JOURNAL OF DEATH AND DYING

OMEGA

Death Education 1975
From the Editors 179

Education for Death, Or Death Becomes Less a Stranger
Dan Leviton 183

Education on Death and Dying: A Neglected Area in the Medical Curriculum
Edward H. Liston 193

The Experimental Manipulation of Death Attitudes: A Preliminary Investigation
Bill D. Bell 199

Death-Related Experiences, Attitudes, and Feelings Reported by Thanatology Students and a National Sample
Venus W. Bluestein 207

A Human Relations Laboratory Approach to Death and Dying
Kenneth Kopel, Walter O'Connell, Joyce Paris, and Peter Girardin 219

On Teaching an Undergraduate Course on Death and Dying
Sholom Bloom 223

Counseling in Catastrophic Illness: A Self-Instructional Unit
Ronald Koenig 227

The Use of Role Playing Techniques as an Instructional Aid in Teaching about Dying, Death, and Bereavement
David Barton and Miles K. Crowder 243

Living Experiences with Death—A Journeyman's View Through Psychodrama
Hannah B. Weiner 251

Media on Death and Dying
Phyllis Duke 275

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From the Editors

DEATH EDUCATION 1975

Formal courses on death education have been proliferating since the early 1960's. The phenomenon seems to hold true for countries other than the United States as well, judging from the requests for curriculum materials that reach people already offering such courses. Hundreds, perhaps thousands, of courses on college and high school levels and in various applied settings have been given (the accurate determination of precisely how many courses has yet to be made). Indications are that even more courses will be developed over the next ten years.

It is not surprising, then, that *Omega* should offer a round-up of current experiences in the field of death education. Some contributions are descriptive, others attempt to evaluate the outcomes of the death education experience, using experimental and quasi-experimental procedures. While methodological criticisms can be made on this latter group of papers, the authors deserve credit for attempting to assess the effect of their offerings. This issue also offers several papers that present specific techniques that their authors have found useful in death education, both within and outside the conventional classroom situation. Role-playing, psychodrama, and a self-instructional unit are among the procedures described.

The articles in this issue give some indication of the state of the art today, and the variety of approaches that are being explored. Heuristic questions press to be answered. How many students enrolled in death education courses are suicidal, as compared with other students? Leviton [1], for example, found that approximately three per cent of his students report contemplating suicide when asked the question both before and after the course. Is this figure too low or too high an estimate for death education courses in general? As a matter of fact, who *are* our students? How do they differ (if they differ) from the general population? What are the attitudinal and behavioral effects of such courses on the short-term? The long term? How much of the effects should be attributed to course methods and contents, and how much to the

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particular person who happens to be the instructor? And, speaking of the instructor, what kind of person is tapped to "teach death"? How well prepared is this person? What makes the death educator tick, and what kind of "vibes" are received from faculty colleagues? These are just a few of the questions that remain to be explored.

Despite its recent developmental pace, death education still seems to represent a semi-taboo area. It has been observed that some commonalities might exist with the vicissitudes of that other feeling-frought area of inquiry, sex education. Both subject-matter areas are concerned with improving the quality of life. Both were conceived and nurtured within the university setting, under the parentage of a variety of disciplines: sociology, psychology, theology, literature, philosophy, and health education, to name some of those most prominently involved. As graduates were assigned their new teaching responsibilities, they began responding to the need for sex and death education in the elementary (to some degree) and secondary school levels (to a large degree). With a grunt and a non-orgasmic groan, the medical and nursing professions have started to offer education to their students in the realms of both sexuality and death and dying. As Liston notes in this issue, there is reason to believe that medical and nursing schools will increase their death education offerings. He observes that only one course has been described in the literature which specifically addresses the reaching of medical students. His data indicate that some kind of formal education is ongoing in 41 of the 83 institutions surveyed. Negovskii [2] has argued that thorough knowledge of the means of "death reversal" (i.e., artificial hypothermia and resuscitation) should be part of the armamentarium of all surgeons and anesthesiologists before they are allowed to ply their crafts. It would seem even more reasonable to urge that physicians and nurses be expected to know something of the biophysiological, psychological, and sociological aspects of death and dying. As one obstetrician-gynecologist remarked after a lecture on human sexuality: "I know the plumbing involved in sex and reproduction—but that is about all I do know." Interacting as they do with the living and the dying, one would hope that nurses and physicians could develop a strong sense of the cognitive and affective aspects of death and dying.

Sex educators had to put up with a great deal of harrassment at first. Some of this still continues to this day. Whether death education will have to marshall its forces to defend itself against attack by those who see it as a conspiracy, or threat to the public morals remains to be seen. It is unlikely—yet possible—that death education will be associated with sin and corruption of youth, as has been the occasional fate of sex education.

Perhaps those who venture into death education can foresee and forestall some of the more serious problems that might be encountered. Should it not be within our power, for example, to hone a keen critical sense for what is known and what is not really known about our relationship to death? We

would like to think of the death educator as a person with respect for the facts and complexities of human experience, rather than a person who encourages facile solutions. And, as implied by some of the questions raised above, should it not be within the power of the death educator to know honestly what he or she *intends* through the courses, *who* is the student, and *what* are the effects?

Death education 1975 . . . the next 10 years should be interesting!

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EDUCATION FOR DEATH, OR DEATH BECOMES LESS A STRANGER*

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ABSTRACT

A death education course for large numbers of students (n = 300+) is described. Students were asked to write essay type responses to certain questions as part of a pilot project to develop a testing instrument. Results indicate that the death education course has an effect on improving conscious thinking about death, communication with others about death, etc. Students are most concerned about the pain associated with dying. About 3 per cent of the students were contemplating suicide both at the time of enrollment and after the course ended. Some observations on the students' psychological styles of adaptation to the course were discussed.

It has been said that we tend to deny or avoid both the thought and phenomenon of death in ourselves and others. Forty years ago Thomas Browne wrote, "The long habit of living ill disposeth me for dying." At the Hamline Symposium on Death Education, John Brantner summed up our reluctance to face death when he said, "Like children playing games at twilight, we don't want to go home when we are called." Familiar to all thanatologists are the remarks of La Rouchefoucauld that one can no more look steadily at death than he can the sun, and Freud who felt that to our

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unconscious we are immortal. Yet experience and evidence seems to indicate that more and more we are becoming aware and conscious of the inevitability and ubiquitous nature of personal death in our industrialized society.

My students accept the notion of inevitable death but they react to dying before their time. They wish to enjoy their life span; to raise their families, to do their thing. They do not wish to live in fear of imminent death. Thus the relationship between life and death; between the view one has of death and its affect on health becomes apparent. Freud knew this when he argued for the removal of the taboo on death, as a first step in "making life bearable by preparing for death" [1]. Socrates urged us to study death if we would enjoy life. The increase in literature, of newspaper and television inquiries and reporting, and college and university course offerings attests to this interest. We are both frightened and curious about death. We are becoming more aware that how one views death, dying, suicide and homicide, both of oneself and significant others, will affect daily living and health.

The purpose of this paper is to describe in an integrated way (1) the Death Education course offered at the University of Maryland; (2) the comments of students both before and after the course as a means of determining any effect of the course; and (3) some insights gained from teaching taboo topics such as human death and human sexuality.

Perhaps the greatest benefit of teaching taboo subject matter is that the taboo is automatically removed. By discussing death, its implied sacred and unclean character, along with the accompanying myths, stereotypes, and invalid generalizations are held open to examination and scrutiny. I asked three hundred or so students enrolled in the "Death Education" course to respond to some questions both before and after the course. One of the post-course questions asked, "How did the course affect your thinking about any aspect of death?" About one-third (n = 101) responded that the course enabled them to crystalize their thoughts about death, to verbalize, communicate, and to think about death consciously. Since communication is the essential method of psychotherapy it seems likely that the course does provide some support in reducing fear of the many aspects of death. For example 91 per cent (n = 281) reported that the course made some significant contribution to their ability to face their inevitable personal death, to work through their fears, and feel more comfortable with their attitude toward death. Forty-nine (16 per cent) mentioned that they felt better able to cope with the death of a significant other person. On the other hand, ten students (3 per cent) reported that their fear of death and attitudes regarding death were exacerbated as a result of taking the course.

One per cent (n = 4) found themselves depressed about death while 7 per cent (n = 21) reported that the frequency in their thinking of death increased. Four per cent or thirteen students reported a fear of hospitals and technology, that is, they worried over the possibility of an "undignified death." In terms

of suicide thirteen students felt that they perceived the phenomena differently, that is, it was no longer associated exclusively with insanity or other simplistic etiological explanation.

In terms of education and understanding the pervasive effect of death upon man, 16 or 5 per cent were appreciative to have learned how other societies viewed death. Nine reported that the course was helpful to their major field of study while 40 felt more empathy with the aged and dying person. In their essays twenty-four students (8 per cent) felt compelled to mention the need for parent education, and 4 per cent felt that they would enjoy life more after taking the course.

From a research perspective we are interested in large numbers and significant statistical changes yet, clinically, we must be sensitive to the small numbers of students who have special needs as a result of their perception of death.

It is obvious that opening the Pandora's box of taboo topics suggests a responsibility to consider the possible traumatic reaction of some students. Experience has indicated that the teacher of death education must be fairly sophisticated about counseling and crisis intervention techniques. Students will come in for help once the topic of death is legitimized. Students need to have a chance to interact so that many can find, as one girl wrote, that "her feelings concerning death and dying were not 'abnormal' but were shared by her classmates." "It was a great relief to know that others worried and thought of their own death and that of their family as I did." Seventeen (5 per cent) students noted that their relief as they realized their attitudes and feelings toward death were appropriate. I have always recommended that courses devoted to the study of taboo topics need to

1. present the science, medicine, and theory of the particular subject matter by the usual pedantic methodology, e.g. lecture, readings, etc.
2. provide small group discussion which allows ventilation of fears, as well as greater exploration of a topic, and
3. individual counseling when so requested [2].

The History of a Death Education Course

Now, let me offer a brief history of our experience in teaching about death. At the University of Maryland a basic one semester course in health education was required of all students until recently. A goal of any health education course should be to help people enjoy happier lives. Parenthetically I should add that great emphasis is placed on understanding variation in human behavior, that is, we try to stay away from moralistic positions in terms of behavior. Secondly some of us feel that health education should be concerned with more important matters other than washing one's hands after using the

lavatory. Such areas relating to human health as human death and dying, human sexuality, ecology, war, parent education and child rearing, hunger and poverty, and self-actualization were felt to be of greater priority.

In 1964 three lectures on death, bereavement, and suicide were presented and later found to be exceeded in popularity only by the material on human sexuality.

During the summer of 1970 a course entitled "Death Education and Suicide Behavior" was offered which attracted twenty-seven students from a variety of disciplines. The following summer fifty registered. In the spring, 1972, "Death Education" became part of our Department's formal curriculum and drew over three hundred students.

When asked why they enrolled for the course, nearly half (49 per cent) gave pragmatic responses, that is, they were curious about the subject matter, it filled an elective need, or could nicely fit into a time slot. Thirty-six per cent (n = 113) took the course to overcome the fear of personal death, and 11 per cent or thirty-six students enrolled with the hope of overcoming their fear of the death of others. Thirty-three students (11 per cent) reported feeling guilty over the death of another while 30 students (10 per cent) reported worry over the eventual death of another.

Others enrolled to enhance their communication about death and to become better educated about death. Seventy-one or 23 per cent wished to learn to help others overcome their fear of death as part of their professional training, e.g., nursing, medicine, psychology, law enforcement, etc. "To better understand the subject matter of death," was mentioned by seventy-eight students (25 per cent). Only 9 per cent or twenty-eight students mentioned taking the course to prepare for their own eventual death. A small number, two per cent, wished to learn to communicate better regarding death, three per cent (ten students) hoped the course would help them become better parents. Two students hoped the course would better help prepare them for old age.

Eight students were motivated to enroll because of an experiential contact with death. Six had experienced the so-called death-trip while using psychedelic drugs, and two reported having a "close call" with death.

Nearly half (49 per cent) of the class noted that recommendation of other students and faculty, previous experience with the instructor or the Department, radio and television programs describing the course played some part in their selection. Fifty-four students were motivated to take the course because of their interest in suicide.

Goals and Syllabus

Basically, the goals and syllabus have remained the same over the years. Hopefully the students will come to understand death to some degree in order

to better enjoy and revere life. We want our students to be able to use the language of death matter of factly without becoming emotionally involved. They should gain some idea of the complex etiology of suicide and be sensitive to and able to help the person who is contemplating self-destruction. Certainly the course hopes to stimulate research in the areas of thanatology and suicidology. We hope that the course enables students to interact and communicate more humanistically with the dying person, and others who might be classified as socially dead. Most importantly, we hope to help the parent and parent-to-be understand the relationship between the meaning of death and the healthy development of children. Great emphasis is given to the effects of separation and loss, death-related punishment, the child's view of death and child abuse.

In my opinion courses on death education are anti-war. Our goal is for students to know fully the catastrophic consequences of war and holocaust so that other options for resolving conflicts are insisted upon. The barbaric practices by the Nazis inflicted on concentration camp prisoners, and our own inhuman behavior toward slaves, and at Mylai are regularly referred to in the course.

The topical areas are subject matter oriented. A great deal of emphasis is placed on the definitions, semantics, and language of death and its effect on behavior. After all, if we are hung up on the language of death then it is quite obvious that learning is inhibited. Shneidman and Kastenbaum have emphasized the need to more precisely define our terms if we are to communicate effectively [3, 4]. What do we mean by suicide, death, dead, and dying.

After discussing the varied biological, psychoanalytic and non-psychoanalytic theories of death and views of religion, our concern focuses on those factors which influence our thinking and reactions to death and dying. How have people, throughout history, from different cultures, both industrialized and non-industrialized, reacted to the theme of death, dying, the dead and suicide? Certainly social factors influence the treatment of the terminally ill patient. Sudnow [5], for example, has postulated that the type hospital (proprietary vs. state or municipal) and their staff is related to the treatment of the dying patient, the handling and disposal of the dead person. A person's social status seems to determine the quality of care which he receives: a derelict from "skid row" and an infant both suffering from cardiac arrest very well may receive different treatment. Fulton's text [6] is of great value in helping to understand the sociology of death. Using the classic work of Jacques Choron as a basis, the philosophical thought of the great eastern and western philosophers and religions are examined [7].

Several sessions are devoted toward gaining an understanding of bereavement, mourning, and grief. Of course contemporary funeral and burial rituals in our own culture are discussed and, I might add, stimulate great

argument if not sheer animosity. Students find it most difficult to accept the materialism of the contemporary funeral even though they accept its possible psychological value. Fortunately, our guest speakers representing the funeral industry and memorial society have been quite open in their approach and, in general, are well received.

How different populations view death from a demographic and developmental viewpoint is the next topic. The view of the child, the adolescent, the young adult, and the aged is of great importance. How do different ethnic and economic groups react to death? Unfortunately little data is available here. How do those in intimate contact with death react to it e.g., nurses and physicians, the dying themselves, hazardous sports participants, etc.?

Because of the great importance and emphasis we place upon the health of children time is devoted to the topics of death, parent-education, and child-rearing.

After examining the complexity of the nature of suicidal behavior and suicide prevention, the relationship between human sexuality and suicide is discussed. In this lecture special reference is made to the aged populations where the incidence of suicide increases with age while functioning sexual expression decreases. Of interest is the research of Masters and Johnson and other investigators [8-10] indicating that sexual functioning need not become extinct with age under certain conditions. It is felt that when sexual drive is expressed without guilt or fear, suicidal behavior is reduced. "When the need expressed by a penile erection or vaginal sweating response is met suicidal behavior is reduced in strength and direction" is an oversimplification but makes the point.

A session is directed toward the relationship between the study of death and human health, and finally we talk of the so-called socially-dead: the aged, the ugly, the handicapped and mentally retarded, the dying, winos, and other social outcasts, with the goal of understanding the generally aversive reaction to these individuals.

Required texts have included the works of Kubler-Ross, Edgar Jackson, Feifel, Stengel, Scott and Brewer, Hinton, Shneidman and Farberow, and Choron [11-17, 7, 1]. Recently we have used Kastenbaum and Aisenberg's *The Psychology of Death* [18].

Besides attending lectures and guest lectures, reading, and doing research students react favorably to their visit to a death-related agency. These have included animal and human cemeteries, morgues, crematoria, and some students have watched and even participated in an autopsy (not the psychological type). By allowing the student free choice in the agency to be visited he tends to select that which he will feel comfortable. For many it is their first contact with death. The film, *Death* (distributed by Filmmakers Library, Inc., 290 West End Avenue, New York City 10023), is a powerful,

moving story of a man dying of cancer. It, too, was rated highly as a death-related experience.

Student Response

This quick run down of our syllabus helps one to see the complexity and variegated subject matter of thanatology as we try to integrate it into death-as-personal experience. This integration is further enhanced when students interact in small groups and when they are provided individual counseling.

Generally the counseling concerns three areas:

1. concern over the impending death or the past death of a loved one,
2. suicidal thinking, either as a continuous preoccupation or as a trenchant, here and now possibility, and
3. preoccupation with the thought of personal death.

One must be aware that a percentage of the population registered for the course are there for therapy and help. For example, six students had made a previous suicide attempt, seven had or were contemplating it, and another twenty-eight were "interested" in the topic. Over the years one student previously enrolled in the course has suicided. Suicide is always a possibility. The instructor in Death Education needs to be prepared for this eventuality. Not only will he have his own guilt feelings to work through but the news media and citizens' groups may blame the course material and the instructor, himself, for the death.

My impression is that our students' greatest conscious concern is the fear of pain associated with dying (72 per cent). Death as loss is a great concern with 52 per cent. Twenty-one per cent were concerned over the effect of their dying on the remaining loved ones. Interestingly, seventy-two students (24 per cent) associated death with feelings of despair and aloneness. Fear of a painful and prolonged dying while in the hospital seemed to be far greater than fear of death.

A few (2 per cent) saw dying as a means of potentiation. Four per cent wrote that they will enjoy life more now that they have some understanding of death, and thirteen per cent reported that they felt more empathetic toward and less fearful of the dying and the aged person.

In closing let me hypothesize a few observations on some stages which students enrolled in a death education class evolve. These might be labeled shock, denial and disbelief, anger, depression, and synthesis. Initially the student seems to be shocked as he spends his first hour listening to repeated usage of death language. The language of death has to be gradually introduced to the listener. Euphemisms and an explanation for their use are appropriate during this first meeting of the class.

After the stage of shock many students report a stage of denial and

disbelief. "I heard you talk of death . . . the possible association between loss of a parent and later child development, and I thought I was in a dream," wrote one student. "I found my mind wandering for the first few lectures . . . it was later that I was able to take notes," writes another. A third student was not attending class because she had forgotten that she was enrolled in the course (a case of amnesia in service to the ego).

The third stage is anger and is often directed toward the instructor, the University, oneself or a guest speaker. "How could the University be so stupid to offer such a course?" "What kind of crazy nut is the instructor?" "What kind of crazy nut am I to have enrolled?" The stage of anger usually passes quickly and some students do not report experiencing it.

On the other hand nearly all go through a fourth stage, depression of some degree or another. Even in a class of three hundred it is fairly easy to spot those who are visibly suffering because of their projection and identification with the subject matter. During a coffee break or following the class, they will be called aside for discussion.

About one third to half way through the course, the fifth and final stage is entered, the stage of synthesis. Our students have been matter-of-factly using the language of death for quite some time. Many have visited death-related agencies. They have read about and talked of death with their friends and relatives. Death is no longer a stranger. Many are fascinated with the richness of the subject matter. Others are applying it to their professional or personal life. The tone of the class is quite somber. Occasionally we have the belly laughs similar to those in our sex education class. Lively debates are common even with three hundred students. Our guest speakers had best refrain from hypocritical, obsequious statements, and unctuous euphemisms. Death is accepted as the end of life by most, a mystery by some and a step to afterlife by others.

A similarity exists between the stages described and those through which the dying themselves seem to evolve. Kubler-Ross, for example, has described five stages very similar to those which we have mentioned: denial and isolation, anger, bargaining with God, depression, and acceptance [11]. One might hypothesize that the student of death vicariously experiences the same emotions, to a degree, as does the dying person, or as the significant other person who comes face to face with the news of the imminent death of a loved one.

It should be mentioned that some students complained that the course was "sad," or depressing. In rebuttal most of the students, themselves, responded that they were never promised a chocolate cake and that the sadness associated with death is as natural as the joy associated with birth. Each is a part of life and if we are to understand ourselves then we had best see death not as a stranger but as a foil, a stimulus, and a teacher which might help us live in greater harmony and peace with oneself and others.

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EDUCATION ON DEATH AND DYING: A NEGLECTED AREA IN THE MEDICAL CURRICULUM

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ABSTRACT

Very little has been reported about instructing medical students on the psychosocial aspects of life-threatening illness, and there is evidence that this subject has been neglected in medical education. Structured courses are preferable to informal instruction but they are not universally employed, for reasons which are more related to resistance and avoidance than to availability of curriculum time or qualified faculty. Indications are, however, that such education is increasing. Yet to be determined are optimal teaching methods for this subject. Improved communication among educators in this area is needed.

Physicians in virtually every sector of medicine must from time to time deal with patients who are dying or who have illnesses which are either fatal or so serious as to be of uncertain outcome. Yet, the extent and quality of the educational preparation of doctors to meet these challenges effectively has remained unknown. A review of the Cumulative Index Medicus heading "Death" for the years 1960 through 1971 fails to reveal even one article which addresses the teaching of medical students about death and dying. Although a few publications in the general sphere of medical education about this subject are found, none is concerned with instruction aimed primarily at medical students. Wagner [1] and Bonine [2] reported on such teaching for nursing students, but in neither of these was direct contact with dying

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patients an integral part of the course. Rich and Kalmanson [3] described a conference for medical residents which included discussion of attitudes toward dying patients, but again, the interviewing of persons with terminal illnesses was omitted in their conference. During that decade apparently only one medical educator, Kubler-Ross [4], had written about a seminar on death and dying which was an accredited medical school course. Her seminars were focused closely toward clinical patient contacts and the course was open to and attended by members of all of the helping professions but was not designed principally for medical students. Not until 1972 was this specific area addressed. Barton [5], noting the need for such instruction, commented on a seminar about death and dying for medical students at Vanderbilt University School of Medicine. Subsequently, with co-workers, he provided a more complete account of their program [6].

The discovery that only one course has been described which specifically addresses the teaching of medical students about this important aspect of medicine prompts consideration of whether death and dying might be a neglected area in medical education. There has been a profusion of articles concerned with the technical determinations of death by such measures as cardiopulmonary function and electroencephalography; and several other reports deal with the care of the dying patient in medical practice. Yet medical school education in this area is rarely even mentioned; and the instruction of medical students on such an important and often difficult subject requires and deserves, it would seem, substantially greater attention in the literature.

Current Status of Teaching

A recent survey of all American medical schools by the author [7] demonstrated that education of medical students about death and dying is occurring in a formal or structured manner to some degree in only 41 of the 83 institutions which replied. From the responses of the 34 schools which provided sufficient information on their programs for tabulation it was possible to develop a composite profile: The typical course on death and dying was inaugurated about four years ago, is a required part of the freshman or sophomore curriculum, and is limited to medical students. The course format is seminar or lecture and seminar, utilizing an interdisciplinary faculty and providing 9-1/2 hours of instruction per student. Teaching methods include patient interviews and videotape recordings or films; and students view the course as a highly valuable part of their education. Of the seven schools which could not be tabulated because of incomplete information, none appeared to deviate greatly from this typical course description. Closer inspection of the data, however, gives a more realistic view of the extent of formal teaching in this area. Of these 34 schools, 22 have required courses,

but of the remaining 12 schools with elective courses, only about 15 per cent of eligible students are enrolled. Thus, even assuming full attendance at the 22 schools, as well as at the seven with insufficient data, the proportion of students who receive such instruction is far less than one-half of the total number of those enrolled in the 83 schools sampled. This survey demonstrates that instruction about death and dying is an area of relative rather than absolute neglect in medical education, since nearly 50 per cent of the responding schools offer formal courses on this subject. (Moreover, the survey was not designed to establish whether appropriate and adequate teaching in this area is lacking in those schools which do not offer structured courses.)

