . (p 460).

While Natterson and Knudson chose to describe the change in the mother's attitude as one of "sublimation," we are prone to suggest that what they observed among the mothers was anticipatory grief.

In sharp contrast to the mother's behavior was the behavior observed among almost all staff members. Initially the staff members' reactions to a particular child were not marked. But, as the staff became increasingly involved in the child's problem, they were prone not only to exert themselves more on the child's behalf but also were reluctant to forego any program of medication that might prolong the child's life. Upon the death, it was noted that the staff became depressive, guilty, and self-examining. Such a disparate reaction between the mothers and the staff is potentially fraught with difficulties. Not only were they out of phase in their response to the death of the child, but also the emotional response of the medical staff in the terminal stage of the dying could well serve to generate a sense of shame or guilt in the mothers who had worked through their grief. The inability of the medical staff, moreover, to remain dispassionate in the face of what is readily recognized as a tragic death, threatened not only to interfere with their medical judgment regarding reasonable measures in the situation, but also served as a marker of appropriate behavior for the mothers and invited a sense of shame or guilt among those who could not generate comparable feelings.

In a retrospective study of 20 families whose children died of leukemia, Binger et al. (1969) confirm the anticipatory grief reaction of the parents as reported by Natterson and Knudson. However, the reaction of some of the physicians they observed to the child's death was opposite to the reaction observed by Natterson and Knudson. They write:

> The professional has his own problems in coping with the imminent death of a child. He is distressed and often feels guilty about the failure of therapy. Simultaneously he is troubled by his own fears and anxieties about death and feels inadequate to support the dying child and his parents. Faced with these conflicts he often avoids the patient or family or makes himself unapproachable by presenting a facade of busyness, impatience, or formality. Thus at a time when most needed, the professional often assumes a neutral or even negative role in contacts with the family of the dying child (p 415).

It was reported by these researchers that more than a quarter of the families believed that the physician and staff members became more remote as the child's condition worsened. Not only was the child physically more isolated (a precaution taken because of leukopenia and the chance of infection) but he was actively "avoided" by the staff as well.

It should be noted that the origin of the physicians' responses in the Natterson and Knudson study as well as in the Binger study were in fact the same. Both studies report feelings of inadequacy, guilt, and anxiety among the physicians at not being able to keep the child alive. The differing manner in which the physicians chose to respond to these similar feelings points up the lack of appropriate behavioral norms for physicians in the face of death.

Binger et al. conclude that when professional personnel understand the attitudes of the parents and are prepared to respond to their needs, they will become a valuable source of help to the family *instead* of getting caught up in a situation laden with mutual hostility and recriminations.

Another finding of the Binger study underscores the need for medical personnel to understand the dynamics of grief in order to assist families in such circumstances. The researchers found that in 11 of the 20 families, one or more members had emotional disturbances severe enough to require psychiatric guidance. None, they report, had required such help before. The emotional disturbances included:

> several cases of severe depression requiring admission to a psychiatric hospital, a conversion reaction wherein a man was temporarily unable to talk, severe psychoneurotic symptoms and behavioral changes in siblings. In some of the other families milder disturbances were also reported in both the adults and the children (p 417).

It is the conclusion of Binger and his colleagues that supportive therapy and counseling for parents and siblings should be considered an essential aspect of total care so that such untoward reactions to death as these can be both understood and prevented in the future.

But perhaps the most significant implication that anticipatory grief has, is for the dying patient himself. While he, along with his survivors, must come to *accept* his illness and his death, it is a problematical thing for him to know whether his survivors are in fact concerned or grieved at his dying. While the answer to this question can only be found within the context of a specific case, there are indications that suggest that this question will loom larger as more and more elderly people, in particular, are removed to nursing homes or terminal hospitals. While conclusive evidence is lacking at this time a number of observers have noted that the visits of family members to chronically ill or dying patients in hospitals or nursing homes diminish in frequency and length soon after their relative is placed in the institution. Riley and Foner (1968) report, moreover, on the basis of different studies, that a disproportionate number of deaths occur among elderly patients soon after commitment to an institution. While it is, of course, possible that the timing of placements in institutions may be due to the severity of the illness of the patient, nonetheless it is also possible—and deserves more careful study—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. Leiberman (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 it was on the waiting list. He concluded, 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 this phenomenon.

In the case of the leukemia victims, we have seen that two grief trajectories can operate in the situation of the institutionalized dying patient: as the family comes to accept the death, their emotional involvement diminishes or becomes intellectualized and diffuse, whereas the medical staff may become caught up in the drama of the death and their emotional investment in the patient may increase (Natterson & Knudson, 1960). The turning away of family members at this time, in a psychological as well as a physical sense, can create an insurmountable problem for the patient. At a time when he needs the support, comfort, and reassurance of his family, the phenomenon of anticipatory grief can serve to block such support. The absence of tears or 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.

In response to the difficult problems inherent in this situation, several different medical centers are sponsoring programs in grief therapy with the hope that para-medical

personnel might play a supportive role as surrogate relatives. While this well-intentioned effort is prompted by the highest ideals of medicine and social service, its consequence may be to aggravate an already difficult situation. It seems to us that the professional functionary could play a more valuable role, once he himself understands the dynamics of anticipatory grief, by explaining and interpreting the phenomenon to the patient, as well as to his relatives and friends. The patient would be better served if his relatives and friends were to be drawn back into an enlightened relationship with him rather than, as it appears to be proposed, that they be replaced by well-meaning but nevertheless professional sympathizers.

It should be quite apparent that the task of dying is not simply a polite exchange of confidences or an expression of affection or concern. Dying involves the taking of one's leave from all of those who have been important to the one who is about to die. The array of questions and issues dealing with such disparate concerns as: the education of a grandchild, the marriage of a daughter or niece, the disposition of a ring to a favorite cousin—to say nothing of how old friendships and animosities are to be concluded—can only be the business of the dying patient and those members of his family or friendship group that are immediately and directly involved. To propose a program of professional intervention for more than those patients who are completely without relatives or friends is, in the face of the total number of dying, to assume what would eventually be an impossible task, as well as one which ultimately would defeat its own purpose.

Finally, the effects of anticipatory grief are felt again when the family confronts the funeral. Traditionally, the funeral has served not only as a ceremony to dispose of the dead, but also it has been recognized as a supportive and integrative ceremony which aids the bereaved to reorient themselves from the shock of death (see Mandelbaum, 1959; Malinowski, 1938). The funeral, moreover, has had other functions, which, while not readily perceived or understood, are nevertheless important (see Fulton, 1971). For instance, reciprocal social obligations are often reinacted and reinforced in the course of a funeral. In this way, the role of a participant not only reflects his position in the community but the community structure itself is also reaffirmed. Moreover, funerary expectations pertaining to dress, demeanor, and social intercourse both declare and reconfirm family cohesion. The family and the larger kinship system are also acknowledged at the time of a death. Distant family members, moreover, are not only expected to console the immediate survivors, but may also share in the expenses of the funeral. Through the participation in a funeral, an individual is presented with and reminded of the various parts and personnel of his social world. The visitation or wake, the funeral service, the interrment or disposal service, and finally the concluding family meal all serve to invoke a sense of being part of a larger social whole, just as the observed order of precedence in this rite of passage reminds one that there is structure and order in the social system.

The death of a person today, however, is perceived by some as simply a matter of disposal. As Blauner (1966) has pointed out, the role of the elderly in contemporary society no longer necessitates a funeral for them such as we have just described. The decline in religious beliefs, moreover, and the strong impetus toward worth (associated or identified with one's contribution to society), have merely added to this trend.

