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

FUNERALS, FANTASY, AND FLIGHT

Ruth Mulvey Harmer

The beginning of wisdom, religious and moral philosophers say, comes only with the acknowledgment of death. Until that ultimate reality has been faced, no man can hope to achieve the good life. That acknowledgment is too fearsome for most of us to make, and the extent to which we seek refuge in fantasy and flight is stunningly revealed by our funeral practices. Consider the following accounts of final arrangements:

The first was given to me by an elderly neighbor, the wife of a man so badly afflicted with arthritis that he had been forced into early retirement from his job as a semi-skilled worker. She was working as a practical nurse—an occupation not calculated to encourage conspicuous consumption—to supplement his modest social security benefit. Yet out of their poverty-level income the couple had paid fifty dollars a month for three years to a large cemetery-mortuary establishment, and the contract required payment for another two years. Mistaking my amazement for applause, as she finished her recital of their "future," she smiled: "It is wonderful, dear, isn't it? Just think! That takes care of everything—even the clothes and the flowers and the minister."

The second was called to my attention by my husband, who teaches at a high school in a predominantly Mexican-American section of Los Angeles. A student—a serious boy who was helping his grandmother care for two younger brothers and a sister—had been set upon and killed by a group of toughs who had mistaken him for a member of a rival gang. "To do something nice for Tommy," fellow students raised more than a thousand dollars at a "dance in." Down to the last penny, the money went to pay funeral expenses—to the apparent approval of everyone concerned, including the grandmother who had to send the other children to a foster home because without Tommy's financial contribution she could no longer afford to keep them.

The third account, given to me by a nun from Denver, involved the widow of a laborer of Middle European background. Without savings, without insurance, the woman could not provide her husband with the kind of funeral that she and her neighbors believed he "deserved." The undertaker obligingly offered to keep the body until she could raise the money "to do it right." That took her eight months, working as a domestic. The widow was, Sister Loretto Madden told me, entirely pleased with the affair—even though she was unable to take time off from work to attend the funeral.

Although other far more extravagant case histories could have been selected, those three typical and unchronicled ones sum up rather tellingly the motivations responsible for the elaborate nature of American funerals: the belief, particularly of the deprived, that death is an escape from the coffin of life that warrants celebration; the desire to elevate a member of the group to heroic stature; the need of the bereaved to punish himself or herself and to avert charges of "not caring" by departing from accustomed ways.

Those attitudes, by no means peculiarly 'American,' have shaped the size and opulence of funerals all over the world. Although funerals in this country have been singled out for sharp criticism, it is apparent to persons even slightly familiar with other cultures that

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elaborate rites are and have been in vogue for centuries–millennia–in the Orient, the Middle East, Latin America, and most of Western Europe. Actually, about the only contributions American undertakers have made, have been such technological 'refinements' as permanent waves for corpses, hospital beds in coffins so that bodies can be cranked up to welcome guests, and drive-in funeral homes–which now make it possible for mourners to sit in their cars while paying last respects to the "loved ones" on display in mortuary windows. It is possible, however, that the blatant association of sex with death and funerals is a distinctly American innovation–and has been since the writings of Edgar Allan Poe set the tone in the middle of the nineteenth century.

What is unique about funeral practices in this country today is their cost. The hard-sell tactics mercilessly employed have made the business of selling funeral services a $2,000,000,000 a year boom and the business of buying them a crushing financial 'bust' for the survivors of most of the 1,800,000 citizens who die each year. And with funerals, as with other escape mechanisms–alcohol or drugs–there is a high price to pay the morning after.

In spite of the inevitability of death, it is very difficult to attempt a rational discussion of final rites; this is partly the result of the unwillingness to acknowledge mortality. Largely, however, it is because of the semantic confusion generated by industry public relations experts. They have created the belief that the "right sort of person" does not question costs "at a time like that." They have fostered the illusion that death is not death (in industry parlance, people "pass on" or "step out of the picture") if the magic rituals are observed. They have persuaded people to accept the notion that indulging in conspicuous consumption is not only the *spiritual* way to behave when a death occurs, but is a vote of confidence in the *American free enterprise system.* In point of fact, of course, the latter notions are also delusions.

When I was doing research into the origins of modern funerals while writing *The High Cost of Dying* (1963), I was startled and impressed by the extent to which Judaism and Christianity departed so radically from the ostentatious rituals favored by all the ancient societies which left records. The epics–those oldest and most spacious of literary forms, which served not merely as entertainment but as guides to conduct–are preoccupied with celebrations of the heroic death. Thousands of the clay tablets on which the *Gilgamesh Epic* was inscribed four thousand years ago, more than a third of the lines of the *Iliad*, an impressive portion of Vergil's *Aeneid*, the entire conclusion of the *Beowulf*, and many of the most moving *laisses* of the *Song of Roland* are concerned exclusively with the funerals and burials of heroes. All of them–Babylonian-Sumerian, Greek, Roman, Anglo-Saxon, Old French–are alike in their insistence that elaborate obsequies constitute guarantees that the shadows will possess all of the rights and privileges possessed by the substance. Upper-caste pagan ancients held this world so much more desirable than the terrifying after-world of death that they used every item that came to hand and mind–food, animals, slaves, wine, blood, clothing, hair, jewels, women, weapons–to link the two existences inseparably and to keep social status intact.

Morally more sophisticated, the Jewish and later the Christian leaders looked coldly upon the world and found it wanting. Unable to free themselves from the knowledge that hunger, sickness, poverty, misery, and injustice were inescapable facts of the universe to which their Creator had exposed them–one in which vice was often rewarded far more handsomely than virtue–they fashioned an afterward that contradicted the *status quo*–a world of perfect justice where the will of a just and perfect God would be done.

The Judaic-Christian conception of the hereafter was not merely a *spirit* world, but a genuinely spiritual one. All of the values and the triumphs of the material universe were perfectly irrelevant in it. Therefore, admittance could not be gained by material bribes, nor could status be determined by material possessions. The poorest man, if he had loved God and his fellows well, was eligible for a highest place. Consequently, lavish funerary display was not merely beside the point; it was blasphemous.

Orthodox funerals still reflect the simplicity held desirable since the burial of Moses set the pattern. A simple shroud is favored; if a coffin is used, it must contain an opening to facilitate the return of "dust to dust." So, too, the Christian funeral eschewed display. Most of the early Christians were buried anonymously and indistinguishably in the winding labyrinths under Rome that offered the living a reasonably safe place of worship. Today, evidence of that starkness is still visible. Only occasionally can it be noted that one grave is set apart from the others—by the scratching of a name or by a design pressed into the mortar. The quiet tone of the early Christian funerals contrasted sharply with the wild lamenting of pagan rites. After all, had not the "real" person—the soul—passed into a new state of glory? Neither mourners nor morticians were hired; all of the members of the community shared the responsibility of providing the funeral.

It was one thing to declare theologically that all men were equal in the sight of God. It was another—particularly for persons of high degree—to accept that there was no way of getting special preferment. And just as the Jewish funerals acquired adjuncts and overtones of those of the hated Egyptians, so those of the Christians became increasingly like those of their Roman persecutors—featuring elaborate coffins instead of shrouds, black drapery instead of white, hired mourners, elaborate tombs. As Robert W. Habenstein and William M. Lamers point out in *The History of American Funeral Directing* (1955), the final services for the Empress Theodolinda in 595 A.D. contrast remarkably with those of Christ and the early Christians. Rites for the friend of Pope Gregory the Great lasted for more than a week, centering around her richly dressed body which lay in state in the Cathedral of Monza—emphasizing pomp, pageantry, and preoccupation with the mortal remains.

As serfs and peasants moved out of feudal darkness into the light of dawning democracy, they, too, began to discard spiritual *egalitarianism*, as kings, prelates, and barons had done. Judy O'Grady might not be able to live like the colonel's lady, but—by earth, if not heaven—she could die like her. O'Grady, whose life style was modeled more by James Joyce than Homer, yearned at the end of his Odyssey for a moment of glory in the heroic style. Thus death, once the great leveler, became the lever for social elevation.

Clergymen—albeit, some reluctantly—went along with the changes: Jewish, Catholic, Protestants of all denominations. They were reluctant to press their followers' faith too far; and a good many of them seemed as eager as the most wavering of their flock to curry favor with those in the Beyond as well as to impress those in the Here and Now.

After undertaking became a vocation and the financial consequences of ostentatious display became apparent, some began to speak up boldly—urging, even insisting that believers return to original practices. The worldwide depression in the 1920s and 1930s accelerated the change in some countries—England and the northern European countries. Spurred on by their example, many clerics in this country decided to act. But by that time, the price was very high, since business pressures were combined with people's doubts and fears and vanities to "upgrade" funerals. Those who acted, found themselves being attacked as un-American as well as irreligious. An interesting indication of the

violence reform measures encountered was given by Reverend Hugh Stevenson Tigner in *The Christian Century* in 1938. The year before, members of the Ministers Association in Middletown, New York decided to speak up against the moral and economic aspects of funeral practices. They would do that in concert since, he said, "It would have been suicide for one of us to have done this alone." The "bitterly hostile" response was more than they had bargained for. Mr. Tigner reported that local undertakers enlisted aid from the regional trade association; out-of-town clergymen were called by undertakers to conduct services "whenever the family would allow it." The undertakers persuaded the business community of Middletown to fight the ministers' action, which was held to be "bordering on subversion."

Only the bravest among the clergymen could hold out against that sort of thing. And only the bravest did. But the groundwork that had been laid in the 1930's for a religious revolt–more properly, for a religious revival–continued to grow, as more and more clergymen began to question the "paganism" of funeral practices and to protest the tendency of businessmen to usurp their roles as spiritual guides. A study made by Dr. Robert L. Fulton in 1958 for the National Funeral Directors Association revealed that 51 per cent of Protestant clerics and 41 per cent of Catholic priests responding to his questions "believed that the funeral director exploits or takes advantage of a family's grief in selling funeral services." Moreover, Dr. Fulton (1961) noted in an article in *Social Forces*, clergymen found it "galling personally" as well as contrary to the tenets of their faith to have undertakers taking complete charge of funerals and even offering the services in their own chapels.

The exploitation by undertakers was also being strongly protested by others: consumers and persons associated with social welfare agencies, insurance companies, and other organizations with first-hand knowledge of the consequences of extravagance. For the funeral industry is no less at odds with traditional principles of economics than of religion. At the heart of our American capitalistic system is a belief in the effectiveness of competition. That belief was a major cause of the American Revolution and played an important role in bringing on the Civil War. Not long after the resolution of that, the Sherman Antitrust measure was enacted to guarantee that competition, the vital keystone of our democratic society would not be dislodged. Lamentably, the funeral industry leaders–who had discovered during the Civil war that death could be the basis of a booming business– were seeking ways to subvert the spirit of the law.

The difficulties were great. No open-ended demand could be created for funerals as could be done for other goods and services. Indeed, a rising standard of living, greater availability of medical care, new discoveries in drugs and medical science, education–all worked effectively to lower demand. Moreover, industry control was widely scattered. The typical undertaker was truly a small businessman, owning a single establishment and performing services for clients personally known to him. (Quite often his undertaking business was a sideline–an adjunct to his trade as carpenter or furniture dealer or general merchandiser.) The big businessmen in the industry were chiefly the manufacturers of caskets and hearses, who had an understandable interest in protecting their "salesmen."

Under normal circumstances, a static demand accompanied by improvements in technology and transportation results in marginal operators falling by the wayside. Not so in the funeral industry. In 1927, Elmer Davis reported that an N.F.D.A. official had told him that only 10,000 were needed to do the job; in that year, there were more than 23,000 undertakers. Dr. LeRoy Bowman (1959) reported in *The American Funeral* that

in 1950 W. M. Krieger of the National Selected Morticians, Inc. told him: "There are too many firms in this business . . . 2000 could do all the business in America." In that year there were about 25,000 undertaking establishments. Today, almost as many exist.

To maintain the marginal operator a condition perilously close to price-fixing had to be established. And it was. By setting floors below which no member of the industry might provide services, all could be guaranteed a living. The owners of chains and very large establishments would, incidentally, be assured of astronomical profits. In more concrete terms, price floors last year perpetuated in business entrepreneurs who had only twelve or fifteen cases. What they did for the profits of "giants" like Forest Lawn and Pierce Brothers in Los Angeles, both of which boasted of about 7,000 cases each, is a matter known only to themselves and the Internal Revenue Service.

Funeral directors and the trade associations deny that any such price fixing exists. However, several years ago a Senate Subcommittee headed by Philip A. Hart held "anticompetitive" such practices as the prohibition of price advertising. As a result of a suit brought by the Department of Justice, price advertising was restored. A more direct example of "anticompetitive" practices was brought to my attention in 1961 at California State Polytechnic College, where I was teaching. Months earlier, sixteen football players and the team's student manager had been killed when a plane flying them home from an Ohio game crashed on takeoff. All of the mortuaries in Toledo had received "a share of the business." Curiously enough, however, the charge for preparing the bodies and providing caskets for them to be flown back to California was almost uniform. Only three bills sent to the committee appointed to raise funds showed variations from the $1225 sum that was standard; one was for $1240, another for $1262.50; a third for $1257.22.

For some years the industry operated in flagrant violation of the antitrust laws to keep members in line–principally through the withholding of supplies. Although no instances of that have been reported in this country in recent years, it has happened in Canada. When I visited Vancouver in 1964, members of the large memorial society there told me that after local undertakers refused to provide them with services, one of the members had obtained an undertaker's license. He "found it impossible" to purchase caskets; as a result, he was forced to make them himself in his garage. Usually, in this country, more subtle pressures are applied. James C. Bleitz, president of Bleitz Funeral Home in Seattle, told me that after he agreed to provide low-cost funeral services for the People's Memorial Association in 1939, he was "ostracized" by colleagues in his trade association. He persisted, however, and his is now the largest undertaking establishment in the state.

In return for such loyalty, the industry's trade associations have worked effectively to increase demand. Special laws in some areas have made it very difficult for persons to donate their bodies to medical schools and other research institutions; special laws in various states have made embalming and caskets mandatory even when cremation is desired. As a result of the lobbying of the cemetery industry, in California and three other states ashes may not be scattered–even in accord with public health regulations. "The law was," one California cemetery owner told me frankly, "a real bonanza." As a result of lobbying activities, bodies of servicemen who die overseas are automatically shipped home–despite the protests of many of their relatives and despite the fact that the government maintains a large network of national cemeteries on foreign soil.

Supplementing the effort to increase demand has been an effort to obtain higher government subsidies for funerals. Government allowances have been increased for

veterans and for persons covered by social security so that combined benefits are now more than $500 and may be expected to rise—as government benefits did recently in some parts of Canada, where the issue was the price paid for funerals of persons who died without funds. In some parts of the United States, excessive sums are taken to pay for funeral expenses when persons die intestate; for example, in Los Angeles those with estates of up to $1500 are allowed at least $500 by the public administrator for funerals; those with estates valued at from $1500 to $7500, $750. What is left of the money, often a small sum, goes to the state.

Very little supervision of the funeral industry is now made. The state regulatory agencies are usually made up entirely of persons from within the industry. And it is not likely that they will bear witness against one of their number—not in an industry where the ultimate 'sin' is to blacken the reputation of an insider. "Always remember," as Mr. Krieger told undertakers at a state convention in California several years ago, "if we can keep a solid front in our dealings with the public we can create the finest public relations that anybody ever dreamed about." Where there is regulation by public relations, there is no regulation.

In addition to all those factors working against public interest, there are others that allow consumers to be manipulated into consent. One is ignorance of the law. Funeral directors in California for several sessions of the legislature have fought very hard to prevent the enactment of Senator Anthony Beilenson's funeral reform bill which proposes, among other measures, that undertakers be required to inform persons of the legal demands. In his files, in my files, and in the files of the Continental Association of Funeral and Memorial Societies are hundreds of protests from persons asserting that they were led to believe that all kinds of unnecessary services were legally required by the county and by the state.

In any normal business transaction, buyers enjoy some advantages: there is no urgency; they are not irrational; they are free to choose and to reject. Generally speaking, they are without those advantages when they go to make funeral arrangements. Since that is done only after the undertaker has possession of the body of the deceased, purchasers are in the position of "take it or else." Occasionally some determined persons do shop around. A friend of mine and her brother, a retired police captain, did just that. Realizing that the selection room into which they had been led by a salesman was wired so that even though he had excused himself he could hear everything they said, the brother wrote a note: "Let's get out of here. This place is bugged." They went to another undertaker, where they were quoted a price they considered satisfactory and had the body of their mother transferred to his establishment.

Sometimes, persons do not have even the possibility of choice. A scandal followed the first successful heart transplant in Chicago. The donor was a young man who had died as the result of a blow received in a brawl. His body was taken from the county morgue to a private mortuary. Cost of the funeral and burial? $3500. The amount of his insurance received by his wife? $1000. In commenting on the affair in the Chicago *Daily News*, Mike Royko said: "You have better odds in a Cicero dice game."

It was in protest against the economic exploitation and the irreligious quality of modern funerals that the funeral and memorial movement was started in the United States in 1939 at two ends of the country by church groups in Seattle and in New York. Their goals were similar: to make it possible for members of the group to have simple, dignified funerals at reasonable cost.

The procedure was simple. Interested persons would pay a small fee to become members of the society. (No other money is/was required to be paid.) This non-profit society then sought out an undertaker willing to cooperate with the group–no easy task because of the pressures exerted by the industry associations. Members would file a declaration of their wishes with the undertaker; when death occurred, there would be no need for survivors to experience the trauma of working out arrangements. By planning in advance, persons could spare those they left behind the emotional and financial drain of an extravagant funeral. By and large, those procedures have been followed by the 103 funeral and memorial societies that have been organized in Canada and in this country since that time, all of which are now members of the Continental Association of Funeral and Memorial Societies.

The budget of that organization is ludicrously small–about $7500 a year obtained from a portion of the membership fee paid into each of the member societies. The annual budgets of the member societies are equally modest–even more modest since almost all of the work in the societies is done by volunteers. (That they are so many and so willing is the only reason they have been able to carry out their educational goals. For example, when the *Reader's Digest* mentioned their existence favorably in an article, "Facts you should know about Funerals," in 1967, volunteers converged on Continental headquarters in Chicago to answer the more than 25,000 inquiries for information that came in.)

Growth of the societies has not been large; for the past five years the annual rate has been about 10,000 families and individuals. Presently, more than 300 groups in Canada and the United States are members. That relatively small figure, however, in no way reflects interest in the movement to obtain simple, dignified funerals at a reasonable cost. People feel about joining funeral and memorial societies much as they feel about making a will. They wish to do it and intend to do it, but resist.

Nor does the relatively small figure in any way reflect the impact the movement has had on American and Canadian funeral practices. Members are articulate. Three of us have written books that have been widely distributed and frequently cited: Jessica Mitford's *The American Way of Death* (1963) was on the best-seller list for months; Dr. LeRoy Bowman's *The American Funeral: A Study in Guilt and Sublimity* (1959) was the first of the volumes and offers a marvelously detailed sociological study of the subject; my own *The High Cost of Dying* (1963) lays considerable stress in tracing the evolution of the funeral from literary, historical, and religious sources. Ernest Morgan's *The Manual of Simple Burial,* a booklet available through Continental and the Celo Press, provides the best current material about the movement. In addition to the many articles written for publication by various members of the societies, our work has been treated favorably in almost every magazine in the country: from the *Atlantic to True;* The same holds in Canada. Hundreds of radio and television programs have called public attention to our work. As a consequence, the major burden of our argument–that ostentatious and elaborate funerals violate our western religious traditions and that the subversion of competitive business practices has resulted in consumer exploitation–has been conveyed to millions of persons on both sides of the border with good effect.

All of the major denominations–Catholic, Protestant and Jewish, have either approved or endorsed our goals. Many churches have taken steps to restore simplicity to funerals–insisting that caskets be closed, covering caskets with a pall cloth, and suggesting that various trappings be dispensed with. The funerals of President Kennedy and

President Eisenhower, although public affairs, reflected some of those trends: closed caskets, absence of floral displays, caskets covered with flags. Some churches have gone further: white, rather than black vestments and draperies are used in original Christian manner; often they advocate memorial services at which the body of the deceased is not present. The National Council of Churches is represented on the Advisory Board of Continental; the United Synagogues of America has publicly approved our organization. Not long ago, the director of Catholic Cemeteries in Chicago said of the funeral societies: "You have restored freedom of choice to funerals." The response of churches is not surprising since the societies emphasize the importance of spiritual over materialistic values. Most of the societies grew out of churches; however, all must function non-denominationally in order to meet Continental Association standards.

Economically, the impact has also been great. Society members have realized great savings. A study made in 1967 by the Cleveland Memorial Society revealed that members had saved approximately $150,000–when the prices of their funerals were compared to prices for comparable funerals to non-members. Other societies report high savings–although not all have had cost analysis studies made. (The Cleveland Memorial Society's interest in that is not surprising considering that its vice-president for several years is a legal counsel for General Motors.) Recent figures released by the Bureau of Labor Statistics indicate that the average funeral cost is well over $900; in Los Angeles and Seattle, members may obtain basic services for as little as $145 plus a few modest service charges. Basic costs are higher in some places: in Florida and Arizona, where competition is less vigorous, the lowest price is about $350. (It should be noted, of course, that many members prefer more elaborate services than the basic plans worked out by societies with cooperating undertakers; their chief purpose in joining is not to get an inexpensive funeral but to exercise freedom of choice.)

Because of the benefits to consumers, *Consumer Reports, Changing Times, Everybody's Money, U.S. Consumer Newsletter,* and the publications of many local consumer groups have carried articles pointing out the advantages of membership in the societies.

The reaction of individual funeral directors and their trade associations has been extremely hostile. For that reason, in many places local societies have been unable to secure the cooperation of morticians. It was necessary, as has been indicated, for one of the members of the Vancouver Memorial Society to obtain an undertaking license. In Santa Barbara, California, the large society has been forced to use the services of one of the funeral directors cooperating with the Los Angeles Society. It could not find a funeral director willing to work with the society within a 100-mile radius. Societies have been accused of indulging in a "Communist conspiracy" in addition to being called "atheistic and unsentimental." I, myself, have experienced what I consider an extraordinary reaction. Private detectives called on our neighbors to investigate our family life and habits; my superiors at the California state college where I work were called and ordered to get rid of "that troublemaker" and "that subversive." Forest Lawn sent a letter to ministers in Southern California warning them that if they quoted from my book they might be included in the libel suit that was supposed to have been brought against me. Even my daughter's Girl Scout troop felt the fury. A local undertaker who had offered to give the troop fifty cents for each member and parent who showed up for a tour of his establishment cancelled the offer when he learned that I was a prospective tourist. Most surprisingly, Dr. Hugh Tyner–a former college president who has served for many years

as the "public member" of the board regulating the funeral industry in California–told me after I stepped down from testifying on behalf of the Beilenson Funeral Reform Bill that: "If I were the president of your college, I'd fire you."

A reason for that reaction is that the movement's influence has extended far beyond the membership. People–at least literate ones–no longer feel squeamish about discussing prices "at a time like that." Societies have worked in various parts of the two countries to prevent costs from getting out of hand. In Toronto, recently, they made a strong–but unsuccessful–case against boosting welfare funeral costs from $250 to $365. Greater success has been experienced in Wisconsin, New York, Pennsylvania, and California, where public displeasure either halted such increases or encouraged less monopolistic practices.

For the past few years the chief emphasis of members of Continental Association has been to extend the benefits of the movement to persons in the lower income groups–particularly members of racial and ethnic minorities. Some are working with church groups, others with government programs in poverty areas, others with organizations of senior citizens and with neighborhood associations. It is not easy. As Paul Jackson, a leader of the program in the Hough area of Cleveland, explained why to members of the Continental board several years ago: "All their lives, my people have been relegated to the wings–underfed, underhoused, underclothed, underprivileged in every way. This is their one chance to occupy the center of the stage." It is our hope they can be persuaded that the good life is not an elaborate funeral, and that others will be persuaded, too.

A great value of the movement is that it encourages people to think in a rational way about the practical aspects of death. From that point, it is not a long step to think about the meaning of death. When the right questions have been asked and answers found, progress will have been made toward learning the meaning of life. Then perhaps it will be possible for more to follow the example of the really great teachers of morals and ethics and come to acknowledge that it is only the body that is buried–the achievements and the goodnesses are not interred with the bones.

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THE PLACE OF THE FUNERAL: THE ROLE OF THE FUNERAL DIRECTOR IN CONTEMPORARY AMERICA

Howard C. Raether

INTRODUCTION

Habenstein and Lamers (1960) conclude their *Funeral Customs The World Over* with the statement,

> ". . . for all people everywhere, funerals and funeral ceremonies satisfy basic needs, allay suffering, and help rescue death from the horror of meaninglessness."

As the 1970's begin, the funeral and the funeral director can become increasingly important facets of our society despite of or because our culture is youth oriented and there are a growing number of persons who are death denying if not death defying.

Death is not commonplace as it once was. Sociologist Robert Fulton maintains that we in the United States have now among us the first death free generation in the world. Millions of Americans have never experienced the loss, by death, of someone close to them. Millions of Americans have never been to a funeral, or have even seen a funeral procession, except one which was televised as coverage of the funeral or for news purposes. Millions of Americans have never seen a dead body except on TV, in a movie, on a battlefield, or on a highway. And when death does come it is often as University of Michigan psychiatrist Andrew Watson says:

> "The ways of dying nowadays deprive relatives and friends of the use of their sensory capacity. A loved one dies behind curtains in a hospital room. His body is quickly cremated, or his coffin is shut. There is no closing of the relationship, no opportunity to say good-bye, no way in which we can feel the death that we rationally know has come." (From University of Michigan News Service, April 25, 1970.)

It can be said that use of "sensory capacity" is implied in *Future Shock* by Alvin Toffler (1970). The book and its author have received much publicity. Robert A. Gross, who reviewed the book for *Newsweek* (August 24, 1970) says Toffler "uses the concept of future shock in a clinical sense to describe the physical and psychic damage wrought by subjecting man to too much change in too little time." Writer Toffler deals not only with change in the sociological sense but also change in the lives of people. He says that "The death of a spouse, incidentally, is almost universally regarded as the single most impactful change that can befall a person in the normal course of his life."

Toffler refers to ritual as "an important change-buffer." He specifies those which have to do with birth, death, puberty and marriage. He adds that "repetitive behavior . . . helps give meaning to non-repetitive events." He mentions the breaking down or the denaturing of many rituals as the pace of change accelerates. He then says:

> "As we accelerate and introduce arythmic patterns into the pace of change, we need to mark off certain regularities for preservation, exactly the way we now mark off certain forests, historical monuments, or bird sanctuaries for protection. We may even need to manufacture ritual" (p. 350).

There is no need to manufacture ritual to meet needs which, for most people, come with death. Existing and modified or adapted funeral rituals, ceremonies and symbols do satisfy basic needs, they do allay suffering, and they do help to rescue death from the horror of meaninglessness. The funeral can be, as pastoral counsellor Paul Irion says, "an experience of value as it meets the needs of those who mourn."

THE CONTEMPORARY FUNERAL AND TRENDS AFFECTING IT

In 1966, Fulton conducted a study of contemporary American funeral practices. Responses from 3,474 practicing funeral directors indicated that in 1966 the vast majority of deaths resulted in a period of the funeral which included a public viewing, a public service (most times religious), and a public committal. Trends away from the full period of the funeral were evidenced in the Pacific Coast states with a move toward privatization of the funeral noted in some of the New England states (Fulton, 1967). There is nothing to indicate a reversal of these trends in the Pacific and New England areas. Furthermore, in all sections of the country there are occasional instances of abbreviated services, of private funerals, and of no viewing of the body.

There are reasons for some of the deviations from the funeral of the past as well as the need for flexibility in the funeral of the future. Before examining them it should be pointed out that few people really want to die. While funeral ceremonies have had meaning and value there have always been those who have tried to "get at" death by being critical of facets of post death activity. Limiting our comments to the United States, history records that long before there were any functionaries, (layers–out-of-the-dead; undertakers; funeral directors) there was criticism of funeral expenses. According to Habenstein and Lamers (1955) "in 1721, 1724 and 1742 the General Court of Massachusetts passed laws prohibiting 'Extraordinary Expense at Funerals.'"

Criticism of funeral practices is not new. Fear and anger and the wish to avoid death and all that is associated with it have not only been reflected in direct criticism and even in legislation, but also in non-direct euphemisms and synonyms for death. Hostility is expressed as much in what *is* said as it is in what is *not* said. Rabbi Earl A. Grollman (1970) writes that the "new four letter word of pornography is *Dead*. It is barely whispered in polite circles." And, George T. Harris writing in *Psychology Today* (1970) states that he suspects "that mortality has replaced sexuality as the obsession of our time."

As we begin the 1970's "dead" and its derivatives have enhanced some old fears and hostilities as well as having taken on "new" meanings and created new "hang-ups." For instance: To a doctor practicing in this day of medical miracles death is often perceived as a personal defeat, the unforgivable failure to prolong life; A clergyman viewing the dead body of a parishioner with a family member who is a space age scientist feels on the spot when asked by the scientist, "What happens now?" "Cryogenic interment" appeals to some persons because they would rather take a chance on it than on its alternative.

There are other factors which are responsible for changes in funerals and the trends associated with them. The most important should be stated.