Formal versus Informal Teaching

Several of the institutions surveyed which do not have structured programs indicated that this subject is taught by informal methods and this may well be the case for most schools without formal instruction. The question arises of why it is that only one-half of the schools have chosen to incorporate this material into the regular curriculum. It is inviting to think that the quality and effectiveness of teaching is greater when a course has a structured and planned format; but, at least with regard to the survey, there is no evidence either to support or to refute such a notion. However, it has been the author's impression from his experiences with this particular subject matter, both as a student and as a teacher, that a structured course is far superior to informal instruction (as on clinical rounds) and that one augments the other.

The principal reason for this impression has to do with the nature of the material. Life-threatening illnesses are frightening not only to patients, but to physicians as well, and most of us tend to avoid frightening experiences. In addition, the physician often finds it extremely difficult to face a seriously ill patient who is crying or angry, and who appears to make demands of the doctor which he cannot meet. Much has already been written about the problems of the doctor and the dying patient and it should not be necessary to repeat it in this article. The important point of this with regard to medical education is that there is all too often an unfortunate but understandable avoidance of the psychosocial aspects of the dying patient in clinical situations of direct patient care. Learning is impeded by anxiety and there are very few situations in medicine which generate as much anxiety in both the patient and the physician as that of incurable illness and its inevitable outcome.

One of the major advantages of employing a structured approach to this subject rests in its providing a means of desensitizing students to these highly charged issues by introducing them to the subject in a controlled manner.

Under circumstances wherein the students have no direct responsibility for the care of a particular dying patient they have the opportunity gradually to develop appropriate therapeutic objectivity, enabling them to deal more effectively with such patients later in their training and practice.

Seminars or even lectures which include demonstration interviews of terminally ill patients and incorporate exploration and discussion of the emotional reactions of the students as well as the patient greatly foster this objective. This method is quite similar, for example, to that used in teaching physical diagnosis to students, wherein demonstrations are presented and the student proceeds through practice examinations and gradually on to direct patient care in the clinical years. By helping to reduce anxiety and fear, such a pedagogic approach can desensitize students without making them callous or insensitive out of their own emotional needs.

If this method of instruction is better (as half of the schools surveyed appear to believe) what are the reasons that it is not utilized even more widely? There are at least three possible explanations. One may be a lack of qualified and motivated teachers. It is unlikely that most medical schools include among their faculties a thanatologist. However, whether such a specialist is actually required is unlikely. Most of the surveyed schools with formal programs have an interdisciplinary faculty, usually under interdepartmental auspices, and not one of them identified an instructor as a thanatologist.

A second reason has to do with the priorities of allocation of available curriculum time. A few respondents commented that finding classroom time for this subject was difficult, especially in those schools where the core curriculum has been compressed into three years. Competition for curriculum hours is certainly great. However, a large number of schools have somehow found a place in their programs for a course on death and dying; and many have evidently been successful courses with a student time expenditure of ten or less hours.

The third reason seems to be the most tenable explanation: Resistance or avoidance of the subject matter itself because of its inherent characteristics. Kubler-Ross [4] among others has emphasized the fact that ours is a death-denying society, and that doctors may have an even greater than usual need to deny the fact of death. In addition to the implications of the failure to heal, and of the insult to unconscious omnipotence, it may be as Wahl [8] suggests, that physicians tend unconsciously to harbor an especially intense personal fear of illness and death, and compensate for this in large measure by such mechanisms as reaction formation and sublimation, attempting to protect themselves through a process of mastery by becoming doctors. If resistance to the development of courses on the understanding and management of the terminally ill does exist, it is probable that these factors are

potent determinants of this phenomenon. Moreover, resistance to these issues seems to increase with the length of time spent in medicine. Kubler-Ross [4] found that the more training a physician had, the more difficult it was to involve him in her educative efforts. It may well be possible to prevent, undo, or at least reduce the development and impact of these emotional factors in physicians by educating them about death and dying in their formative medical years before they become "battle hardened" and further entrenched in a death-avoiding professional style.

Summary and Comment

There is ample evidence that teaching medical students about psychosocial aspects of life-threatening illness has been relatively neglected in formal medical education: Less than one half of the schools recently surveyed [7] offer formal instruction in this area; those which do so provide on the average less than ten hours of instructional time per student; many courses are not required (and elected by small numbers of students); most courses are of relatively recent introduction; and educational methods have apparently been considered of comparative insignificance, judging from the near absence of communications on this subject in the literature.

Expanding medical knowledge and technology, together with the trends toward compressing medical school curricula and toward increasing class sizes have necessitated reduction or elimination of the teaching of some subjects and a tendency to teach by large class lectures rather than by small group seminars. But the importance of educating medical students about patients with life-threatening illnesses clearly overrides these issues. The humanistic approach to dealing with such patients needs to be imparted to students during their formative clinical years, not after their individual styles have become fixed. It is known that the patient who suffers from a fatal illness also may suffer from neglect in that his need for human contact and understanding, especially from his physician, often is unfulfilled. The patient tends to be avoided, because his dying is frightening and threatening to others.
It is conceivable that this phenomenon of neglect also occurs in medical education for the same reasons. A hopeful sign is that most courses on this subject are of relatively recent introduction into medical curricula and that many others are in planning stages. It may well be that instruction of medical students in this area is undergoing the same sort of evolution that has occurred with sex education in American medical schools. That is, death, like sex, has been treated as a taboo subject by its omission until recently from medical education. Perhaps, as with human sexuality, there is a growing trend toward the inclusion of this very important aspect of medicine in medical curricula.

Undetermined as yet are such factors as whether this subject should be taught in the pre-clinical or clinical years (or both) of medical school, which teaching methods are most effective, and what amounts of curriculum time are needed for appropriate instruction. What is needed at this point is for educators in this field to report on their efforts so that others may profit from their experiences.

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THE EXPERIMENTAL MANIPULATION OF DEATH ATTITUDES: A PRELIMINARY INVESTIGATION

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ABSTRACT

This study utilized an experimental format to examine the influence of a course on death and dying on the death attitudes of college students in a mid-southern university. The experimental group (N = 24) consisted of those who had pre-enrolled for the course in question. The control group (N = 50) was chosen at random from the student population. The experimental group was exposed to an 18-week course on the social aspects of death and dying. Pre- and post-test measures of death attitudes were obtained. The data indicate significant changes in the cognitive attitudinal component of those in the experimental group. These individuals entertained more frequent thoughts of death and manifested a greater amount of interest in death-related discussions than was true of the control group. Items constituting the affective dimension, however, were not appreciably changed by experimental procedures. Both groups indicated approximately the same degree of fear in relation to death, and expressed similar feelings toward discussing their own or a close friend's death with other persons.

Attitudes toward death have long been a focus of scientific interest [1-7]. To date, researchers have explored the death attitudes of children [8], adolescents [9-12], institutionalized persons [13, 14], as well as older adults [15-18]. For the most part, these investigations have been descriptive in nature.

At the present time, however, a considerable body of literature suggests significant changes in death attitudes over the past 50 years [15, 19-22]. Nevertheless, because much of this research is of a correlational nature, the qualitative and/or quantitative aspects of these changes are unclear. Such

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ambiguity may reflect the sensitive character of the attitudes in question. On the other hand, it may follow from the fact that these attitudes have seldom been explored in terms of their component features. That is, investigators of death attitudes rarely address themselves in any systematic fashion to the cognitive, affective, or conative dimensions of the attitude construct. Given this situation, it is difficult to determine just what aspects of death attitudes have changed–if at all–over the past few years. In addition, it is not possible to specify what factors or processes are most influential in terms of changing specific attitudinal components.

For the reasons suggested above, the following investigation addresses itself to the componential character of death-related attitudes. In a somewhat limited fashion, however, the study focuses only upon the cognitive and affective dimensions of these attitudes. In pursuing the matter experimentally, the writer has adapted a technique used successfully by Tuckman and Lorge [23] as well as Cicchetti *et al.* [24]. The method consists essentially of the employment of a topically-oriented university course as a medium for selectively altering the attitudes of student enrollees. The present study utilizes pre- and post-test measures of the attitudes in question. In addition, both an experimental and a control group are employed to assess the significance and character of attitude change.

Methodology

PARTICIPANTS

The experimental group consisted of 24 undergraduate students enrolled in a sociology class on the social aspects of death and dying at a university in the mid South. Nine of these individuals were male; fifteen were female. The mean age of the group was twenty-three years. Seven persons were single, fifteen were married, and two were divorced and widowed, respectively. Sixty-one per cent were Protestant and all were in good to excellent health by self report. The mean educational level of the group was 15.9 years. All individuals were residents of the study community.

The control group (N = 64) was selected at random from the student population of the university in question. As fourteen individuals were not available for subsequent post-testing, the responses of these persons were excluded from the analysis. With the omissions indicated, the control group consisted of fifty randomly selected students. Twenty-three were male; twenty-seven were female. The mean age of the group was twenty-three years. Twenty-one persons were single, twenty-four were married, and four and one were divorced and widowed, respectively. 62.5 per cent were Protestant and all were in good to excellent health by self report. The mean

educational level was 15.4 years. As in the case of the experimental group, all individuals were residents of the study community.

PROCEDURE

Initially, both the control and experimental groups were pre-tested in the same manner. The experimental group consisted of the twenty-four individuals who had pre-enrolled for the course in question. Information was obtained by a Likert-type instrument as to (1) how frequently they entertained thoughts of death, (2) the degree of fear associated with death and dying, (3) the amount of interest manifested in death-related discussions, and (4) their willingness or reluctance to discuss either their own or a close friend's death with others.

The experimental group was then subjected to an 18-week course on the social aspects of death and dying. The course in question consisted of lectures as well as selected guest speakers from the medical, legal, and religious communities. In addition, students were responsible for researching specific topics relating to course content and for presenting these to the class at regular intervals. Also incorporated in the design were occasional field trips to hospitals, funeral homes, etc. At the end of the course both experimental and control groups were post-tested using the same instrument as before. Questions on the follow-up measure were arranged in such a way as to minimize pre-test effects. The results of both groups were then subjected to analysis.

Hypotheses

Although the present study was of an exploratory nature, hypotheses were formulated relative to experimental effects. In line with the findings of Tuckman and Lorge [23] and Cicchetti *et al.* [24], it was hypothesized that individuals in the experimental group would not only exhibit significantly more frequent thoughts concerning death, but would also evidence greater interest in discussions of death-related topics. In addition, it was felt that a thorough exploration of all facets of the death experience would eventuate in a significant reduction in any pre-test fears regarding death. In this regard, experimental group members were expected to exhibit less generalized fear relative to death and dying than would be true of the control group. Furthermore, they should demonstrate a more positive attitude toward discussing their own or a close friend's death with other persons.

The Findings

The initial pre-test measure of the control and experimental groups failed to demonstrate significant differences with respect to the five variables under

consideration.[1] Consequently, the following analysis looks primarily at the post-test indications for each variable relative to the groups in question. With reference to the mean scores presented, it should be kept in mind that scale formats were frequently reversed to minimize response sets as well as halo effects. The absolute size of the mean, therefore, is not an indication of a more favorable response pattern.

Table 1. Analysis of Variance of the Cognitive and Affective Dimensions of Death Attitudes for Experimental and Control Subjects

Variables	*Experimental group (N = 24)*	*Control group (N = 50)*	*Mean difference*	*t-value*	*Sig.*[a] *level*
Cognitive Dimension					
Frequency of death thoughts	2.458	3.265	.807	3.539	.0005
Interest associated with death discussions	2.917	2.720	.197	1.800	.05
Affective Dimension					
Fear associated with death	4.000	4.460	.460	0.960	n.s.
Feelings about discussing personal death with others	2.792	2.660	.132	0.641	n.s.
Feelings about discussing death with a terminally-ill friend	2.917	2.796	.121	0.776	n.s

[a] All significance levels are based on one-tailed test criteria.

Table 1 presents the results of the experimental manipulation. As can be observed, significant differences obtain in terms of those items constituting the cognitive dimension of death attitudes. Specifically, those in the experimental group appear to entertain more frequent thoughts about death than do those in the control group ($p < .0005$). In addition, the amount of interest manifested in death-related discussions is greater for those having undergone the classroom experience ($p < .05$). These findings tend to substantiate hypotheses one and two.

On the other hand, with respect to the affective items, no significant differences are in evidence. That is, the experimental and control groups indicate approximately the same degree of fear in relation to death and dying. The same is true with respect to their feelings toward discussing their own or a close friend's death with other persons. Although these findings are contrary to the

[1] This fact is important as the members of the experimental group were not selected at random for the present study. The 24 individuals involved were "self selected" in the sense of prior enrollment in the class.

hypotheses as formulated, it is noteworthy that the scores of the experimental group do tend toward *less* fear relative to death than is the case for the control group. In addition, attitudes toward discussions of death–both one's own death as well as the death of a close friend–appear more *positive* in the case of the experimental group.

Discussion

The findings of the preceding analysis are more suggestive than conclusive. One thing is clear, however. Its apparent that exploration of death attitudes must reach beyond the goal of description and/or correlational investigation. In the present study, the fact that differential success was obtained in manipulating construct dimensions underscores the necessity for a more serious look at the componential features of death attitudes.

A somewhat related issue involves the methodologies of death-attitude research. While the present study illustrates the usefulness of the experimental format in addressing the question, it seems certain that the survey and correlational approaches used heretofore are not without some degree of merit. On the other hand, most of these methodologies represent static approaches to death attitude research. With the exception of the present design, much of the research to date is of little use from the standpoint of predicting changes over time. Even here, however, without the benefit of subsequent research on the present individuals, we have no way to determine the lasting effects of such procedures. In reality, the issue of the stability or fluidity of such attitudes remains open to investigation. We may find, as did Wrightsman [25], that certain attitudinal orientations shift periodically with the impingement of positive or negative stimuli on the individual, only to re-turn to their original levels with the passage of time.

The present findings suggest, further, the need for a thorough exploration of the relationship of death-related attitudes to actual behavior. It seems certain that some kind of behavioral measures are called for in any subse-quent research into this area. It would have been beneficial, for example, had the present study explored such factors as (1) how many in the experi-mental and control groups drew up wills over the test period, (2) how many made funeral arrangements for themselves or loved ones, (3) how many purchased additional life insurance for the benefit of surviving relatives, (4) how many changed their organizational orientations over the period, and (5) to what extent and in what areas interpersonal relationships were affected.

In the final analysis, therefore, it is not appropriate to generalize the present findings much beyond the setting in question. On the other hand, it would seem essential that future research recognize the dimensional character of death attitudes and that multiple methodologies be employed particularly

when addressing the question of social change. In this regard, behavioral indicators would seem of paramount importance.

Summary

The present study utilized an experimental format to examine the influence of a course on death and dying on the death attitudes of college students in a mid-southern university. The experimental group consisted of twenty-four individuals who had pre-enrolled for the course in question. The fifty individuals in the control group were chosen at random from the student population. The experimental group was exposed to an 18-week course on the social aspects of death and dying. Pre- and post-test measures of death attitudes were obtained by means of a Likert-type instrument. The data indicate significant changes in the cognitive component for those in the experimental group. These individuals appear to entertain more frequent thoughts of death and to manifest a greater amount of interest in death-related discussions than was true of the control group. Items constituting the affective dimension, however, were not appreciably changed by experimental procedures. Both groups indicated approximately the same degree of fear in relation to death. The same was true with respect to their feelings toward discussing their own or a close friend's death with other persons. The findings deem it essential that future research recognize the dimensional character of death attitudes and that multiple methodologies be employed when addressing the question of attitude change.

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DEATH-RELATED EXPERIENCES, ATTITUDES, AND FEELINGS REPORTED BY THANATOLOGY STUDENTS AND A NATIONAL SAMPLE

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ABSTRACT

Considering that death continues to be a taboo topic in most circles and that thanatology classes are relatively uncommon, what motivates anyone to choose voluntarily to confront the subject of death? Are such individuals unusually morbid? Have their experiences with death differed in some significant way from those of people in general? Are their attitudes and feelings about death significantly different from others? A 90-item questionnaire exploring death-related attitudes, feelings, experiences was administered to 82 thanatology students. Responses were compared to those given by *Psychology Today* readers to a similar questionnaire. Significant differences were found between the two groups which suggest areas for further research.

Someone once observed that the two human conditions which are most often taboo topics are his beginning and his ending. Man has come far with respect to the first of these "conditions." Sex is discussed more openly today than in previous times. It is dealt with freely in movies, on television, and in the theater. Most modern parents are better able to approach the issue of human sexuality with their children than were their parents. Formal sex education is fast becoming commonplace and acceptable.

Death, unfortunately, still remains a taboo topic in most circles. However, the need for formal and informal education enabling people of all ages to learn to cope with death is becoming evident. Gradually, thanatology courses are becoming more numerous on university campuses, in professional colleges, in high schools, among adult study groups, and elsewhere. Currently, courses on death and dying are still relatively few in number and students

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electing such courses are in the minority. Little has appeared in the scholarly literature relevant to death education per se. One might inquire, for example, about both the people who teach thanatology and the students who voluntarily enroll in such courses. Are they unusually morbid, or exceptionally mature? Have their experiences with death differed in some significant way from those of people in general? Are their attitudes and feelings about death significantly different from others?

For the past two years, the author has offered a course on The Psychology of Death and Dying. In general, the students who have elected the course have been bright, mature, articulate, concerned. Their backgrounds have been varied. Some have done volunteer work in hospitals, nursing homes, or homes for the aged. A few have been practicing professionals (e.g., nurse, director of adult education, aide at the Shriner's Burn Institute, member of a hospital resuscitation team, social worker, psychologist, teacher). The majority have been advanced undergraduate psychology majors enrolled in a liberal arts college. However, students have come also from various other colleges and divisions on the University of Cincinnati campus.

The course has been taken by students planning to enter nursing, psychiatry, psychology, social work, education, the ministry, medicine, and by one young woman who plans to become a funeral director. Each has been of the opinion that the experience would enhance his effectiveness in his chosen career. By and large, students have come to the class hoping to examine their own feelings and to discover how others feel about death. They express a desire to become more sensitive to the feelings of others and to learn to cope better with their own finiteness and with the eventual death of loved ones. Some are attempting to work through old unresolved griefs. Some come to the class out of curiosity or because of the novelty of it, but these are in the minority.

From the description, thanatology students do not seem unusual or atypical. Yet, the fact that they have enrolled in the course at this point in time probably makes them unique in some respects. In order to test out this hypothesis, several pilot studies have been undertaken by the author. One study is described in this paper.

Procedures

In August 1970, a 75-item questionnaire entitled "You and Death" appeared in *Psychology Today* [1]. The questionnaire explored childhood experiences with and attitudes toward death. Questions dealt also with beliefs and wishes about an afterlife, thoughts about one's own death, euthanasia, organ transplants, wills, funeral practices, autopsies, etc. Several questions related to the problems of suicide. Various demographic data were

also solicited. Readers who wished to participate in the survey were requested to return the questionnaire. The June, 1971, issue of *Psychology Today* carried a detailed analysis by Shneidman [2] of the survey results.

A 90-item questionnaire, similar to that described above, was administered on the first day of class to 82 students enrolled in the author's psychology of death course. Since many of the questions were identical to the *Psychology Today* instrument, the responses of the thanatology class were compared to those of the national sample [1] in order to ascertain whether there were significant differences between the two groups. When possible, chi-squares were computed to test the hypothesis that the thanatology students would not differ significantly from the national sample with respect to the responses given. All questionnaires were filled out anonymously by the respondents in both groups.

Death Inventory and Attitude Survey[a,b]

1. Who died in your first personal involvement with death?
2. To the best of your memory, at what age did you first become aware of death?
3. When you were a child, how was death spoken about in your family?
4. Which of the following best describes your childhood conceptions of death?
5. Which of the following most influenced your present attitudes toward death?
6. How much of a role has religion played in the development of your attitudes toward death?
7. To what extent do you believe in a life after death?
8. Regardless of your belief about life after death, what is your wish about it?
9. How often do you think about your own death?
10. If you could choose, when would you die?
11. When do you believe, in fact, you will die?
12. Has there ever been a time in your life when you wanted to die; when you felt that life was not worth the effort?
13. What does death mean to you?
14. What aspect of your own death is the most distasteful to you?
15. Based upon your present feelings, what is the probability of your taking your own life in the near future?
16. What is your belief about the cause of most deaths?
17. To what extent do you believe that psychological factors can influence (or even cause) death?
18. When you think of your own death (or when circumstances make your realize your own mortality) how do you feel?
19. To what extent are you interested in having your image survive after your own death through your children, books, good works, etc.?
20. For whom or what might you be willing to sacrifice your own life?
21. If you had a choice, what kind of death would you prefer?
22. If it were possible, would you want to know the exact date on which you are going to die?
23. If your physician knew that you had a terminal illness and a limited time to live, would you want him to tell you?
24. How do you feel about having an autopsy done on your body?
25. To what extent has the possibility of massive human destruction by nuclear war influenced your present attitudes toward death or life?
26. Which of the following influenced your present attitudes toward your own death?

Death Inventory and Attitude Survey[a,b] (continued)

27.	How often have you seriously contemplated suicide?
28.	How you ever actually attempted suicide?
29.	How do you estimate your lifetime probability of committing suicide?
30.	Suppose that you were to commit suicide, what reason would most motivate you to do it?
31.	Suppose you were to commit suicide, what method would you be most likely to use?
32.	Suppose you were to commit suicide, would you leave a note?
33.	To what extent do you believe suicide ought to be prevented?
34.	Have you ever been in a situation in which you seriously thought you might die?
35.	What efforts do you believe ought to be made to keep a seriously ill person alive?
36.	If or when you are married would you prefer to outlive your spouse?
37.	What is your primary reason for the answer which you gave for the question above?
38.	How important do you believe mourning and grief rituals (such as wakes and funerals) are for the survivors?
39.	If it were entirely up to you, how would you like to have your body disposed of after you have died?
40.	Would you be willing to donate your heart for transplantation (after you die)?
41.	What kind of funeral would you prefer?
42.	How do you feel about "lying in state" in an open casket at your funeral?
43.	What is your opinion about the costs of funerals in the U.S. today?
44.	In your opinion, what would be a reasonable price for a funeral?
45.	What are your thoughts about leaving a will?
46.	To what extent do you believe in life insurance to benefit your survivors?
47.	Assuming that there has been an increase in the amount of concern with death in the U.S. in the last 25 or 50 years, to what principally do you attribute this change?

[a] The questions contained in this table are those which were included on the questionnaires administered to both the TS and the PT sample. The original questions provided multiple-choice-type responses. For a complete list, the reader is referred to *Psychology Today,* 1970, August.

[b] Demographic data were also requested.

Results

Over 30,000 readers of *Psychology Today* returned the research questionnaires, which were analyzed by Shneidman [1]. It is interesting to note that a previous PT questionnaire on sex yielded only approximately 20,000 replies. In response to this, Shneidman wrote:

> It was almost as though thousands of persons had been waiting for a legitimate occasion to unburden themselves about death and then felt somehow cleansed after writing their unspoken thoughts [1, p. 43].

The typical respondent, according to Shneidman, was a 20 to 24 year old, single, Caucasian ("somewhat religious") Protestant female. She was a college graduate who lived in the Midwest and came from a relatively small family (one sibling). The typical thanatology student was 20 to 24, single, Caucasian

and (a "slightly religious") Protestant. Males and females were about equally divided. He or she tended to be an upper classman majoring in psychology and came from a relatively small family (one and a half siblings). The university is located in an urban, Midwestern city and draws students primarily from Cincinnati and surrounding communities. On most of the items which were compared, the thanatology students (TS) did not differ too remarkably from the national *Psychology Today* (PT) sample. However, some significant differences were observed.

CHILDHOOD EXPERIENCES

Fifty-one per cent of the TS and 43 per cent of the PT respondents had their first personal contact with death when a grandparent died. The majority in both groups indicated that they had first become aware of death after the age of five, but before the age of ten. A significantly larger percentage of the TS reported that death had been talked about openly when they were children than was true of the PT sample ($X^2 = 6.76$, 1df, $p < .01$). A significantly higher percentage of the PT sample was unable to recall any discussion about death when they were children ($X^2 = 13.37$, 1df, $p < .01$).

BELIEF IN AN AFTERLIFE

Forty-three per cent of the PT sample and 48 per cent of the TS indicated some degree of belief in an afterlife, while approximately one-third in each sample tended to disbelieve in the hereafter. However, a significantly larger percentage of the TS than the PT group expressed a wish that there were a life after death ($X^2 = 9.59$, 2df, $p < .01$). Like the PT respondents, most of the TS are interested in having their images survive them after death, through their children, books, or good works.

