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Macmillan Encyclopedia of Death and Dying

Robert Kastenbaum

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PREFACE



The *Macmillan Encyclopedia of Death and Dying* is a contribution to the understanding of life. Scientists and poets have long recognized that life and death are so intimately entwined that knowledge of one requires knowledge of the other. The Old Testament observes that “all flesh is as grass.” Religions have addressed the question of how one should live with the awareness of inevitable death. Often the answer has been based upon the vision of a life beyond death. Societies have developed systems of belief and practice to help their people cope with the prospect of death and the sorrow of grief. Children are often puzzled by the curious fact that flowers fade and animals stop moving. This incipient realization of mortality eventually becomes a significant part of the adult’s world-view in which hope contests with fear, and faith with doubt.

The twenty-first century has inherited an anxiety closet from the past, a closet packed with collective memories of unsettling encounters with death. This history of darkness concealed threats from predators and enemies; child-bearing women and their young children would suddenly pale and die; terrible plagues would periodically ravage the population; the dead themselves were sources of terror when resentful of the living; contact with corpses was perilous but had to be managed with diligence, lest the departing spirit be offended; the spirit world often intervened in everyday life; gods, demi-gods and aggrieved or truculent ancestors had to be pacified by gifts, ceremonies, and conformity to their wishes; animal and human sacrifices were deaths intended to protect the lives of the community by preventing catastrophes or assuring good crops. Everyday life was permeated by rituals intended to distract or bribe the spiritual forces who controlled life and death. Fairly common were such customs as making sure not to speak ill of the dead and protecting home and person with magic charms.

Particular diseases have also left their lingering marks. Tuberculosis, for example, horrified several generations as young men and women experienced a long period of suffering and emaciation before death. The scourge of the industrial era did much to increase fears of dying slowly and in great distress. Syphilis produced its share of unnerving images as gross disfiguration and a descent into dementia afflicted many victims near the end of their lives. All of these past encounters and more have bequeathed anxieties that still influence attitudes toward death today.

The past, however, offers more than an anxiety closet. There was also comfort, wisdom, and the foundation for measures that greatly improved the chances of enjoying a long, healthful life, and to palliate the final passage. The achievements of public health innovations and basic biomedical research are fulfilling dreams that motivated the inquisitive minds of early healers. The hospice care programs that provide comfort and pain relief to terminally ill people build upon the model demonstrated by devoted caregivers more than 2,000 years ago. The peer support groups that console grieving people were prefigured by communal gatherings around the survivors in many villages. Religious images and philosophical thought have helped people to explore the meanings and mysteries of death.

The *Macmillan Encyclopedia of Death and Dying* draws extensively from the past, but is most concerned with understanding the present and the future. The very definition of death has come into question. The ethics of assisted death and euthanasia have become the concern of judges and legislators as well as physicians and clergy. Questions about ongoing changes in society are raised by the facts that accidents, homicide, and suicide are the leading causes of death among youth, and that the suicide rate rises so precipitously for aging men. Continuing violence in many parts of the world suggests that genocide and other forms of mass killing cannot only be of historical concern. Other death-related issues have yet to receive the systematic attention they deserve. For example, widowhood in third world nations is a prime example of suffering and oppression in the wake of death, and, on a different front, advances in the relief of pain too often are not used in end-of-life medical management.

Each of these issues are addressed in this two-volume set as part of a more comprehensive exploration of the place of death in contemporary life. The coverage of the topics is broad and multidisciplinary because death threads through society in so many different ways. Attention is given to basic facts such as life expectancy and the changing causes of death. Many of the entries describe the experiences of terminally ill people and the types of care available while others focus on the situation of those who grieve and mourn. How people have attempted to understand the nature and meaning of death is examined from anthropological, historical, psychological, religious, and sociological perspectives. The appendix, which complements the substantive entries, can be found near the end of the second volume. It provides information on numerous organizations that are active in education, research, services, or advocacy on death-related topics.

The contributors are expert scholars and care providers from a variety of disciplines. Many have made landmark contributions to research and practice, and all have responded to the challenge of presenting accurate, up-to-date, and well-balanced expositions of their topics. As editor in chief, I am much indebted to the distinguished contributors for giving their expertise and time so generously. Contributing mightily to the success of this project were associate editors Jim Crissman, Mike Kearn, and Brian Mishara, each also providing many illuminating articles of their own. Macmillan has published reference books of the highest quality on many topics; the high standards that have distinguished their publications have assured the quality of this project as well. The editor appreciates the opportunity to have worked with Macmillan's Shawn Beall, Joe Clements, Elly Dickason, Brian Kinsey, and Jill Lectka.

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A



ABORTION

Abortion is one of the most emotional and divisive moral issues of twenty-first-century American life. Consensus has not been reached on the numerous questions that swirl around the subject, including whether or not a woman has the right to choose a legal abortion, and under what conditions; the role of parents if she is not legally an adult; and the roles of the state and religion having veto power. In addition, the questions of when life begins and at what point it should be protected remain controversial.

Strictly defined, abortion is the expulsion or removal of an embryo or fetus from the uterus before it has developed sufficiently to survive outside the mother (before viability). As commonly used, the term *abortion* refers only to artificially induced expulsions caused by mechanical means or drugs. Spontaneous abortions occurring naturally and not artificially induced are commonly referred to as miscarriages.

Women choose to have abortions for a variety of reasons: They have had all the children they wish to have; want to delay the next birth; believe they are too young or too poor to raise a child; are estranged or on uneasy terms with their sexual partner; or they do not want a child while they are in school or working.

Artificially Induced Abortion around the World

Unplanned and unwanted pregnancies are common, and this fact fuels the controversy in every region of the world. Globally, more than one in

four women who become pregnant have an abortion or an unwanted birth. In the developed countries of the world, including those in North America and Western Europe, where average desired family size is small, an estimated 49 percent of the 28 million pregnancies each year are unplanned and 36 percent of the total pregnancies end in abortion. In the developing countries, including parts of Eastern Europe, the Middle East, and Africa, where desirable family sizes are larger, an estimated 36 percent of the 182 million pregnancies each year are unplanned and 20 percent end in abortion.

Women worldwide commonly initiate sexual intercourse by age twenty, whether they are married or unmarried. In the developed countries, 77 percent have had intercourse by age twenty. This compares to 83 percent in sub-Saharan Africa and 56 percent in Latin America and the Caribbean. Couples in many countries have more children than they would like, or have a child at a time when they do not want one. The average woman in Kenya has six children, while the desired family size is four; the average Bangladeshi woman has four children but desires three.

From a global perspective, 46 million women have abortions each year; 78 percent of these live in developing countries and 22 percent live in developed countries. About 11 percent of all the women who have abortions live in Africa, 58 percent in Asia, 9 percent in Latin America and the Caribbean; 17 percent live in Europe, and the remaining 5 percent live elsewhere in the developed world.

Of the 46 million women who have abortions each year in the world, 26 million women have abortions legally and 20 million have abortions in countries where abortion is restricted or prohibited by law. For every 1,000 women of childbearing age in the world, each year 35 are estimated to have an induced abortion. The abortion rate for women in developed regions is 39 abortions per 1,000 women per year; in the developing regions the rate is 34 per 1,000 per year. Rates in Western Europe, the United States, and Canada are 10 to 23 per year.

Methods of Abortion

About 90 percent of abortions in the United States are performed in the first twelve weeks of the pregnancy. The type of procedure used for an abortion generally depends upon how many weeks the woman has been pregnant.

Medical induction. The drug mifepristone combined with misoprostol has been used widely in Europe for early abortions, and is now used routinely in the United States. Mifepristone blocks uterine absorption of the hormone progesterone, causing the uterine lining and any fertilized egg to shed. Combined with misoprostol two days later, which increases contractions of the uterus and helps expel the embryo, this method has fewer health risks than surgical abortion and is effective 95 percent of the time. Researchers in Europe report few serious medical problems associated with this method. Some of the side effects include cramping, abdominal pain, and bleeding like that of a heavy menstrual cycle.

Both pro-choice activists and pro-life activists see mifepristone with misoprostol as an important development in the abortion controversy. If abortion can be induced simply, safely, effectively, and privately, the nature of the controversy surrounding abortion will change dramatically. Clinics that perform abortions are regularly picketed by antiabortion protesters in the United States, making the experience of obtaining a legal abortion difficult for many women. If use of this method spreads in spite of opposition from antiabortion groups, abortion will become an almost invisible, personal, and relatively private act.

Vacuum aspiration. Also called vacuum suction or vacuum curettage, vacuum aspiration is an abortion method performed during the first trimester of

pregnancy, up to twelve weeks from the beginning of the last menstrual period. It is the most common abortion procedure used during the first trimester in the United States, requiring a local or general anesthetic. The procedure takes about ten to fifteen minutes, although the woman stays in the doctor's office or hospital for a few hours afterward. Preparation for the procedure is similar to preparing for a pelvic examination. An instrument is then inserted into the vagina to dilate the opening to the cervix. The end of a nonflexible tube connected to a suction apparatus is inserted through the cervix into the uterus and the contents of the uterus, including fetal tissue, are then sucked out. Vacuum aspiration is simple and complications are rare and usually minor.

Dilation and curettage or dilation and evacuation. Dilation and curettage (D and C) is similar to vacuum aspiration but must be performed in a hospital under general anesthetic. It is performed between eight and twenty weeks after the last menstrual period. By the beginning of the second trimester of pregnancy, the uterus has enlarged and its walls have thinned. Its contents cannot be as easily removed by suction, and therefore the D and C procedure is used. The cervix is dilated and a sharp metal loop attached to the end of a long handle (the curette) is inserted into the uterus and used to scrape out the uterine contents. Dilation and evacuation (D and E) is a related procedure used between thirteen and sixteen weeks after the last menstrual period. D and E is similar to both D and C and vacuum aspiration, but is a bit more complicated and requires the use of forceps and suction.

Induced labor. For abortions later in the pregnancy (sixteen to twenty-four weeks), procedures are employed to render the fetus nonviable and induce delivery through the vagina. Only 1 percent of abortions in the United States are performed by inducing labor and a miscarriage. Because the woman experiences uterine contractions for several hours and then expels a lifeless fetus, these procedures are more physically uncomfortable and often more emotionally upsetting. The two most common procedures used in this period are prostaglandin-induced and saline-induced abortions. Prostaglandins can be injected directly into the amniotic sac through the abdominal wall, injected intravenously into the woman, or inserted into the vagina as a suppository. They stimulate uterine contractions that lead to delivery. Saline

(salt) solution can also be injected into the amniotic fluid and has a similar effect. Late-term abortions, also called partial-birth abortions by some, stir considerable controversy in the United States.

Hysterotomy. This extremely rare procedure, also performed from sixteen to twenty-four weeks after the woman's last menstrual period, is limited to cases in which a woman's uterus is so malformed that a D and E would be dangerous. In essence, a cesarean delivery is performed and the fetus is removed.

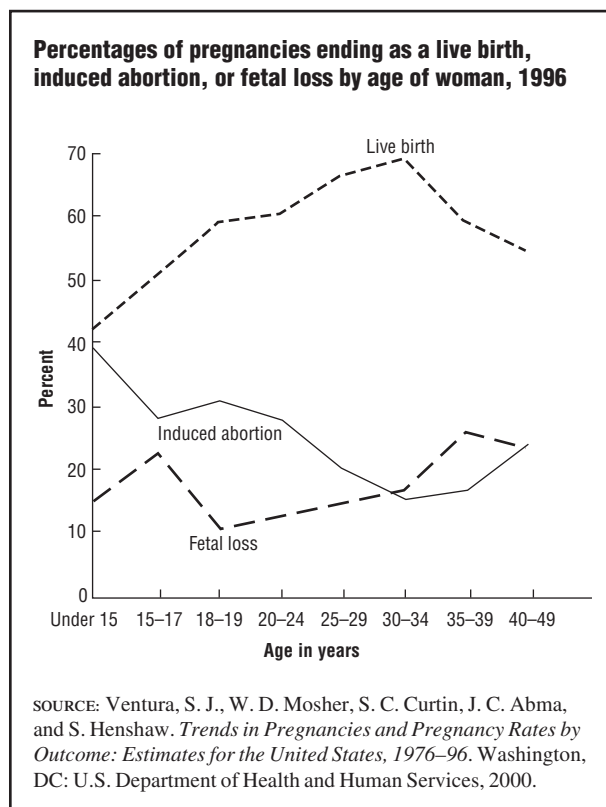
Methotrexate and Misoprostol. Because of social and political pressure from antiabortion activists, the number of obstetricians, gynecologists, and hospitals performing abortions in the United States has been steadily dropping, but this trend could change as doctors adopt a nonsurgical alternative using prescription drugs already marketed for other purposes. A combination of the drug methotrexate, which is toxic to the embryo, with misoprostol, which causes uterine contractions that expel the dead embryo, has been shown to be effective in inducing abortions at home.

The Abortion Issue in the United States

In 1973 the U.S. Supreme Court overturned by a 7–2 vote laws that had made abortion a criminal act. Since that decision by century's end approximately 21 million American women have chosen to have 35 million abortions. Researchers estimate that 49 percent of pregnancies among American women are unintended, and half of these are terminated by abortion. Forty-three percent of women in the United States will have at least one abortion by the time they reach the end of the childbearing period of life, age forty-five. Fifty-eight percent of the women who had abortions in 1995 had used a contraceptive method during the month they became pregnant.

Induced abortion rates vary considerably by age. Figure 1 shows the proportion of pregnancies ending in live births, induced abortion, and fetal loss compared to the age of the woman. Induced abortion rates also differ considerably by race and Hispanic origin. About 16 percent of pregnancies among non-Hispanic white women end in abortion (1 in 6); 22 percent of pregnancies among Hispanic women (1 in 5); and 38 percent of pregnancies among non-Hispanic black women (2 in 5).

FIGURE 1



On average, women in the United States give at least three reasons for choosing an abortion: three-fourths say that having a baby would interfere with work, school, or other responsibilities; approximately two-thirds say that they cannot afford to have a child; and half say that they do not want to be a single parent or are having problems with their husband or partner. Support for abortion varies considerably by social class, with support consistently increasing by income and education.

For more than two centuries in early U.S. history (from the 1600s to the early 1900s), abortion was not a crime if it was performed before quickening (fetal movement, which begins at approximately twenty weeks). An antiabortion movement began in the early 1800s, led by physicians who argued against the validity of the concept of quickening and who opposed the performing of abortions by untrained people, which threatened physician control of medical services. The abortion controversy attracted minimal attention until the mid-1800s when newspapers began advertising abortion preparations. Opponents of these medicines argued that women used them as birth control measures and that women could also hide

extramarital affairs through their use. The medicines were seen by some as evidence that immorality and corruption threatened America. By the early 1900s, virtually all states (at the urging of male politicians; women could not vote at the time) had passed antiabortion laws.

In the landmark 1973 case *Roe v. Wade*, the U.S. Supreme Court made abortion legal by denying the states the right to regulate early abortions. The court conceptualized pregnancy in three parts (trimesters) and gave pregnant women more options in regard to abortion in the first trimester (three months) than in the second or third trimester. The court ruled that during the first trimester the abortion decision must be left to the judgment of the woman and her physician. During the second trimester, the right to abortion remained but a state could regulate certain factors in an effort to protect the health of the woman, such as the type of facility in which an abortion could be performed. During the third trimester, the period of pregnancy in which the fetus is viable outside the uterus, a state could regulate and even ban all abortions except in situations in which they were necessary to preserve the mother's life or health.

The controversy over abortion in the United States did not end with the Supreme Court's decision, but rather has intensified. Repeated campaigns have been waged to overturn the decision and to ban abortion altogether. Although the high court has continued to uphold the *Roe* decision, support for abortion rights has decreased with the appointment of several conservative judges.

A *New York Times*/CBS News Poll taken twenty-five years after *Roe v. Wade* found that the majority of the American public still supports legalized abortion but says it should be harder to get and less readily chosen. Some observers call this a "permit-but-discourage" attitude. Overall, 32 percent of the random sample of 1,101 Americans in the poll said abortion should be generally available and legal; 45 percent said it should be available but more difficult to obtain; and 22 percent said it should not be permitted.

Physical and Emotional Aspects of Abortion

The chance of dying as a result of a legal abortion in the United States is far lower than the chance of dying during childbirth. Before the nine-week point in pregnancy, a woman has a one in 500,000

TABLE 1

| Abortion risks | | Risk of Death In Any Given Year |
|--------------------------|----------------|------------------------------------|
| Legal abortion | | |
| | Before 9 weeks | 1 in 500,000 |
| | 9–12 weeks | 1 in 67,000 |
| | 13–16 weeks | 1 in 23,000 |
| | After 16 weeks | 1 in 8,700 |
| Illegal abortion | | 1 in 3,000 |
| Pregnancy and childbirth | | 1 in 14,300 |

SOURCE: Carlson, Karen J., Stephanie A. Eisenstat, and Terra Ziporyn. *The Harvard Guide to Women's Health*. Cambridge, MA: Harvard University Press, 1996.

chance of dying as a result of an abortion. This compares to a one in 14,300 chance of dying as a result of pregnancy and childbirth (see Table 1). Infection is a possibility after an abortion, but long-term complications such as subsequent infertility, spontaneous second abortions, premature delivery, and low birthweight babies are not likely.

Some women experience feelings of guilt after an abortion, while others feel great relief that they are no longer pregnant. Still other women are ambivalent: They are happy to not be pregnant, but sad about the abortion. Some of these emotional highs and lows may be related to hormonal adjustments and may cease after the woman's hormone levels return to normal. The intensity of feelings associated with an abortion usually diminish as time passes, though some women may experience anger, frustration, and guilt for many years.

Those experiencing severe, negative psychological reactions to abortion are rare, according to research findings reviewed by a panel commissioned by the American Psychological Association. The panel wrote, "the question is not simply whether abortion has some harmful psychological effects, but whether those effects are demonstrably worse than the psychological consequences of unwanted childbirth." Women experiencing distress could find comfort in talking with loved ones, sensitive and trusted friends, and professional counselors experienced in working with abortion issues.

See also: BIOETHICS; BLACK STORK; CHILDREN, MURDER OF; INFANTICIDE; MORTALITY, CHILDBIRTH; MORTALITY, INFANT

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JOHN DEFRAIN

ACCIDENTS

See CAUSES OF DEATH; INJURY MORTALITY.

ADVANCE DIRECTIVES

An advance directive is a statement that declares what kind of lifesaving medical treatment a patient wants after he or she has become incompetent or unable to communicate to medical personnel. Advance directives, which are recognized in every state, are a response to the increasing ability of physicians since the 1950s to delay death through an array of medical technology, such as respirators, feeding tubes, and artificial hydration. This ability to prolong life has led to the need for doctors, patients, and patients' families to make decisions as to whether such technology should be used, especially in those situations when the patient is either near death, comatose, or severely and chronically ill.

Advance directives are an outgrowth of the doctrine of "informed consent." This doctrine, established by the courts, holds that patients, and not their physicians, are responsible for making the final decision about what medical care they want after being provided with complete and accurate medical information. It represents a shift from an earlier more paternalistic model of the doctor-patient relationship in which the physician made most medical decisions. The doctrine is based on the principles of autonomy and self-determination, which recognize the right of individuals to control

their own bodies. An advance directive is a way of recognizing this right prospectively by providing instructions in advance on what the patient would want after he or she is no longer able to communicate his or her decision.

Types of Advance Directives

There are two forms of advance directives: living wills and health care powers of attorney. A living will, so named because it takes effect while the person is still alive, is a written statement expressing whether or not a person wants to accept life-sustaining medical treatment and under what conditions. For example, a living will may state that a person wants a ventilator, but not a feeding tube, in the event of an irreversible or terminal illness. Many states also have Do Not Resuscitate laws, a narrowly tailored type of living will, that allows patients to indicate that they do not want cardiopulmonary resuscitation if they suffer cardiac arrest. These laws also protect health providers from civil or criminal liability when honoring advance directives.

A health care power of attorney, also known as a durable power of attorney or a proxy, provides for someone else, usually a family member or close friend, to make decisions for the patient when he or she is unable. It is broader than a living will because it includes all medical decisions, not just those pertaining to life-sustaining medical treatment. It does not require that the person be terminally ill or in a vegetative state before it is triggered. However, unlike a living will, a proxy may not contain specific instructions on a patient's willingness to accept certain life-sustaining treatment. Instead it is left up to the appointed family member or close friend to determine what the patient would want, based on what the patient has said in the past or the patient's overall life philosophy. For this reason, it is helpful to combine living wills and a power of attorney in one document. Every state has laws that provide for living wills, health care proxies, or both. These laws are commonly referred to as Natural Death Acts.

Advance directives do not have to be in writing and can include oral statements made to family, friends, and doctors before the patient became unable to make a decision regarding his or her medical care. Most states require that evidence

concerning these statements be clear and convincing. In other words, they should not be "casual remarks" but "solemn pronouncements" that specifically indicate what type of life-sustaining treatments the patient wants, and under what conditions. Because such statements are open to interpretation, and past remarks may not be indicative of what a patient presently wants, oral advance directives are often not effective.

If a patient has failed to execute a living will or health care proxy, many states provide for the designation of a surrogate decision maker (usually a family member). However, the situations when a surrogate may be appointed are limited. Depending upon the state, it may only apply when the individual has a terminal illness or is permanently unconscious, or to certain types of treatment, such as cardiopulmonary resuscitation. The surrogate must consider the wishes of the patient, if known, and his or her religious views, values, and morals.

Advance directives may not apply in an emergency situation, especially those that occur outside of a hospital. Emergency medical services (EMS) personnel are generally required to keep patients alive. Some states allow EMS personnel not to resuscitate patients who are certified as terminal and have an identifier, such as a bracelet.

Although the law encourages people to complete advance directives, most do not. It is estimated that only between 10 to 20 percent of the population have advance directives. There are several reasons for this. Young people think that they do not need one, even though the most well-known cases involving the right to die—Karen Ann Quinlan and Nancy Cruzan—involved young women in their twenties in persistent vegetative states. For old and young alike, bringing up the issue with potential surrogates, such as family and friends, can be uncomfortable and upsetting. Some individuals, especially those from traditionally disenfranchised populations such as the poor and minority groups, may fear that an advance directive would be used to limit other types of medical care.

Another primary reason why advance directives are not completed is that oftentimes patients wait for their physicians to broach the subject, rather than initiating it themselves. In a 1991 Harvard study four hundred outpatients of thirty primary care physicians and 102 members of the general

public were interviewed to determine the perceived barriers to executing an advance directive. The most frequently cited reason for not completing an advance directive was the failure of physicians to ask about it. There are several reasons why physicians often do not initiate such discussions, including a belief that such directives are unnecessary (especially for younger patients) and lack of specific knowledge on how to draft one. Also, insurance companies do not reimburse physicians for their time spent discussing advance directives.

Limitations of Advance Directives

Even when advance directives are completed, they may not be complied with. One reason is that they may not be available when needed. In a self-administered questionnaire distributed to 200 outpatients in 1993, half of the patients who had executed an advance directive kept the only copy locked in a safe-deposit box. Hospitals may also fail to include a copy of the patient's advance directive in his or her chart. Physicians may be unaware of a patient's advance directive even when the document is placed in the patient's chart.

Another obstacle to the implementation of advance directives is that the documents themselves may contain ambiguities or terms open to interpretation, making it difficult to apply. For example, some living wills may simply state that the patient does not want heroic medical measures to be undertaken if the condition is terminal. But the term "heroic measures" can mean different things to different people. Artificial nutrition and hydration may be considered heroic to some, but not to others. Other living wills (and some state laws) require that a patient be terminally ill before it is activated. But physicians may disagree over the definition of *terminally ill*; for some it means imminent death and for others it means an irreversible condition that will ultimately result in death. And even a clearly written advance directive may no longer represent a patient's wishes as death becomes imminent.

Health care proxies also have limitations. They often contain no guidance for the appointed person on the patient's views toward life-sustaining medical interventions. Decisions may therefore be based on what the proxy wants and not the patient. Because the proxy is usually a relative or close friend, this person's strong connections to the

patient, and own feelings and beliefs, may influence the decisions made. This is especially true when it comes to withholding certain controversial treatments, such as a feeding tube. Figuring out what the patient would want can also be difficult. Past statements may not be indicative of present desires because a grave illness can alter views held when healthy.

Even when a patient's preference is clear, as expressed by the surrogate or within the document itself, physicians may not always comply with the patient's wishes. One of the largest studies of clinical practices at the end of life, the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (the Support study) involved 4,805 patients in advanced stages of serious illnesses in five teaching hospitals located throughout the United States. The study found that physicians often ignore advance directives. This was true even where, as in the Support study, efforts were made to improve physician-patient communication on end-of-life decisions. The reasons are several, including unclear advance directives and pressure exerted by family members to ignore directives. Physicians may also fear that they may be sued for withholding life supports, although no such lawsuits have ever been successful.

Advance directives also pose a direct challenge to a physician's medical judgment. While the paternalistic model of the physician-patient relationship has been supplanted by one based on shared decision making and informed consent, remnants of the old model still remain. Physicians who see their primary goal as saving lives may also be less willing to yield to the patient's judgment, especially when it is difficult to predict with certainty whether life supports will enhance the patient's life or render dying more painful.

Improving Advance Directives

Attempts to address some of the deficiencies in advance directives have taken several tracks. One approach is to make advance directives more practical and easier to interpret and apply. One suggestion is to include specific medical scenarios and more detailed treatments (although too much specificity can leave out the present scenario). Partnership for Caring, an advocacy group located in Washington D.C., suggests including whether or not artificial nutrition and hydration should be provided

being that these types of treatment often create disagreements. Another suggestion is to include a values history, a detailed rendition of the patient's religious, spiritual, and moral beliefs, which can provide guidance and clarification of the reasons for not choosing life supports. Still another approach recommended by the American Medical Association is the inclusion of general treatment goals, for example "restoring the ability to communicate," that can be used to assess the appropriateness of a given intervention.

Other approaches to increase compliance with advance directives have focused on the behavior of physicians. The medical profession has been criticized for not adequately preparing physicians for dealing with death. Professional medical groups, such as the American Medical Association, have become more involved in preparing physicians by issuing guidelines and reports. A more extreme approach is advocated by some who have proposed imposing sanctions, either professional disciplinary action or penalties and fines, for ignoring an advance directive. Although some state laws provide for such sanctions, they are rarely if ever applied. Legal actions to recover monetary damages from the physician or health care provider for ignoring advance directives have also been initiated.

Other approaches include making the public and medical providers more aware of advance directives, and making them more accessible. A 1990 federal law, the Patient Self-Determination Act, requires hospitals, health maintenance organizations, and others that participate in Medicaid or Medicare to tell patients their rights under state laws to make end-of-life medical decisions. It also requires that advance directives be maintained in patients' charts. An important public education component of the law requires health care providers to educate their staff and the public about advance directives. Several states have tried more experimental approaches, including allowing advance directives to be displayed on driver's licenses and identification cards.

Advance directives are a relatively new phenomenon in medical care, with the first laws providing for them passed in the latter part of the twentieth century. Although there is widespread public support, that support is often more theoretical than practical. Changes in medical practices,

the public's awareness, and the documents themselves have been proposed in order to encourage their use.

See also: BIOETHICS; CRUZAN, NANCY; END-OF-LIFE ISSUES; INFORMED CONSENT; LIVING WILL; NATURAL DEATH ACTS; QUINLAN, KAREN ANN

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VICKI LENS

AFRICAN RELIGIONS

In the religions of Africa, life does not end with death, but continues in another realm. The concepts of “life” and “death” are not mutually exclusive concepts, and there are no clear dividing lines between them. Human existence is a dynamic process involving the increase or decrease of “power” or “life force,” of “living” and “dying,” and there are different levels of life and death. Many African languages express the fact that things are not going well, such as when there is sickness, in the words “we are living a little,” meaning that the level of life is very low. The African religions scholar Placide Tempels describes every misfortune that Africans encounter as “a diminution of vital force.” Illness and death result from some outside agent, a person, thing, or circumstance that weakens people because the agent contains a greater life force. Death does not alter or end the life or the personality of an individual, but only causes a change in its conditions. This is expressed in the concept of “ancestors,” people who have died but who continue to “live” in the community and communicate with their families.

This entry traces those ideas that are, or have been, approximately similar across sub-Saharan Africa. The concepts described within in many cases have been altered in the twentieth century through the widespread influence of Christianity or Islam, and some of the customs relating to burials are disappearing. Nevertheless, many religious concepts and practices continue to persist.

The African Concept of Death

Death, although a dreaded event, is perceived as the beginning of a person’s deeper relationship with all of creation, the complementing of life and

the beginning of the communication between the visible and the invisible worlds. The goal of life is to become an ancestor after death. This is why every person who dies must be given a “correct” funeral, supported by a number of religious ceremonies. If this is not done, the dead person may become a wandering ghost, unable to “live” properly after death and therefore a danger to those who remain alive. It might be argued that “proper” death rites are more a guarantee of protection for the living than to secure a safe passage for the dying. There is ambivalence about attitudes to the recent dead, which fluctuate between love and respect on the one hand and dread and despair on the other, particularly because it is believed that the dead have power over the living.

Many African peoples have a custom of removing a dead body through a hole in the wall of a house, and not through the door. The reason for this seems to be that this will make it difficult (or even impossible) for the dead person to remember the way back to the living, as the hole in the wall is immediately closed. Sometimes the corpse is removed feet first, symbolically pointing away from the former place of residence. A zigzag path may be taken to the burial site, or thorns strewn along the way, or a barrier erected at the grave itself because the dead are also believed to strengthen the living. Many other peoples take special pains to ensure that the dead are easily able to return to their homes, and some people are even buried under or next to their homes.

Many people believe that death is the loss of a soul, or souls. Although there is recognition of the difference between the physical person that is buried and the nonphysical person who lives on, this must not be confused with a Western dualism that separates “physical” from “spiritual.” When a person dies, there is not some “part” of that person that lives on—it is the whole person who continues to live in the spirit world, receiving a new body identical to the earthly body, but with enhanced powers to move about as an ancestor. The death of children is regarded as a particularly grievous evil event, and many peoples give special names to their children to try to ward off the reoccurrence of untimely death.

There are many different ideas about the “place” the departed go to, a “land” which in most cases seems to be a replica of this world. For some

it is under the earth, in groves, near or in the homes of earthly families, or on the other side of a deep river. In most cases it is an extension of what is known at present, although for some peoples it is a much better place without pain or hunger. The Kenyan scholar John Mbiti writes that a belief in the continuation of life after death for African peoples “does not constitute a hope for a future and better life. To live here and now is the most important concern of African religious activities and beliefs. . . . Even life in the hereafter is conceived in materialistic and physical terms. There is neither paradise to be hoped for nor hell to be feared in the hereafter” (Mbiti 1969, pp. 4–5).

The African Concept of the Afterlife

Nearly all African peoples have a belief in a singular supreme being, the creator of the earth. Although the dead are believed to be somehow nearer to the supreme being than the living, the original state of bliss in the distant past expressed in creation myths is not restored in the afterlife. The separation between the supreme being and humankind remains unavoidable and natural in the place of the departed, even though the dead are able to rest there and be safe. Most African peoples believe that rewards and punishments come to people in this life and not in the hereafter. In the land of the departed, what happens there happens automatically, irrespective of a person’s earthly behavior, provided the correct burial rites have been observed. But if a person is a wizard, a murderer, a thief, one who has broken the community code or taboos, or one who has had an unnatural death or an improper burial, then such a person may be doomed to punishment in the afterlife as a wandering ghost, and may be beaten and expelled by the ancestors or subjected to a period of torture according to the seriousness of their misdeeds, much like the Catholic concept of purgatory. Among many African peoples is the widespread belief that witches and sorcerers are not admitted to the spirit world, and therefore they are refused proper burial—sometimes their bodies are subjected to actions that would make such burial impossible, such as burning, chopping up, and feeding them to hyenas. Among the Africans, to be cut off from the community of the ancestors in death is the nearest equivalent of hell.

The concept of reincarnation is found among many peoples. Reincarnation refers to the soul of a

dead person being reborn in the body of another. There is a close relationship between birth and death. African beliefs in reincarnation differ from those of major Asian religions (especially Hinduism) in a number of important ways. Hinduism is “world-renouncing,” conceiving of a cycle of rebirth in a world of suffering and illusion from which people wish to escape—only by great effort—and there is a system of rewards and punishments whereby one is reborn into a higher or lower station in life (from whence the caste system arose). These ideas that view reincarnation as something to be feared and avoided are completely lacking in African religions. Instead, Africans are “world-affirming,” and welcome reincarnation. The world is a light, warm, and living place to which the dead are only too glad to return from the darkness and coldness of the grave. The dead return to their communities, except for those unfortunate ones previously mentioned, and there are no limits set to the number of possible reincarnations—an ancestor may be reincarnated in more than one person at a time. Some African myths say that the number of souls and bodies is limited. It is important for Africans to discover which ancestor is reborn in a child, for this is a reason for deep thankfulness. The destiny of a community is fulfilled through both successive and simultaneous multiple reincarnations.

Transmigration (also called metempsychosis) denotes the changing of a person into an animal. The most common form of this idea relates to a witch or sorcerer who is believed to be able to transform into an animal in order to perform evil deeds. Africans also believe that people may inhabit particular animals after death, especially snakes, which are treated with great respect. Some African rulers reappear as lions. Some peoples believe that the dead will reappear in the form of the totem animal of that ethnic group, and these totems are fearsome (such as lions, leopards, or crocodiles). They symbolize the terrible punishments the dead can inflict if the moral values of the community are not upheld.

Burial and Mourning Customs

Death in African religions is one of the last transitional stages of life requiring passage rites, and this too takes a long time to complete. The deceased must be “detached” from the living and make as smooth a transition to the next life as possible



In the village of Eshowe in the KwaZulu-Natal Province in South Africa, a Zulu Isangoma (diviner), with a puff adder in his mouth, practices soothsaying, or predicting, with snakes. It is impossible to generalize about concepts in African religions because they are ethno-religions, being determined by each ethnic group in the continent.
GALLO IMAGES/CORBIS

because the journey to the world of the dead has many interruptions. If the correct funeral rites are not observed, the deceased may come back to trouble the living relatives. Usually an animal is killed in ritual, although this also serves the practical purpose of providing food for the many guests. Personal belongings are often buried with the deceased to assist in the journey. Various other rituals follow the funeral itself. Some kill an ox at the burial to accompany the deceased. Others kill another animal some time after the funeral (three months to two years and even longer is the period observed). The Nguni in southern Africa call the slaying of the ox “the returning ox,” because the beast accompanies the deceased back home to his or her family and enables the deceased to act as a

protecting ancestor. The “home bringing” rite is a common African ceremony. Only when a deceased person’s surviving relatives have gone, and there is no one left to remember him or her, can the person be said to have really “died.” At that point the deceased passes into the “graveyard” of time, losing individuality and becoming one of the unknown multitude of immortals.

Many African burial rites begin with the sending away of the departed with a request that they do not bring trouble to the living, and they end with a plea for the strengthening of life on the earth and all that favors it. According to the Tanzanian theologian Laurenti Magesa, funeral rites simultaneously mourn for the dead and celebrate life in all its abundance. Funerals are a time for the community to be in solidarity and to regain its identity. In some communities this may include dancing and merriment for all but the immediate family, thus limiting or even denying the destructive powers of death and providing the deceased with “light feet” for the journey to the other world.

Ancient customs are adapted in many South African urban funerals. When someone has died in a house, all the windows are smeared with ash, all pictures in the house turned around and all mirrors and televisions and any other reflective objects covered. The beds are removed from the deceased’s room, and the bereaved women sit on the floor, usually on a mattress. During the time preceding the funeral—usually from seven to thirteen days—visits are paid by people in the community to comfort the bereaved family. In the case of Christians, consolatory services are held at the bereaved home. The day before the funeral the corpse is brought home before sunset and placed in the bedroom. A night vigil then takes place, often lasting until the morning. The night vigil is a time for pastoral care, to comfort and encourage the bereaved. A ritual killing is sometimes made for the ancestors, as it is believed that blood must be shed at this time to avoid further misfortune. Some peoples use the hide of the slaughtered beast to cover the corpse or place it on top of the coffin as a “blanket” for the deceased. Traditionally, the funeral takes place in the early morning (often before sunrise) and not late in the afternoon, as it is believed that sorcerers move around in the afternoons looking for corpses to use for their evil purposes. Because sorcerers are asleep in the early morning, this is a good time to bury the dead.

In some communities children and unmarried adults are not allowed to attend the funeral. During the burial itself the immediate family of the deceased is expected to stay together on one side of the grave at a designated place. They are forbidden from speaking or taking any vocal part in the funeral. It is customary to place the deceased's personal property, including eating utensils, walking sticks, blankets, and other useful items, in the grave. After the funeral the people are invited to the deceased's home for the funeral meal. Many people follow a cleansing ritual at the gate of the house, where everyone must wash off the dust of the graveyard before entering the house. Sometimes pieces of cut aloe are placed in the water, and this water is believed to remove bad luck. Churches that use "holy water" sprinkle people to cleanse them from impurity at this time.

In southern Africa the period of strict mourning usually continues for at least a week after the funeral. During this time the bereaved stay at home and do not socialize or have sexual contact. Some wear black clothes or black cloths fastened to their clothes, and shave their hair (including facial hair) from the day after the funeral. Because life is concentrated in the hair, shaving the hair symbolizes death, and its growing again indicates the strengthening of life. People in physical contact with a corpse are often regarded as unclean. The things belonging to the deceased should not be used at this time, such as the eating utensils or the chairs the deceased used. Blankets and anything else in contact with the deceased are all washed. The clothes of the deceased are wrapped up in a bundle and put away for a year or until the extended period of mourning has ended, after which they are distributed to family members or destroyed by burning. After a certain period of time the house and the family must be cleansed from bad luck, from uncleanness and "darkness." The bereaved family members are washed and a ritual killing takes place. The time of the cleansing is usually seven days after the funeral, but some observe a month or even longer. Traditionally, a widow had to remain in mourning for a year after her husband's death and the children of a deceased parent were in mourning for three months.

A practice that seems to be disappearing in African urban areas is the home-bringing ritual, although it is still observed in some parts of Africa. A month or two after the funeral the grieving family

slaughters a beast and then goes to the graveyard. They speak to the ancestors to allow the deceased to return home to rest. It is believed that at the graves the spirits are hovering on the earth and are restless until they are brought home—an extremely dangerous situation for the family. The family members take some of the earth covering the grave and put it in a bottle. They proceed home with the assurance that the deceased relative is accompanying them to look after the family as an ancestor. Some Christian churches have a night vigil at the home after the home-bringing. The theologian Marthinus Daneel describes the ceremony in some Zimbabwean churches, where the living believers escort the spirit of the deceased relative to heaven through their prayers, after which a mediating role can be attained. The emphasis is on the transformation of the traditional rite, while providing for the consolation of the bereaved family. This example shows how these churches try to eliminate an old practice without neglecting the traditionally conceived need that it has served.

These burial and mourning customs suggest that many practices still prevailing in African Christian funerals are vestiges of the ancestor cult, especially the ritual killings and the home-bringing rites. Because a funeral is preeminently a community affair in which the church is but one of many players, the church does not always determine the form of the funeral. Some of the indigenous rites have indeed been transformed and given Christian meanings, to which both Christians and those with traditional orientation can relate. Sometimes there are signs of confrontation and the changing and discontinuance of old customs to such an extent that they are no longer recognizable in that context.

African funerals are community affairs in which the whole community feels the grief of the bereaved and shares in it. The purpose of the activities preceding the funeral is to comfort, encourage, and heal those who are hurting. Thereafter, the churches see to it that the bereaved make the transition back to normal life as smoothly and as quickly as possible. This transition during the mourning period is sometimes accompanied by cleansing rituals by which the bereaved are assured of their acceptance and protection by God. Because the dominance of Christianity and Islam in Africa has resulted in the rejection of certain mourning customs, the funeral becomes an opportunity to declare faith.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE;
BUDDHISM; CHINESE BELIEFS; HINDUISM; IMMORTALITY;
ISLAM; MIND-BODY PROBLEM; PHILOSOPHY, WESTERN

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ALLAN ANDERSON

AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE

The fear of death and the belief in life after death are universal phenomena. Social scientists have long been interested in the questions of how the similarities and the differences in the views of afterlife and the social reactions to death of different cultures be explained, and the systematic order

that can be found in these similarities and differences. This entry attempts to shed light on a few anthropological, sociological aspects of the organization and distribution of these ideas in connection with the afterlife.

Death As Empirical Taboo and the Consequent Ambivalence

Human consciousness cannot access one's own death as an inner experience. In other words, death is an ineluctable personal experience, which remains outside of an individual's self-reflection throughout his or her entire life.

However, during their lives humans might be witnesses to several deaths, for the quest of the survivors after the substance of death follows the same Baumanian "cognitive scheme" as when they think about the substance of their own mortality. "Whenever we 'imagine' ourselves as dead, we are irremovably present in the picture as those who do the imagining: our living consciousness looks at our dead bodies" (Bauman 1992, p. 15) or, in the case of someone else's death, the agonizing body of "the other."

Therefore, when speaking about the cognitive ambivalence of death, this entry refers to the simultaneous presence of (1) the feeling of uncertainty emerging from the above-mentioned empirical taboo character of death, and (2) the knowledge of its ineluctability. This constellation normally constitutes a powerful source of anxiety.

It is obvious that a number of other situations can also lead to anxieties that, at first sight, are very similar to the one emerging from the cognitive ambivalence of death. However, while such experiences can often be avoided, and while people normally have preceding experiences about their nature, by projecting these people might decrease their anxiety. The exceptionally dramatic character of the cognitive ambivalence of death emerges both from its harsh ineluctability, and from the fact that people have to completely renounce any preceding knowledge offered by self-reflection.

The Concept of Death As a Social Product

In order to locate the problem of death in the social construction of reality in a more or less reassuring way, and thus effectively abate the anxiety emerging from the cognitive ambivalence of death, every culture is bound to attribute to it some meaning.

This meaning, accessible and perceivable by human individuals, involves constructing a unique concept of death and afterlife. Naturally, there is great difference in the intensity of the necessity of meaning attribution to death between different cultures. The construction of a death concept (partially) alleviates the empirical taboo of death, and makes it meaningful. This “slice” of knowledge as an ideology, as a “symbolic superstructure” settles on the physiological process of death, covering, reconceptualizing, and substituting it with its own meanings (Bloch 1982, p. 227).

The necessity of anthropomorphizing. It can hardly be argued that more or less the whole process of the construction of knowledge on the nature of death is permeated by the epistemological imperative of anthropomorphizing. The essence of this mechanism, necessarily resulting from death as an empirical taboo, is that individuals essentially perceive death and afterlife on the pattern of their life in this world, by the projection of their anthropomorphic categories and relations.

The significance of anthropomorphizing was emphasized at the beginning of the twentieth century by a number of scholars. As Robert Hertz claims, “Once the individual has surmounted death, he will not simply return to the life he has left . . . He is reunited with those who, like himself and those before him, have left this world and gone to the ancestors. He enters this mythical society of souls which each society constructs in its own image” (Hertz 1960, p. 79). Arnold van Gennep argues, “The most widespread idea is that of a world analogous to ours, but more pleasant, and of a society organized in the same way as it is here” (van Gennep 1960, p. 152).

Anthropomorphizing the ideas concerning the other world, in other words “their secularization,” is present in all religious teachings with greater or less intensity. It can also be found in systems of folk beliefs that are not in close connection to churches or religious scholars. It is an obviously anthropomorphic feature of the Hungarian peasant system of folk beliefs that is far from being independent from Christian thinking. According to the members of the Hungarian peasant communities, for example, the surviving substance generally crosses a bridge over a river or a sea in order to reach the other world. Before crossing, the soul has to pay a toll. It is also an anthropomorphic

image from the same cultural sphere that on the night of the vigil the departing soul may be fed with the steam of the food placed on the windowsill of the death house, and can be clad by clothes handed down to the needy as charity. Anthropomorphic explanation is attributed to the widespread practice of placing the favorite belongings of the deceased in the tomb. These items are usually placed by the body because the deceased is supposed to be in need of them in the afterlife.

The need to rationalize the death concept. In most cases images concerning the other world take an institutionalized form, that is their definition, canonization, and spreading is considerably influenced by certain social institutions—generally by a church or an authorized religious scholar.

While constructing the reality enwrapping death, the assertions of these social institutions draw their legitimacy from two basic sources. The first is the anthropomorphic character of their death concept, namely that this concept promises the fulfillment of the people’s natural desire for a more or less unbroken continuation of existence, which almost equals to an entire withdrawal of death as a metamorphose. The second is the worldly influence these social institutions, comprising mostly the control of the process and social spaces of socialization, which lays at the basis of the normative efficiency of these social institutions, and which thus endows the beliefs distributed by them with the appearance of reality and legitimacy.

A key duty of those constructing the death concept is, therefore, to create a feeling of probability and validity of this slice of knowledge, and to provide the continuous maintenance of the same. This can be fulfilled on the one hand by the reproduction of the normative competence laying at the basis of the legitimacy, and on the other hand by the “rationalization” or “harmonization” of the death concept—that is, by the assimilation of its elements to (1) the extension and certain metamorphoses of the normative competence; (2) the biological dimension of death; and (3) other significant social and cultural changes.

The necessity of the harmonization of some of the changes of normative competence with the death concept is well exemplified by the twentieth-century eschatological, ceremonial, and moral Christian sanctions against suicides. In the background of this change can be found both the

decomposition of the (at least European) hegemony of Christian readings of reality, the pluralization of religiosity at the end of the millennium, and the exacerbation of the “open market competition” for the faithful, as well as the modification of the social judgement or representation on the “self-determination of life” (Berger 1967, pp. 138–143).

On the other hand, the social institution responsible for constructing and controlling death concepts can never lose sight of the biological aspect of life, which obviously sets limits to their reality-constructing activity: They are bound to continuously maintain the fragile harmony between the physiological dimension of mortality and the ideology “based on it,” and to eliminate the discomposing elements (Bloch and Parry 1982, p. 42). The same concept is emphasized by Robert Hertz based on Melanesian observations:

. . . the dead rise again and take up the thread of their interrupted life. But in real life one just has to accept irrevocable fact. However strong their desire, men dare not hope for themselves ‘a death like that of the moon or the sun, which plunge into the darkness of Hades, to rise again in the morning, endowed with new strength.’ The funeral rites cannot entirely nullify the work of death: Those who have been struck by it will return to life, but it will be in another world or as other species. (Hertz 1960, p. 74)

The aforementioned thoughts on the harmonizing of the physiological dimensions of death and the death concept can be clarified by a concrete element of custom taken from the European peasant culture. It is a well-known phenomenon in most cultures that the survivors strive to “blur” the difference between the conditions of the living and the dead, thus trying to alleviate the dramatic nature of death. It is the most practically and easily done if they endow the corpse with a number of features that only belong to the living. However, the psychological process induced by death obviously restrains these attempts. The custom of feeding the returning soul, which was present in a part of the European peasant cultures until the end of the twentieth century, provides a great example. The majority of the scholarship discussing this concept is about symbolic forms of eating/feeding

(that is, the returning soul feeds on the steam of food; the food saved for the dead during the feast or given to a beggar appear on the deceased person’s table in the afterlife). Texts only occasionally mention that the dead person takes the food as the living would do. If the returning soul was supposed to eat in the same manner as the living, it would have to be endowed with features whose reality is mostly and obviously negated by experience (according to most reports the prepared food remains untouched), thus they would surely evoke suspect concerning the validity and probability of the beliefs. The soul must be fed in a primarily symbolic way because the worldly concept of eating needs to be adjusted to the physiological changes induced by death as well, so that it would also seem real and authentic for the living.

Finally, the social institution controlling the maintenance of the death concept has to harmonize its notions about the substance of death continuously with other significant slices of reality as well, namely, with some changes of society and culture. Consider the debates on reanimation and euthanasia in the second half of the twentieth century. These debates constrained the Christian pastoral power to create its own standpoints, and to partly rewrite some details of the Christian concept of death such as other-worldly punishments of the suicides.

These examples demonstrate that the complete freedom of the attribution of meaning in the construction of death concept is a mere illusion. This freedom is significantly limited by the fact that these beliefs are social products; in other words, that the factors indispensable to the successful social process of reality construction—to make a belief a solid and valid reading of the reality for the “newcomers in socialization”—are generally fairly limited.

See also: BUDDHISM; CHINESE BELIEFS; DEATH SYSTEM; GENNEP, ARNOLD VAN; HINDUISM; IMMORTALITY; MIND-BODY PROBLEM; NEAR-DEATH EXPERIENCES; SOCIAL FUNCTIONS OF DEATH; PHILOSOPHY, WESTERN

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PETER BERTA

AIDS

In June 1981 scientists published the first report of a mysterious and fatal illness that initially appeared to affect only homosexual men. Subsequent early reports speculated that this illness resulted from homosexual men's sexual activity and, possibly, recreational drug use. In the months that followed, however, this same illness was diagnosed in newborns, children, men, and women, a pattern strongly suggesting a blood-borne infection as the cause of the observed illness. The illness was initially identified by several terms (e.g., "gay bowel syndrome," "lymphadenopathy virus (LAV)," and AIDS-associated retrovirus (ARV), but by 1982 this disease came to be known as acquired immune deficiency syndrome (AIDS) because of the impact of the infectious agent, human immunodeficiency virus (HIV), on an infected person's immune system. Since about 1995 the term *HIV disease* has been used to describe the condition of HIV-infected persons from the point of early infection through the development of AIDS.

Over the next two decades AIDS became one of the leading causes of death in the United States and in other parts of the world, particularly in persons younger than forty-five years of age. Since the 1990s in the United States AIDS has come to be viewed as an "equal opportunity" disease, because it affects persons of all colors, class, and sexual orientation. Despite the evolution of major treatment advances for HIV infection and AIDS, HIV disease

has been the cause of death for about 450,000 persons living in the United States since the onset of the epidemic. In addition, an estimated 800,000 to 900,000 Americans are infected with the virus that causes AIDS—and perhaps as many as 300,000 are unaware of their infection. Better treatments for HIV infection have resulted in a reduction in the number of deaths from AIDS and an increase in the number of persons living with HIV infection.

The cause of AIDS was identified in 1983 by the French researcher Luc Montagnier as a type of virus known as a "retrovirus." This newly identified retrovirus was eventually called "human immunodeficiency virus," or HIV. Scientists have established HIV as the cause of AIDS, even though a small group of individuals have questioned the link between HIV and AIDS. An HIV-infected person who meets specific diagnostic criteria (i.e., has one or more of the twenty-five AIDS-defining conditions indicative of severe immunosuppression and/or a seriously compromised immune system) is said to have AIDS, the end stage of a continuous pathogenic process. Multiple factors influence the health and functioning of HIV-infected persons. For example, some persons who meet the diagnostic criteria for AIDS may feel well and function normally, while other HIV-infected persons who do not meet the diagnostic criteria for AIDS may not feel well and have reduced functioning in one or more areas of their lives.

While drugs are now available to treat HIV infection or specific HIV-related conditions, these treatments are expensive and unobtainable to most of the world's infected individuals, the vast majority of whom live in poor, developing nations. Thus the most important and effective treatment for HIV disease is prevention of infection. Preventive measures are challenging because sexual and drug use behaviors are difficult to change; certain cultural beliefs that influence the potential acquisition of infection are not easily modified; many persons at highest risk lack access to risk-reduction education; and many persons (especially the young) deny their vulnerability to infection and engage in behaviors that place them at risk of infection.

An individual may be infected with HIV for ten years or more without symptoms of infection. During this period, however, the immune system of the untreated person deteriorates, increasing his or

her risk of acquiring “opportunistic” infections and developing certain malignancies. While HIV disease is still considered a fatal condition, the development in the 1990s of antiretroviral drugs and other drugs to treat opportunistic infections lead many infected individuals to hope that they can manage their disease for an extended period of time. Unfortunately, the view that HIV disease is a “chronic” and “manageable” condition (as opposed to the reality that it is a fatal condition) may lead persons to engage in behaviors that place them at risk of infection. In the United States, for example, epidemiologists have noted an upswing in the number of HIV infections in young homosexual men who, these experts believe, engage in risky behaviors because HIV disease has become less threatening to them. These individuals are one generation removed from the homosexual men of the 1980s who saw dozens of their friends, coworkers, and neighbors die from AIDS and thus may not have experienced the pain and grief of the epidemic’s first wave.

Origin of HIV

The origin of the human immunodeficiency virus has interested scientists since the onset of the epidemic because tracing its history may provide clues about its effects on other animal hosts and on disease treatment and control. While HIV infection was first identified in homosexual men in the United States, scientists have learned from studies of stored blood samples that the infection was present in human hosts years—and perhaps decades—before 1981. However, because the number of infected individuals was small and the virus was undetectable prior to 1981, a pattern of disease went unrecognized. HIV disease may have been widespread, but unrecognized, in Africa before 1981.

While a number of theories, including controversial conspiracy theories, have been proposed to explain the origin of HIV and AIDS, strong scientific evidence supports the view that HIV represents a cross-species (zoonosis) infection evolving from a simian (chimpanzee) virus in Southwest Africa between 1915 and 1941. How this cross-species shift occurred is unclear and a topic of considerable debate. Such an infectious agent, while harmless in its natural host, can be highly lethal to its new host.

Epidemiology of HIV Disease

Because HIV has spread to every country of the world, it is considered a pandemic. By the end of 2001 an estimated 65 million persons worldwide had been infected with HIV and of these, 25 million had died. An estimated 14,000 persons worldwide are infected every day. Most (95%) of the world’s new AIDS cases are in underdeveloped countries. About 70 percent of HIV-infected persons live in sub-Saharan Africa. Globally 1 in 100 people are infected with HIV. The effects of HIV disease on the development of the world have been devastating. Millions of children in developing nations are infected and orphaned. The economies of some developing nations are in danger of collapse; and some nations risk political instability because of the epidemic.

Over the past decade an estimated 40,000 persons living in the United States have become infected with HIV every year, a figure that has remained relatively stable. Between 1981 and 2000 more than 774,000 cases of AIDS were reported to the Centers for Disease Control and Prevention (CDC). Of these cases, more than 82 percent were among males thirteen years and older, while more than 16 percent were among females thirteen years and older. Less than 2 percent of AIDS cases were among children younger than thirteen years of age. More than 430,000 persons living in the United States had died from AIDS by the end of 1999. The annual number of deaths among persons with AIDS has been decreasing because of early diagnosis and improved treatments for opportunistic infections and HIV infection.

The epidemiologic patterns of HIV disease have changed significantly since the onset of the epidemic. In 1985, for example, 65 percent of new AIDS cases were detected among men who have sex with other men (MSM). Since 1998 only about 42 percent of new AIDS cases have been detected among MSM, although the rate of new infections in this group remains high. Increasing numbers of new AIDS cases are attributed to heterosexual contact (but still only about 11 percent of the cumulative AIDS cases) and among injection drug users (about 25 percent of cumulative AIDS cases). In 2002 women, who are primarily infected through heterosexual contact or injection drug use, account for about 30 percent of all new HIV infections, a dramatic shift in the United States since 1981. In

developing parts of the world men and women are infected in equal numbers.

In the United States new HIV infections and AIDS disproportionately affect minority populations and the poor. Over half (54%) of new HIV infections occur among African Americans, who represent less than 15 percent of the population. Hispanics are disproportionately affected as well. African-American women account for 64 percent (Hispanic women, 18%) of new HIV infections among women. African-American men account for about half of new HIV infections among men, with about equal numbers (18%) of new infections in white and Hispanic men. HIV infections in infants have been dramatically reduced because of the use of antiretroviral drugs by HIV-infected women who are pregnant.

HIV Disease: The Basics

There are two major types of human immunodeficiency virus: HIV-1 and HIV-2. HIV-1 is associated with most HIV infections worldwide except in West Africa, where HIV-2 is prevalent. Both types of viruses may be detected through available testing procedures. HIV is a retrovirus and member of a family of viruses known as lentiviruses, or “slow” viruses. These viruses typically have a long interval between initial infection and the onset of serious symptoms. Lentiviruses frequently infect cells of the immune system. Like all viruses, HIV can replicate only inside cells, taking over the cell’s machinery to reproduce. HIV, once inside a cell, uses an enzyme called reverse transcriptase to convert ribonucleic acid (RNA) into deoxyribonucleic acid (DNA), which is incorporated into the host cell’s genes. The steps in HIV replication include: (1) attachment and entry; (2) reverse transcription and DNA synthesis; (3) transport to nucleus; (4) integration; (5) viral transcription; (6) viral protein synthesis; (7) assembly and budding of virus; (8) release of virus; and (9) maturation. In addition to rapid replication, HIV reverse transcriptase enzyme makes many mistakes while making DNA copies from HIV RNA, resulting in multiple variants of HIV in an individual. These variants may escape destruction by antibodies or killer T cells during replication.

The immune system is complex, with many types of defenses against infections. Some parts of

this system have key coordinating roles in mobilizing these defenses. One such key is the CD4+ T-lymphocyte (also known as CD4+T cell and T-helper cell), a type of lymphocyte that produces chemical “messengers.” These messengers strengthen the body’s immune response to infectious organisms. The cell most markedly influenced by HIV infection is the CD4+T-lymphocyte. Over time HIV destroys these CD4+T cells, thus impairing the immune response of people with HIV disease and making them more susceptible to secondary infections and some types of malignant tumors.

If HIV infection progresses untreated, the HIV-infected person’s number of CD4+T-lymphocytes declines. Therefore, early in the course of HIV disease the risk for developing opportunistic infections is low because the CD4+T-lymphocytes may be nearly normal or at least adequate to provide protection against pathogenic organisms; however, in untreated individuals the risk of infection increases as the number of CD4+ cells falls. The rate of decline of CD4+T lymphocyte numbers is an important predictor of HIV-disease progression. People with high levels of HIV in their bloodstream are more likely to develop new AIDS-related symptoms or die than individuals with lower levels of virus. Thus early detection and treatment of HIV infection and routine use of blood tests to measure viral load are critical in treating HIV infection. HIV may also directly infect other body cells (e.g., those of the brain and gastrointestinal tract), resulting in a range of clinical conditions. When cells at these sites are infected with HIV, such problems as dementia and diarrhea may result; thus even if HIV-infected persons do not develop an opportunistic infection or malignancy, they may experience a spectrum of other clinical problems that require medical treatment or interfere with their quality of life.

How Is HIV Spread?

The major known ways by which HIV infection is spread are: (1) intimate sexual contact with an HIV-infected person; (2) exposure to contaminated blood or blood products either by direct inoculation, sharing of drug apparatus, transfusion, or other method; and (3) passage of the virus from an infected mother to her fetus or newborn in utero, during labor and delivery, or in the early newborn (including through breast-feeding). Some health

care workers have become occupationally infected with HIV, but these numbers are small in light of the millions of contacts between health care workers and persons with HIV infection. Most occupationally acquired HIV infections in such workers have occurred when established “universal precautions” have not been followed.

HIV-infected blood, semen, vaginal fluid, breast milk, and other bodily fluids containing blood have been proven to have the potential to transmit HIV. While HIV has been isolated from other cells and tissues, the importance of these bodily fluids in transmission is not entirely clear. Health care workers may come into contact with other bodily fluids that can potentially transmit HIV. While HIV has been transmitted between members in a household setting, such transmission is extremely rare. There are no reports of HIV being transmitted by insects; by nonsexual bodily contact (e.g., handshaking); through closed mouth or social kissing; or by contact with saliva, tears, or sweat. One cannot be HIV-infected by donating blood. Transfusion of blood products can pose a risk of infection, but the risk is low in the United States, where all such products are carefully tested.

Several factors (called “cofactors”) may play a role in the acquisition of HIV infection, influence its transmission, affect development of clinical signs and symptoms, and influence disease progression. Cofactors that have been mentioned in scientific literature include anal receptive sex resulting in repeated exposure to absorbed semen; coexistence of other infections (e.g., syphilis, hepatitis B); injection and recreational drug use; use of immunosuppressant drugs (e.g., cocaine, alcohol, or amyl/butyl nitrites); douching or enemas before sexual intercourse; malnutrition; stress; age at time of seroconversion; genetic susceptibility; multiple sexual partners; and presence of genital ulcers.

Preventing HIV Infection

HIV infection is almost 100 percent preventable. HIV infection may be prevented by adhering to the following measures:

- engaging in one-partner sex where both participants are HIV-negative and are maintaining a sexual relationship that only involves those two participants;

- using latex or polyurethane condoms properly every time during sexual intercourse, including oral sex;
- not sharing needles and syringes used to inject drugs or for tattooing or body piercing;
- not sharing razors or toothbrushes;
- being tested for HIV if one is pregnant or considering pregnancy;
- prohibiting oneself from breast-feeding if HIV-positive; and
- calling the CDC National AIDS Hotline at 1-800-342-AIDS (2437) for more information about AIDS prevention and treatment (or by contacting www.cdc.gov/hiv to access the CDC Division of HIV/AIDS for information).