We would argue that the phenomenon of anticipatory grief is also an important variable in this development. A survivor who is emotionally emancipated from a deceased individual will not necessarily feel that the traditional funeral rite is an appropriate

response to the death. Rather, he may well believe that the expeditious disposal of the body is most in keeping with the prior reduced status of the decreased, as well as with his own feelings and desires. Anticipatory grief in this context may have positive consequences for the survivor. He has anticipatorily accepted the death and is able to function in his new social environment without the deceased present. To the extent that this is so, he is tempted to dismiss those things associated with the funeral which historically have served as a religious or social aid to his understanding of the death, as well as an aid to his adjustment to it. But, as we have tried to suggest, the funeral offers somewhat more than that. The funeral, like other rituals, ceremonies, rites of passage, pagents, and festivals, serves to reinforce a sense of community as it fashions and refashions social bonds. A recent national study (conducted by the senior author) concerning contemporary funeral practices shows that in certain areas of the country, particularly on the East and West costs, there is a tendency for families to modify traditional funeral rites to the point where no one except the immediate members of the family are present. In addition, there is a tendency with such privitization of the funeral, to modify mortuary rites to the barest requirements including, in some instances, the elimination of the public death notice itself. While it is probably not true that the traditional funeral will wither away in contemporary America, as Blauner suggests, there is indeed evidence to suggest that for great numbers of people it will be significantly different from what it has been.

It is our contention that the phenomenon of anticipatory grief serves to play a large part in this transition, inasmuch as it allows the survivors to make new and different decisions about the disposal of their dead. Although the phenomenon of anticipatory grief can be functional for the adjustment of the immediately bereaved, it may, as we have pointed out, be dysfunctional for the dying patient as well as for the extended social group. In the case of the privatized funeral, for example, another set of behaviors is attenuated–a set of behaviors which have served historically to maintain and enhance familial, friendship, and community relationships. The failure to acknowledge a death publicly not only has humanistic implications for our identity and worth as human beings, and political implications for our status as citizens, such a failure also closes off still another avenue where sympathy, love, and affection may be given and received.

CONCLUSION

As a psychological phenomenon with social consequences, anticipatory grief, as we have tried to show, confronts us with a two-edged effect. It possesses the capacity to enhance our lives and secure our well-being, while possessing at the same time the power to undermine our fragile existence and rupture our tenuous social bonds.

It has been the intention of this paper to point out these implications of anticipatory grief so that we may better understand its functioning. In doing so, we may succeed in turning it to our account rather than to suffer its consequences through our ignorance or misapprehension of its role in our lives.

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THE REACTIONS OF FAMILY SYSTEMS TO SUDDEN AND UNEXPECTED DEATH[1]

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This paper describes a portion of the clinical material gathered from the first year of a four-year research grant,[2] studying the application of crisis intervention techniques to bereaved families as a means of primary prevention. The hypothesis of this study is that intervention at the time of a sudden death will reduce the higher morbidity and mortality rates found by other workers (e.g., Rees and Lutkins, 1967) to occur in the surviving family members.

The focus of the present paper is to discuss some of the concepts that have evolved during our work with bereaved families. These concepts have given us a line of vision which makes clear the kinds of aid that can be offered and accepted, and that will, hopefully, prevent further disorganization in these families which are already in crisis. Specifically, the study centers around the interactive patterns between the family and society, which determine whether or not the family is open to intervention, and the variables operating within the family itself that affect the immediate reaction to the death as well as its eventual reorganization.

Our main working assumption is that families are more than the composite blood or marriage related group that can be counted in fixed terms. Rather, we see the family as a dynamic entity—constantly in flux—accepting and rejecting such diverse members of the community as the minister, the mother-in-law, the babysitter, the doctor, etc. (Polak, 1970). It is this natural group of people with whom we do our work.

The families we see are identified through an arrangement established with the coroners of Denver, Arapahoe, and Jefferson counties in Colorado. The families who consent to participate in the research project are being randomly assigned to a Crisis Intervention Experimental, or a No-Intervention Control Group. An additional matched group of families who have not experienced a recent death will serve as a No-Crisis Control Group.

Those families who have been assigned to the experimental group are contacted by the intervention team within at least 12 hours after the death. Usually, the team accompanies the medical examiner on his routine call to the home of the surviving family members. If the family agrees to participate in the study, they are seen for two to six sessions over a period of one to ten weeks, with the total family or social system being involved in the treatment. This short-term intervention is aimed at increasing the effectiveness of the family in coping with feelings, decisions, and subsequent adjustment related to the death.

Recognizing that there are many inherent problems in the evaluation of a broad-action

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program, such as the present study, assessment is being geared more toward a field approach whereby the focus is not simply to test the hypotheses already formulated, but to suggest new ones as well. Thus, the assessment instruments were designed not only to obtain standard measures of outcome, but also to get qualitative and process-oriented data. The general areas chosen for evaluation are: (a) medical illness; (b) psychiatric illness; (c) family functioning; (d) crisis-coping behavior; and (e) social cost estimates. These areas will be measured six and eighteen months after the death for families in the Crisis Intervention Experimental and No-Intervention Control Groups. For the No-Crisis Control Group, the measures will be taken at initial contact with the families and again one year later.

It might seem presumptuous to describe assessment procedures and data collection when one stops to consider the problem created by strangers entering into a family system at a critical time, such as the event of a sudden and unexpected death. This problem gives a good illustration of the necessity of keeping in mind the fact that, just as an individual can be viewed as part of a family social system, the family must be seen as part of the larger social system. The manner in which a family incorporates societal values into its own familial value system has implications for family success or failure in readjustment after the death.

We have found our work to be most effective with those atomized, nuclear families, who are accustomed to the idea of professionals and experts from whom they willingly accept advice and support. These families have very direct lines to the mass society through its organs of communication and its accepted interactive patterns. They are club members, social churchgoers, and *Life magazine* readers, who conform enthusiastically to the expressed Weltanschauung of middle America. In the absence of the closely knit kin network of fifty years ago, they have their club and professional organization memberships; in the absence of neighborhood assistance, they hold considerable insurance against sudden need or tragedy; in the absence of grandmother's homilies on child-rearing, they have Haim Ginott; and in the absence of strong family traditions about death, they are open to expert intervention. The mortuary initially provides this professional guidance and sets norms. Its implicit messages include: "The 'body' is not to be touched"; "Be quiet–decorum is to be maintained"; or, "Experts are essential to the process surrounding death–to prepare the body, to properly bury it; you are unqualified in this area–defer to us." "To fulfill societal expectations," they say, "these things must be done." And they generally are, regardless of the emotional or monetary cost to the family. In the event of suicide, the family is most vulnerable. Suicide, unacceptable in the pervasive Judeo-Christian ethic, is seen as bringing shame to the family. As a result, natural mourning evoked by the loss is effectively blocked and superseded by guilt. Anger, which is normally veiled and only symbolically expressed in the larger culture to which they are finely attuned, likewise remains unexpressed. Further, anger toward a dead person is widely felt not to be legitimate and is only experienced with great discomfort.

These families, though in many cases financially well-prepared for death, are profoundly unprepared for its emotional impact. The topic of death creates a vague uneasiness which comes from a leery attitude toward againg, and an aseptic approach to the body. Death is the opposite of unblemished skin, white teeth, and regular bowel movements. The vast inexperience and overrefined sensibilities around the physical aspects of death precludes, in many cases, coming to grips with the emotional reality of

eventual or immediate loss. These families, it seems, in the absence of secure and deeply ingrained patterns of coping with real-life crises, and in a situation where their cultural norms are minimal, inefficient, contradictory, or even nonexistent, have a battery of professionals on call to correct what otherwise would remain a raw and painful wound. The families have, in other words, a "contrived" social system from which semi-symbolic gratification of needs is provided on a new model, functionally suitable to current societal reality. Since they trust experts, knowing that they themselves are competent in only one or perhaps two fields, we are most cordially accepted into the "contrived" social system in which they move. As a result, we have been able to give much aid in terms of emotional support, advice, practical help, and guidance, but we have always had the feeling that they would have obtained other aid without much trouble had we been unavailable. These people are the successful "converters" of our culture.