Family Life Change

In his book, *Death and Identity* Fulton (1965) writes:

> "The denial of death and the deritualization of mourning growing apace in America today parallel and reflect other significant changes apparent in family life. These changes

> can be identified briefly as: (1) from predominance of the religious to predominance of the secular, (2) from a large group to a small group, (3) from a stable to a mobile group, (4) from an adult-centered to a child-centered family, (5) from a communal family idealogy to a democratic one, (6) from an integrated to an individualized group, and (7) from a neighborhood-enclosed family to an isolated family in an urban environment."

Derogatory Publicity

To criticize and be criticized seems to be inherent in the so-called American way. Yet few groups have been as consistently and often unjustifiably criticized as have funeral practices and funeral directors. A reason for this undoubtedly is the symbolization of "death" found in them.

Communications media of all sorts have publicized the criticism associated with the funeral and they have avoided or rejected the positive material on the place of the funeral and funeral director. A negative piece predicated on more half than whole truths receives interest generating headlines, a prominent place in the paper, and is picked up by other publications. A fair impartial article is junked with the editor giving as his reason that it was not sensational, it wasn't what he wanted. A television documentary edited to show funeral service and its spokesman in bad light is made available to all who are interested. A well known magazine with national circulation listed where to write for a brochure of a group advocating the bodiless memorial service as opposed to the funeral with the body present. The caption on the paragraph was "funerals." The National Funeral Directors Association immediately requested that under the same caption in a future edition its name and address be given for those interested in some brochures it has available. Months later the request had not been granted.

Negative publicity and a lack of positive material exists in other fields and in many walks of life. But apparently not as consistently as in funeral service. The whole communications situation is of increasing importance because of a growing number of people who have had limited or no personal exposure to death or to the funeral and the funeral director. They have no experience to counteract what they read, see and hear, much of which is derogatory.

Also, a paradoxical situation confronts the public and funeral service in "publicity" of the funeral. When a Kennedy, a King, a MacArthur, a Churchill, or the Pope dies, there are telecasts, broadcasts, and newspaper coverage of the funeral. Likewise when a prominent citizen or a murder victim or person of "news value" is buried, there is news coverage of that event.

Sometimes in the coverage by the media certain procedures are explained and related to the overall funeral. But the media rarely go beyond this. In fact some of their other articles or programs, in essence, are critical of the very ceremonies and rituals they publicized. Yet, they will not relate the good of the funeral generally. Nor will they be specific in their criticism of the funeral as it was conducted for a newsworthy person beyond sometimes using words and phrases with negative connotation as to the funeral. For instance, regardless of how detailed some funerals have been, they have been referred to as a "simple" ceremony. The contradictory and possibly even hypocritical character of this treatment cannot be overlooked. It seems to reflect, among other things, the ambivalence felt toward the need to deny death and the simultaneous need to acknowledge it—particularly with regard to a person of significance.

The Funeral Director

Some funeral directors are to an extent responsible for some existing trends. Some of the practitioners are reticent to counsel on values which a family may be avoiding when they try to take what they think is the emotionally easy way out. By the same token, some funeral directors fail to adjust facets of the funeral to meet particular needs. They sometimes recommend having for mother's funeral what was done for father's service ten years ago without ascertaining whether such a service might in part be stereotyped if not dysfunctional to the members of the immediate family.

Often the place of the casket in the over-all funeral service is unclear or undefined. Historically, U.S. funeral functionaries have been providers of goods and some services. A casket was purchased and all other services provided "free." Today on the average, the merchandise provided by a funeral director amounts to about 20% of his total cost in providing a funeral service. The casket is not the funeral. Nor is the funeral the casket. The failure of some funeral directors to accept this fact and explain it to those they serve is in some ways responsible for some defuneralizing trends.

FUNERAL PRACTICES: WHICH SHOULD CONTINUE AND WHY

There are modifications, adaptations and changes in the funeral which are taking place and there will be others as the years go on. Before focussing upon those practices which should continue in some manner, two factors are basic. They are: (1) Time is seldom of the essence in the urgent sense. There is a therapy in thinking things through, in acting and in proceeding at less than a demanding pace. Therefore, the period of the funeral and making arrangements for it should not be hurried. This may help, also, to alleviate the withdrawal and regrets that sometimes come with "getting it over as quickly as possible" and with trying to intellectualize emotions; (2) "There are many levels or degrees of loss rather than just one," says Fulton (1970). He adds:

> "These different responses to death can be observed in the varied and changing character of contemporary mourning rites and funeral practices. Care, therefore, must be taken not to define too narrowly what funeral rites or behaviors are appropriate for the bereaved. To do so can lead to confusion, tension, or anguish on the part of the survivors. . ."

> "There must be "a stronger recognition by funeral directors and other professional caretakers . . . to acknowledge the important distinction between 'high grief' and 'low grief' and to take into account the changing social and intellectual environment in which death is experienced in America today.

> "For bereaved persons who are genuinely grieved, it is imperative, in the light of growing evidence, that they somehow find the opportunity to resolve their grief. They should be encouraged to mourn. For those who are simply bereaved but not grieved, however, it would appear to be inappropriate and perhaps emotionally harmful to insist that they express feelings they do not, in fact, have."

With these points made, a review of funeral practices which should continue with a brief explanation of why is in order.

"Visitation" or "Wake" or "Calling Hours"

A "visitation" or "wake" or what some refer to as "calling hours" permits family and friends in the presence of the viewable body to express together their feelings about the deceased. This sharing experience is nearly always important to the survivors. When the survivors do not share their grief, they face their grief alone. When they share their grief, "one touch of sorrow makes the whole world kin." They should have the opportunity to express their own emotions. At the same time the family should hear what the life of the deceased has meant to others, some of whom they may not even know. The visitation in the presence of the viewable body provides a proper setting and climate for all of this—a setting and climate which generally does not exist in any other way at any other time.

"Viewing" the Body

In the material under "visitation" reference is made to the "viewable body." It should be made clear that for hundreds of years men of most cultures have viewed their dead and they continue to do so. Viewing is not a custom of American origin The only basic difference between viewing in the United States and elsewhere is the circumstances under which it takes place. Also, as has been stated earlier, some persons today in our land want to deny the death which has occurred. One method of disguising this reality is failing to have the body present during the period of the funeral or not viewing the remains if they are present.

But it is essential to admit to death's presence. This can be a painful experience. It also can be a helpful and rewarding one. Some say that they wish to remember the deceased as he or she appeared alive. However, to view the body is one of the first steps of accepting the death. If the death was violent or the body wasted away, the skills of the funeral service licensee will be employed in such a fashion as to modify or erase the scars of violence or the ravages of disease. Preparation allows for an acceptable recall image of the deceased.

It must be remembered that the period of the funeral, from the first announcement of the death to the committal service, is a declaration that a death has occurred. The body present and viewed, when possible, is an important part of this affirmation. The following statements document the value of the body present and viewed.

Irion has written four books dealing with death and the funeral. He feels mourners should be assisted in their attempts to live with the memory of the deceased as he maintains (1956):

> "There are several ways in which we give this help. One, I believe, is through a tasteful showing of the body. I could not bring myself to endorse any sensational displays or practices that are not in good taste. However, it can be very helpful for a bereaved family to see their loved one in repose. Viewing the body is another means by which the whole situation is focused on reality. Often it is helpful in relieving painful memories of a lingering illness or a terrifying accident."

Reverend James L. Kidd, Wellington Avenue Congregational Church, Chicago, Illinois (1969) wrote about the funeral service for his thirteen-year-old son who died of cystic fibrosis. His first reference is to the funeral for his father-in-law.

> "First, the presence of the dead body was an important factor in helping the mourners to accept the fact of death, to overcome the experience of denial and to enable creative grief to take place.

"In the second place, the body of the deceased cannot be separated from the life and reality of the person. The only way we knew that person was in and through the body. My wife's father was in that casket experiencing his death. To have the familiar body present was to share that last experience in this life with him. That seemed important to us all. So when our son finally died, we planned to have a 'funeral' service rather than a 'memorial' service (without the body present)."

Dr. Charles W. Wahl–Chief, Psychosomatic Service–UCLA

"I was recently again reminded of how valuable and legitimate a funeral service can be. I accompanied a friend to the funeral of his mother. She had died of a chronic and wasting illness and I had been present at her death bed. My friend experienced a deep and profound consolation seeing his mother with the lines of suffering erased from her face and lying at peace."

Reverend Donald Heinz commenting on an article in *The Christian Century*. Reverend Heinz's letter was in the July 23, 1969, issue of the publication.

". . . the fact remains that this corpse, only lately a loving being, is a very significant contact between the grieving husband and his still cherished wife. This corpse is now both the most painful reminder of the terrible vacuum which now fills his life and the sweetest reminder of joys he has known. I believe many writers in the field of pastoral theology would warn against any sudden disinterest in this body, this corpse–provided the interest does not last interminably and become neurotic."

Reverend Clarence Bruninga appearing at an institute on "Help to the Grief Sufferer."

"Again, I'd like to remind you that viewing the remains and the committal service, and other forms, arose not merely through the devious thinking of some undertaker who wanted to make more money, but because of the emotional needs of people, and are perpetuated because they meet some need. This does not mean that all rituals are positive. They may contain negative elements as well. And tragically, I think, a great many reactions against ritual arise out of situations where immature, inadequate, neurotic people reacted to death in an immature, inadequate way. This you can see at almost any wake, which can often serve exhibitionist and masochistic needs."

Some persons would rather not look at the body of a dead person. Others indicate to funeral directors that they are afraid of what they will see. They don't think a body wasted away by cancer or other ravaging disease can be restored to a likeness of the deceased before the physical deterioration began. There are those also who question whether a body can be restored where the cause of death was violence. Sometimes those who question whether the casket should be open will view the body after it has been prepared and placed in the casket. Or they will designate someone else to do this. In most such instances, the casket is left open. And the nearest of kin are forever grateful. Conversely, where the family arbitrarily keeps the casket closed, there often are regrets and doubt as to whether they did the "right" thing. And who knows when a family might be depriving some person from viewing when that person loved the deceased as much or more than the relatives did.

Writing about viewing is not justification of "prettifying" the deceased to make him look better in death than he did during the healthiest days of his life. Cosmetic restoration is not an attempt to deny death by creating an illusion of life but rather it gives the bereaved an acceptable image to recall. Most times the funeral service is a religious rite. When it is the viewing should be completed and the casket closed before the worship begins. Thoughts are transformed thereby from the temporal to the spiritual.

Committal at Graveside

It is argued by some that the committal should be at the church or in the funeral home to avoid the inconvenience of the trip to the cemetery where about 95 percent of all final dispositions are made. The problems of traffic, inclement weather and other reasons are given for suggesting that there be no procession to the cemetery. Yet the same people who are against the graveside committal because of traffic and other inconveniences often think nothing of going to shopping centers during peak periods, of traveling bumper to bumper to go to an athletic event or on a holiday weekend in all sorts of weather. And, those who feel people have the right to gather and to march to express feelings must agree on the right and place of the funeral procession for those who are acting out their feelings.

Irion (1954) says, "The committal service provides, as nothing else . . . does so graphically, a symbolic demonstration that the kind of relationship which has existed between the mourner and the deceased is now at an end" (p. 111). Beyond this final farewell to help complete the grief cycle there is the support that relatives, associates and friends give at graveside. Turning away and leaving the grave is a realistic but traumatic moment for many. It should not be avoided nor should it be faced alone.

Public Funeral and Expressions of Respect and Sympathy

A public funeral gives the community a chance to offer its support and share the sorrow of the immediate family of the deceased. A private funeral limits those who may attend. It arbitrarily shuts out relatives, friends, associates and acquaintances who may be able to bring comfort to the bereaved.

There are a variety of ways in which people share in loss by the way they express their love, respect and grief. Some will come to the visitation and funeral service. Others will just be at the visitation or at the service. Most who are at the funeral will go to the committal. Some of those who will be present during the period of the funeral and others who are unable to attend will further show their affection with a tangible expression such as flowers or another form of remembrance.

The funeral is of the person who died and it is for those who live on. It is important that relatives, friends and associates be permitted to express their sympathy and offer their support through a public funeral. Such expression should be freely given and freely received. It is essential also to realize that the funeral can be just as important to the family who may not be well known as it is to the family of fame and fortune.

THE FUNERAL AS A RELIGIOUS SERVICE

For the religiously oriented, the funeral service is a spiritual occasion. "Weeping may endure for the night, but joy cometh in the morning" (Psalm 30:5). Most times the service is conducted at a church or funeral home with the family's clergyman officiating.

The religious funeral is geared to meet spiritual needs. As to the Christian funeral, Edgar N. Jackson (1966) says in his *The Christian Funeral* that the funeral should do the following for those who share in it: 1. It should recognize that what is done is to meet social, psychological and spiritual needs of those who are able to participate in it; 2. The service is aware of the powerful emotions that are at work and tries to fulfill the feelings

rather than deny them; 3. The funeral is a time for facing reality rather than for denying it; 4. While it would not deny the fact of the event, neither would it deny the validity of the emotions that attend it; 5. The funeral should give the members of the religious community a chance to give evidence of their emotional and spiritual support of the bereaved; 6. The funeral should be a time of affirmation of faith.

For Those Who Do Not Want A Religious Service

Some people do not profess a religious belief. Some of them view as dysfunctional anything with religious overtones. However, the funeral has value for those who profess a religious orientation and for those who do not. It was with this in mind that the previously mentioned Rev. Irion has prepared a manual on the humanistic or secular funeral. (At the time of writing this article, the manual has not yet been published.)

In this regard–a momentary reflection on Toffler's *Future Shock.* In the area of rituals, the writer says that "In the future we can anticipate greater variety in the kinds of rituals adhered to in family life." Just prior to that statement, Toffler mentioned the "non-religious family that periodically offers a secular grace at the dinner table, to honor such benefactors of mankind as Johann Sebastian Bach or Martin Luther King." The American funeral has been mostly a religious rite. At least there was a religious officiant whether the deceased was or was not churched. Now we find a variety in the ritual because it can be secular or humanistic as well as it can be religious as it speaks to the special needs of those in bereavement.

YOUTH AND THE FUNERAL

With half of our population under thirty years of age, and many of the balance wishing and acting like they were under thirty, it can be said ours is a youth culture. This brings up two matters of importance. They are: (1) death and the child; and (2) youth and the funeral.

Death and the Child

In interpreting a study he made in 1962, Fulton (1967) said there were some persons who "strive to bring their children up in a world of reality through the discouraging of such phantasies as ghosts, hobgoblins, Santa Claus, and the bogies of sex. Nevertheless, in this setting they appear to behave contrary to form and seek to shield the ultimate truth (of death) from their children." Then came November of 1963 when John F. Kennedy was assassinated in Dallas. His was a death and funeral from which children could not be shielded. They participated by watching television. Books and articles were written immediately. Some ortho-psychiatrists who never before were interested in children and death prepared papers on the subject.

But funeral directors through their national association had sought and secured advice previously. As an example in 1962 the *National Funeral Directors Association Director* carried a piece written by Dr. Mervyn Shoor who is the psychiatrist in charge of the Santa Clara County Guidance Clinic in California. Dr. Shoor was assisted by a clinical psychologist, Mary Helen Speed. The Shoor and Speed paper says that funeral directors are in a unique strategic position to aid and encourage the normal mourning process for

children. They recommended that funeral directors talk directly to the child in a mourning situation by asking specific questions or making specific comments about the deceased. They further recommend that any questions or comments designed to help the child openly acknowledge the reality of death will prove helpful and that the child should be included in the funeral ceremonies where appropriate, even to the extent of specific assignments such as monitoring the guest register and helping with the floral offerings.

Other have since agreed. Children, researchers have said, as early as age three have an awareness of and respond to death. They must know the truth the funeral tells and should be allowed to attend the services if they want to. They should not be denied the experience of this significant part of their life. If they are it could have future troublesome emotional implications because they could develop a sense of abandonment instead of one of belonging. In fact, there are those who trace juvenile delinquency and other social and psychological problems to unresolved or improperly resolved grief. However, no unwilling child should be made to participate.

Youth and the Funeral

The greatest percentage of participation in a funeral service by an age group is by those between fifteen and twenty-four when a contemporary dies or is killed. Most of these young persons are sensitive to the feelings of others. An example of that sensitivity can be found in a piece written by Louisville funeral director, William Wagner (1970). Mr. Wagner helped conduct the services for a young married couple killed in a traffic accident. In his article Mr. Wagner says:

> "For the next day and a half approximately a thousand people came into the funeral home to pay their respects to the deceased and their survivors. Eighty percent of these people were between fourteen and twenty-four years of age. This is the group that some say flaunts ceremony, that belittles sentimentality, that spurns religion, that doesn't believe in anything. They came with their wide ties, their loud striped shirts, their beards, their long hair. They came on motorcycles, in cars you wouldn't know how to start, with their parents, alone, often in gangs or packs–BUT THEY WERE THERE BECAUSE THEY CARED ENOUGH TO BE.
>
> "And they went up to the caskets and talked with the parents. Some prayed with them. Some just stood there but their presence helped the families. Some not too familiar with prayer gave the now famous two finger peace sign and walked away.
>
> "Solace and comfort were provided by the young people even though to some their ways seemed odd, direct and too honest. I wonder if some older people might benefit thereby–people who feel a stereotyped, syrupy message often on a card, or with a floral remembrance or a memorial gift is the best way to express sympathy.
>
> "I feel no need to be leery of most young people. We don't have to fear them. They are not out to upset the traditional American funeral. They may do some things different to make for a contemporary service. What I have seen of most of them is that they don't want hypocrisy, sham, the phony and the irrevelant wherever they find it, be it in school, religion, politics or in the funeral–if it be there" (p. 7).

Reports of young persons' participation in the funeral tell of a cordon of motorcycles as an honor guard for the procession; placing a cyclist jacket in the casket before closing it; throwing a remembrance into the grave by each person attending the committal; ordering special floral pieces symbolic of a special relationship; or, offering some "farewell" gift

made by the giver. Most times the gift is of something meaningful to the giver. It is not an empty expression.

Funeral directors are becoming aware of the validity of the projections which say that the young people are better educated, are less responsive to organized restraints, want respect as individuals, and seek fulfillment of human wants and needs. The funeral of the future must meet their wants and needs.

A few young people will experience death. Some will lose one of their own young children or infants—often a stillbirth. There are cases of young married couples, or of either the man or wife, becoming physically and/or mentally upset because of advice followed or a procedure used which did not allow for proper grieving. An example is that reported by Dr. Henry Grunebaum (1968) of Massachusetts Health Center. Dr. Grunebaum tells about a young mother whose baby died during delivery and who sought psychiatric help. One of Dr. Grunebaum's comments was:

> ". . . perhaps (the) most vital issue is the influence of the hospital and its way of dealing with stillbirths and the patient's inability to grieve. She was helpless during the delivery, not allowed to see the baby, and encouraged to sign an autopsy and burial permit for a mass grave. We may wonder whether her grieving would not have proceeded more normally had she seen her baby and been able to give it an appropriate funeral service . . ."

ALTERNATE FORMS OF THE FUNERAL

The above caption might be expanded to read "Alternate forms of the funeral and/or alternate forms of the operation of a funeral establishment." There have been both without any real lasting success. There have been and are various groups that bury their own, so to speak. Most of these groups or cults use none of the services, facilities and merchandise of those licensed to provide funeral service. They have not increased appreciably in number or in size.

Cooperative Funeral Homes

There have been and are cooperative burial associations or cooperative funeral homes. These establishments offer funeral services and their personnel are licensed as required by law. In some states these cooperative associations were and are given operation advantages as to taxation and also in being able to be engaged in certain business getting activities which are illegal for other funeral operations. One of these is the selling of certificates of membership in the cooperative. Despite these advantages, the number of cooperative funeral homes is considerably less than it once was.

Labor Union Funeral Homes

There have been and still are labor unions which have their own funeral homes or which had a connection or an arrangement with a particular funeral home. Like the cooperatives, the personnel of these establishments are licensed as required by law. Like the cooperatives, these operations have a competitive advantage at least as to the membership of the union which owns or which is operated with the funeral home. Like

the cooperatives, there are fewer union funeral homes or union associated funeral operations than there once were.

Memorial Societies

There are about one hundred "memorial societies" in about as many cities in the United States. A purpose of the memorial society movement is to encourage immediate disposition of the body with a memorial service to be held at a later date—without the body present. These societies are not in funeral service. Their officers and staffs are not licensed to conduct funerals or to make funeral arrangements. Rather they enter into agreements with funeral directors to do the things a licensee must do where there is a memorial service and a funeral functionary is needed to perform certain tasks. They also have agreements with funeral homes to provide certain minimal funeral services with the body present. Although the movement has existed for some time and has received much publicity for almost ten years, except for a very few societies, the success of the groups has been very limited—if they have had any at all. In fact, some of the societies have ceased to exist.

There are persons who believe in something less than the funeral with the body present. Their beliefs are no doubt sincere and their needs should be served. However, one must look not only at the social and ethical philosophy behind such beliefs but one must assess the implications of them for the bereaved. Some of these persons appear to be running away from fears and conflicts they have regarding death or they may even be giving vent to some unresolved and mishandled grief of their own.

Some memorial society leaders now agree that the funeral with the body present is a way of meeting social and emotional needs which should not be ignored. Nevertheless, they seem to continue to disregard these needs and in the process, deny mourning and ritual support to survivors, as well as ignore the tear that the death has caused in the fabric of the family and the community.

In his *Death, Grief and Mourning*, Geoffrey Gorer (1965, p. 134), the British anthropologist, writes:

> ". . . it would seem correct to state that a society which denies mourning, and gives no ritual support to mourners is thereby producing maladaptive and neurotic responses in a number of citizens."

While Gorer's study in England involved responses to death there and not bodiless funerals, valid application of his conclusions can be made to moves in the U.S. toward individual and public denial of mourning.

Two American psychiatrists who have studied death, grief and mourning have spoken very openly against the bodiless memorial service. One, Alfred A. Messer (1970) of Emory University recently said:

> "Memorial services, held a couple of weeks after death, are for the birds—not for human beings . . . When there is a funeral there should be a body there and I think it should be an open casket . . . When there is death there should be a funeral. There is no association in people's minds between a memorial service and a man who died two weeks ago" (p. 13).

William M. Lamers, Jr. (1969), who practices psychiatry in Kentfield, California, wrote the following in *Medical Economics:*

> "Are there any satisfactory funeral substitutes–a memorial service, for example? In my opinion, there aren't. Though a memorial service is a response to loss and can be extremely satisfying for many, it's not ideal because it lacks several basic elements. First, a memorial service usually doesn't take place when feelings are most intense, which is shortly after the death. Second, members of the family aren't involved in communication, participation, and repeated exposure to the fact that death has occurred. These things force people to acknowledge the reality of loss. Finally, a memorial service doesn't include the presence of the body, which means people aren't given as great an opportunity to fix the fact of death in their minds" (p. 107).

THE FUTURE OF THE FUNERAL AND THE FUNERAL DIRECTOR

Wilbur Schramm (1965) of Stanford, writing on the televising of the funeral of the assassinated John F. Kennedy (*The Kennedy Assassination and the American Public*), said that those viewing the televising of the services were given "an opportunity to experience a real catharsis of grief if they wanted to." He referred to acts of mourning and said the viewers were participating–"They were going to a funeral." Schramm's observations and conclusions confirm what has been known and expressed for years.

Raymond Firth (1964), the British anthropologist, has said, "A funeral is a social rite par excellence. Its ostensible object is the dead person, but it benefits not the dead, but the living" (p. 63). In his recently released *The Dynamics of Grief* Southern Methodist pastoral counsellor David K. Switzer (1970) writes:

> "... The funeral is both the symbol and the reality of the mobilization of the community to sustain those persons in distress as it pushes them along in their grief work" (p. 213-214).

The funeral for JFK allayed fears and restored some confidence as the world stood still for two days in respect, in honor and in remembrance. The funeral for Martin Luther King did something else. The Research Institute of America pointed out shortly thereafter that the funeral brought Negro moderates and black militants, and just people, in solemn unity. One week earlier no occasion could have done that. The RIA Report adds that:

> "The ordinary Negro people were in full charge, all the way. They had come there to bury their dead, and to do it with dignity. Firebrands and demagogues would gladly have done their worst–but their people would not tolerate that for a single moment ..."

The American funeral involves a funeral functionary. Most times he is called the funeral director. His role as it pertains to post death activities, including the funeral, should be maintained and enhanced. Talcott Parsons (1967), the Harvard sociologist, said "No one can take the place of the funeral director."

Joseph Bayly (1969) in his *The View from a Hearse* writes:

> "The funeral director is a man, with all the feelings and capacities of most human beings. More than other men, except for pastors or other religious advisers, and doctors in certain specialties, he lives with sorrow. He is usually able to help us in our moments of grief–moments when the burdens of decision weigh heaviest" (p. 69).

David Switzer apparently agrees. He writes:

> "... With this understanding of the positive aspects of anxiety, it is clear that it not only plays a significant role in the process of therapy but in all interpersonal situations. This needs to be emphasized in regard to grief, because in actual fact people do not normally go to a psychotherapist in their mourning and many do not even have the potentially helpful relationship with a clergyman. In these cases, grief work needs must be met by other members of the family and friends or by other professionals, such as the physician or funeral director, who, by the particular nature of the situation, may be involved" (1970, p. 213-214).

Successful grief work is being done by the funeral service licensee. A study of childhood leukemia, by the Langley Porter Neuropsychiatric Institute University of California, San Francisco, reported in the *New England Journal of Medicine* (Binger et al., 1969) tells of the findings of interviews of 20 families of children who had died of the dreaded disease. In discussing the support parents received, the authors reported that fifteen families expressed positive feelings toward the mortician or funeral director for the services rendered during their bereavement. The authors conclude that the funeral director's experience with grief reactions makes them skilled in offering solace to grieving families.

Cecile Strugnell and Phyllis R. Silverman are associated with the Laboratory of Community Psychiatry at the Harvard Medical School. Dr. Silverman has been identified with the Harvard "Widow to Widow" program. These two social scientists, in an article that has been submitted for publication, state that the increasing isolation of people in our society and the fractionalization of the family often makes the needs of the bereaved very acute. They urge funeral directors—and their wives—to be aware and sensitive to these needs and to play a greater role in meeting them.

Strugnell and Silverman in their "The Funeral Director's Wife As Caregiver" (1971) feel that the funeral director and his wife have an experience with grief that is invaluable and a close cooperation with the mental health specialist could be very fruitful. This is not to say that the funeral director should practice psychiatry or psychology. He has his own knowledge and expertise, founded upon invaluable experiences of day to day encounters. He often does what no one else can because of his unique position. Also, he should be able to recognize when a person's grief is such that the assistance of a professional should be sought.

More than ever before the funeral must continue to be a ritual—a ceremony—a response to death which is of value as it meets the individual needs of those directly involved as mourners. It also must meet the collective needs of the community and of the nation which apparently is changing so fast it sometimes forgets to sense and examine the destructive meanings that some change brings. Concomitantly the role of the funeral director must be adaptive. He will continue to be entrusted with the dead body which was a person who loved and was loved. He will continue to provide funeral facilities, furnishings, and merchandise. He will continue to serve people many of whom will be experiencing a major crisis in their lives.

The funeral director must become more of a caretaker—a caregiver. He must continue to develop his sensitivity to the various levels or degrees of loss that death creates in our present day society. The funeral director must always realize that when he does what he does it is at a point of no return. What is done cannot be changed. What is not done will ever remain so. Neither the funeral director nor the family he is serving will have a second chance.

The place and meaning of the funeral in contemporary America is as it has been defined—a response to death which is organized, purposeful, time-limited, flexible and group centered.

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RESPONSE AND REBUTTAL

Editor's note–Ruth Mulvey Harmer and Howard C. Raether, authors of the preceding articles, are prominent advocates of contrary viewpoints on the place of the funeral in American society. In the belief that controversy is often the keystone of progress, we have invited each author to respond to the views expressed by the other. The results of this endeavor follow in the commentary below. We believe that both the heat and the light are informative and provocative.

RAK

THE PLACE OF WHAT KIND OF FUNERAL?

Ruth Mulvey Harmer

I have read Howard Raether's "The Place of the Funeral" with interest and with dismay. It is, of course, his privilege to protest the growing trend toward simple funerals. It is perhaps his obligation to do so since he is–and the knowledge must be kept in mind–the official spokesman for a trade association whose members directly depend for their profits on expensive and elaborate funerals. However, it seems to me that it is neither proper nor just for him to suggest that critics of funeral practices are motivated by "fear and anger and the wish to avoid death and all that is associated with it." Our principal concerns were briefly summarized by Jerry Voorhis in a speech to the Los Angeles Funeral Society in February, 1971. According to the former president of the Cooperative League of the U.S.A. and a prominent Episcopalian layman, those concerns are the restoration of religious and spiritual values, the exercise of economic sanity, and the right to freedom of choice.

No thoughtful person would deny that a funeral can be of individual and social value when it serves as a mechanism for releasing tensions and for reaffirming beliefs. However, it is *meaning*, not money that determines both the affectiveness and the effectiveness of a rite–qualities which are frequently lacking in ostentatious funerals, which have come to be economic transactions whose chief function is to deny reality.