INFLUENCES ON DEATH ATTITUDES

Questions were asked relevant to experiences that had played the most important role in the development of the respondents' attitudes toward death (in general and their own in particular). Responses were varied but fairly comparable in both groups, for the most part. For example, 35 per cent of the PT sample and 27 per cent of the TS indicated that "introspection and meditation" had been major influences in their own lives. So far as religion is concerned, 58 per cent of the PT group and 57 per cent of the TS intimated that it had played little or no significant role with respect to their death attitudes. On the other hand, a significantly larger percentage of the TS felt that either "ritual" ($X^2 = 4.50$, 1 df, $p < .05$) or "personal health" ($X^2 = 4.00$, 1df, $p < .05$) had been a primary influence. While 15 per cent of the twenty to twenty-four-year olds who returned the PT questionnaire

reported that experiences with narcotic or hallucinogenic drugs had affected their attitudes toward death, significantly fewer (6 per cent) of the TS reported similar experiences ($X^2 = 9.48$, 1df, $p < .01$). Overall, approximately one-half of the PT respondents, compared to 38 per cent of the TS, intimated that the threat of nuclear war had played some role with respect to their present attitudes toward death. However, a significantly smaller percentage of the TS were of the opinion that this had been a major factor ($X^2 = 5.81$, 1df, $p < .05$).

PERSONAL VIEWS OF DEATH

Shneidman noted that attitudes toward death seem to change as one matures. Childhood concepts of death, reported by 57 per cent of the PT sample, involved ideas of heaven and hell and an afterlife. By adulthood, only 23 per cent of the sample still reported a strong belief in an afterlife; 44 per cent saw death simply as the final process of life or equated it with "endless sleep." When asked "What aspect of your own death is the most distasteful to you?," 47 per cent responded that "one could no longer have any experiences" or that all his projects and plans would come to an end; 12 per cent indicated concern about what would happen to them if there is an afterlife; 14 per cent expressed concern about the grief it would cause friends and relatives or the inability to provide for dependents; 15 per cent were afraid that the process of dying might be painful.

Consistent with the national sample, 59 per cent of the TS also reported childhood concepts of death which involved heaven and hell and an afterlife. However, there were significant differences between the two groups with respect to other childhood concepts of death. A significantly larger percentage of the TS reported early views of death which equated it with sleep ($X^2 = 4.09$, 1df, $p < .05$). Whereas all of the TS recalled some childhood concept of death, significantly, 8 per cent of the PT group could recall no childhood concept ($X^2 = 10.00$, 1df, $p < .01$). When compared to the national sample, significantly fewer of the TS view death as the final process of life ($X^2 = 5.92$, 1df, $p < .05$); more see it as a transition into another kind of existence.

What aspect of their own deaths seem most distasteful to thanatology students? Significantly fewer of the TS reported regrets with respect to the termination of "experiences" and "projects" ($X^2 = 7.56$, 1df, $p < .01$), while significantly more of the group than was true of the national sample, expressed concerns for their survivors ($X^2 = 14.45$, 1df, $p < .01$). Similar to the PT group, 11 per cent of the TS indicated concern about their fates if there is an afterlife and 14 per cent expressed fears that the dying process might be painful.

The average PT respondent (57 per cent) thinks about his own death

"occasionally" and the thought is likely to make him feel resolved in relation to life or to take pleasure in being alive. Not surprising, perhaps, is the finding that a significantly larger percentage of the TS think "frequently" or "very frequently" about their own deaths ($X^2 = 20.055$, 1df, $p < .01$). Although 43 per cent of the TS also feel resolved in relation to life or pleasure in being alive when they contemplate their own deaths, they are more heterogenous than the PT sample with respect to other feelings which are reported (e.g., depression, purposeless).

"If you could choose, when would you die?" The majority in both groups would like to die in old age and believe, in fact, that they will die in old age. Most respondents in both samples prefer sudden, quiet, and dignified deaths. On the other hand, a significantly larger number of the TS than the PT group indicated a desire to die following "a great achievement" ($X^2 = 5.142$, 1df, $p < .05$). Approximately eight out of ten respondents in both samples would not like to know, even if possible, the exact date they are going to die. However, seven out of ten of the PT sample and eight out of ten of the TS would want their physicians to tell them if they had a terminal illness. The majority in both samples are of the opinion that psychological factors can influence or even cause death, yet most respondents also indicate the belief that events over which individuals have no control cause most deaths (including old age).

SUICIDE AND THE WISH TO DIE

Approximately two-thirds of all the respondents admitted that they had at one time or another wished to die. About one-fifth of the TS and one-fourth of the PT sample have thought about suicide. However, significantly fewer of the TS have actually attempted suicide ($X^2 = 3.86$, 1df, $p < .05$). Only 15 per cent of the PT sample and 10 per cent of the TS were of the opinion that suicide should never be prevented. Fifty per cent of PT sample compared to 45 per cent of the TS would leave notes if they did commit suicide (fewer than 15 per cent of actual suicides ever leave notes). Both groups expressed a preference for pills as a means of ending their own lives, should they choose that route. What might drive an individual to suicide? Over half in both groups listed loneliness, illness, or physical pain. However, a significantly larger number of the TS say that they would kill themselves to get even or hurt someone ($X^2 = 5.33$, 1df, $p < .05$) or because of family strife ($X^2 = 9.0$, 1df, $p < .01$). Fortunately, approximately 75 per cent of all respondents estimated the life-time probability of their committing suicide to be very low or non-existent.

CONCERN FOR OTHERS

While most respondents seem to feel that life should be long in duration, less than one in ten opts for prolonging life "at all possible costs for as long

as possible." The majority were of the opinion that only those efforts that are "reasonable" for a person's age, physical and mental condition, and state of pain should be made to keep a seriously ill person alive. While 16 per cent of the PT sample held life so dear that they would not sacrifice their lives for any reason, only 8 per cent of the TS felt similarly. Clearly, a somewhat larger number of the TS are willing to sacrifice their lives for some just cause.

Both groups were quite similar with respect to their desires to outlive or preceed their mates in dying. An equal percentage in both samples indicated either yes or no. The majority in each, however, expressed ambivalence. Many of the TS wrote on the forms that they preferred to die at the same time as their spouses. The reasons given for yes or no responses divided themselves equally between the selfish and the selfless, but a significantly larger percentage of the TS did indicate a desire to spare their spouses grief and loneliness by outliving them ($X^2 = 23.272$, 1df, $p < .01$).

Shneidman found that the *Psychology Today* readers were, by and large, generous in their desires to provide for their heirs through insurance and wills. Only 1 per cent indicated no intent to leave a will and only 3 per cent indicated that they did not believe in insurance. The TS were equally generous.

FUNERAL RITES

One-third of all respondents would prefer no funeral at all. Two-thirds are of the opinion that funerals should cost less than $300. Significantly more of the PT readers indicated a belief that funerals are "very much overpriced" ($X^2 = 4.58$, 1df, $p < .05$). While a few individuals claim that it doesn't matter one way or another, over 90 per cent of all respondents definitely do not wish to lie-in-state in an open casket at their own funerals. Fewer than 50 per cent of the respondents feel that funerals and wakes are important for the survivors. Nearly one-fifth are of the opinion that such rituals are not at all important. None of the respondents indicated a preference for burial over other methods of disposing of their bodies (i.e., cremation, donation to medical school). The vast majority approve of autopsies and would be willing to donate vital organs for transplantation.

Both groups of respondents were asked to indicate whether they felt there had been an increase in the amount of concern with death in the U.S. in the last twenty-five or fifty years and, if so, to what they attributed this change. Although the list of possible responses were similar, they were not identical on the two questionnaires. Consequently, direct comparisons are difficult. However, 45 per cent of the PT readers in the Fall of 1970, attributed our heightened preoccupation with death to wars and the presence of "The Bomb." Only 19 per cent of the TS selected these factors, while another 18 per cent chose "feelings of alienation and insignificance in a rapidly moving technological society."

Discussion

A questionnaire exploring death attitudes and experiences was administered to 82 students enrolled in a course on death and dying. Since forty-seven of the items were similar to those contained in a national survey conducted by *Psychology Today* [1], the responses of the two groups were compared. By and large, the thanatology students do not differ remarkably from the PT respondents in the areas measured. However, some significant trends do emerge.

In general, the thanatology student was more likely to remember his childhood concepts of death (which were also more varied than those reported by the PT sample; e.g., heaven and hell, afterlife, sleep) and more likely to recall how death was spoken of in his family as a child. Similarly, death was more likely to have been discussed openly in the home of the TS than was true in the case of the PT reader.

The TS rated themselves as "slightly" religious; the PT sample, as "somewhat" religious. It does not seem surprising, therefore, that over 50 per cent of all respondents indicated uncertainty or disbelief with respect to an afterlife. The thanatology student, however, was more likely to wish there were an afterlife. Shneidman [2] observed that attitudes toward death seemed to change with age. Whereas, the young person tends to view death in terms of heaven and hell, the adult view appears more phenomenological or scientized. Unlike the national sample, the thanatology student is less likely to view death as merely the end of life. Consistent with Shneidman's findings, however, he is even more likely than the PT reader to take a phenomenological or scientized view that he is a part of a continuing process, a link in the never ending chain of life. Apparently, Man still cannot fully accept his own mortality. As he moves farther away from formalized religion and its concomitant espousement of an afterlife, he seems to feel a need to fill the vacuum with some other belief system in order to soften the stark reality of his own finiteness.

The thanatology student is more likely to think frequently or very frequently about his own death, and to be concerned more about the effects his death will have upon his loved ones than about the loss of ego. He is likely to be more willing to sacrifice his life for a loved one or a just cause and would prefer to outlive his mate in order to spare her the loneliness and grief of bereavement. He is less likely to have attempted suicide but, compared to the PT sample, is more likely to end his life because of family strife or to get even with or to hurt someone. And he is more likely to prefer to die following a great achievement.

Whereas, respondents to the national survey felt that their current attitudes toward death in general and toward their own deaths in particular had been influenced largely through introspection and meditation, the thanatology

student tended to be more heterogenous with respect to this issue. Introspection was selected by 27 per cent of the TS sample as an important influence. However, a significantly larger number than expected also listed ritual and their own personal health as equally important influences upon their death attitudes. While 45 per cent of the PT group were of the opinion that "The Bomb" was the principal reason for an increased awareness of and concern about death today, considerably fewer of the thanatology students felt similarly. Rather, emphasis was given also to feelings of alienation and insignificance. Significantly fewer of the TS were of the opinion that wars or drugs had played an important role in the development of their attitudes toward death.

Conclusions

Considering that death continues to be a taboo topic in most circles and that thanatology classes are relatively few in number, what motivates anyone to choose voluntarily to have an open confrontation with the subject of death? Are such individuals unique in some way? The author recognizes several limitations inherent in the present study: for example, the two sets of data were collected three years apart; the instruments used were not identical; some data were obtained by mail, others with the investigator present; the length of the two questionnaires plus the ordering of the content may also have affected the results in unknown ways. While little that is definite may be concluded from the study, the data do suggest possible areas to be explored further in answering the questions raised in this paper.

For example, the data from this and other pilot studies conducted by the author (in preparation) suggest that thanatology students do think a lot about death. This trend is present on the first day of class. Perhaps the act of enrolling in the course stimulates one to think more about death. On the other hand, perhaps one's experiences with death serve as the motivating factor to seek out thanatology classes when these are available. *First experiences* with death (i.e., death of grandparent, parent, pet, etc.) were comparable in the two groups studied. Perhaps thanatology students have experienced *more* deaths among family members and friends compared to the average for their age. This information was not obtained. Have thanatology students encountered more *life-threatening experiences?* Shneidman reports that 79 per cent of the men and 70 per cent of the women in the national survey reported being in a situation in which they seriously thought they would die. Among the thanatology students, 78 per cent of the men and 46 per cent of the women reported similar experiences. If this variable proves to be significant, it would appear to be so only for females.

A more promising lead, perhaps, may be found in the response to a

question which was asked of the thanatology students, but unfortunately not of the PT readers. "Have you ever been in a situation in which someone quite close to you was so ill that he or she might die, or in which someone close to you had a terminal illness?" Eighty-five per cent replied in the affirmative. The same question was asked of a group of college students who were not (or had not been) enrolled in a death class. Significantly fewer of this group, when compared to the TS, reported having these experiences ($X^2 = 7.791$, 1df, $p < .01$). Perhaps thanatology students have had more *intense* personal experiences with death or potential death which have led them to be more aware of its impact and to feel an urgent need to prepare themselves to cope with the eventuality of death in themselves and others.

Somewhat related and perhaps supportive of the hypothesis that thanatology students tend to be sensitive to interpersonal relationships, are several other findings of the study. Compared to the PT respondents, significantly more of the TS expressed concerns about their survivors or a desire to outlive their spouses in order to spare them grief and loneliness. A significantly larger percentage intimated that they might commit suicide to hurt someone else or because of family strife. Significantly more TS preferred to die following a great achievement and more TS reported that ritual had played an important role in the development of their attitudes toward death.

Along different lines, the data also suggest that thanatology students may have fewer hang-ups with respect to death or fewer needs to repress death-related feelings and experiences. Perhaps when one no longer ignores the reality of death, he is freed to seek ways to come to terms with his own mortality and to begin to develop a more meaningful philosophy of life which is predicated upon an acceptance of death.

Shneidman cautions that the PT survey reflects the magazine's readership rather than the general public. One might question whether the sample is even representative of PT readers in general or if those individuals who were motivated to fill out the rather lengthy questionnaire were not in some way unique. Furthermore, neither the national sample nor the college sample may be representative of people in general. On the other hand, Shneidman suggests that while the PT sample may not represent the general public:

> . . . responses from a young and highly educated group of people, perhaps a critical minority, a cutting edge, may reveal where the rest of society is heading [1, p. 44].

Carrying this logic one step further, it is conceivable that these individuals who enroll in death courses represent an even more avant-garde movement within the broader culture.

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A HUMAN RELATIONS LABORATORY APPROACH TO DEATH AND DYING

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ABSTRACT

In response to a request from the hospital nursing service, the authors devised a one day human relations laboratory experience focused on death and the dying patient. The lab consisted of four exercises, two that dealt with personal feelings about death and two that dealt with professional responses to the dying patient. Details of these exercises and reactions of the participants are presented.

Advances in medical technology have moved death into the role of the greatest enemy of the individual. Already a taboo topic of discussion, thoughts of death and the dying patient are pushed even further away from the mainstream of daily life. Funeral jewelry and embroidered mementos have disappeared from the American scene and European children no longer receive miniature coffins for playthings [1]. Fear of one's own death hastens society to send its human reminders to the "Golden Age Manor" or the hospital ward. Hospital staffs reflect the cultural avoidances; therefore, the dying patient is isolated physically and psychologically. He is often an object of reactive rage, since his physical condition reflects defeat and failure to the technician unconsciously competing with death [2].

While friends, and sometimes families, withdraw from the dying patients,

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hospital staffs are forced to at least make some contact with them. The staffs, however, are able to maintain emotional distance by not sharing openly and administering only to the physical necessities required by the patient. The disappointment in failing to prolong the patient's life, awareness of one's own mortality, and a lack of functional knowledge of how to deal with dying patients seem to be primary causes of the withdrawal of hospital personnel. Both medical and nursing schools spend little, if any, time teaching students about dealing with death and the dying. Even those that do leave little opportunity for discussion of personal feelings. This human relations lab on death and the dying was designed as a preliminary step to deal with such a didactic-experiential void.

Laboratory Focus

CONSULTANT TEAM

The consultant team for the death and dying lab consisted of three psychologists and a chaplain who were asked to present a one-day workshop on death to nurses, nursing students, and social workers at the VA Hospital, Houston, Texas. During the planning stage the consultants decided to use an experiential approach in the hopes of stimulating appropriate affective responses and a keener awareness of the human problems involved in dying.

LABORATORY EXERCISES

The lab was divided into four parts, two dealing with personal feelings about death and two dealing with professionals and their responses to dying patients. After introductory remarks the lab began with a round table discussion by the four co-leaders, focused on their reactions to the idea of their own deaths. The panel served two purposes. The participants were allowed to remain somewhat safe without being forced into disclosing their own immediate reactions to death. At the same time the panel modeled openness and introduced the idea of the workshop as a cooperative experiential venture rather than as an abstract intellectual exercise.

For the second exercise of the lab the consultants devised a "death fantasy." Participants were instructed to imagine that a natural disaster had occurred which isolated them from the rest of civilization and would culminate in the death of everyone within seven days. The participants were divided into their work groups of 12 persons, each led by a consultant, with instructions to share their feelings about the situation and to assist everyone in the group to die with dignity. To many participants, the fantasy became very real. In one group a nurse expressed the wish that she would like to have been able to accept the fantasy as truth. She had thought of death

many times and would have felt comfortable dying in this situation. Several others expressed anger at having their lives cut short so abruptly. Some participants resented strangers being present at their deaths while others formed close liaisons to help each other through the last week. When a "messenger" arrived with the announcement that the danger had passed, many seemed noticeably relieved. Knowledge of one's imminent death and dying being shared only with strangers as in the fantasy is quite similar to the situation of the terminal cancer patient, although in reality few persons would volunteer to help the latter "die with dignity."

After lunch the focus of the workshop turned to the dying patient. The consultants role-played dying patients, and their families, while each small group sent a team to help them through the traumatic period. Four types of difficult patients were modeled after Satir's four stances, placating, blaming, computing, irrelevant [3], all consultants modeling the inner and outer life styles of death-denying families [4]. The final part of the lab consisted of participants re-entering their small groups to share with each other ideas about how to deal with the dying patient. Personal experiences were exchanged and new ideas were developed for approaching the dying patient. The large group then met for the final process session and the workshop ended.

Participant Reactions

Most people felt they were physically and emotionally drained by the closing session yet felt that they had accomplished something worthwhile. The general feeling was highly positive and many called for more workshops in the future. Several mentioned the possibility of workshops for medical staff as well as allied personnel. Whether this lab will have any effects on the treatment of dying patients cannot be assessed by this report. However, the nursing service, organizers of the lab, thought that those in attendance will be more attuned to meeting the terminal patient's emotional and physical needs in their future encounters.

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ON TEACHING AN UNDERGRADUATE COURSE ON DEATH AND DYING

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ABSTRACT

The origins, goals and content of an undergraduate course in death education is described. The course received favorable student evaluations and much was learned that was useful in further developments.

During the second term of 1972, eleven college-age students enrolled in an undergraduate course on Death and Dying at Eastern Connecticut State College where it was offered for the first time. Students evaluated the experience and rated it successful and meaningful. They rated the course effectiveness on items such as course content, student participation, class lectures, what they liked and disliked most, what they would recommend for next term, whether they would suggest the course to their friends and what they had learned. Their scorings were positive and indicated a highly successful learning experience. Some of their comments were:

> "Yes, a very interesting and informative course and useful to your everyday life, unlike most of the courses required for degree."
>
> "I learned our attitude towards death was very different from many parts of the world."
>
> "What I learned from the course was enlightening and I learned more about myself and my own concepts of death have become more concrete."

The outline for the course stemmed from a syllabus prepared by White and due to the fortuitous fact that the collateral readings' text by Feifel did not arrive until the end of the course because of shipping difficulties, we were free

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to chart a different course [1, 2]. We were not text-book bound and could proceed in another vein; using the syllabus, but changing it at will.

Resume Highlights

What follows is a resume, highlighting the fruitful outcomes as well as listing new topics that were introduced.

FEELING LEVEL

The mood of the students at the first session was one of great curiosity, mixed with fear. When I asked why they had paid money for a three credit semester course on death, it became quite obvious and advisable that I handle their feelings in an experiential, relevant and non-threatening manner. To achieve this end, I had the class spend time on a variety of exercises such as preparation of their own eulogy and epitaph, do a birth-death continuum, role play family situations. We followed each one with a rap session. These exercises were based on those developed by Toobert and Otto [3, 4]. It allowed for "unfreezing" to transpire and creation of a relaxed attitude and atmosphere where one could examine one's own feelings about death with aplomb and understanding.

COGNITIVE LEVEL

Besides the topics and ideas as outlined by White, several appealing subjects were introduced and consequently provided an avenue for intense and animated group discussion. A series of lectures was held on classical psychoanalytic thinking of Freud, Jung, and Adler [5-10]. The class was also informed of current criticism, especially directed toward the theory of Freud's death instinct as researched by Brun, a statistical study of the number of Freud's followers who did not follow his line of reasoning [11]. Lectures were given on mourning as developed by Klein and grief, following Lindemann [12, 13]. Of great interest to the class was the akin-to-death experiences of "extreme conditions," the concentration camp experience of Frankl and Bettleheim and Hiroshima atomic bomb holocaust as researched by Lifton [14-16]. In addition the class became engaged in the concept of "psychological autopsy" of Weisman and Kastenbaum and the theories of thanatology as delineated by Eissler. Since the class was small, it offered opportunity for full presentation, careful explanation of material and sufficient time to answer questions.

TERM PAPER

The students were informed of a term paper as course requirement at the beginning class, with the stipulation that the topic could be a course-related subject, with both oral presentation followed by class discussion and written

paper in lieu of examination. The quality of both presentations were very good. What was most rewarding to the students was pursuing their personal interests, for example: one student did an in depth paper on "Death in Animals," and another, an analysis of his own art work pointing up death as portrayed and expressed in this medium.

FUTURE DIRECTIONS

Directional signals from these beginning steps are clear. The possibility of adding field trips to a cemetery, funeral parlor and morgue, making use of a film such as "Death" by Filmmakers Library or videotapes by Ross and securing reprints from *Psychology Today's* questionnaire on death by Schneidman would also be desirable [18-20].

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COUNSELING IN CATASTROPHIC ILLNESS: A SELF-INSTRUCTIONAL UNIT*

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ABSTRACT

A self-instructional unit is presented to help students in the allied health fields through their initial experiences in counseling patients with serious illness. This unit is intended to be used in combination with didactic approaches. Clinically, the unit may be particularly useful for those who are learning to apply the problem-oriented record system. In the classroom situation, it may help in easing the student's thoughts and feelings into the world of the seriously or fatally ill individual. Considerable attention is given to the student's own experiences, opinions, and feelings. The unit is most effective when there is active guidance and participation from the instructor, although it is in a self-instructional format.

Those who have already acquired some clinical and teaching experience "the hard way" are in a position to help students who stand on the verge of their first relationships with people suffering from catastrophic illness. One possible technique could be the self-instructional unit. Here, then, is such a unit that the author has devised, applied, and found useful. Perhaps it will have some interest for others as well.

To The Instructor

While this procedure is termed a "self instructional learning unit," it is important that the instructor assume considerable active responsibility to

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prepare the student for initial interviewing assignments. It can be used without much preparation, but is most useful and effective if students have first participated in discussions dealing with life-inventory interviewing concepts, or provided with guidelines for review of important psychosocial areas of life. In clincial situations, this unit is particularly useful for students who are learning to apply the problem-oriented record system.

In classroom situations some preliminary operations are necessary. After discussion of the eroding effects of illness on the lives of patients, students are asked to imagine they have recently been told that they themselves have a potentially fatal disease such as leukemia. The symptoms and normal course of the disease are discussed. Next, they are directed to write a brief (300-500 word) anonymous, *now*-oriented, cross sectional autobiography. The students should be encouraged to describe all important areas of their lives, including problems that concern them, and relating these to the disease and its implications. It is helpful to make specific suggestions to add details about family relationships, work, finances, religion, recreation, future plans, attitudes about dependency, etc. Occasionally a student may find it too threatenting to consider the issue of his or her own fatal illness. In such a case it may be desirable to offer the student the option of developing an imaginary case description if they are in considerable discomfort about the autobiographical approach.

The anonymous cross-sectional autobiographies are then redistributed to the class. Each student receives an autobiography from an unidentified fellow student of the same sex. This information is used to play the role of patient. Half of the class is assigned to be the "counselor," and half "patient." It is important to emphasize the need to "get into" the role of counselor, establish rapport, and develop the relationship toward the goal of understanding the "patient" and his social and emotional troubles.

Students who are playing the role of patient should be encouraged to improvise when there is not enough detail in the autobiography distributed to them. In the next class session, students change partners and reverse roles. Careful matching of "patient" to interviewer will avoid problems that could arise if students receive their own or their interviewer's autobiography. It is generally better if students are asked to find a private place, outside of the classroom, to conduct the interviews.