There are, of course, families in the aforementioned group who interact a great deal with the larger social system, but do not become mirrors of it. They are able, on the one hand, to become aware of the cultural norms and values in the area of death, but somehow they are able to assimilate only those values consonant with the goals and priorities of the family system, discarding the others. On the other hand, this pattern of open but selective interaction makes many support systems, such as religious and fraternal organizations, friends and neighbors, etc., available to the bereaved family, permitting successful use of these resources.

With families who are part of a cohesive cultural subgroup, our success has been less than overwhelming. In contrast to the families mentioned above, we have been intimidated by the sheer number of mourners, by clearly competent friends and neighbors, and by the ease and grace with which these families function at the time of a death. We have found ourselves ornamental at best, and awkward, isolated bumblers at worst. We have been impressed with the fact that, in these families, children are not shunted aside, but carry on in their usual loosely supervised and irrepressible manner–crying, laughing, playing, or whatever. We have seen that the body is not isolated (nor referred to as the "body"), rather, it is touched and wept over freely. We have seen emotional needs met swiftly as they occur. It seems that families who are members of a cohesive subculture are clearly closed to the mass society, in terms of their supreme inability to adhere to the larger norms and values about death. Yet, in their small subculture, there exist norms which most adequately serve needs arising during a crisis of this sort, which allow for extreme expression of grief or anger, and, in general, accept feeling. In this natural structure comprised of family, friends, and neighbors, death becomes again what it once must have been–a highly functional rite of loss and grieving. In its immediate despair and disorganization, death is a deep confirmation of life and of the necessity of human cooperation.

There is still another group in which the families are atomized and nuclear, but interact neither with contrived nor natural social systems which might be called on for help in time of need. They have no club memberships, no huge kin system, no ministers, no bridge parties, and no neighbors who are known to them, even though there are people living on each side of them. In general, they have minimal social contact. They are tied up in their family exclusively, and any outside interests are regarded more as an intrusion than a pleasurable diversion. These isolates have every chance of incurring the physical and mental breakdown seen possible among survivors after a death. These families, with such meager resources, can bankrupt themselves in time of tragedy. It is our hypothesis

that these are the families who need aid and support more than any others; but the task is difficult. Their resistance to outside help is as great as their need.

It would appear then, in general, that the degree to which families allow for and benefit from outside intervention is a function of their incorporation of the norms and values of the larger society into their own familial value system.

Up to this point, we have directed our attention to different ways in which two social systems–the family and society–interact, and the effect this has on how a particular family will respond to a death, as well as that family's willingness to accept and make use of outside intervention. Our focus will now shift to an examination of processes within the family that influence the course of bereavement and subsequent readjustment.

We have found that families with open internal communication systems are more prone to resist the societal taboos surrounding the area of death, and are thus more likely to discuss and make realistic plans for the death of their members. A family that consistently deals with stress by attempting to assess and absorb the reality components of the situation rather than by trying to deny them, is certainly able to cope more effectively with the immediate crisis that a sudden death precipitates. The degree to which it is permissable to express feelings of sadness and loss, as well as the less acceptable reactions of anger, guilt, and relief, seems to play a large role in determining the success of the readjustment period.

These coping patterns are examples of some variables of internal organization within the family system that affect the way it deals with the sudden and unexpected death of one of its members. Our experience to date shows, however, that the single most important factor in the reorganization of a family as a continuing social system following a death, is the role the decedent had been assigned, and which he assumed within the family system.

The resumption of adaptive functioning, following a death, is facilitated in a family where vital roles and functions have been apportioned among members in a just and equitable manner for optimal comfort and satisfaction in their performance. This type of apportionment occurs when roles are assumed according to individual need, ability, and potential. In such a case, role assumption is usually explicit and well understood by all family members. When a member of this type of family dies, the critical period of reorganization is not likely to be experienced as a crisis because the family already has a built-in process which allows it to reallocate the role functions of the decedent with minimal difficulty.

No matter how equitable and explicit the role distribution in a family system, the exact number and type of roles held by the decedent influence the degree of difficulty experienced by that family in its attempts at readjustment. For example, in comparison to a child, an adult assumes primarily instrumental or task-oriented roles. Some of these, like the role of the breadwinner, can be troublesome and time-consuming to reallocate if the skills necessary to fill that role are not available among the surviving family members. On the other hand, the death of a child, while precipitating a lengthy and intense period of emotional stress, usually does not necessitate an extensive period of role reorganization, since children have roles that are primarily expressive or social-emotional in nature.

This is not to imply that expressive roles are easier to redistribute or that they can be left vacant for longer periods of time without repercussion. The death of a family

member whose role was essentially expressive can often times lead to disaster, particularly if the function of that role was to camouflage or resolve a conflict existing within the family system. Take the death of a child, for example. If the child created a distance between the parents or, conversely, if he was a catalyst to stimulate otherwise dormant feelings in order to keep the family emotionally extant, his death would severely tax the family's already inadequate resources to deal with stress, provoking further disorganization and maladaptive behavior.

Expressive roles, particularly those that encompass some type of deviant or unacceptable behavior, are usually assumed on the basis of much more ambiguous criteria than age or sex. A role can be classified as deviant either by the particular norm system of the family or by the one that the larger society employs. If the family member that dies was always a little different from the others–if he never quite fit in–the phase of readjustment will be relatively brief and minimally stressful. This is because the decedent, prior to his death, had already been extruded from the family system, and had held a role perceived by the family as nonfunctional in terms of its own value system. Often it is the deviant, as defined by society, who plays a dysfunctional role in the family. Alcoholics, for example, sometimes become not only uselss to their families in the sense of having ceased to provide either tangible or emotional support, but also become a liability in terms of draining family resources and provoking community censure. Their deaths demand little, if any, need for role reallocation in a family and often engender a sense of relief.

At other times, however, rather than being dysfunctional, the alcoholic, the suicide attempter, or the hysteric–any symptomatic person, in fact–performs one of the most vital role functions for the maintenance of the entire family structure. That crucial role is to symbolize and represent a disturbance in the family social system. The death of that person sets off a process in the family, parallel to symptom substitution in the individual. Symptom substitution has been described by some as the replacement of one set of behavior, thought to express or represent some inner conflict, by another set whose function is identical. This phenomenon occurs when the inner conflict is not resolved, but the symbolic representation of it in behavioral form is discouraged or extinguished in some manner. A similar process has been observed in the family social system. Many family therapists have documented the spontaneous development of symptoms in one family member when those of another member have shown remission during the course of treatment. When the symptomatic member of a family dies, however, his role is not redistributed so easily. His family system, already by definition functioning in a precarious and faulty fashion, will be forced to undergo an extensive and painful period of readjustment which, if unsuccessful, either in terms of reassigning his role or working through the original systems conflict, will eventuate in the collapse of the system.

This paper has described a research project designed to test the effectiveness of crisis intervention techniques, as a model for primary prevention for bereaved families. We have discussed these families' immediate reactions to death and their subsequent reorganization in light of two factors: the interaction pattern that exists between the family and the larger social system, and the one that prevails within the family system itself. Our observations to date have suggested that the degree to which a family will accept and benefit from outside intervention at the time of a death is a function of its incorporation of the norms and values of society into its own familial value system. In

addition, the type of system–coping patterns employed by the family, as well as the role the decedent had assumed within the family system, have been found to be critical variables that influence the course of bereavement and subsequent readjustment.

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CHILDHOOD BEREAVEMENT AND BEHAVIOR DISORDERS: A CRITICAL REVIEW[1]

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Interest in childhood bereavement is part of a growing concern with the meaning that dying and death have for modern society. Increasingly, medical and social scientists are turning their attention toward the issues and problems associated with contemporary mortality. Despite the early work in psychology by Freud, Hall, Schilder, and Bromberg, and the anthropological investigations of such scholars as Rivers, Bendann, Puckle, and Lee, it was not until the 1930's that Eliot (e.g. 1930, 1932) called for a more empirical and analytical study of grief. It was only during World War II, however, with the publication of Lindemann's (1944) classic paper, "Symptomatology and Management of Acute Grief," that the medical, psychological, and sociological significance of bereavement were conjointly studied. Since that time, medical and social science literature has displayed an ever-increasing number of essays and studies in the area of death, grief, and bereavement.