The question is not whether funerals are important. It is where the emphasis shall be placed: on materialistic trappings and conspicuous consumption? or on the spiritual and philosophical meanings of life and death? Mr. Raether surely knows that to answer the former affirmatively is to opt for pagan and primitive practices. Clear evidence of that is contained in the two books by Habenstein and Lamers–*Funeral Customs the World Over* and *The History of American Funeral Directing*–which have been copyrighted by his own organization. Additional dramatic evidence is offered daily in funeral services conducted for Christians and Jews, even for those occupying positions of highest social significance and for whom elaborate funerals had been considered mandatory. Although the funerals of Presidents John F. Kennedy and Dwight D. Eisenhower were affairs of state, they were characterized by quiet dignity. For example, Mr. Kennedy's casket was closed, it was covered by a flag (pall cloths are now being used in some churches), mourners were asked not to send flowers. As *Time* noted after the relatively simple funeral of Mr. Eisenhower, the ritual helped to emphasize the changes that have been occurring in funerals in this country in recent years: "While Catholics are moving away from a tradition of guilt and

grief, U. S. Protestants are trying to retreat from the excesses of funeral-parlor escapism" (April 11, 1969, p.60). Similarly, Jewish funerals–traditionally far more simple–have also been affected. One of the most reassuring responses we have had in the funeral and memorial society movement was from the Synagogue Council of America, which represents all of the major branches of Judaism. In a letter to Dr. LeRoy Bowman, former president of our organization, Council President Jacob Philip Rudin wrote:

> The emphasis placed by the Continental Association of Funeral and Memorial Societies upon funeral procedures and practices which conform to the highest standards of dignity and reverence finds the Synagogue Council of America in hearty concurrence, and we would endorse again, as we have in the past, the efforts made by the Association to achieve these most laudable goals.
>
> It is gratifying to know that there is an Association of Funeral and Memorial Societies whose goal it is to give to a funeral service the kind of quiet and meaningful simplicity which will strengthen the hearts of the bereaved and bring comfort to them in the time of their grief.
>
> (Letter dated March 5, 1969)

This kind of response rather than sensational attacks has characterized the many articles about our efforts that have appeared in religious publications during recent years. And many of the articles–"the derogatory publicity," as Mr. Raether calls it–have also emphasized the economic exploitation that has been rampant. This has been the principal burden of the articles in general and consumer magazines and in newspapers, which have been appearing with increasing frequency. According to the tally of the National Funeral Directors Association, an "unusual" number of articles and features came out during the period from early October to early December in 1970–*True, The Lion, St. Anthony Messenger, Advance, Forbes, Together*, (among the magazines), the *Wall Street Journal*, the New York *Times*, the Los Angeles *Times*, and other newspapers in seventeen states ("Increasing Number of Articles and Features on the Funeral in News Media," *Canadian Funeral Service*, February, 1971, pp. 22-3.).

Reasonably typical of the kind of article that is published is one in the Autumn, 1970, issue of *Everybody's Money*, a magazine with a circulation of more than 2,000,000 to members of credit unions throughout the country. The article, which recommends membership in a funeral or memorial society, was prompted by the experience of the writer in selecting a funeral. Having gone with a brother to select a casket (which set the price for the funeral), they picked out one that cost $650. At that point, the funeral director urged them to reconsider:

> "Yes, but she was your mother. Surely something in a better casket would be more befitting her memory. Now this $800 casket . . ."
>
> Who could say no at a time like this? My mother had just died. The funeral director showed us the more expensive casket.
>
> "Of course, the $800 fee includes all services, a very nice silk gown and the announcements in the newspapers."
>
> Neither my brother nor I could say anything. We just nodded our assent at what burned in my stomach as a high pressure gimmick. Then, after the funeral, we were told the final amount. It had increased due to "extra" services. The total happened to be a few dollars short of my mothers' insurance policy. Who could say no or argue at a time like this?
>
> ("Funeral Societies," *Everybody's Money*, Autumn, 1970, pp. 10-11)

Rabbi Rudin and the staff writer of the magazine focus on the essential reasons for criticism. And those reasons cannot be met by the kind of argument that Mr. Raether has advanced in discussing those practices he wishes to continue: body-centered practices that

are time consuming, costly, and evade the spiritual and material realities. For example, there is the matter of the "wake." In former times, an interval between death and burial during which the dead could be inspected by the living served to insure that death had not been the result of foul play. Coroners offices and autopsy procedures have done away with the need for such insurance—as even the funeral industry acknowledges, since it has re-named the wake a "visitation" or refers to it as "calling hours."

The body of the deceased is not required for members of the family and friends to share grief and affectionate remembrance with the closest survivors. Sensibilities of many are deeply offended by a rouged and powdered corpse, which is sometimes given a "permanent wave," made to appear like a wax dummy. Also offensive to many are flowers that cannot be enjoyed by the recipients—dead or alive. Flowers are a lovely gift for the living; useless for the dead. It is far more appropriate, many believe, to honor the memory of the dead with a gift that will benefit the living—to scholarship funds set up by schools, organizations that are working on a non-profit basis to advance health care and medical skill.

In discussing the role of the undertaker as "grief therapist," Mr. Raether does not mention that he has had neither the training nor the motivation to perform in that role. Although undertaking establishments have appropriated the architecture and decor of churches, and undertakers often assume what they regard as clerical manner and garb, those things only add to the blasphemous nature of the secular ceremonies that are conducted by persons in the business of selling goods and services. The job of the undertaker is to celebrate the body; the role of a clergyman is to celebrate the soul—a celebration in which the things of Caesar have little relevance.

Some of the points in the article are genuinely startling. Dr. Mervyn Shoor and Mary Helen Speed, as trained psychologists, are surely too sophisticated to believe that by having the children help with floral offerings or with monitoring the guest register, the undertaker is helping them to cope with the reality of death. And in his discussion of "Youth and the Funeral," Mr. Raether uses precisely the kind of illustration that I did—in the case of Tommy, whose friends held a "dance-in" to bury him stylishly—for a different reason. Surely, the responses of the young persons he cites—organizing "a cordon of motorcycles as an honor guard for the procession; placing a cyclist jacket in the casket before closing it; throwing a remembrance into the grave by each person attending the committal; ordering special floral pieces symbolic of a special relationship"—indicate a total lack of familiarity with their religious traditions. These are expressions of behavior so totally alien to Christian and Jewish teachings that they suggest the young people were instructed by pagan epics. (Alas, probably the "epics" concocted by Metro-Goldwyn-Mayer and Twentieth Century Fox!)

In the section called "Alternate Forms of the Funeral," Mr. Raether minimizes and misrepresents, I believe, the effects and the activities of funeral and memorial societies. He is correct in saying that presently there are fewer cooperative and labor union funeral homes than there were thirty years ago—establishments which provided the full range of goods and services. Instead, many cooperators and union members prefer to become members in the funeral and memorial societies, which have worked out arrangements with undertakers permitting members to select in advance the kind of funeral they wish to have. The movement has been growing, not only in this country, but in Canada, where there are now enough societies to make practical the establishment of a Canadian federation. The societies do not require that members have memorial services; they are as

non-dictatorial as they are non-denominational. Their function is to make possible freedom of choice and to educate people in the value of simple and dignified funerals which can be obtained at a reasonable cost.

The societies have had a profound impact on funeral practices in this country. Clerical leaders of all denominations, who have supported them, have introduced many changes in funerals–all, as has been noted earlier, tending to minimize ostentatious display and restore the spiritual significance. Clergymen have also stressed the economic benefits of membership. As Msgr. Francis J. McElligott pointed out in 1963, the "torrent of complaints" against the funeral industry is related to public feeling that expense is inordinate.

> Are the costs of death too high? It is quite evident that often more is spent than needs to be spent. For one thing, buying the goods and services related to death has not lent itself to the open marketplace. The public has little chance to learn from experience because the experience of handling a death does not come frequently to an individual. They have had little chance to conduct the sort of prudent investigation they would normally conduct on any other purchase of the magnitude. Most of the public are a salesman's delight–an ill-informed customer who must buy and who must place almost complete confidence in the seller. ("Per Istam Sanctum Unctionem***" *Extension Magazine*, December 1963, p. 282.)

Of course the funeral and memorial societies have helped to reduce costs of funerals–not merely those of members, but generally–by encouraging people to ask questions. As a result of the widespread publicity, particularly that accorded Jessica Mitford's *The American Way of Death*, costs dropped sharply some years ago. In 1965, for example, *Casket & Sunnyside* reported that in some areas funeral establishments were averaging 30 percent less per funeral than they were a year earlier (Mitchell Gordon, "Furor Over Funerals: Attack on High Costs Has Continuing Impact," *The Wall Street Journal*, April 21, 1965). That is why the National Funeral Directors Association and affiliated groups have so vigorously opposed them. The opposition has been manifested in various ways, from attacks on individuals (as I have every reason to know) to disciplining and expelling undertakers who did enter agreements with societies and who have advertised prices. The U. S. Department of Justice was forced to step in several years ago and bring suit, successfully, against the NFDA and its Wisconsin state affiliate for dropping from membership a funeral establishment that felt it was proper to advertise prices. For reasons obvious to anyone who has scrutinized the economics of American funerals, the NFDA considers it "unethical" to advertise prices for funeral goods and services.

No one, I think, will quarrel with the idea that the funeral of President John F. Kennedy, like that of Dr. Martin Luther King, was a valuable event. Both helped to heal the terrible wounds that had been done to the national political and social system. But the funeral business can scarcely credit itself on the role played by at least one of its members. News media said that the charges imposed by the Dallas undertaker for providing the casket in which Mr. Kennedy's body was shipped to Washington (another one was used for the funeral) were considered so excessive by the General Accounting Office that it refused to pay the bill. GAO refused a second time, although the undertaker agreed to reduce the bill by $500 since he had not embalmed the body. ($500 for embalming!) To spare the family further pain, GAO finally paid the bill–after the Dallas mortician reportedly said that he would cancel the charges if the casket were returned to

him for display purposes. Whatever this represents, it has very little to do with the "successful grief work" that Mr. Raether claims is being done by the funeral service licensee.

Obviously some undertakers can and actually do perform such a service. I have heard very grateful expressions from members of the Los Angeles Funeral Society who have been aided by the undertakers who cooperate with that group. The most recent, in July 1971, was from a man with whom I have worked on various writing projects. When his wife of more than forty years died after a year of suffering, during which he cared for her night and day, she was cremated after a simple service in accordance with her wishes. "I can't thank you enough for having introduced me to the society," he said later. "Everything was just the way Helen had asked that it be." Instead of subjecting the husband to high-pressure salesmanship, the undertaker had helped him to survive the ordeal with dignity and understanding because he believes that freedom of choice is a "moral" right. True grief cannot be assuaged by the ministrations of a salesman.

The funeral directors who have had the courage and the integrity to work with our societies have found the association beneficial. James C. Bleitz of Seattle, who was ostracized by the trade association for more than ten years because of his willingness to work with the People's Memorial Association, cited in a letter dated March 1, 1969 the advantages of the relationship which has helped to make his firm the largest in the state of Washington. As is true in any case where a contract is based on volume, the profit margin is low–but it is a "plus business and does return us a profit." More important, he said, is that "we find that we have well over 30,000 missionaries out working for us, and growing by several thousand a year, many of whom are highly educated and professional people . . . . Many of the people reached are not PMA members at all but want conventional funerals. PMA members direct them to us with pride and appreciation. They help to spread our reputation in the best possible manner–something money cannot buy."

Obviously, then, funeral directors can be "caregivers"–as Mr. Raether suggests. They will not be and cannot be if they persist in turning a ritual that may have individual and social value into a spending spree that may have adverse consequences for the lifetime of the ones who indulge in it.

COMMENTS ON RUTH MULVEY HARMER'S "FUNERALS, FANTASY AND FLIGHT"

Howard C. Raether

Ruth Mulvey Harmer writes: "A study made by Dr. Robert L. Fulton in 1958 for the National Funeral Directors Association revealed that 51 percent of Protestant clerics and 41 percent of Catholic priests responding to his questions believed that the funeral director exploits or takes advantage of a family's grief in selling funeral services."

In typical fashion, Mrs. Harmer neglects to cite the rest of the quotation, namely: "These proportions are reduced, however, when those respondents who qualified their opinion by writing 'infrequently' or 'sometimes' next to their answers are subtracted

from the total. When the figures are corrected for these qualifications what is found is a hard core of 23 percent of both the Catholic and Protestant clergy who believe the funeral director takes advantage of his position for personal gain."

This is but one of many instances in which Mrs. Harmer states only some of the facts to reinforce her position. Some of her other half-truths and/or distortions and/or misleading statements are:

Mrs. Harmer writes that ". . . The hard sell tactics mercilessly employed have made the business of selling funeral services a $2,000,000,000 (billion) a year boom and the business of burying them a crushing financial 'bust' for the survivors of most of the 1,800,000 (million) citizens who die each year. And with funerals, as with other escape mechanisms—alcohol or drugs—there is a high price to pay the morning after."

Divide the 1,800,000 deaths into $2,000,000,000. The answer is $1,111.11 per death for funeral and burial expenses if the statistics are accurate. But, they are not. The U. S, Department of Commerce estimates that in 1969 personal consumption expenditures for death amounted to $2,090,000,000. But there were over 1,900,000 deaths. So the average is less than $1,100 per death.

She refers to Social Security and Veterans' benefits (neither of which are of funeral director origin) combining to a total of more than $500. Then consider the union, fraternal, workmen's compensation and other death or funeral funds often available for funeral and/or burial expenses. How can she effectively argue that "buying" funerals is a "crushing financial bust" for the survivors of "most of" the persons who die each year with these funds provided, some of which are available only if used for funeral and burial purposes.

. . Mrs. Harmer laments the difficulty in attempting "a rational discussion of final rites" in the United States. She says part is due to "unwillingness to acknowledge mortality." She adds that the reason largely is the "confusion" generated by "industry public relations experts" who have "persuaded people to accept the notion that indulging in conspicuous consumption is not only the *spiritual* way to behave when a death occurs, but [it] is a vote of confidence in the *American free enterprise system.*" Yet, earlier in her article she wrote that the "motivations responsible for the elaborate nature of American funerals" are "attitudes, by no means peculiarly 'American' [which] have shaped the size and opulence of funerals all over the world." She makes reference to the Orient, the Middle East, Latin America, and most of western Europe. Does Mrs. Harmer imply that "industry public relations experts" have been the persuading factors in these countries? What about the countries that do not have funeral functionaries much less associations of functionaries or public relations experts for those associations.

. . Mrs. Harmer quotes a statement attributed to the late W. M. Krieger of National Selected Morticians that: "2000 (funeral firms) could do all the business in America." She also refers to the Senate Anti-Trust Subcommittee headed by Senator Philip A. Hart and therefore should be familiar with the record of the hearings this committee conducted. Page 35 of the record of the "Hearings before the Subcommittee on Anti-trust and Monopoly" includes a statement of Mr. Krieger in answer to a question directed to him by a member of the subcommittee staff. Mr. Krieger said he was quoted and misquoted regarding the number of funeral homes needed and points out the statement he made was: "that 2500 firms operating multi-unit establishments strategically located could serve the demand. This, of course, is based upon what would then be the capacity or you might say a highly theoretical marketing proposition."

Regardless of what Mr. Krieger or anyone else did or did not say, two things are certain: (1) When death takes place, those who survive usually want to be served immediately in accordance with their needs and desires. They are not willing to wait to be taken care of by efficiency oriented, prescribed work day schedules of an institution operating on theoretical marketing principles. Therefore (2) economic theories which apply to manufacturing and other measurable processes are not applicable to a funeral service practice which is subject to the wishes and needs of many different kinds of people with many different kinds of problems.

. . The author writes about the uniformity of bills submitted for the members of the California State Polytechnic College football team killed in an airplane crash in Toledo in 1961. The reason for the uniformity was because seventeen deaths were not handled separately in Toledo. Rather there was one cooperative operation by the funeral directors in accordance with and under the supervision of the airline with the total charges pro-rated. And there was more to it than body preparation and the furnishing of caskets. There was the work on the scene for both the dead and the injured, ambulance trips to the hospital, and numerous post-disaster consultations including legal counsel, because the insurance of the airline was not in effect.

However, when there were different services rendered for the funerals and burials at the homes of the victims–Mrs. Harmer in her book THE HIGH COST OF DYING (Crowell-Collier, 1963) points out that the charges ranged from $157 to $884.16. Mrs. Harmer says the action of the funeral directors in Toledo was "anti-competitive." Does she want those involved in the providing of any or all services immediately following a disaster to compete with each other, especially in caring for human bodies either alive or dead?

. . Another example of the author making a statement she hopes will stand because no one challenges it is her writing that the Bleitz Memorial Home in Seattle "is now the largest undertaking establishment in the state." It can be correctly assumed that Mrs. Harmer means that this firm's association with the People's Memorial Association has provided it with the largest number of "funerals." She is wrong. The firm is not the "largest" in Washington, nor is it the biggest in Seattle.

In one short paragraph Mrs. Harmer makes four erroneous statements as she writes about what the funeral "industry's trade associations" have done to "increase demand."

Charge: "Special laws in some areas have made it very difficult for persons to donate their bodies to medical schools and other research institutions."

Fact: Funeral director associations have done nothing to bring about special laws to make it difficult for a person to donate a body for medical research. Some groups have pointed out the rights of the survivors where an anatomical gift is made.

Charge: "Special laws in various states have made embalming and casket mandatory even when cremation is desired."

Fact: There are no special laws in various states that have made embalming and caskets mandatory even when cremation is desired. There are laws where public health and welfare are involved prior to cremation, including transportation of the body by common carrier. Such laws are not the result of "the industry's trade associations . . . to increase demand."

Charge: "As a result of the lobbying of the cemetery industry, in California and three other states ashes may not be scattered–even in accord with public health regulations."

Fact: The California law allows for the scattering of the ashes of the body of a person who has been cremated.

Charge: "As a result of lobbying activities, bodies of servicemen who die overseas are automatically shipped home–despite the protests of many of their relatives and despite the fact that the government maintains a large network of national cemeteries on foreign soil."

Fact: America has returned its war dead since the Civil War, long before there were funeral director associations to lobby for such return. Following each of the two great wars the next of kin were asked by the U. S. government whether they wanted their dead returned or buried overseas. The majority wanted them returned and they were. In instances where repatriation was not requested, final burial was overseas. The air age has permitted the dead of the wars in Southeast Asia to be returned within days of their death for the funeralization and/or disposal the next of kin desire. This program was initiated and operates without any lobbying on behalf of those in funeral service. If Mrs. Harmer would have researched her subject before writing, she would have known how quickly many survivors want their dead returned. Some even wait at the airport for the body and ask to have the casket opened there to confirm the death and to mourn their loss.

So much for a few specific examples to set the record straight and to challenge the credibility of what Mrs. Harmer has written. Now for some concluding thoughts. There are unscrupulous funeral directors as Mrs. Harmer writes. This is to be deplored as is the incontestable reality that there are also unprincipled and dishonest politicians, physicians, clergymen, and teachers–and even writers. But we do not retaliate by ridding ourselves of democratic government, hospitals, churches and belles-lettres. You simply do not drown the baby in the bath.

The thrust of Mrs. Harmer's overworked and belabored theme is: The funeral is nothing more than a magical ritual propounded by money-grubbing morticians for the purpose of abetting the survivors to deny the veracity of death. In support of her contention she then cites *typical* (her adjective–not mine) cases of people who deprived themselves in order to have an elaborate funeral because they were motivated by a superego or some other unconscious psychiatric malady. How would she acknowledge death? Simply and easily–just consult the local memorial society in the community.

Ruth Harmer buttresses her arguments with illustrations that are typical and bizarre. She pounces upon those few funeral directors who desecrate the sacredness of the occasion while they pervert their profession. The inference is that they are representative of all those in funeral service. This I submit is prejudice in its most blatant form; a presupposition that forms an opinion based upon an insufficient sampling. For example, she states: "the only contribution American undertakers have made [are the] . . . drive in funeral homes which now make it possible for mourners to sit in their cars while paying last respects to the loved ones on display in mortuary windows." If Mrs. Harmer had properly researched her material she might have discovered that when she wrote there were but two such funeral homes in the entire country. There are now three. Is it not the apogee of unfairness as well as arrogance to indict an entire profession because of the behavior of a very few men?

Her remedy of the memorial society is simplistic and unrealistic. Dr. Fulton, referred to earlier, surveyed the membership of eleven memorial societies, as they are sometimes called. "funeral reform societies." His study indicated that the members are affluent

(reporting an average income twice that of the average American), are highly educated, and are relatively low in traditional religious affiliation. Yet, those who might have represented the vanguard of the enlightened and unfettered "desired to eliminate the body from the funeral . . . and attempted to shield the ultimate truth from their children." Are they not the real culprits and perpetuators of "fantasy and flight?"

Yes, Mrs. Harmer, your initial sentence is correct: "The beginning of wisdom . . . comes only with the acknowledgement of death." This is why the funeral continues to serve the social, religious and psychological needs of its adherents. The presence of the casketed body transforms the process of denial to the acceptance of reality. A kinship system is extended beyond the family in the participation of a dramaturgy. (Sigmund Freud called these community rituals "the clear awareness of an inner identity.") A climate is provided for shared grief and the unburdening of feelings through remembrance. The ritual of the funeral thus helps prevent delayed and/or distorted grief processes and facilitates what Erich Lindemann called "normal grief work."

In short, the funeral not only involves disposition of a body, but it gives honor to the deceased as well as guides the survivors to face life realistically and honestly by *not* "taking refuge in fantasy and flight."

SO?

At some untimed moment
No different than another
I will gather up my death,
Poof!
Monuments are for mourners.

Then, all of the choices I have made
Against myself,
Will matter now and yesterday
And for–myself,
Will matter not at all

When I awoke this morning
I noticed, unsurprised,
That I had forfeited yesterday to time
And only I could even count it
In the cumulative nature of death.

Ronald Koenig

PSYCHOLOGICAL RESPONSE TO DEATH OF AN IDENTICAL TWIN BY THE SURVIVING TWIN WITH THE SAME DISEASE: CONCURRENT MALIGNANT MELANOMA IN IDENTICAL TWINS OF TRIPLETS[1]

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INTRODUCTION

Twin studies have contributed to clarification of genetically determined physical illness (Heizer and Lewiston, 1964) and to hereditary aspects of malignant melanoma (Anderson et al., 1967). Most psychological studies of twins have focused on intelligence (Erlenmeyer-Kimbling, 1963), personality (Cattell et al., 1955), and heredity factors in mental illness (Kallman, 1946; Fosanoff et al., 1934). Green and Swisler (1969) studied the psychosocial setting within which leukemia developed in twins discordant for acute leukemia. They did not, however, study the grief reaction of the surviving twin. A study of discordant suicide in twins (Kallman, 1949) noted no propensity for the surviving twin to commit suicide. He described the response of the surviving twin as within normal limits, with adequate ability in most instances to carry on a solitary life.

Studies of the personality of triplets (Trunnell, 1967) and the possible unique grief and bereavement in triplets composed of identical and fraternal twins, to loss of one member, have been unusual. This psychological study initially encompassed an evaluation of identical twins in a set of triplets with simultaneous onset and surgical treatment of an identical malignant disease. One twin (A_1), however, developed metastatic melanoma and died. The identical twin (A_2) with melanoma has survived with no evidence of disease after operation, and the fraternal twin (B) has experienced no malignancy. Psychological study of the dying twin during treatment for his metastatic malignant melanoma, of the hospitalized identical twin and later of the fraternal triplet, constitutes the basis for this report.

This extraordinary sibship reported by St. Arnault et al. (1969), represents the first medical report of concordance for cutaneous malignant melanoma, congruence for site and identical age of onset in monozyotic twins. Monozygosity was proved beyond the 99% level of confidence. The predominant role of genetic factors in their malignant melanoma is suggested by the congruent anatomical locus of the melanomas, since the etiologic phenomena would have had to occur before twinning in embryonic development (Nagel et al. 1970).

METHODS

All interviews were conducted with full consent and cooperation of the patients and later of the families, in their homes. The open-ended interviews were tape-recorded for

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later analysis of information obtained. The twin who died was interviewed on two occasions in the hospital when already severely ill. The surviving identical twin was first seen as an in-patient in Roswell Park Memorial Institute during evaluation for metastatic disease and immunologic study, while his twin was critically ill. He was later interviewed at home with his wife, three months and eighteen months after the death of his identical twin. The fraternal twin member of the triplets was seen at three months and at eighteen months after the death of the first, also at home with his wife. The older brother with whom the deceased lived was also interviewed, as well as two sisters.

For identification of the triplets, the identical twins are noted as: A_1, the identical twin who died; A_2, the surviving identical twin; and B, the healthy fraternal twin.

INITIAL EXAMINATION

A_1, a 56 year old bachelor bartender, one of identical twins in a set of triplets, was referred to Roswell Park Memorial Institute on October 30, 1968 with an established diagnosis of malignant melanoma. He had always had a brown mole in the left fourth intercostal space. The mole started growing in December, 1964. In February, 1965, it was larger and bled easily. He consulted a surgeon and it was widely excised in March, 1965. He was without symptoms until April, 1967 when a lump developed in the left axilla. Despite radical mastectomy and axillary dissection, bilateral pulmonary metastases developed. He was first seen for psychiatric study at the Institute while undergoing diagnostic study, receiving chemotherapeutic drugs and immunologic treatment. Despite these supportive measures he died on December 7, 1968.

A psychiatric interview was held with A_1 while he was in a vapor tent, seriously ill with extensive pulmonary metastases. He felt grateful for his medical care and despite shortness of breath, was composed and cooperative. He admitted to feeling "down in the dumps" in a "minor way" but managed to stay cheerful by "changing the subject". A_1 noted that he and his twin A_2 had always had similar experiences until now when "he's fine but I'm not doing so well". He expressed concern for the financial status of his older brother with whom he lived, since he was without A_1's help. He also worried about A_2 who had come into the Institute for studies, thus losing his income.

His religion was not bound to a particular denomination. He regarded himself as a student of mysticism and spiritualism, carrying with it the belief in reincarnation. A_1 was cheerful, outgoing and showed no outstanding psychopathological signs despite the level of his illness. His life pattern was consistent with mild passive dependent personality adjustment. He expressed moderate resentment that he was much sicker than A_2, but faced terminal illness and death with quiet calm.

A_2, a married factory worker, identical twin of A_1, was admitted at the request of A_1's physician for elective study. He was difficult to distinguish from A_1, and he too had always had a brown mole in the left third intercostal space. It had grown slowly since October, 1964, but with accelerated growth within two weeks of rapid change in A_1's mole. After a pathological diagnosis was established in A_1 of malignant melanoma, A_2 underwent wide excision of his tumor on March 22, 1965. It was also diagnosed pathologically as malignant melanoma without visible metastasis. A_2 has remained asymptomatic to the present.

A_2 was first interviewed at the time that A_1 was critically ill. He readily accepted hospitalization and repeatedly told the interviewer he would do anything to help because

"I couldn't do enough for my brother". He too seemed to feel some bewilderment at the difference in their situation and outlook, going over their previously identical medical history and noting that now he was healthy and A_1 was gravely ill. He also spoke of similar feelings and experiences and tearfully said, "I see myself lying there when I look at him". A_2 was less outgoing and talkative than A_1. A_2 seemed quite anxious and uncomfortable in conversation, speaking with pressure of speech. He described anxiety attacks antedating the diagnosis of melanoma in himself and A_1, which included trembling and hyperventilation.

B, a married farmer, fraternal triplet of A_1 and A_2, was interviewed in his home with his wife and son three months after A_1's death. He was healthy, and dissimilar in appearance, habits and personality from both A_1 and A_2. He enjoyed talking about his life as the "third" triplet. He felt restless even as a boy and left home as early as he could. He married young and had stayed with jobs that kept him out of doors. He expressed uncertainty about the mystical beliefs of the family, since "nobody comes back after death to tell you what it's like", but he believed in God. He believed that the severe arthritis he had was punishment for alcoholism, serving as a lesson to teach him to stop drinking. He felt Christ once by his side during that time saying "thou shalt live again". He also felt that he saw Abe Lincoln during the height of the arthritic illness. Subsequently, he returned to his outdoorsman's way of life, with complete recovery from his arthritis. He too shared the feeling that he is here for a purpose and when that purpose is finished, "I will die. I wouldn't feel too bad if I died tomorrow–I have done what I intended".

BACKGROUND AND DEVELOPMENT OF TRIPLETS

The triplets were born in a rural area of Pennsylvania to a German-Irish mother and a father of French descent. The family had always lived on a farm. Fourteen children were born, of which two died at birth. All the others survived and grew up there. The triplets were the result of the mother's third pregnancy, and represented the third (A_1), fourth (A_2), and fifth (B), children born. They were preceded by a boy and a girl. Following the present triplets was a second set of triplets (one died at birth), a set of fraternal twins (the male died at birth), and four single births. Birth order of the triplets indicated A_1 was born first, followed by A_2, then B.

Their early life was described as a "hard" life on the farm. The family was close-knit but work was expected of all. A_1 stated, "You were first little, then grown up without a childhood". The mother was felt to be as fair as she could be with so many children, but "probably favored the younger children". The father was "a good provider but couldn't spend much time with the family". A_1 described his and A_2's childhood as "average, but we had a little bit of a complex, you might say, inferior. The three of us, the set of triplets, had a defect in speech and we couldn't talk very plain. We couldn't go to school until we were seven years old. That kind of held us back. Being on the farm, we rarely went through the eighth grade of school which afterward we realized was a handicap".

A_1 was accepted in the army during World War II, resulting in the first separation for the twins. A_2 not accepted in the army, began in construction work, finally accepting a factory position he has held for 35 years. A_1 returned from the army and became a bartender. The twins, then middle-aged bachelors, lived with the parents and took care of them on the farm until their death in their eighties. Following this, A_2 in his forties, married a neighboring childhood friend of the triplets and A_1 went to live with an older

brother. Despite "an understanding" on two occasions with eligible women, A_1 never seriously entertained marriage.