Finally, the "patient" is asked to write a frank evaluation of the strongest and weakest points of the interviewer. This provides feedback to the student interviewer, and useful group discussion about the interview experience tends to follow. Additionally, of course, each student is asked to complete the tasks spelled out in the self-instructional unit. This can be done in less than one hour. The interviews themselves usually require an hour or a little longer. The instructor may want to request that interviewers prepare a "case report."

Note that the pre-test section of the self-instructional unit is intended to orient the student to troubles associated with illness; it is not intended as a research tool.

The Self-Instruction Unit

INTRODUCTION

The following unit is designed to help you "get over the hump" as you begin to help patients deal with the personal troubles that come along with their illness. It is intended to help you to look at yourself and your ideas about sickness. It is mainly intended to help you get started to identify the problems which your patient may have in getting along with his illness. From time to time you will be asked to complete brief exercises and do some thinking for yourself. Please complete each exercise before going on to the next section. Do the Pre-Test now.

PRE-TEST

The following is a list of problems which have been known to trouble patients who have a catastrophic illness. (One which could cause them to die.)

You may regard some to be serious problems and others not to be serious at all. If you think a problem is not serious or that an issue does not really come up, mark it at zero per cent (0%). For example:

a. Are patients troubled because they don't know how to order breakfast?

0% |—|—|—|—|—|—|—|—|—|— 100%

If you think a problem is serious but comes up only in 10 per cent of patients or less, put a mark in the first segment of the line. If you think a problem comes up with ten to twenty per cent of patients, put a check in the second segment (10% to 20%)—and so forth.

1. Are the patients troubled and upset about undergoing tests, procedures and therapies?

0% |—|—|—|—|—|—|—|—|—|— 100%

2. Are patients concerned about losing their active role in life, like their ability to work, travel, take care of children or other responsibilities?

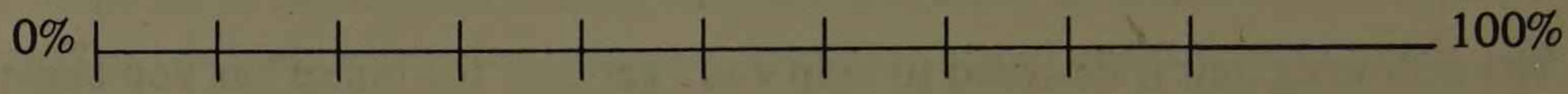
0% |—|—|—|—|—|—|—|—|—|— 100%

3. Are patients upset about being a burden on family, friends or others?

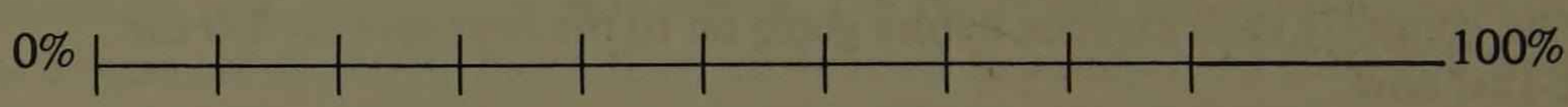
0% |—|—|—|—|—|—|—|—|—|— 100%

4. Are patients concerned about money issues, such as paying for medical care,

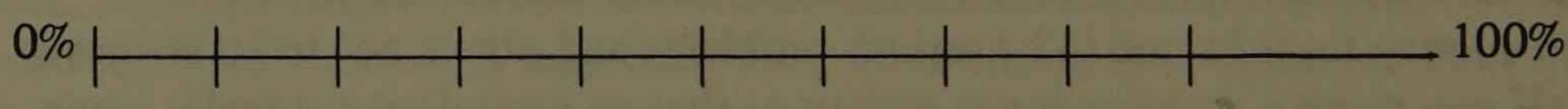
insurances, medicine, or providing enough income to take care of family and other responsibilities?



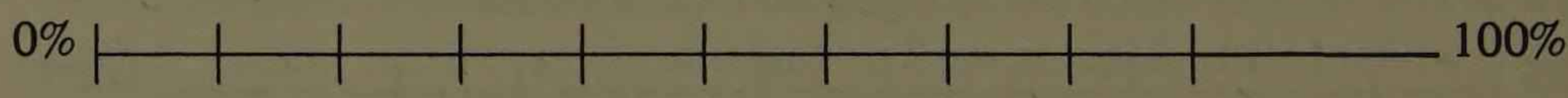
5. Are patients concerned that important relationships with others will be jeopardized by changes related to their illness (for example: changes in sexual performance, ability to join in shared activities) or concerned that already unstable and poor relationships will get worse?



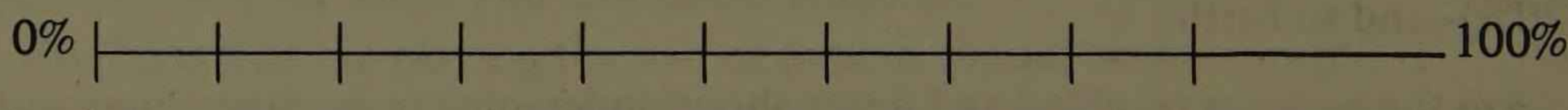
6. Are patients concerned that others are patronizing toward them, that others are too cautious or protective toward them, or in other ways make them feel "different"?



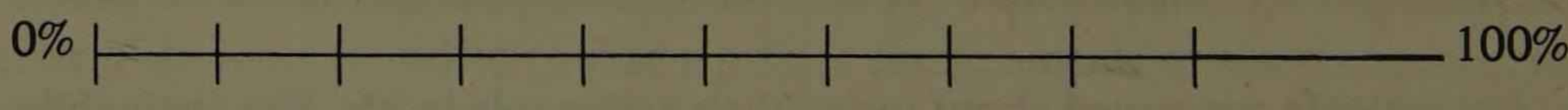
7. Are patients troubled about causing sadness, worry or guilt in family members or those who they are emotionally close to?



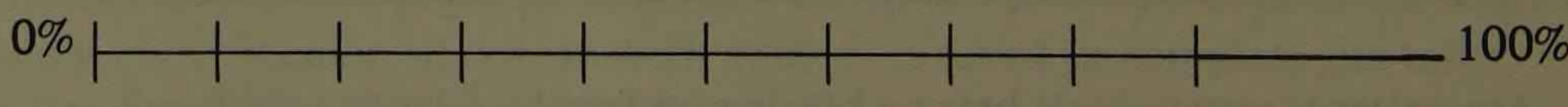
8. Are patients concerned that they may not be adequately cared for when they are sick, or that their basic needs (foods, medicine, nursing care, shelter, etc.) will go unmet?



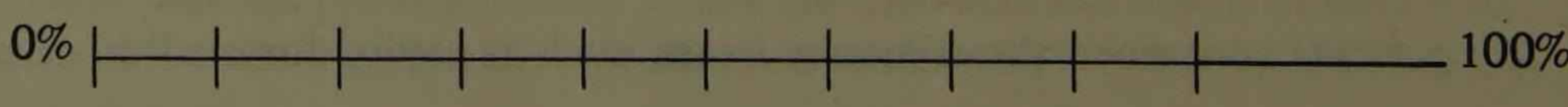
9. Are patients concerned that they will be lied to or that they will not be told all of the important facts about their situation?



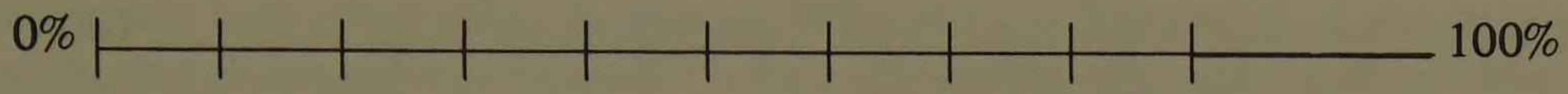
10. Are patients troubled by the feeling that there may be no good times ahead for them?



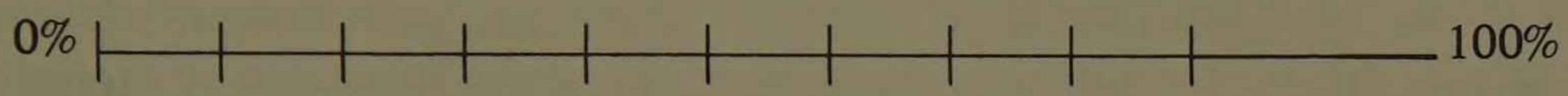
11. Are patients concerned that their doctors may not be competent, that they may make a mistake or fail to understand what is wrong with them?



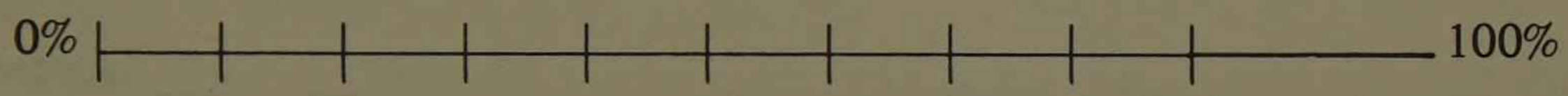
12. Are patients troubled that, as they look over their life, they feel it has been a failure, worthless or without meaning?



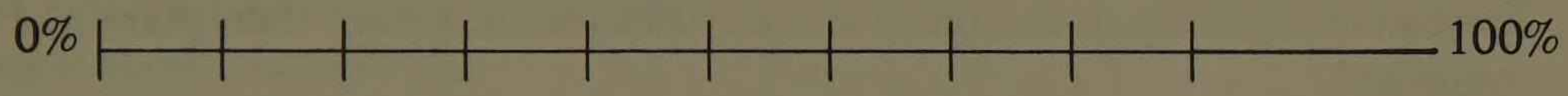
13. Does the idea of being in the hospital and away from their familiar surroundings trouble patients?



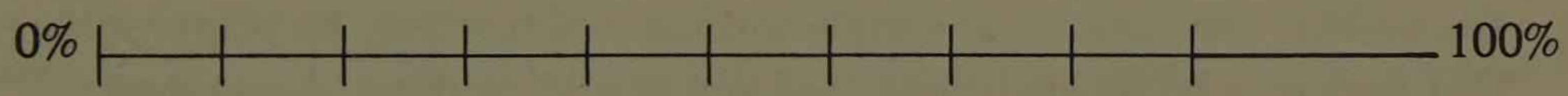
14. Are patients concerned that their illness causes them to be isolated and cut off from others emotionally or physically?



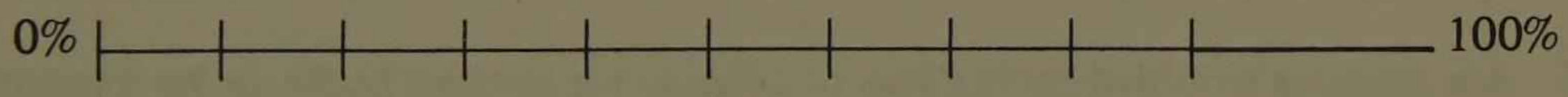
15. Are patients concerned that they *will* get well again and have to go back to the way things were before they were seriously ill?



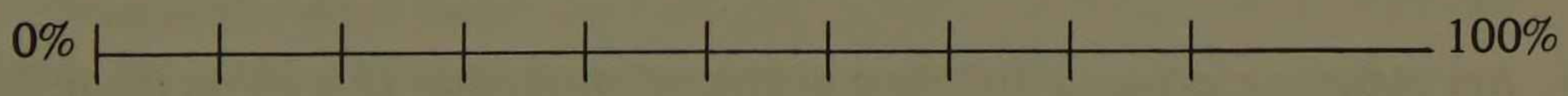
16. Are patients troubled because they feel responsible or to blame for their illness?



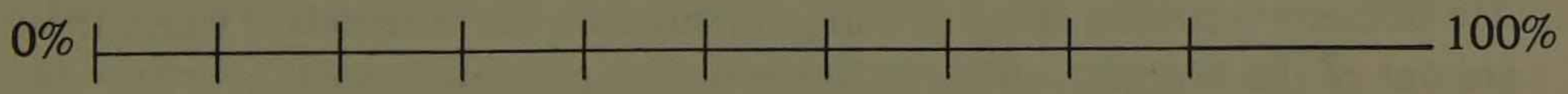
17. Are patients concerned about being unable to provide for their family if they do not survive?



18. Are patients concerned about the loss of independence and that they have to rely on others?



19. Are patients concerned that they will not be treated as an individual; that their personal feelings will not be taken into account, or concerned that they are regarded as a guinea pig?



20. Are patients concerned that they may soon die, either because of worry

about the experience of dying itself, or worry about non-existence or punishment in the here-after?

0% ——————————— 100%

21. Are patients concerned about the changes in the appearance of their body, because of surgery, major loss or gain of weight, or other changes in the way they look to themselves or others?

0% ——————————— 100%

22. Are patients concerned that their situation may be much worse than they realize, and fear bad news?

0% ——————————— 100%

23. Are patients troubled because they can no longer be in full control of their life because their illness demands that they go through hospitalizations, treatment regimens, tests and other activities that interrupt their plans and routines?

0% ——————————— 100%

24. Are patients concerned that their emotional reaction may be inappropriate. That they may be wrong to be so sad and tearful, nervous, demanding, angry, fearful and so forth?

0% ——————————— 100%

25. Are patients troubled by the loss of confidence in their body, or by a point of view that their body is in a revolt against them?

0% ——————————— 100%

26. Are patients concerned that their doctor or others may give up on them, consider them hopeless or in some way cause them to feel abandonment?

0% ——————————— 100%

27. Are patients troubled about getting nursing care for themselves when they are out of the hospital, either at home or in a nursing home?

0% ——————————— 100%

It may be mildly frustrating to learn that there is currently no way to determine whether you did well on the foregoing test. While some of the problems you checked cause serious troubles for sick and dying patients, we can only guess how often this may happen. What is more frustrating–so far as predicting problems is concerned– is that one patient who has a problem may regard it as serious while another who has the same problem may regard it as trivial.

Going through the experience of dying is likely to cause people quite a lot of trouble, inconvenience, and worry. Patients, like the rest of us folks, are about as likely to be concerned about one important thing as they are another. In order to understand which difficulties are troubling any particular patient you have to be with them, talking, listening, observing. It is easy to assume that because a patient knows that he has an incurable disease that he is mainly worried about dying. It is natural for you to assume that the patient who has a fatal illness is worried about the same thing that would trouble you if you were dying with the disease. That is probably not the case. If the patient's problems with his disease were the same kinds of problems that you would have, then it would not be so very important to talk to him about his difficulties in order to understand him. If you want to communicate with a patient, you have to understand *his* point of view about his situation.

EXERCISE

List six problems which you think would be most likely to trouble you if everything in your life was as it is now except that yesterday you were told you have Stage III Hodgkin's Disease.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Now in the space below rate your six problems from one to six with one being the most important to *you* and six the least important.

Do your rating this way: If, for example, the first problem you listed is one of of the least important to you, then you would write something like; 1. = 6. If it was the most important you would write; 1. = 1.

Do your rating on this sheet because next I want you to ask a fellow student or someone else around here to rate the importance to *them* of the problems you have listed, so keep your ratings to yourself for the time being.

1. = _____
2. = _____

3. = _____
4. = _____
5. = _____
6. = _____

Ahah, did you rate them? Now, ask someone else to rate the importance of your list of problems to *them*. At first you should not let them know the way you rated the list of problems. After they do so compare your ratings together. Discuss your reasons for agreeing or disagreeing with each other.

(Note: If there is no one around here you feel you want to rate your problems then I suggest you ask your mother. Mothers are usually very nice for that sort of thing.)

As you were making the list of problems you thought would most trouble you, did you notice that it was not so much fun to think about your Hodgkin's Disease? Lots of patients feel the same way, so if you only ask them to talk about their *troubles* they don't always like to do it. It is usually much easier to talk about work, family, fun, hobbies. Talking about these kinds of things is a lot better way to get acquainted with someone than talking to them only about their miseries. You need to develop a trusting relationship with a patient before he can tell you how he really feels. If you were going to talk to someone about the problems of your Hodgkin's Disease and how you feel about it you would probably like them to get to know you some first.

Look at your list of problems. Why did you pick these instead of some of the other problems you can think of? The uncomplicated answer to that question is: These problems have special importance to you because you are the special person you are. They feel right for you. When you get to know the way your patient's life has been going you can begin to see *why* their disease causes their special troubles. Other peoples' problems are exactly appropriate for them. Imagine whether your worries about your Hodgkin's Disease would be different if:

1. You were twenty years older or younger.
2. You got a divorce last month.
3. Your brother also died of Hodgkin's Disease last year.
4. You were poor.
5. You were a millionaire sweepstake winner.
6. If your Blue Cross had been cancelled.
7. If you also had just learned that your two-year old son was severely mentally retarded.
8. If you were whatever sex you are not.

I hate to leave such an interesting topic, but let's stop talking about you for a minute and talk about me. What are the main points I have been making? (Before you turn to "The Convenient List of Main Points I Have Been Making" which follows, try to write two or three you think I have been making!)

A Convenient List of the Main Points I Have Been Making

1. There is considerable likelihood that the patient who is dying with a chronic fatal disease does not look at this situation in the same way you would.
2. If you want to understand his point of view about his illness, you have to talk with him. You have to develop a relationship. (These usually occur together.)
3. Talking with a patient about his life in general rather than just his problems is a good way to form a relationship that will help you understand each other when you get around to talking about the trouble of his disease.
4. The troubles that dying patients run into are not just related to their disease. Their trobles are related to all the important issues in their life.

It would be interesting to me to know whether the main points *you* thought I was making are the same as the main points *I* thought I was making. I don't want to grade you yet, but leave your main points on the work sheet so we can both see how we are doing.

GETTING STARTED

If you have not talked to a lot of people who have a serious illness, there are a few ideas that can make the experience easier for both of you. For example, pick a time when your patient is not having severe pain, nausea, etc. You will like each other better if you are both comfortable. Explain exactly why you are there.

Can you answer the following questions?

1. How do I start?
2. What do I say?
3. Why should this patient talk about himself to me?
4. What if he cries or gets upset or angry?
5. Will I make him feel worse?
6. Will he make me feel worse?
7. What am I doing here!?

If you cannot answer these questions, do not pass go, do not collect two-hundred dollars. Read the next section.

When your new patient seems not too talkative, a question such as, "What do you understand to be the matter with you that causes you to be in the hospital?," can be a good one for openers. You are not so interested in the specific answer as you are in the topic. Probably the only person more interested in that topic than you is the patient, so it is often a good way to get the ball rolling. Patients usually have a lot to say about their experiences with their disease. Talk about when it started, how they noticed it, what the doctor told them, what treatments they had, what they expect from it, what they call their disease (cancer? a tumor?), and so forth. If you have to do a medical history,

this information will be useful anyway. If you stick with it a while patients get the idea that their illness is important to you. They usually like that, and already you have a basic issue on which you agree. Feel free to be sympathetic and understanding. Throw in at *appropriate* moments comments such as "That must have been tough" or, "That would have made me mad, too." Patients often appreciate it and it makes them feel closer to you. The alternative—not to be sympathetic—does not seem worth considering.

It also makes sick people feel more relaxed and comforted if you touch them. Handholding is pretty asexual when one is sick. It is also appropriate to touch children and old people, but if you do it much to other nonsick people who you don't know too well they tend to act odd about it. Handholding works best when patients are talking about things that make them feel like crying or when they seem to need affection.

You may have some concern about boldly intruding on people's private lives by asking them a lot of questions about personal matters, things like, "How do you get along with your wife?" or, "Have your bills been getting behind since you have been sick?" It would be out of place if you were asking because of personal curiosity, but you should ask these kinds of questions because you need to know how their life is going in order to form strategies to help them. I would like to give now the rule of thumb that, "The better you understand the patient's situation from *his* point of view the better will be the rapport in your relationship."

(Rules of thumb are likely to be true in more than 6 per cent of cases and therefore, make excellent digital computers.)

Talking to patients about the relevant personal circumstances of their lives usually causes them to feel that you are really interested in them. They like that. It also can offset the impersonal nature of most hospital experience. Nobody likes to be a case number.

When patients start to talk about emotionally loaded things, things that are sad, frightening, or make them feel guilty, or angry, you may notice a temptation to change the subject. If you feel the inclination to pull back, if you are tempted to avoid emotionally loaded issues, the chances are you feel either:

1. that they cannot deal with talking about emotionally upsetting issues, or
2. that *you* cannot deal with talking about emotionally upsetting issues, or
3. both of the above.

Patients are usually a lot tougher than we think they are. Their problems and hardships are their own. They are familiar with them and they can tell you what things are troubling them without falling into the depths of depression and despair. Often talking about things that worry them can make troubles seem less frightening and hopeless. Words have a way with people.

If you feel that some issues are too difficult or too delicate to discuss, then the patient will soon feel the same way, too. If you feel that you will mishandle

the situation, that you will damage the patient and your relationship together by saying the wrong thing, you are probably wrong. After all you are in this business because you are interested in helping people. Remember? That's how you got into this mess. This like any other relationship you have been in. If you fail to find just the right thing to say, you get a chance to fix that up the next time you see your patient. You have the big advantage that the patient already knows that you are in the business of helping him. By the "Rule of Placebo Benefit" almost anything you do will prove to be helpful at least 33 per cent of the time because the patient expects that it will be helpful.

There is no rush, take it easy. Your patient has probably had his problems for a long time before you arrived. The most common mistake you are likely to make is to give in to the temptation to leap in and solve a problem for a patient too soon, before you agree about what the problem is and which would be the right solution. Don't plug in your solutions until you see how the rest of his life fits together. Premature efforts to solve problems are usually calculated primarily to make yourself feel better. A more effective approach to dealing with your bad feelings is to:

1. (Very discreetly) sob into your hanky when no one is looking.
2. Go find an attractive member of the opposite sex and invite them to have coffee.
3. Talk to someone around here who has been through the experience.

Feeling bad some of the time about other people's troubles is one of the occupational hazards of this business. It is allright if the patient notices you feel bad about him, so long as he doesn't have to help you deal with it. Patients can get into very serious trouble with the American Psychological Association for practicing psychotherapy without a license. So long as you keep in mind that, for this moment, your patient comes first, things will probably be allright.
The preceding section includes at least thirteen humanistic, homeopathic hints to help you get a handle on talking to patients. They are listed in abbreviated form on the next page. Before turning to the next page:

1. List five hints which make sense to you. Read the section again if you had to peek.
2. Think of, and write below, one or two mistakes that you might make yourself if you are not careful.
3. You already knew a great deal about establishing relationships. See if you can come up with two original hints of your own which you think might be helpful to fellow students as they talk to their patients.

Humanistic Homeopathic Helpful Hints

1. Catch the patient when he is comfortable.
2. Tell him why you are there (honestly).

3. Discuss what the patient already knows about his disease.
4. Be reassuring and supportive about the troubles he talks about.
5. Touch patients.
6. Be interested in their life, not just their disease or problems.
7. Don't worry too much about asking personal questions—it's expected.
8. Don't be afraid to talk about feelings of sadness, anger, anxiety, or guilt.
9. Patients are not too fragile to talk about what troubles them.
10. Stop worrying about being stupid or insensitive, your're O.K.!
11. Being a designated helper helps the patient to trust you.
12. Don't leap in prematurely to solve problems.
13. If the patient makes you feel bad notice it, deal with it yourself in the way that suits you—after you leave him.

Pretty soon you will be asked to formulate a list of problems that are presented by the patient who you are assigned to help. The problems you are prospecting for are likely to be medical, emotional, or financial. They may involve home nursing care, control of disease related symptoms, tension in family relationships, or the way the patient feels about himself. Problems which will concern you may have existed before the onset of the patient's disease or they may come up primarily because the patient has become ill. There is a whole symphony of problems which may exist. Fortunately most patients experience only a few serious troubles, but since the possibilities are astronomical your search of their life must be systematic. Here is where your wise professional demeanor, your evident warm regard for the patient, and your winsome smile come in.

If the patient has decided that you are an ally, that you share common goals, and a common enemy (the disease) you're on. If the patient is uncertain of your motives or doubts your benevolence you have to clean that up before you can go on and get into his life. The relationship is your tool and you have to keep it clean or it won't work. Of course, some patients will take a lot longer to check you out than others. Not every patient will choose to be frank and open with you. Your charm, your wit, your warmth, and your wisdom have been evident to all of us since the day you got here. Patients, however, are not always so perceptive. You can't win them all.