What Happens after Infection with HIV?

Following infection with HIV the virus infects a large number of CD4+ cells, replicating and spreading widely, and producing an increase in viral burden in blood. During this acute stage of infection, which usually occurs within the first few weeks after contact with the virus, viral particles spread throughout the body, seeding various organs, particularly the lymphoid organs (lymph nodes, spleen, tonsils, and adenoids). In addition, the number of CD4+ T cells in the bloodstream decreases by 20 to 40 percent. Infected persons may also lose HIV-specific CD4+ T cell responses that normally slow the replication of viruses in this early stage. Within a month of exposure to HIV the infected individual’s immune system fights back with killer T cells (CD8+ T cells) and B-cell antibodies that reduce HIV levels, allowing for a rebound of CD4+ T cells to 80 to 90 percent of their original level. The HIV-infected person may then remain free of HIV-related symptoms for years while HIV continues to replicate in the lymphoid organs seeded during the acute phase of infection. Also at this point many infected persons experience an illness (called “primary” or “acute” infection) that mimics mononucleosis or flu and usually lasts two to three weeks.

In untreated HIV-infected persons, the length of time for progression to disease varies widely. Most (80 to 90 percent) HIV-infected persons develop AIDS within ten years of initial infection; another 5 to 10 percent of infected persons

progress to AIDS within two to three years of HIV infection; about 5 percent are generally asymptomatic for seven to ten years following infection and have no decline in CD4+T lymphocyte counts. Efforts have been made to understand those factors that affect disease progression, including viral characteristics and genetic factors. Scientists are also keenly interested in those individuals who have repeated exposures to HIV (and may have been acutely infected at some point) but show no clinical evidence of chronic HIV infection.

Testing and Counseling

Testing for HIV infection has complex social, ethical, legal, and health implications. HIV testing is done for several reasons: to identify HIV-infected persons who may benefit from early medical intervention; to identify HIV-negative persons who may benefit from risk reduction counseling; to provide for epidemiological monitoring; to engage in public health planning. Individuals who seek HIV testing expect that test results will remain confidential, although this cannot be entirely guaranteed. Anonymous testing is widely available and provides an additional measure of confidentiality.

HIV testing has been recommended for those who consider themselves at risk of HIV disease, including:

- women of childbearing age at risk of infection;
- persons attending clinics for sexually transmitted disease and drug abuse;
- spouses and sex- or needle-sharing partners of injection drug users;
- women seeking family planning services;
- persons with tuberculosis;
- individuals who received blood products between 1977 and mid-1995; and
- others, such as individuals with symptoms of HIV-related conditions; sexually active adolescents; victims of sexual assault; and inmates in correctional facilities.

Detection of HIV antibodies is the most common approach to determine the presence of HIV infection, although other testing approaches can detect the virus itself. Testing for HIV infection is usually accomplished through standard or rapid

detection (results are obtained in five to thirty minutes) of anti-HIV antibodies in blood and saliva. The most common types of antibody test for HIV serodiagnosis include the enzyme-linked immunosorbent assay (ELISA), the Western blot, immunofluorescence, radioimmuno-precipitation, and hemagglutination. These tests do not directly measure the presence of the virus but rather the antibodies formed to the various viral proteins. One home testing kit—the Home Access HIV-1 Test System—is approved by the U.S. Food and Drug Administration. Oral and urine-based tests are available for rapid screening in medical offices but are typically followed up by one or more tests for confirmation. Most tests used to detect HIV infection are highly reliable in determining the presence of HIV infection, but false-positive and false-negative results have been documented by Niel Constantine and other health care professionals.

Testing for HIV infection should always include pre- and posttest counseling. Guidelines for such testing have been published by the CDC. Pretest counseling should include information about the test and test results, HIV infection, and AIDS; performance of a risk assessment and provision of information about risk and risk reduction behaviors associated with the transmission of HIV; discussion about the consequences (i.e., medical care, pregnancy, employment, insurance) of a positive or negative result for the person being tested and for others (family, sexual partner(s), friends); and discussion about the need for appropriate follow-up in the event of positive test results. Post-test counseling is dependent upon test results, but generally includes provision of test results, emotional support, education, and, when appropriate, referral for medical or other forms of assistance.

Clinical Manifestations of HIV Disease

The clinical manifestations of HIV vary greatly among individuals and depend upon individual factors and the effectiveness of medical intervention, among other factors. Primary infection may also offer the first opportunity to initiate antiretroviral therapy, although all experts do not agree that such therapy should be initiated at this stage of the infection. The symptom-free period of time following primary infection has been extended in many infected persons by the introduction of highly active antiretroviral therapy (HAART). Many HIV-infected persons, especially those who do not



Patchwork of the 1996 AIDS Memorial Quilt covers the grass of the Mall in Washington, D.C. Since the onset of the epidemic, HIV, the virus that causes AIDS, has caused the death of an estimated 450,000 people living in the United States. PAUL MARGOLIES

receive antiretroviral therapy, those who respond poorly to such therapy, and those who experience adverse reactions to these drugs, will develop one or more opportunistic conditions, malignancies, or other conditions over the course of their disease.

Opportunistic Infections

Prior to the HIV epidemic, many opportunistic infections (OIs) seen in HIV-infected persons were not commonly encountered in the health care community. Many of the organisms responsible for these OIs are everywhere (ubiquitous) in the environment and cause little or no disease in persons with competent immune systems. However, in those who are immunocompromised, these organisms can cause serious and life-threatening disease. Since the introduction of HAART the incidence of HIV-related opportunistic infections and malignancies has been declining. The epidemiological patterns of at least some of these opportunistic diseases vary by region and country. Ideally,

treatment of OIs is aimed at prevention of infections, treatment of active infections, and prevention or recurrences. Over the course of the HIV epidemic several new drugs and treatment approaches aimed at OIs have been introduced or refined. Guidelines have also been developed concerning the prevention of exposure to opportunistic pathogens.

Opportunistic infections affecting HIV-infected persons fall into four major categories:

1. Parasitic/Protozoa infections—cryptosporidiosis, toxoplasmosis, isosporiasis, and microsporidiosis.
2. Fungal infections—pneumocystosis, cryptococcus, candidiasis (thrush), histoplasmosis, and coccidioidomycosis.
3. Bacterial infections—*mycobacterium avium* complex (MAC), *mycobacterium tuberculosis* (TB), and salmonellosis.
4. Viral infections—cytomegalovirus, herpes simplex types 1 and 2, and varicella-zoster virus (shingles), cytomegalovirus, and hepatitis.

Parasitic infections can cause significant illness and death among HIV-infected persons. Fungal diseases may vary widely among persons with HIV disease because many are commonly found in certain parts of the world and less common in others. Bacterial infections are also seen as important causes of illness and death in HIV-infected persons. Viral infections are common in this population and are often difficult to treat because of the limited number of antiviral drugs that are available. Persons with HIV disease often suffer from recurrences of viral infections. Those whose immune systems are severely compromised may have multiple infections simultaneously.

Two categories of malignancies that are often seen in persons with HIV disease are Kaposi's sarcoma (KS) and HIV-associated lymphomas. Prior to the HIV epidemic KS was rarely seen in the United States. Since the mid-1990s, researchers have also suggested an association between cervical and anal cancers. When cancers develop in a person with HIV disease these conditions tend to be aggressive and resistant to treatment.

In addition to the opportunistic infections and malignancies, persons with HIV disease may experience Wasting syndrome and changes in mental

functioning. Wasting syndrome is a weight loss of at least 10 percent in the presence of diarrhea or chronic weakness and documented fever for at least thirty days that is not attributable to a concurrent condition other than HIV infection. Multiple factors are known to cause this weight loss and muscle wasting, including loss of appetite, decreased oral intake, and nausea and vomiting. Wasting is associated with rapid decline in overall health, increased risk of hospitalization, development of opportunistic infection, decreased quality of life, and decreased survival. Interventions include management of infections, oral nutritional supplements, use of appetite stimulants, management of diarrhea and fluid loss, and exercise.

AIDS dementia complex (ADC) is a complication of late HIV infection and the most common cause of neurological dysfunction in adults with HIV disease. Its cause is believed to be direct infection of the central nervous system by HIV. This condition can impair the intellect and alter motor performance and behavior. Early symptoms include difficulty in concentration, slowness in thinking and response, memory impairment, social withdrawal, apathy, personality changes, gait changes, difficulty with motor movements, and poor balance and coordination. As ADC advances, the affected person's cognitive functioning and motor skills worsen. Affected persons may enter a vegetative state requiring total care and environmental control. Treatment focuses on supportive care measures and aggressive use of HAART.

Finally, persons with HIV disease frequently experience mental disorders, especially anxiety and depression. These are typically treated by standard drug therapy and psychotherapy. Persons with HIV disease are also at greater risk of social isolation, which can have a negative impact on their mental and physical health.

Management of HIV Disease

Better understanding of HIV pathogenesis, better ways to measure HIV in the blood, and improved drug treatments have greatly improved the outlook for HIV-infected persons. Medical management focuses on the diagnosis, prevention, and treatment of HIV infection and related opportunistic infections and malignancies. HIV-infected persons who seek care from such providers should expect

to receive compassionate and expert care in such settings. Management of HIV disease includes:

- early detection of HIV infection;
- early and regular expert medical evaluation of clinical status;
- education to prevent further spread of HIV infection and to maintain a healthy lifestyle;
- administration of antiretroviral drugs;
- provision of drugs to prevent the emergence of specific opportunistic infections;
- provision of emotional/social support;
- medical management of HIV-related symptoms;
- early diagnosis and appropriate management of OIs and malignancies; and
- referral to medical specialists when indicated.

The mainstay of medical treatment for HIV-infected persons is the use of antiretroviral drugs. Goals of antiretroviral therapy are to prolong life and improve quality of life; to suppress virus below limit of detection for as long as possible; to optimize and extend usefulness of available therapies; and to minimize drug toxicity and manage side effects.

Two major classes of antiretroviral drugs are available for use in the treatment of HIV infection—reverse transcriptase inhibitors (RTIs) and protease inhibitors (PIs). These drugs act by inhibiting viral replication. RTIs interfere with reverse transcriptase, an enzyme essential in transcribing RNA into DNA in the HIV replication cycle. Protease inhibitor drugs work by inhibiting the HIV protease enzyme, thus preventing cleavage and release of mature, infectious viral particles. Dozens of other drugs that may become available in the next few years to treat HIV infection are under development and testing. Because of the high costs of these drugs, individuals needing assistance may gain access to HIV-related medications through the AIDS Drug Assistance Program (ADAP) and national pharmaceutical industry patient assistance/expanded access programs.

Panels of HIV disease experts have released guidelines for the use of antiretroviral agents in infected persons. The guidelines, which are revised periodically to reflect rapidly evolving knowledge relative to treatment, are widely available on the

Internet. These guidelines have greatly assisted practitioners to provide a higher standard of care for persons living with HIV disease.

Viral load tests and CD4+ T-cell counts are used to guide antiretroviral drug treatment, which is usually initiated when the CD4+ T-cell count falls below 500 and/or there is evidence of symptomatic disease (e.g., AIDS, thrush, unexplained fever). Some clinicians recommend antiretroviral drug treatment to asymptomatic HIV-infected persons.

Because HIV replicates and mutates rapidly, drug-resistance is a challenge, forcing clinicians to alter drug regimens when these instances occur. Inadequate treatment, poor adherence, and interruptions in treatment increase drug resistance. This resistance can be delayed by the use of combination regimens to achieve CD4+T-cell counts below the level of detection. Careful adherence to prescribed HAART regimens is crucial in treatment and many interventions have been tried to improve patient adherence. Because some HIV-infected persons are taking multiple doses of multiple drugs daily, adherence challenges patients and clinicians alike. Once antiretroviral therapy has been initiated patients remain on this therapy continuously, although intermittent drug treatment is being studied. Because persons living with HIV disease may take numerous drugs simultaneously, the potential for drug interactions and adverse reactions is high. These persons typically have a higher incidence of adverse reactions to commonly used drugs than do non-HIV-infected patients.

In the United States HIV/AIDS is an epidemic primarily affecting men who have sex with men and ethnic/racial minorities. Homophobia, poverty, homelessness, racism, lack of education, and lack of access to health care greatly influence testing, treatment, and prevention strategies. While an effective vaccine is crucial to the prevention of HIV, efforts to develop such a vaccine have been unsuccessful to date; therefore, current and future prevention efforts, including behavior modification interventions, must be aimed at ethnic minorities, men who have sex with men, and other high-risk populations. Finally, a safe, effective antiviral product that women can use during sexual intercourse would greatly reduce their risk of infection.

See also: CAUSES OF DEATH; PAIN AND PAIN MANAGEMENT; SUICIDE INFLUENCES AND FACTORS; PHYSICAL ILLNESS; SYMPTOMS AND SYMPTOM MANAGEMENT

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JERRY D. DURHAM

ANIMAL COMPANIONS

There are more than 353 million animal companions in the United States. More than 61 percent of households own a pet; 39 percent have dogs as pets; and 32 percent have cats. In addition to dogs and cats, other animals considered animal companions—that is, pets—are birds, fish, rabbits, hamsters, and reptiles. Every year, millions of pets die from natural causes or injury, or are euthanized. Because many people form deep and significant emotional attachments to their pets, at any given time the number of people suffering from grief in relation to the loss of a pet is quite high. Pet loss has been shown to potentially have a serious impact on an owner's physical and emotional wellbeing. Part of what accounts for the profoundness of the human reaction can best be explained through a discussion of the bond between animal and human.

Factors contributing to the formation of bonds between people and their pets include companionship, social support, and the need for attachment. Pets often become active members of a household, participating in diverse activities with the owners. Indeed, according to the grief expert

Internet Resources

- Centers for Disease Control and Prevention (CDC). "Basic Statistics." In the CDC [web site]. Available from www.cdc.gov/hiv/stats.htm#cumajds.
- Centers for Disease Control and Prevention (CDC). "Recommendations to Help Patients Avoid Exposure to Opportunistic Pathogens." In the CDC [web site]. Available from www.cdc.gov/epo/mmwr/preview/mmwrhtml/rr4810a2.htm.

Therese Rando, pets have some outstanding qualities as a partner in a relationship. “They are loyal, uncritical, nonjudgmental, relatively undemanding, and usually always there. Many of them are delighted merely to give and receive affection and companionship. They can be intuitive, caring and engaging, often drawing us out of ourselves” (Rando 1988, p. 59). Understandably, therefore, when the bond between pet and owner is broken, a grief response results.

Grief is defined as “the complex emotional, mental, social, and physical response to the death of a loved one” (Kastenbaum 1998, p. 343). Rando adds that grief is a process of reactions to the experience of loss: It has a beginning and an end. “Research and clinical evidence reveal that in many cases the loss of a pet is as profound and far-reaching as the loss of a human family member” (Rando 1988, p. 60), with grief, sometimes protracted and crippling, as an outcome. However, there is generally little social recognition of this form of loss. Despite the fact that the resolution of the grief often surpasses the length of time seen with human losses, the easy accessibility and replacement of the lost animal often provokes hidden grief reactions. Grief may also be hidden because of the owner’s reluctance and shame over feeling so intensely over a nonhuman attachment. People who have lost a pet may repress their feelings, rationalize or minimize their loss, or use denial as a way to cope. The intensity and stages of grieving depend on various factors, including the age of the owner, the level and duration of the attachment between pet and owner, the owner’s life situation, and the circumstances surrounding the loss.

In 1998 social worker JoAnn Jarolmen studied pet loss and grief, comparing the reactions of 106 children, 57 adolescents, and 270 adults who had lost pets within a twelve-month period. In her study, the scores for grief for the children were significantly higher than for the adults. The fact that children grieved more than adults over the loss of a pet was surprising being that children seem more distractible and are used to the interchangeability of objects. The grief score was higher for the entire sample of the one-to-four-month group—after death—than the five-to-eight-month group. Similarly, in 1994 John Archer and George Winchester studied eighty-eight participants who had lost a pet, and found that 25 percent showed signs of depression, anger, and anxiety a year after

the loss. Grief was more pronounced among those living alone, owners who experienced a sudden death, and those who were strongly attached to their pets. Pet owners who are elderly may suffer especially profound grief responses because the presence of a companion animal can make the difference between some form of companionship and loneliness.

Within a family, the loss of a pet can have a significant impact. Pets frequently function as interacting members of the family; hence, the absence of the pet will affect the behavior patterns of the family members with the potential for a shift in roles.

Grief from pet loss is not confined to owners. For veterinarians, the option of euthanasia places the doctor in the position of being able to end the lives, legally and humanely, of animals they once saved. As the veterinarian injects the drugs that end the suffering of the animal, he or she is involved in the planned death of a creature, perhaps one dearly loved by the owner(s). In the presence of death and grief, the veterinarian is often placed in a highly stressful situation.

For people with disabilities, the loss of a pet takes on another dimension because the animal not only provides companionship but is relied on to assist its owner with a level of independence and functioning. For this population, the necessity to replace the animal is paramount to maintain a level of functioning; the grief over the loss may become secondary. Counseling may be important to help the owner remember the unique qualities of the deceased animal as he or she works to train a new one.

When to replace the animal is often a dilemma. Quickly replacing a pet is rarely helpful and does not accelerate the grieving process. The loss of a pet is significant and immediate replacement tends to negate the healing aspects of grief.

Counseling for grieving pet owners should be considered when individuals experience a prolonged period of grief with attendant depression, when it is the first experience of death (usually for young children), and when a family seems to be struggling to realign itself after the loss. The focus of counseling is to help clients cope with the loss through discussion of their feelings, fostering of remembrances, and support of positive coping mechanisms.

See also: GRIEF: OVERVIEW; HUNTING

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JOAN BEDER

**ANTHROPOLOGICAL
PERSPECTIVE**

It is rather hard, if not impossible, to answer the question of how long anthropology has existed. Should social scientists consider anthropology the detailed descriptions appearing in the work of ancient and medieval historians—which deal with the culture of certain ethnic groups, such as their death rites, eating habits, and dressing customs—just as they consider the fieldwork reports based on long-term participating observations published in the twenty-first century? Although it is not easy

to find the unambiguous answer to this question, it is obvious that no work in history of science can lack a starting point, which helps its readers pin down and comprehend its argumentation. During the mid-1800s anthropology first appeared as a "new" independent discipline in the fast-changing realm of social sciences.

The Evolutionist Perspective

Searching the origins of society and religion, writing the "history of their evolution," seemed to be the most popular topic of nineteenth-century anthropology. Death and the belief in the soul and the spirits play important roles in the evolutionist-intellectual theories of origin written by Edward Burnett Tylor in 1871 and other scholars of the nineteenth century.

Tylor assumed that in the background of the appearance of the soul beliefs, there may be such extraordinary and incomprehensible experiences as dreams and visions encountered in various states of altered consciousness, and the salient differences between the features of living and dead bodies. In his view, "the ancient savage philosophers" were only able to explain these strange, worrying experiences by considering humans to be a dual unity consisting of not only a body but of an entity that is able to separate from the body and continue its existence after death (Tylor 1972, p. 11). Tylor argues that this concept of spirit was later extended to animals, plants, and objects, and it developed into "the belief in spiritual beings" that possess supernatural power (polytheism) (*ibid.*, p. 10). Eventually it led to monotheism. Tylor, who considered "the belief in spiritual beings," which he called animism, the closest definition and starting point of the concept of religion, argues that religion and notion of death were brought into being by human worries concerning death.

Tylor's theory was attacked primarily because he did not attribute the origin of religion to the interference of supernatural powers but rather to the activity of human logic. He was also criticized on the grounds that a part of his concept was highly speculative and unhistorical: He basically intended to reconstruct the evolution of religion from contemporary ethnographic data and through the deduction of his own hypotheses. Although most of these critiques were correct, Tylor can only

partly be grouped among the “armchair anthropologists” of his time.

Two other individuals—Johann Jakob Bachofen and James G. Frazer—are also acknowledged as pioneers during this early period of anthropology. Bachofen prepared a valuable analysis of the few motives of wall paintings of a Roman columbarium in 1859 such as black-and-white painted mystery eggs. He was among the first authors to point out that the symbolism of fertility and rebirth is closely connected with death rites. Based on his monumental collection of ethnographic data from several cultures, Frazer, in the early twentieth century and again in the 1930s, intended to prove that the fear of the corpse and the belief in the soul and life after death is a universal phenomenon.

The French Sociology School

The perspective of the authors of the French sociology school differed considerably from the primarily psychology-oriented, individual-focused views of these evolutionist-intellectual anthropologists. Émile Durkheim and his followers (including Robert Hertz and Marcell Mauss) studied human behavior in a “sociological framework,” and focused their attention primarily on the question of societal solidarity, on the study of the social impact of rites, and on the various ties connecting individuals to society. In other words, they investigated the mechanisms by which societies sustain and reproduce themselves.

In his monumental work *The Elementary Forms of the Religious Life* (1915), Durkheim argues that the most important function of death rites and religion in general is to reaffirm societal bonds and the social structure itself. In his view, a society needs religion (totem as a sacral object in this case) to represent itself in it, and it serves to help society to reproduce itself. In his other work of the same subject (*Suicide: A Study in Sociology*, 1952) Durkheim studies the social and cultural determination of a phenomenon that is considered primarily psychological.

However, it was undoubtedly the 1907 work of Durkheim’s disciple, Robert Hertz, that has had the most significant impact on contemporary anthropological research concerning death. Hertz primarily built his theory on Indonesian data, and focused his attention on the custom of the secondary burial.

Hertz discovered exciting parallels among (1) the condition of the dead body, (2) the fate of the departing soul, and (3) the taboos and restricting measures concerning the survivors owing to their ritual pollution. In his view, where the custom of the secondary burial is practiced, the moment of death can be considered the starting point for these three phenomena: the corpse becomes unanimated and the process of decomposition starts; the taboos concerning survivors become effective; and the soul starts its existence in the intermediary realm between the world of the living and the deceased ancestors. (In this liminal state of being the soul is considered to be homeless and malignant.) This intermediary period ends with the rite of the secondary burial, which involves the exhumation of the corpse and its burial in a new, permanent tomb. This rite also removes the taboos of the survivors, thus cleansing them from the pollution caused by the occurrence of the death. The same rite signals, or performs the soul’s initiation to the realm of the ancestors, by it the soul takes its permanent status in the other world.

Hertz argues that the most important function of these death rites is to promote the reorganization of the social order and the restoration of faith in the permanent existence of the society, which had been challenged by the death of the individual. In addition to these functions, they serve the confirmation of solidarity among the survivors.

The utmost merit of Hertz’s work is undoubtedly the novelty of his theoretical presuppositions. Like Durkheim, he concentrated on the social aspects of death and not on its biological or psychological sides. Hertz was among the first to point out how human death thoughts and rituals are primarily social products, integrated parts of the society’s construction of reality that reflect the sociocultural context (religion, social structure). According to Hertz, the deceased enters the mythic world of souls “which each society constructs in its own image” (Hertz 1960, p. 79).

Hertz emphasized that social and emotional reactions following death are also culturally determined, and called attention to numerous social variables that might considerably influence the intensity of these reactions in different cultures (i.e., the deceased person’s gender, age, social status, and relation to power).

In one and the same society the emotion aroused by death varies extremely in intensity according to the social status of the deceased, and may even in certain cases be entirely lacking. At the death of a chief, or of a man of high rank, a true panic sweeps over the group . . . On the contrary, the death of a stranger, a slave, or a child will go almost unnoticed; it will arouse no emotion, occasion no ritual. (Hertz 1960, p. 76)

From the commentaries on Hertz's work, only one critical remark needs mentioned, which calls attention to the problem of exceptions and the dangers of the overgeneralization of the model of secondary burials.

Arnold van Gennep and the Model of the *Rites of Passage*

In his book *The Rites of Passage* (1960), Arnold van Gennep places the primary focus on rites, in which individuals—generally with the proceeding of time—step from one social position/status to another. (Such events are birth, various initiations, marriage, and death.) The author considers these “border-crossings” crisis situations.

Van Gennep claims that these rites accompanying transitions generally consist of three structural elements: rites of separation—preparing the dying person, giving the last rite; rites of transition—for example, the final burial of the corpse in the cemetery or the group of rites that serve to keep the haunting souls away; and the rites of incorporation—a mass said for the salvation of the deceased person's soul. In the case of a death event, the individual leaves a preliminary state (living) by these rites and through a liminal phase in which the deceased usually is in a temporary state of existence between the world of the living and the dead, and reaches a post-liminary state (dead).

Van Gennep argues that these rites socially validate such social/biological changes as birth, marriage, and death. They also canalize the accompanying emotional reactions into culturally elaborated frames, thus placing them under partial social control, consequently making these critical situations more predictable. His theory served as a starting point and pivot of several further rite studies (including the liminality theory of Victor Turner in 1969), inspired the study of the rites' symbolic

meanings, and promoted research that investigated the ways of an individual's social integration.

The British Functionalist School

While the evolutionist-intellectual anthropologists were interested in finding the reason of the origin of religion and the followers of the French sociology school concentrated on the social determination of attitudes concerning death, members of the British functionalist school were concerned with the relation of death rites and the accompanying emotional reactions. They focused their attention on the question of the social loss caused by death (such as the redistribution of status and rights).

The two most significant authors of this school had opposing views of the relationship between religion/rites and the fear of death. Bronislaw Malinowski considered the anxiety caused by the rationally uncontrollable happenings as the basic motivation for the emergence of religious faith. He suggested that religion was not born of speculation and illusion,

but rather out of the real tragedies of human life, out of the conflict between human plans and realities. . . . The existence of strong personal attachments and the fact of death, which of all human events is the most upsetting and disorganizing to man's calculations, are perhaps the main sources of religious belief. (Malinowski 1972, p. 71)

In his view the most significant function of religion is to ease the anxiety accompanying the numerous crises of a life span, particularly the issue of death.

However, according to Arnold Radcliffe-Brown in the case of certain rites, “It would be easy to maintain . . . that they give men fears and anxieties from which they would otherwise be free—the fear of black magic or of spirits, fear of God, of the devil, of Hell” (Radcliffe Brown 1972, p. 81). It was George C. Homans in 1941 who succeeded in bringing these two competing theories into a synthesis, claiming that they are not exclusive but complementary alternatives.

From the 1960s to Present

There has been continual interest in the anthropological study of death, marked by the series of books and collections of studies published. Among

these works, scholars note the 1982 collection of studies edited by Maurice Bloch and Jonathan Parry that intends to provide a comprehensive coverage of one single area: It studies how the ideas of fertility and rebirth are represented in the death rites of various cultures. The equally valuable book *Celebrations of Death: The Anthropology of Mortuary Ritual* (1991) by Richard Huntington and Peter Metcalf, which relies extensively on the authors' field experience, discusses the most important questions of death culture research (emotional reaction to death; symbolic associations of death, etc.) by presenting both the corresponding established theories and their critiques.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; CANNIBALISM; DURKHEIM, ÉMILE; GENNEP, ARNOLD VAN; HERTZ, ROBERT; HUMAN REMAINS; OMENS; RITES OF PASSAGE; SACRIFICE; VODOO

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PETER BERTA

ANXIETY AND FEAR

A generalized expectation of danger occurs during the stressful condition known as anxiety. The anxious person experiences a state of heightened tension that Walter Cannon described in 1927 as readiness for "fight or flight." If the threat passes or is overcome, the person (or animal) returns to normal functioning. Anxiety has therefore served its purpose in alerting the person to a possible danger. Unfortunately, sometimes the alarm keeps ringing; the individual continues to behave as though in constant danger. Such prolonged stress can disrupt the person's life, distort relationships, and even produce life-threatening physical changes. Is the prospect of death the alarm that never stops ringing? Is death anxiety the source of people's most profound uneasiness? Or is death anxiety a situational or abnormal reaction that occurs when coping skills are overwhelmed?

There are numerous examples of things that people fear—cemeteries, flying, public speaking, being in a crowd, being alone, being buried alive, among others. Unlike anxiety, a fear is associated with a more specific threat. A fear is therefore less likely to disrupt a person's everyday life, and one

can either learn to avoid the uncomfortable situations or learn how to relax and master them. Fears that are unreasonable and out of proportion to the actual danger are called phobias. Many fears and phobias seem to have little or nothing to do with death, but some do, such as fear of flying or of being buried alive.

Theories of Death Anxiety and Fear

Two influential theories dominated thinking about death anxiety and fear until the late twentieth century. Sigmund Freud (1856–1939) had the first say. The founder of psychoanalysis recognized that people sometimes did express fears of death. Nevertheless, thanatophobia, as he called it, was merely a disguise for a deeper source of concern. It was not death that people feared because:

Our own death is indeed quite unimaginable, and whenever we make the attempt to imagine it we . . . really survive as spectators. . . . At bottom nobody believes in his own death, or to put the same thing in a different way, in the unconscious every one of us is convinced of his own immortality. (*Freud 1953, pp. 304–305*)

The unconscious does not deal with the passage of time nor with negations. That one's life could and would end just does not compute. Furthermore, whatever one fears cannot be death because one has never died. People who express death-related fears, then, actually are trying to deal with unresolved childhood conflicts that they cannot bring themselves to acknowledge and discuss openly.

Freud's reduction of death concern to a neurotic cover-up did not receive a strong challenge until Ernest Becker's 1973 book, *The Denial of Death*. Becker's existential view turned death anxiety theory on its head. Not only is death anxiety real, but it is people's most profound source of concern. This anxiety is so intense that it generates many if not all of the specific fears and phobias people experience in everyday life. Fears of being alone or in a confined space, for example, are fears whose connections with death anxiety are relatively easy to trace, but so are the needs for bright lights and noise. It is more comfortable, more in keeping with one's self-image, to transform the underlying anxiety into a variety of smaller aversions.

According to Becker, much of people's daily behavior consists of attempts to deny death and thereby keep their basic anxiety under control. People would have a difficult time controlling their anxiety, though, if alarming realities continued to intrude and if they were exposed to brutal reminders of their vulnerability. Becker also suggested that this is where society plays its role. No function of society is more crucial than its strengthening of individual defenses against death anxiety. Becker's analysis of society convinced him that many beliefs and practices are in the service of death denial, that is, reducing the experience of anxiety. Funeral homes with their flowers and homilies, and the medical system with its evasions, are only among the more obvious societal elements that join with individuals to maintain the fiction that there is nothing to fear.

Ritualistic behavior on the part of both individuals and social institutions generally has the underlying purpose of channeling and finding employment for what otherwise would surface as disorganizing death anxiety. Schizophrenics suffer as they do because their fragile defenses fail to protect them against the terror of annihilation. "Normal" people in a "normal" society function more competently in everyday life because they have succeeded at least temporarily in denying death.

Other approaches to understanding death anxiety and fear were introduced in the late twentieth century. Terror management theory is based on studies finding that people who felt better about themselves also reported having less death-related anxiety. These data immediately suggested possibilities for preventing or reducing disturbingly high levels of death anxiety: Help people to develop strong self-esteem and they are less likely to be disabled by death anxiety. If self-esteem serves as a buffer against anxiety, might not society also be serving this function just as Becker had suggested? People seem to derive protection against death anxiety from worldview faith as well as from their own self-esteem. "Worldview faith" can be understood as religious belief or some other conviction that human life is meaningful, as well as general confidence that society is just and caring.

Another fresh approach, regret theory, was proposed in 1996 by Adrian Tomer and Grafton Eliason. Regret theory focuses on the way in which

people evaluate the quality or worth of their lives. The prospect of death is likely to make people more anxious if they feel that they have not and cannot accomplish something good in life. People might torment themselves with regrets over past failures and missed opportunities or with thoughts of future accomplishments and experiences that will not be possible. Regret theory (similar in some respects to Robert Butler's life review approach) also has implications for anxiety reduction. People can reconsider their memories and expectations, for example, and also discover how to live more fully in the present moment.

Robert Kastenbaum suggests that people might not need a special theory for death anxiety and fear. Instead, they can make use of mainstream research in the field of life span development. Anxiety may have roots in people's physical being, but it is through personal experiences and social encounters that they learn what might harm them and, therefore, what they should fear. These fears also bear the marks of sociohistorical circumstances. For example, fear of the dead was salient in many preliterate societies throughout the world, while fear of being buried alive became widespread in nineteenth-century Europe and America. In modern times many people express the somewhat related fear of being sustained in a persistent vegetative state between life and death. Death-related fears, then, develop within particular social contexts and particular individual experiences. People do not have to rely upon the untested and perhaps untestable opposing views of Freud and Becker—that they are either incapable of experiencing death anxiety, or that death anxiety is the source of all fears. It is more useful to observe how their fears as well as their joys and enthusiasms are influenced by the interaction between cognitive development and social learning experiences. In this way people will be in a better position to help the next generation learn to identify actual threats to their lives while not overreacting to all possible alarms all the time.

Death Anxiety Studies

There have been many empirical studies of death anxiety, but many questions also remain because of methodological limitations and the difficulties inherent in this subject. Nevertheless, a critical review of the literature does reveal some interesting patterns:

- Most people report that they have a low to moderate level of death-related anxiety.
- Women tend to report somewhat higher levels of death-related anxiety.
- There is no consistent increase in death anxiety with advancing adult age. If anything, older people in general seem to have less death anxiety.
- People with mental and emotional disorders tend to have a higher level of death anxiety than the general population.
- Death anxiety can spike temporarily to a higher level for people who have been exposed to traumatic situations.

Religion. The relationship between death anxiety and religious belief seems to be too complex to provide a simple pattern of findings. Death-related teachings differ, and believers may take different messages from the same basic doctrine. Historical studies also suggest that religious faith and practices seem to have sometimes reduced and sometimes increased death anxiety.

Health. The findings already mentioned come mostly from studies in which respondents in relatively good health reported on their own fears. Other studies and observations, though, give occasion for further reflection. There is evidence to suggest that people may be experiencing more anxiety than they are able to report. Even people who respond calmly to death-related words or images show agitation in breathing, heart rate, and reaction time, among other measures. Researchers Herman Feifel and B. Allen Branscomb therefore concluded in 1973 that everybody, in one way or another, is afraid of death. Presumably, people may have enough self-control to resist death-related anxiety on a conscious level but not necessarily to quell their underlying feelings of threat.

Gender. The gender differences also require a second look. Although women tend to report higher levels of death-related anxiety, it is also women who provide most of the professional and volunteer services to terminally ill people and their families, and, again, it is mostly women who enroll in death education courses. Women are more open to death-related thoughts and feelings, and men are somewhat more concerned about keeping these thoughts and feelings in check. The relatively

higher level of reported death anxiety among women perhaps contributes to empathy with dying and grieving people and the desire to help them cope with their ordeals.

Age. The relationship between age and death anxiety is also rather complex. Adolescents may at the same time harbor a sense of immortality and experience a sense of vulnerability and incipient terror, but also enjoy transforming death-related anxiety into risky death-defying activities. What people fear most about death often changes with age. Young adults are often mostly concerned about dying too soon—before they have had the chance to do and experience all they have hoped for in life. Adult parents are often more likely to worry about the effect of their possible deaths upon other family members. Elderly adults often express concern about living “too long” and therefore becoming a burden on others and useless to themselves. Furthermore, the fear of dying alone or among strangers is often more intense than the fear of life coming to an end. Knowing a person’s general level of anxiety, then, does not necessarily identify what it is that most disturbs a person about the prospect of death.

Anxiety levels. The fact that most people report themselves as having a low to moderate level of death anxiety does not offer support for either Freud’s psychoanalytic or Becker’s existential theory. Respondents do not seem to be in the grips of intense anxiety, but neither do they deny having any death-related fears. Kastenbaum’s *Edge theory* offers a different way of looking at this finding. According to the theory, most people do not have a need to go through life either denying the reality of death or in a high state of alarm. Either of these extremes would actually interfere with one’s ability both to enjoy life and cope with the possibility of danger. The everyday baseline of low to moderate anxiety keeps people alert enough to scan for potential threats to their own lives or the lives of other people. At the perceived moment of danger, people feel themselves to be on the edge between life and death, an instant away from catastrophe. The anxiety surge is part of a person’s emergency response and takes priority over whatever else the person may have been doing. People are therefore not “in denial” when, in safe circumstances, they report themselves to have a low level of death anxiety. The anxiety switches on when their vigilance tells them that a life is on the edge of annihilation.

Anxiety and Comfort Near the End of Life

What of anxiety when people are nearing the end of their lives, when death is no longer a distant prospect? The emergence of hospice programs and the palliative care movement is stimulating increased attention to the emotional, social, and spiritual needs of dying people. Signs of anxiety are more likely to be recognized and measures taken to help the patient feel at ease. These signs include trembling, restlessness, sweating, rapid heartbeat, difficulty sleeping, and irritability. Health care professionals can reduce the anxiety of terminally ill people by providing accurate and reassuring information using relaxation techniques, and making use of anxiolytics or antidepressants.

Reducing the anxiety of terminally ill people requires more than technical expertise on the part of physicians and nurses. They must also face the challenge of coping with their own anxieties so that their interactions with patients and family provide comfort rather than another source of stress. Family and friends can help to relieve anxiety (including their own) by communicating well with the terminally ill person.

See also: BECKER, ERNEST; BURIED ALIVE; CADAVER EXPERIENCES; DYING, PROCESS OF; FEIFEL, HERMAN; FREUD, SIGMUND; TERROR MANAGEMENT THEORY

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ROBERT KASTENBAUM

APOCALYPSE

The word *apocalypse* has many meanings. In religious usage, it identifies the last book of the Christian Bible, the Revelation of John; a genre of ancient Judeo-Christian visionary literature; or doomsday, the destruction of the world at the end of time prophesied by the Apocalypse. In more

popular usage, it identifies any catastrophic or violent event, such as the Vietnam War (e.g., the movie *Apocalypse Now*). Apocalypticism is the religious belief system that interprets human history from its origins to the present as signs of the imminent end of the world. It is one feature of Christian eschatology, the branch of theology dealing with the state of the soul after death, purgatory, hell, and heaven.

The adjective *apocalyptic* also has many meanings, from attitudes characteristic of apocalypticism (e.g., the world is so evil it will soon be destroyed), to features of literary apocalypses (e.g., the seven-headed dragon of Apoc. 12), to cultural references to apocalyptic expectations (e.g., the movie *Armageddon*), to exaggerated fears of a crisis (e.g., the apocalyptic reaction to the Y2K "bug").

Apocalypticism is a feature of all three monotheistic religions. The Book of Daniel describes the Hebrew prophet's vision of the end, and messianism has regularly flared up in Jewish diaspora communities, as when Sabbatai Sevi (1626–1676) predicted the end of the world. In the twentieth century apocalypticism influenced responses to the Holocaust and supported religious Zionism. In Islam, the resurrection, day of judgment, and salvation are apocalyptic features of orthodox belief as evident in the Koran, and apocalypticism influenced expectations of an Islamic messiah in Sunni belief, Iranian Shi'ism, and the Bahá'í faith. Apocalypticism, however, is most common in Christianity, probably because of the continuing influence of the biblical Apocalypse, which has informed not only the eschatology of Christianity but also its art, literature, and worship. Its rich, otherworldly symbolism and prophecies of the end of time are well-known and include the Four Horsemen, Lamb of God, Whore of Babylon, Mark of the Beast (666), Armageddon, Last Judgment, and New Jerusalem.

Apocalyptic belief has been associated with heretical and extremist movements throughout history. For example, the Fraticelli, Franciscan dissidents of the fourteenth century, accused Pope John XXII of being the Antichrist; Thomas Müntzer, an apocalyptic preacher, was a leader in the German Peasants' War of 1525; the American Millerites left crops unplanted, expecting Christ to return in 1844; and David Koresh, leader of the Branch Davidians before the conflagration that destroyed their Waco

compound in 1993, claimed to be the Lamb of the Apocalypse. Nevertheless, there is nothing necessarily unorthodox or radical about apocalypticism, which the theologian Ernst Kaseman has called “the mother of all Christian theology” (1969, p. 40). The sermons of Jesus (e.g., Matt. 24) and the theology of Paul are filled with apocalyptic prophecies, and Peter identified Pentecost—the traditional foundation of the Christian church—as a sign of the end of time (Acts 2). Furthermore, the creed followed by many Christian faiths promises the return of Christ in majesty to judge the living and the dead, and many Protestant denominations, such as Baptists and Adventists, have strong apocalyptic roots that support a conservative theology.

The expectation that Antichrist will appear in the last days to deceive and persecute the faithful is based on apocalyptic interpretations, and during the Middle Ages and Renaissance this belief informed drama, poetry, manuscript illustrations, and paintings, from the twelfth-century Latin *Play of Antichrist* to Luca Signorelli’s compelling fresco at Orvieto Cathedral (1498). The twentieth century, with its numerous wars and social upheavals, has thinly disguised the figure of Antichrist and integrated other apocalyptic images into its literature (e.g., William Butler Yeats’s poem “The Second Coming”) and popular culture (e.g., the movie *The Omen*). Apocalyptic notions also pervade religious polemic; during the debates of the Reformation, for example, Protestants and Catholics identified each other as Antichrists, a term still used by some fundamentalists attacking the papacy.

Another expectation derived from the Apocalypse is the millennium, the thousand-year period of peace and justice during which the Dragon is imprisoned in the abyss before the end of time. More generally, the term *millennium* refers to any idealized period in the future. Communism, for example, has been described as a millenarian movement because of its promise of a classless society; like the Russian Revolution of 1917, millenarian movements have often been associated with violence of the sort that occurred during the Brazilian slave revolts in the 1580s. The Center for Millennium Studies at Boston University maintains a database of contemporary millenarian movements.

These social movements indicate the tremendous influence of the Apocalypse and the ways in

which religious apocalypticism has been secularized. Secular apocalypticism is manifest in popular appropriations of physics that, in one way or another, predict the extermination of life, with references to entropy and the infinite expansion of the universe until it fizzles into nothingness or recoils into a primal contraction. It is also evident in environmentalist forecasts of the extinction of species and the greenhouse effect, in predictions of famine and hunger arising from the exponential increase in world population, and in responses to the devastations of the worldwide AIDS epidemic. Modern secular apocalypticism was particularly strong during the cold war in predictions of nuclear destruction, as evident in Ronald Reagan’s references to Armageddon in the 1980s and popular culture (e.g., the movie *Dr. Strangelove* and the ABC television film *The Day After*).

Although the term *apocalypse* brings to mind images of destruction and violence, and although the sociologist Michael Barkun has linked millenarian hopes to various forms of disaster, the biblical Apocalypse includes many promises of peace and assurances of rewards for the faithful, including a millennium ushered in by Jesus—a far cry from dire predictions of bloody revolution and disaster. For Christians, the apocalypse need not be negative, because the New Jerusalem follows the destruction of an evil world, and life in heaven follows death. In an increasingly secular world, however, the apocalypse summons lurid visions of individual or mass death.

See also: AIDS; EXTINCTION; NUCLEAR DESTRUCTION

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APPARITIONS

See GHOSTS.

APPROPRIATE DEATH

See GOOD DEATH, THE.

ARIÈS, PHILIPPE

Philippe Ariès (1914–1984) did not let a career at a French institute for tropical plant research prevent him from almost single-handedly establishing attitudes toward death as a field of historical study. After publishing a number of prize-winning books in France, Ariès came to international attention with the publication of his study of attitudes toward children, *Centuries of Childhood* (1962). In 1973 Johns Hopkins University invited him to America to lecture on “history, political culture, and national consciousness.” Ariès readily accepted the invitation, but his ongoing research into collective mentalities had led him to conclude that death too has a history—and that was the subject he wished to address.

The lectures delivered at Johns Hopkins, published as *Western Attitudes toward Death* in 1974, presented an initial sketch of Ariès’s findings. Surveying evidence from the Middle Ages to the present, Ariès had discovered a fundamental shift in attitude. Where death had once been familiar and

“tamed” (*la mort apprivoisée*) it was now strange, untamed, and “forbidden” (*la mort interdite*). Medieval people accepted death as a part of life—expected, foreseen, and more or less controlled through ritual. At home or on the battlefield, they met death with resignation, but also with the hope of a long and peaceful sleep before a collective judgment. Simple rural folk maintained such attitudes until the early twentieth century. But for most people, Ariès argued, death has become wild and uncontrollable.

The change in Western European society occurred in identifiable stages. During the later Middle Ages, religious and secular elites progressively abandoned acceptance of the fact that “we all die” (*nous mourons tous*) to concentrate on their own deaths, developing an attitude Ariès dubbed *la mort de soi* (“the death of the self”) or *la mort de moi* (“my death”). Anxious about the state of their souls and increasingly attached to the things their labor and ingenuity had won, they represented death as a contest in which the fate of the soul hung in the balance.

The rise of modern science led some to challenge belief in divine judgment, in heaven and hell, and in the necessity of dying in the presence of the clergy. Attention shifted to the intimate realm of the family, to *la mort de toi* (“thy death”), the death of a loved one. Emphasis fell on the emotional pain of separation and on keeping the dead alive in memory. In the nineteenth century, some people regarded death and even the dead as beautiful. With each new attitude, Western Europeans distanced themselves from the old ways. Finally, drained of meaning by modern science and medicine, death retreated from both public and familial experience. The dying met their end in hospitals, and the living disposed of their remains with little or no ceremony.

Ariès was particularly interested in presenting his findings in America because he noted a slightly different attitude there. While modern Americans gave no more attention to the dying than Europeans, they lavished attention on the dead. The embalmed corpse, a rarity in Europe but increasingly common in America after the U.S. Civil War, became the centerpiece of the American way of death. Although embalming attempted, in a sense, to deny death, it also kept the dead present. Thus Ariès was not surprised that signs of a reaction to

“forbidden death” were appearing in the United States. He ended his lectures with the possibility that death might once more be infused with meaning and accepted as a natural part of life.

In 1977 Ariès published his definitive statement on the subject, *L'Homme devant la mort*, which appeared in English as *The Hour of Our Death* several years later. Besides its length and mass of detail, the book's chief departure from Ariès' earlier work was the inclusion of a fifth attitude, which emerged in the seventeenth and eighteenth centuries. Ariès dubbed this attitude *la mort proche et loigne*, or “death near and far.” As death became less familiar, its similarities to sex came to the fore, and some people found themselves as much attracted to as repelled by cadavers, public executions, and the presence of the dead. The appearance of the psychoanalytic notions of *eros* and *thanatos* at this point in Ariès's schema illuminate the deeply psychological nature of his approach, most clearly articulated in the conclusion to *The Hour of Our Death*. This aspect of his thinking generated criticism from historians who see the causes of change, even in collective attitudes, in more objective measures, but most have accepted his reading of the modern period. There are problems with the notion of “tamed death,” however, which Ariès regarded as universal and primordial. Subsequent research has shown how peculiar the “tamed death” of the European Middle Ages was, and how great a role Christianity played in its construction. Nevertheless, his work has become a touchstone for nearly all research in the field and his contributions to death studies, and to history, are universally admired.

See also: ARS MORIENDI; CHRISTIAN DEATH RITES, HISTORY OF; GOOD DEATH, THE; MEMENTO MORI

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FREDERICK S. PAXTON

ARS MORIENDI

The *Ars Moriendi*, or “art of dying,” is a body of Christian literature that provided practical guidance for the dying and those attending them. These manuals informed the dying about what to expect, and prescribed prayers, actions, and attitudes that would lead to a “good death” and salvation. The first such works appeared in Europe during the early fifteenth century, and they initiated a remarkably flexible genre of Christian writing that lasted well into the eighteenth century.

Fifteenth-Century Beginnings

By 1400 the Christian tradition had well-established beliefs and practices concerning death, dying, and the afterlife. The *Ars Moriendi* packaged many of these into a new, concise format. In particular, it expanded the rite for priests visiting the sick into a manual for both clergy and laypeople. Disease, war, and changes in theology and Church policies formed the background for this new work. The Black Death had devastated Europe in the previous century, and its recurrences along with other diseases continued to cut life short. Wars and violence added to the death toll. The Hundred Years' War (1337–1453) between France and England was the era's largest conflict, but its violence and political instability mirrored many local conflicts. The fragility of life under these conditions coincided with a theological shift noted by the historian Philippe Ariès whereas the early Middle Ages emphasized humanity's collective judgment at the end of time, by the fifteenth century attention focused on individual judgment immediately after death. One's own

death and judgment thus became urgent issues that required preparation.

To meet this need, the *Ars Moriendi* emerged as part of the Church authorities' program for educating priests and laypeople. In the fourteenth century catechisms began to appear, and handbooks were drafted to prepare priests for parish work, including ministry to the dying. The Council of Constance (1414–1418) provided the occasion for the *Ars Moriendi*'s composition. Jean Gerson, chancellor of the University of Paris, brought to the council his brief essay, *De arte moriendi*. This work became the basis for the anonymous *Ars Moriendi* treatise that soon appeared, perhaps at the council itself. From Constance, the established networks of the Dominicans and Franciscans assured that the new work spread quickly throughout Europe.

The *Ars Moriendi* survives in two different versions. The first is a longer treatise of six chapters that prescribes rites and prayers to be used at the time of death. The second is a brief, illustrated book that shows the dying person's struggle with temptations before attaining a good death. As Mary Catharine O'Connor argued in her book *The Arts of Dying Well*, the longer treatise was composed earlier and the shorter version is an abridgment that adapts and illustrates the treatise's second chapter. Yet O'Connor also noted the brief version's artistic originality. For while many deathbed images predate the *Ars Moriendi*, never before had deathbed scenes been linked into a series "with a sort of story, or at least connected action, running through them" (O'Connor 1966, p. 116). The longer Latin treatise and its many translations survive in manuscripts and printed editions throughout Europe. The illustrated version circulated mainly as "block books," where pictures and text were printed from carved blocks of wood; Harry W. Rylands (1881) and Florence Bayard reproduced two of these editions.

An English translation of the longer treatise appeared around 1450 under the title *The Book of the Craft of Dying*. The first chapter praises the deaths of good Christians and repentant sinners who die "gladly and wilfully" in God (Comper 1977, p. 7). Because the best preparation for a good death is a good life, Christians should "live in such wise . . . that they may die safely, every hour, when God will" (Comper 1977, p. 9). Yet the treatise

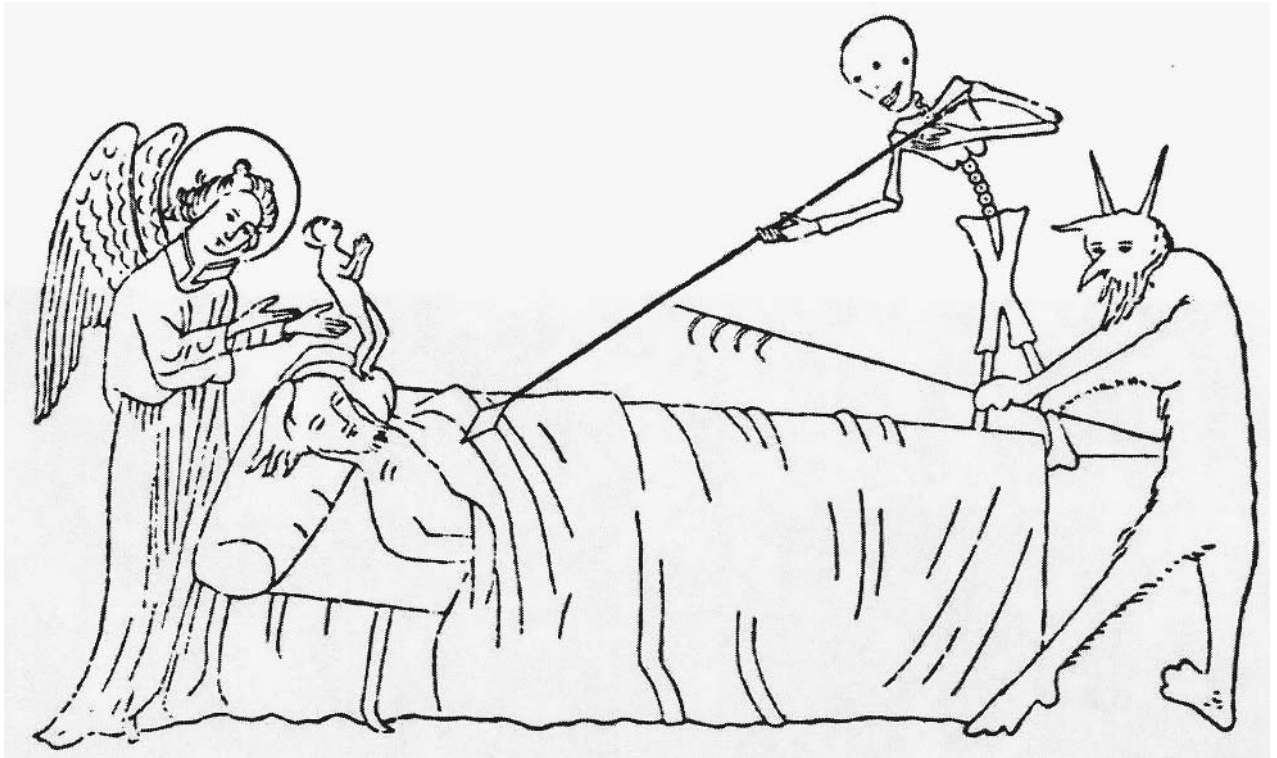
focuses on dying and assumes that deathbed repentance can yield salvation.

The second chapter is the treatise's longest and most original section. It confronts the dying with five temptations and their corresponding "inspirations" or remedies: (1) temptation against faith versus reaffirmation of faith; (2) temptation to despair versus hope for forgiveness; (3) temptation to impatience versus charity and patience; (4) temptation to vainglory or complacency versus humility and recollection of sins; and (5) temptation to avarice or attachment to family and property versus detachment. This scheme accounts for ten of the eleven illustrations in the block book *Ars Moriendi*, where five scenes depict demons tempting the dying man and five others portray angels offering their inspirations.

Of special importance are the second and fourth temptations, which test the dying person's sense of guilt and self-worth with two sharply contrasting states: an awareness of one's sins that places one beyond redemption and a confidence in one's merits that sees no need for forgiveness. Both despair and complacent self-confidence can be damning because they rule out repentance. For this reason the corresponding remedies encourage the dying to acknowledge their sins in hope because all sins can be forgiven through contrition and Christ's saving death.

As Ariès notes, throughout all five temptations, the *Ars Moriendi* emphasizes the active role of the dying in freely deciding their destinies. For only their free consent to the demonic temptations or angelic inspirations determines whether they are saved or damned.

The third chapter of the longer treatise prescribes "interrogations" or questions that lead the dying to reaffirm their faith, to repent their sins, and to commit themselves fully to Christ's passion and death. The fourth chapter asks the dying to imitate Christ's actions on the cross and provides prayers for "a clear end" and the "everlasting bliss that is the reward of holy dying" (Comper 1977, p. 31). In the fifth chapter the emphasis shifts to those who assist the dying, including family and friends. They are to follow the earlier prescriptions, present the dying with images of the crucifix and saints, and encourage them to repent, receive the sacraments, and draw up a testament disposing of their possessions. In the process, the attendants are



The Devil with a hooking staff and Death himself with a soldier's pike are attempting to snare the soul of this dying man. The threatened soul, pictured as a tiny person, prays for help as an Angel offers protection. Ars Moriendi depictions such as this manuscript illustration from fourteenth century England warned believers that they must live the good life or face hideous punishment after death. DOVER PUBLICATIONS, INC.

to consider and prepare for their own deaths. In the sixth chapter the dying can no longer speak on their own behalf, and the attendants are instructed to recite a series of prayers as they “commend the spirit of our brother” into God’s hands.

The illustrated *Ars Moriendi* concludes with a triumphant image of the good death. The dying man is at the center of a crowded scene. A priest helps him hold a candle in his right hand as he breathes his last. An angel receives his soul in the form of a naked child, while the demons below vent their frustration at losing this battle. A crucifixion scene appears to the side, with Mary, John, and other saints. This idealized portrait thus completes the “art of dying well.”

The Later Tradition

The two original versions of the *Ars Moriendi* initiated a long tradition of Christian works on preparation for death. This tradition was wide enough to

accommodate not only Roman Catholic writers but also Renaissance humanists and Protestant reformers—all of whom adapted the *Ars Moriendi* to their specific historical circumstances. Yet nearly all of these authors agreed on one basic change: They placed the “art of dying” within a broader “art of living,” which itself required a consistent *memento mori*, or awareness of and preparation for one’s own death.

The *Ars Moriendi* tradition remained strong within the Roman Catholic communities. In his 1995 book *From Madrid to Purgatory*, Carlos M. N. Eire documented the tradition’s influence in Spain where the *Ars Moriendi* shaped published accounts of the deaths of St. Teresa of Avila (1582) and King Philip II (1598). In his 1976 study of 236 *Ars Moriendi* publications in France, Daniel Roche found that their production peaked in the 1670s and declined during the period from 1750 to 1799. He also noted the Jesuits’ leading role in writing

Catholic Ars Moriendi texts, with sixty authors in France alone.

Perhaps the era's most enduring Catholic text was composed in Italy by Robert Bellarmine, the prolific Jesuit author and cardinal of the church. In 1619 Bellarmine wrote his last work, *The Art of Dying Well*. The first of its two books describes how to live well as the essential preparation for a good death. It discusses Christian virtues, Gospel texts, and prayers, and comments at length on the seven sacraments as integral to Christian living and dying. The second book, *The Art of Dying Well As Death Draws Near*, recommends meditating on death, judgment, hell, and heaven, and discusses the sacraments of penance, Eucharist, and extreme unction or the anointing of the sick with oil. Bellarmine then presents the familiar deathbed temptations and ways to counter them and console the dying, and gives examples of those who die well and those who do not. Throughout, Bellarmine reflects a continuing fear of dying suddenly and unprepared. Hence he focuses on living well and meditating on death as leading to salvation even if one dies unexpectedly. To highlight the benefits of dying consciously and well prepared, he claims that prisoners facing execution are "fortunate"; knowing they will die, they can confess their sins, receive the Eucharist, and pray with their minds more alert and unclouded by illness. These prisoners thus enjoy a privileged opportunity to die well.

In 1534 the Christian humanist Erasmus of Rotterdam wrote a treatise that appeared in English in 1538 as *Preparation to Death*. He urges his readers to live rightly as the best preparation for death. He also seeks a balance between warning and comforting the dying so that they will be neither flattered into arrogant self-confidence nor driven to despair; repentance is necessary, and forgiveness is always available through Christ. Erasmus dramatizes the deathbed scene in a dialogue between the Devil and the dying Man. The Devil offers temptations to which the Man replies clearly and confidently; having mastered the arts of living and dying, the Man is well prepared for this confrontation. While recognizing the importance of sacramental confession and communion, Erasmus says not to worry if a priest cannot be present; the dying may confess directly to God who gives salvation without the sacraments if "faith and a glad will be present" (Atkinson 1992, p. 56).

The Ars Moriendi tradition in England has been especially well documented. It includes translations of Roman Catholic works by Petrus Luccensis and the Jesuit Gaspar Loarte; Thomas Lupset's humanistic *Way of Dying Well*; and Thomas Becon's Calvinist *The Sick Man's Salve*. But one literary masterpiece stands out, which is Jeremy Taylor's *The Rule and Exercises of Holy Dying*.

When Taylor published *Holy Dying* in 1651, he described it as "the first entire body of directions for sick and dying people" (Taylor 1977, p. xiii) to be published in the Church of England. This Anglican focus allowed Taylor to reject some elements of the Roman Catholic Ars Moriendi and to retain others. For example, he ridicules deathbed repentance but affirms traditional practices for dying well; by themselves the protocols of dying are "not enough to pass us into paradise," but if "done foolishly, [they are] enough to send us to hell" (Taylor 1977, p. 43). For Taylor the good death completes a good life, but even the best Christian requires the prescribed prayers, penance, and Eucharist at the hour of death. And *Holy Dying* elegantly lays out a program for living and dying well. Its first two chapters remind readers of their mortality and urge them to live in light of this awareness. In the third chapter, Taylor describes two temptations of the sick and dying: impatience and the fear of death itself. Chapter four leads the dying through exercises of patience and repentance as they await their "clergy-guides," whose ministry is described in chapter five. This bare summary misses both the richness of Taylor's prose and the caring, pastoral tone that led Nancy Lee Beaty, author of *The Craft of Dying*, to consider *Holy Dying*, the "artistic climax" of the English Ars Moriendi tradition (Beaty 1970, p. 197).

Susan Karant-Nunn, in her 1997 book *The Reformation of Ritual*, documented the persistence of the Ars Moriendi tradition in the "Lutheran Art of Dying" in Germany during the late sixteenth century. Although the Reformers eliminated devotion to the saints and the sacraments of penance and anointing with oil, Lutheran pastors continued to instruct the dying and to urge them to repent, confess, and receive the Eucharist. Martin Moller's *Manual on Preparing for Death* (1593) gives detailed directions for this revised art of dying.