A_1 said the triplets as children had "a language all their own". They understood each other, but others could not understand their language. They felt different, set apart by appearance and a severe speech impediment. They repeated first grade three times and they felt "ashamed of being so large–ten years old and still in first grade". All three felt "different" from other children, and self-conscious about their language problems.

The feeling of A_1 and A_2 about being identical twins of the triplets was described as "it had good and bad points". A_1 stated, "the two of us were very much alike while the third one was, what you might call, a little odd or different. The two of us have been mistaken for each other all our lives. We were really identical". They described themselves as having the same thoughts, ideas, and choosing the same clothes and friends. They never disagreed because they "saw things the same way". A_1 noted "we really see eye to eye with each other, as closely, I think, as two people could". A_1's favorite joke was to have A_2 help him tend bar, leading to drinking customers' consternation upon literally "seeing double".

B, the fraternal triplet, was regarded by the identical twins as the "odd one". B described the triplets as looking so much alike as youngsters that at school they couldn't be told apart. He did not, as an adult, resemble the twins closely in habits or appearance. B felt some resentment at being one of fourteen children and the "odd one" of the triplets. He wanted early to "be a man" and quit school at sixth grade. He was never content at home as the twins were and wanted to get away. He left to work at age fourteen when the father became ill and additional income was needed. He married young and continues after thirty-five years to work as the town maintenance man. All the siblings are still very close in their relationships to each other, but B is somewhat more distant from the rest.

PSYCHOLOGICAL TESTING

A psychological test battery consisting of Wechsler Adult Intelligence Scale, Rorschach, six Thematic Apperception cards (TAT), projective drawings, Bender-Gestalt, and an experimental Hospital Incomplete Sentences test (HIS) was administered to each of the triplets. The HIS consists of sentence stems related to hospital events. A_1 and A_2 were tested while hospitalized at Roswell Park Memorial Institute and B was tested at home three months after A_1's death. All three brothers cooperated with the testing procedure, reporting no previous experience with psychological tests.

A_1 and A_2 showed similar patterns of intellectual functioning. Both earned bright normal IQ scores with the only major variation in patterning being A_1's superior practical social skill and A_2's good non-verbal abstract ability. This is consistent with A_1's work as a bartender as opposed to A_2's job as a factory worker. B's intellectual functioning, in contrast to his brothers' was in the average range. His general patterning of subtests was also different from either A_1 or A_2.

Wechsler Adult Intelligence Scale

	A_1	A_2	B
Verbal IQ	110	104	95
Performance IQ	119	116	97
Full Scale IQ	115	110	96

Personality testing, done while A was critically ill, revealed his veiled hostility toward his healthy brothers. He also showed appropriate concern for his health with its resulting marked sense of vulnerability. Both A_2 and B produced relatively barren and constricted protocols. Both of them employed considerable repression of emotional responses. The expression of anger was repressed in all three, perhaps as part of a general family pattern.

A feature shared by all three brothers was their passivity. This was evident in the themes of their TAT stories where most of the characters wait for events to occur and rarely take action. Things were seen to go right or wrong, not as a reflection of their activity, but as the result of fate. People simply are what they are. The reward for passive acceptance of one's fate (and faith) is ultimate rebirth and redemption, an integral part of their religious belief.

STUDY OF A_2 and B AFTER A_1's DEATH

The two surviving triplets were visited by one of us (S. H.) in their homes three months and 18 months after A_1's death had occurred in Roswell Park Memorial Institute.

A_2 was seen in his home with his wife. He expressed relief that A_1 was gone since he had experienced such pain for a year. Contrary to the expectation of all the family members, A_2 did not exhibit any greater degree of grief or reactive depression than the other siblings. His wife and the older brother described A_2 as having become more outgoing, talkative, and zestful than in the past. Comments were made that A_2 was "more like A_1 now". His religious beliefs were expressed with great emotion, and were shared by the extended family, several of whom came to meet the interviewer. Their religious beliefs originated with an itinerant architect who came to their town. He told them about spiritualism and gave them a book. They believe that an Occult Force ordains all things. A divine ledger of good and evil is kept so that bad acts are "paid for" if not in this life, then in a subsequent reincarnation. "Life Force" continues through many lives, up to 30,000 when the soul finally goes to Venus. Meaning exists for every event. A_1's death was felt to afford some good to atone for an evil; otherwise it would not have occurred. A_2 felt that death could not be an end, for then there would be no meaning to life.

The family was visited again eighteen months after A_1's death. Another family member had died of cancer in the interim and much concern existed about the possible meaning of this to the family. A_2 and B were again interviewed, each in his own home. Both were cordial. A_2 had lost his more self-assured manner, returning to his anxious, less talkative behavior, giving little information, though cooperative. His wife stated that the anxiety attacks which A_2 had for many years had returned. Known as "spells" by the family, they often required sedation by the family doctor. Though A_2 minimized the severity of these symptoms, the family described weekly attacks in which he became flushed, tremulous, moved in circles and talked incoherently. They always subsided within twenty minutes occurring at family gatherings or on social occasions. None had occurred at work. A general family concern for A_2's health existed primarily based on his nervous symptoms. B described himself as feeling well, enjoying life to a greater degree. He felt that over that year and a half, a bond had developed to A_1, even though deceased, as if a "Life Force" existed between them. His experience of "supernatural" phenomena appeared to be more culturally determined than psychopathological in nature.

DISCUSSION

A_1 and A_2 showed similar patterns of intellectual functioning, as has been reported for identical twins (Erlenmeyer-Kimling and Jarvik, 1963). A_1, choosing bartending, was more verbal and outgoing than B, but their final IQ's differed only by five points (A_1 115, A_2 110). B's ninety-six IQ indicated that he functioned in the low average range.

The cultural background of rural Pennsylvania in the early 1900's probably contributed to the matter-of-fact, work-oriented picture of the family. Emphasis on simple values of warmth, love and unity between family members, with unwillingness to present less positive qualities, including hostility when it existed, allowed little expression of negative feelings. Family value judgments included close family ties, and survival amidst adversity, with a gentle enjoyment of each other. Schooling was valued for its work potential; intellectual pursuits were unimportant. The greater emphasis was on understanding nature and the spiritual values of life–transcending and spurning rural denominational religions. A dominant theme of guilt, retribution, and ultimate reward for good service was present. A closeness to nature since birth was present in all, with joy (seen most clearly in B) in the outdoors and "nature" in the broadest sense. This may contribute to their easy acceptance of reincarnation, with the faith in the future this provided, when this religion was presented to them as adults.

The death of A_1 was accepted by the family in the light of their strong religious views. B responded initially with mourning similar to the other siblings. This perhaps reflected his lack of orientation as "one of the triplets" though eighteen months after A_1's death, he had incorporated more of A_1's manner, and felt as if a "Life Force" existed between them. He appeared more prone to unreal experiences and may have chosen this way to act out his feelings for loss of A_1. His reaction to A_1's death was matter-of-fact and in keeping with the family views of reincarnation. The "Life Force" with A_1 seemed to be a reassuring, comforting bond.

A_2 was expected to have a more severe and perhaps an abnormal grief reaction. Since the two were similar in appearance, manner and personality, we predicted that the identification was so great that A_2 might be unable to function alone. Grief for loss of an ego-syntonic and identical object was expected to be extreme. Having the same physical disease, we also predicted increased anxiety for his own fate, since the twins had experienced the same phenomena all their lives. Kallman (1949) notes a set of twins in which the first died of cancer and three months later the second twin developed cancer and accepted his fatal disease without emotion as if it were expected.

Three months after A_1's death, when interviewed in his own home, A_2 appeared less anxious than before. A_2's guilt for being well, which had been seen earlier when A_1 felt veiled anger at his own fate, had disappeared. A_2 was noted by the family to be more talkative, outgoing, and in behavior, "more like A_1" than before. It appeared that A_2 was able to handle his grief through repression and spiritual interpretations of death, which were condoned in his family micro-culture. There were virtually no conscious, negative or ambivalent feelings toward A_1 despite the extreme closeness. This supports the concept proposed by Freud (1917) and later clinically observed by Lindemann (1944) that an ambivalent relationship may lead to a more painful grief work. The mourning of A_2 for A_1 was based on an almost absolutely positive relationship that is perhaps only seen between identical twins who are closely associated all their lives. Both heredity and

environment contributed to their similar and compatible psychological states as separate identities, but without dissimilarity.

The guilt felt by A_2 that he had survived the same disease, seemed to influence his behavior in the hospital by a great need to do all he could for his brother. It is interesting that though they were psychologically similar, there was no pathologic dependence. A_2 was able to function independently when necessary. A_2 experienced no serious psychopathological signs following A_1's death beyond a normal grief reaction. It appeared that A_2 may have temporarily utilized introjection as a defense in dealing with A_1's death, by assuming some of A_1's more outgoing personality traits which was minimal difference between them. No significant guilt or depression developed; on the contrary, his outgoing manner may have been expressing a feeling of now "living for both" by assuming the characteristics of A_1. Lindemann (1944) suggests a type of distorted grief reaction to account for such behavior. Increased anxiety, which was expected in A_2 because he knew he had the same malignant disease which proved fatal to A_1, was not apparent at three months. Kallman's (1949) hypothesis that the surviving twin, with overpowering identification, could not "die a second time", might also be an explanation for this picture. The security of medical examination with no disease found, may also contribute to A_2's better appearance at three months after A_1's death. His "spells of nerves" at eighteen months, though worse, were a part of his previous pattern of behavior.

The mystical beliefs, in an urban cultural context, might be regarded as pathological–but they were views widely held by the extended family and their spouses, and appeared to be reassuring to the group, giving both meaning and purpose to life. Death was seen as a change to another existence, occurring for an ultimate good purpose which sustained them during mourning for loss of A_1.

Similarities to Buddhist beliefs of cause and effect (Karma), and rebirth, are pronounced in the religious philosophy of the family. Even the "Life Force" bears resemblance to Buddhist thought of "Universal self-no self". The easy incorporation of this ancient religion into a rural farm family, with strong reliance upon its principles in facing death of a family member is interesting.

Kallman et al. (1949), studied twenty-three sets of twins (10 monozygotic) in which suicide of one twin occurred. Contrary to expectation, the surviving twin did not find life unbearable and all sets studied remained discordant for suicide. The cases cited indicate that the surviving twin continued in much the same life style as before his twin's death. Our findings would extend this view to be pertinent to an identical twin who survives his twin's death from a concurrent identical disease. A contemporaneous control of a normal fraternal twin in a set of triplets made this set of observations unique. The grief reaction appeared to be complete at eighteen months in A_2 with adaptation to A_1's death; his anxiety may have been worse at eighteen months. This may indicate, following an initial period of identification with A_1 during mourning, a more realistic fear of potential disease, masked during the immediate grief reaction.

Longitudinal study of such unique sibships are indicated to answer some of the psychological issues raised by this study of a single set of triplets composed of identical twins and one fraternal twin, during the period following death of one identical twin.

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ATTITUDES TOWARD DEATH TODAY AND THIRTY-FIVE YEARS AGO

DAVID LESTER, Ph.D.[1]

The present time is seen by many authors as one in which the attitudes of people toward death are undergoing a great change. The direction of this change, however, is a source of disagreement. Shneidman for example, sees the present time as one in which death is "in the air". Whatever his daily activities, man lives with the possibility of global annihilation. Long-held taboos against the consideration of death are beginning to be broken. "The topic of death is timely. Its open discussion is part of the new unbooing of long-held taboos relating to sexuality, hostility, civility in behavior, and wanton destruction" (Shneidman, 1969, p. 7). On the other hand, Fulton sees the present time as one in which death is becoming more of a taboo topic. "Death, like a noxious disease, has become a taboo subject in American society and as such it is the subject of much avoidance, denial, and disguise" (Fulton, 1967, p. 32).

Who then is right? It is difficult to obtain data to support either position. People from the past are no longer around, obviously, for us to assess their attitudes. Murphy and Lester (1970) attempted to test these hypotheses about today's society by examining funeral notices during the Twentieth Century. They noted that funerals were becoming increasingly private, less ornate, and moved out of the home into the funeral parlor. They interpreted these trends as indicating support for Fulton's notion that death is becoming more of a taboo topic today. The changes in funeral practices are making the funeral less of a protracted emotional experience. Avoidance seems to be taking place.

By chance, one source of data exists which may have relevance to the issue. In 1936, Middleton published a study of the attitudes toward death of students at Butler University and DePauw University and, due to the relative lack of competition for journal space in 1936, published his raw data. The present paper reports a comparison of students in 1936 with those in 1970 using the same questionnaire used by Middleton.

METHOD

Middleton (1936) reported the results of administering a questionnaire on death attitudes to a population of college students at Butler and DePauw Univeristies. *S*s were 337 male and 488 female students aged fifteen to twenty-four years. The same questionnaire was administered to 175 male and 236 female students aged eighteen to twenty-four years enrolled in psychology courses at DePauw University in 1970.

These two samples are not strictly comparable for two reasons: (1) Middleton used Butler students as well as those from DePauw but he failed to indicate how many Butler students were included in the study and to present the data for the two groups of students separately; and (2) the methods of choosing students to complete the questionnaire may have differed. Again, Middleton did not specify how he selected

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[1]I should like to thank Dr. Harry L. Hawkins at Depauw University for assisting me in collecting the data.

respondents. Although the two sets of data differ in these respects, there is no evidence that these factors, were they controlled for, would change the nature of the results reported here.

RESULTS[2]

The data from students in 1970 were compared with the data from students in 1935 and this comparison was carried out separately for males and females. The results of the data analysis are shown in Table 1. [3]

The results of the comparison differ considerably for the two sexes. Of the twenty-three questions on which the groups were compared, the males differed significantly on eight of these. (In all but one difference, the level of significance was $<$ 0.01, so these eight significant differences cannot be seen as chance occurrences.) The general trend in these significant differences is for the 1970 male students to think of death more and to be less depressed by death and its appurtenances.

Several of the questions used by Middleton are far from ideal. Two of the significant differences for male students appear to contradict the trend noted in the preceding paragraph but this is partly a result of inadequate question construction. The questions that are poor are like the following ones: 4. (a) Are you inclined to entertain thoughts of some specific disease which may cause your death? yes__ no__; (b) How frequently do you entertain such thoughts? very rarely__ rarely__ occasionally__ frequently__ very frequently__.

In the 1970 male sample, 175 *S*s responded to part (a). Thirty-six replied yes and 139 no. Part (b) was answered by 127 *S*s and it not possible to know why the remaining 48 *S*s did not answer it. To distinguish between the parts of these kinds of questions, the work "likelihood" was used in describing part (a), and "frequency" in describing part (b). These questions would be better if part (a) were eliminated and a category "never", added to part (b).

Five of the questions assess affect (picturing death as horribly painful, being depressed by funerals, being depressed by cemeteries, being depressed by death stories, and fear of death). For these five questions, the 1970 male students showed more negative affect on three of the items (binomial p=0.50). Thus, the differences for males, though significant on several individual items, failed to reach significance (and often showed an opposite trend) on the remaining items. The reasons for this lack of consistency are obscure. Two possible explanations are that the results depend critically on the specific items (their content and their wording) and that the differences between the groups are generally small. Rather than this latter cause resulting in small differences on all items, it may interact with the former cause to produce large differences on a small number of items and minimal differences on the remaining items.

Six of the questions assess frequency of thoughts of death (frequency of thoughts of own death, likelihood of entertaining thoughts of dying of a specific disease or accident, likelihood of vividly picturing oneself as dying, frequency of dreams of dying, and frequency of reading stories and poems about death). For these six questions, the 1970 male students indicated a greater preoccupation on four of the items (binomial p = 0.34).

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[2] The data analysis was carried out by Kitty Priebe.
[3] The tests used were the chi-square test and the Kolmogorov-Smirnov test.

TABLE 1

Differences between the attitudes toward death of students in 1935 and students in 1970

Death Item	Males	Females
frequency of thinking of own death	no differences	no differences
whether S vividly pictures self as dying or dead	1970 students more likely $X^2 = 6.72, p < 0.01$	1970 students more likely $X^2 = 34.0, p < 0.001$
frequency of vividly picturing self as dying or dead	1970 students less often $p < 0.005$	1970 students less often $p < 0.001$
whether S thinks of dying from a specific disease	no differences	1970 students more likely $X^2 = 5.85, p < 0.02$
frequency of thinking of dying from specific disease	1970 students less often $p < 0.025$	no differences
whether S thinks of dying in a specific accident	no differences	1970 students more likely $X^2 = 11.8, p < 0.001$
frequency of thinking of dying in specific accident	no differences	no differences
whether S pictures death as horribly painful	no differences	no differences
frequency of wishing self was dead	no differences	1970 students more often $p < 0.001$
frequency of dreams of being dead or dying	1970 students more often $p < 0.01$	1970 students more often $p < 0.001$
avoidance of funerals	no differences	no differences
being depressed by funerals	no differences	no differences
being depressed by cemeteries	1970 students less likely $X^2 = 11.4, p < 0.001$	no differences
liking to read about death in literature	no differences	no differences
frequency of reading about death in literature	no differences	no differences
whether S is depressed by reading about death	no differences	1970 students more likely $X^2 = 8.51, p < 0.01$
fascination with newspaper stories about death	no differences	no differences
fear of death	no differences	no differences
whether S wishes to live after death	1970 students less likely $X^2 = 24.5, p < 0.001$	1970 students less likely $X^2 = 36.9, p < 0.001$
whether S worries over question of life after death	no differences	no differences
whether S wants to know about future life positively	1970 students more likely $X^2 = 9.28, p < 0.01$	1970 students more likely $X^2 = 21.0, p < 0.001$
whether S believes in a life after death	1970 students less likely $X^2 = 7.65, p < 0.01$	1970 students less likely $X^2 = 15.0, p < 0.001$
degree of change in manner of living if S knew there was a life after death	no differences	no differences

The results for females were more substantial. Female students in 1970 were much more preoccupied with thoughts of death; this was found in general for all relevant items. (On the six questions assessing frequency of thoughts of death, the 1970 females showed more preoccupation on all of the six items–binomal $p = 0.016$.) They were also more likely to be depressed by death but this was not found to a general trend over the items for which the differences were not significant.[4] (On the five questions tapping affect about death, the 1970 females showed more negative affect on three of the five items with one item a tie–binomial $p = 0.31$.) The two groups of females differed significantly

[4] Lester (1971, in press) has noted that, both in the 1935 data and the 1970 data, females have a more negative emotional reaction to death and its concomitants than male students.

on ten of the twenty-three questions and for nine of these, the level of significance was <0.01.

Death From Disease

In one question, the respondents were asked to name specific diseases that they think of as possible causes of their death. In 1935 cancer was the disease most commonly mentioned. All of the other diseases listed by the students in 1935 (such as influenza, tuberculosis, etc.) were not cited by students in 1970. Students in 1970 most frequently thought of cancer as a cause of death. The two next most common causes were heart disease and old age, two causes not mentioned in 1935. It is clear that, aside from the preoccupation with cancer which was the most thought of disease in both 1935 and 1970, the two lists (shown in Table 2) differ considerably.

Death From Accidents

In another question, respondents were asked to list what kinds of accidents they think of as possible causes of their death. Here the two lists (shown in Table 3) are quite similar. The major accident present in 1935 and absent in 1970 is "train crash" and the only accident mentioned in 1970 which is absent in 1935 is "motor cycle crash". Both in 1935 and 1970, death in a car crash was ranked most often thought of.

DISCUSSION

What do these results imply for the divergent views mentioned in the introduction about present day attitudes toward death? Overall, the affective reaction to death appears to have changed little from 1935 to 1970. If anything, the tendency for females to respond with more negative affect than males is a little stronger. The major difference is that students in 1970 appear to be more preoccupied with thoughts of death than students in 1935 and this is especially true for females. This indicates that thoughts about death occur more often to today's student. If we assume that these thoughts are communicated to others to some extent, we would expect, therefore, that death is a more

TABLE 2

Diseases, in order of frequency, feared by students in 1935 and 1970. (The number of *S*s mentioning the disease in 1970 is noted in parentheses.)

In 1935	In 1970	
cancer	cancer	(135)
tuberculosis	heart disease	(27)
pneumonia	old age	(10)
appendicitis	leukemia	(6)
child birth	brain tumor	(5)
spinal meningitis	venereal disease	(4)
sleeping sickness		
diabetes	all other causes < 2 respondents	
influenza		
apoplexy		
paralysis		
diphtheria		

TABLE 3

Accidents, in order of frequency, feared by students in 1935 and 1970. (The number of *S*s mentioning the accident in 1970 is noted in parentheses.)

In 1935	In 1970	
auto	auto	(277)
train	plane	(50)
plane	falling	(8)
drowning	motor cycle	(6)
falling	drowning	(5)
burning	accidental shooting	(4)
accidental shooting	burning	(3)
suffocation		
asphyxiation		
	all other accidents < 2 respondents	

common topic of discussion today among students than it was in 1935. Thus, these data would appear to support Shneidman's contention.

Although Fulton's contention is not supported, it is possible that both contentions are valid. What the present study does not enable us to find out is how people resolve their concern with death. Do they continue to face the concern and anxiety or do they deal with the anxiety using denial, repression, and other defense mechanisms of "blockage"? This the data cannot answer. It is of the interest to note the differences in the list of feared diseases in 1935 and 1970. Apart from cancer, most of the major killers of old are no longer threats. The only new disease is that of heart disease. Accidental killings are caused by the same agents now as in 1935.

It is also of interest to note that, in spite of Shneidman's assertion that we live today with the possibility of global annihilation (and we might add with the actuality of an on-going war in Viet-Nam), there was virtually no mention by respondents in 1970 of either of these possibilities. Admittedly, the questions did not specifically ask about these particular concerns but, were they of great importance, mention of them would have surely appeared in the questionnaires. It is as if death is a more personal topic. Death due to people somewhere else giving orders is much less a matter of personal concern than death in the car you are driving. If students are asked today to write an obituary or to imagine their own death, most likely they imagine death due to a disease or an accident (or even old age) rather than a death in which they are one of many thousands dying. When I asked fifteen students in a seminar on death two years ago to write their own obituaries, each of them conceived of their death as solitary rather than as one death in a large scale catastrophe. Even in thinking about death, we cling to our uniqueness.

Students in 1970 were less likely to believe in or to want a life after death but they would like to be more certain whether a life after death existed as compared to students in 1935. This difference was strong both in the males and the females. This appears to indicate that 1970 students are less conventionally religious than 1935 students.

SUMMARY

A questionnaire was administered to students in 1970 identical to one administered to students at the same college in 1935. Compared to 1935 students, 1970 students were

more preoccupied with thoughts of death but did not differ greatly in their affective reaction to death and its appurtenances. In listing specific causes of death, the responses of 1970 students indicated the great progress in the last thirty-five years, with cancer being the only disease common to the two lists. Accidental causes of death were similar in both sets of students. It was concluded that death is of greater concern today than thirty-five years ago but it was noted that we have no data on how people deal with this concern and resolve their anxiety today as compared with thirty-five years ago.

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THE FUNERAL DIRECTOR'S WIFE AS CAREGIVER

Cecile Strugnell and Phyllis R. Silverman

The death of a family member can have repercussions for that family to such an extent that its ability to function in an emotionally intact manner can be permanently impaired. Recent studies of grief and its impact on the mourner shortly after a death occurs, have identified several phases or stages of grieving (Silverman, 1966). These have been labelled impact, recoil, and recovery. It is becoming apparent that grief is a process. To cope successfully with his grief, the mourner must progress from one stage to the next. During impact, the individual is in shock and moves as in a dream. In recoil, the full meaning of his loss is felt. In recovery, the individual begins to find a future without the deceased. As we learn more about these stages and the various needs of people involved in the mourning process, it becomes important to ask what support and assistance society provides for them. What are the ways available to them for expressing their grief (Gorer, 1965)? We, in particular, are interested in the implications for emotional health. Our concern is with what is needed to prevent the occurrence of psychiatric disorders at such times as these. Such interest need not lead us to propose the development of new psychiatric services. We have, instead, looked at the people who are normally in contact with the bereaved and examined whether their influence might have positive repercussions for the grieving families' long-range mental health. At the time of death, the funeral director and the clergyman are the most prominent of these natural caregivers (Silverman, 1967). This paper deals with one aspect of the funeral director's caregiving network: that is, the role his wife plays in helping the bereaved families which the funeral directors serve.

In the United States the funeral director is the only one who has the formal role of burying the dead. As a consequence he is always extremely close to the grieving family during the impact stage. He is very aware of their suffering. Little recognition is given to the fact that he could be helpful to the bereaved family as they try to cope with their loss beyond arranging the details of the funeral. In fact very little that is positive has been written about the role of the funeral director. He is often pictured as avaricious or as foolish, a merchant of death (e.g., Waugh, 1948, Mitford, 1963). In contrast, Fulton observed that this view is maintained by a small segment of society, reflecting their own ambivalence about religious values, customs, and death itself. The funeral director is at the focal point of this confusion in a society which is becoming more secular, and depending less and less on religious tradition to guide the individual in his behavior at a funeral and in his response to grief (Fulton, 1965). Nonetheless, someone has to take responsibility for disposing of the dead. This is the role the funeral director has accepted. In this role he deals with dead bodies which are considered dirty, evil and to be quickly disposed of. This is the profane aspect of his work. In this not-to-be-envied capacity, he does the dirty work of society.[1] He sees all its mistakes, and it falls on him to help

[1] For a summary of Everett C. Hughes' analysis of the role of those who do the dirty work of society, see David N. Solomon. Sociological perspectives on occupations. in Howard Becker (Ed.), *Institutions and the Person.* Chicago: Aldine, 1968. Pp. 8-10.

conceal these very things from that society (Hughes, 1958), by the trappings that dress up a funeral.

The sacred aspect of his work as funeral director relates to the fact that the provision of proper burial is necessary to satisfy the religious, moral, and social needs of the living.[2] The two aspects of his work, the sacred and the profane, are closely intertwined. How the funeral director is accepted as a caregiver will depend on which aspect his clients most emphasize as they view the funeral. Whatever the client's view of him, he and his associates are present at the time of death. How helpful can he be in response to the spectrum of human suffering to which he is constantly exposed?

Our attention was directed to the role of the funeral director's wife as caregiver when Mrs. Silverman gave a talk to a meeting of these women at a national conference of funeral directors. As they reacted to her description of the Widow-to-Widow Program (e.g., Silverman, 1970b), it became apparent to her that in many ways the role some of these women played in their husband's business seemed to have parallels and to be complementary to that played by the widow's aide.[3] As a woman, the wife seemed to be drawn into the more human problems of the surviving family. It became important for us to understand this role, for itself and as a vehicle to learn more about the kind of caregiving possible in the context of a funeral business.

The National Funeral Directors Association agreed to send out a questionnaire to the wives of its entire membership to learn what they do at the time of a funeral. The remainder of this paper is a report of some of the findings from this questionnaire.

METHOD

A questionnaire was mailed to the members of the National Directors Association, for the attention of their wives. We asked if they knew of any programs in their community for the bereaved similar to the Widow-to-Widow Program about which we should be more aware (Silverman, 1970a). We then enquired by means of openended questions about their participation in their husband's work. The response was small (about 3 percent).[4] The value of these answers is to give us some insights into what these women can do and how their possible role could fit into the caregiving network to the bereaved. An in-depth interview with a funeral director's wife and information collected by Silverman at the meetings of funeral director's wives were useful in providing us with a perspective in which to place these responses.

FINDINGS

It seemed that the most useful way to treat this material was to look first at the reasons or set of circumstances likely to determine whether a funeral director's wife

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[2] The Greek tragedy *Antigone* is a good example of this, where the living cannot rest and carry on with life until their loved ones (in this case a brother) are given a proper burial.

[3] As a result of our finding how inadequate help to the bereaved becomes after the first few weeks of the impact stage of grief, the Widow-to-Widow Program was developed. The caregivers are widows who seem to be most able to relate to and understand the grief of the new widow. They have reached out to every new widow in a given community; they seem to be most helpful during recoil and recovery when there are very few resources available to assist a widow.

[4] This is not the place for a methodological discussion. Some of the issues in using small samples and qualitative data are discussed fully in A. Strauss and B. Glazer, *Grounded Theory.*, et al. (Eds.), *Institutions and the Person.* Chicago: Aldine Press, 1968, Pp. 349-350. This is the approach we used with the 600 answers we received out of a possible 15,000.

would or would not get involved with the bereaved. We presume that of the 97% who did not answer, the majority were not involved.[5] Some of the reasons for this and the attitudes related to it may be reflected in the answers we did receive. The major reasons offered by women for not getting involved were: the wish to keep their family life separate; the negative attitude of the husband about his wife being involved; their own feeling that this is not the wife's business; and, finally, in the larger business their help was not needed.

It seems worth looking at the reasons why these women felt it important to keep their private life very separate. They considered that getting involved placed too great a burden on themselves and their children. A constant living with death was contrary, they felt, to the needs of normal family living. As one woman said:

> "We moved our home away from the business. I became depressed and weeping constantly with every family my husband served."[6]

Their lack of involvement may be a reaction to inner tension they may experience because this is a profit-making business as well as a human service. Whose needs would they be serving by becoming involved? These are the sacred and profane aspects of the work described earlier. These effect her to the extent that some wives are reluctant to identify with the work their husbands do.[7]

In rural or small communities there seem to be more active involvement by the wife in the funeral than those living in an urban setting. She is better known among the people her husband serves and has a close everyday relationship with them. This very naturally extends itself to a concern for them in their bereavement. In a fair number of rural communities husband and wife work as a team:

> "I serve as an assistant and hostess with my husband. Many of our patrons are personal friends and come to us as a team knowing I will be here also with warmth and friendship."