In order to answer the question of whether a causal relationship exists between childhood bereavement and later behavior disorders, we will review the literature on this subject, and discuss the substantive findings as well as the methodological problems of previous research. In addition, preliminary findings of an exploratory study conducted this past year at the University of Minnesota will be presented.

Concern with the consequences of parental loss has been stimulated by the theories and observations of such psychoanalysts as Freud (1917), Deutsch (1937), Klein (1948), and Bowlby (1960, 1961). The importance that they attributed to the early parent-child relationship has given rise to the assumption that the rupture of this relationship by death or desertion seriously impedes the emotional development of the child. Sociologists, aware of the changing structure and function of the modern family have suggested, moreover, that such a loss is likely to be more traumatic today in our limited nuclear families than was formerly the case when the traditional extended family was the rule (e.g. Eliot, 1955; Volkart & Michael, 1957). Like other social losses, death disrupts an ongoing social order. The bereaved individual must face not only a personal loss, but also a disruptive vacancy in his social system. Bereavement differs, however, from other social ruptures—such as desertion, divorce, and separation—since death is fundamentally more mysterious, as well as completely irreversible.

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RESEARCH STRATEGIES

Four research strategems have been used to determine the degree of association between childhood bereavement and later behavior disorders. They are: observations of recently bereaved children; clinical case studies; anterospective or follow-up studies and retrospective studies. Each strategy has its own peculiar advantage as well as its own limitations.

Direct observation of children recently separated from their mothers has provided much information about the consequences of parental deprivation (e.g. Bowlby, 1966; Yarrow, 1961). Such studies have, in general, concurred that developmental retardation of an indeterminate duration and reversibility result when the mother-child relationship is interrupted at an early age. The principal weakness of such studies, however, is their inability to provide information on the later consequences of deprivation; their conclusions are applicable only to the duration of the study.

Clinical case studies, primarily of psychiatric patients, have provided a second source of information regarding the possible effects of childhood bereavement. These case studies have prompted researchers to attribute etiological significance to early bereavement for certain emotional disorders in later life. While such inferences are valuable as guidelines to research, the unrepresentativeness of such samples seriously impairs the possibility of valid generalizations to the larger normal population.

The anterospective approach attempts to follow into adulthood a group of bereaved children and a group of non-bereaved children, noting differences in rates of behavior disorder. This strategy potentially provides a means of discovering why some bereaved children do not become maladjusted. While the anterospective approach is the method which permits the researcher to make the most comprehensive kinds of statements of any of the four methods mentioned, such studies, unfortunately, seldom have been undertaken. The reasons for this are due to the prohibitive cost in time and money, the loss of original cases over time, and the possible changes in the theory and method of the study from the time of its inception to the time of its interpretation (Gregory, 1965).

The retrospective approach compares the past histories of two or more groups of adults in order to determine whether they differ with respect to incidence of childhood bereavement. For instance, a group of diagnosed schizophrenics would be compared with a group of normal adults. Retrospective studies permit a comparison of adult behavior with childhood bereavement, and usually employ large numbers of cases. They have been considered to be more effective tests of the "bereavement and maladjustive behavior" hypothesis than either the direct observation approach or the clinical case history method. The evidence we have of the long-term effects of childhood parental bereavement, therefore, is derived primarily from retrospective studies. Because of this fact, let us mention some of the methodological difficulties that have beset such research and, with these limitations in mind, review briefly their substantive findings.

METHODOLOGICAL CONSIDERATIONS IN RETROSPECTIVE STUDIES

Several methodological problems of retrospective studies seriously limit the validity and usefulness of the findings. These problems include difficulties in obtaining "normal" bereavement rates, problems in selecting psychiatric patients for comparison with "normals", deficiencies in data gathering, failure to consider demographic factors, failure

to consider intervening variables which would affect the cause-effect relationship, inadequate use of statistical tests of significance, and fallacious deductions in interpretation.

The problem of establishing normal bereavement rates, against which to compare rates observed in psychiatric samples, is due to the fact that there is no consensus as to which kind of population to use as the normal control population. Retrospective studies have used three sources in order to establish a so-called normal bereavement rate: nonpsychiatric medical patients, actuarial figures, and rates from general population samples. Dennehy cites several studies which question the use of medical patients as representative of a normal population. She indicates that high percentages of medical patients have no discernable organic pathology, and she suggests that disguised or repressed psychiatric problems prompted them to seek medical attention (Dennehy, 1966). Pitts et al. (1965) discuss the limitations of actuarial figures by arguing that such figures underrepresent lower-class people who do not carry life insurance. Because of the sampling techniques employed, general population samples usually fail to satisfy the criterion of representativeness. The only nationwide source of information on normal bereavement rates has been the 1921 British census, but serious discrepancies are found in the various studies which employed it (Brown, 1966; Hopkinson and Read, 1966).

Unfortunately, data on orphanhood were not obtained on subsequent British censuses. In other, smaller population samples, few researchers have controlled for such factors as ethnicity, socio-economic class, religion, marital status, or residence. Some studies have used as their population sample such unrepresentative groups as medical students (Ingham, 1949), college students (Lidz & Lidz, 1949), and state mental hospital employees (Oltman et al., 1952).

Another common problem in retrospective studies is the selection of psychiatric cases. Virtually all of the studies which were reviewed divided patients into conventional diagnostic categories, despite the fact that the validity and reliability of such categories have been repeatedly questioned. For this reason, comparison of studies of the same diagnostic entity is hazardous. Psychiatric patients, moreover, have been drawn generally from a single institution or from a private practice (Hilgard & Newman, 1961, 1963; Pollack, 1962). Selective factors may be operant in either case, since specific institutions and practitioners cater to populations in delimited geographical locations and within narrow socio-economic strata. Since bereavement rates and behavioral pathology vary according to demographic characterics of the population, findings cannot be generalized safely. Hilgard and her colleagues, for example, have published several studies using both controls and patients from exclusively urban, white populations (Hilgard & Newman, 1961). Pitts et al. (1965) note that governmental institutions obtain patients from predominantly lower socio-economic strata and question comparison with normal rates derived from general population samples or actuarial rates.

Deficiencies in data gathering have compromised the validity of many retrospective studies, and the variety of techniques used have precluded comparisons. The major sources of information for retrospective studies are interviews, questionnaires, and case records. In interviews with either patients or family informants, investigators must rely upon the memory, lucidity and goodwill of the patient or relative. Patients may be embarrassed to admit parental desertion and instead claim that the parent died, resulting in an overestimation of the bereavement rate. Questionnaires may be useful, but without an indication of the return rate, their value is uncertain. High rates of nonreturn may

reflect selective factors which merit consideration in analysis and interpretation. Also, without some evidence that the wording avoided some of the frequent methodological problems observed in anonymous questionnaires, the value of the findings is dubious. Case records, which are used in the majority of retrospective studies, are likely to be grossly inadequate means of ascertaining childhood bereavement rates. Such records are seldom compiled for the specific purposes of the research; therefore, the frequency with which cases must be discarded because of inadequate information is often very high. Blum and Rosensweig (1944), for example, discarded fifty percent of their records because they lacked certain data on the siblings, while Wahl (1956) discarded nearly one-third of his records. Many studies do not report the number and percentage of discarded cases, thus possibly introducing a selective bias into the sample which remains. As Gregory states: "Such information (i.e. for hospital records) is often obtained from parents, particularly in the case of unmarried patients, and there is every reason to believe that a higher rate of parental deprivation might well be found among those patients' records which investigators have been obliged to discard on account of inadequate information" (Gregory, 1958).