Karant-Nunn's analysis can be extended into the eighteenth century. In 1728 Johann Friedrich

Starck [or Stark], a Pietist clergyman in the German Lutheran church, treated dying at length in his *Tägliches Hand-Buch in guten und bösen Tagen*. Frequently reprinted into the twentieth century, the *Hand-Book* became one of the most widely circulated prayer books in Germany. It also thrived among German-speaking Americans, with ten editions in Pennsylvania between 1812 and 1829, and an 1855 English translation, *Daily Hand-Book for Days of Rejoicing and of Sorrow*.

The book contains four major sections: prayers and hymns for the healthy, the afflicted, the sick, and the dying. As the fourth section seeks “a calm, gentle, rational and blissful end,” it adapts core themes from the Ars Moriendi tradition: the dying must consider God’s judgment, forgive others and seek forgiveness, take leave of family and friends, commend themselves to God, and “resolve to die in Jesus Christ.” While demons no longer appear at the deathbed, the temptation to despair remains as the dying person’s sins present themselves to “frighten, condemn, and accuse.” The familiar remedy of contrition and forgiveness through Christ’s passion comforts the dying. Starck offers a rich compendium of “verses, texts and prayers” for bystanders to use in comforting the dying, and for the dying themselves. A confident, even joyful, approach to death dominates these prayers, as the dying person prays, “Lord Jesus, I die for thee, I live for thee, dead and living I am thine. Who dies thus, dies well.”

Ars Moriendi in the Twenty-First Century

Starck’s *Hand-Book* suggests what became of the Ars Moriendi tradition. It did not simply disappear. Rather, its assimilation to Christian “arts of living” eventually led to decreasing emphasis on the deathbed, and with it the decline of a distinct genre devoted to the hour of death. The art of dying then found a place within more broadly conceived prayer books and ritual manuals, where it remains today (e.g., the “Ministration in Time of Death” in the Episcopal Church’s *Book of Common Prayer*). The Ars Moriendi has thus returned to its origins. Having emerged from late medieval prayer and liturgy, it faded back into the matrix of Christian prayer and practice in the late seventeenth and eighteenth centuries.

The Ars Moriendi suggests useful questions for twenty-first century approaches to dying. During

its long run, the Ars Moriendi ritualized the pain and grief of dying into the conventional and manageable forms of Christian belief, prayer, and practice. In what ways do current clinical and religious practices ritualize dying? Do these practices place dying persons at the center of attention, or do they marginalize and isolate them? What beliefs and commitments guide current approaches to dying? Although the Ars Moriendi’s convictions about death and afterlife are no longer universally shared, might they still speak to believers within Christian churches and their pastoral care programs? What about the views and expectations of those who are committed to other religious traditions or are wholly secular? In light of America’s diversity, is it possible—or desirable—to construct one image of the good death and what it might mean to die well? Or might it be preferable to mark out images of several good deaths and to develop new “arts of dying” informed by these? Hospice and palliative care may provide the most appropriate context for engaging these questions. And the Ars Moriendi tradition offers a valuable historical analogue and framework for posing them.

See also: ARIÈS, PHILIPPE; BLACK DEATH; CHRISTIAN DEATH RITES, HISTORY OF; GOOD DEATH, THE; MEMENTO MORI; TAYLOR, JEREMY; VISUAL ARTS

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DONALD F. DUCLOW

ASSASSINATION

The term *assassin* comes from the Arabic word *hashashin*, the collective word given to the followers of Hasan-e Sabbah, the head of a secret Persian sect of Ismailities in the eleventh century who would intoxicate themselves with hashish before murdering opponents. The word has since come to refer to the premeditated surprise murder of a prominent individual for political ends.

An assassination may be perpetrated by an individual or a group. The act of a lone assassin generally involves jealousy, mental disorder, or a political grudge. The assassination performed by more than one person is usually the result of a social movement or a group plot. Both forms of assassination can have far-reaching consequences.

Major Assassinations in World History

One of the earliest political assassinations in recorded history occurred in Rome on March 15, 44 B.C.E. when members of the Roman aristocracy (led by Gaius Cassius and Marcus Brutus), fearing the power of Julius Caesar, stabbed him to death in the Senate house. Caesar had failed to heed warnings to “Beware the Ides of March,” and paid the ultimate price (McConnell 1970).

An assassination is usually performed quickly and involves careful planning. The “Thuggee” cult

(from which the word *thug* is derived), which operated in India for several centuries until the British eliminated it in the mid-nineteenth century, consisted of professional killers who committed ritual stranglings of travelers, not for economic or political reasons, but as a sacrifice to the goddess Kali. One thug named Buhram claimed to have strangled 931 people during his forty years as a Thuggee.

The eighteenth and nineteenth centuries saw a plethora of assassinations throughout the Western world. Among the most noteworthy were the murders of Jean-Paul Marat and Spencer Perceval. For his role in the French Revolution, Marat was assassinated in his residence with a knife wielded by Charlotte Corday, a twenty-four-year-old French woman, on July 13, 1793. It is uncertain whether she committed the act for patriotic reasons of her own or whether she was acting on orders. On May 11, 1812, John Bellingham entered the lobby of the House of Commons and assassinated the British prime minister, Spencer Perceval, because he refused to heed Bellingham’s demand for redress against tsarist Russia.

The victim of the most momentous political assassination of the early twentieth century was the Archduke Franz Ferdinand, heir to the Austro-Hungarian Empire of the Hapsburgs, slain during a parade in Sarajevo on June 28, 1914. The assassination helped trigger World War I. The world was shocked once again on October 9, 1934, when King Alexander I, who had assumed a dictatorial role in Yugoslavia in the 1920s in an effort to end quarreling between the Serbs and Croats, was murdered by a professional assassin hired by Croat conspirators led by Ante Pavelich.

Russia experienced two major assassinations in the early twentieth century. Having allegedly saved the life of the son of Tsar Nicholas, Grigori Rasputin (the “Mad Monk”) gained favor with the Tsarina and, through careful manipulation, became the virtual leader of Russia. However, his byzantine court intrigues, coupled with pro-German activities, led to his assassination on December 29, 1916, by Prince Youssoupoff, husband of the tsar’s niece. Ramon Mercader, an agent of the Soviet dictator Joseph Stalin, assassinated Leon Trotsky, who had co-led the Russian Revolution in 1917, in Mexico on August 21, 1940.

On January 30, 1948, India suffered the loss of Mahatma Gandhi, murdered by Nathuram Godse,

a religious fanatic who feared the consequences of the partition that created Pakistan in 1947. The South Vietnamese leader Ngo Dinh Diem was killed on November 2, 1963, by a Vietnamese tank corps major (whose name was never released) because of his submission to the tyrannical rule of his brother, Ngo Dinh Nhu.

Assassinations in U.S. History

The United States experienced a number of major losses to assassins in the twentieth century. Huey Long, an icon in Louisiana politics, was assassinated on September 8, 1935, in the corridor of the capitol building by Carl Weiss, a medical doctor in Baton Rouge and son-in-law of one of Long's many political enemies. Mark David Chapman shot John Lennon, one of the most politically active rock stars of his generation, on December 8, 1980. Attempts were made on other noteworthy men such as George Wallace (May 15, 1972, in Laurel, Maryland) and civil rights leader James Meredith (June 1966 during a march from Memphis, Tennessee to Jackson, Mississippi).

The 1960s was an era of unrest in the United States. Civil rights, women's rights, the war in Vietnam, the student movement, and the ecology controversy were major issues. Malcolm X, who advocated black nationalism and armed self-defense as a means of fighting the oppression of African Americans, was murdered on February 21, 1965, by Talmadge Hayer, Norman Butler, and Thomas Johnson, alleged agents of Malcolm's rival Elijah Muhammad of the Nation of Islam. Martin Luther King Jr. was killed on April 4, 1968, in Memphis, Tennessee by James Earl Ray, who later retracted his confession and claimed to be a dupe in an elaborate conspiracy. Robert F. Kennedy, then representing New York State in the U.S. Senate, was shot by a Palestinian, Sirhan Sirhan, on June 5, 1968, in Los Angeles, shortly after winning the California presidential primary.

Attempted Assassinations of U.S. Presidents

The first attempt to assassinate a sitting president of the United States occurred on January 30, 1835, when Richard Lawrence, an English immigrant, tried to kill President Andrew Jackson on a street in Washington, D.C. Lawrence believed that he was heir to the throne of England and that Jackson stood in his way. He approached the president with

a derringer and pulled the trigger at point-blank range. When nothing happened, Lawrence reached in his pocket and pulled out another derringer, which also misfired. Lawrence was tried, judged insane, and sentenced to a mental institution for the rest of his life.

On February 15, 1933, while riding in an open car through the streets of Miami, Florida, with Chicago's mayor, Anton Cermak, President Franklin D. Roosevelt nearly lost his life to Giuseppe (Joseph) Zangara, an unemployed New Jersey mill worker who had traveled to Florida seeking employment. Caught up in the throes of the depression and unable to find work, he blamed capitalism and the president. The assassin fired several shots at the presidential vehicle and fatally wounded Cermak and a young woman in the crowd; Roosevelt was not injured. Zangara was executed in the electric chair, remaining unrepentant to the end.

While the White House was being renovated in 1950, and Harry Truman and his wife were residing in the poorly protected Blair House nearby, two Puerto Rican nationalists—Oscar Collazo and Grisello Torresola—plotted Truman's death, believing "that the assassination of President Truman might lead to an American Revolution that would provide the Nationalists with an opportunity to lead Puerto Rico to independence" (Smith 2000, p. 3). On November 1, 1950, the two killers attempted to enter the Blair House and kill the president. Truman was not harmed, but in the gun battle that took place, one security guard was fatally shot and two were injured. Torresola was also killed. Collazo, although wounded, survived to be tried, and he was sentenced to death. Not wishing to make him a martyr, Truman commuted his sentence to life in prison. During his presidency in 1979, Jimmy Carter ordered the release of Collazo, and he died in Puerto Rico in 1994.

While President Ronald Reagan was leaving the Washington Hilton in Washington, D.C., on March 30, 1981, he was seriously injured by a .22-caliber bullet fired by twenty-five-year-old John W. Hinckley Jr. After watching the movie *Taxi Driver*, Hinckley was impressed by Robert DeNiro's role as a man who tries to assassinate a senator. Hinckley also became infatuated with Jodie Foster, a young actress in the film, and decided that the way to



Malcolm X, who fought against the oppression of African Americans, on a stretcher after being shot and killed by assassins on February 21, 1965. CORBIS

impress her was to kill the president. Reagan survived major surgery to repair a collapsed lung, and Hinckley was sentenced to a psychiatric facility.

President Gerald Ford survived two attempts on his life. On September 5, 1975, while in Sacramento, California, Ford was nearly killed by Lynette “Squeaky” Fromme, a devoted follower of the cult leader Charles Manson. Fromme believed that killing Ford would bring attention to the plight of the California redwood trees and other causes she supported. Fromme was three to four feet from the President and about to fire a .45-caliber handgun when she was thwarted by Secret Service agents. Seventeen days later, in San Francisco, Sara Jane Moore, a civil rights activist, attempted to take the president’s life. Moore was a member of a radical group and believed she could prove her allegiance by killing the president. Both women were sentenced to life imprisonment.

Theodore Roosevelt was the only former president to face an assassination attempt. In 1912,

after serving two terms as president, Roosevelt decided to seek a third term at the head of the Bull Moose Party. The idea of a third-term president was disturbing to many because no president theretofore had ever served more than two consecutive terms. A German immigrant, John Shrank, decided that the only way to settle the issue was to kill Roosevelt. On October 14, 1912, at a political rally, Shrank fired a bullet that went through fifty pages of speech notes, a glasses case made of steel, and Roosevelt’s chest, penetrating a lung. Covered with blood, Roosevelt completed his speech before being treated. Shrank was adjudicated as mentally ill and spent the rest of his life in a mental institution.

Assassinations of U.S. Presidents

The first president to be assassinated was Abraham Lincoln on April 14, 1865. Believing that he could avenge the loss of the South in the U.S. Civil War, the actor John Wilkes Booth entered the President’s

box at the Ford Theater in Washington, D.C., where Lincoln had gone with friends and family to see a play. Booth fired a bullet into the back of the President's head and then leaped from the stage shouting, "sic semper tyrannis!" and "The South is avenged!" Despite fracturing his shinbone, he successfully escaped. Twelve days later, Booth was trapped in a Virginia barn and killed when he refused to surrender. The coconspirators in the murder were hanged.

James A. Garfield was shot once in the arm and once in the back on July 1, 1881, in a Baltimore and Potomac train station on his way to deliver a speech in Massachusetts. Charles Guiteau, the assassin, had supported the president's candidacy and erroneously believed that he had earned a political appointment in Garfield's administration. When he was rejected, the killer blamed the president. Garfield survived for seventy-nine days before succumbing to his wound. Guiteau was hanged on June 30, 1882, at the District of Columbia jail.

In September 1901 President William McKinley traveled to the Pan-American Exposition in Buffalo, New York, to give a speech on American economic prosperity. While greeting an assembled crowd on September 6, he encountered twenty-eight-year-old Leon Czolgosz, a laborer and self-professed anarchist. The assassin approached McKinley with a handkerchief wrapped around his wrist, and when the President reached to shake his hand, Czolgosz produced a .32-caliber pistol and fired two shots into the chief executive's abdomen. McKinley died eight days later from gangrene that developed because of inadequate medical treatment. Czolgosz was executed, exclaiming that he was "not sorry" (Nash 1973, p. 143).

On November 22, 1963, while traveling in a motorcade through the streets of Dallas, Texas, John F. Kennedy became the fourth U.S. president to be assassinated. Lee Harvey Oswald, a communist malcontent, was accused of the crime and all evidence pointed to his guilt. However, before he could be adjudicated, Jack Ruby, a Texas nightclub owner, killed Oswald. Oswald's motivation for killing Kennedy has never been fully determined: "The only conclusion reached was that he acted alone and for vague political reasons" (Nash 1973, p. 430). Conspiracy theories concerning the murder have not been substantiated.

See also: DEATH SYSTEM; HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; HOMICIDE, EPIDEMIOLOGY OF; REVOLUTIONARIES AND "DEATH FOR THE CAUSE!"; TERRORISM

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AUGUSTINE

For over 1,600 years, the works of Augustine of Hippo (354–430 C.E.), the great Christian theologian and teacher, have strongly influenced religious, philosophical, and psychological thought. His ideas of mortality were informed by various belief systems, such as the early Christian view that death is punishment for original sin and the Platonic notion of the immaterial and immortal essence of the soul.

This instinct is the basis for morality, as the rational self strives to preserve its rational nature and not to become irrational or inorganic in nature. Augustine takes from Greco-Roman culture, particularly from the Stoics, the notion that every living thing has an “instinct” for self-preservation. From the books of the Pentateuch, Augustine receives a juridical account of the origin and character of death: Death is a punishment (Gen. 3:19). In his epistles to early Christian communities, the apostle Paul (an ex-rabbi) makes a juridical understanding of death central to the Christian faith (2 Cor. 1:9); these letters become increasingly important for Augustine’s understanding of the significance of death.

Augustine’s evaluation of death undergoes a profound change after he encounters the theology of Pelagius. In his earlier writings, such as *On the Nature of the Good*, Augustine regards death as good because it is natural: Death is the ordered succession of living entities, each coming and going the way the sound of a word comes and goes; if the sound remained forever, nothing could be said. But in Pelagius’s theology, Augustine encounters a radical statement of the “naturalness” of death: Even if there had never been any sin, Pelagius says, there would still be death. Such an understanding of death is very rare in early Christianity, and Augustine eventually stands with the mass of early Christian tradition by insisting upon the exegetically derived (from the Pentateuch) judgment that death is a punishment that diminishes the original “all life” condition of human nature. It is a distinctive and consistent feature of Augustine’s theology of death that it is developed and articulated almost exclusively through the opening chapters of the Book of Genesis.

The fact of death has ambivalent significance. On the one hand, death is an undeniable reality,

universally appearing in all living organisms: Life inevitably ceases, however primitive or rational that life may be. On the other hand, just as inevitably and as universally, death demands denial: Consciousness rejects the devolution from organic to inorganic.

See also: CATHOLICISM; CHRISTIAN DEATH RITES, HISTORY OF; PHILOSOPHY, WESTERN

MICHEL RENE BARNES

AUSTRALIAN ABORIGINAL RELIGION

Notwithstanding the diversity of Australian Aboriginal beliefs, all such peoples have had similar concerns and questions about death: What should be done with the body? What happens to the soul? How should people deal with any disrupted social relationships? And how does life itself go on in the face of death? All of these concerns pertain to a cosmological framework known in English as “The Dreaming” or “The Dreamtime,” a variable mythological concept that different groups have combined in various ways with Christianity.

There are many different myths telling of the origins and consequences of death throughout Aboriginal Australia and versions of the biblical story of the Garden of Eden must now be counted among them. Even some of the very early accounts of classical Aboriginal religion probably unwittingly described mythologies that had incorporated Christian themes.

There are many traditional methods of dealing with corpses, including burial, cremation, exposure on tree platforms, interment inside a tree or hollow log, mummification, and cannibalism (although evidence for the latter is hotly disputed). Some funeral rites incorporate more than one type of disposal. The rites are designed to mark stages in the separation of body and spirit.

Aboriginal people believe in multiple human souls, which fall into two broad categories: one is comparable to the Western ego—a self-created, autonomous agency that accompanies the body and constitutes the person’s identity; and another that comes from “The Dreaming” and/or from God. The latter emerges from ancestral totemic



An Aborigine from the Tiwi tribe in Bathurst, New South Wales, Australia, stands beside painted funeral totems. Phases of funerary rites are often explicitly devoted to symbolic acts that send ancestral spirits back to their places of origin where they assume responsibility for the wellbeing of the world they have left behind. CHARLES AND JOSETTE LENARS/CORBIS

sites in the environment, and its power enters people to animate them at various stages of their lives.

At death, the two types of soul have different trajectories and fates. The egoic soul initially becomes a dangerous ghost that remains near the deceased's body and property. It eventually passes into nonexistence, either by dissolution or by travel to a distant place of no consequence for the living. Its absence is often marked by destruction or abandonment of the deceased's property and a long-term ban on the use of the deceased person's name by the living. Ancestral souls, however, are eternal. They return to the environment and to the sites and ritual paraphernalia associated with specific totemic beings and/or with God.

The funerary rites that enact these transitions are often called (in English translation) "sorry business." They occur in Aboriginal camps and houses, as well as in Christian churches because the varied

funerary practices of the past have been almost exclusively displaced by Christian burial. However, the underlying themes of the classical cosmology persist in many areas. The smoking, (a process in which smoke, usually from burning leaves, is allowed to waft over the deceased's property) stylized wailing, and self-inflicted violence are three common components of sorry business, forming part of a broader complex of social-psychological adjustment to loss that also includes anger and suspicion of the intentions of persons who might have caused the death. People may be held responsible for untimely deaths even if the suspected means of dispatch was not violence but accident or sorcery. The forms of justice meted out to such suspects include banishment, corporal punishment, and death (even though the latter is now banned by Australian law).

See also: HOW DEATH CAME INTO THE WORLD; SUICIDE
INFLUENCES AND FACTORS: INDIGENOUS POPULATIONS

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JOHN MORTON

AUTOPSY

Autopsies, also known as necropsies or post-mortem examinations, are performed by anatomic pathologists who dissect corpses to determine the cause of death and to add to medical knowledge. “Autopsy,” from the Greek *autopsia*, means seeing with one’s own eyes.

Greek physicians performed autopsies as early as the fifth century B.C.E.; Egyptian physicians used them to teach anatomy between 350 and 200 B.C.E.; and doctors with the Roman legions autopsied dead barbarian soldiers. In 1533 the New World’s first autopsy supposedly determined whether Siamese twins had one soul or two. In 1662 the Hartford, Connecticut, General Court ordered an autopsy to see if a child had died from witchcraft (she died of upper airway obstruction). Into the early twentieth century, many physicians performed autopsies on their own patients, often at the decedent’s residence.

In the twenty-first century, pathologists perform nearly all autopsies. After at least four years of pathology training (residency), anatomic pathologists spend an additional one to two years becoming forensic pathologists. These specialists are experts in medicolegal autopsies, criminal investigation, judicial testimony, toxicology, and other forensic sciences.

While autopsies are performed primarily to determine the cause of death, they also ensure quality control in medical practice, help confirm the presence of new diseases, educate physicians, and investigate criminal activity. Modern medicine

does not ensure that physicians always make correct diagnoses. More than one-third of autopsied patients has discrepancies between their clinical and autopsy diagnoses that may have adversely affected their survival. By identifying treatment errors, autopsies also helped clinicians develop the methods in use today to treat trauma patients. Society also benefits from autopsies; for example, between 1950 and 1983 alone, autopsies helped discover or clarify eighty-seven diseases or groups of diseases.

Who Gets Autopsied?

Whether or not people are autopsied depends on the circumstances surrounding their deaths, where they die, their next of kin, and, in some cases, their advance directives or insurance policies. For many reasons, pathologists in the United States now autopsy fewer than 12 percent of nonmedicolegal deaths. Less than 1 percent of those who die in nursing homes, for example, are autopsied.

Medical examiners perform medicolegal, or forensic, autopsies. The 1954 Model Post-Mortem Examination Act, adopted in most U.S. jurisdictions, recommends forensic examination of all deaths that (1) are violent; (2) are sudden and unexpected; (3) occur under suspicious circumstances; (4) are employment related; (5) occur in persons whose bodies will be cremated, dissected, buried at sea, or otherwise unavailable for later examination; (6) occur in prison or to psychiatric inmates; or (7) constitute a threat to public health. Many also include deaths within twenty-four hours of general anesthesia or deaths in which a physician has not seen the patient in the past twenty-four hours. They can order autopsies even when deaths from violence are delayed many years after the event.

Not all deaths that fall under a medical examiner’s jurisdiction are autopsied because they generally work within a tight budget. Approximately 20 percent of all deaths fall under the medical examiner/coroner’s purview, but the percentage that undergoes medicolegal autopsy varies greatly by location.

In the United States, medical examiners autopsy about 59 percent of all blunt and penetrating trauma deaths, with homicide victims and trauma deaths in metropolitan areas autopsied

most often. Some states may honor religious objections to medicolegal autopsies, although officials will always conduct an autopsy if they feel it is in the public interest. In 1999 the European Community adopted a comprehensive set of medicolegal autopsy rules that generally parallel those in the United States.

Autopsy Permission

While medical examiner cases do not require consent, survivors, usually next of kin, must give their permission before pathologists perform a non-medicolegal autopsy. A decedent's advance directive may help the survivors decide. Survivors may sue for damages based on their mental anguish for autopsies that were performed without legal approval or that were more extensive than authorized; monetary awards have been relatively small.

Autopsy permission forms usually include options for "complete postmortem examination," "complete postmortem examination—return all organs" (this does not include microscopic slides, fluid samples, or paraffin blocks, which pathologists are required to keep), "omit head," "heart and lungs only," "chest and abdomen only," "chest only," "abdomen only," and "head only." Limitations on autopsies may diminish their value.

U.S. military authorities determine whether to autopsy active duty military personnel. Some insurance policies may give insurance companies the right to demand an autopsy, and Workman's Compensation boards and the Veterans Administration may require autopsies before survivors receive death benefits.

Consent is not required for autopsies in some countries, but families may object to nonforensic autopsies. When individuals die in a foreign country, an autopsy may be requested or required upon the body's return to their home country (even if it has already been autopsied) to clarify insurance claims or to investigate criminal activity.

College-educated young adults are most likely to approve autopsies on their relatives. Contrary to popular wisdom, the type of funeral rite (burial vs. cremation) a person will have does not affect the rate of autopsy permission, at least in the United States. Although most people would permit an autopsy on themselves, the next of kin or surrogate often refuses permission based on seven erroneous beliefs:

1. Medical diagnosis is excellent and diagnostic machines almost infallible; an autopsy is unnecessary.
2. If the physician could not save the patient, he or she has no business seeking clues after that failure.
3. The patient has suffered enough.
4. Body mutilation occurs.
5. An autopsy takes a long time and delays final arrangements.
6. Autopsy results are not well communicated.
7. An autopsy will result in an incomplete body, and so life in the hereafter cannot take place.

Increasingly, however, survivors contract with private companies or university pathology departments to do autopsies on their loved ones because they either could not get one done (e.g., many hospital pathology departments have stopped doing them) or they do not accept the results of the first examination.

Religious views about autopsies generally parallel attitudes about organ or tissue donation. They vary not only among religions, but also sometimes within religious sects and among co-religionists in different countries. The Bahá'í faith, most nonfundamentalist Protestants, Catholics, Buddhists, and Sikhs permit autopsies. Jews permit them only to save another life, such as to exonerate an accused murderer. Muslims, Shintos, the Greek Orthodox Church, and Zoroastrians forbid autopsies except those required by law. Rastafarians and Hindus find autopsies extremely distasteful.

Autopsy Technique

Complete autopsies have four steps, including inspecting the body's exterior; examining the internal organs' position and appearance; dissecting and examining the internal organs; and the laboratory analysis of tissue, fluids, and other specimens. In medicolegal cases, an investigative team trained in criminal detection first goes to the death scene to glean clues from the position and state of the body, physical evidence, and the body's surroundings. They also photograph the body, the evidence, and the scene for possible use in court.

The first step in the autopsy is to examine the corpse's exterior. Pathologists carefully examine clothing still on the body, including the effects of penetrating objects and the presence of blood or body fluid stains, evidence most useful in medicolegal cases. They use metric measurements (centimeters, grams) for the autopsy records and the U.S. system of weights and measurements for any related legal documents. Disrobing the body, they carefully examine it for identifying marks and characteristics and signs of injury or violence. They scrape the corpse's nails, test the hands for gunpowder, and collect any paint, glass, or tire marks for future identification. The pathologist also tries to determine the number, entry, and exit sites of gunshot wounds. Radiographs are frequently taken.

In the second step, pathologists open the thoracoabdominal (chest-belly) cavity. The incision, generally Y-shaped, begins at each shoulder or armpit area and runs beneath the breasts to the bottom of the breastbone. The incisions join and proceed down the middle of the abdomen to the pubis, just above the genitals. The front part of the ribs and breastbone are then removed in one piece, exposing most of the organs. Pathologists then examine the organs' relationships to each other. They often examine the brain at this stage. To expose the brain, they part the hair and make an incision behind the ears and across the base of the scalp. The front part of the scalp is then pulled over the face and the back part over the nape of the neck, exposing the skull. They open the skull using a special high-speed oscillating saw. After the skull cap is separated from the rest of the skull with a chisel, the pathologist examines the covering of the brain (meninges) and the inside of the skull for signs of infection, swelling, injury, or deterioration.

For cosmetic reasons, pathologists normally do not disturb the skin of the face, arms, hands, and the area above the nipples. For autopsies performed in the United States, pathologists rarely remove the large neck vessels. However, medical examiners must examine areas with specific injuries, such as the larynx, in possible strangulation cases. In suspected rape-murders, they may remove reproductive organs for additional tests.

In the third step, pathologists remove the body's organs for further examination and dissection. Normally, pathologists remove organs from the chest and belly either sequentially or *en bloc* (in

one piece, or "together"). Using the *en bloc* procedure allows them to release bodies to the mortician within thirty minutes after beginning the autopsy; the organs can be stored in the refrigerator and examined at a later time. Otherwise, the entire surgical part of an autopsy normally takes between one and three hours. During the *en bloc* procedure, major vessels at the base of the neck are tied and the esophagus and trachea are severed just above the thyroid cartilage (Adam's apple). Pathologists pinch off the aorta above the diaphragm and cut it and the inferior vena cava, removing the heart and lungs together. They then remove the spleen and the small and large intestines. The liver, pancreas, stomach, and esophagus are removed as a unit, followed by the kidneys, ureters, bladder, abdominal aorta, and, finally, the testes. Pathologists take small muscle, nerve, and fibrous tissue samples for microscopic examination. Examining and weighing the organs, they open them to check for internal pathology. They remove tissue fragments anywhere they see abnormalities, as well as representative pieces from at least the left ventricle of the heart, lungs, kidneys, and liver.

Pathologists remove the brain from the skull by cutting the nerves to the eyes, the major blood vessels to the brain, the fibrous attachment to the skull, the spinal cord, and several other nerves and connections. After gently lifting the brain out of the skull and checking it again for external abnormalities, they usually suspend it by a thread in a two-gallon pail filled with 10 percent formalin. This "fixes" it, firming the tissue so that it can be properly examined ten to fourteen days later. (Bone is rarely removed during an autopsy unless there is suspected to be injury or disease affecting it.) Pathologists then sew closed any large incisions.

Step four, the most time consuming, consists of examining minute tissue and fluid specimens under the microscope and by chemical analysis. Medical examiners routinely test for drugs and poisons (toxicology screens) in the spinal fluid, eye fluid (vitreous humor), blood, bile, stomach contents, hair, skin, urine, and, in decomposing bodies, fluid from blisters. Pathologists commonly test infants with congenital defects, miscarried fetuses, and stillborns for chromosomal abnormalities, and fetuses and infants, as well as their placenta and umbilical cords, for malformations suggesting congenital abnormalities.

After an autopsy, pathologists usually put the major organs into plastic bags and store them in body cavities unless they have written permission to keep them. Medical examiners must keep any organs or tissues needed for evidence in a legal case. Medical devices, such as pacemakers, are discarded. They routinely keep small pieces of organs (about the size of a crouton) for subsequent microscopic and chemical analysis. National standards require that “wet tissue” from autopsies be held for six months after issuing a final autopsy report, tissue in paraffin blocks (from which microscope slides are made) must be kept for five years, and the slides themselves along with the autopsy reports must be retained for twenty years.

After completing the autopsy, pathologists try, when possible, to determine both a “cause of death” and the contributing factors. The most common misconception about medicolegal investigations is that they always determine the time of death. The final autopsy report may not be available for many weeks. The next of kin signing a routine autopsy authorization need only request a copy of the report. In medical examiners’ cases, if they do not suspect suspicious circumstances surrounding the death, next of kin need to request the report in writing. When the autopsy results may be introduced into court as evidence, a lawyer may need to request the report.

Forensic pathologists also perform autopsies on decomposing bodies or on partial remains to identify the deceased and, if possible, to determine the cause and time of death. Pathologists usually exhume bodies to (1) investigate the cause or manner of death; (2) collect evidence; (3) determine the cause of an accident or the presence of disease; (4) gather evidence to assess malpractice; (5) compare the body with another person thought to be deceased; (6) identify hastily buried war and accident victims; (7) settle accidental death or liability claims; or (8) search for lost objects. In some instances, they must first determine whether remains are, in fact, human and whether they represent a “new” discovery or simply the disinterment of previously known remains. This becomes particularly difficult when the corpse has been severely mutilated or intentionally misidentified to confuse investigators.

See also: AUTOPSY, PSYCHOLOGICAL; BURIED ALIVE;
CADAVER EXPERIENCES; CRYONIC SUSPENSION

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KENNETH V. ISERSON

AUTOPSY, PSYCHOLOGICAL

The psychological autopsy is a procedure for investigating a person's death by reconstructing what the person thought, felt, and did preceding his or her death. This reconstruction is based upon information gathered from personal documents, police reports, medical and coroner's records, and face-to-face interviews with families, friends, and others who had contact with the person before the death.

The first psychological autopsy study was most likely Gregory Zilboorg's investigation of ninety-three consecutive suicides by police officers in New York City between 1934 and 1940. In 1958 the chief medical examiner of the Los Angeles Coroners Office asked a team of professionals from the Los Angeles Suicide Prevention Center to help in his investigations of equivocal cases where a cause of death was not immediately clear. From these investigations, the psychiatrist Edwin Shneidman coined the phrase "psychological autopsy" to describe the procedure he and his team of researchers developed during those investigations. The method involved talking in a tactful and systematic manner to key persons—a spouse, lover, parent, grown child, friend, colleague, physician, supervisor, and coworker—who knew the deceased. Their practice of investigating equivocal deaths in Los Angeles continued for almost thirty years and allowed for more accurate classification of equivocal deaths as well as contributing to experts' understanding of suicide.

In the 1970s and 1980s, researchers using the psychological autopsy method investigated risk factors for suicide. Psychological autopsies have confirmed that the vast majority of suicide victims could be diagnosed as having had a mental disorder, usually depression, manic depression, or alcohol or drug problems. Other studies focused upon the availability of firearms in the home of suicide completers, traumatic events in person's lives, and other psychological and social factors.

There are two major trends in the use of psychological autopsies: research investigation and clinical and legal use. Research investigations generally involve many people who died by suicide and comparing the results with another group, for example, accident victims, in order to see if some factors are important in discriminating between suicides and other deaths. Clinical and legal use of psychological autopsies involves investigations of a single death in order to clarify why or how a person died. These often involve descriptive interpretations of the death and may include information to help family and friends better understand why a tragic death occurred. They also may lead to suggesting means of preventing suicides, for example by suggesting improvements in hospital treatment or suicide prevention in jails.

Psychological autopsies have been conducted for literary interpretation of the deaths of famous people. Of note is Shneidman's analysis eighty-eight years later of the death of Malcolm Melville in 1867, the son of *Moby Dick* author Herman Melville. They also have been used in legal cases to settle estate questions concerning the nature of death; for example, the death of the billionaire Howard Hughes. Psychological autopsies have been used in criminal investigations of blame, including one case where a mother was found guilty of numerous abusive behaviors toward a child who had committed suicide.

There is no consensus on the exact procedure for conducting a psychological autopsy. However, psychological autopsy studies for research purposes often use complex methods to ensure that the information is reliable and valid. All psychological autopsies are based upon possibly biased recollections. Nevertheless, the psychological autopsy constitutes one of the main investigative tools for understanding suicide and the circumstances surrounding death.

See also: AUTOPSY; SUICIDE INFLUENCES AND FACTORS: ALCOHOL AND DRUG USE, MENTAL ILLNESS

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BRIAN L. MISHARA

AZTEC RELIGION

At the time of Spanish contact in the sixteenth century, the Aztec were the preeminent power in Mexico, and to the east controlled lands bordering the Maya region. Whereas the Maya were neither culturally nor politically unified as a single entity in the sixteenth century, the Aztec were an empire integrated by the state language of Nahuatl as well as a complex religious system. As the principal political force during the Spanish conquest, the Aztec were extensively studied at this time. Due to sixteenth-century manuscripts written both by the Aztec and Spanish clerics, a great deal is known of Aztec religious beliefs and ritual, including death rituals.

Probably the most discussed and vilified aspect of Aztec religion is human sacrifice, which is amply documented by archaeological excavations, pre-Hispanic art, and colonial accounts. To the Aztec, cosmic balance and therefore life would not be possible without offering sacrificial blood to forces of life and fertility, such as the sun, rain, and the earth. Thus in Aztec myth, the gods sacrificed themselves for the newly created sun to move on its path. The offering of children to the rain gods was considered a repayment for their bestowal of abundant water and crops. Aside from sacrificial offerings, death itself was also a means of feeding and balancing cosmic forces. Many pre-Hispanic scenes illustrate burial as an act of the feeding the earth, with the bundled dead in the open maw of the earth monster. Just as day became night, death was a natural and necessary fate for the living.

The sixteenth-century accounts written in Spanish and Nahuatl provide detailed descriptions

of Aztec concepts of death and the afterlife. One of the most important accounts of Aztec mortuary rites and beliefs concerning the hereafter occurs in Book 3 of the *Florentine Codex*, an encyclopedic treatise of Aztec culture compiled by the Franciscan Fray Bernardino de Sahagún. According to this and other early accounts, the treatment of the body and the destiny of the soul in the afterlife depended in large part on one's social role and mode of death, in contrast to Western beliefs that personal behavior in life determines one's afterlife. People who eventually succumbed to illness and old age went to Mictlan, the dark underworld presided by the skeletal god of death, Mictlantecuhltli, and his consort Mictlancihuatl. In preparation for this journey, the corpse was dressed in paper vestments, wrapped and tied in a cloth bundle, and then cremated, along with a dog to serve as a guide through the underworld. The path to Mictlan traversed a landscape fraught with dangers, including fierce beasts, clashing mountains, and obsidian-bladed winds. Having passed these perils, the soul reached gloomy, soot-filled Mictlan, “the place of mystery, the place of the unfleshed, the place where there is arriving, the place with no smoke hole, the place with no fireplace” (Sahagún 1978, Book 3, p. 42). With no exits, Mictlan was a place of no return.

Aside from the dreary, hellish realm of Mictlan, there was the afterworld of Tlalocan, the paradise of Tlaloc, the god of rain and water. A region of eternal spring, abundance, and wealth, this place was for those who died by lightning, drowning, or were afflicted by particular diseases, such as pustules or gout. Rather than being cremated, these individuals were buried whole with images of the mountain gods, beings closely related to Tlaloc. Another source compiled by Sahagún, the *Primeros Memoriales*, contains a fascinating account of a noble woman who, after being accidentally buried alive, journeys to the netherworld paradise of Tlalocan to receive a gift and message from the rain god.

Book 3 of the *Florentine Codex* describes a celestial paradise. In sharp contrast to the victims of disease dwelling in Mictlan, this region was occupied by warriors and lords who died by sacrifice or combat in honor of the sun god Tonatiuh. The bodies of the slain heroes were burned in warrior bundles, with birds and butterflies symbolizing their fiery souls. These warrior souls followed the sun to



A group of men in front of the Basilica of Our Lady of Guadalupe in Mexico perform an Aztec dance during the feast of the Virgin of Guadalupe on December 12, the most important religious holiday in Mexico. Here they reenact the preparation of a sacrifice, a recognition of the inextricable interdependence of life and death to the Aztec. SERGIO DORANTES/CORBIS

zenith in the sky, where they would then scatter to sip flowers in this celestial paradise. The setting western sun would then be greeted by female warriors, which were the souls of those women who died in childbirth. In Aztec thought, the pregnant woman was like a warrior who symbolically captured her child for the Aztec state in the painful and bloody battle of birth. Considered as female aspects of defeated heroic warriors, women dying in childbirth became fierce goddesses who carried the setting sun into the netherworld realm of Mictlan. In contrast to the afterworld realms of Mictlan and Tlalocan, the paradise of warriors did relate to how one behaved on earth, as this was the region for the valorous who both lived and died as heroes. This ethos of bravery and self-sacrifice was a powerful ideological means to ensure the commitment of warriors to the growth and well-being of the empire.

For the Aztec, yearly ceremonies pertaining to the dead were performed during two consecutive twenty-day months, the first month for children,

and the second for adults, with special focus on the cult of the warrior souls. Although then occurring in the late summertime of August, many aspects of these ceremonies have continued in the fall Catholic celebrations of All Saints' Day and All Souls' Day. Along with the ritual offering of food for the visiting dead, marigolds frequently play a major part in the contemporary celebrations, a flower specifically related to the dead in Aztec ritual.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; CANNIBALISM; INCAN RELIGION; MAYA RELIGION; SACRIFICE

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KARL A. TAUBE

B



BAHÁ'Í FAITH

Barely more than a hundred years old, the Bahá'í faith emerged from the region of what is now Iran and Iraq, preaching a vision of the unity of all religions and humankind. The Bahá'ís believe that the great founders of the major world religions were divine prophets who served as channels of grace between the unknowable god and humankind. They also believe that revelation is progressive. All the revelations are essentially the same, differing only by the degree of their compatibility with the state of the human race at the time of their appearance.

Origins and Evolution of Bahá'í Faith

The Bahá'í faith is an offshoot of the Bábí religion, founded in 1844 by Mírzá 'Alí Mohammed of Shíráz, originally a Shí'ite Muslim, in present-day Iran. He declared himself a prophet with a new revelation, and spoke also about the future appearance, in exactly nineteen years, of a new prophet who would sweep away centuries of inherited superstition and injustice and inaugurate a golden age of peace and reconciliation among all humans of all religions, sects, and nationalities. Under his title of the "Báb" (Arabic for "gateway"), he propagated his universal doctrine throughout Persia, incurring the ire of the country's predominant Shí'ite Muslim religious establishment and their allies in the government. A massive campaign of official persecution over the next several years led to the death of thousands of Bábí followers and culminated in the execution of the Báb in 1850.

Mírzá Husayn 'Alí Núrí was among the Báb's most ardent and eloquent followers. Dubbing himself Bahá'u'lláh, he renounced his personal wealth and social position to devote himself to proselytizing the Bábí faith. While imprisoned in Tehran in 1852, Bahá'u'lláh experienced an epiphany, which he claimed divine appointment as the prophet announced by the Báb. At the end of the year he was released from prison and deported to present-day Iraq. Settling in Baghdad, he led a vigorous Bábí revival that prompted the Ottoman regime to relocate him to Constantinople, where the Bábí community embraced him as the prophet promised by the Báb and thereafter called themselves Bahá'ís in honor of their new leader.

Seeking to contain the influence of the growing new faith, the Ottomans exiled Bahá'u'lláh first to Adrianople in present-day Turkey and later to Acre in what is now Israel. Yet through the tenacity of his vision, he not only sustained his flock of followers but also managed a modest growth until his death in 1892, when the religion's leadership fell into the hands of his oldest son, 'Abdu'l-Bahá, who was succeeded by his own grandson Shoghi Effendi (d. 1951). Over the ensuing decades the faith won new adherents around the world, undergoing an especially rapid spurt of growth in the West. At the end of the twentieth century, the faith had approximately 6 million adherents worldwide.

The Bahá'í sacred scriptures consist of the formal writings and transcribed speeches of the Báb, Bahá'u'lláh, and 'Abalu'l-Bahá. There are no formally prescribed rituals and no priests or clerics. The only formalized prescriptive behavioral

expectations of the faith are daily prayer; nineteen days of fasting; abstaining from all mind-altering agents, including alcohol; monogamous fidelity to one's spouse; and participation in the Nineteenth Day Feast that opens every month of the Bahá'í calendar, which divides the year into nineteen months, each nineteen days long, with four compensatory days added along the way. New Year's day is observed on the first day of spring.

Bahá'í Beliefs on Death and Dying

The Bahá'í faith posits three layers of existence: the concealed secret of the Divine Oneness; the intermediary world of spiritual reality; and the world of physical reality ("the world of possibility"). It rejects the notion—common to Judaism, Christianity, and Islam—that life in this physical world is a mere preparation for an eternal life to come after death. The Bahá'í faith regards the whole idea of Heaven and Hell as allegorical rather than real. Bahá'ís believe that human life moves between the two interwoven poles of the physical and the spiritual. The only difference is that the world of physical existence has the dimension of temporality whereas the world of spiritual existence is eternal. Although one's physical life is not directly preparatory for a purely spiritual afterlife, the two are interrelated, the current course of life can influence its subsequent course. Death does not mean movement into another life, but continuation of this life. It is simply another category or stage of existence. The best that a person can do in this world, therefore, is to achieve spiritual growth, in both this and the coming life.

Death is regarded as the mere shedding of the physical frame while the indestructible soul lives on. Because the soul is the sum total of the personality and the physical body is pure matter with no real identity, the person, having left his material side behind, remains the same person, and he continues the life he conducted in the physical world. His heaven therefore is the continuation of the noble side of his earthly life, whereas hell would be the continuation of an ignoble life on earth. Freed from the bonds of earthly life, the soul is able to come nearer to God in the "Kingdom of Bahá." Hence the challenge of life in this world continues in the next, with the challenge eased because of the freedom from physical urges and imperatives.

Although death causes distress and pain to the friends and relatives of the deceased, it should be regarded as nothing more than a stage of life. Like birth, it comes on suddenly and opens a door to new and more abundant life. Death and birth follow each other in the movement from stage to stage and are symbolized some in other religions by the well-known ceremonies of the "rites of passage." In this way real physical death is also considered as a stage followed by birth into an invisible but no less real world.

Because the body is the temple of the soul, it must be treated with respect; therefore, cremation is forbidden in the Bahá'í faith, and the body must be laid to rest in the ground and pass through the natural process of decomposition. Moreover, the body must be treated with utmost care and cannot be removed a distance of more than an hour's journey from the place of death. The body must be wrapped in a shroud of silk or cotton and on its finger should be placed a ring bearing the inscription "I came forth from God and return unto Him, detached from all save Him, holding fast to His Name, the Merciful the Compassionate." The coffin should be made from crystal, stone, or hardwood, and a special prayer for the dead must be said before interment.

In its particular respect for the body of the dead, the Bahá'í faith shares the same values of Judaism and Islam, and was no doubt influenced by the attitude of Islam, its mother religion.

See also: ISLAM

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MOSHE SHARON

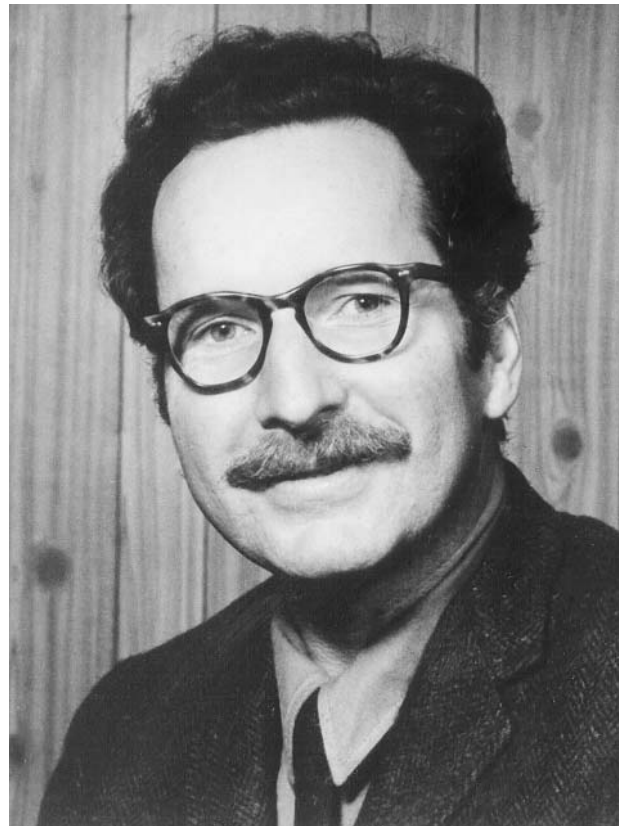
BECKER, ERNEST

The anthropologist Ernest Becker is well-known for his thesis that individuals are terrorized by the knowledge of their own mortality and thus seek to deny it in various ways. Correspondingly, according to Becker, a main function of a culture is to provide ways to engage successfully in death denial.

Becker was born on September 27, 1924, in Springfield, Massachusetts, to Jewish immigrants. His first publication, *Zen: A Rational Critique* (1961), was a version of his doctoral dissertation at Syracuse University, where he pursued graduate studies in cultural anthropology before becoming a writer and professor at Simon Fraser University in Vancouver, British Columbia, Canada. He authored nine books, with the last one, *Escape from Evil*, appearing after Becker's untimely death in March 1974. *Escape from Evil* is an application to the problem of evil of ideas Becker exposed in *The Denial of Death* (1973), a book for which he was awarded a Pulitzer Prize. Becker considered the two books to be an expression of his mature thinking.

The Denial of Death emerged out of Becker's previous attempts to create a unified "science of man" that he hoped would provide an understanding of the fundamental strivings of humans and the basis for the formulation of an ideal type of person—one who, being free from external constraints on freedom, might attain "comprehensive meaning" (Becker 1973). In the second edition of *The Birth and Death of Meaning* (1971) and, more elaborately, in *The Denial of Death* and *Escape from Evil*, Becker presents the more pessimistic view that the quest for meaning resides not outside but inside the individual. The threat to meaning is created by a person's awareness of his or her own mortality.

The change in Becker's view happened under the influence of the psychoanalyst Otto Rank, who viewed the fear of life and death as a fundamental human motivation. Becker used the idea of a "character armor" (taken from another psychoanalyst, Wilhelm Reich) as "the arming of personality so that it can maneuver in a threatening world" and enlarged it with the concept of the society as a symbolic hero system that allows the practice of "heroics" (Becker 1973). By fulfilling their role in such a society—"low heroics"—or by pursuing and realizing extraordinary accomplishments—"high heroics"—humans maintain a sense of self-esteem.



The writings of the anthropologist Ernest Becker (1924–1974) inspired the formulation of a psychological theory of social motivation—Terror Management Theory—that is supported by extensive empirical work. THE ERNEST BECKER FOUNDATION

In *The Denial of Death*, Becker presents examples of low and high heroics in the normal individual, the creator, and the mentally ill. For example, he portrays the schizophrenic as incapable of conforming to normal cultural standards and is thus incapable of death denial. To substantiate his thesis regarding the universality of the death terror, Becker employed arguments from biology, from psychoanalytic theory, and from existential philosophy, especially Kierkegaard. For example, Freud's Oedipus complex is reinterpreted to reflect the existential project of avoiding the implications of being a "body," and thus being mortal. The boy is attracted to his mother in an effort to become his own father, thereby attempting to transcend his mortality through an imagined self-sufficiency.

Notwithstanding his emphasis on death terror as a mainspring of human activity and as a foundation for human culture, Becker does not ignore the tendency of human beings to grow. This ten-

dency has the form of merging with the cosmos (the Agape motive) or of development beyond the present self (the Eros motive). The psychoanalytic concept of transference, as identification with an external object, corresponds to the first motive. While life expansion forces coexist with the fear of death, it is the latter that imbues them with urgency. Transference, for example, reflects both fear of death and possibility for “creative transcendence.” In both cases transference involves “distortion” or “illusion.” The problem of an ideal life becomes the problem of the “best illusion,” the one that allows maximum “freedom, dignity, and hope” (Becker 1973, p. 202). Only religion, with God as an object of transference, can satisfy these criteria. However, this is a religion that emphasizes an awareness of limits, introspection, and a confrontation with apparent meaninglessness.

Becker’s academic career suffered enormously because of his intellectual courage and because of the skepticism of “tough-minded” social scientists toward his ideas. Becker’s writings continue to influence psychotherapeutic, educational, and theoretical work, especially as regards the pervasiveness of the fear of death in governing individual and social behavior into the twenty-first century.

See also: ANXIETY AND FEAR; FREUD, SIGMUND; IMMORTALITY, SYMBOLIC; SARTRE, JEAN-PAUL; TABOOS AND SOCIAL STIGMA; TERROR MANAGEMENT THEORY

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ADRIAN TOMER

BEFRIENDING

Befriending is a free, confidential, and nonjudgmental listening service offered by trained volunteers to help people who are lonely, despairing, and suicidal. Unlike some approaches to suicide prevention, befriending does not involve telling or advising a suicidal person what to do. Befriending respects the right of each person to make his or her own decisions, including the decision of whether to live or die. Befriending centers are nonpolitical and nonsectarian, and the volunteers do not seek to impose their own beliefs or opinions. Instead, they listen without judging, allowing suicidal people to talk about their fears and frustrations. It is common for callers to say that they have nobody else to whom they can turn, and simply talking through problems can begin to suggest solutions.

Befrienders are not paid professionals. They come from many different backgrounds and cultures, and range in age from eighteen to eighty. This diversity is central to the philosophy of the befriending movement, which recognizes the importance of professional psychiatric help but also believes that laypeople—carefully selected, trained, guided, and supported—provide a valuable service by simply listening.

The concept of befriending originated in England in 1953, when Reverend Chad Varah began a service in London. To meet the huge response, he organized laypeople to be with those waiting to see him, and soon noticed a wonderful interaction between the callers and the volunteers who listened to them with empathy and acceptance. He called what the volunteers were doing “befriending.”

From that single center in London grew the Samaritans, which by 2001 had 203 centers across the United Kingdom and Northern Ireland. The concept also spread beyond Britain, and in 1966 Befrienders International was established to

support befriending centers around the world. In 2001 this network spanned 361 centers in 41 countries. There were significant numbers of befriending centers in Brazil, Canada, India, New Zealand, Sri Lanka, the United Kingdom, and the United States. Two other organizations—the International Federation of Telephonic Emergency Services and LifeLine International—have networks of centers that provide similar services.

Befriending is provided in different ways. The most common form of contact is by telephone, but many people are befriended face to face. Some prefer to write down their feelings in a letter or an e-mail. One British center does not have a physical base but instead sends volunteers to major public events, such as shows and musical concerts, to offer face-to-face befriending to anyone who feels alone in the crowd. A number of centers have gone out to befriend people in the aftermath of earthquakes and other disasters. Many centers run outreach campaigns, working with children and young people, and promoting the concept of listening. The Internet provides an unprecedented opportunity to provide information about befriending to a global audience. As of the end of March 2002, the Befrienders International web site offers information in the first languages of half the world's population.

While the situations and processes of befriending can vary, the essence of the contact is always the same: an opportunity for suicidal people to talk through their deepest fears and to know that somebody is interested in them and is prepared to listen to them, without passing judgment or giving advice.

See also: SUICIDE BASICS: PREVENTION; VARAH, CHAD

CHRIS BALE

BEREAVEMENT

See BEREAVEMENT, VICARIOUS; GRIEF: OVERVIEW.

BEREAVEMENT, VICARIOUS

Vicarious bereavement is the state of having suffered a vicarious loss. A vicarious event is one that is experienced through imaginative or sympathetic

participation in the experience of another person. Therefore, vicarious grief refers to grief stimulated by someone else's loss. It usually involves deaths of others not personally known by the mourner. Vicarious grief is genuine grief. It is differentiated from conventional grief insofar as it is sparked by another individual's loss, that person being the actual mourner, and it typically involves more psychological reactions than behavioral, social, or physical ones. Vicarious grief was first reported by the scholar and thanatology expert Robert Kastenbaum in 1987.

There are two types of vicarious bereavement. In Type 1, the losses to the vicarious mourner are exclusively vicarious, and are those that are mildly to moderately identified with as being experienced by the actual mourner. For instance, the vicarious mourner feels that this is what it must be like to be in the actual mourner's position.

In Type 2 vicarious bereavement, Type 1 vicarious losses occur, but there are also personal losses sustained by the vicarious mourner. These personal losses develop because: (a) the vicarious mourner has relatively intense reactions to the actual mourner's loss (e.g., the vicarious mourner feels so personally stunned and overwhelmed in response to the actual mourner's losing a loved one through a sudden death that he or she temporarily loses the ability to function normally); and/or (b) the vicarious mourner experiences personal assumptive world violations because of the loss. An assumptive world violation takes place whenever an element of an individual's assumptive world is rendered invalid by the death. The assumptive world is a person's mental set, derived from past personal experience, that contains all a person assumes, expects, and believes to be true about the self, the world, and everything and everyone in it.

Assumptive world violations occur in vicarious bereavement because the vicarious mourner has heightened identification with the actual mourner (e.g., the vicarious mourner so identifies with the actual mourner after that person's child dies that the vicarious mourner feels his or her own sense of parental control shattered, which invalidates one of the fundamental beliefs in the vicarious mourner's own assumptive world) and/or the vicarious mourner becomes personally traumatized by the circumstances under which the actual

mourner's loved one dies (e.g., the vicarious mourner is so badly traumatized by the death of the actual mourner's loved one in a terrorist attack that the vicarious mourner experiences a shattering of his or her own personal security and safety in his or her own assumptive world). While Type 2 vicarious bereavement does stimulate actual personal losses within the vicarious mourner, technically making vicarious a misnomer, the term is retained because it focuses attention on the fact that bereavement can be stimulated by losses actually experienced by others.

Three sets of factors are especially influential in causing a person to experience vicarious bereavement, primarily because each factor increases the vicarious mourner's emotional participation in the loss and his or her personal experience of distress or traumatization because of it. These three sets of factors include: (a) the psychological processes of empathy, sympathy, and identification; (b) selected high-risk characteristics of the death—particularly suddenness, violence, preventability, and child loss; and (c) media coverage of the death that overexposes the person to graphic horrific images, distressing information, and/or distraught reactions of actual mourners.

Notable events prompting widespread vicarious grief include the September 11, 2001, terrorist attacks, the Oklahoma City bombing, the explosion of TWA Flight 800, and the Columbine school massacre. The phenomenon also explains in part the profound public reactions witnessed following the deaths of certain celebrities. For instance, the deaths of Princess Diana and John Kennedy Jr. appeared to catalyze unparalleled Type 2 vicarious bereavement, although in these cases other factors were present that further intensified that grief. These factors included what these individuals symbolized, what their deaths implied about the average person's vulnerability, and social contagion processes. Social contagion occurs when intense reactions became somewhat infectious to those who observed them and stimulated within these observers their own intense responses to the death.

Vicarious bereavement can provide valuable opportunities to rehearse future losses, challenge assumptive world elements, finish incomplete mourning from prior losses, and increase awareness of life's preciousness and fragility. On the other hand, it can be detrimental if the vicarious mourner

becomes disenfranchised, propelled into complicated mourning, traumatized, bereavement overloaded, or injured from inaccurate imaginings or insufficient information. Many questions still remain about this experience and what influences it.

See also: GRIEF: DISENFRANCHISED, THEORIES, TRAUMATIC

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THERESE A. RANDO

BIOETHICS

Bioethics refers to the systematic study of the moral aspects of health care and the life sciences. Physicians have always made decisions with significant moral components in the context of medical practice guided by the Hippocratic obligation to help patients without causing harm. This traditional medical morality nonetheless became insufficient to address the ethical issues that arose as medical practice changed over the course of the twentieth century to include more care by medical specialists, extensive use of complex medical technologies, and a trend toward dying in the hospital rather than at home. A series of controversies involving research with human subjects and the allocation of scarce new technologies (e.g., kidney dialysis and organ transplantation) made clear that the wisdom of physicians and researchers was inadequate to ensure the appropriate treatment of patients and research subjects. In universities and hospitals, this widespread patients' rights movement galvanized the attention of a growing contingent of theologians, philosophers, and lawyers who came to identify themselves as medical ethicists or bioethicists.

A central task of bioethics has been the articulation of approaches to guide the moral aspects of

medical decision making. Here, a core commitment has been to the empowerment of patients' meaningful participation in their own health care, which is typified by the now common practice of obtaining informed consent (the process in which a clinician gives a patient understandable information about a proposed procedure or intervention, including its risks, benefits, and alternatives, and then the patient makes a voluntary decision about whether to proceed with it). The ethical principle of "respect for autonomy" underpinning this approach distinguishes bioethics most sharply from earlier systems of medical ethics. Three other principles that are also influential include beneficence (doing good for the patient), nonmaleficence (not harming), and justice. These core principles lead to a set of rules such as those regarding truth-telling and confidentiality. Together, these principles and rules comprise a secular means of approaching ethical issues in medicine that is designed to be relevant in a pluralistic society. In practicality the great question in many situations is which principle takes precedence. This conflict is readily apparent in the two prominent bioethical discourses surrounding death and dying: withdrawal of support in the terminally ill and physician-assisted suicide.

Withdrawal of Support in the Terminally Ill

The rise of mechanical ventilation and intensive care technology may be likened to a double-edged sword. While rescuing countless patients from acute illness, it has also made possible the preservation of bodily functions of patients following severe brain injury. The 1981 report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death*, confirmed the appropriateness of the existing practice that allows withdrawal of life support from patients with absent brainstem functions as defined by the 1968 Harvard brain death criteria. Far more controversial have been those patients in irreversible coma who nonetheless still preserve brainstem reflexes, a condition designated as persistent vegetative state (PVS) that may continue many years with technological assistance. Perhaps the most famous such case was that of Karen Ann Quinlan, in which the New Jersey Supreme Court in 1976 recognized the right of the parents of a twenty-one-year-old woman with irreversible coma to discontinue her

ventilator support over the objections of her physicians. The widely publicized decision opened the door for withdrawing such support legally, but still left open many ethical and practical questions.

Here the bioethicists stepped in. On one level, the Quinlan case confirmed their emerging role in the health care setting. Given the difficulty of ascertaining the patient's own wishes based upon the recollections of family and loved ones, the New Jersey Supreme Court recommended that hospitals develop ethics committees to guide such decisions when family and physicians are at odds. Ethicists thus gained a foothold in many hospitals. On a second level, discussions of discontinuing life support underlined the need for a more substantial framework to guide decision making. Many ethicists evoked the principle of autonomy to advocate advance directive—declarations such as living wills or the appointment of a durable power of attorney for health care—to minimize uncertainty regarding the patients' wishes should an event consign them to dependence upon invasive technology, making it impossible for them to participate in decision making about whether to continue the use of such technologies. Yet, less than 10 percent of Americans have completed such wills.

Following a series of legal cases the right to refuse life-sustaining therapies, including ventilator and feeding tube support from patients with irreversible coma, has been established. Nevertheless, in certain jurisdictions the process of refusing therapy may require clear evidence that this would indeed be in concert with the wishes of the patient.