The chances are that, (and this may hurt) the patient who refuses to relate to you doesn't give a damn about you one way or the other. It's not that he decided to reject you, but he never considered relating to you in the first place. He does not *really* regard you as incompetent, so your secret is still safe. If you had read the patient's chart carefully, including the nurses' notes, and if you had talked to some folks who know the patient, you would likely have discovered that others had also enjoyed the humbling benefits of this patient's indifference, resentment, and disdain.

If you are the first to encounter these problems, then it makes very good sense to ask the patient what's going on. Since you will probably assume if you are not getting along, there is something wrong with you personally, it may be

hard to convince yourself and the patient that you really want to know what is wrong in the relationship between you. If you do want to know and you can convince the patient that you really do, the chances are he will tell you what's wrong. Patients are usually very honest that way. In general it is better to accept criticism and go on trying to do better than to try to explain it away or justify your actions to the patient. Remember, you are both more interest in *his* problems than *yours*. Anyway, don't worry too much now about your rapport with your patient. The chances are you will get along fine from the start.

Look at your life for a minute, think about the good things that you draw pleasure from. Think about it. The goodies come from;

1. Your relationship with others,
2. your professional performance,
3. your body,
4. your view of yourself,
5. your interests and recreation,
6. your material resources and financial security,
7. your hopes and dreams for the future, and
8. your happy remembrances.

It's enough to make you grin if you think about all those rich, honey-gold, happy resources. A serious, prolonged illness can erode these sources of comfort and pleasure. What emerges instead are the problems you are trying to identify. For the most part patients will tell you what their troubles are in each of these areas if you ask them.

If you think you only half understand what your patient means or why a particular issue is so important to him, he will usually help you if you ask him to break it down. Some ideas are too big to get in your mind all at one time. For example, your patient volunteers, "I am afraid to die." That is too large a problem to manage all in one chunk. You can break it into more manageable pieces by saying something like, "Most everyone would feel that dying is a scarey idea. When you think about dying what part is most worrysome? What ideas are going thorugh your mind when you are thinking about dying?"

They may then talk about being afraid of pain, about leaving their family, about not being able to look forward to enjoying the future or their uncertainties about the hereafter. Some issues like pain, finances or plans to see that their children are cared for, can become part of your problem list to be solved. Others can only become part of your understanding of your patient.

If this approach seems too direct for your style, then you can probably help the patient to narrow and specify the issues by encouraging him to elaborate in more subtle ways. Perhaps an approach you have used in the past when trying to persuade a teacher to describe what he meant by the questions on his final exam will be more appropriate to your style.

Problem List and Treatment Plan

At the end of this section you will be asked to prepare a problem list and an initial plan of treatment for a patient who you are working with. The following kind of note, while characteristically found under the heading "Social History" in many medical records, will not be sufficient: "Patient smokes one pack of cigarettes a day for the past twenty years, had gonorrhea in 1936, admits to being a 'heavy drinker'."

The kind of problem list which you develop should be a product of your detailed understanding of the patient's life history, the problems that existed at the time of onset of his illness and those life troubles that seem to be a consequence of his illness. Often the troubles that occur in a patient's relationship with his family, his financial trouble, or emotional stresses may be more important to him (and to you) than his disease and its symptoms. This should become a part of your general medical assessment. Your strategies for helping the patient ought to be based upon an understanding of the full spectrum of important issues that affect him. Medical problems and other troubles merge in the patient's life and one of your jobs is to figure out how they fit together.

For example: Mrs. G., a fifty-one year old, divorced ex-nurse with breast cancer, came to the out-patient clinic when her left breast had all but eroded away. She admitted it had been difficult to take care of the lesion and tolerate the smell of the necrotic tissue. Her reply to the question, "Why did you wait so long?" was, "I wanted to die and when I didn't, I had to come here." She felt that her fatal disease was of low priority of importance in relation to other problems in her life. Painful feelings of guilt, loneliness and sadness over her divorce were issues which most troubled her.

I would like to provide a check list of points which would guide you as you talk with your patient about the important issues in his life. I would like to do that just to make things easy for you, but, unfortunately, we are all helpless victims held captive by the bell curve. In most respects, the patient who you are about to talk with will not be an average patient. You will have to sort out what it is that makes him different than other patients. That kind of sorting cannot be done in the abstract so, it's time to go see your patient.

If you would like to think a bit more about how to plan strategies for helping patients who are dying and you don't think you are ready to see your patient yet get a copy of the journal article [1, 2] : if you read it, it will shorten the ride home on the bus.

When you finish your interview, make a list of problems which you and/or the patient have identified. (It's all right to make some notes as you talk to the patient if you want to.) You may want to talk to members of the patient's family, his primary physician, nurse on the ward, etc.

You may want to talk to the patient again. As you go along, note each problem as you become aware of it. When you feel you have a complete picture,

review your problem list and number them in order of their importance to the patient. You may have a different opinion than the patient about what importance to place on certain issues. As soon as you can, discuss the problems you have identified with the patient's doctor. When the patient seems to place different importance on one of his problems than you would, discuss those issues in depth and attempt to develop a theory to account for the difference in opinion between you and the patient.

When you feel you have a fairly complete problem list and after you have numbered the problems in order of their priority go back to the pre-test and check in the margin each problem which you think applies to your patient.

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THE USE OF ROLE PLAYING TECHNIQUES AS AN INSTRUCTIONAL AID IN TEACHING ABOUT DYING, DEATH, AND BEREAVEMENT

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ABSTRACT

Role playing exercises are useful in teaching health care professionals about issues related to dying, death, and bereavement. This paper includes examples of role playing vignettes related to attitudes toward death, the dynamics of family interaction in the context of life-threatening illness, the consideration of an ethical issue, displaced anger toward the caregiver, the role of personality traits in adaptation to illness, and consideration of religious issues. The vignettes simulate clinical situations, facilitate observable interpersonal transactions, provide confrontation, illustrate psychodynamic principles and highlight dimensions involved in caring for the dying patient and his family. The exercises allow students to integrate the experiential and cognitive components of the teaching situation. Role playing is particularly useful in teaching a multidisciplinary class, encouraging the reevaluation of preconceived stereotypes, and facilitating the observation and working through of role conflict.

There is now an increasing interest in providing instruction about dying and death for health care professionals. This instruction is a vital part of any medical curriculum which has as its goals the development of the student's sensitive awareness of the numerous psychosocial, ethical, and humanistic

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issues involved in providing care for the dying patient and his family [1]. Our experience in teaching in this area has led us to conclude that in the classroom the topic is best taught through the use of focal presentations followed by extensive small group discussion [2]. The focal presentation concept allows the instruction to be centered on important issues and, when coupled with extensive group discussion, enables students to perceive and manage their own attitudes toward dying and death, to exchange ideas, and to evaluate their transactions with one another in the context of the death situation. This method of teaching also serves to approach the delicate balance of the didactic and the experiential necessary to effectively provide instruction in this area.

As originally described, our course was developed as an elective course for medical students alone; however, in the past two years we have also included student nurses and theology students as participants in the class [3]. We have found role playing to be a particularly useful instructional aid in teaching in this area, especially in the instruction of multidisciplinary student groups. The purpose of this paper is to describe this technique and present examples of role playing vignettes.

Method

Simulated patient care situations were devised to illustrate varying dimensions of caring for the dying patient and his family. Each patient care situation is organized into a vignette with two or more parts. The individual role to be played is typed on a separate index card. Students are asked to volunteer for the exercise. Because role playing exercises have a definite "here and now" quality and are played in the first person, the level of emotional involvement in these exercises has the potential to become quite intense. Therefore, no student is coerced to participate; the assumption of a role is placed on a volunteer basis, and each participant is instructed that he or she might end the role playing exercise simply by stating his desire to do so.

Those who agree to play the roles are assigned their respective parts and asked to leave the classroom and study the card. Role players are asked not to communicate with each other about their assigned parts until the actual role playing exercise begins. While the role players are out of the room, the entire script of the vignette is given to the rest of the class. Thus, while the class is aware of each part in the exercise, the individual role player knows only the part assigned to him. Members of the class are directed to consider how they might differ in their portrayal of the parts. When the role players are satisfied that they are ready to assume the roles, they return to the classroom and are then asked to enact the situation for the class. The interaction

is allowed to continue as long as productive transactions are evident in the exercise.

The following examples of role playing situations illustrate the design of the exercises. The clinical vignettes are designed to initiate and facilitate a number of transactions, provide confrontation, illustrate important psychodynamics, or highlight important dimensions involved in caring for dying patients and their families.

I. A Vignette Designed to Illustrate the Attitudes of Care Givers Toward Death

PHYSICIAN (OR OTHER CARE GIVER): Your patient has widespread carcinoma of the lung and is in a terminal state.

PATIENT: You have cancer of the lung. You feel frightened and ask your physician, "What do you feel will happen next, doctor?" After he replies, you ask him, "What do you feel death is like and how would you react if you were dying?"

II. A Vignette Designed to Illustrate Family Interaction in the Context of Life-Threatening Illness

PHYSICIAN (OR OTHER CARE GIVER): You have a confirmed diagnosis of osteogenic sarcoma of the mid femur in this sixteen year old young man who depends heavily on activity and athletic performance for his sense of identity. It is likely that amputation of his leg will be necessary.

PARENT: You are the parent of this sixteen year old boy. In the boy you see many of the attributes which you yourself have lacked and you experience many of his athletic skills and successes as an important aspect of your own self esteem system. You recognize the potential seriousness of the boy's complaints and disorder and feel driven to know every detail about the disease, its treatment, possible outcome, etc. You are to persistently push the physician for definite answers to your questions.

PATIENT: You are a sixteen year old man whose main interests are athletic. About two months ago you injured your right leg during football practice. Three weeks ago you began to have severe pain in your right mid-thigh area. A swollen area became apparent. You believe that the injury to your leg was responsible for whatever is wrong and feel no cause for alarm. You are considering a career in athletics.

III. A Vignette Designed to Promote Interaction and Discussion Related to Ethical Issues

PATIENT: You are a forty year old married man who has been ill with

chronic leukemia for about four years. Two months ago, you were informed that there had been a change in the status of your illness. You have now been in the hospital for a period of four weeks and have heard the doctors talking about your "low platelets" and the need for repeated transfusions. You and your wife have discussed the situation at length and you are asking that your physician stop all treatment and allow you to die. Your wife has attempted to persuade you to continue to take any treatment prescribed by your physician, but you are firm in your feelings.

PHYSICIAN: Your patient, a forty year old married man has had chronic myelogenous leukemia for about four years. Two months ago he progressed to a blastic stage and since that time, he has rapidly deteriorated. Available data suggests that the patient has not responded to any treatment thus far, however, there is another experimental protocol available to you. He remains alert and without evidence of any organic brain changes. You note that he is depressed in his mood when you enter the room on your evening rounds. His wife has spoken with you earlier that day asking that you continue with any treatment that you feel has even the slightest chance of prolonging his life.

IV. A Vignette Designed to Illustrate a Response to Death on the Part of a Family Member

PHYSICIAN: You have just pronounced the death of the thirty-two year old wife of this man. You have been in charge of the care of the patient throughout the course of her illness (acute myelogenous leukemia). In the past few days you have sensed increasing hostility on the part of the husband. It is now your responsibility to inform the husband of her death and attempt to obtain permission for an autopsy.

PATIENT'S HUSBAND: You are the husband of a thirty-two year old woman who has just died. Eight months ago your wife was diagnosed as having acute myelogenous leukemia. Throughout her illness, you maintained that she would somehow get over the illness and in spite of being told about the outcome of the illness, you have not been able to accept it. Three weeks ago you decided that it might have been appropriate to take your wife to a large and famous clinic, having heard that they had "new drugs" for the treatment of leukemia. Recently you have felt that your wife's physician seems less interested in the care of your wife and you have felt irritated with him on numerous occasions but have not expressed these feelings. Subjectively, you have had the fantasy that he is using "experimental" drugs in treating your wife.

V. A Vignette Designed to Illustrate the Role of Personality Traits in Adaptation to Illness

CARE GIVER: This is a forty-seven year old bank president whom you recognize as self-sufficient and independent. The patient has never been seriously ill and has avoided any type of medical care including yearly physicals. Assume you have adequate data for making a diagnosis of far advanced carcinoma of the lung. The patient is hospitalized and you are to communicate with him about his illness.

PATIENT: You are a forty-seven year old bank president, married with three children, a son age 18, a daughter 11 and a daughter 6.

Your work entails a considerable amount of responsibility and you feel that you are the only one who can do it adequately. In general, you are a highly organized person, independent and have the need to maintain control and order in your life circumstances.

For the past two months you have intermittently coughed up small amounts of blood. When you noted that you were progressively losing weight, you became anxious and consulted a physician. He advised hospitalization and evaluation. At first you were resistant to this and felt this to be simply a bad cold. When your weight loss reached twenty pounds you reconsidered.

Throughout the hospitalization you have been anxious. Your primary concerns have been how your work has gone on without your presence and you have been bewildered by the numerous tests you have undergone. You are a self-sufficient independent person who tolerates the sick role and being cared for poorly. For the most part your perception of your care giver's communications with you are that he tends to be evasive.

VI. A Vignette Designed to Illustrate the Responses of Care Givers to the Introduction of Religious Issues in the Patient's Care

PHYSICIAN: Your patient is in a terminal state with carcinoma of the pancreas. Throughout his illness, he has proclaimed his religious faith and his faith is a most important aspect in his adaptation to his disease.

PATIENT: You have cancer of the pancreas. You have a firm conviction in your religious faith and believe that your faith will somehow get you through this illness. You are curious as to what your physician's religious views are and ask him. Does he share your view about your faith and your illness? What does he see as the role of religion in health care?

VII. A Vignette Designed to Provide Instruction about Some Aspects of Grief

PERSON WHOSE SPOUSE DIED THREE WEEKS PREVIOUSLY: You are a forty-two year old person whose spouse died three weeks ago after an illness

of a year's duration. Your spouse died of cancer of the lung. At the time of the death, you felt stunned but shortly thereafter you began to have long episodes of crying which came in waves. You consulted your physician a week ago because of a persistent dry cough and were told that he could find nothing physically wrong to explain the cough. For the past week you have continued to have the crying episodes, have felt irritable and feel a sense of your life circumstances having a sort of emptiness. Your brother (sister) has been telling you that you should "cheer up" and become reinvolved in your social activities. You have not felt this possible. Finally, at his (her) insistence you have agreed to talk with someone about your feelings. Your brother (sister) is to accompany you to the care giver to discuss your present situation.

BROTHER OR SISTER: Your younger brother (sister), age forty-two, suffered the death of his (her) spouse three weeks ago. Both of you were raised in a household where the expression of feeling was restricted. For the past three weeks, your brother (sister) has been crying intermittently and has appeared irritable. You are unable to tolerate the expression of feeling and have taken a "cheer up" attitude, telling him (her) to immediately become reinvolved in social activities and to "stop all that crying." "Let the dead rest and forget!" is your position. You feel that the least the care giver can do is prescribe anti-depressants.

CARE GIVER: A forty-two year old person consulted you one week ago about a persistent dry cough. In taking your history, you learned that the spouse of the person had died of carcinoma of the lung three weeks ago. Now, the brother (sister) has called you and asked that you speak with the person about their feeling state. During the first part of the interview, you are to see the two together.

Comment

These role playing exercises are particularly useful in illustrating the wide variation in responses and interactions, and the highly individualized combinations of adaptive mechanisms of the dying person, his family and involved caregivers. Students who enact the roles tend to project their own responses and attitudes, and in so doing not only gain insight into how they may respond in a situation, but also come to recognize that there are wide variations in responses and interactions for each situation. Additionally, the exercises facilitate total group interaction and involvement. Other persons in the class, observing the exercises, also have an opportunity to present and evaluate their feelings and responses and to discuss where they differ or agree with the enacted management of the clinical situations. Through these exercises, students begin to learn to respond flexibly in their management of

clinical situations and increase their ability to interact effectively and therapeutically in the context of the death situation.

In actual clinical situations, the instructor cannot always utilize the situation and transactions as a teaching experience, constructively offering comment on the interactions and interventions as they occur. In the role playing exercises, instructors may at appropriate times reinforce therapeutic interactions and point out those interactions and communications which are non-therapeutic. In the role playing exercises, the instructor may also interject relevant didactic material where it is appropriate.

The exercises are also useful in overcoming the tendency simply to intellectualize about the area. The vignettes allow the students to integrate the experiential dimension of the interactions thereby usefully combining the cognitive and affective components of the teaching exercise.

While the role playing exercise forcefully and convincingly presents a here-and-now, first person, enactment of the situation, it is still considerably less threatening and less anxiety evoking than the actual clinical situation. Even though there is strong projection of the individual into his role, there is always the safety valve of the student's being able to recognize that it is not in reality the actual situation. The anxiety related to the situations may thus be dealt with in the classroom setting in a constructive manner prior to involvement in actual clinical situations. Initial awkwardness and self consciousness, often gives way to meaningful, honest and moving interchanges between participants.

These exercises are particularly useful in teaching a multidisciplinary class. For example, in classes of medical students, nursing students and theology students, some of the vignettes may be enacted more than once with representatives from different disciplines acting the caregiver role in the exercise. When enacted with various caregivers representing different disciplines, the interaction serves to illustrate the subtle differences in attitudes related to the individual's discipline.

Students from one discipline may also be requested to enact the role of the caregiver from another discipline. In this variation of the exercises, the role of the nurse may be played by the medical student, the role of the chaplain by the nurse, and the role of the physician by the student chaplain. Other combinations are obviously possible depending on the disciplines represented in the group. This method is particularly useful in illustrating the presence of preconceived stereotypes, role conflict, hierarchal difficulties and communication problems among caregivers from various disciplines. The method offers an excellent opportunity to correct many of the misconceptions about the duties of various caregivers in their care of the dying patient and his family. Stereotypes emerge in bold relief and may then be reevaluated by the students in the process of the interaction and the discussion.

Communication patterns which are disruptive may be worked through and improved as the role players learn that they must communicate effectively in order to provide effective care for the individual. For example, students quickly learn that discipline-related jargon significantly interferes with effective communication. Also, the exercises underline the universality of many aspects of dealing with dying patients that cross traditional professional lines, and the potential for a collaborative, cooperative and mutually supportive team approach to the care of the dying patient is maximized.

In the vignettes included as examples in this paper, attitudes toward death, the dynamics of family interaction, the consideration of an ethical issue, displaced anger toward the caregiver, the role of personality traits in adaptation to illness, consideration of religious issues and aspects of bereavement are delineated as areas for role playing interaction. These are only a few of the possible areas around which these vignettes might be constructed. Instructors may utilize vignettes which relate to caregivers informing the patient and his family of the diagnosis and prognosis of a life threatening illness or construct a vignette in which the family requests that the patient not be informed of his illness. Vignettes which incorporate a wide variety of ethical issues encountered in the area of the management of life threatening illness and others which deal with disruptive interpersonal behavior interfering with treatment or disrupting the caregiving milieu may be developed. Other vignettes might relate to the management of dying children or the elderly patient.

Role playing exercises thus offer an effective classroom method of providing instruction in this area. Through their use, instructors in the area of dying, death, and bereavement can provide the student with useful learning experiences, allowing them to participate in various transactions which may occur in actual clinical situations, emphasizing important issues in caring for the dying, assisting the students to begin to understand and manage their own attitudes toward various matters involved in caring for the dying, developing flexible approaches to the situations encountered and learning more effective means of utilizing multidisciplinary approaches to caring for the patient and the family in the context of death.

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LIVING EXPERIENCES WITH DEATH—A JOURNEYMAN'S VIEW THROUGH PSYCHODRAMA

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ABSTRACT

The psychodrama processes offer a valuable and flexible approach to death education. Basics of the psychodrama technique are presented and discussed. Techniques and concepts of particular relevance to death education are described, along with a variety of experiences that have been gained with them. Action therapy in the group setting can help people come to better terms with past death-related experiences, and also relate more adequately to future experiences.

"A dying man needs to die as a sleepy man needs to sleep, and there comes a time when it is wrong, as well as useless, to resist."

Stewart Alsop

It is not a uniquely human experience to die, but it is only human beings who are able to observe and contemplate the significance of their own death. This particular insight is really of limited value, however, unless the human being becomes sufficiently open and allows himself to achieve an adequate adeptness in his uses of this new understanding.

Death and the Social Atom

Recently I shared the experience of dying with a close friend, colleague and teacher, J. L. Moreno. For eight weeks I shared in meeting friends and colleagues from all over the world who had come to say goodbye and to continue friendships or mend negative interactions. He did not want anyone who he could

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reach to suffer from his death, nor did he want to die any way but in his own kind of peace. He initiated some overtures to frank discussions of his dying and living. With his wife Zerka he relived their meeting and their sharing. He even suggested she come lie down and die with him. Zerka told him she could not do that, but if he led the way she would follow. With his son Jonathan and his daughter Regina he spoke of his illness, his grandchild, and continuance of life; with his nurse and physician he talked of his illness and of old times; with Anne Schutzenberger of Paris, France and Gretel Leutz he spoke of their times together in Europe and the United States and they sang and read poetry; with Ann, Mary Ellen and me he fought, kidded and loved; with my nephew Robby he wished him the future and patted him on the cheek; with my friend Jane he made a new friend; with my sister Toni he adopted her as his sister. He also established continuance and the opportunity for each of us to share our feelings and our fears. With some he sang and listened to poetry, with others he re-established his love feelings, and in doing so he was never alone, nor were we. He did not want either his family or friends to feel a loss, to feel resentment, or to feel bitter. He treated his death as he treated life . . . as an aggressive adventure. His dying was a psychodrama, a sociodrama and involved a great deal of role playing.

In "Sociatry, the Social Atom and Death" Moreno defined the social atom as the smallest social unit existing in society, composed of individuals, near or distant, related or unrelated, who are emotionally related to the individual [1]. The members of the social atom may change from time to time; members leave to be replaced by others; but a basic consistency remains. As we grow older, replacement of significant members becomes more difficult as we become less outgoing and resilient, and the social atom tends to shrink in size, casting a shadow of social death long before physical or mental death. The death of one, therefore, connects with the death of many others, and we can observe the sometimes accelerated or premature death occurring when an individual is not able to replace members within his social atom. He felt that a "new breath of hope should come to geriatrics . . . from the recognition that we do not live only within ourselves but that there is a 'without' of the self which is highly structured and responsive to growth and decay."

The Psychodrama Process[1]

The psychodrama process to me is very exciting. It is simple and flexible. Psychodrama is a form of action therapy, action training, enactment or re-enact re-enactment of situations that are of emotional significance. "The fact that it involves the body makes it already the most universal of all ways of

[1] If we herewith refer to the use of *thanodrama* to include action training, education and therapy in the field of death, dying, terminal care, suicide, the theater of death, celebration rituals, etc., it might be a better term to use than psychodrama *per se*.

communication. Going above any language barrier, it widens the spread of links between races, countries, social or intellectual levels. Psychologically, it involves the deepest language, one antedating verbal communication in the infant's development, the body language" [2].

Psychodrama is one of the most positive means and ways to explore in the field of death and dying. What might be frightening in real life (dying, having a heart attack, failing a patient, telling a member of the family) can be releasing when dealt with in a safe group setting that is characterized by a blending of emotional and intellectual learning and sharing. Encountering a difficult situation or attitude with other members of the audience helps both the individual and the group digest and work through the feelings presented. It also provides an opportunity through role reversal or watching someone else play your role to develop an observing self, or a more objective viewpoint of how you are coming across, how you might better communicate in the situation.

Psychodrama can help to develop a sense of competence and personal growth through the very fact that a person is able to participate—that he exposes personal feelings and situations, overcomes his fears and actually acts *through* a situation. It helps to overcome anxiety over self-exposure, and inadequacy by asking the person not only to step in front of the group and talk about his problems, but to act upon them and be applauded for it. It gives him an honest and shared personal reaction from the group during the feedback portion of the session. And, perhaps most important of all, psychodrama imparts the feeling of not being alone without resources to effect relief or change. Instead, the individual experiences himself as a member of humanity at large with a surrounding group of empathetic, supportive and loving others with whom to share frustrations, griefs, joys, hope and fears.