The attitude of the funeral director himself and how he views his wife's role in the business will very much determine the extent of her involvement. He may consider it her role to befriend a young bereaved mother or widow, to help out an elderly person in providing transportation or other services. He may feel it the right thing in his community that she should visit the bereaved or help out in some material details. Those that give this type of answer will justify their role as "part of being a funeral director's wife," or "my husband expects it of me."

Some wives mentioned as their main reason for helping their natural compassionate feelings. This was especially mentioned by wives whose fathers had also been in the funeral business so that they had grown up with it and learned to feel for the bereaved. At the same time, whether they became active or not, what they do for the bereaved also depends on what the bereaved themselves wish for at this time, what needs they express, how ready they are to reach out for help.

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[5] The questionnaires were sent to the funeral homes and we know that in many cases they never reached the funeral director's wife. We learned of this at the National Funeral Directors meeting in 1970 when several women told Silverman they had not seen the questionnaire.

[6] Informal communication between Silverman and a member's wife at the National Funeral Directors Association annual meeting, 1967.

[7] Personal communication with Robert Fulton who reported he knew of some women who say their husbands are furniture salesmen or another neutral occupation.

An important factor influencing the wife's involvement seems to be connected with the organizational aspects of the business. A wife would be more likely to help out and fill in as needs arose in a small business where occasional help is needed and a permanent helper would be too costly.[8] The wife then steps in to fill in this occasional need. Sometimes she is employed on a regular basis by the funeral home, doing office work, helping with visiting hours or even in more direct ways in choosing clothing for the deceased and fixing hair, etc. The extreme case of this is that of the widow of a funeral director who is a funeral director herself, having taken over the business (Van Wormer, 1970). A wife's availability to help will also be considerably influenced by the fact that she may live in the funeral home and therefore be in constant contact with the bereaved. The logistics of availability is a critical issue when we look for natural care-givers. These women seem to be the sort who use their position to extend themselves to be more personally involved. They are ready by disposition and position to expand their role.

The kinds of help offered can be grouped in the following manner: 1. To be a listener, to offer sympathy and understanding; 2. To help in material details: babysitting, helping in the bereaved's home, applying for pensions, and so forth; 3. To help in relationship to the funeral itself; and 4. To offer moral or religious support, to give advice, and refer to the clergyman or other appropriate community resources for counselling.

In a great many cases, the wife will be helping on several levels, depending on her role in the funeral home, how well she knows that particular family, or how much she is in contact with the community in general.

CONCLUSIONS

This material gives us some insights into the role a funeral director's wife could play in helping the bereaved. She takes on the caregiving role if she or her husband view this as appropriate and if certain circumstances tend to encourage it. These are: when she is involved in the business in a defined role, when she lives in the funeral home, or when she is so involved in her community that she is known as a helping person. The things she does can range from the profane work of preparing the body to the most sacred work of praying with the bereaved. Where she is active she seems to make the entire situation more sacred, being primarily oriented to the human needs of the mourners. Her husband sees her and she sees herself as specially qualified to meet these needs. The bereaved also tend to accept her as a natural caregiver, all the more readily since they see her as a sympathetic human being and tend to dissociate her from the profane aspects of her husband's work.

The acceptance of this role of caregiver to the bereaved, requires of a funeral director's wife a special attitude of dedication, since this activity will affect not only herself and her husband but the whole way of life of the family. At the same time, she is conscious of being in a very unique position as wife of the funeral director. The problem she has in defining her role is similar to that of the wife of a minister, rabbi, or any professional who tends to very personal needs of people. How far is it appropriate for her to go in showing her concern for the people her husband serves? Unlike these women her status is not as clearly defined, nor does her husband's work bring her special recognition and prestige. In

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[8] At the 1970 National Funeral Directors Association meeting, several women spoke of their role in the funeral service. One reason for their getting involved was to keep the overhead low.

addition her husband is in a profit-making business and her activity can be misconstrued as looking for customers for him. We can speculate that one reason more wives are not involved is that they are ashamed of their husband's work and identify primarily with the profane aspects of it. This may change if the funeral director systematically extends his attention to the broader needs of the grieving families he serves, altering the focus of his work and his public image as well.

The material gives us some information about the kind of contribution the funeral director's wife can make to a widow's mental health. To get through the funeral by participating in a manner appropriate to the mourner's religious and social tradition is a first step in learning to cope with all the subsequent changes that death involves. We can assume that the funeral director's wife, by being available to talk with a new widow, by providing her with support and direction, is enhancing her ability to deal with this stage of her grief.

At this time the new widow also needs to feel connected to other people, to break through the strong sense of isolation that develops in her. She needs to go over the death event again and again, and to speak of her fears and doubts about handling the future alone. The personal contact with a woman close to the funeral service, who is readily available at the time, and who has more than a casual understanding of what is happening, can be very therapeutic in providing an opportunity to talk and to acknowledge these feelings.

A final mental health function is to provide a line between a person in trouble and an appropriate helper. Someone in serious trouble, who may need additional assistance, can be referred to another agency or resource. It may be easier to accept such a referral from someone who has been helpful and who has the trust of the bereaved.

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ETHICAL ISSUES IN KIDNEY TRANSPLANTATION[1]

Roberta G. Simmons, Ph.D. and Julie Fulton, M.A.[2]

As a new medical procedure, organ transplantation has attracted public attention to a virtually unprecedented extent. Each heart transplant has received extensive local and national coverage, and many kidney transplants have also had considerable news attention. In the wake of such publicity, many serious ethical issues have been raised: What are the criteria by which some potential recipients should be selected for transplantation and others refused this life-saving treatment? How can a potential organ donor be protected against premature termination of his life? What is an acceptable definition of death? Should living donors be used? Should the society allocate large sums of money to support transplantation, or should transplantation receive little encouragement in the face of other societal needs?

This paper will address itself to these and other ethical problems inherent in the burgeoning field of organ transplantation and will focus specifically on the area of kidney transplantation. The kidney is the only organ that has been transplanted successfully enough for the operation to be considered a viable cure rather than an experiment. Many of the problems now being experienced within the field of kidney transplantation will undoubtedly be relevant to other types of transplant programs in the future as these programs attain greater success.

Before we discuss the ethical issues surrounding kidney transplantation, a brief explanation of kidney dialysis and transplantation is in order.

HEMODIALYSIS

Hemodialysis, or the purification of a kidney patient's blood by means of an artificial kidney machine, was the first major advance in the treatment of kidney disease. It is used today, on a short-term basis by patients awaiting transplantation, and, on a long-term, relatively permanent basis by those patients who have no transplant operation in sight.

In a hospital, clinic, or even a home setting, the kidney patient is "hooked-up" to the dialysis machine by means of a shunt, or U-shaped tube, one end of which is inserted into a vein and the other into an artery. Approximately twice a week, for a period of from seven to fifteen hours each time, the patient's blood is cycled through the machine, where it is purified, and then returned to his body.

The shunt is, quite literally, the patient's lifeline. Unfortunately, however, the area in which the shunt is inserted is subject to infection and the vessels are subject to clotting. When this happens, the patient must be hospitalized. If the shunt connection should tear apart, emergency measures are required to prevent hemorrhage. This becomes a very serious problem given the limited number of locations that a shunt may be inserted in the patient's body. It should be noted that the alternatives for patients who are sick enough

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to require long-term dialysis are very few. They must either: (1) remain on dialysis treatments; (2) undergo a kidney transplant operation; or (3) face certain death.

KIDNEY TRANSPLANTATION

Kidney transplantation attempts to remove the patient from the status of being "sick" altogether. In this operation, the diseased kidney is surgically replaced with a healthy organ from either a cadaver or a living donor.

According to the Registry of Kidney Transplant statistics, eighty-one percent of those patients who received a kidney from a living brother or sister, and forty percent of those who received cadaver kidneys, have survived two years post-transplant with functioning kidneys (Kidney Transplant Registry, 1969). ("Two years" is the arbitrarily designated period beyond which the patient is felt to be "cured".) In many medical transplant centers today, therefore, patients are receiving kidneys with the *hope* that this operation will give them a normal lifespan as well as an essentially normal life. This hope is strengthened by the knowledge that kidney transplantation, with related donors, is more successful in providing a cure than is any operation designed to cure cancer.

WHO SHOULD BE SELECTED FOR TREATMENT? WHO SHOULD BE REJECTED?

"It was estimated, in 1967, that some 50,000 persons a year die of uremia, or poisoning of the blood due to kidney failure; of that group, it was believed that 7,000 to 8,000 would have been ideally suited for either maintenance therapy, by means of hemodialysis, or for kidney transplantation" (Editorial: J.A.M.A., 1968; Gottschalk, 1967). In that year, however, treatment was available to less than 2,000 kidney patients due to the undeveloped nature of the dialysis and transplant programs. In the past three years, hospital facilities and medical and economic resources have been greatly expanded, yet, as of this writing, many patients die from what is potentially a curable disease. Who, then, is likely to be rejected for treatment? Who should be allowed to live, and who must die?

The fact that dialysis and transplantation require large, highly trained professional staffs, and expensive, highly specialized facilities means that such centers are likely to be limited to urban areas or to university research hospitals. An ethical issue raised by this fact–particularly when the medical facility is in part federally supported–is the difficulty of providing to all citizens the same opportunities for treatment. Patients living in small communities at some distance from these centers and lower-class patients from all areas would seem to suffer most from this concentration of facilities and staff.

Persons from outlying areas and their local doctors are often unaware of the existence of the kidney center or, if they are aware, might possibly be discouraged by the cost of travel and by the adverse reports of patients being denied treatment at these centers.

Many factors seem to work against the lower-class patient in particular. It has been shown that lower-class persons are less likely than others to seek medical care at all (Rosenblatt and Suchman, 1964). In the urban areas, however, this is mitigated somewhat by the existence of large, general hospitals or clinics specifically designed to serve lower-income families from which referral to a transplant center is likely. Nevertheless many low-income patients do not attend these clinics but see neighborhood physicians. It

is very possible that the physician whom the lower-class patient consults will not feel that he would be accepted for kidney treatment, or that he and his family will be able to make the sacrifices of time and money required by this procedure. As a result, the physician may not even refer this patient to the center to be considered for treatment.

If, however, the physician does refer a lower-class patient, there are further, more subtle obstacles for him to overcome. Some centers select patients for treatment only on the basis of medical criteria; in such programs, persons with the best chances for medical recovery, or, perhaps, patients with a particular combination of diseases will be chosen over patients who have less promising medical prognoses. Other centers select patients not only on the basis of medical criteria, but also may employ social factors in their decisions; here again, lower-class persons face heavy odds against them.

At the time of the first dialysis treatments in Seattle, an anonymous committee of primarily lay persons selected the patients for treatment (Alexander, 1962). A major criterion in their decision, over and above the medical considerations, was their judgment of the social value of the patient's life. They decided, in other words, which persons were the most "worth" saving. Such committees would be expected to reject the unemployed, the worker with an "unimportant" job, the person with few family ties, and the person with a history of deviance of any sort (Schreiner, 1966). The Seattle board has since been dissolved and the burden of selection, there as elsewhere, now falls largely onto the physicians themselves (Abram, 1969; Katz and Procter, 1969).

In the treatment of certain other types of patients, physicians have been shown, however, to exhibit a bias toward middle-and upper-middle class patients–patients, that is, who are more like themselves (Hollingshead and Redlich, 1967; Sudnow, 1967). There is some evidence of a similar bias in the selection of dialysis patients. Ninety-one percent of dialysis patients are white; forty-five percent have at least one year of college education as compared to only eighteen percent of the adult population of the United States; and sixty percent had incomes (before dialysis) at, or above, the United States median income (Katz and Procter, 1969). Other studies have also suggested a slight middle-class bias in the selection of patients for heart transplantation (Crane, 1969). There is no systematic study, unfortunately, of the social origins of kidney transplant patients, but it is likely that they would not differ too greatly from those of dialysis patients.

In a study of eighty-seven dialysis centers, it was found that nearly all of the centers (96 percent) use at least one social or psychological criterion in their selection of patients in addition to their assessment of his medical suitability (Katz and Procter, 1969). Ninety-seven percent of the centers believe that willingness to cooperate with the treatment is an important criterion for selection and 82 percent usually use intelligence as an indicator for such cooperation. Approximately three-quarters of the centers believe that the likelihood of vocational rehabilitation is a valuable means of selecting patients for treatment and half of the centers utilize a psychiatric evaluation as a selection device.

It would be an over-simplification, however, to say that the disproportionate number of middle and upper-middle class patients who are receiving kidney treatment is due simply to the physicians' prejudice. Rather, the physicians feel that they face an ethical dilemma in the selection of patients for treatment. Many of them believe that a willingness to cooperate with the strenuous requirements of the dialysis program is vital for the success of the patient in dialysis (Katz and Procter, 1969). The dialysis patient must be able to take directions and to understand the necessity for complying with the

most minute details of his medical program. Many physicians feel that intelligence and education play a part in the patient's ability to see the need for such a program and to execute it (Katz and Procter, 1969). To use intelligence and education as selection criteria, however, once again serves to insure that the more privileged, better educated middle and upper-middle class kidney patient will have an advantage over the lower-class patient in need of treatment.

There are some safeguards—and, in effect, "advantages"—for lower-class patients, but such measures do no apply uniformly to all. For instance, under the Federally-financed Medicaid program, there is a provision (Title 19) which pays for some hospital bills of patients whose incomes are below an established minimum (Kidney Disease Services, 1969). In some states, kidney patients can receive assistance only if they pass a means test or if they are on welfare. For example, in one state a prospective patient cannot be earning more than $2200 a year (with an additional allowance of $500 for each child); his cash assets must not be greater than $1000, and his property assets must not exceed $15,000. If his assets are greater than these amounts, he will be expected to contribute toward the transplant. In a case of non-payment, the hospital can put a lien on all of his property except his home in an attempt to collect the bill. (Obviously, although these requirements may assist some of the very poor, they may put the lower-middle class individual in a financial bind.)

The availability of treatment and finances is determined not only by the patient's income level, but also by the locale in which he happens to live. Certain states have interpreted Title 19 of Medicaid to exclude dialysis and transplant patients completely (Kidney Disease Services, 1969). Frequently one transplant center must service many surrounding states, states which may have a less liberal interpretation of Title 19 than does the states in which the center is located. Hospitals cannot long stand the strain of unpaid bills and it is possible that some kidney centers may be forced to reject all but the wealthy out-of-state applicants.

The discrepancy between states is further widened by the fact that eight states have set aside additional special monies to contribute to kidney patients' care and treatment (Little, 1969). It is clearly better to be sick in some states than in others. Even the county of a patient's origin may be important. In some states, the county decides on the patient's eligibility for Medicaid funds and may also contribute to the benefits. One expensive transplant operation, however, can exhaust a county's entire annual medical welfare budget and render it incapable of aiding other needy applicants.

At the present time, therefore, given the lack of national financial planning, it is likely that patients are being denied treatment on an arbitrary basis, such as their financial status, or their state, or even country of origin.

An additional ethical problem in the selection of patients for dialysis or transplantation involves the use of psychological or psychiatric evaluations in the decision-making process. Psychiatric prediction is always difficult to make with certainty and, more important, kidney disease itself can cause intellectual impairment. There appear to be psycho-physical effects of severe kidney disease that are partly chemical in origin, which are improved but not eliminated by dialysis. Among these are apathy, inability to concentrate, irritability, depression, and intellectual impairment—as revealed in slow speech, erratic memory, confusion, and lower performance on intelligence tests and other psychological tests. In severe cases, a psychosis with paranoiac, hallucinations may develop.

Whereas a successful transplant operation can eliminate some, if not all of these symptoms, the question for the medical judges is whether a psychiatrist can predict the reaction of a severely ill patient to the medical therapy accurately enough to grant him—or to refuse him—life-saving treatment. Whatever the answer, some centers attempt to do just this. One center refused a young man a transplant operation on the grounds that his operation would be extraordinarily expensive and that such funds should not be wasted on someone of his moral character. (The young man had a history of glue-sniffing.) Another center accepted him, performed a successful transplant on him, and found that he responded by a dramatic physical as well as psychological improvement.

THE DONOR: WHO SHOULD BE USED AND HOW SHOULD HIS WELFARE BE PROTECTED?

The patient's opportunity to receive an organ transplant is limited not only by the selection procedures for obtaining access to the scarce medical and financial resources but also by the fact that in every operation, a donor is required.

Transplant operations are performed using either living, related donors, or cadaver donors. As mentioned earlier, patients who receive a kidney from a living relative do twice as well as do those patients who receive a cadaver kidney from a person unrelated to them (Kidney Transplant Registry, 1969). With these facts in mind, two contradictory ethical questions arise: (1) Is it ethical to use a cadaver donor and give the recipient a diminished chance of a successful transplant? and (2) Is it ethical to utilize a living donor and possibly jeopardize one life in order to try to save another?

Several articles have been written about the ethical dangers of transplantation and in many of these, a major concern has been that the poor and powerless will be exploited as donors for more advantaged citizens (Kass, 1968). The concern has also been expressed that dying patients or their families will be under pressure to donate and that the potential donor will be given poor medical care (Kass, 1968).

It is reasonable to expect that a physician would feel caught on the horns of a dilemma, caught, that is, between his need to protect the patient who might be a potential donor and his obligation to the prospective transplant recipient to obtain for him as useful an organ as possible.

Living Related Donors

Physicians are aware that almost all patients with kidneys transplanted from living, related donors do well, whereas more than half of the cadaver recipients return, sooner or later, with irreversible kidney rejection. There is, however, considerable uncertainty and controversy among physicians with regard to the use of living donors. Some physicians argue that it is unethical to jeopardize a normal life. In a fundamental sense, the situation is contrary to medical norms and expectations. *Primum non nocere,* "first of all, do no harm," is a traditional medical rule. The physician is placed in the situation of having to ask a person to assume a surgical risk and to undergo a major operation with no physical benefit to himself. The surgical risk, though small, is a factor to consider. It has been estimated that there is a one-out-of-2000 chance that the donor will lose his life during the operation and a one-out-of-1500 chance that the donor's life will be endangered on a long-term basis (Hamburger and Crosnier, 1968).

Although no deaths or major complications have as yet been reported because of organ donation, the physicians fully realize that as more living donors are used, donor deaths or medical complications can be expected to occur. This dilemma has been widely discussed but no clear rules have emerged to guide the physician except for the necessity of "informed consent." It is agreed that the prospective donor must be informed about the degree of risk and the inconveniences that will occur. There is no agreement, however, concerning the degree of effort a doctor should exert to secure a family donor, nor about the method he should use.

It has been found, in many instances, that there is a positive effect on the donor as a result of donation: he often experiences feelings of greater self-esteem, and, in fact, may think of himself as something of a hero. Psychiatrists Fellner and Marshall, in their study of donor reactions, found that donors, in speaking of their feelings about the donation, often used such phrases as: "I feel better, kind of noble. I am changed. I have passed a milestone in my life, more confidence, more self-esteem," or "my whole life is different. I've done something with my life," (Fellner and Marshall, 1968). If kidney donation enhances the donor's self-esteem, then some of the ethical concerns about the morality of taking from one living individual to give to another might be less urgent. Intensive investigation is needed, however, of the donor's reactions when the transplant is unsuccessful and the kidney is rejected. In such an instance, the initial rise in self-esteem might possibly be replaced with feelings of intense depression over the fact that the sacrifice was for "nothing".

The question of which family member should be a donor for a relative with kidney failure sometimes presents ethical and emotional problems for the entire family. In most cases, the decision to donate appears to be a relatively smooth, satisfying procedure. Sometimes, however, it is difficult to find a medically acceptable and willing donor. Parents seem to feel a greater obligation to donate for their children, if possible–an obligation which, incidentally, is not often felt in reverse. The National Kidney Registry statistics show that few recipients have received kidneys from their children (Kidney Transplant Registry, 1969). This fact, however, is due both to the general unwillingness of children to donate to a parent as well as to the fact that most kidney recipients have been too young to have children of legal age. Siblings also seem to be less willing to donate to their ill brother or sister than are the parents.

Many questions arise with respect to who should be allowed to donate. Some critics of the use of living, related donors fear that undue family pressure may be applied in order to force the donation. For instance, should minors be allowed to donate? Or, should relatives institutionalized due to retardation or mental illness be allowed to be used as donors? There is, of course, a very great danger that the use of such persons may be more a result of coercion than of willingness on their part. Hospitals have been unwilling to make these decisions themselves, and, in several instances, have placed the matter in the hands of the court. In some cases, minors and institutionalized relatives have been approved as donors, after the court concluded that the death of the recipient would be psychologically disadvantageous for the potential donor in question. These decisions are controversial, however, and it is unclear how a general precedent will be established.

In several cases, "black sheep" members of the family have been known to donate with the hope that this act on their part will, once and for all, prove their worth to the family. Many members of the family may be affected by the need to find a related donor. Non-donors, that is, members of the family who could have donated but did not, may

feel great feelings of ambivalence and sometimes experience feelings of guilt. Conflicts which appear prior to the transplant, however, may be resolved by a successful transplantation; the non-donor's guilt may be eased and the donor's self-esteem may be enhanced as the patient is enabled to assume something other than a dependent, invalided status within the family.

The Cadaver Donor

Many kidney transplant operations performed today rely upon a cadaver donor. There are two major reasons for this. First, some centers do not encourage the use of living donors and second, in certain cases it proves to be impossible to find a medically suitable related donor. In these instances, the kidney patient must rely upon a cadaver donor and hope that a suitable kidney will be made available in time to help him. Inasmuch as the organs of elderly patients are not useful, a suitable donor is almost always a young person who is the victim of an accident or who is suffering from brain disease. The potential "cadaver" donor, when first seen is usually a comatose patient whose own life chances are felt to be hopeless, and whose brain has ceased to function almost, if not entirely.

Because of the widespread ethical concern about the medical treatment of the dying donor, new rules and guidelines have emerged. For instance, to prevent a conflict of interest on the part of the physician between the donor and the recipient, it has been agreed generally that the prospective donor should be cared for by one group of physicians, and the prospective recipient by another (Merrill, 1968). The transplant team, therefore, is not involved in the declaration of the donor's death and it is easier for everyone involved to avoid the accusation of having in any way hastened it.

Another ethical problem arises over whether the two teams of physicians should consult with each other at all in the treatment of the dying donor. For example, if the fluid balance of the potential donor is neglected, as occurs sometimes with patients who are considered hopeless, their kidneys will be useless at the time of their death. Should the transplant team therefore be allowed to intervene in his care and suggest a change in treatment? There is no question that a donor's own chance for life must be protected, and usually what is good for the kidney—or for the heart, or the liver, or the lungs—is also good for the patient (Stickel, 1966). In fact, there have been instances in which patients who were expected to die recovered because of just such intervention and advice on the part of the recipient's physician concerning the care and treatment of the donor's kidney (Crosbie, 1970). Yet some have questioned the ethics of instituting certain treatments or procedures which are designed primarily to benefit the needed organ (Stickel, 1966).

The medical treatment of a cadaver donor raises a larger issue and one that has been a problem for physicians for some time—namely, how long should an apparently hopeless patient be kept alive by extraordinary medical means? In the case of organ transplantation, contrary to certain fears, an unconscious, brain-damaged donor is frequently kept alive longer than normally would be the case, because of the anticipated donation. For the potential transplant donor, all emergency procedures are instituted, though such measures may prolong the agony of the family. They are told that their relative is essentially dead, even though death has not been pronounced. The question of exactly when death occurs is a vital one for transplant surgery. The original definition of death which depended upon the cessation of the heart, and with it, a cessation of the circulation of blood to the parts of the body, posed a great problem for transplant

surgery (Stickel, 1966). With new machines it is technically possible to maintain a patient's heartbeat and respiration long after his brain has ceased all function. A new definition of death was needed for the new technology—a definition which would allow for the maintenance of the circulatory system of the body until the time of transplantation, but one which would not imply that the organs were being taken from a still-living individual. The concept of "brain death" promoted by Beecher, at Harvard, seemed to fulfill both of these requirements (Moore, *et al.*, 1968; New Dimensions, 1969). According to his definition, death occurs when the brain is dead, whether or not the heartbeat is being maintained.

Although Beecher's definition of death has been accepted by most, there was, and still is, some conflict over the measurement of brain death. Some physicians use some of Beecher's guidelines but do not use brainwaves to determine when death has occurred. Other physicians believe that a period of three to four hours without brain waves is sufficient to declare the patient dead. Still others insist that twenty-four to forty-eight hours must pass without brain waves before they are willing to pronounce the death (Savage, 1970; Silverman, *et al.*, 1969; Hamburger and Crosnier, 1968; Vaux, 1969; Visscher, 1970).

Essentially the issue is not whether death has occurred, but rather, which criteria are used to determine it. In other words, most physicians feel fully capable of being able to diagnose brain death and of being able to decide when a patient is dead. But because they are anxious to avoid criticism, they feel bound to utilize a set of criteria which allows the use of an objective sign of the death. It is likely that the question of when death occurs will remain an issue among medical practitioners for some time, as will the question of whether a definition of death should be formulated specifically to serve the needs of a new medical technology.

These ethical issues are aggravated further by the limited number of cadaver donor organs that are available at any particular time. Given the total number of kidney patients who could benefit from a transplant operation, there is always a serious shortage of organs available. At the present time, though many persons have signed donor cards willing their organs for transplantation in the event of their untimely death, cadaver organ donation still depends largely upon the willingness of the next-of-kin to donate the organs of a dying relative. The physician must approach the family with the proposal to donate the organs at a tragic moment for the family, frequently just after they have learned that their relative has been the victim of a "fatal" accident. Many physicians find this exceedingly difficult to do, particularly when they must press the family to make a decision as quickly as possible in order to facilitate the medical procedures that must be followed.

It has been suggested that one way to secure cadaver organs and to avoid the problems of "time" and family trauma, would be to utilize the organs of persons whose bodies would be unclaimed after their death. For example, under a law which exists now in Virginia, the medical examiner can give permission for the use of organs for transplantation without the consent of the kin or prior consent of the individual if the case falls under his jurisdiction, if no kin can be located, and if there are no known objections (Code of Virginia, 1968; Pierce, in press). It has been suggested that this type of law be extended to give the state the right to use the organs from any individual who has not indicated prior disapproval (Castel, 1968; Duckeminier and Sanders, 1968; Wolstenholme and O'Connor, 1966). At this point in time it is unclear whether the

removal of organs without the consent of the family or of the donor would be acceptable to the American public. The fear that this type of law might be extended into potentially dangerous or unethical practices might militate against its general adoption. On the other hand, its general adoption would assure a more adequate supply of organs for all types of organ transplant operations.

Living, Unrelated Donors

Many of the problems associated with both cadaver donors and living related donors would be eliminated—or at least greatly reduced—if living, unrelated donors were to be used as volunteers. There is a very serious question, however, as to whether such persons should be used at all. The medical problems which apply to the living, related donor apply as well to the living, unrelated donor; he will have to undergo the surgical procedure with its associated short-term and long-term risks to his life with no physical benefit to himself. There could, of course, be a derivative psychological benefit; like the related donor, the unrelated living donor could experience a boost in his self-esteem as a result of his willingness to save the life of another individual. One center in California has experimented with living, unrelated donors and has found this to be the case (Sadler, et al, 1969).

It has been the hope of surgeons who have conducted these operations that the added time allowed to match living, unrelated donors and potential recipients would produce better results than those obtained by using cadaver donors. It is the feeling of many physicians, however, that living, unrelated donors will not give results that are significantly better than cadaver donors and that it is, therefore, unethical to utilize this source. At one time, inmates of penal institutions were used as volunteer donors (Crosbie, 1970). This practice has since been discontinued on the grounds that however equitably it may have been handled in particular instances, there was a grave danger that an expansion of such a practice would lead to the abuse of prisoners' rights.

The President of the Transplantation Society, Dr. Hamburger, has pointed to one grave threat that he believes may occur with the use of living, unrelated donors, that is, that organs will be sold rather than donated (Hamburger, 1969). He notes that if such a system were instituted, other dangers could follow, particularly the dangers of blackmail, of exploitation of the poor, and of the possible use of coercion in certain societies to obtain organs. There are those who are less opposed to the sale of organs for transplantation than is Dr. Hamburger (Houston, Texas, symposium, 1970). They argue that there should be no legal proscription now against the purchase of an organ since such a law might be unnecessarily restrictive in the future. Still others see little objection to the buying of an organ at the present time if that is the only recourse for a kidney patient (Savage, 1970). Payment for an organ, they argue, would possibly relieve the recipient of his feelings of obligation toward the donor—a feeling which has been noted in several instances involving living, related donors.

It should be noted that at present, most transplant facilities are heavily supported by public funds. If the limited facilities for organ transplant operations are to be used by recipients who can afford to purchase an organ, there will be even less opportunity for the poor to secure treatment. Not only would the poor be unable to compete with the rich for the purchase of an organ (it is possible that the price of an organ would involve thousands of dollars), but also, it is likely that such an opportunity for donor

remuneration would sharply reduce the supply of freely-donated organs from relatives and cadaver families.

The Transplantation Society has passed a resolution forbidding the sale of organs, and while this resolution does not have the force of law, the compliance of the transplant centers is reflected in the fact that at the present time no center permits the sale or purchase of an organ. This issue is not entirely settled, particularly with the prospect of more living, unrelated donors in the future.