Physician-Assisted Suicide

In many ways, the movement in some parts of the United States and in the Netherlands promoting the legalization of physician-assisted suicide (PAS) carries the autonomy argument to its logical conclusion. Here, the patient with a terminal illness proceeds to take complete control of the dying process by choosing to end life before losing independence and dignity. During the 1990s, PAS gained widespread notoriety in the popular media thanks to the crusade of the Michigan pathologist Jack Kevorkian, who has openly participated in the suicides of over a hundred patients. Oregon legalized the practice in its 1997 Death with Dignity Act. Meanwhile, the Netherlands has legalized the

practice of euthanasia (distinguished from PAS in that the physician directly administers the agent ending life) in 2000.

Bioethicists have generally condemned the approach to PAS represented by Kevorkian, but have been divided in opposing the practice under any circumstances. For many observers, Kevorkian's willingness to assist patients on demand devoid of any long-term doctor-patient relationship raises troubling questions about his patients' true prognoses, their other options, and the contribution of depression to their suffering. The physician Timothy Quill's decision to assist in the suicide of a forty-five-year-old woman described in an influential 1991 article has attracted much less condemnation. The woman "Diane" had been Quill's patient for eight years, and he wrote eloquently of how he had come to understand how her need for independence and control led her to refuse a cancer therapy with only a 25 percent success rate. For many ethicists the crucial question is whether PAS could be legalized yet regulated to assure the kinds of basic safeguards demonstrated by Quill's example, without placing vulnerable members of society at risk. In contrast, some ethicists have backed away from condoning any legalization of PAS as creating more potential for harm to the elderly than good—or perhaps marking a fateful step on a slippery slope leading to involuntary euthanasia.

However these issues are resolved, there is increasing recognition that a single-minded commitment to autonomy to the neglect of the other foundational principles of bioethics distorts how death and dying take place in reality. Whether they would allow PAS only rarely or not at all, most bioethicists would argue that a great challenge facing the care of the dying is the provision of palliative (or comfort) care for the terminally ill.

See also: ANTHROPOLOGICAL PERSPECTIVE; BLACK STORK; INFORMED CONSENT; PSYCHOLOGY; SUICIDE TYPES; PHYSICIAN-ASSISTED SUICIDE

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BLACK DEATH

The Black Death pandemic of 1349 is considered to be one of the major events in world history, and it is still the subject of medical, historical, and sociological analysis. The evidence of the plague is found in the broad swath it cut across North Africa, Asia, and Europe, its terrifying symptoms, and its impact on society.

History of the Disease

Ancient history includes vivid descriptions of epidemics that seized their victims suddenly and produced an agonizing death. One such episode occurred in Athens, Greece, in 430 B.C.E., and another occurred in Egypt, Persia, and Rome a century later. Some historians believe these lethal outbreaks were caused by the same disease responsible for the Black Death—the bubonic plague. Other historians, though, note some differences between the symptoms observed in the ancient episodes and those reported during the fourteenth century.

The growth of international trade and military invasions later provided the opportunity for diseases to spread rapidly from one population to another. Smallpox and measles came first, both causing high mortality within populations that had not previously been exposed. Bubonic plague arrived in force in the sixth century C.E., raging throughout most of Arabia, North Africa, Asia, and Europe. The death toll from what became known as “Justinian’s Plague” was even greater than that of the previous epidemics. The powerful and still expanding Byzantine empire, centered in Constantinople (now Istanbul, Turkey), was so devastated that its political and military power sharply declined.

The plague did not entirely disappear but entered a long phase of withdrawal with occasional local outbreaks, especially in central Asia. When it did return it was with a furious rush that created widespread panic in populations already beset with both natural and human-made disasters. The fourteenth century suffered an entire catalog of catastrophes, including earthquakes, fires, floods, freezing weather, nauseating mists, and crop failures—all of which did not even seem to slow down the incessant warfare and banditry. Social order was weakened under the stress, and a hungry and exhausted population became more vulnerable to influenza and other opportunistic diseases.

It was within this already precarious situation that the plague once again crossed into Europe. There had been rumors about a deadly new epidemic sweeping through the Middle East, probably starting in 1338. The plague had taken hold among the Tartars of Asia Minor. Somebody had to be blamed—in this case, the Christian minority. (Later, as the plague devastated Europe, Jews were not only blamed but burned alive.) The Tartars chased Genoese merchants to their fortified town (now Feodosiya, Ukraine, then Kaffa) on the Crimean coast. The besieging army soon was ravaged by the plague and decided to leave. As a parting shot, the Tartars used catapults to hurl plague-infected corpses over the city walls. Some residents died almost immediately; the others dashed for their galleys (a type of oar-propelled ship) and fled, taking the disease with them. Sicily and then the rest of Italy were the earliest European victims of the plague. It would spread through almost all of

Europe, wiping out entire villages and decimating towns and cities.

It is estimated that a third of the European population perished during the Black Death. The death toll may have been as high or even higher in Asia and North Africa, though less information is available about these regions. The world was quickly divided between the dead and their frequently exhausted and destitute mourners.

The Disease and How It Spread

As for the disease itself the bacterial agent is *Yersinia pestis*. It is considered to have permanent reservoirs in central Asia, Siberia, the Yunan region of China, and areas of Iran, Libya, the Arabian Peninsula, and East Africa. *Yersinia pestis* infects rodents, producing blood poisoning. Fleas that feed on the dying rodents carry the highly toxic bacteria to the next victim—perhaps a human. Among the first symptoms in humans were swollen and painful lymph glands of the armpit, neck, and groin. These swellings were known as *buboes*, from the Greek word for “groin.” Buboes became dreaded as signals of impending death. Occasionally these hard knobs would spontaneously burst, pus would drain away and the victim might then recover if not totally exhausted or attacked by other infections. More often, however, the buboes were soon accompanied by high fever and agony. Sometimes the victim died within just a few hours; others became disoriented and either comatose or wildly delirious. Another symptom—perhaps even more certain than the buboes—was the appearance of postules, or dark points on various parts of the body. These splotches were most often called *lenticulae*, from the Italian word for “freckles.”

Medical historians believe that the plague can spread in several ways but that it was the pneumonic or respiratory form that accounted for most of the deaths, being easily spread through coughing and sneezing. An interesting alternative was suggested in 1984 by the zoologist Graham Twigg, who had studied rat populations in more recent outbreaks of the plague in Asia. He doubts that the bubonic plague could have spread so rapidly in the fourteenth-century population; instead he nominates anthrax as the killer. Anthrax can be borne on the wind; it is known as a threat to sheep, goats, cattle, and pigs. Both plague and

anthrax, then, are primarily found in animal populations, with humans becoming “accidental” victims under certain conditions. Whatever its specific cause or causes, the Black Death killed until it ran out of large numbers of vulnerable people. There have been subsequent plague epidemics, some also with high death tolls, and public health authorities continue to monitor possible new occurrences.

Impact on Society

Historians often divide European history into periods before and after the plague. There are several persuasive reasons for doing so. First, the population declined sharply—and then rebounded. Both the loss and the replenishment of the population had significant effects on all aspects of society, from agriculture to family structure to military adventuring.

Second, influential writers, such as the English clergyman Thomas Malthus (1766–1834), would propose that overpopulation produces its own remedy through epidemic, famine, and other means. Some areas of Europe might have been considered ripe for mass death because agricultural production had not kept up with population growth. The overpopulation theory has been criticized as inadequate to explain the catastrophic effects of the Black Death. Nevertheless, concerns about overpopulation in more recent times were foreshadowed by analyses of the plague years.

Third, feudalism—the political and social structure then prevalent in Europe—may have been the underlying cause of the mass mortality. A few people had everything; most people had very little. Those born into the lower classes had little opportunity for advancement. This situation perpetuated a large underclass of mostly illiterate people with limited skills, thereby also limiting technological and cultural progress. Furthermore, the feudal system was showing signs of collapsing from within in the years preceding the Black Death. In his 1995 book *The Black Death and the Transformation of the West*, David Herlihy explained:

The basic unit of production was the small peasant farm, worked with an essentially stagnant technique. The only growth the system allowed was . . . the multiplication of farm units . . . subject to the law of diminishing returns. As cultivation

extended onto poorer soils, so the returns to the average family farm necessarily diminished. . . . As peasant income diminished, they paid lower and lower rents. . . . The lords took to robbery and pillage . . . and also hired themselves out as mercenaries . . . and pressured their overlords, notably the king, to wage wars against their neighbors. (*Herlihy 1995, p. 36*)

The almost continuous wars of the Middle Ages were attempts by hard-pressed nobles to snatch wealth from each other as well as grab whatever the peasants had left. The decline and crisis of the feudal system, then, probably did much to make people especially vulnerable to the plague, while the aftereffects of the plague would make feudal society even more of a losing proposition.

Fourth, loosely organized and short-lived challenges to authority arose from shifting coalitions of peasants and merchants. People laboring in the fields started to make demands, as though they too—not just the high and mighty—had “rights.” Heads of state would remember and remain nervous for centuries to come.

Finally, the devastating and immediate impact of the Black Death prepared the way for a reconstruction of society. Deserted towns and vacant church and governmental positions had to be filled with new people. At first the demand was specific: more physicians, more clergy, and—of special urgency—more gravediggers were needed. The demand for new people to move into key positions throughout society opened the door for many who had been trapped in the ancient feudal system. It was also a rare opportunity for women to be accepted in positions of responsibility outside of the home (e.g., as witnesses in court proceedings). People who lacked “social connections” now could find more attractive employment; merit had started to challenge social class membership. These developments fell far short of equality and human rights as understood today, but they did result in significant and enduring social change.

Long-term Influences of the Plague

The plague years enabled European society to shake off the feudal system and make progress on many fronts. Death, however, had seized the center of the human imagination and would not readily ease its grip. The imagination had much to



In this drawing, Saint Borromeo assists plague victims. In its most lethal periods, the ancient epidemic—whatever its cause—killed as many as four out of ten people in the areas affected. BETTMANN/CORBIS

work on. Daily experience was saturated with dying, death, and grief. Religious belief and practice had given priority to helping the dying person leave this world in a state of grace and to providing a proper funeral with meaningful and comforting rituals. This tradition was overstressed by the reality of catastrophic death: too many people dying too quickly with too few available to comfort or even to bury them properly. Furthermore, the infectious nature of the disease and the often appalling condition of the corpses made it even more difficult to provide the services that even basic human decency required.

Fear of infection led many people to isolate themselves from others, thereby further contributing to social chaos and individual anxiety and depression. The fear for one's own life and the lives of loved ones was rational and perhaps useful under the circumstances. Rational fear, however, often became transformed into panic, and at times panic led to rage and the adoption of bizarre

practices. Some extremists became flagellants, whipping their bodies bloody as they marched from town to town, proclaiming that the plague was a well-deserved punishment from God. Others took the lead in persecuting strangers and minorities as well as those unfortunates who were perceived as witches. As though there was not enough death ready at hand, innocent people were slaughtered because somebody had to be blamed. Medieval medicine was not equal to the challenge of preventing or curing the plague, so there was a ready market for magic and superstition.

A personified Death became almost a palpable presence. It was almost a relief to picture death as a person instead of having to deal only with its horrifying work. Personified Death appeared as the leader in the *Danse Macabre* (the Dance of Death), and as "poster boy" for the *Ars Moriendi* (the art of dying) movement. (The now-familiar skull-and-crossbones image was highly popular, showing up, for example, on rings adorning the fingers of both

prostitutes and ladies of high social standing.) Portraying Death as an animated skeleton was not entirely new; there are surviving images from ancient Pompeii as well. Depictions of Death as skeleton, corpse, or hooded figure, however, had their heyday during the plague years. This connection is not difficult to understand when one considers that social disorganization under the stress of the Black Death had severely damaged the shield that had protected the living from too many raw encounters with the dead.

Did another tradition also receive its impetus from the plague years? Throughout the post-Black Death years there have been people who identify themselves with death. The Nazi and skinhead movements provide ready examples. One way of trying to cope with overwhelming aggression is to identify with the aggressor, so perhaps this is one of the more subtle heritages of the Black Death. Furthermore, the fear that death is necessarily agonizing and horrifying may also owe much to the plague years and may have played a role in the denial of death and the social stigma attached to dying.

See also: ARS MORIENDI; CHRISTIAN DEATH RITES, HISTORY OF; DANSE MACABRE; DEATH SYSTEM; PERSONIFICATIONS OF DEATH; PUBLIC HEALTH

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ROBERT KASTENBAUM

BLACK STORK

From 1915 to 1919, the prominent Chicago surgeon Harry Haiselden electrified the nation by allowing, or speeding, the deaths of at least six infants he diagnosed as physically or mentally impaired. To promote his campaign to eliminate those infants that he termed hereditarily “unfit,” he displayed the dying babies and their mothers to journalists and wrote a book about them that was serialized for Hearst newspapers. His campaign made front-page news for weeks at a time.

He also starred in a film dramatization of his cases, an hour-long commercial melodrama titled *The Black Stork*. In the film a man suffering from an unnamed inherited disease ignores graphic warnings from his doctor, played by Haiselden, and marries his sweetheart. Their baby is born “defective” and needs immediate surgery to save its life, but the doctor refuses to operate. After witnessing a horrific vision, revealed by God, of the child’s future of misery and crime, the mother agrees to withhold treatment, and the baby’s soul leaps into the arms of a waiting Jesus. The film was shown around the country in several editions from 1916 to at least 1928, and perhaps as late as 1942.

Many prominent Americans rallied to Haiselden’s support, from leaders of the powerful eugenics movement to Helen Keller, the celebrated blind and deaf advocate for people with disabilities. Newspapers and magazines published the responses of hundreds of people from widely varied backgrounds to Haiselden’s campaign, more than half of whom were quoted as endorsing his actions. Groups disproportionately represented among these supporters included people under thirty-five years of age, public health workers, non-specialist physicians, lay women, socialists, and non-Catholic Democrats. However, advocates

came from all walks of life, even a few Catholic clergymen.

Euthanasia and Eugenics

These events are important for more than simply their novelty and drama; they constitute a unique record documenting the nearly forgotten fact that Americans once died because their doctors judged them genetically unfit, and that such practices won extensive public support. The events also recover a crucial, defining moment in the history of euthanasia and in the relation between euthanasia and eugenics.

Until late in the nineteenth century, the term *euthanasia* meant “efforts to ease the sufferings of the dying without hastening their death,” but it soon came to include both passive withholding of life-prolonging treatment and active mercy killing. The term *eugenics* was first popularized by Charles Darwin’s cousin Sir Francis Galton in the 1880s. Galton defined it as “the science of improving human heredity.” To improve heredity, eugenicists pursued a diverse range of activities, including statistically sophisticated analyses of human pedigrees, “better-baby contests” modeled after rural livestock shows, compulsory sterilization of criminals and the retarded, and selective ethnic restrictions on immigration.

Beginning in the 1880s, a few supporters of each movement linked them by urging that active or passive euthanasia be employed to end both the individual sufferings and the future reproduction of those judged to have heritable defects. Yet prior to Haiselden’s crusade such ideas rarely won public endorsement from the leaders of either movement. Most eugenic leaders, such as Charles Davenport, Irving Fisher, and Karl Pearson, explicitly distinguished their support for selective breeding from their professed opposition to the death of those already born with defects.

Yet when Haiselden moved the issue from theory to practice, these same leaders proclaimed him a eugenic pioneer. His attention-getting actions were a calculated effort to radicalize the leaders of both eugenics and euthanasia, a strategy anarchists at the time popularized as “propaganda of the dead.” By gaining extensive media coverage of his dramatic acts, Haiselden was able to shift the boundary of what was included in mainstream

eugenics and successfully prod the official movement leaders to publicly accept euthanasia as a legitimate method of improving heredity.

Haiselden’s actions blurred the boundaries between active and passive methods of euthanasia. In his first public case, he refused to perform a potentially life-saving operation, but did not hasten death. In subsequent cases, however, he prescribed high doses of narcotics with the dual purposes of speeding and easing death. He also performed lethal surgical operations, and fatally restarted a previously treated umbilical hemorrhage.

Journalism and film enabled Haiselden to reshape the relation between eugenics and euthanasia, but, ironically, mass culture also contributed to the almost total erasure of his crusade from later memory. Haiselden’s efforts to publicize his actions provoked more opposition than did the deaths of his patients. Three government investigations upheld Haiselden’s right not to treat the infants, but the Chicago Medical Society expelled him for publicizing his actions. Even professional leaders who supported eugenic euthanasia often opposed discussing the issue in the lay media.

Promoters of the new mass media had their own reasons for repressing coverage of Haiselden’s crusade. While his motion picture sought to make those he considered defective look repulsive, many viewers instead interpreted such scenes as making the film itself disgusting and upsetting. Even critics who lavishly praised his ideas found his graphic depictions of disease aesthetically unacceptable. Such responses were one important reason films about euthanasia and eugenics were often banned. *The Black Stork* helped provoke, and became one of the first casualties of, a movement to censor films for their aesthetic content. By the 1920s film censors went far beyond policing sexual morality to undertake a form of aesthetic censorship, much of it aimed at eliminating unpleasant medical topics from theaters.

Professional secrecy, combined with the growth of aesthetic censorship, drastically curtailed coverage of Haiselden’s activities. In 1918 Haiselden’s last reported euthanasia case received only a single column-inch in the *Chicago Tribune*, a paper that had supported him editorially and given front-page coverage to all of his previous cases. The media’s preoccupation with novelty and

impatience with complex issues clearly played a role in this change, as did Haiselden's death in 1919 from a brain hemorrhage at the age of forty-eight. But the sudden silence also reflected the conclusion by both medical and media leaders that eugenic euthanasia was unfit to discuss in public. The swiftness of Haiselden's rise and fall resulted from a complex struggle to shape the mass media's attitudes toward—and redefinitions of—eugenics and euthanasia.

Since 1919 the relationship between euthanasia and eugenics has been debated periodically. Although Haiselden's pioneering example was almost completely forgotten, each time it re-emerged it was treated as a novel issue, stripped of its historical context. In the United States and Great Britain, the debate begun by Haiselden over the relation between eugenics and euthanasia revived in the mid-1930s. At the same time, Germany launched the covert "T-4" program to kill people with hereditary diseases, a crucial early step in the Nazi quest for "racial hygiene." The techniques and justifications for killing Germans diagnosed with hereditary disease provided a model for the subsequent attempt to exterminate whole populations diagnosed as racially diseased.

Postwar Developments

With the defeat of Nazism and the consequent postwar revulsion against genocide, public discussion of euthanasia and its relation to the treatment of impaired newborns was again repressed. In the early 1970s, the debate resurfaced when articles in two major American and British medical journals favorably reported cases of selective nontreatment. Nevertheless, it was not until the 1982 "Baby Doe" case in Indiana, followed by "Baby Jane Doe" in New York State a year later, that the subject once again aroused the degree of media attention occasioned by Haiselden's crusade. In response, the federal government tried to prevent hospitals from selectively withholding treatment, arguing such actions violated the 1973 ban on discrimination against people with disabilities. However, the Supreme Court held that antidiscrimination law could not compel treatment of an infant if the parents objected. Meanwhile, Congress defined withholding medically indicated treatment as a form of child neglect. That law favors treatment but allows for medical discretion by making an exception for

treatments a doctor considers futile or cruel. Conflicts still occur when doctors and parents disagree over whether treatments for specific infants with disabilities should be considered cruel or futile.

Understanding this history makes it possible to compare both the similarities and the differences between the past and the present. Concerns persist that voluntary euthanasia for the painfully ill will lead to involuntary killing of the unwanted. Such "slippery-slope" arguments claim that no clear lines can be drawn between the diseased and the out-cast, the dying and the living, the voluntary and the coerced, the passive and the active, the intended and the inadvertent, the authorized and the unauthorized. Haiselden's example shows that these concerns are neither hypothetical nor limited to Nazi Germany. Americans died in the name of eugenics, often in cases where there were no absolute or completely objective boundaries between sound medical practice and murder. But that history does not mean that all forms of euthanasia are a prelude to genocide. Meaningful distinctions, such as those between the sick and the unwanted, are not logically impossible. However, they require sound ethical judgment and moral consensus, not solely technical expertise.

Haiselden's use of the mass media also provides intriguing parallels with the actions of Michigan pathologist Jack Kevorkian, who began publicly assisting the suicides of seriously ill adults in 1990. Both men depended on media coverage for their influence, and both were eventually marginalized as publicity hounds. But each showed that a single provocateur could stretch the boundaries of national debate on euthanasia by making formerly extreme positions seem more mainstream in comparison to their actions.

See also: ABORTION; CHILDREN, MURDER OF; EUTHANASIA; INFANTICIDE; KEVORKIAN, JACK; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE

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MARTIN PERNICK

BONSEN, F. Z.

Friedrich zur Bensen (1856–1938) was a professor of psychology at the University of Muenster, Westphalia and author of *Between Life and Death: The Psychology of the Last Hour* (1927). In his book, Bensen presents knowledge of his time about death and dying and his own reflections in a very emotive style. He is especially interested in presenting the transition from life to death and exploring the concept that dying is the biggest accomplishment of life. According to the work, the immense richness of the human soul will sometimes be revealed when death happens. Bensen quotes a German bishop who, on his deathbed, asked his close friends to watch him carefully because they were about to witness one of the most interesting aspects of the world: transition into the afterlife.

In sixteen chapters, in a brief 173 pages, Bensen wrote a compendium of a "Psychology of Death." His elaboration is based on books and articles in a variety of fields (philosophy, theology, folklore, history, and classical and popular literature), as well as local and national newspapers, and religious booklets.

For example, Bensen observed no "fear of the soul" during the transition into the afterlife. Close to the end, there is a comforting well-being many dying patients never experienced before. Parallel to this increase in physical well-being is a strengthening of mental power. This idea was previously elaborated in 1836 by Gustav Theodor Fechner, and published *The Little Book of Life after Death* in 1904. During the final disintegration, supernormal abilities appear, and they enable the dying to have an overview over his or her entire life in one moment. The author presents cases where in the last moments of life even sanity came back to patients with longstanding mental illnesses.

Bensen noticed a great calmness of the dying. With respect to religiosity, the author concludes that people will die the way they lived: Religious people will turn to religion, and nonreligious will not. However, there are cases in which non-religious people, shattered by the power of the deathbed, became religious. This is not caused by fear, but rather a reversal to humankind's first and simple sentiments, which are religious in essence.

Very cautiously, Bensen presents reports where people witnessed visions and hallucinations of dying persons. Explaining these phenomenon, he refers to physiological changes in the neurological system. Especially when people are dying of hunger and thirst, the impending death is mercifully, offering delusions. The author believes that in the moment of death, when the soul is separating from the body, the dead person might see everything and religious beliefs are promising; the soul might have a clear view on afterlife.

Most interesting are Bensen's cases of near-death experiences, including drowning soldiers from World War I who were rescued and, without mentioning Albert Heim (1882), people who survived falls in wondrous ways. Heim was the first who collected and published reports of mountaineers who survived deep falls. The victims reported "panoramic views" and felt no pain as they hit the ground. Bensen discusses favorably an explanation of near-death experiences that was forwarded by a person named Schlaikjer in a newspaper article published in 1915. "Panoramic view" is interpreted as an intervention of Mother Nature to protect humans from the terror of an impending death, an idea that was elaborated by the German psychiatrist Oskar Pfister in 1930.



*Friedrich zur Bonsen (1856–1938), in his influential work, *Between Life and Death: The Psychology of the Last Hour*, relied on his own personal experiences, but also collected information by talking to people about their death-related experiences.* MATTHIAS ZUR BONSEN

What kind of psychological processes accompany physical dying? Bonsen's best guess is based on an analogy with the experience of anesthesia, during which people report the feeling of plunging, falling, sinking, and floating. The author, therefore, describes the last moments in the following translation: "The consciousness of the dying is flickering and fleeing, and the soul is lost in confused illusions of sinking and floating in an infinity. The ear is filled with murmur and buzzing . . . until it dies out as the last of the senses" (p. 108).

Bonsen is often remembered as a pioneer of thanato-psychology, despite the fact that his observations and reflections never stimulated any research. At the very least, he is considered an early writer in the field of near-death experience that almost fifty years later was inaugurated by

Raymond A. Moody and his best-selling book *Life after Life* (1975).

See also: ARIÈS, PHILIPPE; NEAR-DEATH EXPERIENCES; THANATOLOGY

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RANDOLPH OCHSMANN

BRAIN DEATH

The term *brain death* is defined as "irreversible unconsciousness with complete loss of brain function," including the brain stem, although the heart-beat may continue. Demonstration of brain death is the accepted criterion for establishing the fact and time of death. Factors in diagnosing brain death include irreversible cessation of brain function as demonstrated by fixed and dilated pupils, lack of eye movement, absence of respiratory reflexes (apnea), and unresponsiveness to painful stimuli. In addition, there should be evidence that the patient has experienced a disease or injury that could cause brain death. A final determination of brain death must involve demonstration of the total lack of electrical activity in the brain by two electroencephalographs (EEGs) taken twelve to twenty-four hours apart. Finally, the physician must rule out the possibilities of hypothermia or drug toxicities, the symptoms of which may mimic brain death. Some central nervous system functions such as spinal reflexes that can result in movement of the limbs or trunk may persist in brain death.

Until the late twentieth century, *death* was defined in terms of loss of heart and lung functions, both of which are easily observable criteria. However, with modern technology these functions can be maintained even when the brain is dead, although the patient's recovery is hopeless, sometimes resulting in undue financial and emotional stress to family members. French neurologists were

the first to describe brain death in 1958. Patients with *coma depasse* were unresponsive to external stimuli and unable to maintain homeostasis. A Harvard Medical School committee proposed the definition used in this entry, which requires demonstration of total cessation of brain function. This definition is almost universally accepted.

Brain death is not medically or legally equivalent to severe vegetative state. In a severe vegetative state, the cerebral cortex, the center of cognitive functions including consciousness and intelligence, may be dead while the brain stem, which controls basic life support functions such as respiration, is still functioning. Death is equivalent to brain stem death. The brain stem, which is less sensitive to anoxia (loss of adequate oxygen) than the cerebrum, dies from cessation of circulation for periods exceeding three to four minutes or from intracranial catastrophe, such as a violent accident.

Difficulties with ethics and decision making may arise if it is not made clear to the family that brain stem death is equivalent to death. According to research conducted by Jacqueline Sullivan and colleagues in 1999 at Thomas Jefferson University Hospital, roughly one-third to one-half of physicians and nurses surveyed do not adequately explain to relatives that brain dead patients are, in fact, dead. Unless medical personnel provide family members with information that all cognitive and life support functions have irreversibly stopped, the family may harbor false hopes for the loved one's recovery. The heartbeat may continue or the patient may be on a respirator (often inaccurately called "life support") to maintain vital organs because brain dead individuals who were otherwise healthy are good candidates for organ donation. In these cases, it may be difficult to convince improperly informed family members to agree to organ donation.

See also: CELL DEATH; DEFINITIONS OF DEATH; LIFE SUPPORT SYSTEM; ORGAN DONATION AND TRANSPLANTATION; PERSISTENT VEGETATIVE STATE

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ALFRED R. MARTIN

BROMPTON'S COCKTAIL

In 1896 the English surgeon Herbert Snow showed that morphine and cocaine, when combined into an elixir, could give relief to patients with advanced cancer. About thirty years later a similar approach was used at London's Brompton Hospital as a cough sedative for patients with tuberculosis. In the early 1950s this formulation appeared in print for the first time, containing morphine hydrochloride, cocaine hydrochloride, alcohol, syrup, and chloroform water.

In her first publication, Cicely Saunders, the founder of the modern hospice movement, also referred to such a mixture, which included nepenthe, or liquor morphini hydrochloride, cocaine hydrochloride, tincture of cannabis, gin, syrup, and chloroform water; she was enthusiastic about its value to terminally ill patients. Over the next twenty years of writing and lecturing, Saunders did much to promote this mixture and other variants of the "Brompton Cocktail."

A survey of teaching and general hospitals in the United Kingdom showed the mixture and its variants to be in widespread use in 1972. Elisabeth Kübler-Ross, the psychiatrist and pioneer of end-of-life care, became one of its supporters, as did some of the pioneers of pain medicine and palliative care in Canada, including Ronald Melzack and Balfour Mount, who saw it as a powerful means of pain relief.

The Brompton Cocktail became popular in the United States, too, and at least one hospice produced a primer for its use which was distributed to both clinicians and patients. Indeed, as a leading

pain researcher and hospice physician, Robert Twycross noted, there developed a “tendency to endow the Brompton Cocktail with almost mystical properties and to regard it as the panacea for terminal cancer pain” (1979, pp. 291–292).

The cocktail emerged as a key element in the newly developing hospice and palliative care approach. Then, quite suddenly, its credibility came into question. Two sets of research studies, published in the same year, raised doubts about its efficacy—those of Melzack and colleagues in Canada and Twycross and associates in the United Kingdom. Both groups addressed the relative efficacy of the constituent elements of the mixture. The Melzack study showed that pain relief equal to that of the cocktail was obtainable without the addition of cocaine or chloroform water and with lower levels of alcohol, and that there were no differences in side effects such as confusion, nausea, or drowsiness. Twycross’s study found that morphine and diamorphine are equally effective when given in a solution by mouth and that the withdrawal of cocaine had no effect on the patient’s alertness. Twycross concluded, “the Brompton Cocktail is no more than a traditional British way of administering oral morphine to cancer patients in pain” (1979, p. 298). Despite these critiques of the cocktail, its use persisted for some time; however, in the twenty-first century it does not have a role in modern hospice and palliative care.

See also: KÜBLER-ROSS, ELISABETH; PAIN AND PAIN MANAGEMENT; SAUNDERS, CICELY

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DAVID CLARK

BROWN, JOHN

The abolitionist crusader John Brown died on December 2, 1859, executed by the state of Virginia for charges relating to treason, murder, and promoting a slave insurrection. Although Brown’s public execution took place before the start of the U.S. Civil War, his life and death anticipated the impending battle between the North and the South over the moral legitimacy of slavery in America, and served as a source of righteous inspiration for both sides immediately before and during the course of the war. Beyond that, Brown’s death serves as a case study in the construction and power of martyrdom. Proslavery supporters reviled Brown, whose often bloody actions against the social institution fueled southern fears about northern aggression. Many supporters and fervent abolitionists, on the other hand, glorified Brown, whose sacrifice for a higher good transformed the unsuccessful businessman into a national martyr.

Born in Connecticut on May 9, 1800, Brown became involved in the abolitionist movement early in life. His father was a strict Calvinist who abhorred slavery as a particularly destructive sin against God. Brown himself witnessed the brutality of slavery when, as a twelve-year-old boy, he saw a young slave ferociously beaten with a shovel by his owner, an image that remained with Brown for the rest of his life. After the Illinois abolitionist publisher Elijah Lovejoy was murdered by a proslavery mob in 1837, Brown publicly declared his intention to find a way to end slavery in the United States.

In the midst of extreme economic hardships and failed business ventures, Brown moved with some of his sons to Kansas following the passage of the Kansas-Nebraska Act. This act, heavily supported by southern slave-holding states, allowed people in new territories to vote on the question of slavery. During the 1850s, Kansas was the scene of a number of horrific acts of violence from groups on both sides of the issue. Brown placed himself in the thick of these bloody conflicts and, with a group of other like-minded zealots, hacked five proslavery men to death with broadswords, an event that came to be known as the Pottawatomie Massacre.

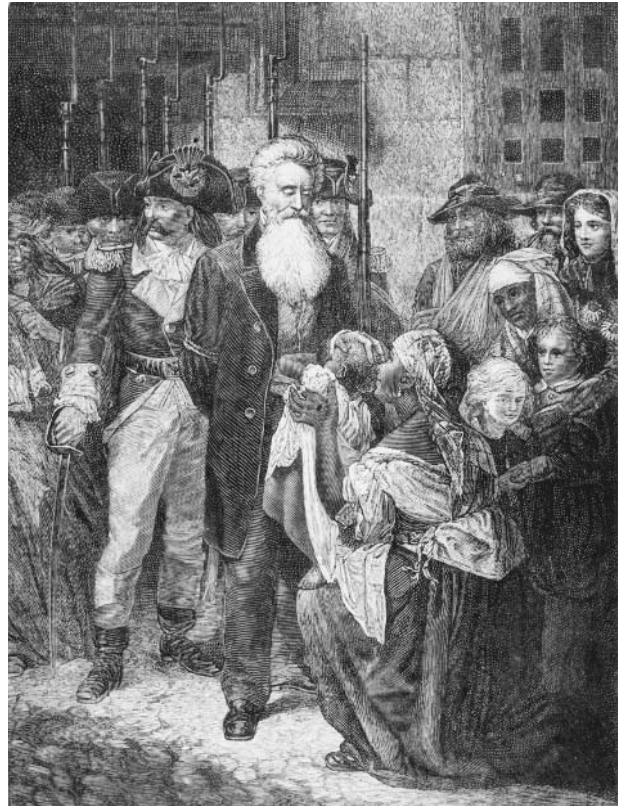
In the summer of 1859, Brown led a small army of men, including his own sons, to Harper’s

Ferry, Virginia, with a plan to invade the South and incite a slave rebellion. The group successfully raided the armory at Harper's Ferry but, after the arrival of Colonel Robert E. Lee and his troops, Brown's plans fell apart, and his men either escaped, died, or were captured by Lee's men in the ensuing battle. Brown himself was captured and stood trial in Virginia, where his fate was determined by an unsympathetic jury.

Brown, however, did not understand his failed invasion and impending death as a defeat for the abolitionist cause. Instead, he believed these events had crucial historical and religious significance, and that rather than signaling an end would be the beginning of the eventual elimination of slavery in America. Brown greatly admired stories about the prophets in the Bible, and came to believe that God, rather than a Virginia jury, had determined his fate. Convinced that his martyrdom could have more of an impact than any of his earlier schemes, Brown faced death with calm assurance and optimism that an abolitionist victory was secured with his imminent execution.

Brown was not the only one who understood the significant political implications of his execution in religious terms. Indeed, major northern abolitionists who would not countenance Brown's violent strategies to end slavery while alive, embraced the language of martyrdom after his death on the gallows. New England cultural figures like Ralph Waldo Emerson, Henry David Thoreau, and Lydia Maria Child, to name a few, identified Brown as the first true abolitionist martyr, serving as an iconic symbol of righteousness, redemption, and regeneration. Although others perished with him on the gallows, for many northerners John Brown was transformed into a hero who deserved to be included in the pantheon of great Americans and who died for the good of the United States.

Not everyone agreed with this assessment though. Immediately after his death, southern citizens and many in the North turned him into a demon rather than a hero, and wanted his corpse to suffer indignities reserved for the lowest criminals, including the suggestion that it be turned over to a medical school for dissection. The governor of Virginia decided to release the body of the deceased to Brown's wife, Mary, and allow it to be transported to the family farm in North Elba, New York. During the journey north, Brown's dead



Abolitionist John Brown, being escorted from prison to his execution in Virginia, 1859. His death foreshadowed the approaching battle between the North and the South over the morality of slavery. ARCHIVE PHOTOS, INC.

body aroused a great deal of interest. In Philadelphia, a large crowd of people from African-American abolitionist and proslavery communities turned out to meet the body upon its arrival in the city. The mayor, along with Mary Brown and her supporters, feared a riot might ensue, and decided to send an empty coffin to the local undertaker as a decoy so the container with Brown's body could make it to the wharf and continue its journey by boat to New York City.

Reaching its final destination, people came to see the coffin containing Brown's body, with some towns finding various ways to commemorate the martyr while the corpse passed through. On December 7, 1859, Brown's body arrived in North Elba, and was laid out in the front room of the house for visiting relatives, friends, and supporters to see before it vanished for good after the funeral the next day. After the corpse of John Brown had been placed in the ground at his home, the memory of his violent campaign to end slavery and the

symbolism of his death in the state of Virginia continued to materialize in American imaginative and social landscapes. During the U.S. Civil War, for example, one of the most popular songs among Union forces urged soldiers to remember his body “a-mouldering in the grave”—in time, a song that would be transformed with new lyrics by Julia Ward Howe into “The Battle Hymn of the Republic.” The cultural memory of John Brown’s life after the war and into the twentieth century assumed a variety of forms, including Stephen Vincent Benét’s famous Pulitzer Prize-winning poem, “John Brown’s Body,” and the establishment of schools bearing his name.

See also: CIVIL WAR, U.S.; LINCOLN IN THE NATIONAL MEMORY; MARTYRS

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GARY M. LADERMAN

BUDDHISM

“Decay is inherent in all compounded things, so continue in watchfulness.” The last recorded words of Siddhartha Gautama (Gotama), the founder of Buddhism, might be taken to mean, “Work out your own salvation with diligence” (Bowker 1997, p. 169).

From its inception, Buddhism has stressed the importance of death because awareness of death is what prompted the Buddha to perceive the ultimate futility of worldly concerns and pleasures. According to traditional stories of the life of the Buddha, he first decided to leave his home and

seek enlightenment after encountering the “four sights” (a sick person, an old person, a corpse, and someone who had renounced the world). The first three epitomized the sufferings to which ordinary beings were and are subject to, and the last indicates that one can transcend them through meditation and religious practice. The greatest problem of all is death, the final cessation of all one’s hopes and dreams. A prince of the Shakyas family in what is modern Nepal, Gautama became dissatisfied with palace life after witnessing suffering in the nearby city of Kapilavastu. At the age of 29, he renounced his former life, cut off his hair and started to wear the yellow robes of a religious mendicant. Buddhism, the faith he created through his teaching, thus originated in his heightened sense of suffering, and begins with the fundamental fact of suffering (*dukkha*) as the human predicament: “from the suffering, moreover, no one knows of any way of escape, even from decay and death. O, when shall a way of escape from this suffering be made known—from decay and from death?” (Hamilton, 1952, pp. 6–11).

Origins of Buddhist Faith

The Buddhist faith originated in India in the sixth and fifth centuries B.C.E. with the enlightenment of Gotama (in Sanskrit, Gautama), the historical founder of the faith (c. 566–486 B.C.E.). The teaching of Gotama Buddha, also known as Buddha Sakyamuni (that is, “the Wise One” or “Sage of the Sakya Clan”) is summarized in the Four Noble Truths: the truth of suffering (existence is suffering); the truth of suffering’s cause (suffering is caused by desire); the truth of stopping suffering (stop the cause of suffering (desire) and the suffering will cease to arise); and the truth of the way (the Eightfold Path leads to the release from desire and extinguishes suffering). In turn, the Eightfold Path requires right understanding, right thought, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration. There is also a twelve-step chain of cause. This chain of conditions consists of (1) spiritual ignorance; (2) constructing activities; (3) consciousness; (4) mind-and-body; (5) the six sense-bases; (6) sensory stimulation; (7) feeling; (8) craving; (9) grasping; (10) existence; (11) birth; (12) aging, death, sorry, lamentation, pain, grief, and despair. This chain of cause or Doctrine of Dependent

Origination explains the dukka that one experiences in his or her life. Finally, there is the continuing process of reincarnation. “If, on the dissolution of the body, after death, instead of his reappearing in a happy destination, in the heavenly world, he comes to the human state, he is long-lived wherever he is reborn” (Nikaya 1993, p. 135). Disillusioned with the ascetic path, Gotama adhered to what he called “the middle way.” He chose to sit beneath a Bo or Bodhi Tree (believed by scholars to now be situated at Bodhgaya, Bihar), concentrating on “seeing things as they really are” and passing through four stages of progressive insight (*jhanas*), which led to enlightenment (scholars believe this stage was achieved in c. 535 B.C.E.). The rest of his life was spent wandering in the area of the Ganges basin, gaining adherents and probably spending the rainy months in a community of followers, the beginnings of the Buddhist monastic establishment (*vihara*). The Buddha is said to have made no other claim for himself than that he was a teacher of transience or suffering (*dukkha* or *dubbkha*), the first of his Four Noble Truths.

Two and a half centuries after the Buddha’s death, a council of Buddhist monks collected his teachings and the oral traditions of the faith into written form, called the *Tripitaka*. This included a very large collection of commentaries and traditions; most are called *Sutras* (discourses). Some twelve centuries after the Buddha’s death, the faith spread from India into Tibet and from the early seventh century C.E. onward, Buddhism became firmly entrenched in all aspects of Tibetan society.

The significance of the conversion of Tibet lies in the exceptionally rich early literature that survives: The original Sanskrit texts of the Sutra on “Passing from One Existence to Another” and the Sutra on “Death and the Transmigration of Souls” are no longer extant and are known only through their Tibetan versions. Buddhism spread also to central and southeast Asia, China, and from there into Korea (c. 350–668 C.E.) and Japan (c. 538 C.E.). Although there have been conversions to Buddhism in modern times, especially the mass conversion of *dalits* (or untouchables) following the leadership of Dr. Bhimrao R. Ambedkar, the dispersion of the centers of Buddhist learning led to a dwindling of the faith in most of India during the centuries of Islamic predominance.

Buddhist Traditions

Buddhism has two (or in some interpretations, three) main divisions, or traditions: Mahayana and Hinayana. Those Buddhist adherents in Mongolia, Vietnam, China, Korea, and Japan follow Mahayana, the so-called Great Vehicle tradition, and those in Sri Lanka and southeast Asia, except Vietnam, where the Mahayan tradition was brought by Chinese settlers, follow Hinayana, also known as Theravada, the so-called Lesser Vehicle tradition. More controversial is whether Vajrayana (the “Diamond Vehicle” or Tantric tradition emanating from Mahayana, now dominant in Tibet and the Himalayas) constitutes a distinctive and separate tradition or not.

Mahayana emphasizes, among other things, the Sutras containing the developed teaching of the Buddha, and recognizes the Buddha-nature (*Buddhata*, or Buddha-potential) in all sentient beings (and not exclusively humans). Mahayana emphasizes the feeling of the suffering of others as one’s own, which impels the soul to desire the liberation of all beings and to encourage adherence to the “enlightenment” (*bodhisattva*) path. A *bodhisattva* is defined as one who strives to gain the experience of things as they really are (as in the experience of Gautama under the tree, hence the name *bodhi*) and scorns *nirvana* “as he wishe(s) to help and succour his fellow-creatures in the world of sorrow, sin and impermanence” (Bowker 1997, p. 154). An early Buddhist, Candrakirti, calls *nirvana* “the cessation of every thought of non-existence and existence” (Stcherbatsky 1965, p.190).

In contrast, Hinayana or Theravada (the latter term meaning “teaching of the elders”) emphasizes the aspect of personal discipleship and the attainment of the penultimate state of perfection (*arhat*). The followers of Mahayana view it as a more restricted interpretation of the tradition. There is also a basic disagreement on how many Buddhas can appear in each world cycle. In Theravada, there can only be one, the Buddha who has already appeared; hence only the penultimate state of perfection can be attained and Buddha-nature is not recognized. There are also other differences between the traditions, particularly with regard to the status of women (which is somewhat higher in the Mahayana tradition). Buddhism in its various manifestations is the world’s fourth largest religion with about 362 million adherents in 2000,



Buddhist Monks collect alms in Bangkok, Thailand. The Buddhist faith, which stresses the awareness of suffering and death, originated in sixth and fifth century B.C.E. India and then spread to Tibet, Asia, China, Korea, and Japan. CORBIS

or about 6 percent of an estimated world population of 6 billion.

The Sutra on “Passing from One Existence to Another” relates that during the Buddha’s stay in Rajagriha a king named Bimbisara questioned him on the transitory nature of action (*karma*) and how rebirth can be effected by thoughts and actions, which are by their very nature momentary and fleeting. For the Buddha, an individual’s past thoughts and actions appear before the mind at the time of death in the same way that the previous night’s dreams are recalled while awake; neither the dreams nor past karma have any solid and substantial reality in themselves, but both can, and do, produce real effects. An individual’s past karma appears before the mind at the final moment of

death and causes the first moment of rebirth. This new life is a new sphere of consciousness in one of the six realms of rebirth (the worlds of the gods, demigods, humans, hungry ghosts, animals, and hell-beings) wherein the person experiences the fruits of his or her previous actions.

The discourse on “The Great Liberation through Hearing in the Bardo” is one of a series of instructions on six types of liberation: liberation through hearing, wearing, seeing, remembering, tasting, and touching. It is a supreme example of Tibetan esoteric teaching on how to assist in the “ejection of consciousness” after death if this liberation has not happened spontaneously. If the body is present, the guru or dharma-brother, that is, the fellow-disciple of the guru, should read the text of

the Sutra close to his ear three or seven times. The first *bardo*, or intermediate state between life and death, is called “the luminosity of the essence of reality (*dharmata*)”; it is a direct perception of the sacredness and vividness of life (Fremantle and Trungpa 1975, p. 36). The work is thought to have been written by Padmasambhava, known by his followers as “precious teacher” (Guru Rinpoche), a great eighth-century Tantric master and founder of the Nyingma school. He is considered by Tibetans to be a second Buddha. He describes in detail the six bardos, or intermediate states, three of which comprise the period between death and rebirth and three which relate to this life: the bardo of birth; the bardo of dreams; the bardo of meditation, in which the distinction between subject and object disappears (*samadhi*, or meditation); the bardo of the moment before death; the bardo of the essence of reality (*dharmata*); and the bardo of becoming.

The Tibetan Book of the Dead

The German Tibetologist and scholar of comparative religion Detlef Lauf regarded the Tibetan *Book of the Dead* (*Bar-do thos-grol* or *Bardo Thodrol*, or *Thötröl*) as an example of “yoga-practice” (Yogacara) or Vijnanavada idealism, “which proceed(s) from the premise that karmically laden awareness by far outlasts the earthly life span of the individual.” This branch of Mahayana philosophy “places above all conceptualisation emptiness, suchness [sic], pure buddha-nature, or the crystal clear diamond nature of human awareness, which is of imageless intensity. . . . Therefore the Tibetan Book of the Dead can first proclaim the philosophical reality of the buddhas and their teachings, and after these have been grasped and penetrated, it can then say that these are only illusory images of one’s own consciousness, for the pure world within needs no images of external form” (Lauf 1977, pp. 225–226).

Mind or pure awareness is, in Vijnanavada theory, “the indispensable basis and essence of reality and is therefore absolute. Because nothing is imaginable without mind, it is called the absolute, or all-pervading emptiness, or simply *nirvana*” (ibid., p. 221). Although appearing to be an instruction manual for the guidance of human awareness after death, Lauf argued that the *Bardo Thodrol* was in reality “primarily a book of life, for the knowledge

of the path through the bardo must be gained ‘on this side’ if it is to be put into practice ‘on the other side’” (ibid., p. 228).

Lauf also generalized from the various Tibetan texts the duration of the bardo state: “It is generally accepted that the total time of the intermediate state between two successive earthly incarnations is forty-nine days. The various cycles of emanation of the deities divide this time into a rhythm that is always determined by the number seven. . . . From the fourth to the eleventh day there is the successive emanation of the forty-two peaceful bardo deities from out of the fivefold radiant light of the buddhas. From the twelfth until the nineteenth day the fifty-eight terrifying deities take shape out of the flames, and the journey through the [bardo and the experience of the worlds of hell] *Srid-pa’i bardo* lasts . . . twenty-one days in all. The last seven days are dedicated to the search for the place of rebirth which is supposed to take place on the eighth day . . .” (pp. 95–96).

Two modern approaches to the Tibetan *Book of the Dead* deserve mention. Based on lectures presented at his own Buddhist institute in Vermont, the charismatic Tibetan teacher Chögyam Trungpa (1939–1987) published his own edition of the work in 1975 with Francesca Fremantle. His highly individualized commentary to the translation certainly owes a debt to the psychoanalyst Carl Jung. In Chögyam Trungpa’s view, the bardo experience is an active part of every human being’s basic psychological makeup, and thus it is best described using the concepts of modern psychoanalysis, such as ego, the unconscious mind, neurosis, paranoia, and so on. This view was popularized in Trungpa’s *Transcending Madness: The Experience of the Six Bardos* (1992).

A second approach is that of Robert Thurman, a professor at Columbia University, the first American to be ordained a Tibetan Buddhist monk and president of Tibet House in New York City, who sets out to produce an accessible version of the Tibetan text for those who might wish to read it at the bedside of their dying friend or relative. In this way, Thurman’s *Tibetan Book of the Dead* is presented clearly as an “easy-to-read” guidebook for contemporary Americans. It is “easy for bereaved relatives to read and for lost souls to hear in the room where they anxiously hover about their

corpses and wonder what has happened to them . . .” (Sambhava and Thurman 1994, p. xxi).

Buddhism and Death and Dying

Robert Thurman’s text leads to a consideration of the relationship of Buddhism to modern clinical medical ethics and attitudes to death and dying in particular as well as to the pastoral care of the terminally ill. The Swiss-born psychiatrist Elisabeth Kübler-Ross interviewed over 200 dying patients better to understand the psychological aspects of dying. She illustrates five stages that people go through when they know they are going to die. The stages include denial, anger, bargaining, depression, and acceptance. While a sequential order is implied, the manner in which a person comes to terms with impending death does not necessarily follow the order of the stages. Some of these phases are temporary; others will be with that person until death. The stages will exist at different times and can co-exist within each other. Denial and feelings of isolation are usually short lived. Isolation is related to the emotional support one receives. If a person feels alone and helpless he or she is more likely to isolate. During the anger stage, it is important to be very patient with the dying individual, who acts in apparent anger because of an inability to accept the reality of the diagnosis. Bargaining describes the period in which the ill person tries to bargain with doctors, family, clergy, or God to “buy more time.”

When the denial, anger, and bargaining come to an end—and if the ill person continues to live—depression typically arises. Kübler-Ross talks about two forms of depression (reactive and preparatory). Reactive depression comes about from past losses, guilt, hopelessness, and shame. Preparatory depression is associated with impending loss. Most ill persons feel guilty for departing from family or friends, so require reassurance that life will change in the absence of the dead person but will nevertheless continue. The acceptance stage is a product of tiredness and numbness after the various preceding stages with their struggles. The model has been criticized and may not be applicable to the majority who die in old age, where a terminal diagnosis may be more acceptable to the individual. Many of the aged have experienced a gradual diminution of health and abilities that predates any knowledge of impending death. Such a diagnosis

may be better accepted by the elderly both because of gradual infirmity and because approaching death is not viewed as a “surprise,” but rather as part of a long and total life experience. For all the caveats, there are important resonances between the Kübler-Ross model and the stages of liberation in the bardo experience described above.

Julia Ching writes that “the central Mahayan insight, that Nirvana is to be found in the *samsara*, that is, *in* this life and this world, has made the religion more acceptable to the Chinese and Japanese” (Ching 1989, p. 217). She questions the content of Buddhist belief in East Asia: “. . . it appears that many Chinese, Japanese, and Korean Buddhists are less than clear about their belief in the cycle of rebirth. Their accounts of *samsara* include the presupposition of a wandering *soul*, which is not in accord with strict Buddhist teaching, and they tend to perceive life in linear terms. Besides, they frequently equate Nirvana with the Pure Land [named after *Sukhavati*, a Sanskrit word representing an ideal Buddhist paradise this side of Nirvana, believed to be presided over by the Buddha Amitabha, the Buddha of infinite life and light], and the Buddhas with the bodhisattvas” (1989, p. 220).

Ch’an and Zen, the respective Chinese and Japanese transliterations of the Sanskrit word for meditation (*dyhana*) are a distinctively East Asian development of the Mahayana tradition. Zen teaches that ultimate reality or emptiness (*sunya*), sometimes called “Buddha-nature,” is, as described by Ching, “inexpressible in words or concepts and is apprehended only by direct intuition, outside of conscious thought. Such direct intuition requires discipline and training, but is also characterized by freedom and spontaneity” (Ching 1989, p. 211). Japanese Buddhism, she contends, “is so closely associated with the memory of the dead and the ancestral cult that the family shrines dedicated to the ancestors, and still occupying a place of honor in homes, are popularly called the Butsudan, literally ‘the Buddhist altars.’ . . . It has been the custom in modern Japan to have Shinto weddings . . . but to turn to Buddhism in times of bereavement and for funeral services” (Ching 1989, p. 219).

The tradition of death poems in Zen accounts for one way in which the Japanese regard Buddhism as a funerary religion. Minamoto Yorimasa

(1104–1180 C.E.), lamented that “Like a rotten log / half buried in the ground— / my life, which / has not flowered, comes / to this sad end” (Hoffman 1986, p. 48). Shiaku Nyûdo (d. 1333) justified an act of suicide with the words: “Holding forth this sword / I cut vacuity in twain; / In the midst of the great fire, / a stream of refreshing breeze!” (Suzuki 1959, p. 84). At what would be considered the relatively youthful age of fifty-four, Ota Dokan (1432–1486) clearly considered himself in decline already by the time of death: “Had I not known / that I was dead / already / I would have mourned / my loss of life” (Hoffman 1986, p. 52). For Ôuchi Yoshitaka (1507–1551) it was the extraordinary event that was significant: “Both the victor / and the vanquished are / but drops of dew, / but bolts of lightning—thus should we view the world” (1986, p. 53). The same image of dew, this time reinforced by dreams, was paramount for Toyotomi Hideyoshi (1536–1598): “My life / came like dew / disappears like dew. / All of Naniwa / is dream after dream” (Berry 1982, p. 235). Forty-nine years had passed as a dream for Uesugi Kenshin (1530–1578): “Even a life-long prosperity is but one cup of sake; / A life of forty-nine years is passed in a dream / I know not what life is, nor death. Year in year out—all but a dream. / Both Heaven and Hell are left behind; / I stand in the moonlit dawn, / Free from clouds of attachment” (Suzuki 1959, p. 82). The mists that cloud the mind were swept away at death for Hôjô Ujimasa (1538–1590): “Autumn wind of eve, / blow away the clouds that mass / over the moon’s pure light / and the mists that cloud our mind, / do thou sweep away as well. / Now we disappear, / well, what must we think of it? / From the sky we came. / Now we may go back again. / That’s at least one point of view” (Sadler 1978, pp. 160–161).

The death poems exemplify both the “eternal loneliness” that is found at the heart of Zen and the search for a new viewpoint, a new way of looking at life and things generally, or a version of enlightenment (*satori* in Japanese; *wu* in Chinese). Daisetz Suzuki writes: “. . . there is no Zen without *satori*, which is indeed the alpha and omega of Zen Buddhism”; it is defined as “an intuitive looking into the nature of things in contradistinction to the analytical or logical understanding of it.” This can only be gained “through our once personally experiencing it” (1963, pp. 153, 154).

See also: CHINESE BELIEFS; HINDUISM; ISLAM; LAST WORDS; MOMENT OF DEATH

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RICHARD BONNEY

BURIAL GROUNDS

Three kinds of gravescapes—that is, memorials and the landscapes containing them—have dominated the funerary scene in North America from colonial times to the present. The first, the graveyard, almost invariably is located in towns and cities, typically adjoined to a church and operated gratis or for a nominal fee by members of the congregation. The second, the rural cemetery, is usually situated at the outskirts of towns and cities and is generally owned and managed by its patrons. The third, the lawn cemetery, is typically located away from towns and cities and ordinarily is managed by professional superintendents and owned by private corporations. These locations are generalities; in the nineteenth century both the rural cemetery and the lawn cemetery began to be integrated into the towns and cities that grew up around them.

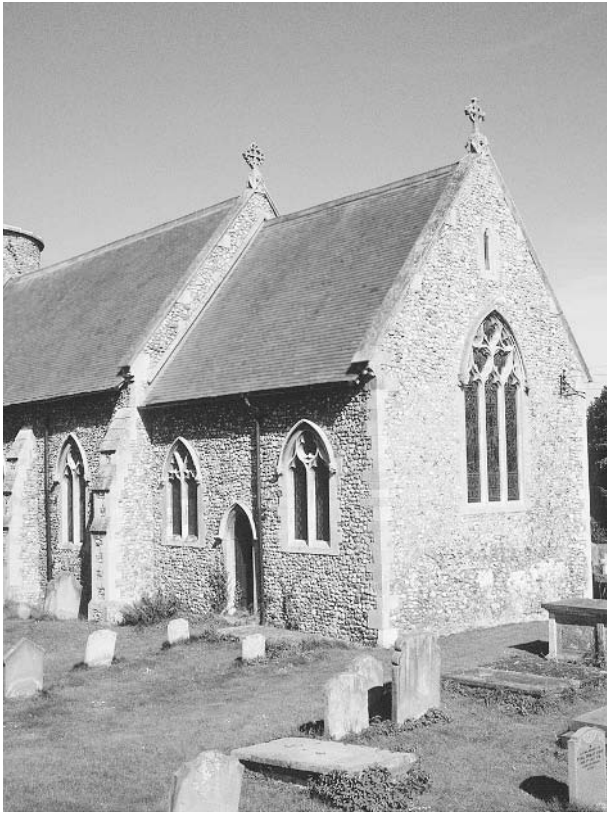
The Graveyard

From the beginning of colonization and for many years thereafter, Euroamerican gravescapes in North America uniformly presented visitors with a powerful imperative: Remember death, for the time of judgment is at hand. The graveyard serves as a convenient place to dispose of the dead; however, its more significant purpose derives from its formal capacity to evoke or establish memory of death, which serves to remind the living of their own fragility and urgent need to prepare for death. Locating the dead among the living thus helps to ensure that the living will witness the gravescape's message regularly as a reminder "to manifest that this world is not their home" and "that heaven is a reality" (Morris 1997, p. 65). Devaluation of all things accentuating the temporal life is the starting point for a cultural logic that embraces the view that "the life of the body is no longer the real life, and the negation of this life is the beginning rather than the end" (Marcuse 1959, p. 68).

Inscriptions and iconography continually reinforce these imperatives by deemphasizing temporal life and emphasizing the necessity of attending to the demands of eternal judgment. Only rarely, for example, do the memorials indicative of this perspective provide viewers with information beyond the deceased's name, date of death, and date of birth. Icons reminiscent of death (for example, skulls, crossed bones, and the remarkably popular winged death's head) almost invariably appear at or near the center of the viewer's focus, while icons associated with life appear on the periphery. Popular mottos like *memento mori* ("remember death") and *fugit hora* ("time flies," or more literally "hours flee") provide viewers with explicit instruction.

Certain actions run contrary to the values that give this gravescape its meaning. For example, locating the dead away from the living, enclosing burial grounds with fences as if to separate the living from the dead, decorating and adorning the gravescape, or ordering the graveyard according to dictates of efficiency and structural linearity. The constant struggles to embrace and encourage others to embrace the view that life is nothing more than preparation for death demands constant attention if one seeks to merit eternal bliss and avoid eternal damnation. This view thus unceasingly insists upon a clear and distinct separation of "real life" (spiritual life, eternal life) from "illusory life" (physical life; the liminal, transitory existence one leads in the here and now). The formal unity of memorials in this gravescape both ensures its identity and energizes and sustains its rhetorical and cultural purpose.

Even from a distance the common size and shape of such memorials speak to visitors of their purpose. Although the graveyard provides ample space for variation, an overwhelming majority of the memorials belonging to this tradition are relatively modest structures (between one and five feet in height and width and between two and five inches thick), and most are variations of two shapes: single and triple arches. Single arch memorials are small, smoothed slabs with three squared sides and a convex or squared crown. Triple arch memorials are also small, smoothed slabs with three squared sides but feature smaller arches on either side of a single large arch, which gives the impression of a single panel with a convex crown



This graveyard adjoined with the Saxon Church of Norfolk, England, is the type of traditional gravescape that dominated colonial North America. CORBIS

conjoined on either side by similar but much narrower panels, or pilasters, with convex crowns. Together with location and general appearance, such minimal uniformity undoubtedly helped to ensure that visitors would not mistake the graveyard for a community pasture or a vacant lot.

The Rural Cemetery

For citizens possessed of quite different sensibilities, the graveyard was a continual source of discontentment until the introduction of a cemeterial form more suited to their values. That form, which emerged on September 24, 1830, with the consecration of Boston's Mount Auburn Cemetery, signaled the emanation of a radically different kind of cemetery. Rather than a churchyard filled with graves, this new gravescape would be a place from which the living would be able to derive pleasure, emotional satisfaction, and instruction on how best to live life in harmony with art and nature.

Judging from the rapid emergence of rural cemeteries subsequent to the establishment of Mount Auburn, as well as Mount Auburn's immediate popularity, this new cemeterial form quickly lived up to its advocates' expectations. Within a matter of months travelers from near and far began to make "pilgrimages to the Athens of New England, solely to see the realization of their long cherished dream of a resting place for the dead, at once sacred from profanation, dear to the memory, and captivating to the imagination" (Downing 1974, p. 154). Part of the reason for Mount Auburn's immediate popularity was its novelty. Yet Mount Auburn remained remarkably popular throughout the nineteenth century and continues to attract a large number of visitors into the twenty-first century.