Psychodrama is a method of learning through the spontaneous enacting of situations. It is both social-emotional and task-oriented, and it may give rise to the elimination of undesirable behavior of the development of new behavior. In a broad sense, the term includes a battery of skills, techniques, processes and forms involved in an action method which focuses directly on role playing. The scenes that are played out may either be planned out in advance, spontaneous, or a combination of the two. It concentrates on developing spontaneity and social learning and permits communication on an action level with insight for both protagonist and group members, as well as the director, with feelings and images surfacing quickly.

In this article, I would like to share with you a journeyman's experiences in using psychodrama, as well as defining some of the techniques and the method, which can be used universally. For the use of these methods and techniques with other strangers will help reinforce that each man is the therapeutic agent of the other, and that a new awareness of death and direct confrontation will help us to draw our own conclusions.

Structured and Spontaneous Role Playing[2]

Role playing methods used for education, training and research may be to explore and evaluate interpersonal behavior in the form of spontaneous role playing; or to develop patterns of "how to" handle situations constructively in the form of structured role playing. The basic objectives of structured role playing typically focus on making the individual more proficient in some area of his work or job-related skills. The basic objective of spontaneous role playing is to help the individual to understand himself and others better, as well as to explore new approaches in dealing with problems or human relationships. The following basic comparisons are outlined in Table 1. There are various applications of role playing which depend on the objective of the situation. The objective of a role playing situation ranges from evaluation and preparation of action to diagnosis and application of change in behavior.

THE INSTRUMENTS OF PSYCHODRAMA

There are five basic instruments used in any psychodrama session:

The action area – a space for action large enough to permit some freedom of movement; to include chairs and table; with freedom of access for group members to and from the area. This action space at times has been a cemetery. It may include some "props"–stethoscopes, clip boards, caskets, flowers, candles, religious ritualistic items.

Table 1

Structured Role Playing	*Spontaneous Role Playing*
1. To develop training in human relations.	1. To aid participants to achieve insight into their own behavior.
2. To teach how to handle a specific situation correctly.	2. To aid participants to achieve insight into the behavior of others.
3. To prepare for taking anticipated new roles.	3. To modify attitudes related to self, family or social life.
4. To effect an attitude change.	4. To aid in achieving new ways of dealing with problem situations.
5. To improve a present role and develop insight into the role of the other.	5. To develop diagnostic information concerning the style and approaches of participants to certain types of problem situations.

[2] This distinction has been made independently by Mal Shaw, Hannah B. Weiner, and Anne Schutzenberger.

The director – The role of the psychodrama director is an art in itself which requires training, as well as intuition, a clear sense of purpose, and an ability to improvise and see that covert meaning behind the act, and creativity to handle the warmup and keep the emerging drama flowing by means of the various psychodramatic techniques. The director guides the flow of the drama, suggests role reversals, handles resistance, interprets when necessary, holds the group together if friction seems to be rendering it, lends support during difficult periods, and guides the drama to its conclusion. The session is only a frozen moment in the life of the person. The true psychodrama began before the session and will continue after. The director of any session develops his own style. It should be *in the moment* and natural. In the structured role playing sessions, the role of the director is less exacting and more ritualistic. The basic functions of the director include:

- planning the session to include the needs and interests of the group or individual,
- introducing the episode informally and enthusiastically,
- recruiting the players and making them feel at ease in the situation,
- setting up the episode and helping the group decide upon its goals,
- getting the actors into role and helping the audience decide upon their part in the episode,
- swinging the episode into action,
- watching for members who fall out of role and helping them regain roles,
- cutting and re-casting the scenes,
- watching for sensitive areas for individuals and preventing over-exposure,
- bringing out the aims of an episode and questioning the players to emphasize certain points as necessary,
- cutting the scene, helping the actors step out of their roles, and re-establishing them in the group,
- helping the group discuss the episode or replay it,
- conducting a post session evaluation by providing reaction sheets or an open atmosphere for discussion,
- fully understanding the topic sensitivity of the person,

The protagonist – is the individual who, is chosen by both the group and the director to present his problem situation in the enactment portion of the psychodrama to be experienced. He enacts or re-enacts any scene that *he* considers to be important–past, present, future or fantasy. He is given freedom of expression and instructed to act spontaneously and not worry about the exactness of what happened or might happen in the situation. The director may make suggestions into which areas to move or explore, but the final decision is left to the protagonist and his autonomy is respected at all times. In selecting a protagonist, the director takes into consideration the needs and interests of all

of the members of the group as if he is not a majority choice, the group may not wholeheartedly participate, creating unfairness to the protagonist.

The auxiliary ego – The auxiliary egos are the supporting players who portray absent members in the enactment episode. These auxiliaries may be part of the directorial staff or chosen from the group members. The auxiliary ego represents the various non-selves in the drama. By demonstrating less fear and inhibition in expression of intense feelings, they can infect the protagonist with the same freedom, enabling him to take direct action and increase his reintegration and learning.

The group – Members of the group are involved in the session as actor-observers. They are continually trying out their patterns of behavior with the other members of the group. All action and all situations are products of the group–for the protagonist the problem and problem solving devices are within the framework of the group itself. The role taking ability of individuals in the group depends upon their interest in the action and their ability to empathize. The function of the group is to produce a situation, a principle subject, substitute players, and analysis and support of the role playing episode.

THE PHASES OF PSYCHODRAMA

The warmup – is the initial phase of any psychodrama session when the participants, the director and the group prepare for action. They become acquainted with each other; respond to each other as social stimuli; discover, select and understand the situations to be explored. Varied approaches are used to create a common interest and feelings about the problem under consideration and to encourage the group to discuss their own experiences. Some of the techniques leading to choosing the problem and encouraging the spontaneity of the protagonist:

- Video-tapes, slides or tape recordings centering around a problem or theme
- Prepared scripts with simple questions such as "Where are you now?" or "What happens from this point on?"
- Game-like warmups
- The group listing their problem areas or arriving at them through group discussion
- Participants may be warmed up through their agreement to assist in an experiment
- Self warmup to a specific issue
- Through the director asking an individual or the group at large what they would like to do or see portrayed

- The director may simply present a problem or role playing prepared skit[3]
- Through a reluctant approach where the director appears to refuse to direct or states negative feelings about running the session
- Director may simply choose one member of the group to present his problem
- Through frustration where the director overtalks to the point that the audience appears to take over
- The lassiez-faire approach where the director takes a non-directive approach and acts as a catalyst.

The enactment – After the warmup has taken its effect, the group members are ready and encouraged to illustrate their feelings, ideas and approaches to the problem under consideration. The protagonist is brought to the action space. This begins the role playing enactment phase. He acts out the situation with group members serving as resource person, either as participant observers or auxiliaries in the session. He may be permitted to "soliloquize" for a period of self-presentation, but should be brought to focus on an actual, concrete situation. Action takes place in the *here and now*. Even if the protagonist is enacting a scene from the past, future or fantasy, he is instructed to project himself into the role he is living at the time.

The sum up or post session analysis – is a form of closure in which the group is asked to discuss their reactions to the performance and their identification with the protagonist. Criticism per se should be avoided. The group might be asked to offer alternative approaches to the solution of the situation. Discussion is kept as objective as possible. It is necessary to sum up the feelings and reactions of group members involved in sessions to eliminate the misunderstanding of roles and to create understanding through identification. The director should use this portion of the session constructively to eliminate the tendency on the part of the group and the supporting role players to criticize the protagonist and also assist the protagonist or the auxiliary egos to "get out of" role and stabilize their personal identity to themselves and to other group members.

SELECTED TECHNIQUES FOR DEATH EDUCATION

The double – is an auxiliary ego whose function is to be (a) voice the unexpressed thoughts and feelings of the protagonist, (b) assist in establishing

[3] If preparing role playing skits, please remember that you should take material from a number of sources following the covering points: comprehensibility; identifiability; role maneuverability; conflict; focus. For example, a doctor telling the woman of the family that she has cancer when her husband doesn't want her to know; making a will, etc.

the identity of the particular role or role player and (c) challenge actions and behavior of the protagonist with such phrases as "Why do I do this?" One of the principle functions of the double is to bring out ideas and feelings which might otherwise be overlooked. The double may be another part of the individual, a coaching double, or there may be two or more conflicting doubles.

The technique of the double is extremely important in training to help set the stage. At St. Lukes Hospital in New York, for example, Dr. Samuel Klaghorn trains physicians and other medical staff in a death awareness workshop by asking for a volunteer from the group to play the part of the dying patient. He then walks around as a coaching double with the "dying patient," assisting him to get into role by telling him (as the double) how he is feeling; what kind of pain he has; the progress of the disease; and the prognosis—he sets the role on a depth level. When the "patient" fully feels he has an understanding of the role, he is asked to select his own family from the group members and the role plays involve things that go on with the family and between the doctor and the patient.

Another use of the coaching double and proding double can be illustrated in a different kind of training session involving two brothers from the same family. Their father was dying of cancer of the pancreas. The older brother brought his younger brother to provide him with an opportunity for experiential learning. The younger brother chose a tall, gaunt man to play his father—the hollows of the man's cheeks even looked skull-like. He set up the living room of his house and had the man lie down on the couch with his mouth slightly open and his eyes closed. We had the young man (with his older brother as his double) enter the room and begin to soliloquize about how he was feeling inside. He said "Oh my God, he looks like he's dead. I'm so afraid whenever I come into this room that he's dead." The instructions to him were to do with this father what he felt he couldn't do with his own father. He picked up his father and shook him . . . "Are you alive?" (the man playing the father just stared). He held tightly to his Dad and began to cry . . . begging his father not to die . . . telling him how much he needed him . . . sharing all the fears that he had; at the same time holding him very tightly as if trying to get the life from his own body transferred over to his father. He talked to himself (with the aid of his brother) about the concers for his mother; concerns about his own independence and his own attempt at living. A few days after this session, the mother, father and two boys sat down and talked about the father's fear of dying. Without the help of the session the two boys felt that they could not have been as supportive but would have been more alienated and fearful. In this case the double acted out the rage and it could be shared, resulting in a cathartic learning. The "real suffering" is tackled and not avoided. The "dying patient," or survivor is never alone in exploration of death while the double is present—it is a good tool for de-alienation.

Role reversal – This takes place when the role players exchange roles. The director asks the role players to change positions: A become B and B becomes A.

This helps sensitize the principle player and auxiliary egos to their own roles, the situation, and the role of the other player. It provides the opportunity to show A would like B to treat him. For example, nurse and dying patient; or dying nurse and patient; father and son, etc.

Surplus reality – A technique in which various roles are extended, intensified or over-played, it is used to increase and expand the reality impact of a session. It is an opportunity for the individual to re-experience a difficult situation but with a "second chance" to "correct" his reactions and feelings and thus eliminate or minimize the trauma. Parents and other loved/hated individuals who have died can be brought back to life for a confrontation, guilt out of a ritualized role presentation becomes a healing moment. (Hallucinations are brought into focus–trips to heaven, a rebirth after death, the doctor becoming the patient).[4]

Soliloquy – is an aside from the action in which the protagonist expresses his covert feelings: "I feel nervous." These asides may either be a part of the enactment and in a continuous flow or the action may be stopped while the protagonist expresses his feelings and attitudes about the situation.

Auxiliary chair – A technique in which an empty chair is utilized to represent a person or animal with whom the protagonist is interacting. This technique provides a number of roles, a greater opportunity for the expression of negative (and physically violent) feelings, as well as positive feelings without embarrassment to actual people. An individual may feel much less threatened by this type of encounter. This is used as a warmup technique quite well as it can appear to be used in a lighter vein. The chair is also used within a session for the same purpose.

[4] In one session a doctor who had been upset at his feelings of "being unable to die" and at his "rage" over our doing such an activity stated: "only someone who has experienced a death should participate" and acted out a "joke" as a relief:

(Setting is the Gate of Heaven amidst white and pink clouds and a barrier to the entrance. The doctor rises and "flaps" his way up to St. Peter)

St. Peter: Welcome, I'm sorry, but you'll have to wait, we have a backlog.

New Arrival: But, I'm very important and I'd like to get settled in so I can get to work.

St. Peter: Well, you can speak to Gabriel if you'd like to. He's in charge of complaints and changes.

(He walks over to Gabriel who has a huge waiting line. The new arrival rushes to the front of the line)

Gabriel: I'm sorry, sir, but you'll have to go to the back of the line.

New Arrival: But, but . . . (he goes resentfully and angrily to the rear. Suddenly another man with a stethoscope flying and a white coat enters, goes directly to the front of the line, is listened to for a time (all non-verbal) and goes away).

New Arrival: (Loudly) Just what do you think you are doing. Just who was that?

Gabriel: (Smiling) I don't blame you for not recognizing him. That was God–he thinks he's a Doctor.

Psychodramatic shock – is having an individual relive the moment of trauma over and over again until it becomes burned out. An example of this: one woman protagonist relived a moment around her dinner table. Her elderly father was getting on her nerves and she became very angry. She told him to drop dead and he did. We enacted the scene over and over until it became stabilized in her life.

The magic shop – This technique is an impromptu fantasy technique often used as a warmup or closure since it seems to be more fun and fancy than reality. It is a place developed by members of the group where all dreams, desire, and values can be purchased by bartering with the shopkeeper and leaving in trade those things of values no longer useful to the shopper. Group members are encouraged to present to the group a shop they conjure up—what it is like in both feeling and image; who they are as shopkeepers; whether they are mortal or immortal. They are also encouraged to shop in the Magic Shops presnted and seek out something of value to themselves. Another application of this technique in a large group is to have the entire group break into smaller groups of two and take turns being the shopkeeper and shopper to each other.

Behind-the-back technique – developed by Corsini, an individual voluntarily retires psychologically from the group by sitting with his back to everyone. He may not verbally answer the group since he is "out of the room." The group then discusses him, his behavior, his situation or how they feel towards him. A variation of this with a large group is to have the group break into groups of four. Each person in turn in the smaller group turns their chair for about 5 minutes while the other three talk about him. When all members of the small group have had their turn, they are permitted to respond within and among each other. This is a very good warmup technique and often serves to let people know how much they express through non-verbal behavior.

Sociodrama – An action psychodrama session utilizing methods and techniques of role playing but having as its focus a problem or situation which is of common concern to the group (i.e. motivating a dying patient to throw off his depression; informing a significant other of the patient that he is terminally ill). Two good sociodramatic death and rebirth techniques:

- Everyone in the group, one-by-one, acts as the deceased. Members of the group talk about him as if he is no longer here. Local customs (such as having a candle to send the soul to heaven) can be injected into the scene. The group resurrects him at the end.
- The entire group is instructed to lie down in an embryo position, and to spend about 2 minutes just experiencing what this feels like. Slowly begin to crawl around the floor; then walk on your knees; and finally stand up and make your way round walking (eyes closed). Experience just feeling

> what it is like to be in these various positions and your relationship to the world. Finally open your eyes and take a look around you . . . walk about and just feel how good it is to be in the world.

Letter writing – The protagonist or the entire group at the same time engages in contacting the deceased by writing a letter (out loud or on paper) requesting their return to complete loss feelings, establish a relationship or "punish" them, tell them something they never had a chance to say, etc. They begin with the salutation, then the body of the letter and ending including signature (have them use any pet name or nickname they were called by the deceased). In response to the letter the deceased comes back and makes contact with them (this may or may not involve touch).

The death scene – In addition to imagining or enacting one's own death, a more commonly used scene involves the death of a significant other. The director may, to enable the protagonist to deal with this death state: "You have just received a telegram notifying you of his death." In the case where the protagonist fears the impending death[5] of someone close: "You have five minutes to say whatever you have left unsaid before he dies." This process of "saying goodbye" can strengthen ego by letting the protagonist know that it may hurt, but he can stand on his own two feet and let the person go. It can dispense with remorseful feelings of never having had the opportunity to say all the things you wish you had said before the person dies and it provides an opportunity to "make peace." We have used this technique to deal with abortion where in the case of the father who has had an abortion experience we used spontaneous role playing to deal with his sense of loss, guilt or anger. With the mother it may be again a sense of loss, or there may be a need to meet the unborn child psychodramatically and to bring the child into future projection scenes, or to experience what life would be like without the child.

A note of caution:

> "The psychodramatic realization of suicidal or homicidal fantasies may give courage and prepare a patient to carry out the suicide in life itself. Such an individual may be already warmed up to the near-action point when the treatment begins. It is obvious that such a treatment process is contra-indicated unless the greatest precautions are taken to protect the person against himself. First of all, he has to be in the supervised environment of a hospital community. It is contra-indicated in day hospitals, in doctors' offices and in extra-mural clinics[6] [3].

[5] One creative development in this field has been the founding of MAKE TODAY COUNT, in Greenwich, Connecticut which is a self-help group composed of people with terminal illnesses.

[6] It is not on indications and contra-indications for acting out in psychodrama [3].

Warmup Techniques

THE ROBOT

The group is asked to stand up and assume the position of a robot (arms folded across chest, body stiff, eyes closed). They have no feelings and can only follow the instructions of the voice they hear, which instructs them to: "Take small shuffling steps forward and backward; if you bump into another robot, change direction immediately; now gradually you are able to go in different directions (sideways, in a circle, moving faster and faster); now halt. Stand still for a moment . . . realize that you want to be alive . . . feel the space around you, enjoy this space. Explore your own physical being, experience how your body feels. Now move around the room and if you bump into another person, shake hands with him, shake as many hands as you can find. Become more expansive, give each person you meet a hug; get as many hugs from as many people as you can. Now stop, open your arms wide and hug as many people at once as you can. Now open your eyes and look at where you are." Usually a great deal of laughter and a sense of feeling alive pervades the room

CIRCLE WARMUP

Everyone stands in a circle with their arms around each other. Very briefly each person in turn states how he is feeling at the moment. Rounds of speaking in turn are carried out to answer the following questions:

- What do you fear most about death? (What do you hope for, who is most afraid now?)
- How do you feel?
- What are you most afraid of?
- What was your first experience with death?

MULTIPLE ROLE PLAYING

The group at large breaks into dyads. One person of the pair takes the role of the counselor and the other of a dying patient (or member of the family of a dying person). Simultaneous dialogue occurs in all the smaller groups for about five minutes. Then the individuals in each dyad are told to reverse roles and carry on for an additional five minutes.

THE SURVIVOR

We have used another technique in which people cluster in selected groups (size to be determined by the people choosing each other) and talk about their feelings as a survivor of someone who has died; to share memories, feelings and anecdotes in an extended free-wheeling discussion. At the end of about 20 minutes, as many people as would care to make a statement about their feelings

to the group at large. However, these sessions often are "enough without the session." From these discussions, volunteers come forward to present their particular psychodrama. Most often these sessions involve the painful last moments with loved ones. Feelings expressed are those of guilt, anger, mass destruction, masochism, punishment, loss, trauma, deliverance, sleep, reunion, rebirth, love and sexuality, separation as well as rage and feelings of helplessness and powerlessness.

MILLING

The entire audience is encouraged to get up; move around and meet someone they have never met before—but to make this meeting non-verbal; first in an approving way and then in a negative way. After everyone has met someone at least once, they are encouraged to sit down and talk about their experience.

PAPER BAG

Give each group member a brown paper bag. The outside of the bag is to represent how you present yourself to others and the inside of the bag represents how you see yourself. Using pictorial magazines, decorate the outside of the bag with clipped out slogans or pictures; decorate the inside of the bag by placing items loosely within it. You might for example, paste a picture of a big football player on the outside, but inside place a picture of a little boy looking shy. Sit in groups of four and each person explains why he feels people see him as he appears on the outside of the bag and then takes two or three items from inside the bag and explains why he feels they represent the way he really feels.

OBITUARY

At the Jewish Hospital and Home for the Aged in New York City, we began the session on death and dying with each person writing his own obituary (1) as he thinks it would be sometime in the future, (2) as it would read if he died today, including his achievements, whom he left behind and the essence of himself as a person, and (3) as he would ideally like it to read if he died at a very old age. They then broke into groups of two and discussed and compared all three obituary versions.

LAST DAY OF LIVING

Live the entire day as if it were the last day of living. Come back the next day and discuss what changes have taken place.

TOMBSTONE

Write one's own tombstone inscription. In the role of the survivor, discuss the will of the person; what were the intrinsic and extrinsic things left to the family and society.

SIGNIFICANT DECEASED

The group breaks into dyads. Number 1 becomes a significant deceased person in Number 2's life and acts out a scene important to Number 2. Repeat the exercise by reversing roles and having Number 2 play the significant person for Number 1. The group should be encouraged to include animals, beliefs, "lost" people or happenings.

THE JURY TECHNIQUE

Member of the group are requested to "feel" into a specific role without openly participating; to compare their feelings, reactions and behavior with those manifested by the role player and compare the role taking ability of both; to constructively criticize role interpretations and offer fruitful suggestions to improve their own ability to assume the role of another. During the sum up, the group is invited to review, suggest and evaluate the scene in terms of what the role players did and did not do and what might have been more efficient alternatives by stating what they would have done if they were the role player.

JUDGMENT TECHNIQUE

The protagonist is encouraged to explore the judgment situation by role reversal. He is placed in the role of the judgmental figures in his life in real or hypothetical situations (such as a courtroom scene). When the auxiliary ego (who is now playing the person) is accused by him (in the role of judge) he staunchly denies any wrongdoing and demands proof. The protagonist is allowed therefore to recall the events more fully and after reversing roles to become himself again is often absolved.

Closure Techniques

Generally, the communion and fellowship of the sessions is a closure in itself, but following are some additional techniques which we have found useful.

REBIRTH

The group sits in a circle with closed eyes and is instructed to relax. One by one the facilitator gently moves each person into a lying position, spooning him into the person in front until everyone is cuddled next to somebody else in one row. They are instructed to relax, to listen to the breathing around them, to generate the good feelings and warmth they feel to the person in front of them, and to feel the peace and oneness with other human beings around them. After about five minutes, the facilitator gently wakes the first person and greets him with a hug for his rebirth into the world, then asks him to wake the person in front of him in the same manner until the whole group is reborn. This technique

may be extended to having individuals demonstrate what they came back into life with by acting it out.

Blackout technique – By blacking out the entire space and limiting all visual perceptions, individuals within the group can experience absolute solitude. In maintaining this technique with an individual who has an unstructured, shifting and temporary membership in his particularized groups or low level of personal identity, this enables him to experience the "alone world." It also tends to free inhibitions and can help him to experience a very painful situation where he may lose his composure without being observed by the other group members.

Crib scene – Group members are asked to lie down on the floor in whatever position they find most comfortable and to "be babies again," lying in their cribs and to just relax. A windup musical box is sometimes used to set the scene. They are told that a mommy and/or daddy will be around to tuck them in and check everything out. Auxiliary egos or other members of the group take this role and give the babies physical affection and cover them with coats, sweaters, or blankets to tuck them in. The "babies" are told just to experience being loved and duccled and take a little nap. After about 15-20 minutes the babies are asked to begin to wake up slowly; stretch a little; open their eyes; begin to sit up; to begin to grow up slowly; to feel good and content and alert; to do this at their own speed. An open discussion of positive and negative feelings may follow and sharing of individual experiences as babies is encouraged.

Ego building technique – The group is asked to get together in small groups of four after the session and share a give-and-take for about five minutes. Then each person in the small group (one-by-one until all have had a turn) listens while the other members negate him by describing the qualities they like most about him. After everyone has had a turn, each listener expresses what qualities he would like most to develop and change about himself. No comment is made by the other members. The group then interacts in a symbolic, affirmative way how they feel and as a group show how they feel–either in a chant, a song, a prayer or non-verbal interaction.

Boasting – Each person in the group stands up in front of the others and gives five or ten boasts about what he like about himself (can be physical, emotional, skill or spiritual traits).

In performing the psychodrama of death and the survivor, the following points should be kept in mind. In running spontaneous sessions, the director should at all times take his lead from the protagonist and the group, and so these points are not to be used rigidly.

- Brief introduction by the director
- Participants circle with one word description of how they are feeling at the moment

- Director determines what future date the individual members visualize in fantasy for their own death
- Briefly determine the cause of each for each participant
- Break into small groups of four
- Individuals fantasize their own death and share it within their own small group
- Director discusses the role of the comforter and survivor
- Individuals take the role of their significant survivor and talk in this role within their small group
- Further sharing in small groups about the meaning of the experience for each person
- Reforming of larger group by director
- Group affirmation, chant and conclusion.