Several researchers have criticized retrospective studies for failing to consider such secular, demographic trends as the generally declining death rate and the differential distribution of death rates among various sections of the population. For example, Oltman et al. (1952) argue that if the control and patient groups are not carefully matched according to age, the difference in bereavement rates may be misinterpreted. Likewise, Gregory (1958) cites evidence that atypically high bereavement rates are observed in the lower socio-economic strata, among immigrants from certain countries, and among children whose parents are above average age. The importance and difficulty of controlling for such secular factors when obtaining control and patient groups constitutes a major limitation of the retrospective design.

Retrospective studies are based on comparing the presence or absence of specific factors in two groups at two points in time. In the case of the behavior disorder hypothesis, we compare the presence or absence of behavior disorders at the present time, and the presence or absence of parental loss in the past. Such a research design, therefore, runs the risk of making an unwarranted causal connection between the two factors and neglecting the possible presence of an intervening variable. Any attempt to assess the causal importance of a single traumatic experience in childhood for a specific behavior pattern in later life must consider the possible effects of intervening experiences. It must be noted that not all children who suffer early bereavement manifest later behavior disorders. The explanation for their freedom from traumatic aftermath may lie in such intervening experiences as the nature of the pre and postbereavement home environment, the circumstances of the death, and the emotional characteristics of the surviving parent. If a retrospective study fails to acknowledge such potentially important factors, its basic design is inherently limited.

In his comprehensive methodological review, Gregory (1958) states that almost no adequate statistical tests of the significance of the observed differences in bereavement rates, have been utilized in presenting figures on parental deprivation. In most studies published since Gregory's review, however, researchers have demonstrated greater statistical and methodological sophistication. Such statistical sophistication is meaningless, however, as long as *any* of the problems mentioned earlier are still present in the research design or in the data-gathering process.

FINDINGS IN RETROSPECTIVE STUDIES

Turning from an examination of the methodological problems that have plagued retrospective studies to the substantive findings that these studies have generated bears out our initial reservations concerning the adequacy of the method. Numerous studies among schizophrenic patients, for example, have shown higher childhood bereavement rates among the patient group than among the control group, (e.g. Barry, 1939; Berg & Cohen, 1959; Blum & Rosensweig, 1944; Dennehy, 1966; Hilgard & Newman, 1961; Lidz & Lidz, 1949; and Wahl, 1956). The opposite findings were reported in several other studies: (Brill & Liston, 1966; Granville-Grossman, 1966; Frazee, 1953; Lystad, 1959; Neilson, 1954; Oltman, et al., 1952; Munro & Griffiths, 1969; Pitts et al., 1965; and Schofield & Balian, 1959). Obviously, no conclusions can be ventured on the possible etiological significance of early parental loss for later schizophrenia, until the discrepancies among the findings are resolved. Hilgard and Newman (1961) used for their control group an urban community sample; Granville-Grossman (1966) used nonschizophrenic siblings of his patients as the control; Oltman (1952) and her colleagues administered an anonymous questionnaire to state mental hospital employees; Pitts et al. (1965) used a matched, stratified sample of medical patients; Wahl (1956) used inductees into the Navy; while Dennehy (1966) relied on the 1921 British census data. A similar diversity is observed with respect to data collection and data analysis techniques.

Studies of depression also report discrepant findings. Definitional ambiguities and methodological idosyncracies prevent us from drawing any conclusions (e.g. Munro, 1966). With respect to other diagnostic entities, such as neurosis or alcoholism, contradictory findings are once again observed; some studies report finding a significant association while others find none (e.g., Shoor & Speed, 1965).

On the basis of the current limitations of the retrospective method, one must conclude that retrospective studies have not provided a reliable answer to the question of whether early childhood bereavement is predictive of later behavior disorders.

PRESENT FINDINGS

We feel that our own findings, derived from an exploratory study utilizing the anterospective or follow-up strategy, provide a potentially more fruitful approach to this issue. Our original data were obtained by Hathaway and Monachesi in 1954, when they obtained samples of 11,430 ninth-grade students in Minnesota (Hathaway & Monachesi, 1963). In their discussion they argued that Minnesota is an advantageous source of population samples, since it has a predominantly second-generation and native born population, an absence of large racial minorities, and an average economic position relative to other states. Although their specific interest at the time of the study was to obtain a sample of sufficient size to permit valid predictions about delinquency, they were careful to gather a wealth of data which has been, and still is, useful to researchers concerned with many different issues. Two extensive follow-up studies of the original cases were undertaken in 1956-57 and again between the years 1960 and 1966.

The average age of the ninth-graders at the time of the original 1954 sample was approximately 15 years. Thus, in the second follow-up, the average age of those interviewed in 1960 was approximately 21; and for those followed up as late as 1966, the average age was approximately 27. The data, unfortunately, do not permit us to

distinguish which cases were followed up in which years between 1960 and 1966, and this seriously limits the refinement of our analysis.

In order to determine whether a significant relationship exists between childhood bereavement and later behavior disorder, we divided the followed-up cases of the original sample (N = 11, 197) into three childhood family status groups: intact family with both parents alive and together (N = 9, 719); family broken by separation or divorce (N = 715); and family broken by the death of one or both parents (N = 763). We had intended to divide further the bereaved group according to sex of parent lost, but found that this would have precluded statistical analysis by reducing the number of cases in the cells of our statistical tables. The use of this secondary data imposes further limitations on our analysis. Some information which we would have like to have had was not obtained in the original study. We do not have, for example, data on the age of the child at bereavement, the cause of the parent's death, the quality of the post-bereavement home environment, or other potentially relevant circumstances. Moreover, while the 1960-66 follow-up was efficient in locating original subjects, the information gathered on each case was frequently incomplete. We had hoped, for example, to use three adult status variables obtained on some follow-ups as indicators of behavior disorders: marital status, hospitalization for emotional problems, and offenses against the law. The information was relatively complete with respect to marital status, but for offenses against the law and for emotional problems, almost half the cases could not be analyzed because the information was incomplete. In addition, other difficulties with the data compelled us to eliminate "emotional problems" as an adult status variable and to analyze only "marital status" and "offenses against the law." In our analysis we controlled for sex of subject, father's socio-economic status (as of 1954), rural versus urban residence, and size of community lived in at the time of the original study. None of these controlling variables showed any significant differences when the chi square test of significance was applied. Therefore, the significant relationships found were between childhood parental loss and adult marital status, and between childhood parental loss and later offenses against the law.

The analysis of the relationship between early bereavement and marital problems involved collapsing the marital status values into three categories: single and never married; currently married; and broken marriage (including legal separation and divorce). Unknown marital status or other statuses (e.g., widowed) which in total represented close to twenty percent of our cases were eliminated from this analysis. Tables 1, 2, 3 and 4,

TABLE 1

The Relationship Between Early Parental Loss Through Divorce or Separation, and Adult Marital Status: For Females

Childhood Family Status, 1954	Adult Marital Status, 1960-1966			
	Single and Never married	Currently Married	Broken Marriage	Total
Intact Family Background	646 14%	3668 82%	176 4%	4490 100%
Parents Divorced or Separated	23 8%	251 84%	24 8%	298 100%

Chi square = 15.37, d.f. = 2, $P < .001$

TABLE 2
The Relationship Between Early Parental Loss Through Death and Adult Marital Status: For Females

Childhood Family Status, 1954	Adult Marital Status, 1960-1966			
	Single and Never married	Currently Married	Broken Marriage	Total
Intact Family Background	646 14%	3668 82%	176 4%	4490 100%
One or both Parents Dead	54 15%	273 80%	16 5%	343 100%

Chi square = .88, d.f. = 2, P = not significant

TABLE 3
The Relationship Between Early Parental Loss Through Divorce or Separation, and Adult Marital Status: for Males

Childhood Family Status, 1954	Adult Marital Status, 1960–1966			
	Single and Never married	Currently Married	Broken Marriage	Total
Intact Family Background	1486 33%	2866 64%	112 3%	4464 100%
Parents Divorced or Separated	85 30%	187 66%	12 4%	284 100%

Chi square = 4.69, d.f. = 2, P < .10

TABLE 4
The Relationship Between Early Parental Loss Through Death and Adult Marital Status: for Males

Childhood Family Status, 1954	Adult Marital Status, 1960-1966			
	Single and Never married	Currently Married	Broken Marriage	Total
Intact Family Background	1486 33%	2866 64%	112 3%	4464 100%
One or Both Parents Dead	115 34%	212 64%	6 2%	333 100%

Chi square = .69 d.f. = 2, P = not significant

show that when children from intact families are compared first with children from divorced or separated families, and then with children from families broken by death, a significant difference appears in the current marital status of those from divorced or separated homes. More men and women from childhood homes broken by divorce or separation had not only been married by the time of the follow-up, but also the incidence of divorce among this group was significantly higher.