Moreover, within a few short years rural cemeteries had become the dominant gravescape, and seemingly every rural cemetery fostered one or more guidebooks, each of which provided prospective visitors with a detailed description of the cemetery and a walking tour designed to conduct visitors along the most informative and beautiful areas. "In their mid-century heyday, before the creation of public parks," as the scholar Blanche Linden-Ward has observed, "these green pastoral places also functioned as 'pleasure grounds' for the general public" (Linden-Ward 1989, p. 293). Mount Auburn "presented [and still presents] visitors with a programmed sequence of sensory experiences, primarily visual, intended to elicit specific emotions, especially the so-called pleasures of melancholy that particularly appealed to contemporary romantic sensibilities" (p. 295).

The owners of rural cemeteries played a significant role in the effort to capture the hearts and imaginations of visitors insofar as they sought to ensure that visitors would encounter nature's many splendors. They accomplished this not only by taking great care to select sites that would engender just such sentiments but also by purchasing and importing wide varieties of exotic shrubs, bushes, flowers, and trees. Both from within the gravescape and from a distance, rural cemeteries thus frequently appear to be lush, albeit carefully constructed, nature preserves.

Promoting a love of nature, however, was only a portion of what patrons sought to accomplish in their new gravescape. "The true secret of the

attraction,” America’s preeminent nineteenth-century landscape architect Andrew Jackson Downing insisted, lies not only “in the natural beauty of the sites,” but also “in the tasteful and harmonious embellishment of these sites by art.” Thus, “a visit to one of these spots has the united charm of nature and art, the double wealth of rural and moral association. It awakens at the same moment, the feeling of human sympathy and the love of natural beauty, implanted in every heart” (Downing 1974, p. 155). To effect this union of nature and art, cemetery owners went to great lengths—and often enormous costs—to commission and obtain aesthetically appealing objects to adorn the cemetery and to set a standard for those wishing to erect memorials to their deceased friends and relatives.

In this way cemetery owners recommended by example that memorials were to be works of art. Even the smallest rural cemeteries suggested this much by creating, at the very least, elaborate entrance gates to greet visitors so that their cemeteries would help to create “a distinct resonance between the landscape design of the ‘rural’ cemetery and recurring themes in much of the literary and material culture of that era” (Linden-Ward 1989, p. 295).

The Lawn Cemetery

The rural cemetery clearly satisfied the values and needs of many people; yet a significant segment of the population found this gravescape too ornate, too sentimental, too individualized, and too expensive. Even Andrew Jackson Downing, who had long been a proponent of the rural cemetery, publicly lamented that the natural beauty of the rural cemetery was severely diminished “by the most violent bad taste; we mean the hideous ironmongery, which [rural cemeteries] all more or less display. . . . Fantastic conceits and gimeracks in iron might be pardonable as adornments of the balustrade of a circus or a temple of Comus,” he continued, “but how reasonable beings can tolerate them as inclosures to the quiet grave of a family, and in such scenes of sylvan beauty, is mountain high above our comprehension” (Downing 1974, p. 156).

Largely in response to these criticisms, in 1855 the owners of Cincinnati’s Spring Grove Cemetery instructed their superintendent, Adolph Strauch, to remove many of the features included when John

Notman initially designed Spring Grove as a rural cemetery. In redesigning the cemetery, however, Strauch not only eliminated features typically associated with rural cemeteries, he also created a new cemeterial form that specifically reflected and articulated a very different set of needs and values.

In many ways what Strauch created and what lawn cemeteries have become is a matter of absence rather than of presence. The absence of raised mounds, ornate entrance gates, individualized gardens, iron fencing, vertical markers, works of art dedicated to specific patrons, freedom of expression in erecting and decorating individual or family plots, and cooperative ownership through patronage produces a space that disassociates itself not only from previous traditions but also from death itself. This is not to say that lawn cemeteries are devoid of ornamentation, as they often contain a variety of ornamental features. Nevertheless, as one early advocate remarked, lawn cemeteries seek to eliminate “all things that suggest death, sorrow, or pain” (Farrell 1980, p. 120).

Rather than a gravescape designed to remind the living of their need to prepare for death or a gravescape crafted into a sylvan scene calculated to allow mourners and others to deal with their loss homeopathically, the lawn cemetery provides visitors with an unimpeded view. Its primary characteristics include efficiency, centralized management, markers that are either flush with or depressed into the ground, and explicit rules and regulations.

Yet to patrons the lawn cemetery affords several distinct advantages. First, it provides visitors with an open vista, unobstructed by fences, memorials, and trees. Second, it allows cemetery superintendents to make the most efficient use of the land in the cemetery because available land is generally laid out in a grid so that no areas fail to come under a general plan. Third, by eliminating fences, hedges, trees, and other things associated with the rural cemetery and by requiring markers to be small enough to be level or nearly level with the ground, this gravescape does not appear to be a gravescape at all.

Although lawn cemeteries did not capture people’s imaginations as the rural cemetery had in the mid-nineteenth century, they did rapidly increase in number. As of the twenty-first century they are

considered among the most common kind of gravescape in the United States.

See also: CEMETERIES AND CEMETERY REFORM; CEMETERIES, WAR; FUNERAL INDUSTRY; LAWN GARDEN CEMETERIES

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RICHARD MORRIS

BURIED ALIVE

"Buried alive"—the phrase itself frightens people with its thoughts of being enclosed in a narrow space with one's breathing air diminishing, helpless, and unable to escape. A 1985 Italian study of patients recovering from myocardial infarction, found that 50 percent of them suffered from phobias that included being buried alive. The fear of

being buried alive is denoted by the word *taphephobia*. The state of the appearance of death while still alive has been denoted by the term *thanatosis*, although the phrase "apparent death" is used more frequently by medical professionals and those in the scientific community.

This fear of premature burial is not wholly without basis. On January 25 and 26, 2001, the *Boston Globe* reported the case of a woman found slumped lifelessly in her bathtub, with a suicide note and evidence of a drug overdose nearby. The police and the emergency medical technicians found no pulse, no sign of breathing, her skin was turgid, and her eyes were unresponsive. She was transported to a nearby funeral home, where the funeral director, on his way out, was startled to hear a faint sound, which he recognized as someone breathing. He quickly unzipped the body bag, held her mouth open to keep her air passages clear, and arranged for her removal to a hospital. Similarly, according to an 1815 volume of the *North American Review*, a Connecticut woman was nearly buried alive, but fortunately showed signs of life before the coffin was closed.

Cases of people thought dead and being disposed of are reported from ancient times. William Tebb and Vollum, in 1905, speak of Pliny the Elder (23–79 C.E.), who cites the case of a man placed upon a funeral pyre who revived after the fire had been lit, and who was then burnt alive, the fire having progressed too far to save him. Plutarch, Esclepiades the physician, and Plato give similar stories of men who returned to life prior to burial. Hugh Archibald Wyndham wrote a family history, published in 1939, which included the story of Florence Wyndham, who, after a year of marriage, was thought to be dead and buried in the family vault in 1559. The sexton, knowing there were three valuable rings on one of her fingers, went to the vault and began to cut the finger. Blood flowed, the body moved, and the sexton fled leaving his lantern behind. Florence returned to the house in her grave clothes, frightening the household who thought she was a ghost and shut the door against her.

A considerable number of similar premature burial stories have been reported. These burials occur when the individual gives the unmistakable appearance of being dead due to a trance state or a similar medical condition. Burial alive also occurs

in natural disasters such as the earthquake in India in 2001, and in avalanches. In such cases the individual's thoughts turn to the hope of rescue.

According to Rodney Davies, author of *The Lazarus Syndrome: Burial Alive and Other Horrors of the Undead* (1998), the percentage of premature burials has been variously estimated as somewhere between 1 per 1,000 to as many as 1 or 2 percent of all total burials in the United States and Europe. The percentage increases in times of pestilence or war. Premature burials of Americans during World War II and during the Vietnam War has been estimated to have been as high as 4 percent (Davies 1998, p. 133).

Burial alive has sometimes been deliberate. In Rome, vestal virgins who had broken their vows of chastity were imprisoned in an underground chamber with a lighted candle, some bread, a little water mixed with milk, and left to die. In Edgar Allan Poe's story *The Cask of Amontillado* (1846), the narrator exacts revenge by luring his enemy to the wine cellar and then walling him in. Poe was obsessed with the theme of premature burial, which he used in many stories. William Shakespeare also used premature burial as a theme, the best known example occurring in *Romeo and Juliet* (1595). Juliet is given a potion that mimics death; Romeo, not knowing she is still alive, kills himself. Juliet, finding him dead, then kills herself. Shakespeare repeats this theme in *Henry IV, Part Two* (1598), and *Pericles, Prince of Tyre* (1607). A number of other authors, such as Bram Stoker, Gertrude Atherton, and Wilkie Collins have used variations of the buried alive theme.

Since the nineteenth century, the fear of being buried alive has resulted in the creation of devices that allow one to signal from the coffin. A 1983 U.S. patent (No. 4,367,461), describes an alarm system for coffins that is actuated by a movement of the body in the coffin. In the mid-nineteenth century in Munich, Germany, a building was set aside

in which bodies were kept for several days, with an attendant ready to rescue any who had been buried alive. The fingers of the body were fastened to a wire leading to a bell in the room of the attendant. Mark Twain visited this place in 1878 or 1879 and described it in a story which he included in chapter 31 in *Life on the Mississippi* (1883).

The deliberate invoking of a state mimicking death has been reported from India. Those adept in yoga are able to reduce their respiratory and pulse rates and then be buried for several days before being brought out alive.

See also: ANXIETY AND FEAR; CRYONIC SUSPENSION; DEFINITIONS OF DEATH; PERSISTENT VEGETATIVE STATE; WAKE

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SAM SILVERMAN



CADAVER EXPERIENCES

Studies by sociologists have found that no experience has a more profound impact on medical school students than the first encounter with death, which typically occurs during the first-year course of gross anatomy. With its required dissection of human cadavers, the course seeks to impart a variety of explicit lessons, including the size, shape, and exact location of organs varies from one individual to another; organs vary in their “feel” and texture and are connected to other parts of the body in complex ways that textbook illustrations cannot effectively reproduce; and surgical instruments have specific purposes and must be handled properly to avoid injury to the patient or oneself. A less explicit, but no less important, result is overcoming the natural emotional repugnance at handling a cadaver.

First-year medical students report having the most difficulty dissecting those parts of the body with strong emotional associations, especially the hands, face, and genitals, as opposed to the arms, legs, and abdomen, which can more easily be bracketed as mere physical body parts. One common method of dealing with the emotional upset of cadaver dissection is the use of humor—students often circulate cadaver stories as a test of one another’s proper emotional preparation through humor involving a dismembered corpse.

Cadaver stories. Cadaver stories (jokes involving anatomy-lab cadavers) have been studied by researchers interested in urban folklore.

Researchers have found that most of these stories are unlikely to be true and that they fall into five basic categories, all connected with the emotional socialization of medical students:

1. Stories describing the removal of cadaver parts outside of the lab to shock ordinary citizens (mailing body parts to friends or handing change to a toll collector with a severed hand are examples of this category).
2. Manipulation of the cadaver’s sexual organs which shocks or offends another medical student.
3. The cadaver appearing to come to life at an unexpected time, supposedly frightening a novice student. One such story features a medical student taking the place of the cadaver under the sheet; at the right moment, the student twitches and then sits upright to the screams of the emotionally unprepared.
4. Stories featuring the cadaver as a food receptacle. Students may claim to have heard of a student in another lab who hid food in a corpse and later removed and ate it during class. Like the previous type of story, this category is supposed to test the queasiness of medical students who are expected to find the story amusing.
5. The realization that the medical student has finished dissecting a member of his or her own family (the head is the last part of the cadaver to be dissected and because it is so



The dissection of human cadavers in medical school imparts not only the lessons of gross anatomy, but lessons on dealing with death. YANN ARTHUS-BERTRAND/CORBIS

emotionally charged, it is almost always kept covered until the end of the anatomy course).

Stories of this last kind have more credibility with medical students than those in the first four categories, which require conscious misbehavior on the part of some other medical student. In this cadaver story, a well-prepared medical student is still capable of being emotionally assaulted by the realization that she has spent the entire semester dissecting her own mother. Although such an event is highly unlikely, some physicians are obliged to operate on a friend or someone resembling a family member.

Taken together, cadaver stories reveal the common need for medical students to verbalize their discomfort with death and dead bodies. While the stories are about medical students or emotionally squeamish laypersons, the students reciting these legends are themselves skittish and use the stories as a type of emotional fortification.

Dog labs. A second stage in the emotional socialization of medical students is associated with so-called dog labs that, until recently, were found in

many medical schools. In dog labs, medical students operate on anesthetized dogs supplied by local animal-control shelters. Unlike cadavers, these creatures are alive and must be kept alive during dissection. Overt learning outcomes include familiarity with anesthetics, care in working on a living creature that bleeds and needs to be kept breathing, and additional training in the use of surgical instruments. A less explicit outcome is another lesson in emotional socialization because the dogs are expected to die on the operating table. Anesthetized and thus incapable of feeling pain, the animals are given a fatal drug overdose. Recently, this practice has been eliminated from most medical schools, but for years it was considered a necessary step in preparing the student to work on living human patients.

Witnessing an autopsy. The third component in preparing future physicians for dealing with death involves attending and participating in an actual autopsy. Usually scheduled for the second year of medical school training, the autopsy moves students closer to what had very recently been a living human being. Unaffected by preservatives, the body's organs look and feel exactly as they would on the operating table, allowing students an opportunity to collect information even closer to the real thing. At this point, most students report that they have arrived at a new stage in emotional detachment from death. Shorn of the protective layer of cadaver stories, students use the scientific knowledge gained during their many chemistry and biology classes as a bulwark against emotional distress. Students report that cadaver dissection does not completely prepare them for the autopsy, and some experience difficulty remaining in the room during the procedure.

Patients with terminal illnesses. Having reached their third and fourth years of medical school, students begin to come into contact with actual patients. Some of these patients are terminally ill and represent a new challenge to emotional control and response to the prospect of death. None of the previous stages prepare students for interaction with a patient whose death is imminent. By this point in their education, some students report that they are troubled by their desensitization to the suffering and deaths of patients and fear that they will come to resemble the icy, hardened practitioners they have always despised. By the fourth

year of medical school, however, most students report an overcoming of this feared detachment and an attainment of a proper emotional balance.

Changes in Medical School

This sequence of stages in emotional socialization coincides with stages in the training of medical students. For many years, that training was fairly uniform among medical schools. Similarly, the sorts of students enrolling in medical school often shared certain characteristics: male, white, twenty-two to twenty-five years of age, middle- to upper-middle-class background, a thorough grounding in the hard sciences, and a high grade point average from a reputable undergraduate institution. By the end of the twentieth century, however, significant changes occurred in the training of medical students, who were increasingly likely to be female, non-white, and to have taken many non-science courses. These developments may mean that the model of emotional socialization for confronting death is changing. For example, many medical schools now routinely bring medical students into contact with patients during their first year. Although this usually involves taking medical histories or simply overcoming discomfort in speaking with strangers about their health problems, it may well affect the manner in which emotional detachment develops. Also, cadaver stories appear to be evolving. Initially, many stories featured female medical students as their target. Analysts interpreted this as a thinly veiled form of sexism. Recently, however, stories have appeared that feature pranks backfiring against male perpetrators. In another shift in gross anatomy labs, female students sometimes choose to work together in dissection of female cadavers, believing that male students do not show proper respect for female genitalia.

The studies summarized above describe the experience at institutions offering training in conventional allopathic medicine. Nontraditional medical training (e.g., homeopathy or chiropractic) may produce a very different set of reactions in the encounter with death. Likewise, the confrontation with death in medical schools in other countries varies with the unique cultural mores that have shaped the students.

See also: AUTOPSY; DEATH EDUCATION; NURSING EDUCATION

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JONATHAN F. LEWIS

CAMUS, ALBERT

Born in 1913, Albert Camus was a French philosopher, writer, and playwright of Algerian descent. Camus was confronted very early in his life by the contradictions that forged his conception of death. While celebrating the multiple splendours of life and the exuberance of nature, he was struck by an illness (tuberculosis) that had lasting effects throughout his life. This was the beginning of his conception of the absurdity of life, best summarized by the title character of his 1938 play *Caligula*, who said, "Men die, and they are not happy" (1.4).

Camus was an atheist, and the notions of divinity or life after death were evacuated from his philosophical conception. So, if one cannot find sense in dying, one must invest all of one's energies (despite the apparent absurdity of existence) into action: There is an obligation on humans to act—by revolting against things as they are, assuming their freedom, fighting for the values of justice, equality, and brotherhood. This, however, presupposes that one chooses to live; to Camus, as he writes at the very beginning of his essay on the

absurd, *The Myth of Sisyphus*, “There is but one truly philosophical problem and that is suicide” (p. 11). This affirms the liberty that individuals have to dispose of their life as they wish. Camus is not, however, an apologist of suicide. He is a passionate advocate for the freedom of choice. In concluding *The Myth of Sisyphus*, Camus cannot help but ask the reader to “imagine Sisyphus happy.” Camus was awarded the Nobel Prize for Literature in 1957. He died in a car accident in 1960.

See also: KIERKEGAARD, SØREN; PHILOSOPHY, WESTERN;
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JEAN-YVES BOUCHER

CANCER

To many people, the word *cancer* is synonymous with death; however, that is not the reality. In industrialized countries cancer mortality rates have slowly and progressively declined between 1950 and 2000. In 2000 overall cure rates reached approximately 50 percent. Nevertheless, cancer remains the second leading cause of death in industrialized countries and a rapidly increasing cause of death in developing countries.

The scope of the problem in the United States is large. Some 1.2 million people were diagnosed with potentially fatal cancer in the year 2000. Of these, 59 percent were expected to live for at least five years (in some, the cancer may be continuously present for more than five years) with or without evidence of cancer. People of all ages, from birth to advanced age, can manifest cancer, making it the second-leading cause of death in the United States. In children cancer is unusual, but it has consistently been the leading cause of death from disease. As mortality rates from cardiovascular disease decline, the proportion of cancer deaths

increases. It is anticipated that the mortality rate from cancer will surpass that from heart disease by the year 2050. Direct and indirect financial costs of cancer in the United States for the year 2000 were \$178 billion.

Developing countries represented 80 percent of the world's approximately 6 billion people in the year 2000. In these countries, cancer has grown from a minor public health issue in the early 1990s to a rapidly expanding problem by the beginning of the twenty-first century. The emergence of a middle class, with attendant changes in lifestyle, increased longevity and exposure to potential carcinogens, and expectations of improved medical delivery systems have fueled the growing impact of cancer in the third world. The financial resources and socio-medical infrastructure needed to diagnose and treat, much less screen and prevent these cancers, are lacking in the developing world.

A controversial issue in the United States is whether there has been progress in the “War on Cancer” declared by Congress in 1971. Since then a large flow of tax dollars has been directed to basic and clinical research with the goal of eliminating cancer. Mortality rates from all forms of cancer have declined slightly from 1990 through 2000, but with large variations among different types of cancer. Optimistic explanations include significant improvements in treatment and prevention. More pessimistic analyses suggest that some of the more common cancers can be diagnosed earlier so that benchmark five-year mortality rates have diminished, but that the actual course of the disease is unaffected because treatments are not really more effective.

Biology

Cancer is a disease whereby the genes regulating individual cell behavior and interactions with other cells malfunction. It is therefore a “genetic” disease, although not necessarily “inherited.” Cancers clearly traced to inherited susceptibility are unusual, accounting for fewer than 10 percent of cases. Rather, the majority of cancers seem to result from complicated interactions between the environment and “normal” cells.

The routine operations of cell growth, division, cell-to-cell communication, and programmed cell death (apoptosis) are complex and must be tightly

controlled to preserve the integrity of the organism. Chromosomes, which contain DNA molecules organized into genes, control these regulatory processes. Similar mechanisms are present in all animals and plants, are highly conserved through evolution, and so must provide significant survival benefit. The phenomenon of cancer is infrequent in wild animals and has only come to prominence in human beings since 1900. These statistics suggest that interactions of environmental agents with the genes result in fixed alterations that eventually manifest themselves as cancer. Public health measures have increased longevity so that the progressive, possibly inherent deterioration of regulatory functions accompanying aging allows less effective repair of chronic genetic damage.

Although no single cause has been or is likely to explain all of cancer, research has demonstrated that environmental factors predominate in the development of most cancer. Proven causes of DNA damage leading to malignant change include viruses, radiation, and chemicals. Viruses such as Epstein-Barr, HIV, and papilloma can contribute to cancer development (carcinogenesis). Both therapeutic and normal environmental exposure to radiation increase the risk of cancer. Multiple chemicals have been linked to cancer, of which the best examples are the constituents of tobacco. How these and other unknown environmental factors, particularly dietary and airborne, interact with human genes to cause irreversible, malignant transformation is the subject of intensive research.

Malignant cells can multiply and divide in the tissue of origin and can travel through the circulatory system and create secondary deposits (metastases) in vital organs. These capabilities underlie the phenomena of invasive lumps (tumors) and the potential for the dissemination of cancer. Most cancer cells, whether at the primary or secondary site, divide at about the same rate as their cells of origin. Malignant cells, however, do not typically undergo normal programmed cell death (apoptosis) and consequently accumulate. Most often, the cause of death in cancer is a poorly understood wasting process (cachexia).

Prevention and Screening

Prevention of cancer, or the reduction of risk for a person who has never experienced the disease, is a desirable goal. For those cancers resulting from

known environmental exposures, such an approach has been most successful. Avoidance of tobacco products is no doubt the best proven means of preventing cancer. In industrialized countries, regulatory agencies monitor chemical and radiation exposure. Dietary habits are felt to influence the risk of developing certain cancers, but there is very little evidence that dietary manipulations lead to significant risk reduction.

Screening is the attempt to diagnose an established cancer as early as possible, usually before the onset of symptoms, in order to optimize the outcome. A screening technique is designed to simply, safely, and cheaply identify those patients who may have a certain type of cancer. If screening-test result is positive, further testing is always necessary to rule the diagnosis in or out. There is considerable controversy in this field. It cannot be assumed that early detection is always in the patient's best interest, and the overall financial costs in screening a population must be weighed against the actual benefits. Screening may be counterproductive under the following conditions:

1. Treatment is not more effective with early detection.
2. The patient will die of an unrelated condition before the diagnosed cancer could be troublesome or fatal.
3. The screening examination can be harmful.
4. The screening examination is falsely "negative" and thus falsely reassuring.
5. The treatment causes complications or death in a patient in whom the cancer itself would not have led to problems.

In spite of these limitations, there have been successes. Good evidence exists that not only early detection but also improved survival can be achieved in breast, cervical, and colorectal cancers. With minimal danger and cost, appropriate populations screened for these diseases benefit from reduced mortality. Prostate cancer, however, is more problematic. Measurement of prostate-specific antigen (PSA), a substance made by both normal prostate as well as malignant prostate cells, can identify a patient with prostate cancer before any other manifestations. But because of the relatively elderly population (often with unrelated

potentially serious conditions) at risk, it has been difficult to prove that treatment confers a quantitative or qualitative benefit. Continued efforts will be made to create screening techniques that truly allow more effective treatment for cancers detected earlier.

Diagnosis and Treatment

Once a malignancy is suspected, tests (usually imaging techniques, such as X rays, ultrasounds, nuclear medicine scans, CAT scans, and MRIs) are performed for confirmation. Ultimately a biopsy, or removal of a piece of tissue for microscopic examination, is necessary for determination of the presence and type of cancer. Staging tests reveal whether the disease has spread beyond its site of origin. Because of the inability of current techniques to detect microscopic deposits of cancer, a cancer may frequently appear to be localized but nevertheless exist elsewhere in the body below the threshold of clinical detection.

The diagnostic and staging process should permit the optimal clarification of the goals of treatment. Curative treatment intends permanent elimination of cancer, whereas palliative treatment intends to relieve symptoms and possibly prolong life. In every cancer situation there are known probabilities of cure. For example, a specific patient with “localized” breast cancer may have a 50–60 percent chance of cure based on predictive factors present at the time of diagnosis. Follow-up “negative” tests, however, do not yield the certainty that there is no cancer, whereas the documented presence of recurrent cancer has clear significance. Cancer, indeed, is the most curable of all chronic diseases, but only the uneventful passage of time allows a patient to become more confident of his or her status.

Surgery is the oldest and overall most effective cancer treatment, particularly when tumors appear to be localized and cure is the goal. It is a preferred modality for breast, prostate, skin, lung, colon, testicular, uterine, brain, stomach, pancreas, and thyroid tumors. The aims of cancer surgery include elimination of as much cancer as possible, preservation of organ function, and minimal risk and suffering for the patient. Occasionally surgery is intentionally palliative, particularly when other treatment modalities are added in an effort to improve symptoms.

Radiation therapy has been a mainstay of cancer treatment since the 1940s, when doctors first began to understand its potential benefits and short and long-term risks. Therapeutic ionizing radiation is generated by a linear accelerator and delivered externally to a well-defined area. It thus shares with surgery an advantage for localized tumors. The inherent differences in radiation sensitivity between malignant tissues and the surrounding normal tissues permits the exploitation of radiation for therapeutic benefit. When the cancerous tissue is less sensitive to radiation than the normal tissues, radiation can cause more harm than good. Radiation has been a useful primary treatment modality in tumors of the head and neck, lung, cervix, brain, pancreas, and prostate. For tumors that have metastasized to tissues such as bone and brain, radiation has been very useful for palliative purposes.

Systemic treatments, either by themselves or in concert with surgery and/or radiation, offer the most rational options for a disease, which so often has spread before diagnosis. The ideal treatment would be a substance that travels throughout the body, neutralizes every cancer cell, but causes no harm to any normal cell. Research has not yet yielded such a completely specific and non-toxic substance.

The 1950s saw the advent of anticancer drugs that came to be known as “chemotherapy.” By the year 2001 approximately sixty chemotherapy drugs became commercially available. In general these drugs cause irreversible cell damage and death. They tend to be more destructive to rapidly dividing cells and so take their heaviest toll on relatively few malignancies as well as predictability on normal tissues (mucous membranes, hair follicles, and bone marrow). For some very sensitive disseminated cancers such as testicular, lymphomas, and leukemias, chemotherapy can be curative. For many others, such as advanced breast, ovarian, lung, colon cancers, chemotherapy may offer palliative benefits. Since the 1980s chemotherapy has played an important role in the multimodality treatment of localized breast, colon, lung, and bladder tumors. Except for curable and highly chemosensitive malignancies, chemotherapy kills at most 99.99999 percent of cells, but with a burden of trillions of cancer cells, millions of resistant cells remain. Even using high-dose chemotherapy, it

appears that by the year 2001 chemotherapy may have reached a plateau of effectiveness.

Insights into the basic genetic, molecular, and regulatory abnormalities of malignant cells have opened up entirely new systemic approaches. "Natural" substances such as interferons and interleukins have therapeutically modulated cell proliferation and led to regression of some tumors. Antiangiogenesis agents interfere with the malignant cell's need for accessing new blood vessels. Chemicals designed to inhibit the inappropriate production of growth factors by malignant cells have been synthesized and show promise. Monoclonal antibodies aimed at proteins concentrated on the malignant cell's surface have achieved tumor shrinkage. By the year 2000 the thrust in basic cancer research had focused on manipulation of the fundamental processes that allow malignancies to grow and spread.

The Internet has allowed patients, families, and medical providers rapid access to information previously obtainable only through libraries or physicians. Such information, however, may be unfiltered, unsubstantiated, and misleading. Even when the information is correct, consumers may be unable to process it properly because of fears concerning their condition. All observers agree, however, that this form of communication will rapidly affect cancer research and treatment.

"Complementary" or "alternative" modalities have existed for many years and represent nonscientific means of attempting to cure or palliate cancer. The multitude of available products and techniques is enormous: herbal extracts, vitamins, magnetic therapies, acupuncture, synthetic chemicals, modified diets, and enemas. The vast majority of these have never been evaluated in a rigorously controlled scientific way that would allow more definitive and precise evaluation of their benefits and risks. Nevertheless, evidence has shown that as many as 50 percent of all cancer patients, irrespective of treatability by conventional methods, try at least one form of complementary medicine. Some proponents feel that these treatments should serve as adjuncts to conventional ones, while others feel that all conventional treatments are toxic and should be replaced by alternative ones. To investigate the potential of these approaches, the National Institutes of Health established the Institute of Alternative Medicine in 1996.

End-of-Life Care

Because approximately 50 percent of cancer patients will die from their cancer, management of their dying takes on great importance. In the 1980s and 1990s multiple studies demonstrated that such basic concerns as pain and symptom control, respect for the right of the individual to forego life-prolonging measures, and spiritual distress have been mismanaged or ignored by many health care providers. In spite of the emergence of the modern hospice movement and improvements in techniques of symptom alleviation, most cancer patients die in hospitals or in nursing homes while receiving inadequate palliative care. The American Society of Clinical Oncology (ASCO) in 1998 mandated that part of fellowship training for oncologists include the basics of palliative care in order to rectify these problems.

See also: CAUSES OF DEATH; PAIN AND PAIN MANAGEMENT; SYMPTOMS AND SYMPTOM MANAGEMENT

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CANNIBALISM

Cannibalism, or anthropophagy, is the ingestion of human flesh by humans. The idea of people eating parts of other people is something that has occurred wherever and whenever humans have formed societies. In traditional accounts cannibalism has emerged from peoples' history and cosmology, embedded in their myths and folklore. In all of these contexts, anthropophagy connotes moral turpitude.

The concept of cannibalism, its ethical encumbrances, and its cultural expression in history and myth are unquestionably universal. To be human is to think about the possibility of cannibalism. Anthropophagy is hard-wired into the architecture of human imagination. Cannibal giants, ogres, bogies, goblins, and other "frightening figures" populate the oral and literate traditions of most cultures, summoning images of grotesqueness, amorality, lawlessness, physical deformity, and exaggerated size. The Homeric tradition of the Greek Cyclops, the Scandinavian and Germanic folklore giants, or the Basque Tartaro find parallels in Asia, Africa, India, and Melanesia. In a fusion of the

historical and the fabled, these pancultural incidences of cannibal indicate a remarkable similarity in the way meanings are assigned to cannibalism across the world.

Constructing History with Cannibals

Many cultural mythologies posit a prehistory that antedates the onset of acceptable mores, an epoch closed off from the beginnings of human settlement and social organization, when cannibalistic dynasties of giants prevailed. This common motif in cultural history indicates that cannibalism often symbolizes "others" that are less than fully human in some way. The imputation of anthropophagy draws a boundary between "us" and "them," the civilized and uncivilized, in a manner that depicts humans as emerging from a chaotic and bestial epoch dominated by a race of human-eating giants. These images of cannibal predecessors constitute a story that people tell themselves through myth to explain their past and present circumstances. So conventional are these patterns of thought across time and culture that we have come to understand cannibalism as the quintessential symbol of alterity, an entrenched metaphor of cultural xenophobia.

Constructing Fiction with Cannibals

These themes of primordial anthropophagy serve other functions as well. Most oral traditions contain such folktales and fables that are passed down through the generations. One thinks here of the Western stories such as "Jack and the Beanstalk," "Hansel and Gretel," and early versions of "Little Red Riding Hood." These are not just dormant figures inhabiting the fairytale world, they convey for caretakers a vision of control and are frequently used—like the Western bogeyman or little green monster—to coerce, frighten, and cajole children into obedience. The threat of cannibalization provides an externalized and uncontrollable projection of parenthood capable of punishing misdeeds. In this sense, cannibal figures share certain characteristics with imaginary companions and fictions such as the Easter Bunny, Tooth Fairy, or Santa Claus, which, by contrast, project positive reward rather than negative punishment.

Cannibal representations are part of the universal stock of imaginative creations that foster

obedience and conformity. Psychologists thus argue that anthropophagy is an archetype unaffected by cultural relativism and is, perhaps, a reflection of childhood psychodynamic processes. Flesh eating, from this perspective, may reflect child-engendered projections of parenthood and innate destruction fantasies.

Parallels between Western and non-Western fictional mediums illuminate the power cannibalism exerts on the human psyche. The commercial success of films such as *Silence of the Lambs*, *Manhunter*, and *The Cook, The Thief, His Wife, and Her Lover*, along with the extensive media coverage of cannibalistic criminals such as Jeffrey Dahmer, Gary Heidnik, and Albert Fish, speaks volumes about the public's fascination with cannibalism. Moviegoers' sympathetic cheering for Hannibal Lecter is a way of suspending disbelief, of inverting societal norms in the sanctuary of a movie theater. An alternative reality of moral turpitude is assumed as escapism, as if the audience is saying, "Do your best to scare me because I know it isn't really true." As a metaphor for abandonment, cannibalism scandalizes, titillates, and spellbinds.

In the context of folklore, cannibalism allows a rich re-imagining of the boundaries between the human and nonhuman, civilized and barbarian, male and female, the utopian and real. As such anthropophagy promotes not only social control but also teaches lessons about history, morality, and identity.

Cannibalism emerges in these discourses of imaginative literature and sacred history as an "otherworldly" phenomenon that is unfavorable to human survival and thus likely to command fear and respect—hence the prevalence of cannibalistic motifs in nursery rhymes. These profound pancultural similarities have led some analysts to argue that the term "cannibalism" should be reserved only for the fantasy, both European and native, of the flesh-eating "other" rather than the practice of flesh-eating.

Constructing the Practice of Cannibalism

As soon as one starts to consider questions about which peoples have eaten human flesh, one finds controversy. The main issues are the colonial history of attributions of flesh-eating as a political

form of domination; the problem of what is acceptable evidence in the context of scientific knowledge of the day; and the problems of interpreting oral, archaeological, and written evidence.

Although there is no accepted consensus on the various types of cannibalism encountered by researchers, the literature differentiates generally among a few types.

Survival cannibalism. This well-documented variant involves consumption of human flesh in emergency situations such as starvation. Some of the most famous cases are the 1846 Donner Party in the Sierra Nevada and the South American athletes stranded in the Andes in 1972, whose plight later became the subject of the film *Alive* (1993).

Endocannibalism. Endocannibalism is the consumption of human flesh from a member of one's own social group. The rationale for such behavior is usually that in consuming parts of the body, the person ingests the characteristics of the deceased; or through consumption there is a regeneration of life after death.

Exocannibalism. Exocannibalism is the consumption of flesh outside one's close social group—for example, eating one's enemy. It is usually associated with the perpetration of ultimate violence or again as a means of imbibing valued qualities of the victim. Reports of this practice suggest a high incidence of exocannibalism with headhunting and the display of skulls as war trophies. The majority of the controversies about the practice of cannibalism refer to endocannibalism and/or exocannibalism.

Evidence in the Twenty-First Century

In the popular Western imagination, knowledge and understanding of cannibals were shaped by early explorers, missionaries, colonial officers, travelers, and others. The most commonly cited accounts are those about the South American Tupinamba Indians; the Caribbean Cariba (the word *cannibal* comes from, and is a corruption of, *carrib* and *Caliban*) of St. Vincent, St. Croix, and Martinique; and the South American Aztecs. These accounts were followed by numerous reported incidences of cannibalism in Africa, Polynesia, Australia, and Papua New Guinea. These often dubious attributions of cannibalism were a form of "othering"—denigrating other people and marking



Similar to many tribes in Papua New Guinea, this group of Iwan warriors were once cannibals. While the tyranny of time often hampers these interpretive processes, the very act of attributing cannibalism to a society is now seen as a controversial political statement given modern sensitivities to indigenous peoples and cultures. CHARLES AND JOSETTE LENARS/CORBIS

a boundary between the good “us” and the bad “them.” The “primitive savage” was thus constructed as beyond the pale of civilization. As Alan Rumsey has noted, “Cannibalism has been most fully explored in its Western manifestations, as an aspect of the legitimating ideology of colonialism, missionization, and other forms of cultural imperialism” (1999, p. 105). Books that charted the travels of early explorers during the 1800s and early 1900s invariably carry titles with the term *cannibal*.

How reliable are these early accounts, and what kinds of evidence for cannibal practices do they contain or rely upon? One of the most famous commentators and critics, has concluded, “I have been unable to uncover adequate documentation of cannibalism as a custom in any form for any society. . . . The idea of the ‘other’ as cannibals, rather than the act, is the universal phenomenon” (Arens 1979, p. 139).

Many historical texts are compromised by Western prejudices, so that cannibalism emerges

more as colonial myth and cultural myopia than as scientifically attested truth. The accounts do not stand the test of modern scholarly scrutiny. Most anthropologists, however, tend to reject the argument that unless one has photographic or first-hand evidence for a practice, one cannot infer its existence at some period. Anthropologists and archaeologists rely on a host of contextual clues, regional patterns, and material-culture evidence when drawing conclusions about past social practices. What the anthropologist gains by way of notoriety may be lost by heated dispute with ethnic descendants who find the attribution of past cannibalism demeaning because of the connotations of barbarism.

The Main Disputes

Among the principal academic disputes about evidence for cannibalistic practices, two in particular stand out. First, archaeologist Tim White has conducted an analysis of 800-year-old skeletal bone

fragments from an Anasazi site at Mancos in southwest Colorado. William Arens has responded that White was seduced by the Holy Grail of cannibalism and failed to consider other explanations for the kind of perimortal bone trauma he encountered.

Second, Daniel Gajdusek found a fatal nervous disease known as *kuru* among a small population of the Fore people in Papua New Guinea. The disease is related to Creutzfeldt-Jacob, bovine spongiform encephalopathy (BSE), and Gertmann-Stausler-Scheinker syndrome. Working with anthropologists, Gajdusek claimed the disease was caught through the mortuary practice of eating the brains from dead people in Fore. Arens questioned the photographic evidence provided by Gajdusek and others. He suggested other forms of transmission by which the disease may have been contracted. The result is clashing scholarly perspectives on the historical occurrence of cannibalism.

Social Explanations and Conditions for Cannibalism

The cross-cultural evidence for cannibalism among societies in Papua New Guinea, such as the Gimi, Hua, Daribi, and Bimin-Kuskusmin, suggests it is linked to the expression of cultural values about life, reproduction, and regeneration. Flesh is consumed as a form of life-generating food and as a symbolic means of reaffirming the meaning of existence. In other areas of Papua New Guinea, the same cultural themes are expressed through pig kills and exchanges. Cannibalism was a means of providing enduring continuity to group identity and of establishing the boundaries of the moral community. But it was equally a form of violence meted out to victims deemed amoral or evil, such as witches who brought death to other people.

A second line of research has suggested that this latter exocannibalism is an expression of hostility, violence, or domination toward a victim. In this interpretation, the perpetrator eats to inflict an ultimate indignity and thus an ultimate form of humiliation and domination. The archaeologist John Kantner, reviewing the evidence for reputed Anasazi cannibalism in the American Southwest, has concluded that with the gradual reduction in available resources and intensified competition, exocannibalism became a sociopolitical measure aimed at enforcing tribal inequities. However the evidence remains hotly disputed. Skeletal trauma is

indexed by bone markings made by tools or scrapers, disarticulations, breakage patterns, and “pot polish,” blackened bone fragments suggesting abrasions caused by the boiling of bones. Such data indicate intentional and targeted defleshing of bones for the extraction of marrow. Such bone markings are quite different from mortuary bones found elsewhere in the region. Controversy surrounds these findings because other causes for the same bone markings have been proffered, including, second reburial of remains and external interference with bones by animals and natural hazards. Other scholars are therefore reluctant to impute cannibalism in the absence of any direct observation of it.

Other analysts, looking at the famous Aztec materials, have suggested that such large-scale cannibalism is related both to hunger and the appreciation of the nutritional value of flesh. In other words, cannibalism is a response to material conditions of existence such as protein depreciation and dwindling livestock. In Mesoamerica these predisposing conditions ensure that cannibalism is given a ritual rationale so that themes of renewal are manifested through flesh-eating. The evidence of perimortem mutilation is overwhelming; the inference from these data to cannibalism and its rationales remains, however, contestable and less compelling.

Conclusion

From the available evidence, scholars have gleaned a seemingly reliable historical account of how cultures have constructed and used their concepts of cannibalism to provide a stereotype of the “other.” Whatever technological advancements might yield in the way of more refined analysis of skeletal materials, proving that culture “X” or “Y” conducted cannibalism may not be quite the defining moment in human self-definition that some have thought it to be. The key insight is that in pancultural discourse and imaginative commerce, the human consumption of human flesh has served as a social narrative to enforce social control. Moreover, attributions of cannibalism remain a potent political tool wielded by those who pursue agendas of racial and ethnic domination.

The French philosopher Michel Montaigne long ago disabused society of the Western-centered notion that eating human flesh is somehow

barbaric and exotic: "I consider it more barbarous to eat a man alive than eat him dead" (1958, p. 108). How one interprets cannibalism is thus always circumscribed and inflected by a culturally shaped morality.

For many researchers, then, the issue of whether cannibalism was ever a socially sanctioned practice is of secondary importance. Developments in experts' understanding of archaeological remains include the etiology and transmission of diseases like BSE, and interpretation of oral accounts and regional patterns that will likely point to some forms of cannibalism in some past cultures, even if such findings are tempered by contemporary cultural imperatives to avoid the appearance of stigmatization of the "other."

See also: AZTEC RELIGION; SACRIFICE

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CAPITAL PUNISHMENT

The death penalty, the most severe sanction or punishment a government entity can impose on an individual for a crime, has existed in some form throughout recorded history. The first known official codification of the death penalty was in eighteenth century B.C.E. in the Code of King Hammurabi of Babylon, where twenty-five crimes could result in the ultimate sanction by the state. From then until the twenty-first century the variants of capital punishment throughout the world have included crucifixion, drowning, beating to death, stoning, burning alive, impalement, hanging, firing squads, electrocution, and lethal injection. The death penalty has been abolished in Western Europe and Japan, but its persistence in the United States has incited heated debate over its efficacy and inherent justness.

The Purposes and Effectiveness of Capital Punishment

The major rationalizations for capital punishment are retribution, deterrence, incapacitation, and rehabilitation. Obviously, the last bears no relation to the death penalty. Retribution, which argues that the state has the right to impose a level of pain and punishment equal to or greater than the pain suffered by the victim, seeks to justify the death

penalty on principle rather than efficacy in reducing crime. The notion of deterrence does make this claim imply a utilitarian purpose. There are two forms of deterrence: general and specific. The latter focuses on the individual offender, who, it is claimed, is deterred from committing future crimes by punishing him/her for previous criminal activity. The former seeks to prevent such crimes from occurring in the first place. In the case of the death penalty, the well-publicized knowledge that the state punishes some crimes by death presumably deters potential criminals. Many criminologists argue that the goal of incapacitation—removing an offender from society—can be achieved equally effectively through a life sentence without the possibility of parole (LWOP).

The results of the more than 200 studies done on capital punishment are either inconclusive or adverse to the claim that it is an effective deterrent to murder. The typical research design compares murder rates in state that have and use the death penalty with (1) those that either have not used it, although the law permits its use and (2) states that have abolished it. In general, these studies tend to show no difference in homicide rates for comparable states that with and without capital punishment. Nor is there evidence that homicide rates decline or increase as states decide to reinstate or abolish the death penalty.

Why has the death penalty been an ineffective deterrent in the United States? First, capital punishment is applied with neither certainty nor swiftness, the two key characteristics of an effective deterrent. When the death penalty is imposed, it often takes many years for the sentence to be carried out, and in some cases the sentence is not upheld. In the United States in 1999, 271 prisoners were admitted to death row, while more than 15,000 murders were reported to police. In the same year, 88 persons had their sentences overturned.

The idea of deterrence presupposes rationality and premeditation on the part of the murderer. In most murders, such factors take a backseat to non-rational influences such as rage, alcohol or drug abuse, or psychological disorder, none of which are susceptible of deterrence by death sentence. For these reasons, the most persistent and persuasive arguments for the death penalty rely on notions of just retribution and revenge by the state on behalf of the citizenry.

Opponents of the death penalty point not only to its lack of deterrent effect but also raise other key arguments. First, from a moral perspective, the abolitionists believe state executions signal that violence is an acceptable means of resolving conflicts and thus actually contribute to a climate of increased violence. Second, opponents point to the unfair and discriminatory application of the death penalty, noting the disproportionate numbers of poor people and people of color on death row, many of them having lacked vigorous and effective legal counsel. Moreover, advances in DNA analysis have exonerated enough prisoners on death row to give pause to many lawmakers who point to the ever-present possibility that the state might, for lack of adequate probative or exculpatory evidence, take the life of an innocent person. This concern has led to several U.S. states to implement a moratorium on the death penalty until it can be shown to be applied fairly to all such cases.

International Trends

Comprehensive data on the use of the death penalty for all countries is difficult to collect and verify. Most of the data presented here come from two organizations opposed to capital punishment: Amnesty International and the Death Penalty Information Center. Yet the trend is clear; more and more countries are either abolishing or placing further restrictions and limitations on capital punishment.

As of 2001, 108 countries have abolished the death penalty in law or in practice, up from 62 in 1980. Of that 108, 75 have abolished it for all crimes while another thirteen have done so for “ordinary crimes.” Another 20 have the authority to carry out this sanction but have not done so. Of those that have retained its use, the death penalty is used with regularity in the Islamic nations, in most of Asia, many parts of Africa, and the United States. The United States, Kyrgyzstan (the former Soviet republic), and Japan are believed to be the only other countries where the mentally retarded are put to death.

By far, the world’s leader in the use of the death penalty is China. In 1998 China reported more than 1,000 executions, which represented two-thirds of all executions worldwide (see Table 1). The other leading counties were the Congo, the United States, Iran, and Egypt. These

TABLE 1

| Number of executions worldwide, 1998 | | |
|--------------------------------------|--------------|---------------|
| Country | Number | Percent |
| China | 1,067 | 65.7% |
| Congo (DR) | 100 | 6.2% |
| USA | 68 | 4.2% |
| Iran | 66 | 4.1% |
| Egypt | 48 | 3.0% |
| Belarus | 33 | 2.0% |
| Taiwan | 32 | 2.0% |
| Saudi Arabia | 29 | 1.8% |
| Singapore | 28 | 1.7% |
| Sierra Leone | 24 | 1.5% |
| Rwanda | 24 | 1.5% |
| Vietnam | 18 | 1.1% |
| Yemen | 17 | 1.0% |
| Afghanistan | 10 | 0.6% |
| Jordan | 9 | 0.6% |
| Kuwait | 6 | 0.4% |
| Japan | 6 | 0.4% |
| Nigeria | 6 | 0.4% |
| Oman | 6 | 0.4% |
| Cuba | 5 | 0.3% |
| Kirgyzstan | 4 | 0.2% |
| Pakistan | 4 | 0.2% |
| Zimbabwe | 2 | 0.1% |
| Palestinian Authority | 2 | 0.1% |
| Lebanon | 2 | 0.1% |
| Bahamas | 2 | 0.1% |
| All others | 7 | 0.4% |
| Total | 1,625 | 100.0% |

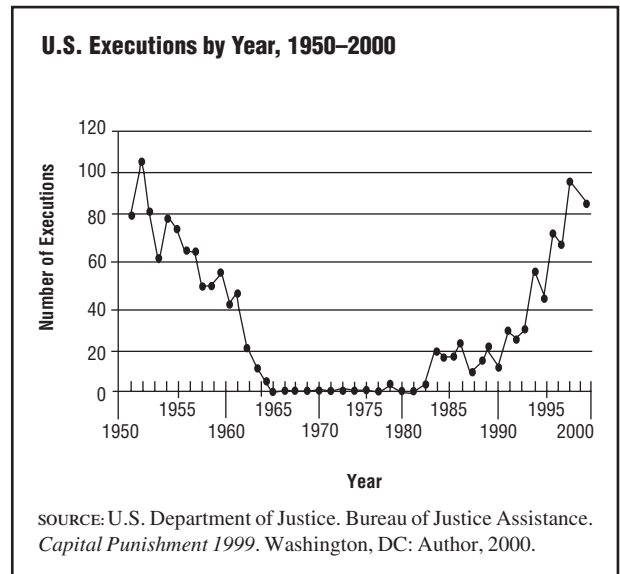
SOURCE: Death Penalty Information Center, Washington, DC. Available from www.deathpenaltyinfo.org.

five countries accounted for more than 80 percent of all executions.

The use of executions in China is even greater than these numbers would suggest. According to Amnesty International, from 1990 to 2000, China has executed 19,446 people, which compares to the 563 the United States put to death over the same period. In 1996 alone, more than 4,000 persons were put to death by China as part of its “strike hard” campaign against crime. This policy results in mass application of the death penalty for persons convicted of both crimes of violence and property crimes. For example, on June 30, 2001, four tax cheats were executed for bilking the government out of nearly \$10 million in tax rebates.

The divergence between the United States and Europe on this issue is quite striking. Prior to the 1970s, capital punishment was common in both the United States and Europe, while declining throughout the West after World War II. During the 1970s, however, the death penalty disappeared from Western Europe and it was repealed in Eastern Europe in the postcommunist regimes that

FIGURE 1



emerged beginning in the late 1980s. For example, from 1987 to 1992, East Germany, Czechoslovakia, Hungary, and Romania eradicated the death penalty, and all twelve of the Central European nations that retained the death penalty during the Soviet era have since abolished it. The Ukraine abolished its death penalty in 2000, and Russia suspended executions in mid-1999.

U.S. Trends

The death penalty has been a controversial part of the U.S. social and legal orders since the country’s founding in the late eighteenth century. Initially persons were regularly put to death by the state for a wide array of criminal acts that included murder, witchcraft, and even adultery. And up until the 1830s, most executions were held in public. Public executions continued until 1936, when 20,000 citizens observed a public execution in Owensboro, Kentucky.

Prior to the 1960s, executions were relatively frequent in the United States, averaging about 100 per year during the early postwar period and slowly dwindling to fewer than ten per year in the mid-1960s. In 1967, executions were suspended by the U.S. Supreme Court in a series of landmark decisions that, among other things, found the application of the death penalty to be “arbitrary and capricious” and inhumane. Shortly thereafter, states reformed their death penalty statutes to meet the concerns of the Court. Subsequent Court rulings

TABLE 2

| Percent distribution of executions in the United States by region, five-year intervals | | | | | | |
|--|-----------|---------------|------|-------|-------|------|
| Year | Northeast | North Central | West | South | Total | |
| | % | % | % | % | # | % |
| 1950–1954 | 14 | 10 | 16 | 60 | 407 | 100% |
| 1955–1959 | 17 | 5 | 17 | 61 | 301 | 100% |
| 1960–1964 | 9 | 9 | 25 | 57 | 180 | 100% |
| 1980–1984 | — | 3 | — | 97 | 29 | 100% |
| 1985–1989 | — | 2 | 6 | 92 | 88 | 100% |
| 1990–1994 | — | 10 | 8 | 82 | 139 | 100% |
| 1995–1999 | 1 | 14 | 9 | 76 | 341 | 100% |

SOURCE: Death Penalty Information Center, Washington, DC. Available from www.deathpenaltyinfo.org; Zimring, Franklin E., and Gordon Hawkins. *Capital Punishment and the American Agenda*. Cambridge: Cambridge University Press, 1986.

in 1976—*Gregg v. Georgia*, *Proffitt v. Florida*, and *Jurek v. Texas*—allowed the resumption of capital punishment. As shown in Figure 1, executions resumed shortly thereafter. By the late 1990s the totals were close to those of the early 1950s.

In 2001 there were approximately 3,500 prisoners under the sentence of death in the United States. Of this number, 55 percent were white and 43 percent were black. All have been convicted of murder; 2 percent received the death sentence as juveniles. Fifty women were on death row as of 2001. Fifteen states, along with the federal government, ban the execution of prisoners who are mentally retarded, but twenty-three do not. The most common form of execution is now lethal injection, which is used in thirty-four states.

The Death Penalty by Geography

Although the federal courts have played a significant role in death penalty reforms, it is also true that until the 2001 execution of Timothy McVeigh, death sentences and executions since *Gregg v. Georgia* have been solely carried out by state courts. Moreover, there is considerable variation among the states in the use of the death penalty that seems to have little to do with crime rates.

As of 2000, thirty-eight states had death penalty statutes, although only twenty-nine actually executed prisoners; of those, only a handful account for most of the executions. According to the Bureau of Justice Statistics, as of 1999, there had been 4,457 persons executed since 1930. States that have conducted the most frequent number tend to be southern states, led by Texas (496) and Georgia (389).

Conversely, Michigan was the first state to abolish the death penalty for all crimes except treason, more than a century before France and England enacted such a reform. Seven states that provide a death sentence in their statutes have not conducted any executions for more than twenty-five years. South Dakota and New Hampshire have not had executions in more than half a century. New Jersey legislated a death penalty statute in 1980 but has not applied it thus far.

As shown in Table 2, the southern states have consistently and increasingly accounted for the vast majority of U.S. executions since the 1950s. In 2000 seventy-six of the eighty-five U.S. executions were in the South, even though that region accounts for about one-third of the population and about 40 percent of the American states that authorize a death penalty. Two-thirds of all American executions in 2000 were conducted in three of the thirty-eight states that authorize executions (Texas, Oklahoma, and Virginia).

The Issue of Race and Class

A major topic revolving around the death penalty is the extent of racial and class bias in its implementation. As noted above, only very few persons convicted of murder actually receive the death penalty. This raises the important question of how decisions are reached by prosecutors to pursue punishment by death penalty. According to a recent U.S. Department of Justice study, in nearly 80 percent of the cases in which the prosecutor sought the death penalty, the defendant was a member of a minority group, and nearly 40 percent of the death penalty cases originate in nine of the

states. Another study found that the race of the victim and the race of the offender were associated with death penalty sentences.

See also: DEATH SYSTEM; HOMICIDE, EPIDEMIOLOGY OF;

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JAMES AUSTIN

CARDIOVASCULAR DISEASE

The American Heart Association (AHA) uses the term cardiovascular disease (CVD) to describe various diseases that affect the heart and circulatory system. These diseases include coronary artery (heart) disease, hypertension, congestive heart failure, congenital cardiovascular defects, and cerebrovascular disease. CVD is a chronic disease. These diseases frequently progress as people age. This article limits its discussion to the two most common forms of CVD—coronary artery disease and hypertension.

Cardiovascular disease is the leading cause of death in the United States, responsible for one death every 33 seconds or 2,600 deaths per day. In 1998 CVD claimed the lives of 949,619 Americans. The second leading cause of death, cancer, was responsible for 541,532 deaths. It is estimated that approximately 60.8 million individuals in the United States have one or more types of CVD. The most common form of cardiovascular disease is hypertension, which affects approximately 50 million Americans, or one in every four individuals. Hypertension is a significant risk factor for the

development of other types of CVD, including congestive heart failure and cerebrovascular accidents.

The second most prevalent form of CVD is coronary heart disease or coronary artery disease, which affects approximately 12.4 million individuals. Coronary heart disease includes both angina pectoris (chest pain) and myocardial infarction (heart attack). In 1998 the American Heart Association estimated that 7.3 million individuals had suffered a heart attack, and 6.4 million had experienced chest pain. The third most prevalent form of CVD is congestive heart failure, which affects 4.7 million Americans. Cerebrovascular accidents are the fourth most prevalent form of CVD, affecting 4.5 million individuals. Congenital cardiovascular defects affect 1 million Americans, comprising the fifth most prevalent form of CVD. In general, approximately one in five Americans will develop some form of cardiovascular disease in their lifetime.

Risk Factors

Risk factors for CVD may be divided into three classifications: modifiable, nonmodifiable, and contributing factors.

Modifiable factors. Modifiable risk factors are those that an individual can change, including elevated serum cholesterol levels, a diet high in saturated fats, obesity, physical inactivity, hypertension, nicotine, and alcohol use. A serum cholesterol level greater than 200 mg/dl or a fasting triglyceride level more than 200 mg/dl is associated with an increased incidence of coronary artery disease. Obesity is associated with a higher incidence of mortality from CVD. Physical inactivity increases the risk for developing CVD as much as smoking or consuming a diet high in saturated fats and cholesterol.

The National Heart Lung and Blood Institute defines hypertension as a blood pressure greater than 140/90. Hypertension is a significant risk factor for the development of CVD and stroke. The AHA estimates that one in five deaths from cardiovascular disease are directly linked to cigarette smoking. Individuals who smoke are two to six times more likely to develop coronary artery disease than nonsmokers. However, individuals who quit smoking will reduce their risk to levels equivalent to those of a nonsmoker within three years.

Nonmodifiable factors. Nonmodifiable risk factors are those risk factors that an individual cannot

change, such as age, gender, ethnicity, and heredity. The incidence of CVD increases as people age. However, 150,000 individuals die from it before 65 years of age. Males are more likely than females to experience CVD, until the age of 65, when the incidence rate equalizes among genders. Young men aged 35 to 44 years old are more than six times as likely to die from CVD than their same-age female counterparts. However, the death rates equalize after 75 years of age. Furthermore, women may experience different symptoms of CVD than those experienced by men, thus causing women to be underdiagnosed or diagnosed at a more advanced stage of the disease.

Ethnicity also plays a role in the development of CVD. Non-Hispanic black males have a higher age-adjusted prevalence of CVD than Caucasian or Mexican-American males. Black and Mexican-American females have a higher age-adjusted prevalence of CVD than Caucasian females. Overall, middle-aged Caucasian males have the highest incidence of heart attacks.

Heredity may also play a role in the development of CVD. Individuals with a family history of early heart disease are at a greater risk for the development of elevated blood lipid levels, which has been associated with the early development of coronary artery disease. Additionally, most individuals who have experienced either chest pain or a heart attack can identify a close family member (father, mother, brother, or sister) who also had or has CVD. It is expected that the role of genetics and heredity will be more fully understood in the future due to the advances associated with the human genome project.

Contributing factors. Contributing factors are those factors that may increase the risk for developing cardiovascular disease. Diabetes mellitus and a stressful lifestyle are examples of contributing factors. Diabetics are more likely than the general population to experience CVD. Additionally, they experience coronary artery disease at an earlier age than the nondiabetic individual. Two-thirds of individuals with diabetes mellitus die from some form of heart or blood vessel disease.

The role of stress in the development of coronary artery disease is not clearly understood. Historically it was believed that individuals with a type A personality were at a greater risk for the development of CVD. However, the research findings

were mixed and did not clearly support this relationship. Stress may also increase the process of atherogenesis (formation of plaque in arteries) due to elevated lipid levels.

Treatments

Ischemic CVD, such as angina pectoris and myocardial infarction, are usually diagnosed based on patient symptoms, electrocardiogram findings, and cardiac enzyme results. Additionally, coronary angiography may be performed to visualize the coronary arteries and determine the exact location and severity of any obstructions. Coronary artery disease can be treated using medical treatments, surgical treatments, or interventional cardiology. The treatment goal for ischemic CVD is to restore optimal flow of oxygenated blood to the heart.

Medical treatment for the patient with angina includes risk factor modification, consumption of a diet low in saturated fats and cholesterol, and administration of pharmacological agents. Medications commonly used to treat chest pain or heart attacks include drugs that decrease cholesterol levels, alter platelet aggregation, enhance the supply of oxygenated blood to the heart, or decrease the heart's need for oxygenated blood. Additionally, the person experiencing an acute anginal attack or a heart attack may also receive supplemental oxygen. Thrombolytic medications may be used to treat a patient experiencing a attack, as they may dissolve the blood clot, thus restoring blood flow to the heart.

The blood flow to the heart may also be restored surgically though the use of a common procedure known as coronary artery bypass grafting (CABG). This procedure bypasses the obstructed coronary artery or arteries, thus restoring the flow of oxygenated blood to the heart. Women have poorer surgical outcomes after coronary bypass surgery than men. Specifically, women have a higher relative risk of mortality associated with CABG, longer intensive care unit stays, and more postoperative complications than men.

Nonsurgical revascularization techniques, such as percutaneous transluminal angioplasty, transmyocardial laser revascularization, or the placement of stents in the coronary arteries, are techniques to restore the flow of oxygenated blood to the heart. Percutaneous transluminal angioplasty involves the

insertion of a balloon-tipped catheter into the coronary artery, and inflating the balloon at the location of the vessel obstruction. The balloon widens the blood vessel, restoring blood flow through the obstructed vessel. A wire mesh stent may be inserted into the coronary artery and placed at the location of the obstruction. The stent provides an artificial opening in the blood vessel, which helps to maintain the flow of oxygenated blood to the heart. Transmyocardial laser revascularization is a procedure that uses a laser to create channels in the heart to allow oxygenated blood to reach the heart, and is generally used when other techniques have failed.

Research into the efficacy of cardiac gene therapy is being studied to determine how to eliminate heart disease by replacing malfunctioning or missing genes with normal or modified genes. Gene therapy may be used to stimulate the growth of new blood vessels, prevent cell death, or enhance functioning of genes.