Some Experiences with Psychodrama

I would now like to share with you, some of my experiences in using psychodrama, sociodrama and role playing. Whenever one uses psychodrama as a therapy, there are opportunities to explore separation and anxiety ridden concerns involving the death of a friend, a loved one, family, a public figure, a country, and forms of social deaths. The reuniting of an untimely deceased person in order to complete incomplete moments or purge emotional feelings is a catharsis, to say the least. For example, Moreno and his associates have run sociodramas on the Eichmann trial, the assasination of President Kennedy, the departure of a family from Cuba, and the assasinations of Robert Kennedy, Martin Luther King and Malcolm X. He stated at the 1964 APA Convention in Los Angeles while conducting a session on John Kennedy's recent death: "We are all suffering from a tremendous amount of unresolved guilt and confusion over what happened to President Kennedy. After all, if you can 'kill the father,' anything goes."

One evening I was running a public psychodrama session at the Moreno Institute in New YOrk City. This is an open session where people come from the streets, classrooms, or by word of mouth. It has always been to me a form of street theater . . . very real, in the moment and for keeps. During the warmup, the people (mixed in terms of ages, races, colors and sex) were milling around, getting to know each other. In response to "What shall we explore tonight?", one member of the group whispered: "Dr. Martin Luther King has been shot." When I announced this to the group, one man in the group came in and said "He's dead." The session became very real. Various members of the group came forth to pay tribute to a man we selected to play Dr. King, each one purging himself and seeking comfort in his own way or identifying his own prejudice. Another person told how he had tried to make contact with blacks (he was white) and the social pain and death that he felt. Still another man came forth

and started to talk to Dr. King, then began to cry uncontrollably. Dr. King became this man's deceased father. We went through a two hour session where we discovered this particular man's pain of living as a black man—the pain of losing his one friend, his father—and the difficulties he had experienced in establishing himself as a person.

One of the most daring psychodramas I ever ran was in a teaching seminar. We had with us a group of inmates from a penitentary, college students, citizens and professional colleagues. In one scene a woman from Norway relieved her fright in looking at a newspaper clipping of the deaths of white missionaries in an African village. Her father never fully explained to her what this was all about. We chose a "militant" black inmate to play the tribal leader and this woman role played herself at an earlier time (age about seven). We gave her a chance to confront this black chieftan and she went up to him and said "Would you kill me?" His reply was almost instantaneous . . . "Yes, I would!"

With this admission, he requested a session of his own. It seems that every night for thirteen months, before he fell asleep he would ask himself the same question: "Will I ever kill again?" He could never answer this question. But now felt he had just answered the question in the session. When we set up the scene of his life, he began in the here-and-now and went back into the past. The scene that seemed to motivate his focus (he was now in his mid-twenties or early thirties) was when he was about eleven or twelve years old and went to visit his grandma in a southern town. He was happy to be there. One afternoon, a white boy came up to him and asked to be his friend. The glee of the moment was evident on his face and the tensions and frustration that he began the session with vanished. He was indeed an eleven year old child. They became friends for awhile because his cousin worked in the white boy's house. He then went to a party one evening on the invitation of his white friend. We set the scene where his friend (who was an older boy) was driving him in a car to the party. The expression on the eleven year old boy's face changed to fear as he said, "We're not turning down the right street." His friend replied: "Don't worry." His face of fear then turned to terror because what the little boy was seeing was a field of burning crosses. He was beaten up and left for dead. His uncle and aunt found him and took him to the hospital where he remained for weeks. As he lay in his hospital bed, all that he kept thinking over and over in his mind (in the darkness of his mind since he was now partially blind) was that if he got out of the hospital, he would find the boy and kill him.

We role played several scenes: his getting out of the hospital and going immediately home to another state; going to some people who would help him; getting out and being surrounded by his family; getting out of the hospital and killing the boy. We had to force him to do every exercise but the last one. In real life he had done just that—found his grandaddy's shotgun and shot the boy. His secret was that no one knew. The sharing revolved around a discussion of having the right to kill.

Requiem for Raphy—A Model to Explore Feelings About Death and Social Helpers

An *Ars Moriendi* conference the following means were used to explore our personal attitudes and concerns about death and dying, and in part to create social repair and come to grips with our feelings.

STEP ONE

A paper cup was passed around in groups of four, four times (after the group looked at each other face-to-face, eye-to-eye). The first time was to hold the cup in silence and place into it one's own feelings, attitudes, concerns, beliefs and disbeliefs about death and dying. The second time each person was to do something to the cup that symbolized his attitudes, concerns, fears, anxieties or acceptance of death. Some people drank from it; others threw it away, crumpled it, tore it open petal-fashion to explore, put holes in it, sat on it, or held it closely to them. The third time it was passed in silence to re-evaluate one's own concepts and try to specialize one's own ability in the field—one's ability to change and develop. The fourth time the cup was placed in the center while everyone could look at it, then look at each other and share what this all meant to them. We all became vulnerable and very naturally shared deep personal moments.

STEP TWO

Everyone imagined his own death—when, how and where it would happen. Each person kept his hand in the air and brought it down (to the count of the director) the year that he died. Each person could see who died first, last, and so on; we shared what categories of death we suffered (heart attack, alcoholism, violent death, etc.). This role play avails people not only one chance to die, but alternate courses of action and a chance to explore the idea of how this death affects people closest to them; how death develops from one's life; and to face one's own death as well as the death of others.

STEP THREE

After sharing where each person went and what the death meant to him, the group helps each member become alive again.

STEP FOUR

Each person is instructed to become his own survivor—to play the part of that person close to him and discuss (as that person) with his group of four what the life of the person he was close to meant to him while being emotionally concerned, open, vulnerable and extending fellowship.

STEP FIVE

The same group then, after the bereavement session, discusses re-evaluations of both personal and professional roles. (Leave some time for each person to reconnect with himself before opening the discussion).

One woman, a nurse, had been deeply touched by the experience as well as physically touched by the wires from the camera, lighting and loudspeaker system on the floor. These "wires" and her vulnerability immediately threw her back to her work and she shared with us the fact that she was a head nurse in a life-extension intensive care unit. Her job was to make sure all the machinery that assists in keeping a human being alive was working, as she did on the day that her husband was having his pacemaker inserted. She walked around in both her professional and her wife role and told us that this was the first time she had been separated from her husband since the operation (the conference was in Philadelphia, her husband in New York). When she began to cry, we had someone play her husband role. She could say at that point what she had been holding back from saying to her own husband, at the same time, settling her own fears and pent up anxiety.

Another nurse was overwhelmed by the fact that the cup we had used had a slogan on it "How can we best serve you?" She said, "Oh my God, this is exactly what I have been doing: I have only been serving and taking care of my patients, not listening or talking to them." We had someone walk around with her and double her. What she selected to explore was the last day she had seen her friend (another young woman) alive. She had been on vacation and when she came home her friend was already in the hospital dying. She wanted to give blood but couldn't. She wanted to go in and say goodbye but was told not to. In the psychodrama we provided her with the opportunity to speak to her friend, hold her friend and say goodbye.

Another poignant event was an intense session involving a young publisher. We watched as we saw him ride in a car that his wife was driving. With them were their children, a little girl and a boy named Raphy. They suddenly got into an accident. The little boy was thrown out of the car. We listened to the dilemma of the father who had to make a decision of whether to go to the hospital with his little boy or to stay with his wife who had only a learning permit. He went with his little boy. We watched as he entered the hospital and was separated from his boy by the first helping person (a nurse). We watched him wait for the operation and heard him talking to the second helping person (a doctor) who informed him that his son had died. We watched him reverse roles so we could get a clear picture of what these helping people were like. We watched him in his own role greet people playing the part of his wife, his daughter (who were also obstructed by helping people). We watched as the father, mother and little girl asked if they could be, for a few moments, with their dead brother and son. We watched the helpers get very upset. We watched them go to find other helpers and we watched after the permission had been given—the three of them sitting

around the little boy, speaking to him, holding him and saying goodbye. We watched the uneasiness of the doctor, the nurse and the other helpers as the family became more involved—coming in and out and asking the family such questions as "Are you alright?" . . . "Do you need us?" . . . "Perhaps the little girl should come with me." We watched the loving, the caring, the grieving and the celebration of this one family. After this we all began to share. A doctor spoke of his feelings, a mother spoke of her feelings and we all related profoundly.

Other Experiences in the Field

One session involving a murder occurred when I went with Moreno and his wife Zerka to Mattawan Penitentiary where we worked with a man who could not remember the crime he had committed. Moreno's warmup with the man was much like a man going to confession, as he psychodramatically explored the evening when he picked up a prostitute and brought her home and then wanted nothing to do with her. We acted out a scene where he asked her to leave because he did not want to pay her. I (in the role of the prostitute) went to my purse and pulled out a knife. One of the psychiatrists who was observing the psychodrama was convinced that this man killed under the influence of vodoo and blurted out: "Did you see a sign?" The man replied . . . "I sure did. When I saw the knife I knew it was a sign that either she would kill me or I would kill her." In our physical tussle with my imaginary knife, he fought so hard that my fingers were bleeding—but he remembered the crime and therefore could be tried. Afterward, one of the doctors who had been watching said "We were very worried about you in that struggle." But I noticed that no one came to my aid. The memory of the event was unleashed by the action of the session and by the skillful doubling for this man by Zerka Moreno who was a probing and sensitive other self.

Some other experiences I would like to share with you are the other experiences gained with Charles Loomis at Union Theological Seminary and John Green at the Episcopalian Diocese of Newark. In each group, we would turn the entire class into a congretation. Each member of the class, in multiple role plays would act out the parts of clergy and congregation members from baptism to the last rites. Each member of the class had a chance to die and to be at the funeral of his close friend. Discussions followed on such phenomena as distancing, fear, and being able to truly console other human beings. In the sessions involving investigation of attitudes towards euthanasia, Protestant Clery and Roman Catholic psychology students playing the role of the minister found it difficult to identify with him because of their personal convictions in opposition to euthanasia. They were unable to come to grips with such problems as legal vs. illegal euthanasia. Their attempts at sympathy for the humanitarian motivation of the tormented daughter (played by a matronly Jewish woman who identified strongly with her role) left her feeling devoid of any empathy

from them. The rabbi discussants in the symposium charged those in role of minister with "playing God" in passing judgment on the daughter's deed. Role reversal presented the same dilemma. The Jewish woman assumed the role of an empathizing minister, and thóse who had played the role of minister were unable to accept the role of the daughter. Doubles proved effective in bringing the dilemma more into focus.

The death theme appeared over and over again in the training of both long term and short term missionaries. Separation anxiety, guilt, and self-actualization themes developed within almost every group. The following is an example. When we arrived at Stoney Point Missionary Training Center, there was a general malaise centering around one woman's loss of faith and depression. She was leaving her children in a missionary center in Egypt and going into deeper African "cannibal country." She had stopped speaking to her husband, and her faith and belief were no longer enough. We began the session by asking her to set up any situation she would like. She began by saying goodbye to her children. We had a number of role reversal exchanges and there seemed to be no difficulty, disbelief or fear. We then had her talk to God, and from this discussion we went immediately to another separation scene. It was 1951 during the Korean war. She was leaving the Presbyterian Church in Tokyo, Japan and as she came to say goodbye to the pastor and thank him for his Sunday sermon, she noticed a naval captain approaching to take her hand, pull her aside and tell her that her husband was dead. We then went with her on a flight with the captain as pilot, over the swamp where her husband's plane had gone down. This was her last memory of her husband.

The next scene she showed us was her ironing in the United States in her friend's house where she was living when she returned. She soliloquized about her angry feelings towards her friends and church for trying to fix her up with available men who might be prospective fathers for her children. During her ironing she heard a knock on the window and looked up to see a man cleaning them. He asked her for a drink of water and was invited in. They soon began to date. This, of course, was set up by her friend but was something she could laugh about. We later went to her wedding to this man and shared with her her inability to give herself completely to him as well as their devotion to the Christian faith. We shared her bitterness, her terror and her despair. We asked her if there was anything she would like to do. She said yes, she would like to speak with her first husband. We asked her to choose someone to play him and she chose her second husband to play the role. The change in her physical being, the freedom she had to reach out to this man (whom she had previously kept at an arms distance) was evidence of an immediate catharsis. What followed was a touching scene of farewell, of reuniting of completion and of re-birth. It was the moment needed to finally become the wife of her second husband, as well as develop a creative renewal of faith. When she played her husband who had died, her words were for her to live again and not to mourn. When she reversed roles

and heard the words spoken to her, she finally cried the tears she had never shed.

The response of the audience was lethal. They felt I was the devil himself, that I had made a public display of something very private. When I asked the audience of sixty people to raise their hands in response to "How many of you have heard this for the first time?" . . . no hands went up. When I asked who had heard the story before, all hands went up. The sharing session was not only of death and dying, but of the failure to communicate effectively, to be a good Christian and to reach out and touch. The rest of the workshop was devoted to expanding one's own awareness, with role reversal to understand the feelings of other people.

The psychodrama method has also been used in nursing homes with administrators and their staff. Some typical role plays involved playing the part of an undertaker; the nursing home administrator; other nursing home residents and the relatives of the deceased. Other sessions involved the differences in Jewish, Protestant and Catholic death rituals; how long do the last rites last; where is the body placed—where all the resident can see it or do we pretend that it just disappeared?; who comes to a death and dying conference at a nursing home—the staff, different members of other nursing homes; should residents ever come?

At Coney Island Hospital and Community Hospital in Brooklyn, death scenes were a natural part of a continuing education program for physicians in the area of autopsy. We rediscovered that the physician does not want to die, as demonstrated by great difficulties. The feeling about autopsy was the same as with the general public. The doctor did not like to ask for an autopsy on his own patient because of his keen sense of failure in a life preserving process. The physician who could die in the role playing had a personal experience and used the session as a catharsis. The physician who was able to obtain autopsy successfully was one who never asked for autopsies for his own patients but volunteered to do so for other physicians.

At Temple University in a class on death and dying with John Fryer and Ken Spilman, we explored individual's immediate, here-and-now fears and disbeliefs with their own terminal patients. We ran structured role plays on casual interviewing and supportive techniques.

We have also run sessions with police, dealing with deaths in a hospital emergency room where both policeman and perpetrator are wounded, with the perpetrator being wounded more severely. Questions dealt with were who should be attended to first and why. We also dealt in role plays with situations of an officer being shot by a fellow officer and an officer shooting a civilian.

In the field of drug addiction and alcoholism at Phoenix House in New York and Interim House in Philadelphia, the death theme comes up over and over again, either dealing with the individual being a self-killer or accidental killing by overdose, muggings or untimely deaths which occurred in the past. After every session there is a feeling of being unburdened and released and they are very teary sessions.

The psychodrama process has almost unlimited applications and uses and is flexible and complete with an acting out process that is a living through process on a group or individual level. I have enjoyed and learned much from this process. My own concerns and fears about dying are re-evaluated each time I die in a session. My ability to be more spontaneous with other deaths, both professional and personal, are very rewarding. I think the validity for using psychodrama is best expressed by Ted Rosenthal's stanza in one of his poems [4] emphasizing that the "stage" is life, as do the role theorists Moreno, Goffman and Shakespeare; that all the world's a stage, it's a tangible togetherness.

"O people, I am so sorry.
Nothing can be hid.
It's a circle in the round.
It's group theater,
No wings, no backstage, no leading act.
O, I am weeping, but it's stage center for all of us.
Hide in the weeds but come out naked.
Dance in the sand while lightning bands all around us."

Summary

In life training physicians, nurses, social workers, counsellors, police and patients, we were essentially working with belief systems and strategic issues, with various psychic states, tension, anxiety and psychologically binding conditions. It is my belief that we must develop at least simulated situations in addition to psychodrama and its derivatives to allow the release of tension and risk-taking, as well as to develop spontaneity and creativity. The use of double and role reversal is extremely important in interfering with the habituated pattern of one's awareness and behavior. By interfering with habitual associations, and social and conventional ruts, we can set up conditions for creative moments, where a new insight is developed or we change our behavior—even in practice. Psychodrama helps a person align his own reality and not the reality of convention, to uncover his own transactions and not those expected of him. As Christopher Fry once said: "Reality is incredible, reality is a whirlwind. What we call reality is a false god, the dull eye of custom [5]."

In using psychodrama in the field of death, we always seem to be working with the entire group because of the theme or topic and our mutual search. We begin first with the problem of one person relating it to the entire group. In a sociodrama, dealing in such things as survival and the survivor or all dying at the same time, we are using a type of all-inclusive psychodrama. Each technique seems to offer a re-birth for the participant as well as a new alignment for their capabilities. We have used psychodrama in exploring attitudes and feelings with Vietnamese families, as well as Americans who have returned home from the war to explore their brutal feelings of being survivors and their attitudes towards their dying friends. With Rev. Green we have explored euthansia, with Dr. Kantor

the entire concentration camp syndrome, and on a more personal level the death of my mother and the incomplete feelings we all were left with in playing the charade of her not dying.

It is my estimation that the psychodrama sessions on a therapeutic level, as well as on a training level, remove the sense of hopelessness.

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MEDIA ON DEATH AND DYING

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ABSTRACT

An annotated list of films, tapes and other instructional aids appropriate for death education courses is provided. A broad range of topics and approaches concerned with death is encompassed.

This list has been developed as a result of a wide search for media appropriate for utilization within a three-credit University of Wisconsin–Milwaukee course, Understanding Death, Dying and Bereavement. The course, offered by the School of Nursing, and taught by Professor Helen Swain, involves a large and heterogeneous student enrollment. Lecture sessions are primarily accomplished via instructional media, whereas discussion sections focus on small group process. The media list was compiled by Mrs. Phyllis Duke, M.S., Acting Media Coordinator, after several years of screening and research. The media materials asterisked are those which are currently utilized in the course.

BETWEEN THE CUP AND THE LIP–Film, color, 11 min. Rental/Sale. Mass Media, 1720 Chouteau Ave., St. Louis, Mo. 63103. Translucent animation is utilized in this somber film on death. Life is shown as a slow-moving, never-ending procession, seen as a funeral cortege in black, in which everybody is making his solemn pilgrimage in the same direction. At various points in the procession symbolic candles are snuffed out to announce an expiration. Most unusual and symbolic (Zagreb Films).

CARE OF THE DYING PATIENT–Filmstrips with audiocassettes or records.

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Sale only. Train-Aide Ed. Systems, 229 N. Central Ave., Glendale, Calif. 91203. Two (2) programs: Nursing-Patient Relationships; Signs and After Care.

CARE OF THE DYING PATIENT–Filmstrip w/record or audiocassette. Sale only. Trainex Corp., P.O. Box 116, Garden Grove, Calif. 92640. The physical, emotional, and spiritual needs of the dying patient are explained; signs of approaching death are depicted along with what to do when the patient dies and how to prepare the body.

CASE OF SUICIDE, A–Film, black and white, 30 min. Rental/Sale. Time/Life Films, 43 W. 16 St., N.Y., N.Y. 10011. Case history of a young woman who commits suicide and the sense of guilt felt by those close to her who did not do more to prevent it. Designed to spark discussion about traumatic death and its effect upon family and friends, as well as show warning signs which nurses and medical personnel should learn to recognize in patients. (BBC)

CHILD'S EYES, A–Film, color, 9 min. Rental/Sale. Contemporary Films–McGraw-Hill, Princeton Rd., Hightstown, N.J. 18520. The reactions of children to the death of President Kennedy are expressed in this filmed collection of children's drawings of the assassination. The drawings were done by a class of forty (40)–5 & 6 year olds. The children themselves narrate the film providing great insight into their personal feelings on death. (Snodgrass Prod.)

**CHILDREN'S CONCEPTIONS OF DEATH*–Videotape, color, 28 min. Loan/Sale. School of Nursing, University of Wisconsin-Milwaukee, Milwaukee, Wi. 53201. Provides an overview of the developmental acquisition of various concepts of death. Emphasis is on three general stages through which normal children move between toddlerhood and adolescence. Graphics, still photography and filmed sequences are incorporated into the videotape to illustrate the ways in which children approach the subject of death at different ages. (UW-M School of Nursing Production).

**CONFRONTATIONS OF DEATH*–Film, color, 35 min. Rental. Oregon Div. of Continuing Education Film Library, P.O. Box 1491, Portland, Oregon 97201. Filmed during a seminar at which participants tried to discover their personal feelings about their own deaths. Various devices are used to involve the participants: listening to music, viewing slides on death, writing their own eulogies.

COPING WITH DEATH AND DYING–Audiocassettes. Sale only. Ross Medical Assoc., 1825 Sylvan Court, Flossmorr, Ill. 60422. Series of five (5)–1/2 hour audiocassettes featuring Dr. Elizabeth Kubler-Ross.

CRIB DEATH–OR SUDDEN INFANT DEATH SYNDROME–Videotape,

b/w, 47 min. Rental/Sale. Georgia Regional Medical Group, P.O. Box 26121, Atlanta, Ga. 30303. Dr. Barbara Bruner, M.D. discusses the 10,000-15,000 babies who die of SIDS each year. She is area chairman of the National Foundation for Sudden Infant Death in Georgia. (Ga. Regional Medical Program.)

DAY IN THE DEATH OF DONNIE B., A–Film, b/w, 18 min. Rental/Sale. NIMH. Drug Abuse Film Collection, National Audiovisual Center, GSA, Washington, D.C. 20409. This film confronts the viewer with unflinching look at an inner city youth who is killing himself on drugs. There is no narration except for the outspoken voices of mothers, ex-addicts, policemen, clergy, and doctors–and a ballad which carries the story of Donnie through to the end of the road. Emotion packed. Pulls no punches in telling it like it is. (NIMH.)

**DAY GRANDPA DIED, THE*–Film, color, 11 min. Rental/Sale. Bailey Film Assoc., 2211 Michigan Ave., Santa Monica, Calif. 90404. A beautiful and sensitive film designed for viewing by children. Depicts a young Jewish boy whose grandfather has just died. Demonstrates the parent-child interactions in adjusting to the loss, the ways in which children react during grief, and the importance of the funeral ritual as friends gather to commemorate the memory of the grandfather and help the family to accept their loss. Discussion questions accompany the film. (BFA.)

DAY OF THE DEAD–Film, color, 15 min. Sale. Charles Eames Office, 901 Washington, Venice, Calif. 90291. Mexico's Festival for the Day of the Dead is described as one watches preparations for it. The Mexican acceptance of death is seen through a party being planned in memory of a dead girl.

DEAD BIRD, THE–Film, color, 13 min. Rental. Bureau of Audiovisual Instruction (BAVI), P.O. Box 2093, Madison, Wis. 53701. This film for children tells the story of four youngsters as they discover a dead bird and decide to bury it in the woods. Shows their ceremony and tells of their visits to the burial site over a period of time. (Oxford.)

DEAD MAN–Film, no sound, 3 min. Foundation of Thanatology, 67 Park Ave., Room 11-B, N.Y., N.Y. 10016. A stark, shocking segment, devoted to showing different views of an old man's naked dead body in the morgue.

DEALING WITH THE TERMINALLY ILL PATIENT–Videotape, b/w, 16 min. Rental. NCME, 15 Columbus Circle, N.Y., N.Y. 10023. Dr. Elizabeth Kubler-Ross covers the five stages of the dying patient and the reaction of people around the patient. (NCME.)

**DEATH*–Film, black and white, 43 min. Rental. Filmmakers Library, 290 West End Ave., N.Y., N.Y. 10001. Film dramatically depicts the isolation of

the dying as the staff busies itself with care of the living. A powerful film that elicits human feeling about the impersonal ways in which the terminal patient is approached vs. the very human aspects as the patient looks back at his life. Care of the body, wrapping, the morgue, and the funeral director are also part of this program. A good discussion vehicle.

**DEATH* (FAMILY OF MAN SERIES)–Film, color, 45 min. Rental/Sale. Time-Life Films, 43 West 16th St., N.Y., N.Y. 10011. A cultural view of death rituals is depicted by contrasting attitudes towards death in various cultures of the world.

DEATH AND DYING–Videotape, black and white, 58 min. TV Div., Naval Medical Training Institute, Natl. Naval Medical Center, Bethesda, Md. 20014. (Dubbed onto your videotape without charge.) Discusses death as a human act and the nursing staff's feelings about the subject. Emphasizes regard for the dying patient as a person and recognizes his feelings of denial, defense and hope. Discusses the right to die and role of the priest, minister and family. (Natl. Naval Medical Center.)