Hence, our data show that loss of a parent by divorce or separation may be

significantly associated with later behavior problems—when marital dissolution is considered to be a behavior problem—but this association does not hold for those who lost one or both parents through death. It must be remembered, however, that the respondents were relatively young at the time of the follow-ups and that the number of broken marriages would be expected to increase with the age of our sample. We should caution that our findings, while significant, may be partially a function of the very large "N" we are working with.

In our analysis of the relationship between parental loss and offenses against the law, we were compelled to eliminate nearly 80 percent of our cases, since we lacked complete information. We then placed the remaining cases into three broad categories: no offense, minor offense (misdemeanors, one jail sentence, and YCC commitment), and major offense (probation for a felony, more than one jail sentence, and one or more prison sentence). The following findings, moreover, are based only on the male cases, due to the small number of women offenders.

Although we appreciate the serious problems entailed in analyzing data from which so many cases were discarded, we decided to investigate any possible relationships for two reasons: first, this is a very preliminary study and we felt that any findings would be provocative and, second, since we expect to undertake a third major follow-up of the original 1954 study, in which we would hope to avoid the nearly incapacitating difficulties presented to us by the 1960-1966 follow-up, we wanted to exploit the original data as far as was reasonable in order to discover possible clues to further analysis.

As indicated in Tables 5 and 6, persons from homes broken either by divorce or death are significantly more likely to have committed some offense against the law than are persons from intact homes.

These findings confirm previous criminal studies, such as the Gluecks' studies (1950), and others, which have shown such a correlation. What is important to point out here is that homes broken by bereavement *also* show differences from intact homes with respect to offenses against the law. Our findings support the findings of other studies that have established this connection (e.g., Shoor & Speed, 1965). However, as is shown in Tables 7 and 8, when the severity of the offense is examined, the males from homes broken by divorce or separation commit a disproportionate number of the major offenses.

These findings underscore the need to explore more fully the role of early bereavement, as well as divorce or separation, in subsequent delinquent or antisocial behavior.

TABLE 5

The Relationship Between Early Parental Loss Through Divorce or Separation, and Later Offenses Against the Law: for Males

	Offenses Against the Law		
Childhood Family Status, 1954	No Offenses	Some Offense	Total
Intact Family Background	1765 89%	211 11%	1976 100%
Parents Divorced or Separated	104 79%	27 21%	131 100%

Chi Square = 11.5, d.f. = 1, $P < .001$

TABLE 6
The Relationship Between Early Parental Loss Through Death, and Later Offenses Against the Law: for Males

Childhood Family Status, 1954	Offenses Against the Law		
	No Offenses	Some Offense	Total
Intact Family Background	1765 89%	211 11%	1976 100%
One or Both Parents Dead	135 84%	26 16%	161 100%

Chi Square = 4.31, d.f. = 1, P < .05

TABLE 7
The Relationship Between Early Parental Loss Through Divorce or Separation, and Offenses Against the Law: for Offenders

Childhood Family Status, 1954	Severity of Offense		
	Minor Offense	Major Offense	Total
Intact Family Background	173 82%	38 18%	211 100%
Parents Divorced or Separated	18 66%	9 34%	27 100%

Chi square = 4.39, d.f. = 1, P < .05

TABLE 8
The Relationship Between Early Parental Loss Through Death, and Offenses Against the Law: for Offenders

Childhood Family Status, 1954	Severity of Offenses		
	Minor Offense	Major Offense	Total
Intact Family Background	173 82%	38 18%	211 100%
One or Both Parents Dead	20 77%	6 23%	26 100%

Chi Square = .28, d.f. = 1, P = not significant

CONCLUSION

The preceeding examination of the literature reveals that most studies of the early bereavement-later behavior disorder hypothesis have been plagued by methodological problems which have generated discrepant findings. Retrospective studies are especially prone to the *post hoc, ergo propter hoc* fallacy.

Our exploratory anterospective study, which had the benefit of a very large sample relatively free of selective factors, tentatively indicates that early parental bereavement

may significantly affect adult behavior—specifically with respect to offenses committed against the law. We recognize, however, that these findings are seriously compromised by the methodological deficiencies inherent with the use of secondary data. It is our hope to undertake a third major follow-up of the original 1954 sample, which would avoid the problems that the deficiencies in the two follow-up studies presented to us. We would like to know, for instance, at what age the child was when the death occurred, the cause of the death, and the quality of the post-death home environment. Also, it would be important to seek better indicators of adult adjustment than merely marital status or offenses against the law. The use of such scales as the MMPI, for example, would supplement the traditional means of evaluating adjustment in later life. Our projected follow-up would carefully study those adults from bereaved or divorced backgrounds who did not manifest any apparent signs of behavior problems in the hope of finding distinguishing characteristics between them and those who evidence maladjustment.

Anterospective studies are valuable prophylactically as well as theoretically. Such studies allow researchers to make theoretical statements with regard to the correlation between childhood bereavement and subsequent problems in social adjustment. The studies become prophylactically valuable, therefore, when such associations are recognized and steps are taken to prevent a maladaptive response on the part of the bereaved. Studies of the possible problems associated with bereavement will hopefully promote greater awareness of the need to withdraw the fact of death from its netherworld and to assist persons, particularly young ones, to cope with their loss.

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BOOK REVIEWS

Shneidman, Edwin S. (Ed.). *Essays in Self-Destruction.* New York: Science House, Inc., 1967. 554 pages, $12.50.

In 1965 I visited the Los Angeles Suicide Prevention center and had an opportunity to meet several senior fellows who had come to Los Angeles courtesy of Edwin Shneidman's intellectual entrepreneurialism to "contemplate suicide." The present volume is a major result of that exciting and visionary experiment. *Essays* is founded on the basic assumption that what the waxing (Shneidman would say "aborning") profession of suicidology needs most is ideas, rather than statistical reports of experimental or empirical studies of self-destruction. That is, Shneidman argues that the most appropriate tools for advancing the field are contemplation, exposition, discursiveness, and (specifically) "intellectual forays and adventures." Taken as a whole the collection "points to the crucial importance of developing 'good theoretical formations of significant problems which can can be tested by appropriate data.' " To this end, twenty-five "gracious guests and old friends" of Dr. Shneidman's have contributed essays which are literary and philosophic (Part I), sociologic and enthnographic (Part II), psychological and psychiatric (Part III), and taxonomic and forensic (Part IV).

The papers by Murray, Pepper, Garfinkel, Weisman, and Litman are absolutely first-rate. Like their editor, these authors are thought-provoking, imaginative, and at the same time, scholarly and thorough. Basically their chapters are open-ended—sometimes disturbing—exercises in concept formation. Although positions are taken and defended, the reader himself is challenged to participate in the dialectic of the arguments. Other good essays are those by Choron, Parsons and Lidz, Breed, Tabachnick, Schaefer, and Shneidman. By Shneidman's criteria of "intellectual forays and adventures," I would rate the latter as good, but not outstanding. Using a scale of 1 (outstanding) to 5 (terrible) and subjective judgment (as to the originality and development of their key ideas), I rated each chapter and averaged the results for the four parts of the book. Part I, 2.3; Part II, 3.2; Part III, 2.9; and Part IV 3.6.