Hypertension is initially treated by behavioral and lifestyle modifications. If these modifications do not successfully manage the individual's hypertension, pharmacological agents are added. The lifestyle modifications recommended to control hypertension include diet, exercise, and weight reduction for the overweight individual. The recommended dietary modifications include increasing consumption of fruits, vegetables, low-fat dairy products, and other foods that are low in saturated fat, total fat, and cholesterol. Furthermore, the individual with hypertension is advised to decrease intake of foods high in fat, red meats, sweets, and sugared beverages. It is advisable for hypertensive individuals to decrease their intake of sodium to less than 1,500 mg/day. Not adding table salt to foods and avoiding obviously salty foods may accomplish this restriction. Doctors suggest that hypertensive individuals limit their consumption of alcohol to one to two drinks per day, and decrease or stop smoking. Smoking causes hardening of the arteries, which may increase blood pressure.

Various classes of pharmacological agents may be used to treat hypertension. They include drugs that relax the blood vessels, causing vasodilation, thus decreasing blood pressure, such as angiotensin converting enzyme inhibitors, calcium channel blockers, angiotensin antagonists, and vasodilators. Drugs such as alpha- and beta-blockers

decrease nerve impulses to blood vessels, and decrease the heart rate, slowing blood flow through the arteries, resulting in a decreased blood pressure. Diuretics may also be used to manage hypertension. They work by flushing excess water and sodium from the body, causing a decrease in blood pressure.

Reoccurrence

Coronary artery disease and hypertension are both chronic diseases that require lifelong treatment. Frequently, interventional cardiology techniques and surgical procedures produce palliative rather than curative results. For example, percutaneous transluminal angioplasty fails in six months in approximately 30 to 60 percent of the cases, resulting in restenosis of the blood vessel. Additionally, 50 percent of the grafts of patients who have undergone coronary artery bypass surgery reocclude within five years. Once this has occurred, the patient may be required to undergo additional procedures or surgery.

Individuals who have experienced a heart attack are at a significantly greater risk for future cardiovascular morbidity and mortality. The death rates for people after experiencing a heart attack are significantly higher than the general public. Twenty-five percent of males and 38 percent of females will die within one year of experiencing a heart attack. Additionally, morbidity from cardiovascular disease is higher in individuals who have previously experienced a heart attack. Two-thirds of all heart attack patients do not make a full recovery. CVD is progressive: Twenty-two percent of males and 46 percent of females who previously experienced a heart attack are disabled with heart failure within six years.

Hypertension increases the rate of atherosclerosis, resulting in common complications such as hypertensive heart disease, cerebrovascular disease, peripheral vascular disease, nephrosclerosis, and retinal damage. Uncontrolled hypertension is strongly correlated with the development of coronary artery disease, enlargement of the left ventricle, and heart failure. Additionally, hypertension is a major risk factor for the development of stroke and end stage renal disease.

See also: CAUSES OF DEATH; NUTRITION AND EXERCISE

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BRENDA C. MORRIS

CATACOMBS

Burial places for the dead come in a variety of forms. One ancient form is the catacomb, an underground city of the dead consisting of galleries or passages with side recesses for tombs. A related form is the ossuary, a Native American communal burial place or a depository (a vault, room, or urn) for the bones of the dead.

Catacombs originated in the Middle East approximately 6,000 years ago. These earliest examples were often secondary burials where the bones of the dead were placed in ossuary containers. Initially, the dead were buried within settlements, but with the progressive urbanization of the ensuing millennia, burials moved outside of the towns. From 3300 to 2300 B.C.E., several generations of one family were typically buried in a single cave, whether natural or artificial. Pastoral nomads also used caves that were entered through a vertical shaft. Multiple interments in caves continued over succeeding millennia, together with other forms of burial. There is evidence of the use of long subterranean channels and spacious chambers by about 1500 B.C.E. By the time of the Assyrian and Babylonian conquests of Israel and Judah, some burial caves were quite large and elaborate.

After the Roman conquest of Palestine, many Jews settled in Rome and adapted the burial customs of the Middle East to their new environment. In contrast to the Roman practice of cremation, the Jews buried their dead in catacombs they created for this purpose. Jewish catacombs can be recognized by inscriptions of the menorah, the seven-branched candlestick, on gravestones and lamps. Used only for burials, they are not as elaborate as the later multipurpose Christian catacombs.

Early Christians were regarded as a Jewish sect, and their dead were buried in catacombs modeled on those of the Jews. Early Christian martyrs buried in the catacombs became objects of veneration, so that the wish for burial near these martyrs ensured the continued use of the catacombs until the early fifth century C.E., when the Goths invaded. In the eighth and ninth centuries the remains of the martyrs were moved to churches, and the catacombs fell into disuse; by the twelfth century they were forgotten. Since their rediscovery in 1578, they have been the object of constant excavation, exploration, and research. Although the Roman catacombs are the best known, others have been found throughout Italy (in Naples, Chiusi, and Syracuse), in North Africa (in Alexandria and Susa), and in Asia Minor.

A vast literature describes and discusses the Roman catacombs. Because interment was forbidden within the boundaries of the city, these catacombs are all found outside the city. From the fourth century, consistent with the cult of martyrs,



Loculi, shelves for remains, can be seen in the ancient catacombs of St. Sebastian in Rome. ALINARI-ART REFERENCE/ART RESOURCE

the catacombs served not only as tombs but also for memorial services.

A first level of the catacombs is from thirty-three to forty-nine feet below the surface, with galleries ten to thirteen feet high; sometimes there are three or even four levels. Niches for the bodies line the passages. The walls and ceilings, made of plaster, are generally painted in the fresco manner—with watercolors before the plaster is dry. From about the fourth century C.E., shafts were dug from the galleries to the surface to provide light and air.

The inscriptions reflect the changing values of society. As conversions to Christianity became more common, nobler names appeared more frequently. With the gradual decline of slavery, there were fewer distinctions noted between slaves and freed men.

Catacombs, primarily a curiosity and tourist attraction in the twenty- and twenty-first centuries, are sparsely written about in fiction. However, one example by Arthur Conan Doyle, the creator of Sherlock Holmes, is “The New Catacomb,” a story of two young colleagues, one extremely shy, the other a womanizer, both noted experts on catacombs. The womanizer has enticed a young woman away from an unknown fiancé, then abandoned her. The shy one tells the other of a new catacomb he has discovered, which will make him famous, and offers to show it to him. Deep in the labyrinth he leaves his colleague to die in the dark, informing him that it was his own fiancé who had been abandoned.

See also: BURIAL GROUNDS; CHARNEL HOUSES; CHRISTIAN DEATH RITES, HISTORY OF

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SAM SILVERMAN

CATHOLICISM

In Roman Catholicism, death has been understood primarily in terms of an issue of justice. Having turned away from God, humans are deprived of the life-giving energy that they need and which is to be found solely in God. Death, then, is both a sign of and an effect of human estrangement from God. The radical character of this consequence mirrors the radical character of human (intended) dependence upon God for identity and existence. For some Catholic theologians in the past, death is the most symmetrical consequence of a desire for ontological independence, as death reveals the fundamental limitation of that very ontology. In the very early Church, Catholics were encouraged to reject any fear of death, as it seemed to express too great an attachment to the life of "this world." But by the end of the fourth century, fear of death was understood as an internal sign that something about the way things were—the cosmic order—was indeed wrong. As a pedagogic device, then, the fact of death should teach humility; fear of death is the beginning of a wise appreciation of human fragility. "Death" became an ascetic metaphor for selflessness and the end of pride.

If death is the greatest sign of human dislocation, it is the punishment for the act of will that produced the fundamental dislocation—sin. Traditional Catholic theology emphasized the just character of the punishment, in part to explain why the sentence of human mortality could not be simply overturned. Human explanation of the efficacy of

the incarnation—God becoming human—and crucifixion has been that the unjust death of Jesus, the Son of God, ended the just claim death had upon humanity. In his resurrection, Jesus was thus the physician who dispensed the "medicine of immortality." The incarnation, crucifixion, and resurrection reveal something about God as well, namely that the old punishment was overturned "not through power," as St. Augustine put it, "but through humility."

As a community, Catholics live and die with the ambivalence typical of the modern world: A loved one's death is a great loss and an occasion of intense trauma, and must be acknowledged as such. Death is also a great transition for the deceased, who exchanges penalty for reward, replacing estrangement from God with fellowship. To deny grief is to deny what the experience of death teaches; to deny hope is to deny what the resurrection offers.

See also: CHRISTIAN DEATH RITES, HISTORY OF; HEAVEN; HELL; JESUS; PROTESTANTISM; PURGATORY

MICHEL RENE BARNES

CAUSES OF DEATH

Data on the causes of death provide an important source of information on death. Such data are crucial for monitoring the reasons why people die and for targeting where, when, and how health resources should be expended. Causes of death can be categorized as proximate and non-proximate. Proximate (or immediate) causes of death are those that finally lead to death; for example, heart disease or cancer. Non-proximate causes of death are the factors that increase the likelihood of experiencing one of the proximate causes. For example, tobacco smoking is a non-proximate cause of death due to its link to lung cancer (a proximate cause). Non-proximate causes are the risk factors for dying from a particular proximate cause. Almost always the proximate causes of death are presented in discussions of death causation; this likely reflects the dominance of Western biomedicine in the conceptualization of cause of death.

The proximate causes of death are themselves further broadly categorized as: infectious and

parasitic diseases (deaths of infants and maternal mortality are usually included in this category); chronic and degenerative diseases; and deaths due to injury (accidents, homicide, suicide). This distinction (and particularly the difference between infectious/parasitic diseases and chronic/degenerative diseases) figures prominently in later sections of this entry. The following commentary focuses upon proximate causes of death, unless specified otherwise.

Measurement of Causes of Death

Deaths are classified using a standard coding system called the ICD (International Classification of Deaths), which has been organized and published by the World Health Organization since 1946. The ICD is revised periodically (approximately every ten years) to reflect changes in medical and epidemiological knowledge and in the light of diseases that are either new or of growing importance as takers-of-life, such as HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) and the cognitive dementias such as Alzheimer's disease. The tenth revision, which became effective in 1999, categorizes deaths into seventeen very broad categories. These are: (1) infectious and parasitic diseases; (2) neoplasms; (3) endocrine, nutritional, and metabolic diseases and immunity disorders; (4) diseases of the blood and blood-forming organs; (5) mental disorders; (6) diseases of the nervous system and sense organs; (7) diseases of the circulatory system; (8) diseases of the respiratory system; (9) diseases of the digestive system; (10) diseases of the genitourinary tract; (11) complications of pregnancy, childbearing, and the puerperium; (12) diseases of the skin and subcutaneous tissue; (13) diseases of the musculoskeletal system and connective tissue; (14) congenital anomalies; (15) certain conditions related to the perinatal period; (16) symptoms, signs, and ill-defined conditions; and (17) external causes, injury, and poisoning. These broad categories are similar to the ninth revision.

Within each category are several specific classes that are further divided into particular diseases, disease sites, or conditions. For example, circulatory diseases are further broken down into ischemic (coronary) heart disease and cerebrovascular diseases, among others, which are further divided into more detailed causes. External causes

are divided into accidents (further broken down by type), suicides (detailing several methods), and homicides. It is in the specificity of these subcategories that the ninth and tenth revisions differ most. While the ninth revision contains about 4,000 codes, the tenth revision contains nearly twice as many—approximately 8,000. Thus, users of the tenth revision are able to obtain much more finely tuned information.

Measurement Limitations

In theory the ICD is a very useful tool in the analysis of trends and differentials in cause of death and in the assessment of progress in overcoming life-threatening diseases and conditions. In practice, however, the ICD contains a number of limitations. First, cross-national comparisons are affected by variations in data quality. These variations result from differences in the diagnostic skill and type of training of the certifying medical attendant or coroner, in the accuracy of the diagnosis recorded on the death certificate, and in the accurate coding of the information. At an even more fundamental level, the ICD is based on a number of assumptions (e.g., that medical personnel are present at or near a death, that deaths are recorded by medical personnel, that there are death certificates) that do not necessarily hold for less developed countries and/or in times of social and political upheaval, such as war. Thus, while ICD data are accurate for Western countries (and Eastern countries with a high level of economic development, such as Japan), they are not as accurate for less well developed countries. If countries do not have the infrastructure to systematically record causes of death (or even deaths), then no classification system will create high-quality data. Thus, cause of death data for less developed countries are "best estimates" only.

A second limitation is that ICD categories are based on a single cause of death. This is the "underlying" cause that is deemed by the medical examiner to have generated the sequelae leading to death. For populations in developed countries, in which most deaths occur in old age and in which multiple causes are often involved, a classification system based on a single cause of death can result in a distorted picture of mortality causation. At the same time, deaths due to HIV/AIDS may be underestimated since the disease lowers immunity and it may appear that the individual

died from another infectious disease, such as pneumonia.

Third, trend analysis can be affected by changes over time in the ICD categories themselves. An apparent increase or decrease in a cause of death may be the result of a coding/classification change only. While changing categorization is necessary given advances in knowledge and transformation in disease patterns, a downside is that some distorted trends may emerge. Thus, any analyst of cause of death trends must be aware of ICD changes that could lead to findings that are merely artifacts of reclassification.

A fourth limitation is that a new cause of death may be uncategorized, which occurred in the case of HIV/AIDS. The ninth revision became effective in 1979, before medical professionals were aware of HIV/AIDS, and the tenth revision was not implemented until 1999 (the usual ten-year interval in revisions did not occur). In the interim, AIDS/HIV emerged as an important taker-of-life. In response to this epidemic, in the 1980s the United States began to include HIV/AIDS as a separate cause of death. However, this initiative was a national one, and as such included deaths to U.S. residents only. Given the crisis, in 1996 the United Nations, through UNAIDS, took on the task of globally monitoring the number of cases of the disease and deaths due to it. (In the 1980s, the World Health Organization attempted this, but the growing enormity of the undertaking led to the need for a larger, United Nations-coordinated effort.)

Causes of Death in International Context

The more developed and less developed countries differ significantly in causes of death; hence a global summary of causes of death is not useful. As shown in Table 1, the distribution of causes of death is markedly different in the two areas of the world. In the developed countries, diseases of the circulatory system and cancer (both associated with advanced age) are the chief takers-of-life, accounting for approximately two-thirds of all deaths. In contrast, these diseases account for only one-third of deaths in the less developed world. Infectious and parasitic diseases—which often attack young people—are the major killers in the third world, making up 43 percent of deaths. Another important contrast lies in deaths associated with childbirth (both deaths to infants and to

mothers), which make up 10 percent of deaths in less developed countries but only 1 percent in more developed countries. Overall, it can be concluded (keeping in mind that cause of death information for the non-Western world is plagued with data quality problems) that the chronic and degenerative diseases associated with old age predominate in the West, whereas the infectious and parasitic diseases (along with childbirth-related deaths) associated with much younger ages prevail in less developed countries.

Epidemiologic Transition

The observation of this global dichotomy in causes of death led to the theory of epidemiologic transition—a three-stage model proposed in 1971 and based on the Western experience—that deals with changing mortality levels and causes of death. It is less a theory than it is a description of mortality decline and accompanying changes in causes of death as experienced in Western populations. Its basic premise is that a society or population goes through three mortality stages. The title of the first stage—The Age of Pestilence and Famine—is self-evident; this stage is characterized by high death rates that vacillate in response to epidemics, famines, and war. Epidemics and famines tend to go hand in hand, since malnourished people are particularly susceptible to infectious diseases. In the second stage, The Age of Receding Pandemics, death rates start to steadily decline and the proportion of deaths due to infectious diseases decreases as a result of the improved nutrition and sanitation and medical advances that accompany socioeconomic development. Eventually, the third stage is reached—The Age of Degenerative and (Hu)man-Made Diseases—in which death rates are low (life expectancy at birth is over seventy years) and the chief takers-of-life are chronic diseases associated with aging, such as cardiovascular disease and cancer. It is implicitly assumed that infectious and parasitic diseases become less and less important, and that causes of death in the less developed countries will eventually come to be like those in the West.

There is little doubt that the epidemiologic transition model generally holds for the Western case, at least for the time period from the agricultural revolution until the late twentieth century. Prior to the agricultural revolution, it is highly likely that malnutrition (starving to death) was a

TABLE 1

| Estimated number of deaths worldwide resulting from fifteen leading causes in 1998 | | | |
|---|--|--|--|
| Rank | Males | Females | Both sexes |
| 1 | Ischaemic heart disease 3,658,699 | Ischaemic heart disease 3,716,709 | Ischaemic heart disease 7,375,408 |
| 2 | Cerebrovascular disease 2,340,299 | Cerebrovascular disease 2,765,827 | Cerebrovascular disease 5,106,125 |
| 3 | Acute lower respiratory infections 1,753,220 | Acute lower respiratory infections 1,698,957 | Acute lower respiratory infections 3,452,178 |
| 4 | Chronic obstructive pulmonary disease 1,239,658 | HIV/AIDS 1,121,421 | HIV/AIDS 2,285,229 |
| 5 | HIV/AIDS 1,163,808 | Diarrhoeal disease 1,069,757 | Chronic obstructive pulmonary disease 2,249,252 |
| 6 | Diarrhoeal disease 1,149,275 | Perinatal conditions 1,034,002 | Diarrhoeal disease 2,219,032 |
| 7 | Perinatal conditions 1,120,998 | Chronic obstructive pulmonary disease 1,009,594 | Perinatal conditions 2,155,000 |
| 8 | Trachea/bronchus/lung cancers 910,471 | Tuberculosis 604,674 | Tuberculosis 1,498,061 |
| 9 | Tuberculosis 893,387 | Malaria 537,882 | Trachea/bronchus/lung cancers 1,244,407 |
| 10 | Road-traffic injuries 854,939 | Measles 431,630 | Road traffic injuries 1,170,694 |
| 11 | Interpersonal violence 582,486 | Breast cancers 411,668 | Malaria 1,110,293 |
| 12 | Malaria 572,411 | Self-inflicted injuries 382,541 | Self-inflicted injuries 947,697 |
| 13 | Self-inflicted injuries 565,156 | Diabetes mellitus 343,021 | Measles 887,671 |
| 14 | Cirrhosis of the liver 533,724 | Trachea/bronchus/lung cancers 333,436 | Stomach cancers 822,069 |
| 15 | Stomach cancers 517,821 | Road traffic injuries 315,755 | Cirrhosis of the liver 774,563 |

SOURCE: Violence and Injury Prevention, World Health Organization. *Injury: A Leading Cause of the Global Burden of Disease*, edited by E. Krug. Geneva: World Health Organization, 1999.

more important killer than infectious diseases. Once agriculture predominated, the denser settlement pattern of humans as well as closer proximity to animals and animal waste contributed to the spread of infectious diseases. One of the most well-known examples of epidemic-caused loss of life in the West was the Black Death (the plague) that hit hardest in the middle of the fourteenth century but which continued to reoccur for more than

three centuries. By the eve of the Industrial Revolution, the plague had virtually disappeared in Europe, as a result of changes in shipping, housing, and sanitary practices that affected the way that rats, fleas, and humans interacted. Other types of infectious diseases (such as cholera, influenza, smallpox, pneumonia) remained important killers, and were eventually conquered by improved nutrition, hygiene, and public health measures, and knowledge thereof. Medical advances played a small role, although the smallpox vaccine was important until well into the twentieth century. As we move into the twenty-first century, however, advances in bioterrorism (such as the post-September 11th anthrax assault in the U.S.) may lead to increasing deaths from infectious diseases).

The epidemiologic transition model applies less well to the developing world. Western mortality decline, and the changing configuration of causes of death associated with it, was fueled by socioeconomic development. In contrast, in third world countries, there is a much smaller relationship between morality and development. In the postwar decade of the 1950s, mortality declines in many third world countries were substantial. In those cold war years, the West (largely the United States) imported public health measures and death-reducing technologies to many less developed countries. As a result, deaths due to infectious diseases fell dramatically in the absence of any significant development.

However, probably the biggest challenge to epidemiologic transition theory comes from the emergence of new, and the reemergence of old, infectious diseases in the latter part of the twentieth century. This has led to debate about epidemiologic transition theory's end stage. Is the third stage the final one? A number of fourth states have been proposed by epidemiologists and demographers. The most popular is the Age of Delayed Degenerative Diseases, corresponding to declines in death rates due to cardiovascular disease experienced in Western countries through the 1970s and 1980s. This stage corresponds with the "compression of morbidity" hypothesis proposed by James Fries, stating that the future holds quick deaths due to degenerative diseases at very old ages. In other words, the typical death will be from a sudden heart attack at approximately age eighty-five, before which one was healthy and hearty. However, now a radically different fifth stage is being proposed in light of

increasing death rates due to viruses and bacteria. Indeed the anthropologist Ronald Barrett and his colleagues at Emory University view the trend of increasing mortality due to infectious disease as characterizing a new epidemiologic transition altogether. Others, such as Christopher Murray and Alan Lopez, taking both death and disability into account, argue that noncommunicable diseases will take on increasing importance in the “global burden of disease” (Murray and Lopez, 1996).

The emergence of new infectious and parasitic diseases (AIDS/HIV, Legionnaires’ disease, Lyme disease), the reemergence of diseases (smallpox, malaria) that scientists thought had been conquered, and the evolution of antibiotic-resistant strains of bacteria have led to a reappraisal of the possible future role of microbes in mortality. While it does not seem likely that infectious and parasitic diseases will overtake degenerative and chronic diseases as killers, it is difficult to predict the relative importance of the two major categories of death causation in the future. Much appears to depend on how successful medical professionals will be in controlling HIV/AIDS, which is estimated to have taken anywhere between 1.9 million and 3.6 million lives worldwide in 1999 alone. (Given the depression of the immune system that comes with AIDS, it is possible that even the high estimate is low; some persons with AIDS might be counted as dying from another infectious disease to which they are vulnerable.)

Proximate and Non-Proximate Causes of Death in the United States

Table 2 presents the five leading proximate and non-proximate causes of death in the United States. Of the proximate causes, the top four are the classic degenerative diseases associated with aging; the fifth cause is accidents. The non-proximate causes (the risk factors) provide a different lens through which to view death causation. The top three non-proximate causes include tobacco smoking, diets rich in sodium, cholesterol and fat in conjunction with sedentary lifestyles, and excessive alcohol drinking (which is, of course, implicated in accidental deaths as well as in degenerative conditions such as liver disease). The fourth non-proximate cause of death is microbial agents; that is, viruses and bacteria. While some proximate causes of death (such as HIV/AIDS and pneumonia) are directly linked to viruses/bacteria, research indicates that

TABLE 2

| Leading causes of death | |
|---|--|
| Five leading proximate causes of death in the United States, 1998 | Five leading non-proximate causes of death in the United States, 1990s |
| 1. Heart disease | 1. Tobacco |
| 2. Cancer | 2. Diet/activity patterns |
| 3. Stroke | 3. Alcohol |
| 4. Chronic obstructive pulmonary disease | 4. Microbial agents |
| 5. Accidents | 5. Toxic agents |

SOURCE: Adapted from National Center for Health Statistics. *Final Data for 1998: National Vital Statistics Report*, 48, no. 11. Hyattsville, MD: National Center for Health Statistics, 2000; McGinnis, J. M., and W. H. Foege. “Actual Causes of Death in the United States.” *Journal of the American Medical Association* 270 (1993):2208.

some of the degenerative diseases, such as liver disease and cancers, have microbial causes. In fact, the classic dichotomy between infectious/parasitic diseases, on the one hand, and chronic/degenerative diseases, on the other hand, is being questioned by scientists. Microbes can both cause degenerative disease and increase peoples’ susceptibility to them. Since this dichotomy is foundational to epidemiologic transition theory, health researchers are rethinking historical change in causes of death (both proximate and non-proximate).

All of the non-proximate causes of death listed in Table 2 are preventable through public health measures and education. However, this does not mean that all deaths can be prevented. While the researchers Michael McGinnis and William Foege estimate that 50 percent of deaths are due to preventable causes, eliminating these causes would not lower mortality by 50 percent. People are at multiple risk of death at all times, and eliminating one cause of death does not necessarily lower the risk of dying from some other cause. Nevertheless, it is true that healthy behaviors with regard to drinking, eating, smoking, and exercise increase the probability of living longer. However, individuals can only do so much; ultimately, public health measures are critical to mortality level and cause.

See also: AIDS; CARDIOVASCULAR DISEASE; MORTALITY, INFANT; LIFE EXPECTANCY; MORTALITY, CHILDBIRTH

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ELLEN M. GEE

CELEBRITY DEATHS

In 1999 nearly 100 people showed up at the Hollywood Forever Cemetery to visit the grave of the silent-screen heartthrob Rudolf Valentino on the seventy-third anniversary of his death. When the victim of acute peritonitis was buried at age thirty-one in 1926, 80,000 people showed up for the funeral. A pandemic of mass hysteria followed; dozens of women committed suicide.

In 1997 some 50,000 people gathered in Memphis to observe the twentieth anniversary of the death of Elvis Presley. The all-night candlelight vigil occurred during the same month that Britain's Lady Diana, Princess of Wales, died in a Paris automobile accident; her death engendered more column inches in Britain's largest newspapers than the most dramatic stages of World War II. Her funeral, broadcast to 180 countries, attracted history's largest television audience.

What accounts for the magnitude and emotional reactions to celebrity deaths? Does it involve some identification the public has with these individuals, or does the surfeit of mass-media attention create its own audience? Being unconsciously imitative, do we cry because mass mediums overwhelm us with images of weeping family and friends? Because grief involves some form of loss, it is necessary to begin with the connections individuals have with celebrities.

On Celebrity

The essence of celebrity involves the focusing of public attention on select individuals. These recipients may be heroes who embody society's notion of goodness or villains who embody its notion of evil—for example, John Wilkes Booth, Adolf Hitler, or serial killer Ted Bundy. Or they may, like game show hosts or publicized socialites, be simply "well-known for [their] well-knowingness" (Boorstin 1962, p. 57). Such attention giving often does not end with death and, in fact, may even be enhanced, as evidenced by the post-mortem attention given to such rock stars as Buddy Holly and Ritchie Valens.

The rise of celebrities corresponds with the evolution of mass media and changes in public appetite for the stories of others. Leo Braudel has



Graceland in Memphis, Tennessee, was the home of celebrity Elvis Presley for 20 years until his death in 1977. It is now one of the most popular tourist attractions in the United States, visited by thousands each year on the anniversary of Presley's death. CORBIS

noted, “As each new medium of fame appears, the human image it conveys is intensified and the number of individuals celebrated expands” (1986, p. 4). The ubiquity of mass-media images creates familiarity with such persons, forming novel attachments and identifications between them and the general public.

The rise of celebrity also corresponds with a public increasingly devoid of total relationships with others, individuals’ connectedness with others and the broader society dampened by the anonymity of urban life, reduced civic involvements, increasing rates of singlehood and living alone, and by the instrumental relationships demanded by the workplace and marketplace. Further amplifying appetites for celebrities’ stories is the new personality type populating the social landscape, characterized by sociologist David Riesman as being “other-directed,” relying on others to define one’s own lifestyles and beliefs—particularly those publicly identified as living more interesting, glamorous, or important lives. Thus the public may know more about the celebrities’ stories than they do of those of their neighbors and associates.

The grief over the death of a national leader can be understood in terms of feelings of loss of

some father figure or of the symbol of a people. Broadly shared emotions produce a sense of community. Political regimes have long understood this and have capitalized on the power of state funerals as a mechanism by which to enhance social solidarities and to reaffirm the legitimacy of the power structure.

But the grief over celebrities like Valentino or James Dean (a screen idol of the early 1950s) is another matter. Here the sense of loss is more like that of a friend because these are not so much role models as reflections of who we are or who we want to be. These are individuals whom one has paid to see or who have been frequent televised “guests” in one’s home.

People identify with their artists, whose gift, in part, is their ability to capture mass longings in art. Such individuals are generational totems, reflecting the identities and ideals of those who share their age. People grow old with them and project their own hopes and fears on to them. They imagine what they would do with virtually limitless resources if placed in similar circumstances. And when celebrities die so does a portion of their admirers; hence the appearance of the SuperNova card company, which markets thousands of celebrity condolence cards.

With the rise of celebrity tabloids, people are able to get even closer to the everyday lives of their favorite celebrities. There is an attraction to those whose private lives increasingly overlap with their public images, revealing ordinary human chinks in the armor of idolatry. And, in a curious twist of the economics of adulation, their mystique increases in proportion to the privacy they seek, as was the case with Charles Lindbergh, Greta Garbo, and Jackie Kennedy.

Public Deaths in a Death-Denying Culture

In a society where, as Philippe Ariès observed, death is a cultural taboo and where most deaths occur hidden away in institutional settings, Americans' death knowledge is increasingly learned secondhand from the mass media. The styles in which celebrities die and grieve are matters of considerable interest. From the tabloids people learned of Jackie Kennedy's stoicism following the assassination of her first husband, and of her own efforts to die with dignity a quarter century later. With rapt attention they followed the death trajectories and good-byes of Michael Landon, Frank Sinatra, and Jimmy Stewart. Not only do the deaths of actors become "news," but so do the "deaths" of the characters they portray. On television, for instance, the demise of phased-out characters is a well-established tactic for enhancing ratings, such as Lt. Col. Henry Blake (McLean Stevenson) from *M.A.S.H.* or Bobby Ewing (Michael Duffy) from *Dallas*.

The more grisly the celebrities' demise, the more morbid the curiosities aroused, a syndrome that produces a lucrative market for death-scene mementos. When the body of the Lindbergh son was found two months after being kidnapped in 1932, reporters entered the morgue and broke into his casket to photograph the mangled remains. Prints were sold on the streets of New Jersey for five dollars each. A reported \$5,000 was paid by the *National Enquirer* for the morgue photograph of John Lennon's corpse. In 1994 Post Mortem Arts was selling copies of Kurt Cobain's death certificate for twenty-five dollars. And in Los Angeles, during the 1990s, Graveline Tours transported curious fans in a classic hearse to view the places where stars were murdered, committed suicide, or were laid to rest.

In addition to their growing control over the traffic of death symbolizations, the media have

expanded the traditional ability of the arts to confer immortality on their creators and performers. Because of film, for instance, one can still see and listen to Thomas Edison and George Bernard Shaw, men who were teenagers during the U.S. Civil War. And as the power of celebrity is transferred in endorsements, so too can it transcend death. A great-great-great grandfather is remembered because he served with Ulysses S. Grant; the other great-great-greats who had no such associations are typically forgotten. This logic entered the decision of an Austrian novelty firm to approach Mick Jagger in 1988 for permission to market his cremated remains in million-dollar hourglasses.

A final cause of interest in celebrity deaths entails the perverse satisfaction in outliving such august personages, a feeling enhancing one's own illusions of personal immortality. The motivation for producing such books as *They Went That-A-Way: How the Famous, the Infamous, and the Great Died* clearly caters to such needs for identification rather than to any authentic personal grief.

How the Timing of a Celebrity's Death Affects Grief and Immortality

In the death-denying United States there is a search for cultural scripts for the dying—guides to dying well. There is a fascination with the premature deaths of immortals (or their relations) fueled by Hollywood and the press. The degree of public mourning following the deaths of Lady Diana and John F. Kennedy Jr. led social observers to wonder if grief is an ever-present latent feeling just waiting to be exploited by the political elite, if people's lives are so empty that they engage in recreational grief, or whether empathic fusions of self with certain celebrities can be so great that the grief is as authentic as that experienced with the loss of a family member. Perhaps individuals are emotive puppets manipulated by the mass media and/or political elite, and people cry because they are shown other people crying for a celebrity.

In the case of JFK Jr. the grief was not for the man, whose accomplishments were quite modest when compared to his father and whose death was blamed on his own poor judgment, but rather for the young boy saluting the funeral cortege of his slain father. Public mourning was extensively orchestrated. The president authorized the use of a

naval warship to conduct his burial at sea, even though Kennedy had never served in the military. Hours of prime television time were devoted to long-distance camera shots of grieving family members and of the vessel from which his ashes were scattered.

The untimeliness of a celebrity's demise cannot only provoke extreme adulation for the deceased but also enhance his or her prospects for cultural immortality. In sports and the performing arts, death comes disproportionately prematurely. From 1940 to the present, there have emerged about 300 entertainers whose names could be recognized easily by many people. Over thirty of them died early and tragic deaths—a proportion about three times that of famous politicians or sports celebrities. Writers have proved to be a suicide-prone lot, with notables such as Sylvia Plath, Anne Sexton, and Ernest Hemingway exemplifying research by the psychiatrist Kay Jaimison that shows that writers are ten to twenty times as likely as others to suffer manic depression or depressive illnesses.

The immortal cultural status of these celebrities who died prematurely is reflected by the fact that, like the Catholic Saints their memories are honored on their death days and not birthdays. Dying young, these celebrities remain frozen in time and never have to grow old like those who followed their lives. On the other hand, when death comes with forewarning, such as in old age or due to cancer, other machinery of celebrity canonization comes into play. Attention increases in a cultural deathwatch. Final performances hit paydirt as swan songs, even the mediocre ones, such as the concluding films of Gary Cooper and Steve McQueen. Lifetime achievement awards are given, and amends are made for past oversights. Henry Fonda had to wait until he was on his deathbed to receive an Oscar for his final role in *On Golden Pond*.

Capitalizing on the Attraction to Deceased Celebrities

Celebrity death generates its own pattern of economics. Because the deceased celebrity will not create anymore performances or sign anymore autographs, whatever artifacts he or she leaves behind become more valuable. In the year following his death, Mickey Mantle's used bats, balls, and uniforms increased 25 to 100 percent in value.

There are, in addition, the unreleased and incomplete works that may have been left behind. Posthumous books and records have proved to be lucrative business; for example, the dozen years following the death of the novelist Vladimir Nabokov in 1977 saw the publication of ten of his previously unpublished manuscripts.

With new technologies, however, dead celebrities were put to work during the last decade of the twentieth century. Natalie Cole recorded a song with her long-dead father Nat; the deceased Frank Sinatra was nominated for a 2001 Grammy with Celine Dion, who performed a duet with his posthumously generated voice; and the surviving Beatles reunited with the voice of the late John Lennon to play "Free As a Bird" and "Real Love." Madison Avenue discovered that the dead make excellent spokespersons, because they never will embarrass the sponsor. In 1994 Babe Ruth was receiving 100 endorsement deals a year. Ruth, followed by James Dean, was the most popular client at Curtis Management Group, an Indianapolis firm that markets late "greats" on behalf of descendants (who, in some states, own the rights to their dead relatives' image for fifty years). Curtis's services triggered a trend of resurrected dead celebrities hawking products—through the 1990s Louis Armstrong sipped Diet Coke in television commercials, Groucho Marx danced with Paula Abdul, Fred Astaire pranced with a vacuum cleaner, and Janis Joplin peddled Mercedes Benzes.

In 2001 *Forbes* magazine published a ranking of the earnings of the images of dead celebrities. Heading the list was Elvis Presley, whose estate earned \$35 million. He was followed by Charles Schulz (\$20 million), John Lennon (\$20 million), Theodor "Dr. Seuss" Geisel (\$17 million), and Jimi Hendrix (\$10 million).

Celebrities need not have to generate revenue in order to have their cultural immortality assured. In recent decades over two hundred halls of fame have been founded to preserve the memories of celebrities in sports, the arts, and entertainment. Concurrently, the U.S. Postal Service moved beyond the memorialization of dead presidents and founding fathers to issuing stamps with the images of such deceased celebrities as actresses Lucille Ball and Marilyn Monroe, football coaches Vince Lombardi, and Bear Bryant, and musicians Louis Armstrong and Charlie Parker.

See also: ARS MORIENDI; ELVIS SIGHTINGS; GRIEF: OVERVIEW; ROYALTY, BRITISH; SERIAL KILLERS; TABOOS AND SOCIAL STIGMA

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MICHAEL C. KEARL

CELL DEATH

Cell death is a vital and common occurrence. In humans, some 10 billion new cells may form and an equal number die in a single day. Biologists recognize two general categories of cell death, which include genetically programmed death and death resulting from external forces (necrosis).

Genetically programmed cell death is necessary for replacing cells that are old, worn, or damaged; for sculpting the embryo during development; and for ridding the body of diseased cells. Toward the end of the twentieth century biologists recognized several mechanisms by which cell death could occur. In apoptosis, the most common form of normal cell death, a series of enzyme-mediated events leads to cell dehydration, outward ballooning and rupture of the weakened cell membrane, shrinking and fragmentation of the nucleus, and dissolution of the cell. By a different mechanism some cells generate special enzymes that "cut" cellular components like scissors (known as autophagy, or "self-cutting"). Damaged cells that will become necrotic may lose the ability to control water transport across the membrane, resulting in swelling from excess fluid intake and disruption of protein structure (oncosis).

Programmed cell death is an important component of embryonic development and eliminates cells that are no longer needed. These include, for example, the cells between what will become fingers, or cells making up the embryo's original fish-like circulatory system as adult blood vessels form. Coordinate processes are called "cell determination," which involves a cell line becoming progressively genetically restricted in its developmental potential. For example, a cell line might become limited to becoming a white blood cell, thus losing the ability to become a liver cell. Cell differentiation occurs when cells take on specific structure and functions that make them visibly different from other cells (e.g., becoming neurons as opposed to liver epithelium).

All life is immortal in the sense that every cell is descendent from a continuous lineage dating back to the first nucleated cells 1.5 billion years ago. Life has been propagated through a repeating process of gamete (egg and sperm) formation by meiotic cell division (which creates genetic

diversity by blending maternal and paternal genes), fertilization, and the development of the fertilized egg into a new multicellular organism that produces new gametes.

Can individual cells or cell lines, however, become immortal? This may be possible. HeLa cells (tumor cells from a patient named Henrietta Lack) have been kept alive and dividing in tissue culture for research purposes since 1951. But normal cells have a limit to the number of times they can divide, which is approximately fifty cell divisions (known as the Hayflick limit). The key to cell immortality seems to be the tips of the chromosomes, or telomeres, that protect the ends from degradation or fusion. Telomeres consist of a repeating sequence of DNA nucleotides. They shorten with each replication so that after some fifty divisions replication is no longer possible. An enzyme called “telomerase” adds these sequences to the telomere and extends the Hayflick limit. However, this enzyme is not very abundant in normal cells. When the biologists Andrea G. Bodnar and colleagues introduced cloned telomerase genes into cells, the telomeres were lengthened and the Hayflick limit for the cells greatly extended, suggesting the potential for cellular immortality.

See also: BRAIN DEATH; DEFINITIONS OF DEATH

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ALFRED R. MARTIN

CEMETERIES AND CEMETERY REFORM

When death strikes in society certain events and rituals must be undertaken. The decaying of the corpse and beliefs about death make the presence

of the dead person among the living unacceptable. Throughout history almost all societies have employed different practices for disposing of and commemorating the dead. One such form is the cemetery.

The term *cemetery* derives from the Greek (*koimeterion*) and Latin (*coemeterium*) words for “sleeping place.” The concept is closely related to *burial ground*, *graveyard*, *churchyard*, and *necropolis*, which is Greek for “city of the dead.” The boundary between these designations is not clear-cut. A burial ground and a graveyard consist of one or several graves. The term *burial ground* is more often employed than the term *graveyard* to designate unplanned or nonconsecrated places for burial. A churchyard is a consecrated graveyard owned by the church and attached to church buildings. A necropolis is a large graveyard. In this entry cemetery is defined as a large area set apart for burial, which is not necessarily consecrated, and initially was situated on the outskirts of a municipality. In the following sections the focus will be on the development and function of cemeteries in the West, but will also touch on functions of other forms of burial places.

Functions

The most evident function of all burial grounds is to provide a means for getting rid of a dead body. Although burial is the most common way it is not the sole option. Many Hindus, for example, cremate the body on a pyre and shed the ashes in the Ganges River.

Cemeteries have multifarious social- and personal-level functions. It is important to make a distinction between individual and societal functions of cemeteries. Besides disposing of bodies, communities commemorate the dead with the displaying and construction of identity that this entails. Yet another social function is to express basic cultural beliefs concerning death and the meaning of life. Throughout history burial grounds have also been places where people met for different sorts of social gatherings. The individual function primarily concerns commemoration. One way to assure oneself of symbolic immortality is to buy a sizeable grave plot and construct an impressive memorial. However, the dead do not bury themselves, and a grave is as much an index of the

social status of the funeral organizers as of the deceased. For the bereaved, the cemetery is a place where the relationship between the dead and the bereaved is established and maintained. Consolation is taken from visits to the grave, and from planting around and decorating the plot. Cemeteries are sites where family and communal loyalties are linked and reaffirmed.

Cemeteries and graves dramatize the stratification orders of the living. The segregations of living are reaffirmed in death. In the United States there are often different cemeteries for different ethnic and religious groups and different social classes. Even when this is not the case, different sections of a cemetery can be designated to different categories of people. To deny someone a grave among others, or individuality at death, is a way for society to express repudiation. Another strategy, common in warfare or civil conflict, is to eliminate any reminder whatsoever of the deceased.

The location and organization of cemeteries, the way in which they are kept, and the inscriptions on, and shape and size of, grave markers reflect beliefs and notions about death and life and set the boundaries between the worlds of the living and the dead. For example, the original meaning of cemetery as a “sleeping place” reflects the notion of some kind of resurrection, and the diminishing frequency of crosses on grave markers reflects secularization. The emergence of inscriptions in Arabic and the symbolic use of a half moon reflect a growing presence and recognition of Muslims. Cemeteries are far more than space sectioned off and set aside for the burial of the dead: They are, as the scholar Richard E. Meyer has maintained, cultural texts to be read by anyone who takes the time to learn a bit of their language.

From Parish Churchyards to Extramural Cemeteries

The most salient predecessor to the modern Western cemetery is the Roman cemetery, where each body was given an identifiable home in a separate grave. Excavations from fourth-century British cemeteries reveal extensive urban burial grounds, often on new sites outside the borders of town. The separation of the living from the dead, with the town boundary as the dividing line, was absolute. With the weakening of the Roman

Empire, the organization of society in rural villages, and the Christian cult of martyrs, this practice gradually changed. When funerary chapels, baptisteries, and churches were constructed over the remains of martyrs, death moved into the center of the lives of the living. From approximately the tenth century the parish churchyard was the most common burial ground in all Christian countries. Except for the most honored members of the community, who had private burial grounds or vaults inside the church, and the most despised, who were buried outside the churchyard, the deceased were buried in collective burial pits surrounded by charnel houses. Due to an emerging individualism around the thirteenth century, the practice to bury in individual sepulchers with personalized tombstones became common custom.

The nineteenth century saw a development from churchyards to cemeteries. There were three major reasons for this change. First, urbanization led to overcrowded churchyards in the big cities. Second, the church became increasingly secularized. Besides being at risk of losing ideological and symbolic power over burial customs and death rituals, the churches wanted to sustain their significant income of burial fees. Lastly, many people believed that graveyards imposed health hazards. Together this led to an increase in establishment of cemeteries free from the control of the church and by the 1850s the monopoly of the churchyard was broken. In the United States, where immigrants to the New World did not have memories of numerous generations to maintain, or extreme class differences to exaggerate, people buried the dead in unattended graveyards or small churchyards in association with ethnic congregations. This procedure started to change in the 1830s with the creation of Mount Auburn near Boston, which initiated the aforementioned European kind of cemetery.

Ethnic and Cultural Variations

It is common to equate home with the place where the ancestors are buried. This is salient at old rural churchyards where several generations are buried side by side, and in the not so uncommon practice of first generation immigrants to repatriate the remains of the dead. According to the scholar Lewis Mumford it is likely that it was the permanent location of graves that eventually made people settle in villages and towns.

People are stratified in death as they are in life. The location of burial is often based on ethnicity, religion, and social class. The size of the grave marker indicates the relative power of males over females, adults over children, and the rich over the poor. Inscriptions, epitaphs, and art reflect emotional bonds between family members and the degree of religious immanence in everyday life.

Ethnic difference in death can be expressed either through separate ethnic cemeteries, separate ethnic sections in cemeteries, or ethnic symbols inscribed on grave markers. These means of expressing ethnicity can also be regarded as three steps in the gradual enculturation of ethnic groups or reaffirmations of their ethnic identity despite enculturation. While ethnicity is not an essential trait, it is a possibility that can be actualized when individuals want to express membership and exclusion. One such situation is burial and cemeteries, where ethnicity often also becomes fused with religious identity.

It is possible to discern at least seven different ways different groups express their ethnic identity within an ethnic cemetery or an ethnic section of a cemetery:

1. The location of the grave.
2. The position of the grave; Muslims are buried on the side facing Mecca, and Orthodox Christians are buried in an eastward position.
3. The form and shape of the grave marker; Polish Romes in Sweden use large grave memorials in black marble.
4. Symbols on the grave marker, such as a flag, an orthodox cross, or a Muslim half moon.
5. The place of birth, which is clearly stated on the grave marker.
6. Epitaphs from the country of origin.
7. Inscriptions in a language or alphabet that differs from that of the majority.

Moreover, different nationalities employ different grave decorations and visit the grave at various occasions. Markers of ethnicity are by no means unambiguous. In cemeteries where different ethnic groups are buried next to each other the majority culture and minority cultures tend to incorporate

practices from each other, thereby blurring the boundaries.

Although there are apparent similarities between cemeteries from the middle of the nineteenth century and forward, there are also differences between countries. These differences can be understood as cultural differences. For instance, the cemeteries in Sweden and France are usually well kept. In France cemeteries are in most cases surrounded by high walls, and are locked during the night. The same kind of high walls and locked gates can be found in Britain, but with less concern over the maintenance of the graves. This difference is partly a consequence of ideals concerning garden architecture; the British garden is less formal than the French garden.

Graveyard Hazards to Community Health

The view on the danger of the corpse spread in the eighteenth century from France to other nations. Immigration to industrializing towns and cities with high mortality rates resulted in overcrowded urban burial grounds, which rapidly degenerated into public health hazards. Corpses were buried in shallow graves and disinterred after a brief period, usually in a state of semi-decay, to make room for others. Scientific theory maintained that cemeteries threatened public health because of the emanations of air released from the dead. It was the cholera epidemics in the mid-nineteenth century that finally became decisive in closing down inner-city graveyards and establishing out-of-town cemeteries. Since the end of the nineteenth century, when the French scientist Louis Pasteur's discovery that microbes cause infection was accepted as doctrine, medical concern about cemeteries has concentrated on their effects on water supply.

Modern environmental laws circumscribe cemetery establishment and management of the twenty-first century. If bodies have not been subjected to preservative measures, and if they are buried at least three feet (one meter) above groundwater level, there is no risk for spread of infectious disease. However, groundwater can be contaminated from bodies injected with chemical preservatives, including formaldehyde, which is employed in embalming. Although sanitary reasons are brought forward as an argument for cremation, there is a growing awareness of the pollutants in

crematory emissions, including high levels of dioxins and trace metals.

Status

Burial laws vary between different countries. There are rules governing how close to a populated area a cemetery can be situated, how far down a corpse must be buried, how long a grave must be left untouched until it can be reused, and the size and form of tombstones.

In France, Sweden, and other countries where cemetery management is considered a public concern, and the cultural attitude has historically been marked by decorum for the dead, neglected burial grounds are a rare sight. Furthermore, unlike the United States and Britain, France and Sweden have laws regulating reuse of graves after a set time period (in Sweden it is twenty-five years). In Britain it is illegal to disturb human remains unless permission is secured from church authorities or the home office. Although graves are “leased” for a given period—usually up to 100 years—burial is essentially in perpetuity. This is also the case in the United States. Perpetual graves induce vast areas of cemeteries with unattended graves. In Britain there is a growing awareness of the problem of neglected cemeteries, which take up space and bring up the issue of how long a city should conserve old cemeteries. The British and the U.S. system induce a less regulated and more differentiated market. Environmental concerns, shortage of burial space in certain areas, and neglected cemeteries are likely to bring about cemetery reforms in these and other countries in the new future.

A clear trend in the Western world is increase in cremation at the expense of inhumation. Because urns and ashes require less space than coffins, and there is a growing preference of depersonalized gardens of remembrance instead of personalized graves, it is likely that cemeteries in the future will turn into forms of public parks or gardens. There is also a trend away from ethnic cemeteries, to more heterogeneous graveyards, reflecting the present multicultural society.

Countries that practice reuse of graves, and where cremation is common, have no shortage of burial space. However, countries that combine low rates of cremation with burials for perpetuity need to continually seek solutions regarding how to manage old neglected cemeteries and how to find

new burial space. It is likely that most of these countries will become more and more reluctant to allow burial in perpetuity, instead advocating for reuse of graves and cremation.

See also: BLACK DEATH; BURIAL GROUNDS; CEMETERIES, MILITARY; CHARNEL HOUSES; DEAD GHETTO; IMMORTALITY, SYMBOLIC

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EVA REIMERS

CEMETERIES, MILITARY

After 174 years, twenty-eight American Revolutionary War soldiers were returned in aluminum coffins by Canada for burial in the United States in 1988. A dozen years later, the United States was annually spending \$6 million to locate and retrieve the remains of fewer than 2,000 American MIAs from



Military cemeteries, designated to honor men and women who served in national defense, are becoming overcrowded, forcing them to close. COREL CORPORATION

Vietnam, Laos, and Cambodia. At the Tomb of the Unknown Soldier at Arlington Cemetery stand guards twenty-four hours a day, 365 days a year.

Across America and the world stretch the graves of approximately 1.1 million Americans killed in the line of military service. The federal government maintains 119 national cemeteries in the United States and twenty-four others in a dozen foreign countries, containing approximately 2.5 million gravesites. In addition, also restricted to those who served in the armed forces and their immediate families are sixty-seven state veterans' cemeteries. These homes for the dead are preserved by the nation for those who sacrificed their lives in its defense.

To understand such actions and expenditures one needs to consider the workings of civil religion, or the ways in which politics command the sacred and thereby divinely endow its causes. Evidence of civil religion is on U.S. currency ("In God We Trust") and within the Pledge of Allegiance (the phrase "under God" was added in 1954 in the

midst of the cold war). Memorial Day is the state holy day, and national cemeteries and memorials its sacred sites.

Political systems, like religion, confer immortality to their elect. And what more deserving recipients than those who sacrificed their lives for the state? In a highly individualistic culture such as the United States, the preservation of these individuals' unique identities is paramount in the immortality business, which explains in part the considerable lengths the military goes to recover and identify its fallen—and the ritual care given to those whose identities are unknown. The Department of Veterans Affairs furnishes at no charge a headstone or marker for the unmarked grave of any deceased U.S. Armed Forces veteran not dishonorably discharged. When in 1980 the Veterans Administration began removing 627 bodies of unknown Civil War soldiers in the Grafton National Cemetery in West Virginia from their individual grave sites to be placed in a mass grave (with an imposing headstone bearing the inscription "Now

We Are One”) there was collective outrage from veterans and amateur historians. Despite the fact that space was badly needed, the right to individualized memorials was preserved.

To preserve the sanctity of these burial sites, the Veterans Administration runs a limited number of cemeteries, with one exception: the most sacred of sacred sites, Arlington National Cemetery. Administered by the Department of the Army, here across the Potomac from the national capitol lie the remains of more than 250,000 Americans. To preserve its purity occasional pollution rituals occur, as in late 1977 when the body of M. Larry Lawrence, the late ambassador to Switzerland and a fabricated World War II hero, was unceremoniously exhumed and removed.

With over 1,000 World War II veterans dying each day, and because the United States has been engaged in so many wars and “police actions,” the problem faced by the National Cemetery Administration is lack of space. As of the beginning of 2001, thirty-one of the 119 national cemeteries are closed to new burials; only sixty of Arlington’s 612 acres can hold new graves.

See also: BURIAL GROUNDS; CEMETERIES AND CEMETERY REFORM; CEMETERIES, WAR; CIVIL WAR, U.S.; FUNERAL INDUSTRY; IMMORTALITY, SYMBOLIC; TOMBS

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MICHAEL C. KEARL

CEMETERIES, WAR

The question of what do with soldiers killed in war has been a problem throughout recorded history, addressed in different ways by different cultures.

An extreme solution was eating the killed individual, an act often connected with the idea that the power of the victim would be added to that of the eaters. Or the deceased might be left on the ground until the corpse was decayed or devoured by animals, which would be considered a disgrace, especially to the losers of a fight or battle. More often than not, killed individuals would be buried.

Throughout history the dead, mainly the losers, were often deprived of their belongings. This was seen as part of the spoils of war. The winners often displayed a more honorable reaction to their own dead than to those of the losers. Another principle permitted the leaders to be appreciated in a special manner. One can find impressive monuments to the leaders, while ordinary fighters were buried anonymously. The so-called Drusus Stone, a huge monument in the town of Mainz, Germany, was erected for the Roman general Drusus, a brother of the emperor Tiberius, who was killed in 9 B.C.E. in a battle at the River Elbe.

Burying the War Dead

Modern times saw the inauguration of the practice of burying soldiers who were killed in battle. This was done partly due to hygienic considerations common throughout the world—unburied corpses can soon create epidemics. The burial grounds are often found where the fights took place. However, there can also be “regular” cemeteries in which the bodies are buried side by side with the dead of the region or, more frequently, in war cemeteries dedicated exclusively to fallen soldiers.

Because of the huge numbers of casualties on both sides in the U.S. Civil War (more than 600,000 victims), the dead of both sides were often buried side by side, hence giving birth to the idea of posthumous reconciliation of the warring sides and respect for the sacrifice of the individual soldier, each of whom now had his own grave site, a contrast to earlier practices of mass military burials in which all soldiers achieved a rough equality in death, without all distinctions of rank, religion, and race erased by collective interment.

The uniformity of design of all U.S. war cemeteries was influential on the subsequent design of war cemeteries in other countries. Each nation selected its own special grave symbol. The French had a cross made of concrete with the victim’s name and a rose; the British typically employed a stele.

The annual honoring of the American war dead occurs on Memorial Day, at the end of May. However, in some countries this day of remembrance has been expanded to the memory of all the war dead of all countries, as in Finland after World War II.

German War Cemeteries

Although World War I primarily took place in Europe, many of the participating nations drafted men from their far-flung colonies. During World War I, 10 million people were killed, among them 2 million German soldiers. By 1928, 13,000 cemeteries had been completed in twenty-eight countries for these dead. World War I is also another example for the different attitudes toward losers and winners, as outlined above. The French government, for example, did not permit German officials to design their own war cemeteries.

Fifty-five million people were killed in World War II, among them 13.6 million soldiers of the Red Army and 4 million German soldiers. For those 1.8 million German soldiers who died beyond German borders, 667 cemeteries in forty-three countries were completed. Most of these were created in Western countries such as France, Italy, or Belgium. The task of properly burying all German soldiers of WWII has not yet been completed. With the lifting of the Iron Curtain in 1989, it was possible to lay out new cemeteries in former communist countries. In the 1990s a new cemetery was opened for 70,000 soldiers near St. Petersburg in Russia. The task of lying to rest all fallen German soldiers is expected to be completed by the end of 2010.

Honoring the German War Dead

The body responsible for completing war cemeteries for passed German soldiers is an independent organization founded in 1926; its name is *Volksbund Deutsche Kriegsgräberfürsorge* (People's Community for the Care of German War Graves). It can be observed that the functions of this organization and of the cemeteries have changed since World War II. Its initial task was to bury the soldiers and to enable the families to visit the graves. Each year, between 700,000 and 800,000 persons visit the German war cemeteries. Originally, war cemeteries were established to honor those who

gave their lives for their countries. The dead soldiers were declared heroes. The memorial day for killed soldiers was called *Heldengedenktag* (Heroes' Memorial Day) during the Third Reich in Germany. Such a name held strong connotations toward nationalism and chauvinism. After World War II the name for the memorial day was changed into *Volkstrauertag* (People's Mourning Day) and designated to be the Sunday two weeks before Advent. The new name signifies a change of attitudes. The idea of commemorating the deeds of proud heroes was abolished and has been replaced by the grief for killed fathers, brothers, and sons, which is the focus of memorial sermons.

In the case of Germany there is a special historical burden that required this change of attitudes. Not only had Germany lost World War II, but that war had been provoked by an authoritarian and terrorist regime. Thus, there is an ambiguity toward their soldiers who sacrificed their lives for their country. The *Volkstrauertag* remembrance sermons, held in many towns in the frame of a ceremony, are now not only for soldiers, but for *alle Opfer der Gewalt* ("all victims of violence")—as is now the official term. The victims include the refugees, the resistance fighters against Nazism and all those who died or were killed in the concentration camps. Thus, any glorification of war and Nazism is excluded.

There is another change in the purpose of war cemeteries, namely toward reconciliation and work for peace. The two slogans of the *Volksbund Arbeit für den Frieden* ("work for peace") and *Mahnung über den Gräbern* ("warning over the graves"), characterize its activities. The graves themselves, often many hundreds to a cemetery, point to the importance of peace. Different countries send participants to youth camps dedicated to this aim. These young people not only work in the cemeteries but they also learn to respect each other and permit new friendships to develop. Since 1953, 3,670 camps have been held involving 170,000 participants.

Conclusion

An increasing number of the dead soldiers no longer have surviving family members. In just one generation there will be far fewer visitors going to the cemeteries. The dead have a right of eternal

rest, so no war graves are levelled, which is a sensible principle in the light of the changing functions of war cemeteries. Visitors with no personal interest in the graves can still be impressed by the huge area of the cemetery and thereby be encouraged to contribute toward maintaining peace.

See also: CEMETERIES, MILITARY; MOURNING; WAR

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GERHARD SCHMIED

CHANNELERS/MEDIUMS

See COMMUNICATION WITH THE DEAD.

CHARNEL HOUSES

A *charnel house* is a building, chamber, or other area in which bodies or bones are deposited, also known as a mortuary chapel. Charnel houses arose as a result of the limited areas available for cemeteries. When cemetery usage had reached its limits, the bodies, by then only bones, would be dug up and deposited in the charnel house, thus making room for new burials. For example, at St. Catherine Monastery on Mount Sinai, where thousands of monks have lived and died over the centuries, the monks are buried in the small cemetery, later exhumed, and their bones placed in the crypt below the Chapel of St. Trifonio. The pile of skulls presents an imposing sight.

Charnel houses are fairly common. A Cornish (England) folktale tells of a wager in which a man offers to go into the parish charnel house and come out with a skull. As he picks one up a ghostly voice says, "That's mine." He drops it, and tries again a second and third time. Finally the man replies, "They can't all be yours," picks up another, and

dashes out with it, winning the wager. His discomfited opponent then drops from the rafters. By speaking of the "parish" charnel house the story illustrates the widespread usage of such repositories.

Charnel houses can be found in many cultures and in many time periods, including the present. Late prehistoric peoples of Maryland saved the dead in charnel houses and periodically disposed of them in large mass graves. In Iroquoian and southeastern Algonquian Native American tribes corpses were first allowed to decompose and then placed in mortuaries, or charnel houses. They were then interred in an ossuary, a communal burial place for the bones, after a period of eight to twelve years (Blick 1994). In the Spitalfields section of London, a 1999 archaeological dig uncovered a medieval vaulted charnel house, used until the seventeenth century. The charnel house was beneath a chapel built between 1389 and 1391. In 1925 a memorial charnel house was built in Bukovik, Serbia (now the town of Arandjelovac) to contain the remains of several thousand soldiers, both Serbian and Austro-Hungarian, who died in nearby battles during World War I. In 1938 Italians completed a charnel house in Kobarid, Slovenia, to contain the remains of 1,014 Italian soldiers who also had been killed in World War I. Along the main staircase are niches with the remains of 1,748 unknown soldiers. Charnel houses still exist in the twenty-first century. A Korean manufacturer, for example, sells natural jade funeral urns and funeral caskets for use in charnel houses.

See also: BURIAL GROUNDS; CATACOMBS; CREMATION

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SAM SILVERMAN

CHARON AND THE RIVER STYX

Charon, in Greek mythology, acts as the ferryman of the dead. Hermes (the messenger of the gods) brings to him the souls of the deceased, and he ferries them across the river Acheron to Hades (Hell). Only the dead who are properly buried or burned and who pay the *obolus* (silver coin) for their passage are accepted on his boat, which is why in ancient Greek burial rites the corpse always had an *obolus* placed under his tongue. A rather somber and severe character, Charon does not hesitate to throw out of his boat without pity the souls whose bodies received improper burial or cremation.

The Styx is only one of the five rivers of the underworld that separate Hades from the world of the living. These five rivers of Hell are Acheron (the river of woe), Cocytus (the river of lamentation), Phlegethon (the river of fire), Lethe (the river of forgetfulness), and finally, Styx. The word *styx* comes from the Greek word *stugein*, which means “hateful” and expresses the horror of death. The eighth century B.C.E. Greek poet Hesiod considered Styx to be the daughter of Oceanus and the mother of Emulation, Victory, Power, and Might. More recently, Styx has been identified with the stream called Mavronéri (Greek for “black water”) in Arcadia, Greece. Ancient beliefs held that the Styx water was poisonous. According to a legend, Alexander the Great (356–323 B.C.E.), king of Macedonia and conqueror of much of Asia, was poisoned by Styx water.