DEATH AND LIFE–Audiotape or audiocassette, 60 min. Sale only for non-broadcast use. Canadian Broadcasting Corp. Learning Systems, Box 500, Station A, Toronto, Ontario, Canada. A documentary illustrating what people from all walks of life think about death, what it means to them, how they visualize it, their fear of it. These same people are then asked what they think about life, and their answers reflect their experience of it.

**DEATH, GRIEF AND BEREAVEMENT*–Audiocassettes. Sale only. Center for Death Education and Research, 1167 Social Science Building, Univ. of Minnesota, Minneapolis, Minn. 55455. A series of 18 programs by various authorities on death.

DEATH, DRUGS AND WALTER–Film, color, 13 min. Sale/Rental. Films, Inc., 1144 Wilmette Ave., Wilmette, Ill. 60091. Drugs substituted for many things in Walter's life. He grew up without the emotional support of his family in a neighborhood where drug use was a way of life. Suspended from school at the age of nine, he never went back. Even schools for emotionally disturbed couldn't help him. The few who were close to him said he needed someone to love and someone to love him, but this he never found. Walter died from an overdose of heroin. He was only 12 years old. (NBC.)

DEATH: ITS PSYCHOLOGY–Audiotape or audiocassette, 60 min. Sale only for non-broadcast use. Canadian Broadcasting Corp. Learning Systems, Box 500, Station A, Toronto, Ontario, Canada. A documentary about the five stages of death as determined by the research of Dr. Elizabeth Kubler-Ross. A woman, terminally ill, and her husband also talk about their reactions and their acceptance.

DEATH, PART V–Film, black and white, 26 min. Rental. Association Instructional Materials, 866 Third Avenue, N.Y., N.Y. 10022. A group of people come together to role play life situations. Among the situations played are such death-related themes as explaining a diagnosis to a relative, dealing with self-destructive behavior, and dilemmas related to military inscription. These role play situations appear to develop spontaneously, and the viewer is left much to his own devices. Should be followed by discussion. (Look Up and Live Series.)

**DEATH OF A PEASANT*–Film, color, 10 min. Rental/Sale. Mass Media, 1720 Chouteau Ave., St. Louis, Mo. 63103. A true story of a Yugoslav peasant who had to face a German firing squad in 1941. His flight from the Germans, the hopelessness of the situation, and his eventual decision to take his own life, make this a gripping film. Because of the controversial nature of this man's desperate decision, the film should definitely be followed up by discussion delving into the motivations behind the act, the relevance of cheating death, martyrdom, etc. (Fastava Films.)

DEATH OF A SIBLING–Videotape, color, 19 min. Rental. NCME, 15 Columbus Circle, N.Y., N.Y. 10023. Two physicians focus on specific problems that result from the death of a sibling: questions to expect, points to emphasize, emotions to look for, how to help the families. (NCME.)

DIGNITY OF DEATH–Film, color, 30 min. Rental/Sale. ABC News, 7 West 66th St., N.Y., N.Y. 10023. Program deals with St. Christopher Hospital in London and its philosophy that all patients can experience pain relief during their terminal stages. Shown in the home environment with visitors and pets, and the staff who works with the patients. Patient interviews are included. No extraordinary measures are used to preserve life, but rather, nature is allowed to take its course.

DIVINE HEALING–Film, color, 30 min. Loan. Dawn Bible Students TV., 611 Newton St., San Fernando, Calif. 91340. Panel discussion interspersed with art and dramatic scenes of Biblical times. Emphasis is on Biblical references to death and faith healing, esp. during the life of Jesus. Useful for religious study groups or for broad death education courses which include study of theological approaches to death.

DRAMA OF DEATH: COUNSELING THE DYING AND THEIR FAMILIES–Audiocassettes, Sale only. Creative Resources, Box 1970, Waco, Texas. This pair of tapes comes packed in hard cover case with study guides.

DYING PATIENT, THE–Film, color, 68 min. Rental. Medical Ed. Resources Program, Indiana School of Medicine, 1100 W. Michigan St., Indianapolis, Ind. 46202. Focuses on the clinical approach to the dying patient, and is directed to general medicine, mental health, personnel, and paraprofessional staffs, who work with dying patients. (Indiana.)

**EQUAL KNOCK ON EVERY DOOR, AN*–Videotape, color, 30 min. Sale only. WKYC-TV, 1403 East Sixth St., Cleveland, Ohio. Deals with death, and especially the arrangements and details of the funeral, such as selecting the coffin and helping the family work through the grief of bereavement. Involves both practical and philosophical aspects of funerals. (WKYC Prod.)

FACING DEATH–Film, color, 20 min. Free loan. Medical Resources Branch, NMAC Annex, Station K, Atlanta, Ga. 30324. Discusses the psychological problems confronting the physician when he must inform the patient and his family of a terminal condition. Stresses individual rapport and the necessity for understanding the patient's reaction to stress. (NBC.)

**FUTURE UNKNOWN*–Film, black and white, 15 min. Rental. Univ. of Pittsburgh, School of Nursing, Pittsburgh, Pa. 15213. Film depicts the emotional trauma experienced by a young woman who has been hospitalized for a recurrent malignancy. The patient feels that the hospital personnel avoid talking with her, and that the doctor has given up all hope of helping her. Even though the couple suspect that the illness is terminal, neither is able to discuss it. The nurse helps the patient express her feelings about death and gives her the support that has been missing during her illness. Discussion guide is available to accompany the film.

GALE IS DEAD–Film, color. 51 min. Rental/Sale. Time-Life Films, 43 W. 16th St., N.Y., N.Y. 10011. Gale's funeral begins and ends this documentary of a teenager's death from drugs. Interviews are shown with friends and people who tried to help–along with an interview of Gale in a hospital shortly before her death. Probes the responsibility of society for the young victim. (BBC.)

GREAT AMERICAN FUNERAL, THE–Film, black and white, 55 min. Rental. Mass Media, 1720 Chouteau Ave., St. Louis, Mo. 63103. Details funeral practices in Western society over the past half century. The business relationship between the funeral director and the consumer is explored along with the economic ramifications of the funeral industry: garment-makers, limousine dealers, cemetaries, etc. Interviews funeral directors, the clergy and Jessica Milford. Considers the funeral from the view of costs, rewards, and alternatives. (CBS.)

HOW COULD I NOT BE AMONG YOU–Film, color, 28 min. Rental. Univ. of Calif. Ext. Media Center, Berkeley, Calif. 94720. Sensitive portrait of poet confronted by his own premature death from leukemia. Shows the last few months of his life, capturing the agony, hope, terror, and faith of his final days. (ECCW.)

**HOW LONG IS A YEAR?* Videotape, black and white, 27 min. Rental/Sale. A UCLA School of Nursing program distributed by Medical Media Network,

10995 Le Conte Ave., Los Angeles, Calif. 90024. A nurse adjusts to a program which provides services to families facing loss of a child with leukemia. (UCLA School of Nursing.)

IMPLICATIONS OF NURSING–THE DYING PATIENT–Videotape, color, 55 min. Rental. Milwaukee Regional Medical Instructional Television System, Inc., 500 West National Ave., Milwaukee, Wis. 53193. Rose Marie Chioni, R.N., Ph.D. of the University of Wisconsin School of Nursing discusses the nurse's role in dealing with terminal patients, and raises many stimulating questions on whether we are meeting the needs of the patient or the needs of the professionals who deliver the care.

**JOSEPH SCHULTZ*–Film, color, 13 min. Rental/Sale. Wombat Productions, 77 Tarrytown Road, White Plains, N.Y. 10607. The same true story depicted in *Death of a Peasant,* but this time told from the viewpoint of a member of the German firing squad who refuses to shoot, and who subsequently dies because of his convictions.

JOY OF LOVE–Film, color, 9 min. Rental. Univ. of Michigan AV Center, Ann Arbor, Michigan, 48104. Without words, the film depicts courtship, marriage, old age and death. The aged widower lives on with his memories of his wife, young and lovely as she was many years before.

JUST A LITTLE TIME–Film, color, 21 min. Rental. AJN Film Library, c/o Assoc.-Sterling Films, 600 Grand Ave., Ridgefield, N.J. 07657. A documentary exploration of the shared experience of a 49 year old terminally ill woman and her nurse, a specialist in oncology. The dialogue reveals the unique rewards as well as the special problems involved in the relationship between the nurse and the dying patient. (Barey-Callaci-Video Nursing Prod.)

JUST A LITTLE TIME–Audiocassette and study guide to be used in conjunction with the film of the same title. This is a nursing staff conference to develop a care plan for the patient in the film. Sale only from AJN, Educational Service Division, 10 Columbus Circle, N.Y., N.Y. 10019.

**LAST AND LASTING GIFT, A*–Film, color, 28 min. Rental. Inland Empire Human Resource Center, 2 West Olive Avenue, Redlands, Calif. 92373. A tastefully produced film which describes the alternatives to a funeral, especially alternatives relating to donation of body parts following death. The film includes scenes which demonstrate ways in which human tissue is tested, stored and utilized. Includes an interview with a recipient of a cornea transplant who could now see for the first time in years.

LEARNING TO LIVE WITH DYING–Videotape, color, 39 min. Rental. NCME, 15 Columbus Circle, N.Y., N.Y. 10023. Medical students, physicians, and theologians discuss dying as the most difficult and least understood

phase of life. Guidance for terminally ill and their families goes beyond clinical care. (NCME.)

**LEINBACH-EISDORFER SERIES*–Videotape, six programs. Health Sciences Learning Resources Center, T-252 Health Sciences Bldg., Univ. of Washington, Seattle, Wash. 98195. Actual interviews with the patient and his family and those who attended to his physical and spiritual care. Titles include: Interviews with the Patient–25 min., The Role of the Physician–41 min., Pain Management–37 min., Religion and the Clergy–35 min., The Grieving Process, Part I–25 min., and The Grieving Process, Part II–45 min. The terminal patient in the series is Dr. Gary E. Leinbach, Professor of Medicine at the University of Washington Medical School. As the cancer progressed, he continued to be an active faculty member and together with his family, participated in developing this series of videotapes about his feelings and experiences. His experiences, fears and reactions are those faced by all who must face impending death.

LIFE CYCLE: DEATH, THE–Audiotape or audiocassette, 30 min. Sale only for non-broadcast use. Canadian Broadcasting Corp. Learning Systems, Box 500, Station A., Toronto, Ontario, Canada. Dr. Vivian Rakoff, Univ. of Toronto–Department of Psychiatry, talks about the meaning of death in a time-bound culture, with references to the various attitudes towards death held by people of different ages and philosophies.

LIVING WITH DYING–Filmstrip (two parts). Sale. Sunburst Communications, Pound Ridge, N.Y. 10576. The first part examines the stage of life in all living things, peoples' concept of death, and their attempts to deny it. The second half deals with the individual's various experiences with death and the five stages through which the terminal patient passes.

**LYN HELTON STORY, THE*–Film, color, 10 min. Rental. American Medical Assoc. Film Library, 535 N. Dearborn St., Chicago, Ill. 60610. A filmed "diary" of the innermost thoughts and feelings of a young woman who is dying of cancer. (Al Wooley, Family Health Prod.) Also titled–"Soon There Will Be No More Me," available from Oregon Division of Continuing Education Film Library, P. O. Box 1491, Portland, Oregon 97210. NOTE: *Sunshine,* the book and TV Special were based on this same person.

MANAGEMENT OF THE TERMINALLY ILL: THE FAMILY–Videotape, b/w, 16 min. Rental. NCME, 15 Columbus Circle, N.Y., N.Y. 10023. Dr. Ross offers practical help to physicians in dealing with the dying patient and his family. (NCME.)

MARK WATERS STORY, THE–Videocassette, color, 29 min. Rental/Sale. The Public Television Library, 475 L'Enfant Plaza, S.W., Washington, D.C.

20024. True story of a Honolulu newsman who wrote his own obituary as he lay dying of lung cancer. (Hawaii ETV.)

MASQUE OF RED DEATH–Film, color, 10 min. Rental. Univ. of Michigan AV Center, Ann Arbor, Michigan 48104. The inevitability of death is depicted through animated paintings in this film version of Poe's story.

**MEDICINE, MORALITY AND THE LAW: EUTHANASIA*–Film, b/w, 30 min. Rental/Sale. Univ. of Michigan TV Center, 910 Maynard St., Ann Arbor, Mich. With the advent of medication which can prolong life, euthanasia–the painless causing of death to end suffering–has become a serious issue. Euthanasia is defined, and three case studies are presented to a panel from various disciplines. The panel brings out legal and moral distinctions that place a "mercy killing" in and beyond the range of manslaughter. (Univ. of Mich. Prod.)

MERCY KILLERS, THE–Film, b & w, 30 min. Rental/Sale. Time-Life Films, 43 West 16th St., N.Y., N.Y. 10011. A study of euthanasia, utilizing actual case histories and interviews. The subject is discussed frankly within the moral and ethical framework, without taking sides or drawing conclusions about the conflicting viewpoints given. (BBC.)

MERCY KILLING–Audiotape or audiocassette, 30 min. Sale only for non-broadcast use. Canadian Broadcasting Corp. Learning Systems, Box 500, Station A, Toronto, Ontario, Canada. A panel discussion on the technical and moral implications of euthanasia.

MY TURTLE DIED TODAY–Film, color, 5 min. Rental. Bailey Film Assoc., 2211 Michigan Ave., Santa Monica, Calif. 90404. An animated film for children dealing with the subject of death. (BFA.)

ONE IN THREE-HUNDRED FIFTY: SUDDEN INFANT DEATH–Film, b/w, 30 min. Natl. Foundation for SID, 1501 Broadway, N.Y., N.Y. 10036. Parent interviews bring out the impact upon family relationships when an infant dies suddenly of unknown causes. Reactions of relatives, neighbors, and tactless handling of the cases by professionals compound the problem. Program stresses need to find the cause through biomedical research, and urges a "bill of rights" for families of these infants.

**PARTING, THE*–Film, color, 16 min. Wombat Prod., 77 Tarrytown Rd., White Plains, N.Y. 10607. The ritual of death in a Yugoslavian village is seen as the villagers make their way to the cemetary, openly express their grief and return to their normal routines.

**PATIENT'S RIGHT TO DIE, THE*–Videotape, b/w, 60 min. Available without charge on borrower's raw stock tape. Walter Reed Army Medical Center, Video-tape Library, Room 1077, Bldg. 34, Washington, D.C. 20305.

A lecture presentation regarding the moral-ethical dilemmas in today's society. Especially involved is how long and under what circumstances life should be preserved. Discusses the difference between active and passive euthanasia, and the concepts of minimal care as well as extraordinary means of therapy. Presented in terms of Christian theology. (WRAMC-TV.)

**PERSPECTIVES ON DYING*–Series of 6 filmstrips with records or audio-cassettes. Supportive materials such as questionnaires, role play cards, text also available. Sale only. Concept Media, 1500 Adams Avenue, Costa Mesa, Calif. 92626.

POTENTIAL SUICIDE: WOULD YOU KNOW HIM? Film, color, 18 min. Rental/Sale. Medical Media Network, 10995 Le Conte Ave., Los Angeles, Calif. 90024. Discusses whether suicide actually occurs without warning, and what the nurse can do to help prevent it. (UCLA Extension.)

PSYCHOSOCIAL ASPECTS OF DEATH–Film, b/w, 39 min. Rental. University of Indiana, AV Center, Bloomington, Indiana 47401. Dramatized story of a leukemia patient, his wife, and a nursing student who is facing the death of the patient. The terminal patient continually looks toward the future. His wife is pregnant and very much wants him to live to see the baby. When he unexpectedly dies, the nurse, who has become attached to the patient and his wife, becomes upset but must learn her role in helping the family work through their grief. (University of Indiana School of Nursing.)

RABBIT–Film, color, 15 min. Rental/Sale. The Eccentric Circle, P.O. Box 1481, Evanston, Ill. 60204. A film on death, suitable for children as well as adults. Shows a nine year old boy's first encounter with the death of one of his pet rabbits, a result of an unwise decision on his part.

RICK: AN ADOLESCENT SUICIDE–Film, color, 29 min. Rental/Sale. Medical Media Network, 10995 Le Conte Avenue, Los Angeles, Calif. 90024. A reconstructed investigation into the psychological background of a 17 year old high school senior who takes his own life. (UCLA Extension.)

**RIGHT TO DIE, THE*–Film, color, 56 min. Rental/Sale. Macmillan Films, Inc., 34 MacQuesten Parkway South, Mount Vernon, N.Y. 10550. Face to face interviews with courageous dying patients, ranging from age 12 through adult. Raises questions of the best means for families, medical personnel, and the clergy to deal with the dying. Involves the conflicts about whether the person should be told he is dying, whether one has the right to end his own life, and whether technology should be withheld to enable a patient to die with dignity. (ABC Closeup.)

ROSENTHAL, TED: A POET–Film, b/w, 7 min. Rental/Sale. Indiana University AV Center, Bloomington, Indiana 47401. Thirty-one year old poet,

Ted Rosenthal, discovers he is dying of leukemia and reveals his innermost feelings concerning his impending death. Still photos of the hospitalized poet and his family provide a background for his poetry, which reflects the anguish and isolation experienced by an individual who knows he is going to die. (NET.)

SERIES OF PERSONAL INTERVIEWS WITH DYING PATIENTS, A–Videotape, b/w. Univ. of Southern Calif., Division of Research and Training, 1739 Griffin Ave., Los Angeles, Calif. 90031. Mr. S, Bella, Marc, and Rocco are four interviewees who give personal feelings on how they feel as terminal patients. Average length is 50-60 min. Also available from same source is a videotape on "Nurses' Discussion" and "Medical Students," both dealing with the subject of death.

SPECIAL KIND OF CARE–Film, color, 13 min. Rental. Assoc.-Sterling Films, 600 Grand Ave., Ridgefield, New Jersey, 07657. The impact that a diagnosis of terminal disease has upon the entire family as the father has to face telling the children that their mother is dying.

**SUICIDE*–Videotape, b/w, 60 min. NMAC, TV Div., Atlanta, Ga. 30333. Illustrates types of depression and some of the fallacies about suicide. (Medical College of S. Carolina.)

TEACHING DEATH: AS A PROCESS OF AWARENESS AND COPING–Videotape. Rental/Long Term Lease. Nebraska TV Council for Nursing Education, 1800 N. 33rd, Lincoln, Nebraska, 68503. A three lesson series focusing on the processes and techniques of teaching others how to care for and cope with dying patients. (Nebraska Ed. TV Network.)

THOSE WHO MOURN–Film, color, 5 min. Rental/Sale. Association Instr. Materials, 866 Third Ave., New York, N.Y. 10022. Through memory flash-backs and montage, the film explores the death of one man and its meaning to his wife. The film moves beyond this particular experience to encompass the spectrum of mourning on both a personal and a universal level. Particularly effective is the use of black and white photography contrasted against flashback scenes in color to depict the harshness of death vs. the warmth of life.

**THOUGH I WALK THROUGH THE VALLEY*–Film, color, 30 min. Rental/Sale. Pyramid Films, Box 1048, Santa Monica, Calif. "I wish I could live my life over again because I enjoyed it so much," says cancer victim Tony Brouweer in this statement on death and Christian faith. Filmed during his final weeks of life, Tony and his family discuss their feelings about his illness, death and God. (Mel White Prod.)

THREAT OF SUICIDE, THE–Videotape, color, 27 min. Rental. NCME, 15 Columbus Circle, N.Y., N.Y. 10023. Those who commit suicide frequently

attempt to communicate their desperation to their physicians. How can we be sensitive to these warnings, either open or covert, and how can we help a patient once his suicidal intentions are known. (NCME.)

UNTIL I DIE–Audiocassette version of film by same title. Sale only. AJN, Ed. Service Div., 10 Columbus Circle, N.Y., N.Y. 10019.

**UNTIL I DIE*–Film, color, 30 min. Rental. AJN Film Library, c/o Assoc.-Sterling Films, 600 Grand Ave., Ridgefield, New Jersey 07657; or BAVI, Box 2093, Madison, Wis. Dr. Elizabeth Kubler-Ross explains her work with the terminally ill and examines the five stages through which the patients progress after learning of their approaching death. A patient interview and a follow-up conference with staff members are also shown. (Video Nursing.)

**WALK UP THE HILL, A*–Film, color, 30 min. Church Films, 2923 North Monroe St., Spokane, Wash. 99205. A physician, about to retire, suffers a stroke, with no hope of recovering. He pleads with his young assistant physician not to take life-preserving measures. Questions raised are whether the relatives make the decision not to preserve life, whether the physician makes that decision or whether God makes that decision. The decision is not shown, leaving it open for discussion.

WHAT CAN I SAY?–Film, b/w, 31 min. Rental. AJN Film Library, c/o Assoc.-Sterling Films, 600 Grand Ave., Ridgefield, N.J. 07657. How the nurse can handle questions of the dying patient and deal with her own anxieties. (Univ. of Arizona.)

**WHAT MAN SHALL LIVE AND NOT SEE DEATH?* Film, color, Reel I–30 min. Reel II–27 min. Rental/Sale. Univ. of Iowa, Iowa City, Iowa, 52240. There is a conspiracy of silence surrounding the subject of death. Through conversations with doctors, clergymen, terminally ill patients and bereaved people, the silence is lifted. The study of death and how Americans deal with it provides insight into a profound and universal experience. (NBC.)

WHO SPEAKS FOR THE BABY? Videotape, color, 20 min. Rental. NCME (Network for Cont. Medical Ed.), 15 Columbus Circle, N.Y., N.Y. 10023. A baby born mongoloid with defective heart and duodenal atresia needs lifesaving surgery which the parents request not be performed. The pediatrician seeks a court order to operate. Is such a decision within the physician's province? Should this child live or die? A presentation by professionals on points of view on infant euthanasia. (NCME Prod.)

**YOU SEE, I'VE HAD A LIFE*–Film, b/w, 30 min. Rental/Sale. Eccentric Circle Cinema, 347 Florence Ave., Evanston, Ill. 60202. A teenager is diagnosed as having leukemia. His family elects not to hide it from him, but attempts to share and face the experience with him. The quality, rather than the length of the family's interpersonal relationship is stressed.

WILL DRAFTING–Film, b/w, 40 min. Rental/Sale. U. of Calif. Ext. Media Center, Berkeley, Calif. 94720. Interview techniques are demonstrated by an attorney as he serves two clients, drafting wills to meet their widely different estates and family needs. (EMC.)

**WILLS, P. I. & P. II.*–Audiocassettes. Sale only. Center for Cassette Studies, 8110 Webb Ave., North Hollywood, Calif. 91605. Purchase includes rights to make multiple dubs for students. *You've Got Six Months To Live* is also from this source. Suggested readings and study questions come with every program.

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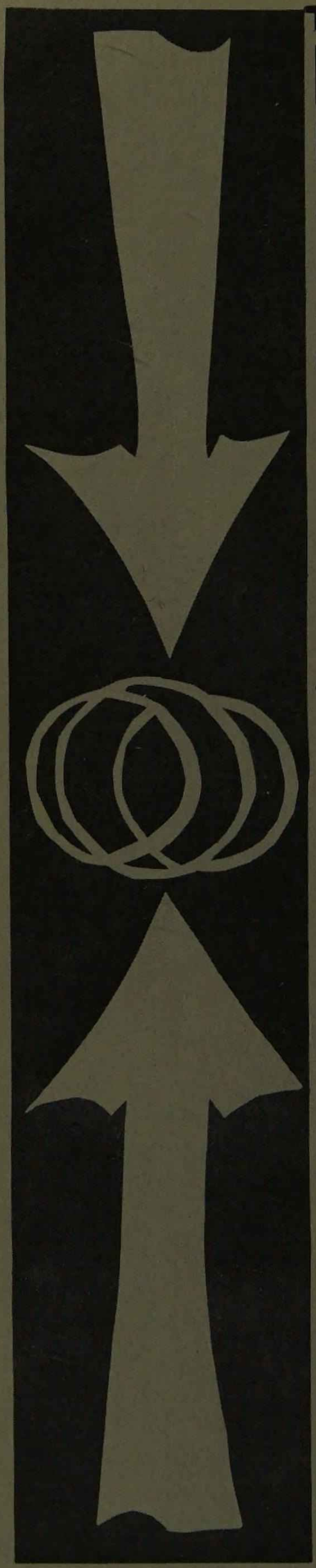

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