SHOULD TRANSPLANTATION BE ENCOURAGED AT ALL?

Technological advances in medicine are extremely expensive and often require governmental support, particularly in the initial stages. It has been estimated that the cost of a kidney transplant operation now averages about $13,300 (Gottschalk, 1967). In addition the yearly cost of follow-up medical care can run anywhere from $200 to $1000. If the operation is not successful, the patient may be faced with the need for a second transplant or perpetual hemodialysis. Such dialysis at a hospital center costs approximately $14,000 a year. If it is possible for the patient to obtain a home dialysis machine, which costs between $10,000 to $12,000, there will still be a yearly cost to him of approximately $4,000 (Bethesda Conference Report, 1968). As additional medical technologies develop, the government increasingly will be confronted with a fundamental decision: is it possible and/or reasonable for this society to allocate major sums of money in order to save the lives of the previously incurable? It was recommended by the Committee of Chronic Kidney Disease that the Bureau of the Budget expend $800 million to $1 billion during the years 1969-1975 for the training of transplant personnel, for needed facilities, and for the actual care of kidney patients (Gottschalk, 1967). Such funds have not as yet been allocated.

The decision must be made as to whether the potential benefits of the new technology will justify the costs and, moreover, whether this expenditure is as important as, or more important than, other critical needs of our society. Some physicians object to enormous sums of money being spent on transplantation to the exclusion of other health needs, particularly the basic health and nutritional needs of the poor (Allgower and Gruber, 1968; Fox, 1970; Norman, 1969).

An editorial in a well-known public health journal questions the expenditure of large sums of money on organ transplant operations in general, claiming that other medical programs contribute to the health of more persons for less cost (Editorial, *American Journal of Public Health, 1969*). The editorial points to the adverse psychological and physical consequences for the recipient of a transplant operation. Some patients do suffer physical side-effects from the drugs they must take following the operation. These drugs are necessary to prevent their body from rejecting the new kidney. In particular, the face and body may swell, acne may occur, there may be hair loss, and a bone damage may occur which can impair the recipient's ability to walk. Most of the serious problems, however, seem to occur shortly after transplantation or in patients whose body constantly threatens to reject the new kidney. Evidence of adverse psychological consequences for kidney recipients, however, is not sufficiently clear to warrant restricting this life-saving operation. There is certainly no evidence to suggest that patients who have undergone a successful transplantation are any worse off, psychologically or physically, than they were prior to the operation, or, for that matter, that they are any

worse off than are patients on perpetual hemodialysis. In fact, the evidence seems to suggest that following a successful transplant they, like the donor, experience a boost in self-esteem and a feeling of having been given a second chance in life (Fellner and Marshall, 1968, 1970; Eisendrath, *et al.*, 1969). Their vocational rehabilitation, moreover, seems excellent. It has been reported by one transplant center, that eighty-eight percent of those patients who have not rejected their kidneys six months or more after the operation were working full-time, were fully active as housewives, or had returned to school (Gottschalk, 1967).

The fact that such rehabilitation is possible would seem to argue for the continuation of organ transplantation and for the establishment of a national policy to ensure that all persons, regardless of income, educational level, or geographical origin, can have an equal opportunity to receive this treatment. Even if such a policy is instituted, however, many ethical problems will persist, particularly those concerning the organ donor. Whether the society can effect changes in the needed areas within a short period of time, and in the face of many other compelling demands, remains an open question.

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SUICIDE IN OPERA: A BRIEF ANALYSIS

K. Warren Walley, M. P. H., and Richard A. Kalish, Ph.D.

Dramatic themes that outlive the decay of time are often assumed to express a universality of feeling. Thus, an analysis of popular literature in a given region and at a given period of time, presents clues regarding the socio-emotional climate of that community. Suicide and other acts of self-destruction are common themes in dramatic literature today, as they have been over the centuries. Some of this popularity may be due to the dramatic–usually sudden and violent–impact of the severence of a life. At the same time, the reoccurrence of this theme certainly speaks of its relevance to society.

The present brief study offers some insights into the use of suicide in grand opera. Although fiction and drama are often cited by behavioral scientists as examples, it is unusual to find a content analysis of such writings. Inevitably, operas retain popularity not merely because of the plot, but because of the music. Nonetheless, the power of music in opera depends heavily upon the impact of what occurs to the people involved.

PROCEDURES

Two sources of data were obtained for this study, one representing opera in three major houses in the United States, and the second representing opera in eleven major houses throughout the world.

The three American houses were: the Metropolitan Opera Association (New York); the Chicago Opera Company; and the San Francisco Opera Company. These were selected because of their popularity and reputation, and also because of location, size, age, and representative quality of productions. Required information was obtained from standard sources (Bloomfield, 1961; Davis, 1966; Seltsam, 1949).

To be included in the tabulation, an opera had to be performed at least twenty times between 1850 and the present. Following selection of the final list of operas, each plot was evaluated to determine whether or not the opera involved at least one death; each death was then evaluated as to its suicidal intent, with suicide defined as "The intentional taking of one's own life or the failure when possible, to save one's life when death threatens" (Cavan, 1965). Once a suicide was established, further analysis was undertaken to determine the sex of the person committing suicide, the method of suicide, and the reason for suicide. An initial attempt to investigate age as a variable was abandoned, due to lack of sufficient information.

The second source of data consisted of eleven opera houses in major centers throughout the world (see Table 1). For each house, the ten most frequently performed operas were selected (Martin, 1961).

RESULTS

A total of 104 operas fulfilled the qualifications for the three American opera houses. Of these, 68 involved at least one death and 28 involved at least one suicide. Thus, suicide occurs in 26 percent of the frequently performed operas; of all operas in which any form of death occurs, 41 percent also include a suicide.

Altogether, 31 characters committed suicide. Stabbing (11), poison (7), and burning (4) were the most frequent methods. Two characters each were drowned, guillotined, or died of despair, and one each leaped, was crushed or suffocated. No suicide involved the use of firearms, although most plots were set well after the time when guns for hunting and warfare were commonly used. Slightly over half (58 percent) of the characters committing suicide were women.

The senior author evaluated the reasons for each suicide. The largest number occurred because of wishing to be reunited with a loved one after the latter's death (55 percent); lost love accounted for 32 percent, and feelings of guilt were responsible for 13 percent. (Cause of death was analyzed for only one character in each opera.)

In analyzing the ten most popular operas from each of the eleven houses around the world, the number of operas containing suicide ranged from one, at Copenhagen, to six at Parma. Of the total 110 operas, 44 (40 percent) involved suicide; and of the 39 different operas (after eliminating duplications), 10 (26 percent) involved suicide. These ten operas and the frequency with which they were represented at the eleven houses, are shown in Table 1.

DISCUSSION AND CONCLUSION

The purpose of this brief note is to point out the importance of suicide in one major field of drama–opera. The authors feel that it underlies the importance of the act of suicide in the dramatic fiction of the Occident.

In opera, suicide is a unique combination of music and theater, necessarily involving a slowed pace of action, use of recitative, and musical episodes. None of these are witnessed

TABLE 1. (From Martin, 1961)
Frequency of being among ten most performed operas at eleven opera centers of the world.
(Limited to operas involving suicide.)

Theatre	Opera among ten most performed									
	1	2	3	4	5	6	7	8	9	10
Teatro Municipal, Rio de Janeiro 1909-1959	X	X					X	X		
Maly Opera House, Leningrad 1918-1958		X					X	X		
Royal National Opera House, Copenhagen 1821-1959						X				
Landestheater, Linz, Austria 1857-1959				X			X			X
Metropolitan Opera, New York 1883-1959	X		X					X	X	
Royal Opera House, Covent Garden, London 1847-1959	X	X	X				X			
Teatro Regio, Parma 1829-1960	X		X	X	X		X			X
Hungarian State Opera House, Budapest 1884-1959	X	X	X			X	X			X
Teatro La Scala, Milan 1900-1959	X	X	X				X	X		
Teatro Colon, Buenos Aires 1908-1959	X	X		X			X	X		
Deutsche Staatsoper, Berlin 1886-1959		X	X			X				
Number times mentioned	7	7	6	3	1	3	8	5	1	3

1. Aida (Verdi), 2. Madame Butterfly (Puccini), 3. Lohengrin (Wagner), 4. Lucia di Lammermoor (Donizetti), 5. Norma (Bellini), 6. I. Pagliacci (Leoncavallo), 7. Rigoletto (Verdi), 8. Tosca (Puccini), 9. Tristan & Isolde (Wagner), 10. Il Trovatore (Verdi)

in suicide in real life (Apel, 1951). Nevertheless, perhaps because opera is a reflection of life, suicides in opera have their counterparts in actual life. A few plots serve as illustration.

Aida (Verdi): Suicide because of loss of a loved one

Place: Memphis and Thebes in ancient Egypt; time: dynasty of the Pharoahs. Aida is an Ethiopian girl and a slave to Amneris—the daughter of the king of Egypt. In her own land, however, Aida was herself a princess, the daughter of Amonasro, king of Ethiopia. Radames is an Egyptian captain of the guard, very much in love with Aida, but bethrothed to Amneris. Prior to a decisive battle, Amonasro persuades Aida to elicit information from Radames. Aida does so unwillingly. Radames realizing what he has done, turns himself over to the high priest, Ramfis, as a traitor, thus allowing Aida and Amonasro to escape. Radames is condemned to death, much to the despair of Amneris. He is sealed in a tomb, all the while declaring his love for Aida. Unbeknown to Radames, Aida has hidden herself in the tomb and now makes herself known to him. They declare their love for each other—and the opera ends.

Madam Butterfly (Puccini): Suicide because of shame and grief

Place: Nagasaki, Japan; time: nineteenth century. Madame Butterfly has renounced a heritage of ancestors and religion to marry a lieutenant in the United States Navy, B. F. Pinkerton. They have a son, Trouble. (Upon the return of Pinkerton from the United States, the son will be renamed Joy.) Three years have passed since Pinkerton left for the United States. Meanwhile, Pinkerton has married an American woman and returns to Nagasaki with his new wife. They have come to take Pinkerton's son, Trouble. When Madame Butterfly learns of this situation, she is overcome with shame and grief. She picks up a dagger, kisses it, and stabs herself. The inscription on the dagger reads: "Death with honor is better than life without honor."

Tosca (Puccini): Suicide because of fear and sorrow

In the opera Tosca, Floria Tosca, a famous opera singer, after having killed the chief of the Roman police, Baron Scrapia, and finding her lover, Mario Cavaranossi dead, leaps to her death in fear and despair (Kohrs, 1955).

CONCLUSIONS

People, both in operas and in real life, do in fact commit suicide for reasons of fear, grief, despair, guilt, loneliness, and myriad others. They do use knives, poison, and a variety of other methods. They are of both sexes, although the greater frequency of women committing suicide is inconsistent with reality. And, they are of both high and low status, though—as in real life—more often of high status.

Further studies are needed regarding differences that might arise from the composers themselves, their native countries, the cultures from which the original stories are derived, the popularity of certain operas in various countries, and trends in the content of opera plots, as well as in the frequency of performances of operas involving suicides relevant to particular times of depression, wars, or periods of significant change. The authors

recognize the limitations in this study as presented. But these impressions can lead to more stringent analyses in which the above mentioned areas can be further explored.

SUMMARY

One hundred and four frequently performed operas were analyzed to determine the extent to which suicide was intrinsic to opera plots, to consider the popularity of operas involving suicide, and to evaluate the persons committing suicides in operas.

Suicides occurred in 26 percent of the operas. An additional analysis of eleven prominent opera houses throughout the world was conducted to determine the ten most popular operas in each house. These 110 operas were subsequently evaluated for suicidal acts. A total of 44 operas (40 percent) included a suicide; of the 39 different operas, 26 percent involved suicide.

Suicides are performed by more women than men, by more high-status people than lower status people, and by a variety of methods, excluding the use of firearms. In opera, there are no unsuccessful attempts.

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ROBERT SEYMOUR: A PSYCHO-HISTORICAL AUTOPSY

Fred Cutter

Robert Seymour, who was Charles Dickens' first illustrator, died on April 20, 1836, but like all suicides left a lingering series of unresolved questions. Why? What caused it? Why then and not earlier? What previous traumas facilitated his death? These questions are not easily answered despite the abundance of tautological explanations such as insanity, depression, disappointments. These are merely pseudo answers since they label behavior in question. An equally ubiquitous phenomena in suicidal deaths is the assigning of blame and its denial by all parties involved. Regretably, this type of controversy has also marked the death of Robert Seymour.

THE PSYCHOLOGICAL AUTOPSY

Seymour's wife made financial demands on Dickens with the explicit charge that her husband was the source of *Pickwick Papers.* Her allegations in a suppressed pamphlet (Kitton, 1901) externalized an implicit charge: Dickens drove Seymour to suicide. By using the method known as the psychological autopsy (Shneidman, 1969), it is possible to present a more adequate perspective on Robert Seymour's death and the bitter fallout which all suicides spawn for the survivors.

Psychological autopsies are usually conducted with the survivors, the people most involved with the victim and those who are knowledgeable about any relevant aspect of his life. In practice these criteria are often restricted by sheer availability of informants. With Robert Seymour, there are published statements by four people: 1. Jane Seymour, his wife of nine years; 2. Charles Dickens, then a young writer; 3. Robert W. Buss, the illustrator who replaced Seymour; and 4. Gilbert A' Beckett, Seymour's editorial collaborator for *Figaro In London.*

All of these "informants" are biased sources, since the object of each was to elevate his own participation to unquestioned innocence and possibly heroic proportions. These motives are to be expected in any psychological autopsy. The most probable approximation to truth is the one that incorporates the most information and reconciles all apparent contradictions.

The journalistic facts of Robert Seymour's death are reported in the London Times, April 22, 1836, following the coroner's inquest. Robert Seymour shot himself between the hours of 6:00 and 7:00 a.m., on April 20, 1836, by means of a fowling piece pointed at his heart; the muzzle must have been held close enough to ignite his clothing. Seymour made efforts to prevent rescue by seeking an isolated spot in the garden, early in the morning. He left a suicide note (reproduced in Table 1). Close friends describe him as "low in spirits" and quote the victim as saying "He could not live very long."

THE WISH TO DIE

Since suicidal victims have varying wishes to die, it is useful to assess how Robert Seymour intended to end his life. The assessment procedure is described elsewhere

(Cutter, 1962; 1971b). Briefly, the wish is rated by evaluating the prior planning, the lethality of the method and the prevention of rescue apparent in the suicide event. Each is rated on a scale of one to six. Thus for Mr. Seymour's suicide:

Planning	6	Three previous attempts, prior threats and preoccupation, leaves note.
Method	6	Gunshot, by fowling piece, in heart.
Prevention of Rescue	5	Seeks isolated place, early in the morning
Total	17	

On a scale of 1-18, Robert Seymour manifests a maximum wish to die. While this may seem obvious, some victims die with ratings as low as 8. Every victim, including Mr. Seymour, experiences conflicts in the simultaneous wish to live and die. This ambivalence, like all conflicts, tends to inhibit or impair effective action until resolved. Similarly, modern experience documents that potential or actual victims can change their minds, regardless of the intensity. It is clear that even before his death Seymour often experienced the wish to die. He hints of this in his suicide note, while the inquest brings out three prior attempts. No description is given of these but one can be inferred to have occurred at the climax of the A'Beckett feud, December 20-27, 1834. Since this is around the time he made a drawing of an attempted suicide, it is reproduced here as illustration #1 (Seymour, R.). The drawing reflects Seymour's fantasies about suicide and becomes a measure of his wish to die approximately eighteen months before his death.

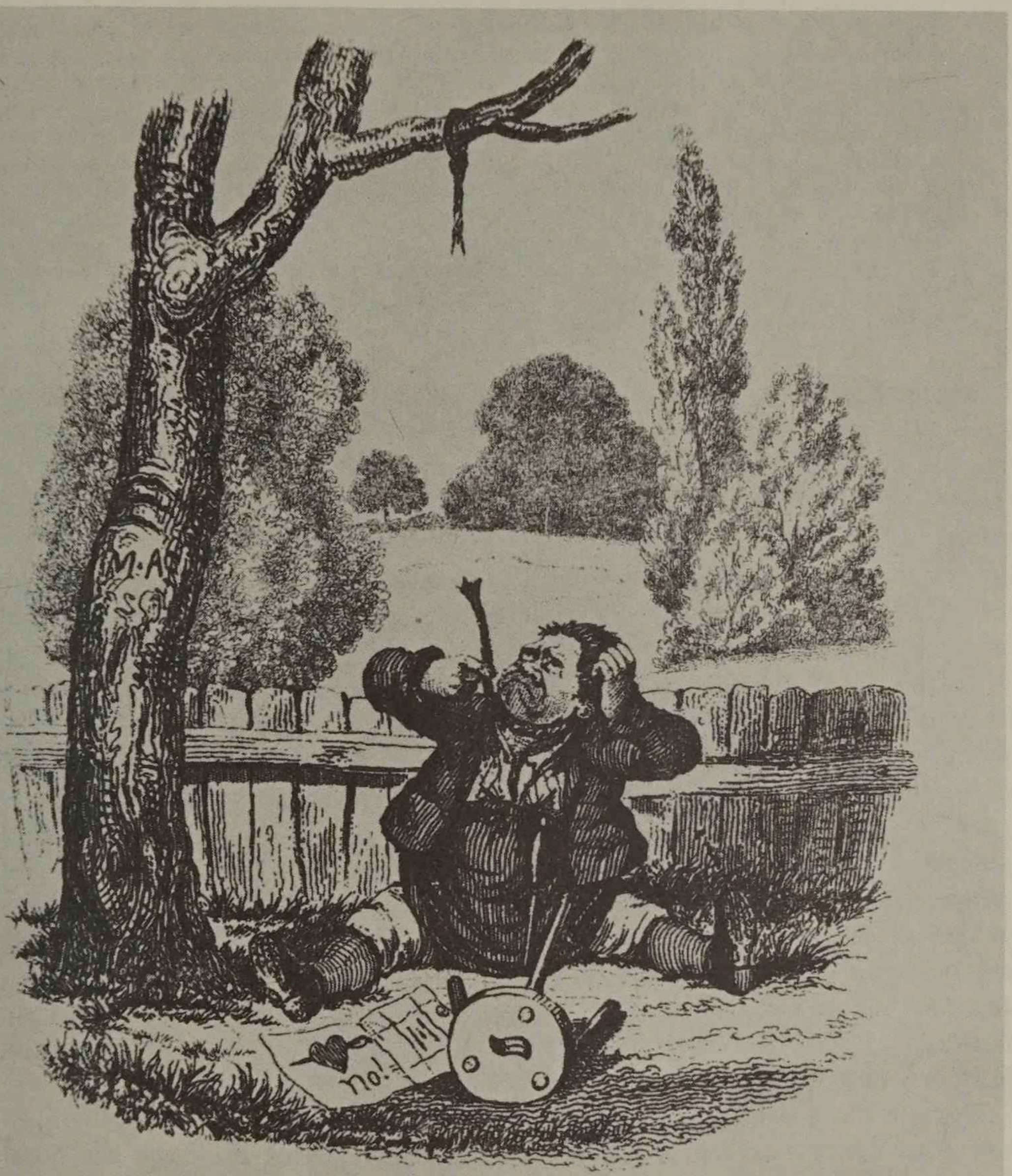
Plan	1	Impulsive, precipitated by rejection of valentine
Method	6	Hanging
Rescue	4	Leaves rescue to chance, rope breaks
Total	11	

By modern standards this rating is in the lower ranges of intention to die (Cutter, 1971a). Unfortunately, many victims die accidentally even with such ratings. In the drawing, if the rope hadn't broken accidentally the victim's outcome would be death. The artist invokes a rare event to save the victim, who makes no effort to save himself. These two ratings document two inferences: 1. Robert Seymour had a long standing wish to die, greater than usually found in the general population, but of relatively low degree in suicidal victims; 2. Despite three prior suicide attempts, his wish to live was stronger than his wish to die. This balance, or resultant of conflicting forces, was reversed shortly before his final self-injury.

PRECIPITATING EVENTS

The question now emerges, what circumstances precipitated an increase in the wish to die? And no matter what the answer, how did it become a cause of self-injury in this victim? Although aspiring to success in fine arts, Seymour found himself working as an illustrator, and never making enough to stay ahead of financial needs. This seemed to be due to an inability to negotiate favorable rates of pay, since his work was in demand and he had a sufficient reputation to gain his own terms (Dexter and Ley, 1936).

Seymour's interest in shooting and angling is apparent in his book of drawings *Maxims and Hints for an Angler and Miseries of Fishing* (Lambert, 1914). He was especially



Better luck next time.

amused by the cockney folks he observed in his frequent walks. Out of these originated the visual characters later given literary flesh by Charles Dickens. Seymour conceived of a "Nimrod" club of "Cockney Neophytes whose misfortunes and adventures he was qualified to depict." Seymour presented the idea in 1835 to Edward Chapman of Chapman and Hall publishers. After a dilatory year they agreed upon Charles Dickens in February 1836, then a twenty-four year old reporter and author of *Sketches by Boz* published on February 1, 1836. Seymour expected the younger and less well-known Dickens to write about his Cockney illustrations. Mrs. Seymour is even more patronizing in her later pamphlet (Kitton, 1901) Dickens' response is described by Harvey (1970):

Dickens, however, had no intention of writing up anyone else's pictures. When the Seymour plan was put to him, he insisted that he should write his own story and Seymour should illustrate *that.* To Seymour himself he was alternately preemptory and patronizing, and he had no qualms about telling him to redraw a design. 'The furniture of the room you have depicted, admirably' he said of one illustration, being generous rather than ironic. When Seymour died (with the second issue) the amount of text was doubled, from sixteen pages to thirty-two, and the number of etchings halved, from four to two. Dickens did not, however, try to reduce the number of illustrations below two, and there is no evidence that he wanted to. It was a question not of dismissing the artist, but of wresting control from him and putting him in his place. Seymour's successor, H. K. Browne, was younger than Dickens, little-known, and pliable; and the collaboration was harmonious and happy. Now Dicken's authority was secure, he unbent, and would forget his own text in his eagerness to make the illustrations as comical as possible.

Author and illustrator met only once at Dicken's Rooms in Furnivals Inn on Sunday, April 17, 1836. The first number of the collaboration had appeared on March 31st. Their meeting was some kind of a confrontation in which Seymour perceived himself the loser (Dexter and Ley). He was expected to illustrate the *Stroller's Tale* and any others Dickens introduced. To further aggravate the situation, Dickens criticized his Dying Clown illustration (#2). He made a revision (#3) and subsequently, it was engraved. Phiz revised it in 1838. He worked on this plate the Monday before his death and eventually gave up in exasperation. He killed himself on the morning of the 20th.

These kinds of fantasies while childlike, nevertheless occur to creative people as well as to psychotic persons. Their externalization in the form of drawings here serves an aesthetic and humorous purpose in touching similar feelings in everybody. Without diminishing their worth as humor or art, it is still possible to infer sensitivities as those of a unique person.

Seymour's notion or understanding of death is a relevant factor in understanding his motives. The conventional religious belief then prevalent was life after death in the form of heaven, hell or limbo. This generalized notion does not indicate Seymour's personal understanding. The suicide note refers to "peace in death" and a desire for relief rather than any unique meaning. If regarded verbally it offers minimal insight with respect to motivation. However, a review of his drawings and captions provides some hint of what death may have meant.

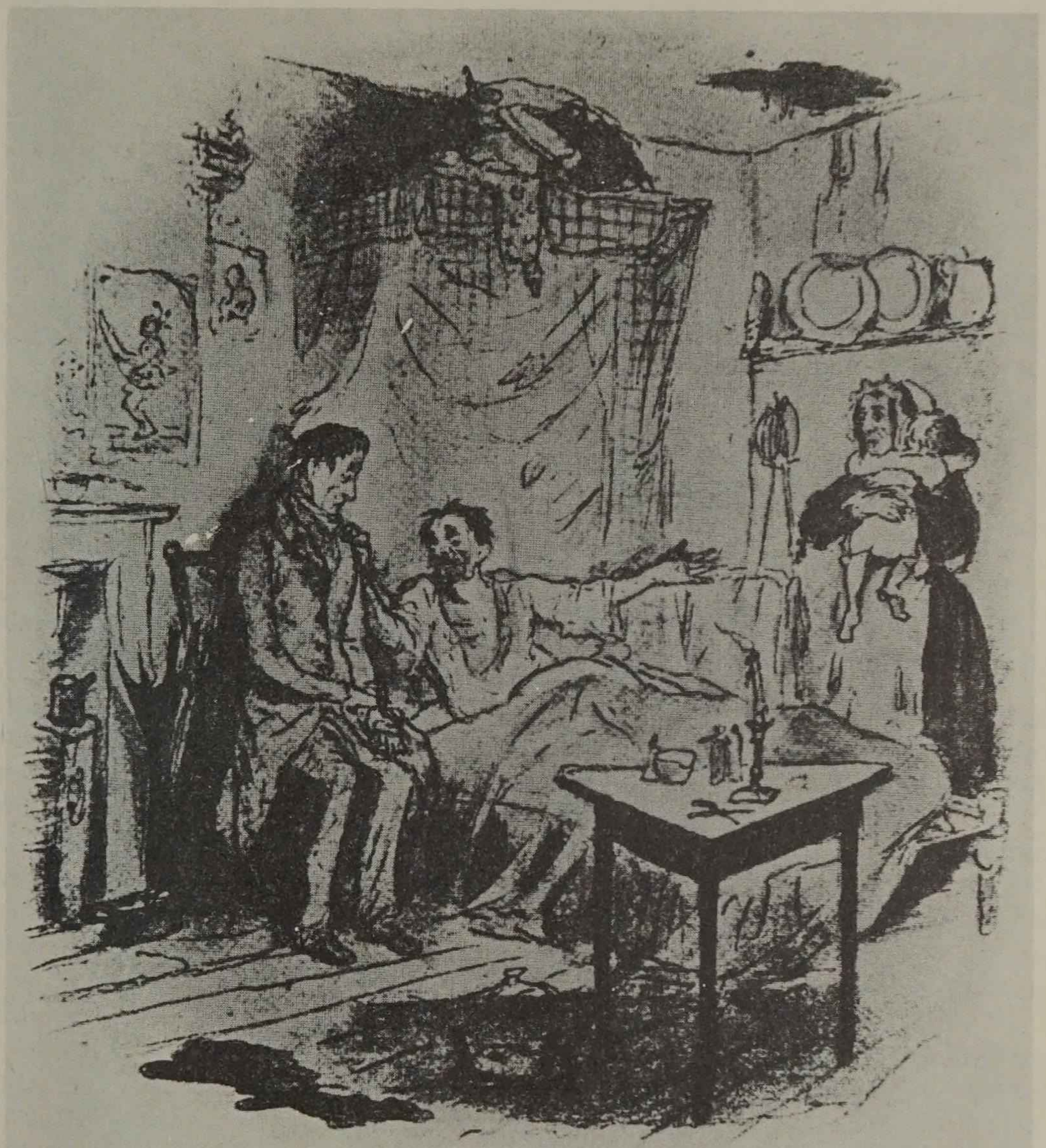
Seymour illustrated Shakespeare's plays in a collection drawn about 1833-35, entitled *New Readings of Old Authors.* It is clear that he chose the plays and the lines to be illustrated. Using a projective hypothesis, the final selection reflects his feelings and sensitivities and is therefore expressive or projective of his personality. Three cautions are appropriate here: (1) the illustrations are primarily works of art; (2) captioned with quotes from Shakespeare to emphasize humor; and (3) selected by the writer. Despite the foregoing, these visual and verbal products provide a glimpse of Seymour's specific fantasies in the areas selected.

Table 1 is a juxtaposition of the complete suicide note, with captions and selected illustrations that seem to add further depth of meaning.

Robert Seymour's personal notion of death comes into sharper focus with its inherent contradictions, irrationalities and unconsciously influenced fantasies. Thus #6 implies the satisfaction in revenge while #5 provides a justification for murder. Considering his distress at doing and revising the dying clown and his inability to complete the last two drawings, Seymour must have perceived Dickens as his murderer.