The use of the figures of Charon and the River Styx is quite recurrent in Western literature. The most important occurrence is found in the Italian poet Dante’s (1265–1321) *Divine Comedy*, in which Charon sees a living man (Dante’s alter ego) journeying in the inferno and challenges him.

See also: GILGAMESH; GODS AND GODDESSES OF LIFE AND DEATH; HELL; ORPHEUS

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JEAN-YVES BOUCHER

CHILDREN

Most people in American society resist associating the words *children* and *death* in a single phrase. They do not wish to contemplate the possibility that children may encounter death-related events either in their own lives or in the lives of others. As a result, they try not to think about the actual realities implied by the phrase “children and death” and they attempt to shield children from contact with or knowledge of such realities.

Although this effort at “misguided protectionism” is usually well meant, it is unlikely in most instances to be either successful or helpful. To explain why this is true, this entry explores how death and death-related events impinge on the lives of children and what their significance is for such lives. In addition, this entry considers the elements of a constructive, proactive program that helps children in their interactions with death and death-related events.

Children as Harbingers of the Future and Repositories of Hope

For many people in American society, children represent ongoing life and the promise of the future. In them, many hopes and ambitions are embodied. They foreshadow what is yet to come and act as a pledge of its surety. In a special way for females, they enter into life by emerging from their mothers’ bodies. In addition, human children are vulnerable in special ways and for an unusually prolonged period of time. They call upon their adult caregivers to care for them. Their presence in adult lives is, more often than not, a source of pride and delight. As they grow and mature, children become their own persons and their parents’ companions. In some cases, eventually they become caregivers of the adults who raised them. All these descriptions are true for one’s natural children, as well as for those who are adopted or are foster children, and even when the latter are of a different ethnicity or culture.

Children, Adolescents, and Normative Development

In the 1950s the psychoanalyst Erik Erikson proposed that there are four major eras (sometimes called “ages,” “periods,” or “stages”) in the lives of

children and an additional one for adolescents (see Table 1). His depiction of childhood has been highly influential to other developmental psychologists and scholars, although it is no longer universally accepted. Moreover, subsequent scholarship has sought to distinguish between three subperiods within adolescence. Still, a broad Eriksonian framework helps to draw attention to prominent aspects of physical, psychological, and social development in humans during childhood and adolescence, although it may not comment on spiritual development. Within limits, it can be useful as a general background for an overview of death in childhood and adolescence.

Erikson's model seeks to describe the normal and healthy development of an individual ego. It proposes that a predominant psychosocial issue or central conflict characterizes each era in human development. This is expressed as a struggle between a pair of alternative orientations, opposed tendencies, or attitudes toward life, the self, and other people. Successful resolution of each developmental struggle results in a leading virtue, a particular strength or quality of ego functioning. For Erikson, the task work in these developmental struggles is associated with normative life events, those that are expected to occur at a certain time, in a certain relationship to other life events, with predictability, and to most if not all of the members of a developmental group or cohort. This developmental framework is only roughly correlated with chronological age. Further, it might not apply at all or might only have limited relevance to individuals within different familial, cultural, and societal groups, and it might only apply uniformly to members of both genders when males and females are given equal options in life.

The importance of Erikson's work is the contrast between normative developmental events, however they may be described, and death-related events, primarily because most death-related events are nonnormative. They are unexpected or unforeseen events that occur atypically or unpredictably, with no apparent relationship to other life events, and to some but not all members of a developmental cohort. Still, nonnormative life events occur in a context of normative developmental events and each can influence the other in significant ways.

Both normative and nonnormative life events and transitions are life crises or turning points.

They present "dangerous opportunities" that offer occasions for growth and maturation if an individual copes with them effectively, but also the potential for psychological harm and distorted or unsatisfactory development if the coping response is inappropriate or inadequate. Accordingly, the way in which a child or adolescent resolves the issue that dominates a particular era in his or her development and thereby does or does not establish its corresponding ego quality or virtue is likely to be relatively persistent or enduring throughout his or her life.

With respect to adolescence, various scholars have offered a fine-tuned account that distinguishes between three developmental subperiods, along with their predominant issues and corresponding virtues:

- *Early adolescence*: separation (abandonment) versus reunion (safety); leading to a sense of emotional separation from dependency on parents
- *Middle adolescence*: independence or autonomy versus dependence; leading to a sense of competency, mastery, and control
- *Late adolescence*: closeness versus distance; leading to a sense of intimacy and commitment.

The Swiss developmental psychologist Jean Piaget looked at child development in a different way by focusing on processes involved in cognitive development during childhood. His work and later research on the development of death-related concepts in both childhood and adolescence is groundbreaking to the field of developmental psychology.

The various schemas all relay the fact that children and adolescents may encounter the deaths of others and even their own deaths. These and all other death-related events will be experienced within the ongoing processes of their own individual maturation. As the psychologist and gerontologist Robert Kastenbaum wrote in his article "Death and Development through the Life span": "Death is one of the central themes in human development throughout the life span. Death is not just our destination; it is a part of our 'getting there' as well" (Kastenbaum 1977, p. 43). Death-related events can affect human development during childhood and adolescence. Equally so, cognitive, psychological, biological, behavioral, social, and spiritual aspects

TABLE 1

| Principal developmental eras during childhood and adolescence in the human life cycle | | | |
|--|--|------------------------------|----------------------|
| Era | Approximate Age | Predominant Issue | Virtue |
| Infancy | Birth through 12 to 18 months | Basic trust vs. mistrust | Hope |
| Toddlerhood | Infancy to 3 years of age | Autonomy vs. shame and doubt | Will or self-control |
| Early childhood, sometimes called "play age" or the "preschool period" | 3 to 6 years of age | Initiative vs. guilt | Purpose or direction |
| Middle childhood, sometimes called "school age" or the "latency period" | 6 years to puberty | Industry vs. inferiority | Competency |
| Adolescence | Puberty to about 21 or 22 years of age | Identity vs. role confusion | Fidelity |

Note: All chronological ages are approximate.

SOURCE: Adapted from Erikson, 1963, 1968.

of that development, along with life experiences and communications from the environment that surround children and adolescents, will all be influential in how they cope with intrusions into their lives by death. According to Kastenbaum, adults who help children and adolescents in this coping work need to be sensitive to the developmental context and the individual perspective of each child or adolescent in order to be successful.

Encounters with Death during Childhood and Adolescence

"The kingdom where nobody dies,' as Edna St. Vincent Millay once described childhood, is the fantasy of grown-ups" (Kastenbaum 1973, p. 37). In fact, children and adolescents do die, and all young people can be and are affected by the dying and deaths of others around them.

The most dangerous time for children themselves is prior to birth (where they face the implications of miscarriage, stillbirth, and spontaneous or elective abortion), at birth (with all its risks of perinatal death), immediately after birth (with the potential perils of neonatal death), and during the first year of life. The best data available are for infant mortality. Data from the National Center for Health Statistics indicated that a total of 27,953 infants died in the United States during

1999. This figure represents 7.1 infant deaths for every 1,000 live births, the lowest rate ever recorded for the United States.

More than twenty other countries with a population of at least 2.5 million have lower infant mortality rates than those in the United States. Moreover, it is also true that infant mortality rates in the United States are nearly 2.4 times higher for African Americans (8,832 deaths or 14.2 per 1,000 live births) than those for non-Hispanic Caucasian Americans (13,555 deaths or 5.8 per 1,000) and Hispanic Americans (4,416 deaths or 5.8 per 1,000).

Congenital malformations, disorders related to short gestation and low birth weight, sudden infant death syndrome (SIDS), and maternal complications of pregnancy caused just under one-half (49.6%) of all infant deaths in the United States in 1999. There was a decline from 1988 to 1999 of 53.4 percent in the rate of SIDS deaths (from 140.1 to 65.3 per 100,000 live births). However, SIDS still remains the leading cause of death for infants between one month and one year of age, accounting for 28 percent of all deaths during that period.

Overall data on deaths and death rates during childhood and adolescence in the United States in 1999 are provided in Table 2, along with more specific data by age, sex, race, and Hispanic origin. (Note that racial and cultural categories overlap in the data presented in this table; thus, totals for all races are not identical with the sum of each subordinate category.) From Table 2 one can see that the largest numbers of deaths take place in infancy or the first year of life in childhood and in middle to late adolescence. In every age, racial, and cultural category, more males die than females, especially during middle and late adolescence. And in every age and gender category, death rates for African-American children are notably higher than those for non-Hispanic Caucasian Americans and Hispanic Americans. Death rates among Native-American children are typically lower than those for African-American children, but higher than for children in other racial and cultural groups—with the exception of fifteen- to twenty-four-year-old Native-American females who have the highest death rate in their age group. Death rates for Asian Americans and Pacific Islanders are uniformly lower than those for all other racial and cultural groups.

The leading cause of death in all children from one year of age through adolescence is accidents.

TABLE 2**Deaths and death rates (per 100,000) in the specified population group by age, sex, race, and Hispanic origin, United States, 1999**

| | DEATHS | | | | | | | | | | | |
|--|---------------------------|---------|---------|------------|-------|---------|------------|-------|---------|-------------|--------|---------|
| | Under 1 Year ^a | | | 1-4 Years | | | 5-14 Years | | | 15-24 Years | | |
| | Both Sexes | Males | Females | Both Sexes | Males | Females | Both Sexes | Males | Females | Both Sexes | Males | Females |
| All races | 27,953 | 15,656 | 12,297 | 5,250 | 2,976 | 2,274 | 7,595 | 4,492 | 3,103 | 30,664 | 22,419 | 8,245 |
| Non-Hispanic Caucasian Americans | 13,555 | 7,722 | 5,833 | 2,820 | 1,606 | 1,214 | 4,488 | 2,643 | 1,845 | 17,869 | 12,678 | 5,191 |
| African Americans ^b | 8,832 | 4,899 | 3,933 | 1,309 | 745 | 564 | 1,789 | 1,096 | 693 | 7,065 | 5,350 | 1,715 |
| Hispanic Americans ^c | 4,416 | 2,411 | 2,005 | 883 | 482 | 401 | 1,014 | 592 | 422 | 4,509 | 3,549 | 960 |
| Asian Americans & Pacific Islanders ^b | 708 | 375 | 333 | 167 | 97 | 70 | 207 | 112 | 95 | 699 | 467 | 232 |
| Native Americans ^b | 344 | 180 | 164 | 82 | 48 | 34 | 105 | 55 | 50 | 540 | 396 | 144 |
| | DEATH RATES | | | | | | | | | | | |
| | Under 1 Year ^a | | | 1-4 Years | | | 5-14 Years | | | 15-24 Years | | |
| | Both Sexes | Males | Females | Both Sexes | Males | Females | Both Sexes | Males | Females | Both Sexes | Males | Females |
| All races | 731.8 | 802.0 | 648.4 | 34.7 | 38.5 | 30.8 | 19.2 | 22.2 | 16.1 | 81.2 | 116.0 | 44.7 |
| Non-Hispanic Caucasian Americans | 572.7 | 636.8 | 505.4 | 29.7 | 33.0 | 26.2 | 17.5 | 20.1 | 14.8 | 71.4 | 98.7 | 42.6 |
| African Americans ^b | 1,552.8 | 1,694.6 | 1,406.2 | 58.8 | 65.9 | 51.4 | 28.7 | 34.6 | 22.6 | 123.1 | 185.7 | 60.0 |
| Hispanic Americans ^c | 612.0 | 655.3 | 567.0 | 32.2 | 34.4 | 29.8 | 16.9 | 19.4 | 14.4 | 82.4 | 125.0 | 36.5 |
| Asian Americans & Pacific Islanders ^b | 390.3 | 406.6 | 373.4 | 23.2 | 26.6 | 19.7 | 12.2 | 12.8 | 11.5 | 44.0 | 58.7 | 29.2 |
| Native Americans ^b | 808.6 | 839.5 | 777.3 | 51.4 | 59.4 | 43.1 | 22.4 | 23.1 | 21.7 | 125.9 | 183.5 | 67.5 |

^a Death rates are based on population estimates; they differ from infant mortality rates, which are based on live births.

^b Race and Hispanic origin are reported separately on death certificates. Data for persons of Hispanic origin are included in the data for each race group (unless otherwise specified), according to the decedent's reported race.

^c Includes all persons of Hispanic origin of any race.

SOURCE: Adapted from Kochanek, Smith, and Anderson, 2001.

In children from one to four years of age, the second, third, and fourth leading causes of death are congenital malformations, cancer, and homicide. In children from five to fourteen years of age, the second, third, and fourth leading causes of death are cancer, homicide, and congenital malformations. In adolescents from fifteen to twenty-four years of age, the second and third leading causes of death are homicide and suicide, followed at some distance by cancer and heart disease.

Children encounter the deaths of others that are significant in their lives. Such deaths include those of grandparents or parents, siblings or peers, friends or neighbors, teachers and other school personnel, and pets or wild animals. Many adults undervalue the prevalence and importance of such deaths for children. However these experiences of childhood and adolescence can have immediate impact and long-term significance. Some prominent examples include the school shooting at

Columbine High School in Colorado in April 1999, the countless instances of fantasized deaths and violence that children witness on television at an early age, and the many children who are members of families in which someone has died or is dying of AIDS (acquired immunodeficiency syndrome).

Children's Efforts to Understand Death

Children and adolescents are curious about the world around them. When death-related events intrude into their lives, they strive to understand them. Many factors affect such strivings, such as the intellectual capacities of the child, his or her life experiences, what society at large and adults around the child might say about the events, and the child's personality. Children's efforts to understand death may not always lead to thinking about death in the ways that adults do. It is incorrect to conclude from the way children respond to death that children have no concept of death or are never interested in the subject. To claim that "the child is so recently of the quick that there is little need in his spring-green world for an understanding of the dead" (Ross 1967, p. 250) is to be unfamiliar with the lives of children or to betray a personal difficulty in coping with death and a projection of those anxieties onto children. In reality children do try to make sense of death as they encounter it in their lives. According to Charles Corr, an educator who has written widely about issues related to children and death, such strivings should be aided by open communication and effective support from adults who love the child.

Expressions of Death-Related Attitudes in Games, Stories, and Literature for Children

Play is the main work of a child's life, and many childhood games are related to death. For example, little boys often stage car crashes or other scenes of violent destruction that they can manipulate and observe from a safe psychic distance, while little girls sometimes act out the ritual of a funeral or compare the deep sleep of a doll to death. Adah Maurer described peek-a-boo as a game in which the entire world (except, of course, the participating child) suddenly vanishes (is whisked away from the child's life) only to reappear subsequently in an act of instantaneous resurrection or rebirth. There is also the song in

which "the worms crawl in, the worms crawl out," the lullaby "Rock-a-Bye Baby" that sings about the bough breaking and the cradle falling, and the child's prayer, "Now I lay me down to sleep," which petitions for safekeeping against death and other hazards of the night.

Similarly, children's oral and written fairy tales offer many examples of death-related events. For example, Little Red Riding Hood and her grandmother are eaten by the wicked wolf in the original version of the story, not saved by a passing woodsman or hunter. The Big Bad Wolf in the "Three Little Pigs" died in a scalding pot of hot water when the wolf fell down the last chimney. And while Hansel and Gretel escaped being shut up in a hot oven, the wicked witch did not.

There is a very large body of literature for children and adolescents that offers stories with death-related themes or seeks to explain death to young readers. Books range from simple picture books about children who find and bury a dead bird in the woods to more detailed stories that relay experiences involving the death of a beloved grandparent or pet, parent, sibling, or peer.

Children Who Are Coping with Life-Threatening Illnesses and Dying

Children with a life-threatening illness experience changes in their daily routines, acquire new information about their illnesses and themselves, and find themselves confronted with unexpected challenges. Many are anxious about those experiences, most need information that they can understand, and all need support as they make efforts to cope. In 1997 Michael Stevens, an Australian pediatric oncologist, suggested that the emotional needs of dying children include those of all children regardless of health, those that arise from the child's reaction to illness and admission to a hospital, and those that have to do with the child's concept of death. One twelve-year-old girl infected with HIV (human immunodeficiency virus) wrote: "Living with HIV and knowing that you can die from it is scary. . . . I think it is hardest in this order: Not knowing when this will happen. . . . Not knowing where it will happen. . . . Worrying about my family. . . . What will happen to my stuff and my room? . . . Thinking about what my friends will think" (Wiener, Best, and Pizzo 1994, p. 24).

Children Who Are Coping with Loss and Grief

Three central issues likely to be prominent in the experiences of bereaved children are: Did I cause the death?; Is it going to happen to me?; and Who is going to take care of me? These issues of causality, vulnerability, and safety cry out for clear explanations and support. In response, in 1988 Sandra Fox identified four tasks that are central to productive mourning for children: (1) to understand and try to make sense out of what is happening or has happened; (2) to express emotional and other strong responses to the present or anticipated loss; (3) to commemorate the life that has been lost through some formal or informal remembrance; and (4) to learn how to go on with living and loving.

When confronted with a death-related event, adults often try to block children's efforts to acquire information, express their feelings, obtain support, and learn to cope with sadness and loss. According to Charles Corr, this strategy cannot be helpful to a child in the long run because its effect is to abandon a child and its major lesson is that the child should not bring difficult issues to such an adult. By contrast, emotionally sensitive adults anticipate that sooner or later children need to turn to someone for help with death and loss. On that basis, they can try to prepare themselves for such moments, strive to ensure that they are responding to a child's real needs, try to communicate clearly and effectively, and work cooperatively with children, other adults, and relevant resources in society. This leads to a proactive program of helping that involves three elements: education, communication, and validation.

Experts note a good way to begin is with education; for example, by teaching children about death and loss in relatively safe encounters and by exploiting "teachable moments" for the insights they can offer and the dialogue they can stimulate. Next, one can turn to effective communication by asking three questions:

1. What does a child need to know?
2. What does a child want to know?
3. What can a child understand?

Euphemisms and inconsistent or incomplete answers are not desirable because they easily lead to misunderstandings that may be more disturbing

than the real facts. Honesty is dependable and encourages trust, the basis of all comforting relationships. So it is better to admit what you do not know than to make up explanations you really do not believe.

A third element of a proactive program is validation. Validation applies to children's questions, concepts, language, and feelings. It involves acknowledging these things in a nonjudgmental way and helping the child to name or articulate them so as to have power over them.

The advantages of a proactive program of education, communication, and validation can be seen in the examples of children who take part in funeral rituals and in support groups for the bereaved. Many adults in American society exclude children from funeral rituals, feeling that children might not be able to cope with such experiences and might be harmed by them. In fact, research has shown that taking part in funeral planning and funeral ritual in appropriate ways—not being forced to participate, being prepared ahead of time, given support during the event, and offered follow-up afterward—can help children with their grief work. Similarly, being given opportunities to interact and share experiences with others who are bereaved in the protected environment of a support group can help children and adolescents come to understand and learn to cope with death and grief.

Adult Children

One other sense in which the term "children" can be and is used in connection with death-related experiences has to do with adults who remain the children of their older, living parents. As average life expectancy increases in American society, growing numbers of middle-aged and elderly adults are alive when their children become adults. Indeed, some of the oldest members of American society, including the so-called old-old who are more than eighty-five or even one hundred years of age, may find themselves with living children who are also elderly adults.

Death-related events are relevant to these population groups in many ways. Among these, two stand out. First, when an adult child dies that may constitute a particular tragedy for a surviving parent. For example, the adult child may have been the primary care provider for the parent in his or her home, the only person to visit that parent in a

long-term care facility, the individual who took care of practical matters such as handling finances or filling out tax forms for the parent, or the sole survivor from among the parent's family members, peers, and offspring. In these and other situations, the death of an adult child may impact the surviving parent in myriad ways, invoking losses and challenges in forms that had not hitherto been faced.

Second, the death of a parent at an advanced age who is survived by an adult child has its own spectrum of ramifications. Deaths of family members (especially parents) from an earlier generation often exert a "generational push" on younger survivors. These younger survivors, especially adult children, are now no longer "protected" in their own minds by their perceptions of the "natural order" of things. Previously, death may have seemed to them to be less of a personal threat as long as their parents and other members of an older generation remained alive. Now the adult children themselves are the members of the "oldest" generation. These adult children may be relieved of care giving responsibilities and other burdens that they had borne when their parents were alive, but new and often highly personalized challenges frequently arise for these adult children in their new roles as bereaved survivors.

See also: CHILDREN AND ADOLESCENTS' UNDERSTANDING OF DEATH; CHILDREN AND MEDIA VIOLENCE; LITERATURE FOR CHILDREN; SUICIDE OVER THE LIFE SPAN: CHILDREN

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CHILDREN AND ADOLESCENTS' UNDERSTANDING OF DEATH

Parents often feel uneasy and unprepared in responding to their children's curiosity about death. Studies indicate that many parents felt they had not been guided to an understanding of death in their own childhood and as parents either had to improvise responses or rely on the same evasive techniques that had been used on them. It is useful, then, to give attention to the attitudes of adults before looking at the child's own interpretations of death.

The Innocence of Childhood

Two contrasting developments occurred as a prosperous middle class arose during the Industrial Revolution, which began in the mid-eighteenth century. In the past children had been either economic assets or liabilities depending upon circumstances, but seldom the focus of sentiment. Now both children and childhood were becoming treasured features of the ideal family, itself a rather new idea. By Victorian times (the period of the reign of Britain's Queen Victoria, from 1837 to 1901), the family was viewed as a miniature replica of a virtuous society under the stern but loving auspices of God. Instead of being regarded primarily as subadults with limited functional value, children were to be cherished, even pampered. Frilly curtains, clever toys, and storybooks written especially for young eyes started to make their appearance. The idea of childhood innocence became attractive to families who had reached or were striving for middle-class success and respectability. Fathers and mothers had to meet obligations and cope with stress and loss in the real world, while it was considered that children should be spared all of

that. It was believed that children cannot yet understand the temptations and perils of sex or the concept of mortality and loving parents should see to it that their children live in a world of innocence as long as possible.

Furthermore, Sigmund Freud suggested that in protecting their children from awareness of death, then, parents, in a sense, become that child and vicariously enjoy its imagined safety and comfort.

One of history's many cruel ironies was operating at the same time, however. Conditions generated by the Industrial Revolution made life miserable for the many children whose parents were impoverished, alcoholic, absent, or simply unlucky. The chimney sweep was one of the most visible examples. A city such as London had many chimneys that needed regular cleaning. Young boys tried to eke out a living by squeezing through the chimneys to perform this service. Many died of cancer; few reached a healthy adulthood. While mothers or fathers were reading storybooks to beloved children, other children were starving, suffering abuse, and seeing death at close range in the squalid alleys.

Children so exposed to suffering and death did not have the luxury of either real or imagined innocence; indeed, their chances for survival depended on awareness of the risks. Many children throughout the world are still exposed to death by lack of food, shelter, and health care or by violence. Whether or not children should be protected from thoughts of death, it is clear that some have no choice and consequently become keenly aware of mortality in general and their own vulnerability in particular.

Children's Death-Related Thoughts and Experiences

Encounters with death are not limited to children who are in high-risk situations, nor to those who are emotionally disturbed. It is now well established that most children do have experiences that are related to death either directly or indirectly. Curiosity about death is part of the normal child's interest in learning more about the world. A goldfish that floats so oddly at the surface of the water is fascinating, but also disturbing. The child's inquiring mind wants to know more, but it also recognizes the implied threat: If a pretty little fish

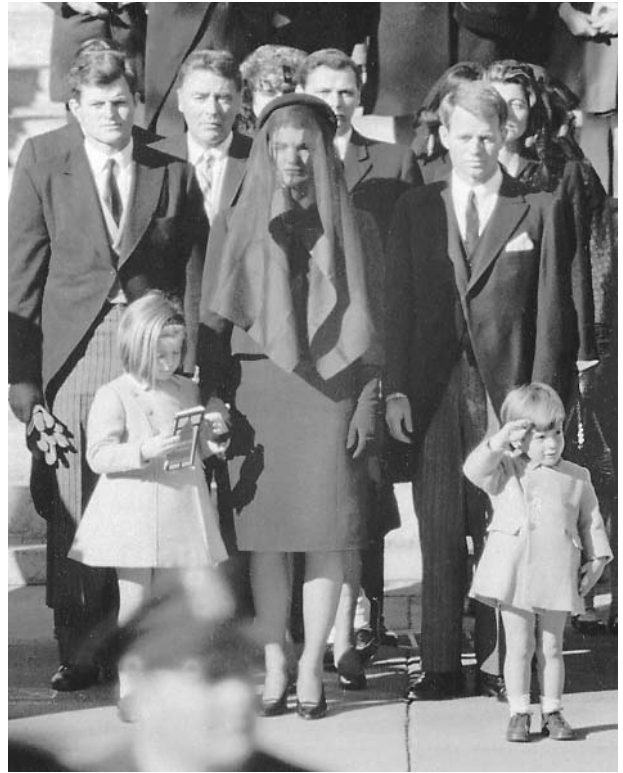
can die, then maybe this could happen to somebody else. The child's discovery of death is often accompanied by some level of anxiety but also by the elation of having opened a door to one of nature's secrets.

Child observation and research indicate that concepts of death develop through the interaction between cognitive maturation and personal experiences. Children do not begin with an adult understanding of death, but their active minds try to make sense of death-related phenomena within whatever intellectual capacities they have available to them at a particular time. Adah Maurer, in a 1966 article titled "Maturation of Concepts of Death," suggested that such explorations begin very early indeed. Having experienced frequent alternations between waking and sleeping, some three-year-olds are ready to experiment with these contrasting states:

In the game of peek-a-boo, he replays in safe circumstances the alternate terror and delight, confirming his sense of self by risking and regaining complete consciousness. A light cloth spread over his face and body will elicit an immediate and forceful reaction. Short, sharp intakes of breath, and vigorous thrashing of arms and legs removes the erstwhile shroud to reveal widely staring eyes that scan the scene with frantic alertness until they lock glances with the smiling mother, whereupon he will wriggle and laugh with joy. . . . his aliveness additionally confirmed by the glad greeting implicit in the eye-to-eye oneness with another human. (Maurer 1966, p. 36)

A little later, disappearance-and-reappearance games become great fun. Dropping toys to the floor and having them returned by an obliging parent or sibling can be seen as an exploration of the mysteries of absence and loss. When is something gone for good, and when will it return? The toddler can take such experiments into her own hands—as in dropping a toy into the toilet, flushing, and announcing proudly, "All gone!" Blowing out birthday candles is another of many pleasurable activities that explore the riddle of being and nonbeing.

The evidence for children's exploration of death-related phenomena becomes clearer as language skills and more complex behavior patterns



This popular image of the Kennedy family taken during John F. Kennedy's funeral shows John Jr. paying tribute to his father with a salute. AP/WIDE WORLD PHOTOS

develop. Children's play has included death-themed games in many societies throughout the centuries. One of the most common games is tag and its numerous variations. The child who is "It" is licensed to chase and terrorize the others. The touch of "It" claims a victim. In some versions the victim must freeze until rescued by one of those still untouched by "It." The death-related implications are sometimes close to the surface, as in a Sicilian version in which a child plays dead and then springs up to catch one of the "mourners." One of the most elaborate forms was cultivated in the fourteenth century as children had to cope with the horrors of the Black Death, one of the most lethal epidemics in all of human history. "Ring-around-the-rosy . . . All fall down!" was performed as a slow circle dance in which one participant after another would drop to the earth. Far from being innocently oblivious to death, these children had discovered a way of both acknowledging death and making it conform to the rules of their own little game.

There are many confirmed reports of death awareness among young children. A professor of

medicine, for example, often took his son for a stroll through a public garden. One day the sixteen-month-old saw the big foot of another passerby come down on a fuzzy caterpillar he had been admiring. The boy toddled over and stared at the crushed caterpillar. "No more!" he said. It would be difficult to improve on this succinct statement as a characterization of death. The anxiety part of his discovery of death soon showed up. He no longer wanted to visit the park and, when coaxed to do so, pointed to the falling leaves and blossoms and those that were soon to drop off. Less than two years into the world himself, he had already made some connections between life and death.

Developing an Understanding of Death

Young children's understanding of death is sometimes immediate and startlingly on target, as in the fuzzy caterpillar example. This does not necessarily mean, however, that they have achieved a firm and reliable concept. The same child may also expect people to come home from the cemetery when they get hungry or tired of being dead. Children often try out a variety of interpretations as they apply their limited experience to the puzzling phenomena associated with death. Separation and fear of abandonment are usually at the core of their concern. The younger the child, the greater the dependence on others, and the more difficult it is for the child to distinguish between temporary and permanent absences. The young child does not have to possess an adult conception of death in order to feel vulnerable when a loved one is missing. Children are more attuned to the loss of particular people or animal companions than to the general concept of death.

A pioneering study by the Hungarian psychologist Maria Nagy, first published in 1948, found a relationship between age and the comprehension of death. Nagy described three stages (the ages are approximate, as individual differences can be noted):

- Stage 1 (ages three to five): Death is a faded continuation of life. The dead are less alive—similar to being very sleepy. The dead might or might not wake up after a while.
- Stage 2 (ages five to nine): Death is final. The dead stay dead. Some children at this level of mental development pictured death in the form of a person: usually a clown,

shadowy death-man, or skeletal figure. There is the possibility of escaping from death if one is clever or lucky.

- Stage 3 (ages nine and thereafter): Death is not only final, but it is also inevitable, universal, and personal. Everybody dies, whether mouse or elephant, stranger or parent. No matter how good or clever or lucky, every boy and girl will eventually die, too.

Later research has confirmed that the child's comprehension of death develops along the general lines described by Nagy. Personifications of death have been noted less frequently, however, and the child's level of maturation has been identified as a better predictor of understanding than chronological age. Furthermore, the influence of life experiences has been given more attention. Children who are afflicted with a life-threatening condition, for example, often show a realistic and insightful understanding of death that might have been thought to be beyond their years.

The Adolescent Transformation

Children are close observers of the world. Adolescents can do more than that. New vistas open as adolescents apply their enhanced cognitive abilities. In the terminology of influential developmentalist Jean Piaget, adolescents have "formal operations" at their command. They can think abstractly as well as concretely, and imagine circumstances beyond those that meet the eye. This new level of functioning provides many satisfactions: One can criticize the established order, take things apart mentally and put them back together in a different way, or indulge in lavish fantasies. The increased mental range, however, also brings the prospect of death into clearer view. The prospect of personal death becomes salient just when the world of future possibilities is opening up.

Adolescents have more than enough other things to deal with (e.g., developing sexual role identity, claiming adult privileges, achieving peer group acceptance), but they also need to come to terms somehow with their own mortality and the fear generated by this recognition. It is not unusual for the same adolescent to try several strategies that might be logically inconsistent with each other but that nevertheless seem worth the attempt. These strategies include:

Playing at Death: To overcome a feeling of vulnerability and powerlessness, some adolescents engage in risk-taking behavior to enjoy the thrilling relief of survival; dive into horror movies and other expressions of bizarre and violent death; indulge in computerized games whose object is to destroy targeted beings; and/or try to impersonate or take Death's side (e.g., black dress and pasty white face make-up worn by "goths").

Distancing and Transcendence: Some adolescents engross themselves in plans, causes, logical systems, and fantasies that serve the function of reducing their sense of vulnerability to real death within real life. Distancing also includes mentally splitting one's present self from the future self who will have to die. One thereby becomes "temporarily immortal" and invulnerable.

Inhibiting Personal Feelings: It is safer to act as though one were already nearly dead and therefore harmless. Death need not bother with a creature that seems to have so little life.

These are just a few examples of the many strategies by which adolescents and young adults may attempt to come to terms with their mortality. Years later, many of these people will have integrated the prospect of death more smoothly into their lives. Some will have done so by developing more effective defensive strategies to keep thoughts of death out of their everyday lives—until they become parents themselves and have to deal with the curiosity and anxiety of their own children.

See also: ANIMAL COMPANIONS; CHILDREN; DEATH SYSTEM; FREUD, SIGMUND

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CHILDREN AND MEDIA VIOLENCE

The impact of violent media on children and adolescents has been the subject of debate since the advent of mass media, and has involved a complex interplay of policies, politics, research, commercial interest, and public advocacy. The U.S. Congress and federal agencies, prodded by professional organizations and child advocacy groups, have claimed that violence in the entertainment media negatively affects children and have called for more self-regulation and social responsibility by the media industries. The industries, especially television, have responded by criticizing a number of studies on which the claims were based, disputing findings or their interpretations, and pointing to their First Amendment rights.

While the overall U.S. rate of individual homicide has been fairly consistent over the past decades, the rates of homicidal behavior in school-age children have risen sharply. Gun-related homicide among fifteen- to nineteen-year-olds has tripled since 1980. Several highly publicized murders in schools have alarmed the public and politicians.

Youth violence is a complex problem caused by the interaction of many factors, among them ineffective parenting (including inadequate or inappropriate patterns of communication, domestic violence, poor monitoring), drug use, poverty, racism, peer pressure, peer rejection, and violence in the culture. It is difficult to determine the impact of each of these factors because parents have been considered the most potent and prominent force in children's emotional and social development; the role of the media in this process has been underestimated.

The telecommunications media have become a pervasive feature of American family life and thus

a powerful force in the child's socialization and cultural upbringing. As a result, symbolic violence is now recognized as a pressing social issue. The *Fifth Annual Survey of Media in the Home* (2000) shows that nearly all families have a television set and a VCR, and the majority have a computer and video game equipment. More than half of the children in the survey had a television set in their bedrooms. Children spend an average of four and a half hours per day looking at some form of video screen, half of this time being television.

Such extensive exposure underscores the question of the media's power to shape perceptions and attitudes. Death is not a topic parents like to discuss with their children. Because personal encounters with natural death are less frequent in the early twenty-first century than in previous eras, there are fewer counterbalances to media's violent death themes. In younger children, the distinctions between fantasy and reality are less clear, making them more susceptible to misunderstandings of death. Thus, what is at issue is the media's potential to adversely affect children's perceptions of reality. The high level of violence in entertainment media provides a model for understanding death and grief that is a gross distortion of the demographic facts, and a failure to portray adequately at least part of the pain and suffering a death causes surviving family members and friends. For the entertainment industry, whether in action drama or homicide/detective programs, violent death is a tool to drive tension and propel dramatic action. Pain, suffering, and funeral rituals do not contribute to this kind of plot.

Violence in Television Programming

Scholars have made extensive studies of both the extent of violence and the contexts in which it occurs. Since the 1967 television season, George Gerbner and his associates have analyzed prime-time programming and children's Saturday morning cartoons by network and number of violent acts per hour and have derived the "violence index" and what Gerbner calls the "cultivation effect."

In 1998 Barbara Wilson and her team sampled the entire television landscape (individual programs throughout the day and evening, including sitcoms, sports, and talk shows). They also performed content analyses of violent portrayals, building on factors identified in previous work by

George Comstock, who proposed that identifying the contexts in which violent acts occur may help to reveal the potential impact of depicted violence on the child viewer. The analysis of violent content is guided by questions such as:

- Is the aggressive behavior on the screen rewarded or punished?
- Is the violence gratuitous or justified? Does it have consequences?
- Does the child identify with the aggressor or the victim?
- Does the child see television violence as realistic?

Two key findings emerged: First, the amount of television violence has been consistently high over the years and has been rising. Nearly two-thirds of the programs contain violence, which is most prominent in action dramas and homicide/detective series. A third of violent programming contains at least nine violent interactions. Nearly one-half of the theatrical films shown on television depict acts of extreme violence (e.g., *The Gladiator* (Fox), *Marked for Death* (CBS), and *The Rookie* (ABC)), some of them containing more than forty scenes of violence.

The amount of violence in prime-time "family-oriented" programs has increased steadily over the years in violation of an agreement reached between network broadcasters and the Federal Communications Commission in the 1970s. Children are frequent viewers of prime-time and other programs designed for adults.

Violent incidents are highest in children's programming, with an average of twenty to twenty-five acts per hour. What mainly distinguishes children's cartoons from adult programs is that animated characters are repeatedly smashed, stabbed, run over, and pushed off high cliffs, but they do not stay dead for long. The portrayal of death as temporary and the characters as indestructible reinforces young viewers' immature understanding of death.

The second key finding is that the contexts in which most violence is presented also poses risks for the child viewers. Most violent incidents involve acts of aggression rather than threats: Perpetrators are frequently portrayed as attractive characters and heroes rather than as villains; perpetrators and victims are predominantly male; most violence is committed for personal gain or

out of anger; and most violent acts do not have consequences—that is, they portray little or no pain and suffering by victims or survivors. In nearly three-fourths of the violent scenes, there is no punishment of the aggressor, no remorse or condemnation; some acts are even rewarded. In children's cartoons, humor is a predominant contextual feature.

There is a striking contrast in the depiction of death in the entertainment media: In prime-time action drama death is often glamorized, and in children's cartoons it is trivialized; depictions in both types of programs are a misrepresentation of real life and death.

Effects on Children

Most studies are based on social learning theory, pioneered by psychologist Albert Bandura, particularly the principle of observational learning called "modeling." Models can be physical, involving real people, or symbolic, involving verbal, audio, or visual representations, or combinations of these. Modeling is recognized as one of the most powerful means of transmitting values, attitudes, and patterns of thought and behavior. According to modeling theory, television violence has negative effects on children, particularly when the perpetrators are attractive characters and are not punished, and when there is little pain and suffering by the victims.

Two distinct methodological approaches, correlational and experimental, have been employed. Correlational studies seek to determine whether exposure to television violence is indeed related to young viewers' behavior and attitudes and also tries to measure the strength of such relationships. However, a correlation between the two variables does not establish a cause-effect relationship. Violence in the media may lead a child viewer to aggressive behavior, but also an aggressive child may like to watch violent media.

The experimental method involves the manipulation of filmed or televised aggression shown to children. Most experimental studies are carried out in the laboratory. Children are randomly assigned to an experimental group that is shown aggressive videos and to a control group that is shown nonviolent programming, and then children are observed on the playground or in similar social settings to find out whether there are differences in the behavior between the two groups. The strength

of experimental studies lies in their ability to attribute direct causality. Experimental studies can also be longitudinal, carried out in natural contexts or "the field." A widely known field experiment reported by Leslie Joy, Ann Kimball, and Merle Zabrack in 1986 involved children in three rural Canadian communities before and after the introduction of television in towns receiving either the government-owned channel (CBC), U.S. networks, or a combination. Children were studied in first and second grades and re-evaluated two years later.

The extensive research literature was reviewed in 1972 by the Surgeon General's Advisory Commission, in 1982 by the National Institute of Mental Health, and in 1993 by the American Psychological Association's Commission on Violence and Youth. Their reports and those of more recent investigations are consistent across time, methods, child populations, and funding sources. Key findings show the following:

1. There is a causal link between the viewing of televised violence and the subsequent aggressive behavior and attitudes in children who are frequent viewers of violent episodes, ranging from preschool to late adolescence. These children are more likely to model their behavior after aggressors in the programs than those who watch infrequently, particularly when the aggressors are depicted as attractive and get away without punishment, and when there is no apparent pain and suffering on the part of the victims. Children who have few positive role models in their lives are more vulnerable than those who do.
2. Aggressive behavior and attitudes are learned at young ages and can result in life-long violence unless there are interventions.
3. Violent behavior is a preventable problem. There is a wide availability of broad-based programs. Reduction in media violence and access to media violence are a component of these programs.
4. Frequent viewing of television violence leads to the belief that such violence is an accurate portrayal of real life, resulting in an exaggerated fear of violence from others. Fear stemming from watching scary media may be immediate and short-term but can also be enduring.

5. Prolonged viewing of filmed and televised violence can lead to emotional desensitization toward actual violence. Because young viewers tend to identify with the perpetrator and violent episodes seldom depict pain and suffering, there is a blunting of viewers' empathy for the victims and a reduced willingness and readiness to help.

Considering the finite amount of time in a child's day, frequent exposure to violent media content affects children's behaviors, attitudes, and perceptions while depriving them of opportunities for viewing equivalent amounts of prosocial behaviors as viable solutions to interpersonal problems.

Government Policies to Benefit Child Viewers

Major policy battles over programming for children date back to the Communications Act of 1934 and to policies adopted in 1974 and 1990. Health professionals and private advocacy groups led the U.S. Congress to enact the Telecommunications Act of 1996, which mandates that parental guidelines and procedures be established by the industries for rating upcoming video programming; that parents be provided technological tools that allow them to block violent content ("V-chip"); and that regularly scheduled programming designed for children be developed. To gain license renewal, every broadcast station in the country is required to air a minimum of three hours per week of children's programming—this is known as the "three-hour rule."

Studies evaluating industry compliance with the Telecommunications Act show the following:

1. The broadcasting, cable, and program production industries have developed a rating system for children's and general programming, the "TV Parental Guidelines." It was found to be adequate for general classification but lacking in specific content categories that would guide parents. In addition, the "TV Parental Guidelines" are inadequately publicized.
2. V-chips have been installed in new televisions since 2000.
3. Commercial broadcasters appear to be complying with the three-hour rule. However, a fourth of the programs were found to be of

questionable educational value, with most of them clustered around Saturday and weekday mornings; less than a tenth were during after-school hours and none during prime time, when children are most likely to watch television.

4. Children's programs sampled in this study contained less violence than those aired in the past.

Feature Films, Home Videos, and Electronic Games

Experts agree the violence level found in feature films exceeds that on television. For years violent films have been among the top box-office draws in movie theaters across the country. Although the film industry rates films by age groups, local movie theaters often fail to adequately check ticket buyers' ages. Community standards for what is an acceptable level of violence have changed over the years. Many parents are more lenient or less concerned about possible negative influences. Parents can also be observed taking their preadolescent children and even young children to see feature films deemed unsuitable for children by the film industry's own ratings system. Home videos remain largely unrated. Studies have shown that parents are only slightly concerned that their children seek out extremely violent home videos.

Public health and advocacy groups are alarmed at the extent of violence in video games (among them *Mortal Kombat*, *Lethal Enforcers*, and *Ground Zero Texas*). Interactive media may have an even greater impact on children than the more passive media forms. According to a 2000 Federal Trade Commission Report, "Marketing Violent Entertainment to Children," the graphics in video games are approaching motion-picture quality, making them more realistic and exciting. Many parents are unfamiliar with the content of the video games that their children play in arcades or purchase and play at home.

Television News

Television news has become a major source of information for children as well as adults; most children rank it as a more reliable source than teachers, parents, and peers. There is news coverage throughout the day and evening, with frequent repetitions and "breaking news." Because of the



Sixty percent of the audience for interactive games, like this video hockey game, are children. The electronic gaming industry has voluntarily begun to rate its products, although rating labels and advisories are widely ignored by distributors and retailers. CORBIS

capability for instant communication across the globe, an enormous number of events are potentially “newsworthy.” Because most news programs are owned by the major conglomerates in the entertainment industry, an attendant blurring of news and entertainment values exists.

The major networks and cable companies are highly competitive. In all news programs there is a bias toward over-reporting dramatic events. Improved technologies for visual reconstruction or recreation of events make the portrayals more graphic. Depictions of violent actions and events are not balanced with representations of others that are positive and constructive. The merging of news and entertainment (e.g., the “docu-drama”) may blur the distinction between fantasy and reality. Learning to distinguish between fantasy and reality is an important developmental task for the young child.

Media coverage of violent behavior in children seems particularly high, causing fears and alarm

and unwittingly contributing to distorted perceptions in parents, children, and the public about the rates and incidence of youthful homicidal behaviors. Extensive attention to such behavior in the news tends to lead other young people to copy such acts.

Suggestions for Parents

While most scientists conclude that children learn aggressive attitudes and behavior from violent media content, they also agree that parents can be a powerful force in moderating, mediating, and reducing such influence.

Talking about real deaths. Parents can help their children deal with death as a natural and normal process by permitting them to share their thoughts and fears about death, answering questions honestly, and allowing children to participate in the care of ill and dying family members, in funerals and memorial services, and during the grieving process.

Being informed. Parents need to know the major risk factors associated with media violence. They should become familiar with the programs and video games that their children favor and with existing parental guidelines, ratings, and advisories. The Federal Communications Commission (FCC) publishes the “TV Parental Guidelines” on its web site at www.fcc.gov/vchip/#guidelines. Information on activating and programming the V-chip is available through the V-Chip Education web site at www.vchippeducation.org/pages/using.html. The National Institute on Media and the Family, an independent nonprofit organization, has developed a universal rating system that applies to video games, TV programs, and films, and can be found at www.mediaandthefamily.com.

Setting limits. A 2001 study by Thomas Robinson and colleagues shows that reducing children’s television and video game use reduces aggressive behavior. The V-chip can be used to block out content that parents deem potentially harmful. In family discussion, parents may set up rules for extent, times, and types of media interaction by children.

Mediation and intervention. Mediation and intervention may be the most effective antidotes to media violence. Parents who watch television with their children can discern their children’s preferences and level of understanding. This co-participation provides an opportunity for parents to counteract violent messages in drama programs by pointing to their fictional nature. Watching the news with children enables parents to provide perspective and comfort, convey their values, and encourage their children to watch programs that demonstrate prosocial behavior. Family oriented activities away from the mass media can provide a healthy alternative to the violence-saturated airwaves and video games that increasingly dominate the consciousness of the youth of the United States.

See also: CHILDREN; GRIEF: FAMILY; HOMICIDE, EPIDEMIOLOGY OF; LITERATURE FOR CHILDREN

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HANNELORE WASS

CHILDREN AND THEIR RIGHTS IN LIFE AND DEATH SITUATIONS

In 2003 approximately 55,000 children and teenagers in the United States will die. Accidents and homicide cause the most deaths, and chronic illnesses such as cancer, heart disease, and congenital abnormalities are the next greatest cause. The

loss of a child or adolescent is life-altering for the family, friends, community members, and health care providers, regardless of the cause of death. Most children and adolescents who have a terminal illness are capable of expressing their preferences about how they will die. These preferences have not always been solicited or honored by the adults involved in their care.

Defining the End of Life in Pediatrics

The term *end-of-life care* for children and adolescents has a more global meaning than the commonly used terms *terminal care*, *hospice care*, and *palliative care*. Rather than defining a specific time period, "end-of-life care" denotes a transition in the primary goal of care from "curative" (in cases of disease) or "life sustaining" (in cases of trauma) to symptom management (the minimization or prevention of suffering) and on psychological and spiritual support for the dying child or adolescent and for the family. To provide this kind of care to fatally ill children and adolescents and to their family members, health care providers must focus on the individual patient's values and preferences in light of the family's values and preferences. *Hospice care* is considered to be end-of-life care, but it usually includes the expectation that the child's life will end in six months or less. *Palliative care* is defined variously among health care providers. Some characterize it as "a focus on symptom control and quality of life throughout a life-threatening illness, from diagnosis to cure or death." Others define it as "management of the symptoms of patients whose disease is active and far advanced and for whom cure is no longer an option." This entry uses the term *end-of-life care* in its broader sense.

Historical Evolution of End-of-Life Care for Children and Adolescents

Today, as in the past, the values and preferences of children who are less than eighteen years of age have little or no legal standing in health care decision making. Some professionals doubt that children have the ability to adequately understand their health conditions and treatment options and therefore consider children to be legally incompetent to make such decisions. Instead, parents or guardians are designated to make treatment choices in the best interests of the minor child and to give consent for the child's medical treatment.

Since the 1980s clinicians and researchers have begun to challenge the assumption that children and adolescents cannot understand their serious medical conditions and their treatment options. Clinical anecdotes and case studies indicate that children as young as five years of age who have been chronically and seriously ill have a more mature understanding of illness and dying than their healthy peers. Still other case reports convey the ability of children and adolescents to make an informed choice between treatment options.

Researchers have documented children's preference to be informed about and involved in decisions regarding treatment, including decisions about their end-of-life care. Although there have been only a few studies about ill children's preferences for involvement in treatment decision making, a growing number of professional associations have published care guidelines and policy statements urging that parents and their children be included in such decision making. In fact, several Canadian provinces have approved legislative rulings supporting the involvement of adolescents in medical decision making. The American Academy of Pediatrics recommends that children be included in clinical decision making "to the extent of their capacity." At the federal level, the National Commission for Protection of Human Subjects of Biomedical and Behavioral Research identified the age of seven years as a reasonable minimum age at which assent of some type should be sought from a child for participation in a research protocol. According to the commission's findings, a child or adolescent at the end of life, as at other times, should be informed about the purpose of the research and given the option of dissent. In such cases, researchers should approach a child or adolescent about a study while the child is still able to give assent or to decline to participate. If this is not possible, a proxy (parent or guardian) must decide in the child's best interest.

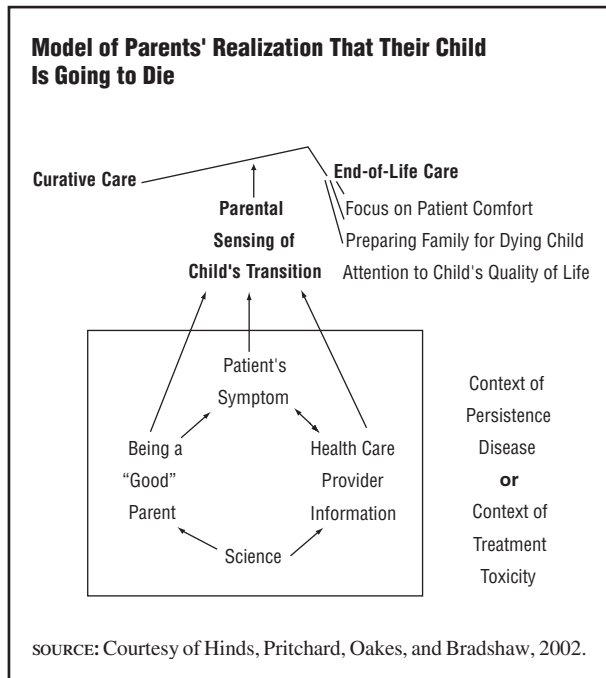
Although parents or guardians generally retain the legal right to make final care decisions for their children, it is respectful of a child's dignity to engage the child in discussions about his or her wishes and goals. In one study, parents who were interviewed after the death of their child described finding comfort in the fact that they had made end-of-life treatment decisions that their child had preferred or that they felt certain their child would have preferred. In sum, children and adolescents

nearing the end of life benefit from age-appropriate explanations of their disease, treatment options, and prognosis, and from having their preferences about their care respected as much as possible.

Talking about Dying with Children or Adolescents

One of the most difficult aspects of caring for seriously ill children or adolescents is acknowledging that survival is no longer possible. The family looks to health care providers for information about the likelihood of their child's survival. When it is medically clear that a child or adolescent will not survive, decisions must be made about what information to share with the parents or guardians and how and when to share that information. Typically, a team of professionals is involved in the child's care. Before approaching the family, members of the team first discuss the child's situation and reach a consensus about the certainty of the child's death. The team members then agree upon the words that will be used to explain this situation to the parents and the child, so that the same words can be used by all members of the team in their interactions with the family. Careful documentation in the child's medical record of team members' discussions with the patient and family, including the specific terms used, is important to ensure that all team members are equally well informed so that their care interactions with the child and family are consistent. Regrettably, a study by Devictor and colleagues of decision-making in French pediatric intensive care units reported in 2001 that although a specific team meeting had been convened in 80 percent of the 264 consecutive children's deaths to discuss whether to forgo life-sustaining treatment, the meeting and the decision had been documented in only 16 percent of the cases in the patient's medical record.

The greatest impediment to decision making at the end of life is the lingering uncertainty about the inevitability of a child's death. Such uncertainty, if it continues, does not allow time for a coordinated, thoughtful approach to helping the parents and, when possible, the child to prepare for the child's dying and death. Depending on the circumstances, such preparation may have to be done quickly or may be done gradually. The child's medical status, the parent's level of awareness, and the clinician's certainty of the child's prognosis are all factors in how much time will be available to prepare for the

FIGURE 1

child's dying. Figure 1 is a model that depicts the factors that influence efforts to prepare family members and the child who is dying of cancer. The factors that help parents to "sense" that their child is going to die include visible symptoms, such as physical changes and information obtained from trusted health care professionals. Parents are assisted in making end-of-life decisions for their child when they believe that they and the health care team have done all that is possible to save the child and that everything has been done well. Throughout the transition from curative care to end-of-life care, the partnership among patients, family members, and health care professionals must be continually facilitated to ensure that end-of-life care is optimal.

Although there is little research-based information about end-of-life decision making and family preparation, evidence-based guidelines for decision making are available. While some studies and clinical reports support the inclusion of adolescents in end-of-life discussions and decisions, there are no studies that examine the role of the younger child. Clinical reports do, however, support the idea that younger children are very much aware of their impending deaths, whether or not they are directly included in conversations about their prognosis and care.

Health care professionals uphold that continuous communication be maintained between the parents and the health care team about the status of the dying child. Parents may react to their child's terminal status in various ways, including denial. If parents appear to be in denial, it is important to ensure that they have been clearly told of their child's prognosis. In 2000 the researcher Joanne Wolfe and colleagues reported that some parents whose child had died of cancer realized after the death that they had perceived that their child was going to die significantly later than the health care team had known. Parents and other family members often vacillate between different emotional responses and seek opportunities to discuss and rediscuss their child's situation with the health care team.

Parents will often want to know when their child will die and exactly what will occur. Although it is difficult to predict when a child will die, useful information can be given about symptoms the child is likely to experience, such as breathing changes, decreasing appetite, and decreasing energy. Most importantly, parents will need to be assured that their child will be kept comfortable and that members of the health care team will be readily available to the child and the family.

Siblings may exhibit a variety of responses to the impending death of a brother or sister. These responses will be influenced by the sibling's age and developmental maturity, the length of time the dying child has been ill, and the extent to which the sibling has been involved in the patient's care. Siblings need to be told that it is not their fault that the brother or sister is dying. Siblings have indicated their need to be with the dying sibling and, if possible, to be involved in the sibling's daily care; if these are not possible, they need at least to be informed regularly about the status of their dying sibling.

Keeping the Dying Child Comfortable: Symptom Management Strategies

Children who have experienced suffering may fear pain, suffocation, or other symptoms even more than death itself. Anticipating and responding to these fears and preventing suffering is the core of end-of-life care. Families need assurance that their child will be kept as comfortable as possible, and clinicians need to feel empowered to provide care that is both competent and compassionate. As the

illness progresses, treatment designed to minimize suffering should be given as intensively as curative treatments. If they are not, parents, clinicians, and other caregivers will long be haunted by memories of a difficult death.

The process of dying varies among children with chronic illness. Some children have relatively symptom-free periods, then experience acute exacerbation of symptoms and a gradual decline in activity and alertness. Other children remain fully alert until the final hours. Research specific to children dying of various illnesses has shown that most patients suffer “a lot” or “a great deal” from at least one symptom, such as pain, dyspnea, nausea, or fatigue, in their last month of life.

Although end-of-life care focuses on minimizing the patient’s suffering rather than on prolonging life, certain supportive measures (such as red blood cell and platelet transfusions and nutritional support) are often continued longer in children than in adults with terminal illnesses. The hope, even the expectation, is that this support will improve the child’s quality of life by preventing or minimizing adverse events such as bleeding. Careful discussion with the family is important to ensure that they understand that such interventions will at some point probably no longer be the best options. Discussions about the child’s and family’s definition of well-being, a “good” death, their religious and cultural beliefs, and their acceptance of the dying process help to clarify their preferences for or against specific palliative interventions. For example, one family may choose to continue blood product support to control their child’s shortness of breath, whereas others may opt against this intervention to avoid causing the child the additional discomfort from trips to the clinic or hospital. Health care professionals should honor each family’s choices about their child’s care.

It is crucial that health care professionals fully appreciate the complexities of parental involvement in decisions about when to stop life-prolonging treatment. Parental involvement can sometimes result in the pursuit of aggressive treatment until death is imminent. In such cases, it becomes even more important that symptom management be central in the planning and delivery of the child’s care. Conventional pharmacological and nonpharmacological methods of symptom control, or more invasive measures such as radiation for

bone pain or thoracentesis for dyspnea, can improve the child’s comfort and thus improve the child’s and family’s quality of life. As the focus of care shifts from that of cure to comfort, the child’s team of caregivers should be aware of the family’s and, when possible, the child’s wishes regarding the extent of interventions.

Not all symptoms can be completely eliminated; suffering, however, can always be reduced. Suffering is most effectively reduced when parents and clinicians work together to identify and treat the child’s symptoms and are in agreement about the goals of these efforts. Consultation by experts in palliative care and symptom management early in the course of the child’s treatment is likely to increase the effectiveness of symptom control.

Accurate assessment of symptoms is crucial. Health care professionals suggest that caretakers ask the child directly, “What bothers you the most?” to assure that treatment directly addresses the child’s needs. Successful management of a symptom may be confusing to the child and his parents, especially if the symptom disappears. It is important that they understand that although the suffering has been eliminated, the tumor or the illness has not.

Although it is not always research-based, valuable information is available about the pharmacological management of symptoms of the dying child. A general principle is to administer appropriate medications by the least invasive route; often, pharmacological interventions can be combined with practical cognitive, behavioral, physical, and supportive therapies.

Pain. A dying child can experience severe pain; vigilant monitoring of the child’s condition and regular assessment of pain intensity is essential. When the child is able to describe the intensity of pain, the child’s self-report is the preferred indicator. When a child is unable to indicate the intensity of the pain, someone who is very familiar with the child’s behavior must be relied upon to estimate the pain. Observational scales, such as the FLACC, may be useful in determining the intensity of a child’s pain (see Table 1).

Children in pain can find relief from orally administered analgesics given on a fixed schedule. Sustained-release (long-acting) medications can provide extended relief in some situations and can

TABLE 1

| FLACC Scale | | | |
|--------------------|--|---|---|
| Category | Scoring | | |
| | 0 | 1 | 2 |
| Face | No particular expression or smile | Occasional grimace or frown, withdrawn, disinterested | Frequent to constant quivering chin, clenched jaw |
| Legs | Normal position or relaxed | Uneasy, restless, tense | Kicking or legs drawn up |
| Activity | Lying quietly, normal position, moves easily | Squirming, shifting back and forth, tense | Arched, rigid, or jerking |
| Crying | No crying (awake or asleep) | Moans or whimpers, occasional complaint | Crying steadily, screams or sobs, frequent complaints |
| Consolability | Content, relaxed | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort |

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Crying; (C) Consolability is scored from 0–2, resulting in a total score range of 0 to 10.
SOURCE Merkel, 1997.

be more convenient for patients and their families. Because the dose increments of commercially available analgesics are based on the needs of adults and long-acting medications cannot be subdivided, the smaller dose increments needed for children may constrain use of sustained-release formulations (see Table 2, which offers guidelines for determining initial dosages for children). The initial dosages for opioids are based on initial dosages for adults not previously treated with opioids. The appropriate dosage is the dosage that effectively relieves the pain. One review completed by Collins and colleagues in 1995 reported that terminally ill children required a range of 3.8 to 518 mg/kg/hr of morphine or its equivalent.

The appropriate treatment for pain depends on the type and source of the pain. Continuous clinical judgment is needed, especially when potentially interacting medications are given concurrently. If morphine is contraindicated or if the patient experiences unacceptable side effects, clinicians can use a conversion table (see Table 3) to calculate the equivalent dose of a different opioid. Approximately 50 to 75 percent of the morphine-equivalent dose should be used initially. It is usually not necessary to start at 100 percent of the equianalgesic dose to achieve adequate pain control. Constipation, sedation, and pruritus can occur as side effects of opioids. Table 2 lists medications

that can prevent or relieve these symptoms. The fear of addiction is a significant barrier to effective pain control, even in dying children. Family and patient fears should be actively addressed by the health care team.

Dyspnea and excess secretions. As the child's death approaches, respiratory symptoms may be distressing for both the child and the family. Anemia, generalized weakness, or tumor compression of the airways will further exacerbate respiratory symptoms. Air hunger is the extreme form of dyspnea, in which patients perceive that they cannot control their breathlessness. When a child becomes air hungry, the family may panic. Dyspnea must be treated as aggressively as pain, often with opioids. Although some medical practitioners believe that opioids should not be used to control air hunger at the end of life because they fear the opioids may cause respiratory depression, other medical professionals believe this is untrue and that the optimal dose of opioid is the dose that effectively relieves the dyspnea.