Substantively, the essays are so rich and diverse as to defy meaningful condensation. Most of the chapters are "think-pieces," rather than data analyses. By my estimation about one-fourth to one-third would be acceptable to scientific journals. Only two (Whalley and Shneidman) use anything more than descriptive statistics. Most of the authors construct hypotheses, rather than theories (the exceptions are Breed and Sachs). Just seven of the twenty-four have an explicit research design. Of course, all this is not a criticism of the book, since Shneidman explicitly disavows empirical or experimental considerations as his primary objective. But it does mean that at best, *Essays* is a prolegomena to the scientific study of self-destruction. Most of the chapters are nonfalsifiable; they are more about their authors' free-associations than they are about self-destructive behaviors.

Still there is a wealth of pregnant suggestions in the better essays. Murray, Weisman, and Litman all focus upon some of the latent functions of self-destructive behavior—an often overlooked subject. For example, Weisman and Litman argue that many self-destructive individuals see death and dying as erotic, as an extension of their libidinal field. There are types of sado-masochism where defeat, pain, and submission are simulated pretexts for pleasure and domination. In both suicide attempts and sexual perversions, the ego is *nearly* overwhelmed, *almost* overcome by death, etc. Litman argues that all specific suicide mechanisms involve breaking down of ego-defenses (ego-splitting, regression, and disorganization). Sexual perversions and mass aggression (both actual and vicarious) probably lower actual suicide potential. Paradoxically, both destruction and self-destruction are sometimes preservative both of self and social order. Many pathological behaviors (e.g., aggression and affectlessness or "being dead to the world") are prophylactics to complete annihilation.

Pepper and Garfinkel are "catchers-in-the-rye." For example, Pepper contends that being rational ("having a philosophy") does not imply being emotionally balanced ("being philosophical"). That is, "correct reasoning from true concepts (sic) will not always be effective in leading a man to act reasonably." A suicide justified upon mystical premises is usually a rationalization of the underlying affect which really motivated the suicide. Garfinkel, who was a fellow at the Los Angeles Suicide Prevention Center, was impressed with the difficulty of determining "what-really-happened" in retrospective analysis of a suicide, using (for example) the "psychological autopsy" method. Many of the accounts of self-destruction by suicide prevention workers are characterized by an "uninteresting essential reflexivity," because workers have well-formed formulae and labels for characterizing a death (which is taken as nonproblematic), and because they assume in advance that a suicide occurred. Furthermore, SPC workers tend to substitute objective expressions for subjective "indexical" expressions referring to situated meanings of the suicide. The result is that most accounts of self-destruction do not reflect what-really-happened and do not serve as a meaningful base for explanations of the rationality of suicidal behavior.

It is difficult not to lapse into an *ad hominem* fallacy in evaluating *Essays*, because it is admittedly a "nonbook" (in the more traditional sense of the word) which mirrors Shneidman's genius. Like Shneidman, *Essays* is witty and heavy on taxonomy. Without detracting from Shneidman's pioneering achievements, many of us would like to see something more than edited collections of essays. "Ideas" do not need to be developed in essay form, divorced from empirical and experimental studies. As a matter of fact, "good theoretical formulations of significant problems" seldom result from brief "forays" by twenty-four different authors. Suicidology, if it is to persist, needs to move from classificatory and artistic levels of analysis to those of the basic researcher-theoretician. What suicidology needs are more Freuds and Durkheims, not more essays. The issue is not whether more theory is needed, but rather what theory is. I would claim that theories are most usefully conceived of as logically or mathematically connected sets of lawlike propositions. Concepts, even the most adventuresome, only provide variables for propositions. Some of that "appropriate data" needs to be introduced to determine if our propositions about self-destruction are true; then, the true propositions should be systematically interrelated. Suicidology is not too young to move on to such tasks. One begins to suspect that our aesthetic preferences and professionally trained incapacities are keeping us from confronting our subject matter. As to Dr. Shneidman's disturbed sleep while editing *Essays*, he should rest assured of a job well begun.

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Jones, Barbara. *Design for Death*. London: Andre Deutsch Limited, 1967. 304 pages, $10.00.

This is a most readable book, and—perhaps in spite of one's expectations—an enjoyable one. The emphasis is on art; it is filled with marvelous black and white photographs and line drawings. But to view death objects as art requires some "distancing" from the weightiness of death itself, and the author ably provides this with her rich, soft, somewhat cynical humor.

To identify a tomb as a "paperweight to pin down the poor soul forever" (p. 203), to describe an ill-designed casket as "the oxidized metal offspring of a cumulus cloud and a half-sucked lozenge" (p. 74) appearing like a "Victorian bassinet" (p. 80), to note that "Relics of famous criminals used to be as popular as those of saints and stardom as haphazardly given" (p. 253), is to play lightly with a cannonball, perhaps, but with a purpose, and for a purpose.

The purpose and the message pervade the book; it is the plea to deal with the matter of

death sensibly and artistically. It is a plea to do away with the massive wooden seats in some cemetaries that are neither comfortable nor beautiful; to examine our motivation for preserving a body with embalming, encasing it in a steel casket, and then cremating it; to consider the relative advantages of so simple an idea as pasturing sheep in churchyards to keep the grass cropped around upright tombstones.

The book has a historical and broadly ethnographic perspective. It opens up possibilities for dealing with the dead body, the funeral, written announcements, etc. Some of these seem exotic and without personal meaning, yet others, though strange, seem to be positive, natural, and very meaningful in comparison with some of our customary 20th century western practices. Consider, for example, substituting books for flowers at one's funeral, consider the kinds of mementos one would like to leave to loved ones (hair, jewelry, a bone, a poem . . .), consider the opportunity of building one's own tomb before one dies—a relatively lasting contribution of esthetic worth, an object d'art from one's *life*.

As an anthropological work (Miss Jones is a Fellow of the Royal Anthropological Society in addition to her art background), the book is sketchy, overgeneralized, and occasionally inaccurate in ethnographic detail. The emphasis is on *British* customs, but non-Western civilizations and preliterate peoples are represented as well. Many useful insights and nascent hypotheses glimmer from the pages. For example, the author noted that the terms "fry", "cremate", and "commit" were used within ten minutes of one another in differing social contexts in the same funeral home (p. 152). Again she notes that "Eastern (funeral) processions are calculated for movement, towers are zigzagged or the heavy fans and umbrellas sway and there are curtains and fringes for the winds. In the west, the aim is stillness" (p. 175). Perhaps these are opposite to the contrasting life styles in the East and West as well.

But the criticism of the book as poor academic anthropology is really only tangential. The book is anthropology in a broader sense. It is a source book for ideas on humanistic, life-oriented art and behavior in the area of death.

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ANNOUNCEMENTS

TRAINEESHIPS AVAILABLE FOR GRADUATE PROGRAMS WITH SPECIALIZATION IN GERONTOLOGY

The Institute of Gerontology, The University of Michigan-Wayne State University, has announced that traineeships are available for graduate study with specialization in gerontology in a number of schools and departments in the two universities. Persons interested in fall registration may enroll in graduate programs in public policy, social work, architecture, public health, or educational gerontology at The University of Michigan; and public administration, social work, library science, education, or occupational therapy at Wayne State University. For further information on The University of Michigan programs, contact Dr. David Peterson, 1021 East Huron Street, Ann Arbor, MI 48104. At Wayne State University, contact Miss Laura Hardy, 672 Putnam, Detroit, MI 48202.