RELATIONSHIPS WITH OTHERS

The data establish the precipitating events and the meanings that death may have had

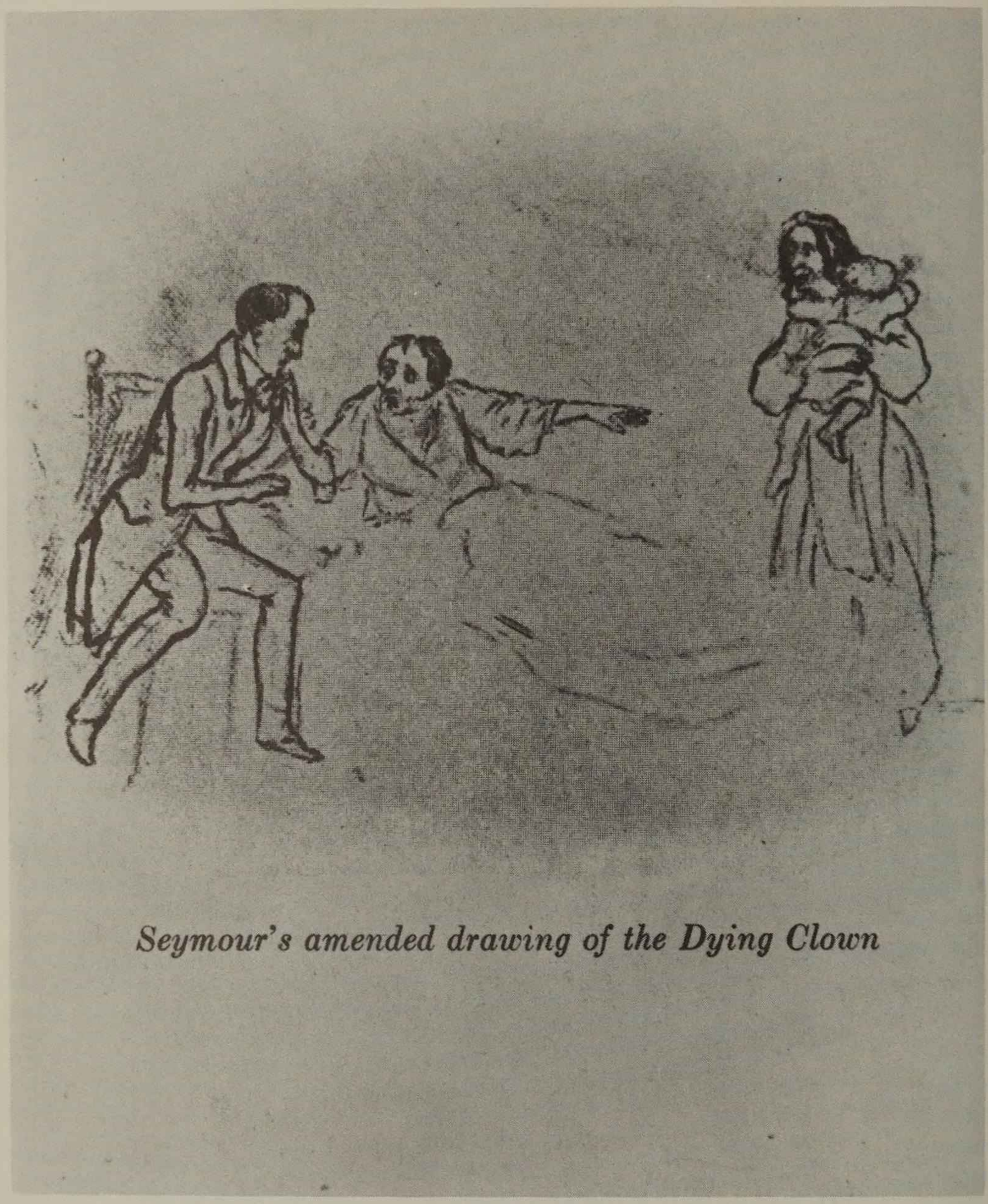


Robert Seymour's first drawing for the story of the Dying Clown. It was to this drawing that Dickens took exception.

for Seymour. All of this documents a sudden increase in the wish to die, facilitated by his perception of himself as a constant failure. The intensification of Seymour's wish to die can be seen by tracing his biography and his relationships with significant others.

Henry Seymour

The Dictionary of National Biography provides the only reliable information about Robert Seymour's origins since it is given by his son. Henry Seymour, Robert's father, is described as a gentleman of Somerset who, falling upon hard times, moved to London where he obtained employment as an upholsterer. Henry died before the birth of his son, and left his widow to raise three children. No other information, such as the mode of



Seymour's amended drawing of the Dying Clown

death, his relation to Elizabeth Bishop, Robert Seymour's mother, or even the names of the siblings, is given.

From this information, though meager, some inference can be made that Robert was predisposed for distress by early bereavement, which is known to be significantly associated with subsequent mental illness and criminality in the United States. There is also an association between the mode of parental death and the mode of death for children.

Elizabeth Bishop

Elizabeth Bishop is considered to be of nervous temperament, like her son, the artist. She is described as struggling to provide for her three children—if the education of Robert

Table 1
Suicide Note of Robert Seymour

Best and dearest of wives-for best of wives you have been to me	#4	*Tempest,* Act 5, Sc 2; She and our bottle are past praying for
blame, I charge you not any one,	#5	*Merchant of Venice,* Act 4, Sc 1 You take my life when you do take the means whereby I live.
it is my own weakness and infirmity	#2, #3	*Stroller's Tale,* two versions of The Dying Clown
I don't think anyone has been a malicious enemy to me	#6	*Merchant,* Act 2, Sc 1; he is well paid that is well satisfied
I have never done a crime, my country's laws punish with death. Yet I die my life it ends.	#7	*Tempest,* Act 3, Sc 1; I fear you have done yourself some wrong
I hope my creator will grant me peace, which I have prayed so for in vain whilst living.	#8	*Tempest,* Act 3, Sc 2; He that dies pays all debts

is a measure of her success, one has to conclude that she did an incomplete job. Perhaps this is her style, since whether widowed or abandoned, she attempted to be both mother and father. One can infer a closer relation between mother and son, since Seymour did not marry until the year of her death and after reaching the age of twenty-eight.

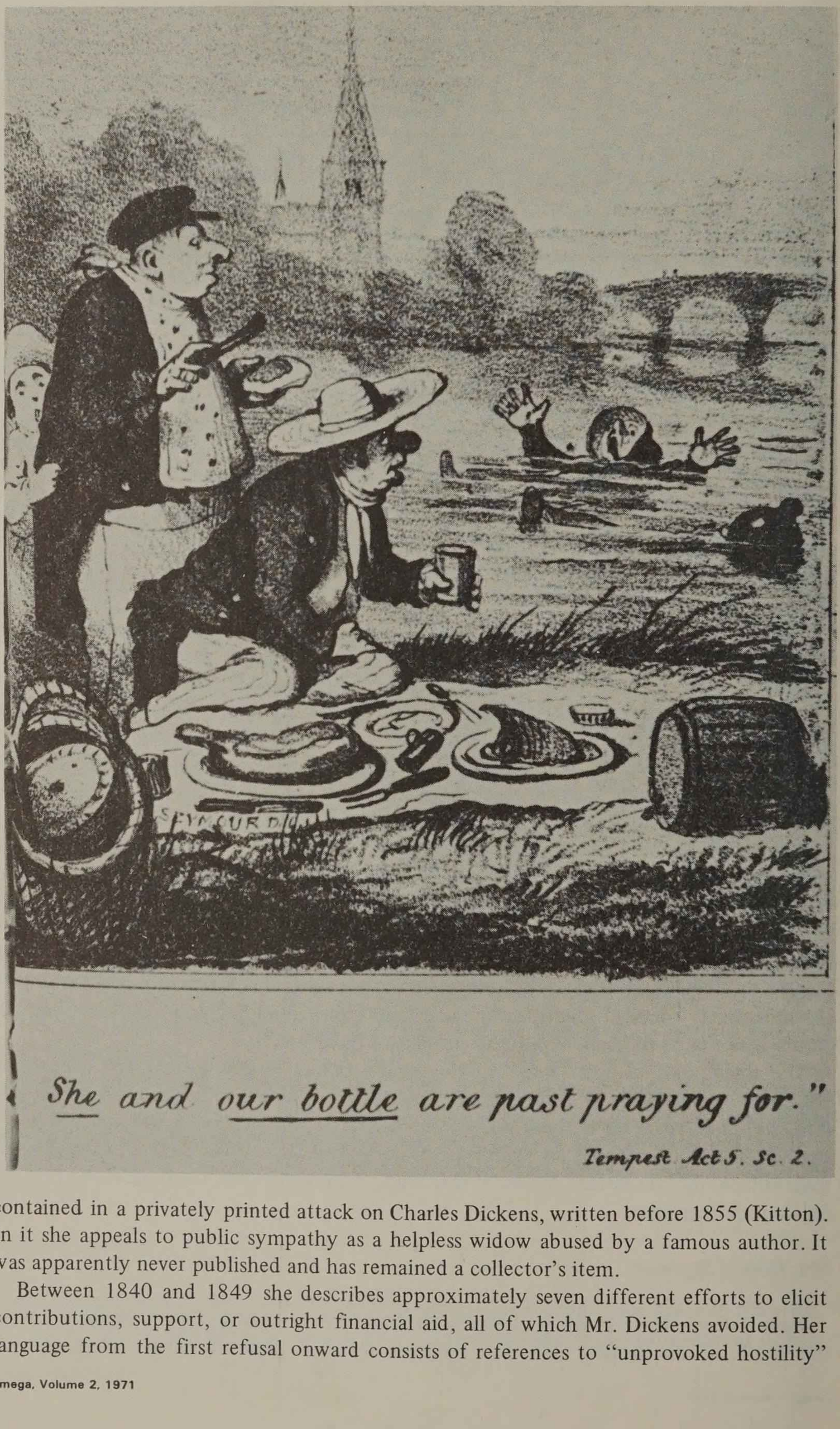
Elizabeth Bishop maintained a close relation to Thomas Holmes, an artist with a relatively large family. The latter is described as an uncle to Robert but, since the names differ, it would appear that they were related by marriage. Was Mrs. Holmes formerly a Bishop or a Seymour? Though the information is lacking, a probable inference would be that she was a Bishop, since Elizabeth is described as a native of Somerset before conceiving and bearing Robert. Mrs. Holmes living nearby was most likely her sister.

The two women provide a communality for Robert and his cousin, Jane, whom he later married. In the absence of details the sisters can be assumed to share more values than not, and consequently the notions of motherhood carried by Robert and Jane were functionally more alike than different. An additional point here is that both families, the Holmes and Bishops, shared relatively intimate relations for an extended period (1807-1827 according to Jane Holmes). In this association, Thomas Holmes represents the most likely focus of identification as a father for Robert Seymour. Again, he and his future wife shared the same functional notions of fatherhood.

The final point of this review of Seymour's family is that Robert and Jane were childhood friends, who probably behaved as siblings for most of their childhood and well into the adult years (late twenties) before turning to each other as husband and wife. Implicit in the preceding is an equivalent notion of all social roles such as husband-wife, male-female, mother-father. A hint of this comes from another of Seymour's drawings, to illustrate Shakespeare.

Mrs. Robert Seymour

Jane Holmes (1801-1869) is undoubtedly the person closest to Robert Seymour, after the death of his mother and their marriage in 1827. Her published statements are

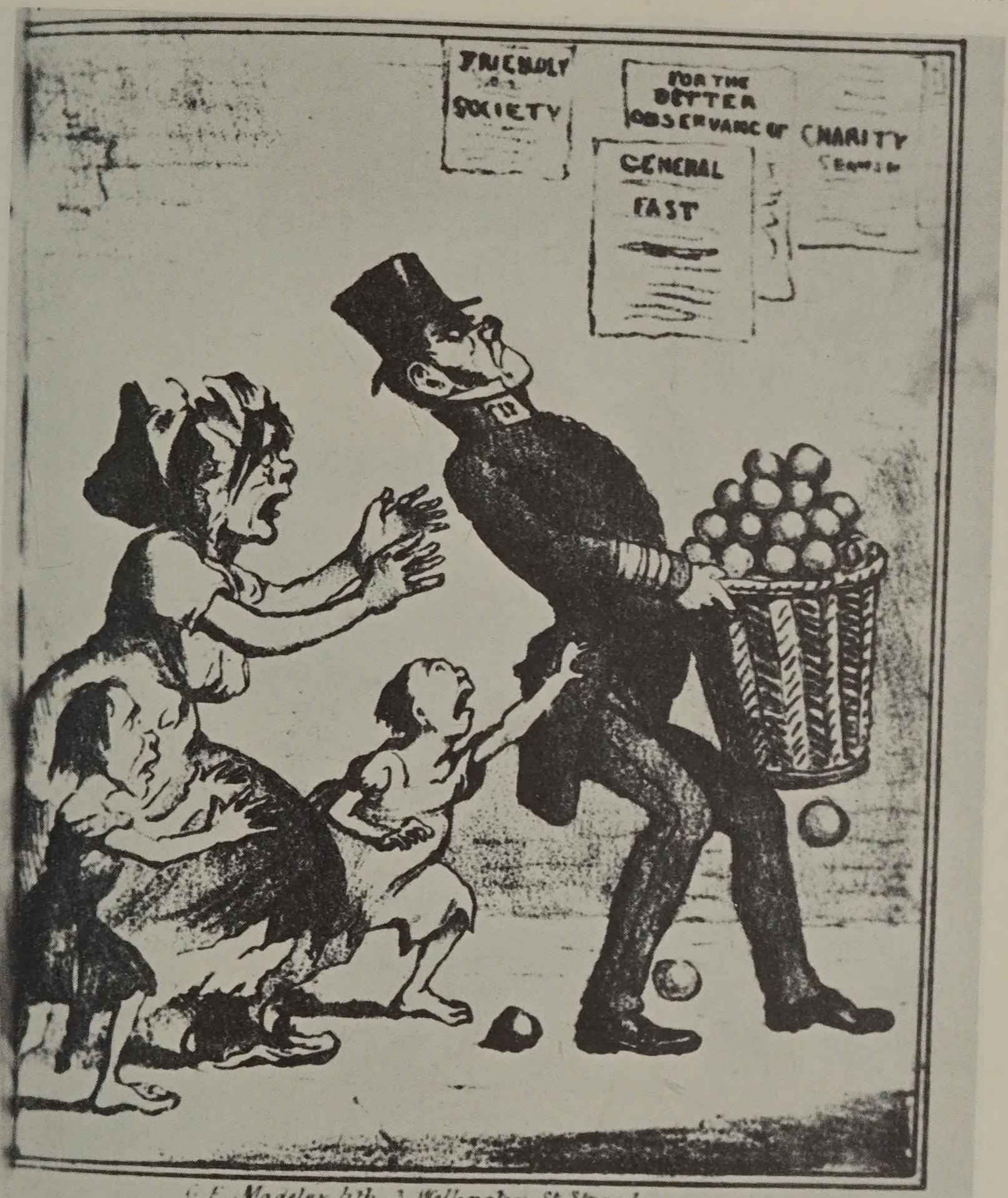


She and our bottle are past praying for."

Tempest Act 5. Sc. 2.

contained in a privately printed attack on Charles Dickens, written before 1855 (Kitton). In it she appeals to public sympathy as a helpless widow abused by a famous author. It was apparently never published and has remained a collector's item.

Between 1840 and 1849 she describes approximately seven different efforts to elicit contributions, support, or outright financial aid, all of which Mr. Dickens avoided. Her language from the first refusal onward consists of references to "unprovoked hostility"



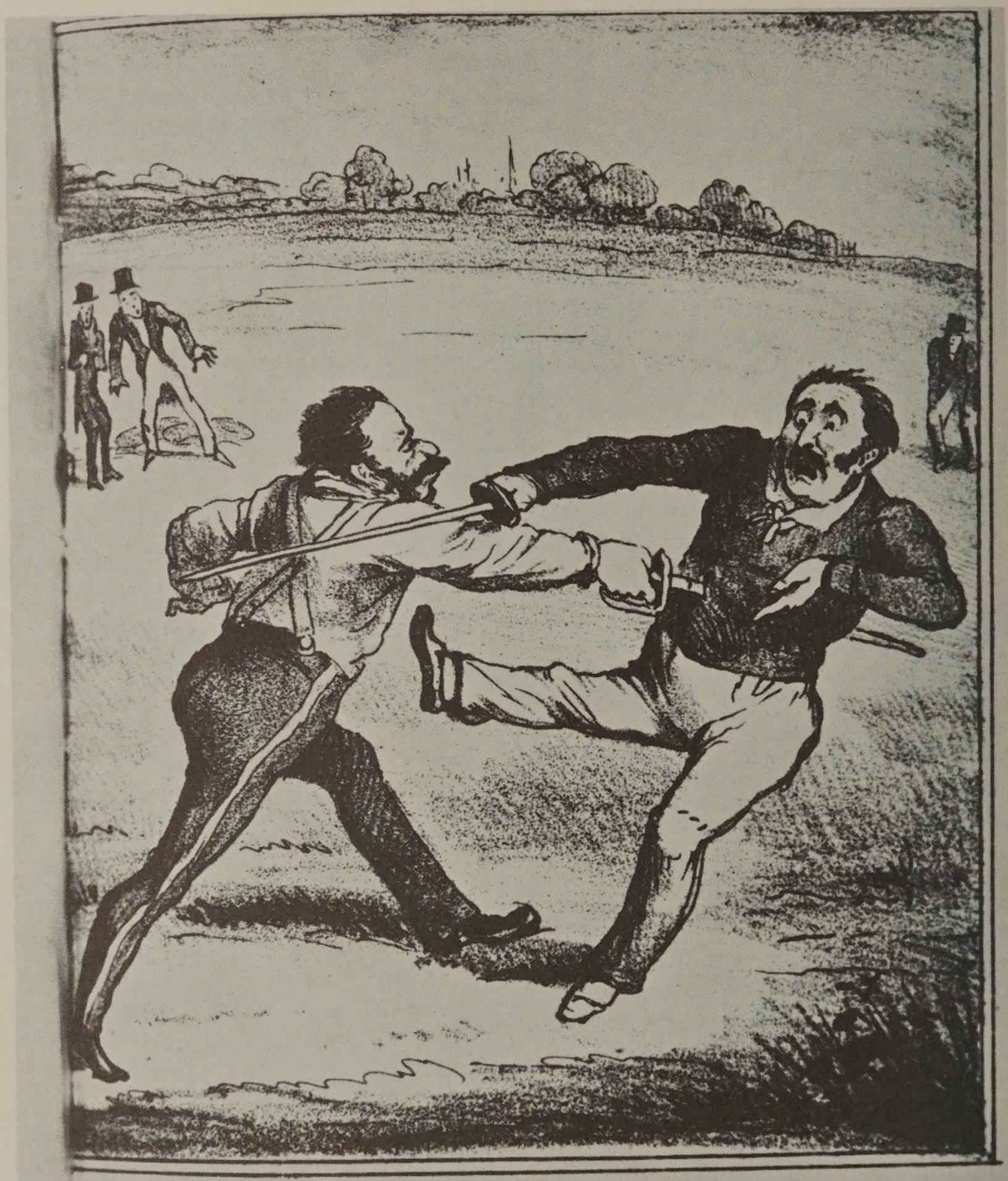
C. F. Maudsley Lith. 3 Wellington St Strand

"I take my life. when you do take the means
whereby I live." Merch of Ven. Act 4 Sc. 1.

and "persecution." It is clear that she expected some largess from Dickens, and his failure to respond favorably to her demands are labelled "hostile."

Her demands for assistance are based upon and gave rise to the now famous literary controversy "who invented *Pickwick.*" Kitton's appraisal seems fair; namely, the idea and visual image were Seymour's; the literary flesh and broad (extra sporting) developments were Dickens'.

She describes herself as his (Robert's) "guiding star." On the last page of her account

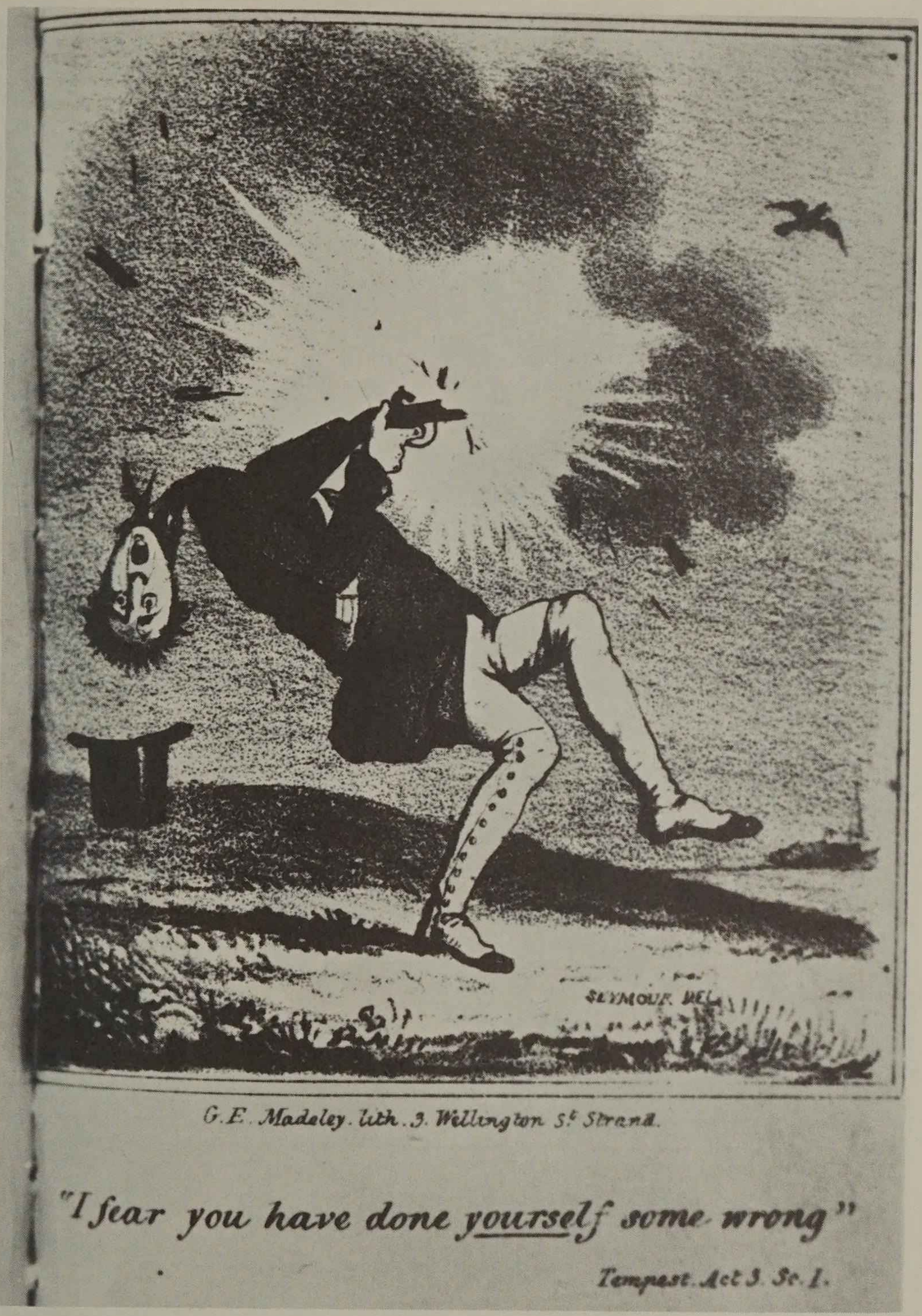


"He is well paid, that is well satisfied."

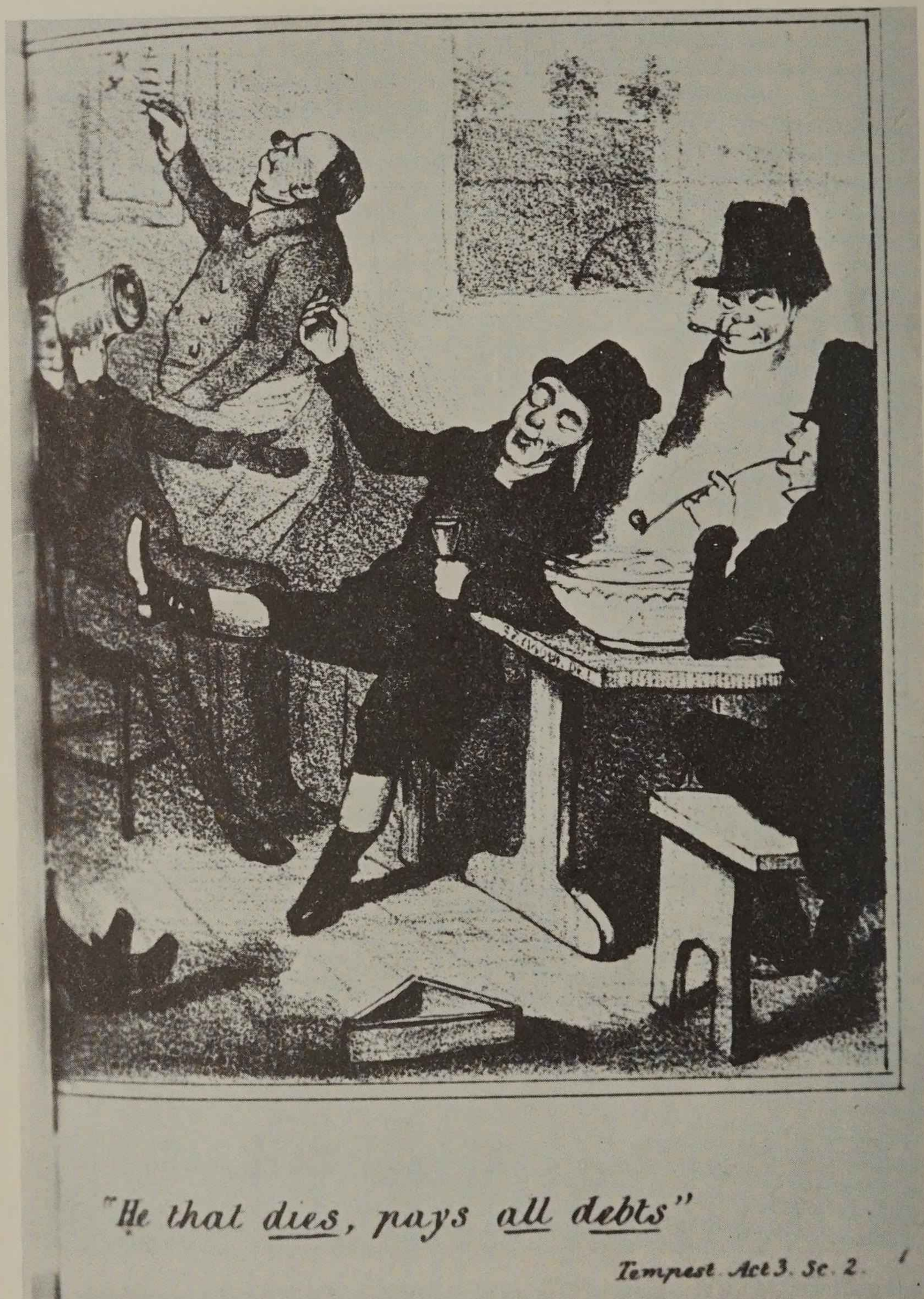
Merch. of Ven. Act 4 Sc. 1.

she writes "my husband had from my seventh year been ambitious of acquiring fame and fortune, that they might pour the blessings of life around me. My smiles and frowns from my earliest childhood had been the clouds and sunshine of his life."

Today, the statements themselves appear as exaggerations. There is also present in the preceding, a curious transposition. In apposition to "smiles and frowns" stands "clouds



and sunshine." In what seems to be a classical Freudian slip, Mrs. Seymour reverses the expression she intended. To the preceding can be added Robert's first suicide attempt, which occurred about the same time as their marriage; whether it occurred before or after is not known. It has also been recently reported that he had a mental breakdown around 1830 (House and Storey, 1965) and later in 1834.



These events merely document the presence of mixed feelings rather than the poetic or pious sentiments she writes. Even further, it stands in strange contrast to the unknown relation she shared with Robert Seymour. Just as all men are different, so too are their wives. One dimension of this difference is the role played as wife. In relation to

self-injury, Shneidman (1971), has recently attempted to identify suicide among gifted individuals posthumously. One of his guiding concepts is the wife's role in supporting versus competing with, or exploiting their late husbands. In applying this effective concept to Mrs. Seymour, the evidence suggests non-support, if not outright competition. Table 2 summarizes the available data.

Mrs. Seymour raised her claims four years after her husband's death and when Dickens was clearly established as a successful author. Her belated demands on Dickens were

Table 2
Documentation for Non-Supportive Role of Wife, Jane Seymour

Datum	*Relation to Role as Wife*
*1. Transposed sentence in origin of Pickwick "Smiles and frowns . . . . clouds and sunshine."	1. Perception of her husband's failure to cater to her whims both before and after marriage.
2. "Easy astonishment" of mother (see figure #9).	2. The child-like, irrational, and yet continuing expectation in a context of paternal absence and maternal indulgence would predispose Robert Seymour to disappointment with mother substitutes and they to greater criticisms.
3. Blames Dickens, A'Beckett, Chapman and Hall despite suicide note, expressing last wishes of husband to "blame no one."	3. Ignores husband's wish; omits own role in his death.
*4. Discrepant account of Dicken's choice.	4. Elevates her role, denigrates Dickens. Buss reports Robert Seymour liked Dickens' writings and made choice.
*5. Intercedes in urging cooperation with Dickens and redrawing the "Dying Clown."	5. She fails to recognize his "irrational reactions" as a sign of great need, i.e., identification with the clown requiring sympathy and explanation; and his domination by Dickens as reminiscent of the near fatal feud with A'Beckett. Her blindness in this area suggests attendance to her own needs–husband's steady employment at Chapman and Hall.
6. Expectations for Dickens in contrast to patronizing orientation to him; and inability to modify over balance of her life time.	6. Attack on Dickens' vanity provoked rejection when other tactics might have won generous treatment as with his numerous dependent relatives. Mixed feelings and rigidity imply she also expressed these towards husband.
*7. Suggest ruse to brush off Chapman and Hall ask four times sum they would like to give."	7. Manipulative approach using deception.

*From suppressed pamphlet by Jane Seymour (11).

probably opportunistic rather than a wish to "rectify" an injustice as claimed (Kitton). Her approach to Dickens is double-binding. If he responds to her manifest claim for aid as a widow, he must surrender his pride. If he denies her claim he disgraces himself and suffers a greater insult to his pride. Dickens' effort to cope with Mrs. Seymour are well-known. Here it is important to note Mrs. Seymour's schizophrenogenic qualities in terms of the conflicts she imposes in her basic encounters (Bateson, et al., 1956). This quality is offered as further documentation for a predisposing role in the mental disorder and subsequent self-injuries of her husband.

Jane Seymour attributes her husband's death to the following events and conditions: (1) An unfortunate feud between him and Mr. A'Beckett in 1834; (2) The introduction of the *Stroller's Tale* by Dickens; (3) "The drawing . . . . being spoilt;" (4) "The firm had not given the price . . . . stipulated;" (5) "When he was over-whelmed with business;" (6) "And before his health was completely restored from a recent and dangerous illness (this seems to be a euphemistic reference to the second and third suicide attempts)." (Kitton)

Gilbert Abbott A'Beckett

A'Beckett (1811-1856), a descendent of St. Thomas A'Beckett, collaborated with Robert Seymour for *Figaro in London*, a predecessor of *Punch.* He edited while Seymour illustrated this weekly from 1832. In 1834, A'Beckett passed through insolvent court and Seymour applied as creditor. Annoyed by Seymour's action, he attacked him publicly in No. 143, August 30, 1834 (*Figaro in London*, 1834), and continuing until the December 20th issue.

In the first, August 30th, he refers to "a mental crucifixion" which is meaningful for its suggestive effects, whether he intended this or not. A'Beckett was quite sensitive in detecting Seymour's weak points. Thus, he refers to Seymour's bad spelling and writing, even of his own name. Seymour was educated by his mother and was said to be illegitimate (Dexter and Ley). Another area of sensitivity was the allegation that "Seymour never had an idea of his own . . . . " To some degree there is evidence that Seymour did copy other artists, but of more significance was A'Beckett's casting him in the role of a "mere illustrator."

A'Beckett continued his attacks through the December 20th issue. The next week, A'Beckett announced his resignation in somewhat defensive tones and with reference to "literary suicide" and not intending any "injury." A likely explanation is Seymour's possible attempted suicide between December 20 and 27, 1834 and its apparent induction by A'Beckett's attacks. Mrs. Seymour's euphemistic references to "recent and dangerous illness" is confirmatory.

Of special note is Mr. A'Beckett's youth. He was hardly twenty-one when he launched *Figaro.* At the time of the "feud" he was just turning twenty-four. His public attacks and direct suggestions about "crucifixion" contributed directly to Seymour's third suicide attempt. More indirectly, Mrs. Seymour (Kitton), and others hold A'Beckett responsible in some degree. All agree that it contributed to Robert Seymour's eventual suicide. However, the explicit process of this predispostion is obscure.

Robert Seymour was attacked publicly by the young, twenty-four-year-old A'Beckett who touched on his education, parentage, lack of orginality, and "being a perfect dolt excepting the mechanical way he wields his pencil." Seymour was thus predisposed to overreact to any other young collaborator with even superficially similar traits.

Robert W. Buss

Robert W. Buss (1804-1875) is the artist engraver who was temporarily chosen to replace Robert Seymour. Mr. Buss in turn was replaced by "Phiz" who successfully illustrated the remainder of *Pickwick Papers.* Mr. Buss is far from objective in recalling his part. However, in 1872 nearly thirty-six years after the event, he attempted to explain his "two unsuccessful etchings." Buss (1956) provides some information that helps explain Seymour's motivations.

First Buss gives a vivid description of Seymour's reading *Sketches by Boz* to his friends. It is clear that this is his first opportunity to review the writings of a potential collaborator. Buss describes Seymour's reading and enjoyment of Dickens' humor in detail. He documents Seymour's preference for Dickens as potential writer for his illustrations. This description is discrepant with that of Jane Seymour in which she claims the decision for Dickens out of pity for his poverty (Kitton).

Messrs. Chapman and Hall are described as less than reliable in their dealings with Buss. They did not appreciate his willingness to attempt to illustrate *Pickwick* in the emergency created by Seymour's death, and they readily abandoned him after only one issue, even though they knew that he was inexperienced with the etching process; a lack that he was able to overcome in subsequent work. Dexter and Ley suggest it was Dickens' decision to drop Buss in favor of Phiz. Further evidence about the nature of Chapman and Hall, is shown in their parsimony for Buss' drawings. In this last complaint, it becomes clear that while Seymour's rate of pay is unknown, it was clearly equal to or more than Buss's but less than journeymen, carpenters, and apparently much less than Dickens received–inferior with respect to his merit and reputation.

Several other details are supplied by Buss that document further the physical labors and difficulties of etching in general, and working for Chapman and Hall in particular, at those "wretched sums." He then documents the pressure under which Seymour was required to work in illustrating the chapters, rather than following his own inclination, as originally proposed by him. Additionally, Buss describes the time pressure in meeting deadlines, when copy is late, as it was between Dickens and Seymour.

Charles Dickens (1812-1870)

In February 1836, Charles Dickens was twenty-four, newly betrothed to his wife, Catherine Hogarth, and a young reporter who saw his first book, *Sketches by Boz,* published on the first of February.

Seymour had a reputation at this time for unpredictable overreactions with implications of "nervousness," "insanity" and "manic depression." His history of self-injury was also known. Whether to avoid unpleasantness or merely the natural consequence of making better deals, the communication to Seymour about Dickens must have been impaired or at least delayed.

Chapman and Hall found themselves in the middle. They had made commitments to Dickens at variance with their prior understandings, if not binding agreements. The moment of truth began to manifest itself, probably in terms of the *Stroller's Tale.* This was introduced by Dickens and, of course, had no sporting aspect to it at all. To even admit this story was to acknowledge Dickens' dominance, an eventuality reminiscent of Seymour's recent feud with A'Beckett. The request to represent the "Dying Clown,"

contributed to Seymour's frustrations. He drew this only upon the intervention of his wife and was himself disappointed on the first drawing (#2).

Aside from the dominance dispute, it is clear that the dying clown theme had some special poignancy for Seymour–it was too close to home and the self-image he carried, unappreciated and unloved. The story itself while dramatic, is one of those character sketches that in recent time could be labelled "psychological" for its accurate portrayal of powerful, yet obscure human feelings in the husband/wife relation.

These conventionally unacceptable feelings and insights are usually repressed out of awareness. Dickens' ability to describe them is, of course, a measure of his talent, but they are drawn from his childlike fantasies much as Seymour's. From this depth of feeling comes its power for the reader. How much greater its power over Seymour? The theme elicited all the dormant conflicts present since childhood, externalized in his relation to his wife and recently traumatized by A'Beckett. The impact of this theme was distressing to Seymour and hence his first drawing was unacceptable to all, including himself.

The biographical evidence suggests an identification with the self-image of moral failure. Seymour's bad feelings about the dying clown must have fed his self-perception as now unable to work (draw, adequately) and Dickens as his psychological murderer for depriving him of the "means to work." This conjecture is given as a description of Seymour's perceptions, not necessarily the reality.

To Dickens, the worst had happened. His big opportunity to write a popular book, illustrated by the well-known Seymour, was now in jeopardy. Who could adequately replace the artist, and would the public accept the replacement? Would the publishers even continue the monthly? Additionally, Seymour worked cheaply. An adequate successor would raise costs. Dickens vetoed several well-known artists. Thackeray, Cruickshank, John Leich, William Heath and others were considered and some even interviewed. Dickens, it is clear, wanted only a competent artist, "unlikely to thrust his own personality into the forefront . . . . and accept instruction." (Dexter and Ley). It is quite telling that Dickens should be as concerned about the potential dominance of his new illustrator as Seymour had been of Dickens. But the similarity goes deeper.

The *Stroller's Tale* and its predecessor in *Sketches of Boz*–"the drunkard's death," were not introduced arbitrarily. They were part of Dickens' childhood and adult fantasies. They externalized continuing preoccupations for good and evil, and more importantly between husband and wife.

The climax of the *Stroller's Tale* comes in the delusion of the Dying Clown". . . .and now I am weak and helpless Jem, she'll murder me for it (references to his abuse) . . . ." A clear statement of projection; he expects from his wife what he has given her. Yet in the next paragraph the clown expresses puzzlement; ". . . . she does hurt me. There's something in her eyes wakes such a dreadful fear in my heart, that it drives me mad." "Jem she must be an evil spirit–a devil! Hush! I know she is. If she had been a woman she would have died long ago. No woman could have done what she has." Her continued love is inexplicable. This theme is universal. What husband hasn't had a similar feeling, but the writer is more deeply involved in this theme than ordinary men.

The early version of this story, "The Drunkard's Death", gives a more explicit description of the prior abuse by the husband. It starts with the wife's death and goes on to tell of the drunkard's subsequent troubles. Dickens gives the reader a picture of the drunkard's experience leading up to suicide–including a classic example of ambivalence in the victim–his wish to continue life after jumping into the Thames.

The ability to write these stories requires direct knowledge, whether actual participation or fantasies stimulated by observation. Either way, Dickens is overly involved in this theme and thus shares the same conflict. The difference between Seymour and Dickens occurs in the different reactions to the theme. Where Seymour sees himself as the Dying Clown abused by the world, his wife, (mother), and women, Dickens perceives himself guilty of evil and needing to expiate by suffering and suicide. Clearly, both men suffered the same sensitivity. In this last confrontation, Dickens won, except that Seymour's suicide has from the start represented the threat of a final dominance.

Between 1836-1840, Dickens achieved literary and financial success. He established his dominant position in the English language yet he was continuously threatened by the "ghost of Seymour." By committing suicide, Robert Seymour was able to put his psychological skeleton in Dickens' emotional closet. The power of this act on the survivors is well-known and documented elsewhere. Dickens achieved dominance over his illustrator at a price. The amount of this cost is suggested by his subsequent defensiveness and distortions, in which he attempted to write off Seymour's part in much the same tone as used by A'Beckett (see Dickens' 1847 and 1866 prefaces).

Over the balance of his life, recurring questions, demands and accusations were made, primarily by Mrs. Jane Seymour, and later continued by her son Robert. Even after his death this controversy erupted again between John Forster, Dickens literary executor, and others beside the Seymour family, mainly George Cruickshank and K. Shelton McKenzie (Lambert).

The bitterness of this controversy should have been avoidable. Considering Dickens' generosity with a large number of dependents, it seems strange he didn't offer Mrs. Seymour some token consideration. Lambert suggests: "conceit kept him (Dickens) to the end, jealous of sharing one little part of his reputation even with a man who helped him suddenly to gain an eminence from the bottom of the literary ladder of London . . . ."

This interpretation needs to be qualified by recognizing that Mrs. Seymour consistently attacked Dickens in his vanity. If she wanted redress, more tact would have been appropriate. Her double-binding approach has already been mentioned. Mrs. Seymour's importunate demands required Dickens to defend himself. Still, if he really regarded her as "mad," why couldn't he indulge the woman or simply ignore her? Each reaction merely fed the controversy. Mr. Dickens couldn't extricate himself from Mrs. Seymour because he was in the psychological bind suggested in the "Drunkard's death" and "The Dying Clown." Mrs. Seymour reminds him of the "evil wife" and his apparently irrational need for expiation impairs him from coping effectively with her.

The Dickensians

The acrimony expressed by both Dickens and Seymour is a measure of something petty and mean in both, which subsequent partisans continued. The Dickens influence has been externalized by the many admirers collectively as the Dickensians. While their motives and efforts are admirable and beyond question, they still manage to express, in tangible form, some of Dickens' own vanity and defensiveness with respect to his place in history. For this reason, it may add to the psychological autopsy of Robert Seymour by reviewing some of the collective behavior of the periodical known as *The Dickensian.* This publication is devoted to the memory of Dickens and seems to have functioned in a tradition suggestive of a human role, i.e., devoted brother, jealous protector.

In reviewing the volumes of the *Dickensian*, references to Robert Seymour were omitted from the first to the 1917 volume. Subsequently, he is mentioned next in 1925, 1931, 1934, etc. Considering Seymour's role in at least starting *Pickwick*, this minimal citation suggests an avoidance phenomenon. Seymour's part is perceived as a blot on the Dickens escutcheon. This was also Charles Dickens' response to Seymour's role. The aspersion apparently cast by Seymour's contribution, however small its size, was that of diminishing the image of Charles Dickens, again another blow at his vanity.

In the various defenses of Charles Dickens against Seymour, the strategies have always been that of counterattack, denial or avoidance in a context of pity and contempt with poorly covered hostility. The modern label for this behavior in an individual is defensiveness. The implication is that something unpleasantly true is being hidden. This is not a reference to the content of the traditional Dickens-Seymour controversy, but rather the underlying feelings about achievement, success and status.

Dickens himself, and subsequently the Dickensians, have been especially defensive in the area of his place in literary history and especially with reference to the legitimacy of Seymour's creative claims. Incidentally, the Dickensians have been the ones to raise the question about Seymour's birth and legitimacy, documented nowhere else, in the sources available here. There is a regretable tendency of later Dickensian to repeat uncritically the assertions of prior writers. Another example of this occurs in Seymour's final act of self-injury. The coroner's inquest reports he shot himself in the left side and through the heart. Yet all references by the acknowledged experts on Dickens speak of the head or mouth. What is their basis for saying this? Are they collectively implying Seymour "shot his mouth off too much"?

It seems fair to infer that both Dickens and Seymour were equally vain about the legitimacy of their respective achievements. The twenty-four-year-old Dickens had relatively less than the thirty-eight-year-old Seymour. However, both felt uncertain of their place in history, a feeling carried into the grave and subsequent posterity by both.

SUMMARY AND CONCLUSIONS

Why did Robert Seymour kill himself? A summary of this psychohistorical review can approximate an answer. Death in general and suicide in particular require the cooperation of all the people in the victim's life. An adequate summation of the factors in Seymour's suicide takes on the aspects of a Directory, but can be abstracted in terms of the six major participants in his life.

1. Henry Seymour's premature death and failure to act as father set the stage. Early bereavement, inadequately compensated, predisposes for all behavior disorders. His psychological replacement by Thomas Holmes while helpful, set the stage for reinforcement of his mother's traits through his cousin, Jane, Thomas' daughter.

2. Elizabeth Bishop's inadequate raising and education of her son sensitized him to the importance of success/failure.

3. Jane Holmes, whose marriage coincided with Elizabeth Bishop's death and Robert's first suicide attempt, appears to have expected a great deal more from Seymour than his mother. She was his cousin and probably continued the demeanor of his mother but now in the role of wife. She was prone to exaggerate, manipulate and otherwise impair communications with her husband. Since she took a more demanding role as opposed to a supportive one, she tended to consume his limited emotional resources rather than

conserve them. In this role she contributed to his history of self-injuries. Her intervention on behalf of the dying clown illustration was exploitive of her husband's irrational needs.

4. Gilbert A. A'Beckett's sensitivity and skill as a writer permitted him to traumatize Seymour, at all those vulnerable points alluded to earlier. In thus opening up old wounds and enlarging them in a contemporary context–even with suggestions of self-crucifixion, A'Beckett gave Seymour a vigorous shove toward self-injury. A'Beckett's youth, twenty-four, is a significant link to the role played by Charles Dickens.

5. Charles Dickens, at twenty-four, later unknowingly replaced A'Beckett and rubbed fresh salt in the still festering wounds. Dickens' motives were the same as Seymour's, namely professional dominance of a colleague. It just so happens that Dickens was more successful in this context.

6. Robert Seymour, of course, did injure himself in four separate attempts, the last fatal. He was helped each time by the specific contribution listed earlier and by the impaired communication between the people closest to him. Underlying the preceding is the image of failure, running throughout his whole life.

A direct answer is now possible for the long standing Seymour-Dickens feud. Aside from who wrote *Pickwick*, there is the more moral question of who killed Seymour? The preceding should have made clear that suicide is not caused by any one person. However, some people are ideally suited for the role of precipitant. With Seymour, A'Beckett seems to have been the second or third, and nearly the last but for some chance variations. Dickens was the final precipitant of Seymour's self-injuries and like A'Beckett fell into this role by chance.

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COMMENT—SOME THOUGHTS ABOUT THE COMPLEXITIES OF EDUCATION FOR HUMANISTIC CARE IN THE FACE OF DEATH

Jeanne Q. Benoliel

When young people decide to become doctors and nurses, they tend to see themselves in the position of helping other people to recover from illness. Often they have little if any expectation that sooner or later they will be confronted with situations in which they must make choices affecting another person's way of dying or actual death. For each beginning practitioner there is that first experience through which he learns that his patient faces a death that cannot be prevented. These are profound and moving experiences because they are clear acknowledgements that the capacity to help other people to live has sharply defined limits.

There is a good deal written in the literature about the importance of people being able to have a decent kind of death. Yet the educational experiences available to newcomers in the fields of medicine, social work, nursing, and other health-care disciplines may provide little opportunity for learning what is involved in helping the person who is dying to achieve a humane and dignified death.

The problem of educating health professionals to offer humanistically-oriented care in the face of death is a complex one because to do so means to violate many of the primary values and practices of the society. That the people of the United States attach a high value to life-saving goals and procedures is clearly evident in popular articles that extol the valor of saving lives and provide colorful photographs of heroic events in action. Surely it is not surprising that the personal and social rewards associated with practice accrue to those members of the health professions who are engaged in recovery-oriented activities—the highest rewards going to those whose feats are extremely daring, e.g. heart transplantation and other dramatic surgical intervention.

Anyone who has spent time in a large university medical center perceives readily that much activity and technology are devoted to keeping people alive. The educational programs associated with these centers cannot help but reflect the primary emphasis given to professional practice. Hence the students learn very early that the social rewards granted within the health-care social system or subculture are given principally for actions that promote cure; and activities associated with care assume a secondary position. This is not to say that no attention is given to the concept of care, for the literature is full of notions about what "should be" done to help patients cope with their psychological and social problems when they are facing death or are afraid. Rather the problem lies in the personal difficulties that are involved in trying to offer a service that in many ways is directly in conflict with the major goals of the health-care establishment.

To provide a patient with the opportunity to have a humane and dignified death implies that the patient's wishes are known and are incorporated into the day-by-day planning done by other people for whatever number of days, weeks or months he has remaining. Such a goal means that someone is willing to communicate with him at the level of his basic concerns and to the extent that he is able, on a regular basis. Yet the

hospital system is not effectively organized to provide this kind of personalized attention. Authority for the provision of ongoing psychological care has not been clearly delegated to specific individuals in many institutions but is more likely to be diffused into a team effort where authority-responsibility is hard to pin down. In addition, the expansion of a mechanized technology for maintaining and supporting biological life and physiological systems has been accompanied by the growth of objective and depersonalized methods for monitoring the state of the patient. Involvement in these activities can rather effectively be used (unconsciously as well as consciously) to avoid personal involvement with the people being treated.

These comments in no way imply that people who work in hospitals are deliberately and intentionally uncaring and unfeeling. Rather they often cover up their feelings of concern with a protective professional demeanor. Many do so because they have learned from personal experience that involvement with patients through open communication can lead to pain as well as to pleasure. Beginning students tend to talk relatively freely with their patients, but sooner or later they learn that such open conversation can cause them to experience feelings that are difficult to handle. Just as they can have the personal rewards of "feeling good" when a patient recovers and goes home, so at the other extreme can they feel depressed or angry or guilty through their interactions with patients who are facing death.

The point is that students learn from experience that the provision of a dignified death is no simple matter. The patient may want one thing, and his family may want another. The doctors may not be in agreement about what to do, and they may or may not consult with the patient about what he wants or they may not share their decisions with the nursing staff. The patient may be angry, depressed or difficult in a variety of ways. He may want to talk about his death, even to request his death, and the student finds himself trapped in feelings of helplessness and hopelessness–perhaps even a terrible sense of failure.

Stating the case in an oversimplified way, students in the health fields learn fairly early that the work they have chosen involves a conflict in social values when the goals of recovery and the reality of non-recovery converge. The decision to allow the patient to have a dignified death often means a renunciation of the goal of cure. In a profound sense it may mean that the patient's choice is given primacy over the practitioner's choice. To educate students to deal with the kinds of decisions where there are no easy answers is complex and difficult. It means that the faculties involved must themselves come to grips with the serious issues underlying professional practice and be willing to find innovative ways for helping students learn how to approach the reality of death in their daily work–with sensitivity and human concern instead of avoidance.

BOOK REVIEWS

SUICIDE: PREVENTION, INTERVENTION AND POSTVENTION. By *Earl A. Grollman*. Boston: Beacon Press, 1971. 140 pp., paperback, $1.95

Upon opening this book's covers one finds only one letter on the first page, a gigantic lower case s. Each page that follows also contains only one letter until, seven pages later, the word *suicide* has been spelled out and the title page faces you: SUICIDE, Prevention, Intervention and Postvention. But there is no rest for the eye, for the word SUICIDE is then printed on a jarring, uneven line, forcing the reader to pull it together. There is more in this vein within the book itself, where print distortions and "attention getters" take the form of: pages with one sentence, each word printed under the other; pages with a sentence four times the size of the usual print; or with words leaning sideways; or going around in circles, in short, bringing the reader to a screeching halt everytime he gets started in his reading. One must suppose that the author, Earl A. Grollman, a rabbi whose previous book on how to tell children about death is an excellent help in a difficult situation, had nothing to do with the choice of print or the style of the page. The blame, then, must be placed on the editors, for subjecting the reader to such visual gymnastics. I cannot believe it serves any purpose more positively than would straight print.

Aside from such an unfortunate format, what about the content? The summary on the back cover of the book tells us it is directed to a specific audience, that is, gatekeepers, such as doctors, nurses, clergymen, "those in a position to help and who are willing to act." It also starts with some highly familiar lines, "Once every minute, someone tries to kill himself with conscious intent." Anyone who has read *Clues to Suicide* will immediately recognize Dr. Karl Menninger's moving opening statement from the Preface. No credit, however, is given to the original author of the lines, a practice apparently followed fairly often in the book as well.

There are nine chapters, if one includes the one and one half page epilogue. The chapters deal with: the problem, views on suicide throughout history; the theorists; the social surround; clues to suicide; prevention; helping the potential suicide: intervention; when a suicide is committed; postvention; and a summons for community action. These chapter headings indicate that Rabbi Grollman has touched on the most important material, that is, not only recognition and identification, evaluation, and treatment possibilities, but also material about suicide, its history, its epidemiology and demography, some definitions of suicide, and some of its motivations. He also includes material on the occurrence of suicides in specific groups, such as the adolescent, the elderly, the social misfit.

The author writes most clearly and straightforwardly when he speaks directly to the potential worker or when he comments on the role of the community in suicide prevention. There are a few instances when his factual information is just plain wrong, as when he states (page 27) that "until recently Japan's suicide rate was the highest in the world." (It depends on how recent is recently. According to WHO data, Hungary has been highest of the listed countries for many years, 29.6 in 1966, while West Berlin, as a separate locality, has long had the highest rate of any reporting areas, 41.7 in 1964. Japan's rate in 1965 was 14.7.) He states (page 49) that the rate of suicide under age 24 is higher for married than for single, but 1959-61 averages listed in the National Center for Health Statistics, "Suicide in the United States, 1950-1964" indicate the same total rate of 3.4, for married and single suicides. A higher rate for married than for single appears only in age group 15-19 for white male, 8.3 versus 5.4, and for white female, 2.4 versus 1.3. ("Other" races are also higher.) However, from age 20 on up until age 80, the single rate exceeds the married rate in every age group for male, female, white, and "other" categories.

But while some question can be raised about epidemiological accuracy, it can be said that many of the important points are covered and presented well. For example, the

discussion on suicide in the various religions is good, undoubtedly a reflection of the Rabbi's own extensive background and knowledge of comparative religions. His description of some of the clues to suicide in terms of situational, family and emotional hints is informative, and he makes a clear distinction between emotional (he calls it "mental") illness and psychosis, pointing out that being emotionally distressed is not the same as being crazy—an important point for gatekeepers. The chapter on intervention is directed mainly to the person responding, identifying pitfalls and locating some of the sources of help in the community, including friends, family, and professionals. The short chapter on postvention is useful in focussing on the survivors and their problems.

One important aspect of suicide prevention missing was the usefulness of understanding suicidal behavior by seeing it as a communication. While the author does write about communicating (pages 91-92), he concentrates on how the worker should listen and communicate his concern. He does not touch upon the way in which suicidal behavior serves as a communication process, one which informs the significant other and the rest of the world of the feeling raging inside. Nor does he adequately explain the prevalent ambivalence (except for two sentences on page 13) that so often elucidates the so-called gestures and the provision for rescue.

The Rabbi does touch on the pornography of death and adds his voice to the many that have been raised recently declaring the need to lift the taboos on this part of existence so that death becomes recognized to be as much a part of life as is birth. His recommendations for more public education about death and about suicide as one form of death are appropriate, and he strikes a responsive chord in calling urgently for more research.

The professionals will find nothing new in this book, and may have doubts about using it in training or educating the gatekeeper groups in their own communities. They will more readily find what they want in some of the many books now in print, such as Dublin's 1963 book, *Suicide: A Sociological and Statistical Study;* and Shneidman, Farberow, and Litman's 1970 book, *The Psychology of Suicide.* The gatekeepers themselves, however, might find the book useful for a quick overview of the field and for an introduction to some of the basic aspects of intervention. As stated earlier, the Rabbi writes well, and the reader probably will long remember and quote the highly felicitous phrase with which the book ends, "For it is the death of love that evokes the love of death" (page 140).

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MEN IN CRISIS, A STUDY OF A MINE DISASTER. By *Rex A. Lucas*. New York: Basic Books Inc., 1969. pp. IX + 335, $10.00

This book, the product of an interdisciplinary study by a disaster research team, is primarily concerned with the behavior of eighteen men trapped in a coal-mine disaster for periods of six-and-one-half to eight-and-one-half days. Interpretation of the data necessitated a detailed study of life in a community where the risk of death due to disaster is great. As a result, the book is informative about those normative and ritualistic elements which arise in a community where awareness of possible death by disaster is customarily high. These elements are analyzed in terms of processes in the community as a whole, in the family, in the work organization, in the "miners' code", and in other institutional contexts. I wish to focus, however, on the treatment of the trapped men themselves, for herein lies the unique contribution of the book.

Lucus views dying as role behavior. Employing the conceptualizations of the behavioral interactionist, Georg Simmel and such symbolic interactionists as Goffman, Glaser and Strauss, his treatment leads to the conclusion that coping with impending death involves interacting with others in defining the meaning of death, in making death explicable or accountable in terms of such larger meaning systems as religion, and defining one's self as a dying person in terms of one's past biography, one's social roles, and the prospects of one's other-worldy and this-worldly immortality.

Sociologists can ordinarily study status and role transitions by interviewing persons during the transition (in the role) or following the transition. Unfortunately, the dying role leads to a terminal state where we cannot interview the former incumbent of the role. Persons "in the role" are rarely available for interviews. Being able to interview these trapped coal miners after their rescue is somewhat akin to bringing someone back from beyond death.

In the two areas where the men were trapped, roughly comparable numbers of men died either instantaneously or shortly thereafter (Lucas, 1969, pp 46-64). The situation suggests analogies to hospitals or nursing homes where dying persons are confronted with the death of others and with the increasing likelihood of their own death. Lucas emphasizes that the men became defined, and came to define themselves, as "socially dead" (see especially pp. 248-257).

Although the trapped men were young or middle-aged, and although the interruption of their normal life processes was abrupt, we are able to learn from their situation: (1) the effects on the dying of the death of proximate others; (2) the development and effects of growing awareness of one's own impending death; (3) the meaning of death for the dying; (4) the reactions to various forms of real or imagined impending death; (5) the social implications of death viewed from the perspective of persons who consider themselves to be "socially dead"; and finally, (6) coping mechanisms of those facing impending death.

The data in this book are sensitively analyzed, as may be ascertained from the following example. Lucas noted the paradoxical finding that the trapped men frequently made statements to others which, on the surface seemed pessimistic. A man might say to the others, "You can never tell, they (the rescuers) might not work over the weekend" (1969, p 272). Lucas interprets such explicit expressions of despair as actual mechanisms for eliciting hope. "By stating doubts in the appropriate way, a miner forced another to express confidence in ultimate rescue" (1969, 273).

Thus one effect of heightened awareness of impending death was to increase death-defensive interaction. At the same time the miners were striving to maintain hope, they were assuming they had no future. They said goodbye to each other. All of them prayed. They appealed to both fatalism and to the supernatural. The insightful treatment of the fundamental ambivalence between commitment to life and to death which Lucas gives us in the book, might well assist students of other dying persons, for whom the same processes might obtain.

Space permits only a listing of additional concepts which this conceptually rich presentation of empirical data provides. The book offers material relevant to Diggory and Rothman's (1961) suggestions on death and the utility of the self; Kalish's (1966) distinctions between physiological, psychological and sociological death; Glaser and Strauss' (1965) conception of "awareness context," the quest for "social immortality" (Kalish, 1966); Peter Berger's (1967) emphasis on the interface between death and religion; and the wide range of material on life review, reminiscence, and the identity of the dying person (Butler, 1964; Chellam, 1965; Erikson, 1950).

The book is not without flaws. Readers more interested in death and dying than in small-scale interaction or disaster research *per se* might find the presentation somewhat tedious. They are referred to an article (Lucas, 1968) where Lucas more concisely states his major findings relevant to death and dying. It is somewhat disturbing to find misquotations of the same passage from Simmel in both of these sources, and in two different ways (Lucas, 1969, 245; 1968, 3). Nevertheless, because this study attunes us to the possible fruitfulness of disaster research literature in our understanding of death and dying (See also Lifton 1967; Barton, 1969; Wolfenstein and Kliman, 1965); and because of its conceptual and empirical additions to that understanding, I would strongly recommend it and other studies of disaster research to those interested in the social psychology of death and dying.

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