EQUINOX INSTITUTE

The Equinox Institute has been established in Boston by Dr. Melvin J. Krant, Director of the Tufts University Medical Cancer Unit. The Institute is devoted to creating an educational opportunity for understanding the social and personal meanings of death, dying, and bereavement in our communities. Their initial program was a series of seminars on death, dying, and bereavement, running six consecutive Monday evenings from March 1, 1971, through April 5, 1971. Additional programs are now in the planning stages, including programs for high school and college students. A statement of purpose distributed by the Institute follows:

The Equinox Institute, a non-profit, tax-exempt organization, was created by a group of professional individuals from several walks of life, principally in the health and religious spheres, to promote an open awareness of the needs and concerns of people, of patients, of families, and of staff in facing dying, death, and bereavement. In a society accused of being scientific, materialistic, and temporal, death is viewed as impersonal–indecent and in general unworthy–and the concern and care given to the dying and his family, especially in large, urban areas, tends to be indifferent and institutional. The needs of the bereaved are rarely understood in either philosophic, religious, or health (physical and psychic) terms.

The Equinox Institute believes that the medical, psychologic, philosophic, cultural, and religious issues concerning death and dying should be opened and explored as a personal interaction between the individual involved in care-giving and individuals involved in living and dying in our communities at large. A group of seminars is planned in which an opportunity will be created for education and personal exploration into the meaning of death and dying, as well as into the responsibility of the various care-givers. In addition, seminars will be planned for the public-at-large, and for students at high school, college, and other levels.

The Equinox Institute is devoted to improvement in the care given to patients and

families directly through stimulating services in hospitals and other institutions but especially in the home; and to improvement in social, health, and religious services and counselling in the area of grief resolution and bereavement. The Institute plans to operate as a center for information gathering and distribution, for consultation and initiation of programs for help for the dying and the living, and to develop techniques for prevention of future health breakdowns through intervention in the crisis of grief and aiding in appropriate resolution.

The attitude that is taken towards death, and the manner in which we react to it, will be reflected in the social and mental well-being of this nation.

Additional information about the Equinox Institute is available from Dr. Krant, 11 Clinton Road, Brookline, Massachusetts 02146, 617-522-8400.

EUROPEAN LEAGUE FOR MENTAL HYGIENE

Helsinki will serve as host for the 1971 Congress of the European League for Mental Hygiene, to be held from August 16 through August 20, 1971. Registration is $40 per person, with $20 requested for accompanying individuals. The program will consist of panels, scientific papers, and plenary sessions, with French, English, and German languages all to be included. Of particular interest to readers of this journal is that suicide prevention will be one of the two main topics. Host organization is the Finnish Association for Mental Health, Toinen linja 17, 00530 Helsinki 53, Finland. The President of the Congress is Kalle Achte, M. D.

GERONTOLOGICAL SOCIETY

The Twenty-Sixty Annual Meeting of the Gerontological Society will take place at the Shamrock Hilton in Houston, Wednesday, October 27, through Sunday, October 31, 1971. Symposia, scientific papers, and discussion groups will represent the diverse membership of this organization: clinical medicine, biological sciences, behavioral sciences, and social and public services and administration. For information, contact the Society headquarters at One Dupont Circle, Washington, D. C., 20036.

INTERNATIONAL ASSOCIATION FOR SUICIDE PREVENTION

The International Association for Suicide Prevention is sponsoring the Sixth International Congress on Suicide Prevention to be held December 5 to 8, 1971 in Mexico City at the Hotel Aristos. The plenary sessions themes will be: Drugs and Suicide, Psychoanalysis and Suicide, and Suicide in Different Cultures. Short papers on all aspects of research and prevention may be submitted for non-plenary sessions.

The Congress will be international and interdisciplinary and anyone active in the field of suicide research and prevention is invited to participate. For further information, contact: Miss Beatriz Pinal, Administrative Secretary, 6th International Congress for Suicide Prevention, Apartado Postal 35-541, México 10, D. F.

AMERICAN ASSOCIATION OF SUICIDOLOGY

Several matters of interest have come to our attention from the AAS, whose concerns are so closely related to our own. First, the Association will hold its next annual meeting on Friday, March 30, through Sunday, April 2, 1972, at the Statler-Hilton in Detroit. Dr. Robert Kastenbaum, Department of Psychology, Wayne State University, Detroit, Michigan, 48202, is the local arrangements chairman. The theme of the meeting will be *Suicide, Death and Violence*, and the person to receive paper submissions is Dr. Albert C. Cain, Department of Psychology, University of Michigan, Ann Arbor, Michigan, 48104.

The second matter worthy of note is that the Association presented the first Louis I. Dublin award for outstanding contributions to suicidology to Dr. Karl Menninger.

And third, the AAS now has an official journal, LIFE-THREATENING BEHAVIOR. The concerns of death, suicide, and related matters are now served by three periodicals: OMEGA, THE BULLETIN OF SUICIDOLOGY, and LIFE-THREATENING BEHAVIOR.

CONTRIBUTORS

BYRON BACKLAR was selected as reviewer in spite of, not because of, his university affiliation. Suffice it to say, for our present purposes, that his encounter with loss through death was existential.

JEANNE QUINT BENOLIEL, D.N.S. is better known to students of death and bereavement by her first two names. Author of a book addressed to student nurses as caretakers of the dying, she is now on the faculty of the School of Nursing, University of Washington.

RAYMOND De La GRAVE was a graduate student in the School of Business, UCLA, at the time of his participation in research in suicidology.

JULIE FULTON, M.A., is working toward her doctorate in sociology at the University of Minnesota, where she holds an NIMH fellowship.

ROBERT FULTON, Ph.D., is probably best known as being Professor of Sociology, University of Minnesota, and author of the Wiley Publishing Company book, *Death and Identity* (1965). Future historians may note that Professor Fulton planned to do his doctoral dissertation on bereavement (circa 1957), but was persuaded by his faculty that such research was inappropriate for a sociologist.

AMY GANZERT is working on a B.A. degree in international relations at the University of Denver. She is interested in setting up a semi-sheltered community hostel for the treatment of chronic schizophrenics. Her special interests include the Baroque city and Novgorodian icons.

DAVID LESTER, Ph.D., has joined the faculty of the newly-opened Stockton College, a New Jersey state college that is oriented to educational innovations. Psychologist Lester has contributed numerous studies to the literature on death and suicide.

RONALD MARIS, Ph.D., is a sociologist with the School of Medicine at Johns Hopkins University of Baltimore. His involvement with the study of suicide dates back several years.

ERIC MARKUSEN, M.A., is a National Institute of Mental Health Fellow in the Department of Sociology, University of Minnesota. He is presently engaged in a follow-up study of an original MMPI sample of 11,000 Minnesota public school children, focussing upon those who reported the loss of one or both parents.

THEODORE McEVOY, Ph.D., has a doctorate in psychology and works as a student counselor at the University of California, Los Angeles. He is spending the 1970-71 academic year in Europe.

LEWIS PICHER, Ph.D., has been doing grief intervention with recently bereaved families in the Denver area for the past two years. Before that he worked three years as a clinical psychologist on the Adams County adult psychiatric team of Fort Logan Mental Health Center. He obtained his Ph.D. in clinical psychology from the University of Texas in 1965.

DAVID K. REYNOLDS, Ph.D., recently received his doctorate in anthropology at the University of California, Los Angeles. He is now Assistant Professor of Behavioral Sciences in the School of Public Health, UCLA, and serves both as a teacher and a research investigator, with his primary interest in death and suicide and in mental health.

THOMAS J. SCHUR, M.S., is working as a family therapist with disturbed children and their families at the Onondaga County Child Guidance Center in Syracuse, New York. His interests include the impact upon attitudes toward death and other forms of separation of recent changes in human relationships.

RITA R. VOLLMAN, Ph.D., received her degree in clinical psychology from UCLA in 1970. Besides being part of the bereavement intervention team, she is co-ordinator of a training program for volunteer workers on the Crisis Intervention Division at Fort Logan and is responsible for evaluating the effectiveness of the Division's community crisis hostel, an in-patient hospital alternative.

W. VAIL WILLIAMS, Ph.D., received his degree from the University of Oklahoma in 1968. He is a research psychologist and head of the assessment team for an NIMH grant, Crisis Division, Fort Logan Mental Health Center. He also maintains a private practice as a clinical psychologist.

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