The management of dyspnea is the same in children and adults: positioning in an upright position, using a fan to circulate air, performing gentle oral-pharyngeal suctioning as needed, and supplementary oxygen for comfort. The child may have copious, thin, or thick secretions. Pharmacological options for managing respiratory symptoms are

TABLE 2

| Pharmacological approach to symptoms at the end-of-life of children | | | |
|--|--|---|---|
| Symptom | Medication | Route: Starting dose/schedule | Additional comments |
| Mild to moderate generalized pain | Acetaminophen (Tylenol) | PO: 10 to 15 mg/kg q 4 hrs PR: 20 to 25 mg/kg q 4 hrs | Maximum 75 mg/kg/day or 4000 mg/day; limited anti-inflammatory effect |
| | Ibuprofen (Motrin) | PO: 5 to 10 mg/kg q 6 to 8 hrs | Maximum 40 mg/kg/dose or 3200 mg/day; may cause renal, gastrointestinal toxicity; interferes with platelet function |
| | Choline Mg Trisalicylate (Trilisate) | PO: 10 to 15 mg/kg q 8 to 12 hrs | Maximum 60 mg/kg/day or 3000 mg/day; may cause renal, gastrointestinal toxicity; less inhibition of platelet function than other NSAIDs |
| | Ketoralac (Toradol) | IV: 0.5 mg/kg q 6 hrs | Limit use to 48 to 72 hours |
| Mild to severe pain | Oxycodone | PO: initial dose of 0.1 to 0.2 mg/kg q 3 to 4 hrs (no maximum dose) | Available in a long-acting formulations (oxycotin) |
| | Morphine (for other opioids see conversion chart; usual dosages are converted to dose already established with the morphine) | All doses as initial doses (no maximum dose with triation) PO/SL: 0.15 to 0.3 mg/kg q 2 to 4 hrs IV/SC intermittent: 0.05 to 0.1 mg/kg q 2 to 4 hrs IV continuous: <i>initial bolus</i> of 0.05 mg/kg followed by an <i>infusion</i> of 0.01 to 0.04 mg/kg/hr IV PCA: 0.02 mg/kg with boluses of 0.02 mg/kg q 15 to 20 min. Titrate to desired effect | PO: available in several long-acting formulations (Oramorph; MS Contin) For severe acute pain, IV: 0.05 mg/kg boluses every 5 to 10 minutes until pain is controlled. Once controlled, begin continuous infusion and bolus as indicated on the left. |
| | Gabapentin (Neurontin) for neuropathic pain | PO: 5 mg/kg or 100 mg BID | Takes 3–5 days for effect; increase dose gradually to 3600 mg/day |
| | Amitriptyline (Elavil) for neuropathic pain | PO: 0.2 mg/kg/night | Takes 3–5 days for effect; increase by doubling dose every 3 to 5 days to a maximum of 1 mg/kg/dose; use with caution with cardiac conduction disorders |
| Bone pain | Prednisone | PO: 0.5 to 2 mg/kg/day for children > 1 year, 5 mg/day | Avoid during systemic or serious infection |
| Dyspnea | Morphine | PO: 0.1 to 0.3 mg/kg q 4 hrs IV intermittent: 0.1 mg/kg q 2 to 4 hrs | |
| For secretions contributing to distress | Glycopyrrrolate (Robinul) | PO: 40 to 100 mg/kg 3 to 4 times/day IV: 4 to 10 mg/kg every 3 to 4 hrs | |
| Nausea | Promethazine (Phenergan) | IV or PO: 0.25 to 0.5 mg/kg q 4 to 6 hours | Maximum 25 mg/dose; may have extrapyramidal side effects |
| | Odansetron (Zofran) | IV: 0.15 mg/kg q 4 hrs PO: 0.2 mg/kg q 4 hrs | Maximum 8 mg/dose |
| <i>*If caused by increased intracranial pressure</i> | Lorazepam (Ativan) | PO/IV: 0.03 to 0.2 mg/kg q 4 to 6 hrs | IV: Titrate to a maximum 2 mg/dose |
| <i>*If caused by anorexia</i> | Dexamethasone | IV/PO: 1 to 2 mg/kg initially; then 1 to 1.5 mg/kg/day divided q 6 hrs | Maximum dose of 16 mg/day |
| <i>*If caused by reflux</i> | Metoclopramide (Reglan) | IV: 1 to 2 mg/kg q 2 to 4 hrs | Maximum 50 mg/dose; may cause paradoxical response; may have extrapyramidal side effects |
| Anxiety or seizures | Lorazepam (Ativan) | PO/IV: 0.03 to 0.2 mg/kg q 4 to 6 hrs | IV: Titrate to a maximum 2 mg/dose |
| | Midazolam (Versed) | IV/SC: 0.025 to 0.05 mg/kg q 2 to 4 hrs PO: 0.5 to 0.75 mg/kg PR: 0.3 to 1 mg/kg | Titrate to a maximum of 20 mg |
| Anxiety or seizures | Diazepam (Valium) | IV: 0.02 to 0.1 mg/kg q 6 to 8 hrs with maximum administration rate of 5 mg/kg PR: use IV solution 0.2 mg/kg | Maximum dose of 10 mg |
| | Phenobarbital (for seizures) | For status epilepticus, IV: 10 to 20 mg/kg until seizure is resolved | Maintenance treatment IV/PO: 3 to 5 mg/kg/day q 12 hrs |
| | Phenytoin (Dilantin) for seizures | IV: 15 to 20 mg/kg as loading dose (maximum rate of 1 to 3 mg/kg/min or 25 mg/min) | Maintenance treatment IV/PO: 5 to 10 mg/kg/day |

[CONTINUED]

TABLE 2 [CONTINUED]

| Pharmacological approach to symptoms at the end-of-life of children [CONTINUED] | | | |
|--|----------------------------|--|--|
| Symptom | Medication | Route: Starting dose/schedule | Additional comments |
| For sedation related to opioids | Methylphenidate (Ritalin) | PO: 0.1 to 0.2 mg/kg in morning and early afternoon | Maximum dose of 0.5 mg/kg/day |
| | Dextroamphetamine | PO: 0.1 to 0.2 mg/kg in morning and early afternoon | Maximum dose of 0.5 mg/kg/day |
| Pruritus | Diphenhydramine (Benadryl) | PO/IV: 0.5 to 1 mg/kg q 6 hrs | Maximum dose of 50 mg/dose |
| Constipation | Senna (Senekot) | PO: 10 to 20 mg/kg/dose or 1 tablet BID | |
| | Bisacodyl | PO: 6–12 years, 1 table q day > 12 years, 2 tablets q day | |
| | Docusate | PO divided into 4 doses: < 3 years, 10–40 mg 3–6 years, 20–60 mg 6–12 years, 40–120 mg > 12 years, 50–300 mg | Stool softener, not a laxative |
| | Pericolace | 1 capsule BID | Will help prevent opioid-related constipation if given for every 30 mg of oral morphine per 12-hour period |

PO = by mouth; SL = sublingual; PR = per rectum; IV = intravenous route; SC = subcutaneous route; PCA = patient controlled analgesia pump; q = every;
NSAIDs = non-steroidal anti-inflammatory drugs

SOURCE: Adapted from McGrath, Patricia A., 1998; St. Jude Children's Research Hospital, 2001; Weisman, Steven J., 1998; World Health Organization, 1998; Yaster, M., E. Krane, R. Kaplan, C. Cote, and D. Lappe, 1997.

also outlined in Table 2. Anxiolytic agents are often needed to relieve the significant anxiety that can accompany dyspnea.

Nausea. Multiple effective options are available for the management of nausea and vomiting in dying children. Unrelieved nausea can make other symptoms worse, such as pain and anxiety (see Table 2).

Anxiety and seizures. Restlessness, agitation, and sleep disturbances may be caused by hypoxia and metabolic abnormalities related to renal and hepatic impairment. A supportive environment may be the most effective strategy to counter these symptoms. Cautious use of anxiolytics may also be helpful (see Table 2). Although dying children rarely have seizures, they are upsetting for the child and his caregivers. Strategies to manage seizures are listed in Table 2.

Fatigue. Dying children commonly experience fatigue, which can result from illness, anemia, or inadequate calorie intake. Fatigue may be lessened if care activities are grouped and completed during the same time period. The use of blood products to reduce fatigue should be carefully considered by the family and health care team.

TABLE 3

| Drug | Equianalgesic dose | |
|--------------------|---------------------------|---------------|
| | IM/IV | PO |
| Morphine (mg) | 10 | 30 |
| Hydromorphone (mg) | 1.5 | 7.5 |
| Fentanyl (mg) | 0.1–0.2 | Not available |
| Oxycodone (mg) | Not available | 15–30 |

SOURCE: Adapted from Weisman, 1998; Yaster, 1997.

Choosing a Hospice

Ensuring the availability of appropriate home care services for children who are dying has become more challenging in this era of managed care, with its decreasing length of hospital stays, declining reimbursement, and restricted provider networks. Health care providers and parents can call Hospice Link at 1-800-331-1620 to locate the nearest hospice. Callers should ask specific questions in order to choose the best agency to use for a child; for example, “Does your agency . . .”

- Have a state license? Is your agency certified or accredited?

- Take care of children? What percentage of patients are less than twelve years of age? From twelve to eighteen years?
- Have certified pediatric hospice nurses?
- Have a staff person on call twenty-four hours a day who is familiar with caring for dying children and their families?
- Require competency assessments of staff for caring for a child with _____ (specific disease of the child); certain health care equipment, etc.?
- Require a Do Not Resuscitate (DNR) order?
- Provide state-of-the art symptom management geared to children? Please describe.
- Not provide certain interventions such as parenteral nutrition or platelet transfusions?
- Commit to providing regular feedback from the referring agency/provider to promote continuity of care?

Visiting the Web

The increasing number of web sites related to end-of-life care for children makes additional information available to both health care providers and families. Visiting a web site that describes a model hospice may be useful in selecting one that is within the family's geographic location (www.canuckplace.com/about/mission.html). Information about hospice standards of care can be found at www.hospicenet.org/ and www.americanhospice.org/ahfdb.htm (those associated with American Hospice Foundation).

See also: CHILDREN; CHILDREN AND ADOLESCENTS' UNDERSTANDING OF DEATH; CHILDREN, CARING FOR WHEN LIFE-THREATENED OR DYING; END-OF-LIFE ISSUES; INFORMED CONSENT

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CHILDREN, CARING FOR WHEN LIFE-THREATENED OR DYING

A child's terminal illness and/or death is an almost unspeakable and fortunately rare tragedy in the developed world; the death of a child is considered an affront to the natural order in these societies because parents are not supposed to outlive their children. However, the death of a child is a far more common experience in developing nations. The experience is colored by these relative frequencies. In nations with seemingly limitless resources for cure, the tragedy of a child's illness and death is

often unwittingly compounded by well-meaning members of the family, the medical establishment, and the community, through lack of acknowledgment of the child's suffering; continued application of harmful and unhelpful therapies; and a lack of effective response to the human issues the child and family endure as they struggle to maintain dignity and normalcy. The repercussions of this approach are felt long after the death of the child. Increased knowledge of the circumstances of childhood death and helpful responses may prevent these problems and improve the quality of life for all concerned.

Who Are the Children Who Die?

Patterns of childhood death vary substantially among nations, related primarily to the level of education of the masses, availability of resources, and other public health issues. In developing countries, children often die in the first five years of life from diarrheal illnesses and pneumonia (the most common and most preventable causes, each accounting for 3 million childhood deaths worldwide per year) and other infectious diseases. AIDS (acquired immunodeficiency syndrome) is becoming epidemic in many countries, particularly in sub-Saharan Africa. Every day, 6,000 young people under age twenty-four are infected with HIV. Every day, 2,000 infants contract HIV through mother-to-child transmission. Every day, more than 6,000 children under age five are left orphans by AIDS. And every day, 1,600 children die of AIDS. Across the globe, children under eighteen make up approximately 10 percent of the 40 million people who are living with HIV. Prevention and treatment of AIDS and its related complications is very expensive, and few African nations can provide their citizens with the required therapies. Thus AIDS is a more rapidly fatal disease in these countries; figures from the World Health Organization indicate that globally, during the year 2001, 2.7 million children under the age of fifteen were living with HIV/AIDS, 800,000 children were newly infected, and 580,000 children died of the disease; of these, the vast majority are in sub-Saharan Africa.

In countries with access to greater education and resources, far fewer children die; those who do die during childhood die of a vastly different spectrum of causes. In the first year of life (infancy), these include congenital defects and malformations, extreme prematurity (birth prior to twenty-eight weeks gestation), and sudden infant

death syndrome (SIDS). In the United States 27,000 infants die annually. Similar causes and rates of death are seen in the United Kingdom and Canada. The remainder of childhood deaths, occurring from age one to nineteen years, includes trauma as the leading cause (motor vehicle occupant, driver and pedestrian injuries, drowning, murder, suicide, and other trauma), cancer, and death related to congenital heart disease. Other less frequent causes of childhood death include cystic fibrosis, muscular dystrophy, and rare genetic disorders leading to severe brain dysfunction or other end-organ failure, such as liver, kidney, and immune system failures.

The causes of death in children clearly differ substantially from adults. The rarity of childhood death hides it from view and from the collective consciousness of the public, thus depriving the common citizen and the health care professional alike of a feeling of competence in responding to such a situation, whether the affected child is one's patient, son or daughter, friend, or neighbor. Lack of experience with childhood terminal illness in particular and the promise of modern medical "miracles" in highly developed nations sometimes prevents the acknowledgment of the terminal state, with parents and health care personnel often insisting on trying one last "life-prolonging" or "curative" intervention, often when chances of improving or prolonging life are relatively small. The losers in this situation are often the patients as well as the guilt-ridden family, particularly as the latter reflect on their decisions after the child's death.

Siblings, similarly, need support during the child's illness, during the terminal phase, and after the death. Siblings often feel responsible in some way for the ill child's fate, lonely and not loved by absorbed and exhausted parents, and guilty for wishing the child would die (especially when the death occurs). Children (and adults) engage in magical thinking: "If I didn't get mad and wish he would go away and leave mom and dad to me, he would not be sick." For this reason, it is important for caregivers to ask siblings (and the sick child) why they think the illness came about and then to help them understand the real reason in an effort to allay their fears and guilt about being the causative agent. The community can respond to the siblings' needs by listening to them, allowing them to be angry, committing to spending time with them in the parents' absence, spelling the



The neonatal intensive care unit in hospitals, certainly a foreign and technical environment to non-medical personnel such as parents, is one that many parents have to visit when their child's life is in danger. Unfortunately in less-developed nations, parents whose infant children die do not have the opportunity or funds to invest in this type of technological care. CORBIS (BELLEVUE)

parents from the ill child's bedside to enable the parents to spend time with the sibling, and offering to do simple things, such as running errands to expand parents' free time.

Families are particularly isolated in the case of traumatic death of their child, as there are no systematic provisions for bereavement care of such families and the grief is felt throughout the community, forcing society to recognize that death is unpredictable and that all children are vulnerable. This realization is difficult for members of the community, and creates barriers to support.

When a child dies from a traumatic injury, there is no preparation for the death, no feeling that the child is "in a better place," no longer having to suffer the ravages of illness. Instead, a young, healthy life has been cut short, with no redeeming features of the loss. However, when the possibility of organ donation is offered, many families feel that something good has come of their

pain. Nevertheless, sudden death, whether from trauma or SIDS, seems the most difficult for bereaved parents to mourn and to effectively reconstruct a new life without the child.

Medical Caregiver Expertise in Caring for the Incurable

Medical care providers, trained to focus on cure as the only positive outcome, often feel at a loss as to how to be helpful when it is determined that the child will in fact die. With no education regarding symptom relief or how to address psychological and spiritual distress, the medical caregiver may retreat from the care of the patient in order not to be reminded of his or her inability to "do something." Training in medical school, once focused on providing comfort, has devolved to a technically oriented, fact-filled curriculum, often with little to no emphasis on enduring and unchanging issues of human interaction or on inevitable death.

Virtually no curricular time is devoted to the management of symptoms, outside of the symptom relief achieved by the reversal of the pathophysiologic process. This problem is exacerbated in pediatrics and pediatric subspecialty training, as death is considered to be so rare as to not merit allocation of educational time.

Bereavement care, critical to the well-being of survivors of childhood death, is virtually never addressed. It is of interest that veterinarian trainees are taught to send condolence cards, but the idea is never mentioned in the medical curriculum. In fact, the *New England Journal of Medicine* published an article in 2001 that was an impassioned plea regarding how and why to write condolence letters. Bereaved parents, when interviewed about what would help alleviate the pain of the loss of a child, recurrently stated that evidence that people care about and remember their child, including sending a note using the child's name or a simple phone call, meant more than most people imagine. Ignorance about the tremendous healing provided by communication and contact with bereaved families prevents health care personnel—including physicians, nurses, social workers, and members of the larger community—from providing such healing. In response, health care personnel, not used to this feeling of impotence, may leave practice or become hardened to the needs of the child and family, becoming brusque and seemingly uncaring. When medical education addresses the full spectrum of medical care, including care for those who will not be cured, many of these problems will be resolved.

Research in Pediatric Palliative Care

Palliative care is “control of pain, of other symptoms, and of psychological, spiritual and other problems. . . . The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are applicable earlier in the course of illness. . . .” The research base in adult palliative care, though not the accumulated experience, is scant. Research that has been conducted in pediatric patients who are chronically and terminally ill is even less voluminous. There are four reasons for this lack of available research:

1. Few children have terminal conditions; many more children die of trauma.
2. Of the remainder, few die of the same disorder; for example, cancer, which is itself very heterogeneous, claims 1,200 children's lives per year in the United States and is the most common disease diagnosis among children who die. Thus, it is difficult to obtain an effective research sample size.
3. Because of the small numbers affected, allocation of research dollars has not been generous, compared to other causes.
4. Ethicists are concerned about whether it is possible to get non-coerced consent from children and their families when the child may also be dependent on the same care providers for maintenance of life and comfort. (However, researchers and institutional review boards curiously do not seem to have the same degree of concern about allowing parents and children to consent to research protocols directed at finding new cures, even when there is no hope that the individual patient will benefit.)

Without research, provision of pediatric palliative care will continue to vary from institution to institution. It will be based only on the expertise of the local practitioners and their own uncontrolled experience with relatively few patients, compared to research studies. Therapies offered will not be proven to be efficacious, but rather be therapies that have worked in one or a few other patients. Academics and the medical community feel that such anecdotally based care is not worthy of teaching to trainees, as it is unproven and not scientific. Thus, the vicious cycle of ignorance of how to care for such children and families is perpetuated. In the absence of research and education, children and their parents will continue to suffer unnecessarily.

For example, the provision of effective pain management for children terminally ill with cancer is not taught. A study by Wolf at the Boston Children's Hospital of the Harvard Medical School, found in a retrospective survey of parents of 103 children who had died of cancer, that only 80 percent of children, most of had pain severe enough to cause substantial suffering, were assessed as having pain at all. Moreover, while there was an attempt to treat the pain in 80 percent of these cases, treatment was effective in relieving the pain in only 30 percent.

Research specific to children, not research performed on adults, is essential. Children of different age groups have different physiology from each other and from adults. Infants and younger children differ physiologically from older children in many ways, such as with regard to enzyme maturity, organ function, percentage of body water, and neural processing. In addition, infants and children differ dramatically according to age and maturity in their perceptions of their situations, the ability to employ self-calming techniques, the success of external sources of comfort, the degree of the spiritual impact of illness, and other “psychosocial” ramifications of their conditions. Thus, extrapolation from adult literature and data is insufficient. It is critical that research on palliative care specific to children be conducted—for both the ethical care of these children and the effective reintegration of their survivors. Moreover, once the information is documented scientifically, academic medical centers are more likely to include the information in their curricula, tremendously broadening the impact of the research on the care of children living with life-threatening conditions. In fact, both the Royal College of Pediatrics and Child Health in the United Kingdom and the American Academy of Pediatrics have called for increased research in palliative care for children, in addition to exhorting increased education on the topic during pediatric and subspecialty training.

Programs for Pediatric Palliative Care

At its best, palliative care for children addresses the child, parents, siblings, extended family, schoolmates, and other affected members of the community. It addresses the physical, social, spiritual, and emotional aspects of death and dying. In order to accomplish such goals, a team—consisting of the family, community, hospital, and hospice personnel—delivers palliative care. Principal team members include the child, family, physicians (primary care and specialist), nurse, care manager, social worker, and chaplain. Other critical team members include pediatric psychologists and child life therapists, both of whom address the concerns of the child and siblings in a developmentally appropriate manner. These professionals often use art therapy—art, play, music, and behavioral observation—to treat the child. Because children may be unwilling to divulge information directly to parents or their main caregivers due to their fear of

hurting them or offending them, these skilled therapists are available to assist with the communication and interpretation of the child’s concerns and desires, as well as to provide the child with advice and an open invitation to reveal innermost thoughts. When child life therapists or child psychologists are involved in the care team, children’s views of their situation and their priorities are more likely to be solicited and honored. However, the role of these therapists is neither understood nor reimbursed by payers, primarily because their participation is seen as being “not medically necessary,” and thus their availability is often tragically limited. In 2000 the American Academy of Pediatrics validated the role of the child life therapist in providing the child with the opportunity to participate meaningfully in his or her care decisions.

Pediatric palliative care is in the early developmental stages. The United Kingdom has the most highly developed system, with two specialist physicians and a nurse training program, as well as twelve hospices devoted to children in England, one in Scotland, one in Wales, and one in Australia. Helen House, founded by Sister Frances Dominica in 1982, was the first of such houses. Hospice in England was initially funded purely through private donations. The houses were designed to care for children from the time of diagnosis of a life-threatening condition. Their function is to provide respite care (care when the child is in his or her usual state of health, providing family caregivers with a needed rest and time to rejuvenate themselves for their continued efforts), to provide or train community based pediatric specialist nurses, to provide case coordination, and to provide a twenty-four-hour hotline for symptom distress. Children may also come to the hospice for their final days. Children cared for in these hospices often have chronic, progressive, or severe, static neurological dysfunction. Research on palliative care for children is infrequently reported by these busy clinical services. In addition, there are two pediatric palliative care physician members of interdisciplinary palliative care teams based in academic hospitals. Their primary focus has been the child dying of cancer, although the programs are expanding to include children with other diagnoses.

In the United States, the term *hospice* denotes a package of services only available to patients who have been determined by their physicians to have less than six months’ life expectancy and who have

chosen (or, in the case of children, whose parents have chosen) to forgo further life-prolonging therapies. The package is determined by the federal government (with other payers in general mimicking this program) and mandates standards of care, including that the care is overseen by a physician; that visits occur every other week at a minimum, and more often as needed, by nurses and social workers; and that pastoral counselors, home health aides, and volunteers are also part of the team. There is no requirement for caregivers to have pediatric experience or education. Care is delivered primarily in the child's home and respite appropriate to the needs of children and their families is infrequently available. Bereavement care for the family is mandated for thirteen months after the death, but with no additional reimbursement provided to the hospice; thus, some programs provide written information on a monthly basis, while others may provide personal counseling and support groups. Rarely is there a sibling-specific program for bereavement; their needs generally go unmet. It has been found that the shorter the patient's hospice stay the longer the bereavement needs of the survivors; children tend to be very short stay hospice patients.

The U.S. hospice benefit is paid as an all-inclusive daily rate of reimbursement. All professional time, medications, equipment rental, therapy, and other care are included in this rate. In 2001 the average daily rate was \$107 per day. This rate of reimbursement may preclude the administration of symptom-relieving interventions, including, for instance, the administration of blood products that increase the child's energy enough to play and interact with others, decrease breathlessness, and thus improve the ability to sleep and eat, or decrease bleeding problems. These are frequent concerns in childhood cancers, which primarily affect the bone marrow.

Arriving at a prognosis of less than six months for a child is fraught with difficulty due to societal expectations as well as the rare and thus unpredictable nature of some pediatric fatal disorders. Choosing to forgo "life-prolonging therapies" can be difficult for other reasons, as well. Some children have been ill all their lives; differentiating daily therapeutic routines that bring comfort from consistency versus life-prolonging care may be impossible for the family, practically and psychologically. To address these problems, large hospices have

obtained expensive home health licensure to enable the care of children not willing to accept the restrictions of hospice, but who need palliative care in addition to the traditional life-prolonging care model. This marriage of hospice and "traditional" care is called "palliative care" in the United States. It is care that is rarely available for adults or children. However, hopeful changes have been occurring since the early 1990s. Forerunners in this area include Drs. Kathleen Foley and Joanne Lynn, with funding from the Open Society Institute and the Robert Wood Johnson Foundation.

Due to these and other efforts, palliative care for adults and children is slowly beginning to emerge. In 1999, at the urging of pediatric palliative care experts, the federal government of the United States allocated a small amount of funds to investigate new models of care for children living with life-threatening conditions and their families through five state Medicaid waivers. The Institute of Medicine, a branch of the National Academy of Sciences, a nonprofit, non-governmental body of expert scientists and consultants, is reviewing the evidence regarding the benefits and costs of pediatric palliative care. Numerous curricula on pediatric palliative care and texts devoted to the subject have been published or are under development, including the *Compendium of Pediatric Palliative Care*, distributed to various nations in 2000 by the U.S.-based National Hospice and Palliative Care Organization.

In London; Sydney, Australia; and Boston, Massachusetts, three major children's hospitals have pediatric palliative care services with physician directors. These services began from care for children with cancer and are expanding to include children with other life-threatening disorders. One innovative program at the University of Texas in Galveston addresses the needs not only of the chronically ill or cancer patient but also the victims of sudden death. Called the Butterfly Program, the program consists of home-based hospice and palliative care, hospital-based palliative care consultation, and a room (called the Butterfly Room) devoted to the care of children living with or dying from life-threatening conditions, including children who are the victims of trauma.

Although it has many uses, the Butterfly Room, located one floor above the pediatric critical care unit and on the same floor as the cancer and chronic care wards, most benefits families whose

children die suddenly. There is space for over fifty people to be present. The room has numerous rocking chairs, a living room area, a kitchenette, and a sitting alcove, in addition to sofa beds, a full bath, and the equipment to care for a child receiving any kind of life support. When children are transferred to the room, the agreement has been made to remove life-support systems that same day. Prior to transfer, all monitors are removed, all investigations and interventions that do not promote comfort are discontinued, and all equipment that is unnecessary for comfort is also removed. Families are invited to bring other family members, friends, neighbors, or any other supporters with them. The reasons for the family and care team's decision to stop attempts to prolong life are reviewed. Questions are entertained. Explanations of the events of the day are provided and questions again answered. Any rituals are encouraged, including bathing the child, dressing him or her in personal clothing, singing, chanting, crying, praying, and taking photographs and videos of the events. Handprints and or hand molds are made, if desired. When everyone is prepared to let go, the parents are asked whom they wish to be present at the time of the removal of the life-support machines and who should be holding the child. Prayers may be offered as well as the comforting idea of seeing the child's face once more without tape and tubes. Hospice personnel provide bereavement assistance for as long as the family needs attention and care. The program has successfully been transferred to other sites at university hospitals in San Antonio, Texas (where it is called the Mariposa Room), and Kansas City, Missouri (where it is called the Delta Room). Another is being developed in Greenville, North Carolina. However, reimbursement for this highly valued care is nonexistent.

Acknowledging Death

Although the best outcome for children is a long and healthy life, that end result is not always possible. When a child is not responding to therapies, it is time to entertain the possibility that he or she may die and to increase the emphasis on the importance of quality of life considerations and the child's priorities (when developmentally appropriate) in making treatment decisions. Medical care, for all its promise, is still filled with pain, other adverse treatment-related symptoms, isolation, fear, self-doubt, and loss of freedom to be a child, to

enjoy playing and exploring one's world. When the child is still well enough to enjoy the opportunity to participate in life, that time is too often spent pursuing an elusive "cure." When the focus should be on the optimization of symptom control and attainment of personal goals or being in a familiar and comfortable place, too often the time is spent in the clinic, hospital bed, or intensive care unit. Parents need "permission" from the medical community, family, and friends to stop pursuing life-prolonging therapies; often they are afraid of offending their physicians, being accused of not loving their children, or being neglectful or selfish. Unfortunately, children's own ideas and preferences about their care are not routinely solicited and, if offered, are ignored, which frequently increases their sense of unimportance and isolation.

Grief, Guilt, and Bereavement

Not only are the children victims of the societal mandate to "keep trying," but so are other members of the family, who are deprived of opportunities to share new adventures and insights or to invest in new forms of hope, rather than in the all-consuming quest for cure. Parents suffer in all cases of chronic illness and of death of their children; unable to protect their children, they are rendered powerless and helpless, too often feeling guilty for things beyond their control. Parents often ask themselves: "What if I had noticed the lump sooner?" "What did I do to cause this?" "Why couldn't it have been me?" Well-intended family and friends who do not know how to respond may inadvertently compound the problem by avoiding contact in order "not to remind the family" of their loss, isolating them at the time they most need companionship. Employers may not understand the demands of a sick child or the duration and toll of parental bereavement and may exhort the parents to "get on with their lives."

The ill child him- or herself often feels guilty; children are able to feel the tension and are aware of the fact that they are in the center of it. The ill child is also aware that he or she is ill and even that he or she is dying, even if the child is never told. In fact, the ill-advised admonition (and natural tendency) to "hide" the status of the child's illness from the child was reversed when Bluebond-Langner's research in the 1970s (*The Private Worlds of Dying Children*) indicated that children (with cancer) who were terminally ill were aware of the

fact, often before their physicians and parents were aware of it. When adults and others denied how ill they were, the children felt abandoned. Current advice of informed professionals is to involve children in the own care, clarify their questions, and answer them simply and honestly, remaining open to additional queries and disclosures of fears and concerns. Adults can help by allowing the child to see his or her sorrow, share how to respond, and offer mutual strength.

Creating Effective Responses to Childhood Death

Difficulties in caring for terminally ill children include: (1) the lack of a definition of the relevant population; (2) societal, family and medical practitioner unwillingness to acknowledge the terminal nature of certain conditions; (3) lack of research-based knowledge to enable effective treatment specific to the population; (4) lack of existing personnel with appropriate child-specific expertise; and (5) poor access to resources and systems to care for such children and their bereaved survivors. Regardless of the wealth and advancement of nations, care of terminally ill children remains challenging.

Despite these challenges, pediatric palliative care of the twenty-first century is improving. Needed changes to the delivery of care for children living with and dying from life-threatening conditions are beginning to emerge. There is a desperate need for the community, educators, researchers, and legislators to acknowledge these children and their families. Simple compassion is a good start, both for laypeople and health care professionals. Scientific investigation, intensive education, and changes in the regulation and reimbursement of health care will lead society to the realization of the potential for effective care for children who die and their families.

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MARCIA LEVETOWN

CHILDREN, MURDER OF

On October 25, 1994, Susan Smith, a South Carolina wife and mother, drowned her two-year-old and fourteen-month-old sons. Marilyn Lemak, a forty-one-year-old registered nurse drugged and then suffocated her three young children (ages three to seven) in her home in Naperville, Illinois, on March 5, 1999. Slightly more than one month later, on April 20, 1999, seventeen-year-old Dylan Klebold and eighteen-year-old Eric Harris entered Columbine High School in Littleton, Colorado, killed twelve fellow students and a teacher, and then killed themselves. Although modern sensibilities are shocked and saddened by tragic cases such as these, as children are not supposed to die, both sanctioned and unsanctioned murders have occurred throughout human history.

Murder is the killing of one person by another person with "malice aforethought" (e.g., an aim to cause death or do bodily harm). The term *malice*, or *malicious intent*, is used in relation to a murderous act, even if the perpetrator did not mean to

hurt anyone. An assault (an attempt to harm someone without killing them) can be murder if death is a foreseeable possibility. Criminal justice experts James Alan Fox and Jack Levin state, "A parent, distraught over a crying colicky baby, who shakes the infant to silence her, and does it so vigorously as to cause death can . . . be charged with murder, so long as the parent is aware that this rough form of treatment can be detrimental" (2001, p. 2).

Historical and Cross-Cultural Overview

Historically and cross-culturally, the murder of children has taken many forms. Anthropological studies of traditional societies, such as the Yanomamo of South America, and sociological studies of some advanced civilizations indicate the practice of infanticide (the killing of children under the age of five), past and present. Female infanticide has been discovered among some traditional patriarchal groups such as the Chinese. Often the murder of children has been noted for humanitarian reasons, such as because of overpopulation or an inadequate food supply. Similarly, poor and low-income families have killed their children when they have been unable to support them. Some societies have promoted the killing of children born with birth defects, mental challenges, or a serious disease or disorder. In certain societies, children who were believed to be tainted by evil (e.g., twins) were slain at birth. Among the ancient Greeks and Romans, a father could dispose of his child as he saw fit.

Although there have been several accounts of the ritual killing of children, especially sacrifice for religious purposes, according to folklorist Francis James Child, many are without foundation. One story tells of the murder and crucifixion of a little boy named Hugh in the thirteenth century by Jews. English folk ballads such as "The Cruel Mother" and "Lamkin" tell of the sadistic murder of children. "Mary Hamilton" relates the story of feticide (the act of killing a fetus, which has been proven beyond a reasonable doubt to be capable of, at the time of death, surviving outside of the mother's womb with or without life support equipment) in sixteenth-century England.

Throughout the Christian world, the main source of information concerning the importance of children is biblical teachings found in the Old and New Testaments. For example, Psalm 127

notes that children are a gift, a reward from God. Mark 10 states that the Kingdom of God belongs to children, and "whoever does not receive the Kingdom of God like a child shall not enter it at all." While biblical scriptures emphasize the importance of children, there is a multiplicity of passages that reflect the murder of children. God sanctions the killing of all Egyptian first-born children in the last plague before the exodus, in an attempt to free the Hebrews from Egyptian control. King Herod has male children in Bethlehem two years of age and under murdered. The Book of Deuteronomy states that the parents of rebellious children are to have them stoned to death.

The United States has experienced hundreds of child murders since the first settlers landed at Jamestown, Virginia, in 1607. One of the earliest examples of the murder of children in America occurred on Friday, August 10, 1810, at Ywahoo Falls in southeast Kentucky. White racists, desiring to drive the Cherokee from their land, decided that the best way to get rid of the Indian problem was to kill all the children so there would be no future generations. The Indians, learning that "Indian fighters" were gathering in eastern Kentucky to carry out their barbaric act, gathered the women and children together at Ywahoo Falls and prepared to march them to a Presbyterian Indian school near present-day Chattanooga, Tennessee. Over a hundred Cherokee women and children were slaughtered before they could make the trip (Troxell, 2000).

Numerous child murders gained notoriety in the first thirty years of the twentieth century. In fact, Nathan Leopold and Richard Loeb committed what some have termed the "crime of the century" when they murdered fourteen-year-old Bobbie Franks on May 21, 1924, in Chicago, Illinois. Albert Fish, the oldest man ever executed in the electric chair at Sing Sing Prison, was killed on January 16, 1936, for the murder and cannibalism of 12-year-old Grace Budd. The most sensational murder case of the twentieth century involved the kidnapping and murder of the young son of the famous aviator Charles Lindbergh on March 1, 1932. These classic cases, as well as more contemporary cases such as the murder of ten-year-old Jeanine Nicarico of Naperville, Illinois, in February 1983, the Marilyn Lemak case, and Susan Smith's murder of her two children, have alerted Americans to how vulnerable children are to acts of homicide.

Recent school killings such as the incident at Columbine High School in Littleton, Colorado, have forced the nation to realize that children can be killed in mass numbers.

Factors in the Murder of Children

The United States has the highest homicide rate for children of any industrialized nation in the world. Federal Bureau of Investigation statistics show that slightly more than 11 percent of murder victims in 1999 were children under the age of eighteen. The firearm-related homicide rate for children is more than twice that of Finland, the country with the next highest rate.

Both adults and older children (ages five to eighteen) who are victims of homicide are likely to die as the result of a firearm-related incident. However, only 10 percent of homicides among younger children (under age four) are firearm related. Young children are generally murdered via abandonment, starvation, suffocation, drowning, strangulation, or beating, the victims of adults or other children. They may die at the hands of parents, siblings, friends or acquaintances, or strangers.

Studies of murdered children under twelve years old reveal that nearly six out of ten are killed by their parents. Half of these are under the age of one. The next highest category of perpetrator is a friend or acquaintance. A significant number of children are killed by offenders in their own age cohort, as the recent rash of school killings indicates. According to James Fox and Jack Levin, authors of *The Will to Kill* (2001), with the exception of infanticide, "most offenders and their victims are similar in age" (p. 27). Reasons why children kill other children are many and varied. When the teenagers Nathan Leopold and Richard Loeb killed Bobbie Franks in 1924, their objective was to commit a "perfect" crime. A large portion of the school killings in the late twentieth-century years has resulted from the perpetrator being cruelly teased or ostracized by classmates. In large cities, many children are victims of gang killings, whether they belong to a gang or not. Wearing the wrong color of shoelaces, having one's hat tilted in the wrong direction, or just being in the wrong place at the wrong time can result in death. Gang members kill other gang members as a consequence of petty jealousy or a need to display their manhood. There have been occasions when children have

killed their victim because he or she refused to obey an order. For example, in Chicago, Illinois, two children threw another from the roof of a building because the victim refused to obtain drugs for the murderers.

Familial Homicides

The psychiatrist P. T. D'Orban classifies the factors that play a role in filicides (the killing of a son or daughter) into three categories: family stress, including a family history of mental illness and crime, parental discord, parental maltreatment, and separation from one or both parents before age fifteen; social stress, involving financial and housing problems, marital discord, a criminal record, and living alone; and psychiatric stress, comprising a history of psychiatric symptoms, a psychiatric diagnosis, and a suicide attempt after the offense.

A history of child abuse or neglect is the most notable risk factor for the future death (i.e., murder of a child). Scholars note that the best predictor of future violence is a past history of violence. Most child abuse killings fall into the category of battering deaths, resulting from misguided, but brutal, efforts to discipline, punish, or quiet children. According to a study conducted by Murray Levine and associates, 75 percent of maltreatment-related fatalities occur in children under age four. Very young children are at the greatest risk because they are more physically vulnerable and less likely to be identified as at-risk due to their lack of contact with outside agencies. Shaken baby syndrome, in which the child is shaken so violently that brain damage can occur, takes the lives of many young children.

There are numerous risk factors for child murder. The criminal justice expert Neil Websdale has identified several situational antecedents such as a history of child abuse and/or neglect, a history of domestic violence, poverty, inequality, unemployment, criminal history, the use of drugs and/or alcohol, and the availability of weapons. Male and nonwhite children are more likely to be victims of child murder than female and white children.

According to the American psychiatrist and expert on child murder, Phillip Resnick, typical neonaticidal mothers (mothers who kill their children the first day of birth) are young, unmarried, are not suffering from psychotic illness, and do not

have a history of depression. They characteristically conceal their pregnancy, often denying that they are pregnant. Other researchers have concluded that most deaths are the result of unwanted pregnancies, and that many mothers are overwhelmed by the responsibilities and have little or no support system. A number of women have serious drug and/or alcohol problems and lose control in a fit of intoxication.

Mental disorder is a major factor in the killing of children. In *Fatal Families* (1997), Charles Ewing notes that psychotic infanticide and filicide perpetrators are most likely to be suffering from postpartum psychosis, while parents who batter their children to death are more likely to suffer from nonpsychotic mental illnesses, such as personality disorders, impulse control disorders, mood disorders, anxiety disorders, and/or substance abuse disorders. The *Diagnostic and Statistical Manual of Mental Disorders* (1994) explains that postpartum psychotic episodes are characterized by command hallucinations to kill the infant or delusions that the infant is possessed. Other researchers report that mothers who kill their newborn are often suffering from dissociative disorders at the time of the birth because they feel overwhelmed by the pregnancy and perceived lack of support, necessitating their handling the traumatic experience on their own. However, when mothers kill older children, it is the children who have mental aberrations or psychiatric conditions rather than the mother, who in fear of her life or the lives of other family members, feels she has to end the life of her child.

According to Levine and colleagues, not only are males predominantly the perpetrators, but the presence of a male in the household increases the risk of maltreatment-related fatalities, especially from physical abuse. Fathers kill infants when they cry excessively and the father has little tolerance for such disruption due to the influence of alcohol or drugs, or because he is suffering from antisocial personality disorder. Some fathers kill their son when he is old enough to challenge the father's authority and they physically fight. Occasionally, fathers have killed their daughters following rape or sexual exploitation, when they threatened to reveal the abuse.

The rate of child murder is greatly elevated in stepfamilies. Martin Daly and Margo Wilson found

that whereas young children incurred about seven times higher rates of physical abuse in families with a stepparent than in two-genetic-parent homes, stepchildren were 100 times more likely to suffer fatal abuse. In a sample of men who slew their preschool-age children, 82 percent of the victims of stepfathers were beaten to death, while the majority of children slain by genetic fathers were killed by less violent means.

Suggestions for Prevention

Given the multifaceted character of fatal child abuse, only a multidagnostic and multitherapeutic approach can deal adequately with its clinical prevention. The multidagnostic component requires an individual, marital, family, and social assessment. The multitherapeutic approach involves the use of several therapeutic modalities including individual psychotherapy, hospitalization, and/or temporary/permanent removal of the child from the home.

Physicians may also play a role in prevention by identifying particular stresses that might lead to an aberrant or unusual postpartum reaction. Postpartum changes in depression or psychosis can be observed, monitored, and treated. The physician can look for evidence of abuse, isolation, and lack of support from family or friends. Many child abuse deaths could be prevented by identifying parents at risk of abusing their children and making parenting less stressful for them. There is a need for more and better education programs aimed at teaching people how to parent and alternatives to corporal punishment. The development of programs to better identify domestic violence, along with a stronger response to identified cases of family violence, can also reduce child deaths. Finally, clinicians who identify and treat psychoses should be aware of the possible danger to children of psychotic parents and monitor the child's risk.

See also: CHILDREN; INFANTICIDE; SACRIFICE

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CHINESE BELIEFS

In premodern China, the great majority of people held beliefs and observed practices related to death that they learned as members of families and villages, not as members of organized religions. Such beliefs and practices are often subsumed under the umbrella of "Chinese popular religion." Institutional forms of Buddhism, Confucianism, Taoism, and other traditions contributed many beliefs and practices to popular religion in its local variants. These traditions, especially Buddhism, included the idea of personal cultivation for the purpose of living an ideal life and, as a consequence, attaining some kind of afterlife salvation, such as immortality, enlightenment, or birth in a heavenly realm. However, individual salvation played a small role in most popular religions. In typical local variants of popular religion, the emphasis was on (1) passing from this world into an ancestral realm that in key ways mirrored this world and (2) the interactions between living persons and their ancestors.

Basic Beliefs and Assumptions

In every human society one can find manifestations of the human desire for some kind of continuance beyond death. In the modern West, much of human experience has been with religious theories of continuance that stress the fate of the individual, often conceived as a discrete spiritual "self" or "soul." Typically, a person is encouraged to live in a way that prepares one for personal salvation, whether by moral self-discipline, seeking God's grace, or other means. Indic traditions, such as Buddhism and Hinduism, include similar assumptions about the human self/soul and personal salvation. In premodern China, especially if one discounts Buddhist influence, a person's desire for continuance beyond death was rooted in different assumptions and manifested in practices not closely related to the pursuit of individual salvation.

First, Chinese emphasized biological continuance through descendants to whom they gave the gift of life and for whom they sacrificed many of life's material pleasures. Moreover, personal sacrifice was not rooted in a belief in asceticism per se but in a belief that sacrificing for one's offspring would engender in them obligations toward elders

and ancestors. As stated in the ancient text, *Scripture of Filiality* (Warring States Period, 453–221 B.C.E.), these included obligations to care for one's body as a gift from one's parents and to succeed in life so as to glorify the family ancestors. Thus, one lived beyond the grave above all through the health and success of one's children, grandchildren, and great-grandchildren.

Second, because of the obligations inculcated in children and grandchildren, one could assume they would care for one in old age and in the afterlife. Indeed, afterlife care involved the most significant and complex rituals in Chinese religious life, including funerals, burials, mourning practices, and rites for ancestors. All this was important not only as an expression of each person's hope for continuance beyond death but as an expression of people's concern that souls for whom no one cared would become ghosts intent on causing mischief.

Finally, there was a stress on mutual obligations between the living and the dead; in other words, an emphasis on the same principle of reciprocity that governed relations among the living members of a Chinese community. It was assumed that the dead could influence the quality of life for those still in this world—either for good or for ill. On the one hand, proper burial, careful observance of mourning practices, and ongoing offerings of food and gifts for ancestors assured their continued aid. On the other hand, failure to observe ritual obligations might bring on the wrath of one's ancestors, resulting in family disharmony, economic ruin, or sickness. Ancestral souls for whom no one cared would become “hungry ghosts” (*egui*), which might attack anyone in the community. Royal ancestors, whose worship was the special responsibility of the reigning emperor, could aid or harm people throughout the empire, depending on whether or not the emperor upheld ritual obligations to his ancestors.

In traditional China, the idea that personal continuance after death could be found in the lives of one's descendants has been closely linked to practices rooted in mutual obligations between the living and the dead: those who had moved on to the ancestral state of existence. But what is the nature of the ancestral state? What kind of rituals for the dead have been performed by most Chinese? And under what circumstances have individual Chinese

sought something more than an afterlife as a comfortable and proud ancestor with loving and successful descendants; that is, some kind of personal salvation?

Conceptions of Souls and Ancestral Existence

There is evidence from as early as the Shang period (c. 1500–1050 B.C.E.) that Chinese cared for ancestors as well as feared them. This may well have been the main factor in the development of beliefs in dual and multiple souls. Late in the Zhou dynasty (1050–256 B.C.E.), cosmological thought was dominated by the *yin-yang* dichotomy, according to which all aspects of existence were a result of alternation and interplay between passive (*yin*) and active (*yang*) forces. Philosophers applied the dichotomy to soul theory. Lacking any absolute distinction between physical and spiritual, they considered the *yin* soul (*po*) as more material, and the *yang* soul (*hun*) as more ethereal. In practice, the *po* was linked to the body and the grave. The less fearsome *hun* was linked to the ancestral tablet kept in the family home and the one installed in an ancestral hall (if the family's clan could afford to build one). For some, this meant there were two *hun*, just as, for others, there might be multiple *po*. One common view included the idea of three *hun* and seven *po*. These multiple soul theories were among the factors in popular religion that mitigated widespread acceptance of belief in salvation of the individual soul. At the same time, however, multiple soul theories helped Chinese to manage contrasting perceptions of ancestral souls (as benevolent or malevolent, for example) and to provide an explanatory framework for the differing rituals of the domestic, gravesite, and clan hall cults for ancestors.

While the intent of all these rites was clear—to comfort ancestors rather than to suffer their wrath—the nature of ancestral existence was relatively undefined. Generally speaking, the world of the ancestors was conceived as a murky, dark realm, a “*yin*” space (*yinjian*). While not clear on the exact details, Chinese considered the world of departed spirits similar to the world of the living in key ways. They believed residents of the other realm need money and sustenance, must deal with bureaucrats, and should work (with the help of the living) to improve their fate. After the arrival of Buddhism in the early centuries of the common

era, it contributed more specific ideas about the realm of the dead as well as more exact conceptions of the relationship between one's deeds while alive and one's fate afterward.

For example, the "bureaucratic" dimension of the underworld was enhanced by visions of the Buddhist Ten Courts of Hell, at which judges meted out punishments according to karmic principles that required recompense for every good or evil deed. Moreover, regardless of whether or not they followed Buddhism in other ways, most Chinese embraced the doctrines of *karma* (retribution for past actions) and *samsara* (cyclical existence) in their thinking about life and death. These doctrines helped people to explain the fate of residents in the realms of the living and the dead, not to mention interactions between them. For example, the ghost stories that fill Chinese religious tracts as well as secular literature typically present ghosts as vehicles of karmic retribution against those evildoers who escaped punishment by worldly authorities (perhaps in a former lifetime). While reading such stories often has been just a casual diversion, performing rites to assure that departed ancestors do not become wandering ghosts has been a serious matter.

Rites for the Dead

Over the course of Chinese history, classical texts on ritual and commentaries on them had increasing influence on the practice of rites for the dead. The text *Records of Rituals (Liji)*, after being designated one of Confucianism's "Five Scriptures" during the Han era (206 B.C.E.–220 C.E.), became the most influential book in this regard. The *Family Rituals according to Master Zhu (Zhuzi jiali)*, by the leading thinker of later Confucianism (Zhu Xi, 1130–1200 C.E.), became the most influential commentary. The influence of these texts resulted in widespread standardization of funeral rites in particular and rites for the dead in general. According to the cultural anthropologist James Watson, standardized funeral rites became a marker of "Chineseness" for Han (ethnically Chinese) people in their interactions with other ethnic groups as they spread into new territories.

In his article, "The Structure of Chinese Funeral Rites," Watson identifies nine elements of standardized funeral rites: (1) the family gives public notification by wailing, pasting up banners, and

other acts; (2) family members don mourning attire of white cloth and hemp; (3) they ritually bathe the corpse; (4) they make food offerings and transfer to the dead (by burning) spirit money and various goods (houses, furniture, and other items made of paper); (5) they prepare and install an ancestral tablet at the domestic altar; (6) they pay money to ritual specialists (usually Taoists priests or Buddhist clerics) so that the corpse can be safely expelled from the community (and the spirit sent forth on its otherworldly journey); (7) they arrange for music to accompany movement of the corpse and to settle the spirit; (8) they have the corpse sealed in an airtight coffin; and (9) they expel the coffin from the community in a procession to the gravesite that marks the completion of the funeral rites and sets the stage for burial.

While burial customs were more subject to local variation than funeral rites as such, throughout China there was a preference for burial over alternative means of dealing with the corpse. For example, few Chinese opted for Buddhism's custom of cremation, despite the otherwise strong influence this religion had on Chinese ideas and practices related to life and death. Unlike Indians, for whom the body could be seen as a temporary vehicle for one's eternal spirit, Chinese typically saw the body as a valued gift from the ancestors that one should place whole under the soil near one's ancestral village. In modern China, especially under the Communist Party since 1949, Chinese have turned to cremation more often. But this has been for practical reasons related to land use and to the party's campaign against "superstitious" behavior and in favor of frugality in performing rituals.

Traditionally, the corpse, or at least the bones, represented powers that lasted beyond death and could affect the fate of living relatives. For this reason, the use of an expert in *feng-shui* (Chinese geomancy) was needed to determine the time, place, and orientation of the burial of a corpse. This usage was in line with the aforementioned belief that the *po*, which lingered at the grave, was more physical in character than the *hun* soul(s). Its importance is underlined by the fact that the practice is being revived in China after years of condemnation by Communist officials.

Caring for the *hun* soul(s) has been at the heart of ritual observances that occurred away from the



The procession to the gravesite of this funeral in China signifies a completion of the funeral rites. CORBIS

grave. Among these observances were very complex mourning customs. They were governed by the general principle that the closeness of one's relationship to the deceased determined the degree of mourning one must observe (symbolized by the coarseness of one's clothes and the length of the mourning period, for example). In addition to observing mourning customs, relatives of the deceased were obliged to care for his or her soul(s) at the home altar and at the clan ancestral hall, if one existed. At the home altar the family remembered a recently deceased relative through highly personalized offerings of favorite foods and other items. They remembered more distant relatives as a group in generic ancestral rites, such as those which occurred prior to family feasts at the New Year, mid-Autumn, and other festivals. Indeed, one of the most significant symbolic reminders that ancestors were still part of the family was their inclusion as honored guests at holiday meals.

Individual Salvation

Chinese beliefs and practices related to death were closely tied to family life and, therefore, shaped by its collectivist mentality. In his article, "Souls and

Salvation: Conflicting Themes in Chinese Popular Religion," the anthropologist Myron Cohen, has even argued that the pursuit of individual salvation was inimical to orthodox popular religion. Nonetheless, this pursuit was not absent from traditional religious life. The spread of Buddhism throughout China was one factor contributing to its acceptance. Another factor was the increasingly urban and mobile nature of Chinese society over time. Since at least the Song dynasty (960–1279), both factors have exerted strong influence, so that for the last millennium China has seen tremendous growth in lay-oriented Buddhism and in other religions with salvationist ideologies derived from Buddhist, Taoist, and other sources.

Lay Buddhists have been interested to an even greater extent than their monastic counterparts in the goal of rebirth in the Western paradise, or "Pure Land" (*jingtu*), of Amitabha Buddha. Unlike the ordinary realm of ancestors, which mirrors this world in most ways, the Pure Land is desired for ways in which it differs from this world. It is inhabited not by relatives, but by wise and compassionate teachers of the Buddhist Dharma, and it is free of the impurities and sufferings of the mortal

realm. For some it is not a place at all, only a symbol of the peace of *nirvana* (enlightened state beyond cyclical existence).

To an even greater extent than Buddhism, certain syncretic religions set forth ideas that stood in tension with the hierarchical, earthbound, and collectivist assumptions of the traditional Chinese state and society. Whether one studies the White Lotus Religion of late imperial times, the Way of Unity (Yiguan Dao) in modern China and Taiwan, or the Falun Gong movement in the twenty-first-century's People's Republic of China, the emphasis is on individual spiritual cultivation and, when relevant, the fate of the individual after death. Evidence of interest in individual spiritual cultivation and salvation is found in these sects' remarkable popularity, which has alarmed both traditional and contemporary governments.

Groups like the Way of Unity or Falun Gong typically stress the need for a morally disciplined lifestyle and training in techniques of spiritual cultivation that are uniquely available to members. Their moral norms are largely from Confucianism, and their spiritual techniques from Taoism and Buddhism. Falun Gong promises that its techniques are powerful enough to save members from fatal illnesses. The Way of Unity promises that individuals who take the right moral-spiritual path will avoid the catastrophe that faces others as they near the end of the world. Unlike others, these individuals will join the Eternal Venerable Mother in her paradise. Since the 1600s, the idea of salvation through Jesus has also attracted the attention of some Chinese. In the past, these Chinese Christians were required to abandon ancestral rites, since 1939 the Catholic church has allowed Chinese to worship Jesus as well as perform rituals for ancestors, with some Protestant groups following the trend.

As the acids of modernity continue to eat away at the fabric of traditional Chinese society, many more Chinese are embracing religions that preach individual salvation after death. Those who do so may abandon practices related to traditional beliefs about life, death, and ancestral souls, or they may find ways to reconcile these practices with the new belief systems they adopt.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE;
BUDDHISM; GHOSTS; HINDUISM; IMMORTALITY;
MOURNING; QIN SHIH HUANG'S TOMB

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CHRISTIAN JOCHIM

CHRISTIAN DEATH RITES, HISTORY OF

In the world in which Christianity emerged, death was a private affair. Except when struck down on the battlefield or by accident, people died in the company of family and friends. There were no physicians or religious personnel present. Ancient physicians generally removed themselves when cases became hopeless, and priests and priestesses served their gods rather than ordinary people. Contact with a corpse caused ritual impurity and hence ritual activity around the deathbed was minimal. A relative might bestow a final kiss or attempt to catch a dying person's last breath. The living closed the eyes and mouth of the deceased, perhaps placing a coin for the underworld ferryman on the tongue or eyelids. They then washed the corpse, anointed it with scented oil and herbs, and dressed it, sometimes in clothing befitting the social status of the deceased, sometimes in a shroud. A procession accompanied the body to the necropolis outside the city walls. There it was laid to rest, or cremated and given an urn burial, in a family plot that often contained a structure to house the dead. Upon returning from the funeral, the family purified themselves and the house through rituals of fire and water.

Beyond such more or less shared features, funeral rites, as well as forms of burial and commemoration, varied as much as the people and the ecology of the region in which Christianity developed and spread. Cremation was the most common mode of disposal in the Roman Empire, but older patterns of corpse burial persisted in many areas, especially in Egypt and the Middle East.

Christianity arose among Jews, who buried their dead, and the death, burial, and resurrection of Jesus were its defining events. Although Christians practiced inhumation (corpse burial) from the earliest times, they were not, as often assumed, responsible for the gradual disappearance of cremation in the Roman Empire during the second and third centuries, for common practice was already changing before Christianity became a major cultural force. However, Christianity was, in this case, in sync with wider patterns of cultural change. Hope of salvation and attention to the fate of the body and the soul after death were more or less common features of all the major religious movements of the age, including the Hellenistic mysteries, Christianity, Rabbinic Judaism, Manichaeism, and Mahayana Buddhism, which was preached as far west as Alexandria.

Early Christian Responses to Death and Dying

In spite of the centrality of death in the theology and spiritual anthropology of early Christians, they were slow to develop specifically Christian responses to death and dying. The most immediate change was that Christians handled the bodies of the dead without fear of pollution. The purification of baptism was permanent, unless marred by mortal sin, and the corpse of a Christian prefigured the transformed body that would be resurrected into eternal life at the end of time. The Christian living had less need than their neighbors to appease their dead, who were themselves less likely to return as unhappy ghosts. Non-Christians noted the joyous mood at Christian funerals and the ease of the participants in the presence of the dead. They observed how Christians gave decent burials to even the poorest of the poor. Normal Roman practice was to dump them in large pits away from the well-kept family tombs lining the roads outside the city walls.

The span of a Christian biography stretched from death and rebirth in baptism, to what was called the "second death," to final resurrection. In a sense, then, baptism was the first Christian death ritual. In the fourth century Bishop Ambrose of Milan (374–397) taught that the baptismal font was like a tomb because baptism was a ritual of death and resurrection. Bishop Ambrose also urged baptized Christians to look forward to death with joy, for

physical death was just a way station on the road to paradise. Some of his younger contemporaries, like Augustine of Hippo, held a different view. Baptism did not guarantee salvation, preached Augustine; only God could do that. The proper response to death ought to be fear—of both human sinfulness and God’s inscrutable judgment.

This more anxious attitude toward death demanded a pastoral response from the clergy, which came in the form of communion as *viaticum* (provisions for a journey), originally granted to penitents by the first ecumenical council at Nicea (325), and extended to all Christians in the fifth and sixth centuries. There is, however, evidence that another type of deathbed communion was regularly practiced as early as the fourth century, if not before. The psalms, prayers, and symbolic representations in the old Roman death ritual discussed by the historian Frederick Paxton are in perfect accord with the triumphant theology of Ambrose of Milan and the Imperial Church. The rite does not refer to deathbed communion as *viaticum*, but as “a defender and advocate at the resurrection of the just” (Paxton 1990, p. 39). Nor does it present the bread and wine as provisions for the soul’s journey to the otherworld, but as a sign of its membership in the community of the saved, to be rendered at the last judgment. Thanks, in part, to the preservation and transmission of this Roman ritual, the Augustinian point of view did not sweep all before it and older patterns of triumphant death persisted.

However difficult the contemplation (or moment) of death became, the living continually invented new ways of aiding the passage of souls and maintaining community with the dead. In one of the most important developments of the age, Christians began to revere the remains of those who had suffered martyrdom under Roman persecution. As Peter Brown has shown, the rise of the cult of the saints is a precise measure of the changing relationship between the living and the dead in late antiquity and the early medieval West. The saints formed a special group, present to both the living and the dead and mediating between and among them. The faithful looked to them as friends and patrons, and as advocates at earthly and heavenly courts. Moreover, the shrines of the saints brought people to live and worship in the cemeteries outside the city walls. Eventually, the dead even appeared inside the walls, first as saints’ relics, and then in the bodies of those who wished

to be buried near them. Ancient prohibitions against intramural burials slowly lost their force. In the second half of the first millennium, graves began to cluster around both urban and rural churches. Essentially complete by the year 1000, this process configured the landscape of Western Christendom in ways that survive until the present day. The living and the dead formed a single community and shared a common space. The dead, as Patrick Geary has put it, became simply another “age group” in medieval society.

Emergence of a Completely Developed Death Ritual in the Medieval Latin Church

However close the living and dead might be, it was still necessary to pass from one group to the other, and early medieval Christians were no less inventive in facilitating that passage. The centuries from 500 to 1000 saw the emergence of a fully developed ritual process around death, burial, and the incorporation of souls into the otherworld that became a standard for Christian Europeans until the Reformation, and for Catholics until the very near present. The multitude of Christian kingdoms that emerged in the West as the Roman Empire declined fostered the development of local churches. In the sixth, seventh, and eighth centuries, these churches developed distinctive ritual responses to death and dying. In southern Gaul, Bishop Caesarius of Arles (503–543) urged the sick to seek ritual anointing from priests rather than magicians and folk healers and authored some of the most enduring of the prayers that accompanied death and burial in medieval Christianity. Pope Gregory the Great (590–604) first promoted the practice of offering the mass as an aid to souls in the afterlife, thus establishing the basis for a system of suffrages for the dead. In seventh-century Spain, the Visigothic Church developed an elaborate rite of deathbed penance. This ritual, which purified and transformed the body and soul of the dying, was so powerful that anyone who subsequently recovered was required to retire into a monastery for life. Under the influence of Mosaic law, Irish priests avoided contact with corpses. Perhaps as a consequence, they transformed the practice of anointing the sick into a rite of preparation for death, laying the groundwork for the sacrament of extreme unction. In the eighth century, Irish and Anglo-Saxon missionary monks began to contract with one another for prayers and masses after death.

All of these developments came into contact in the later eighth and ninth centuries under the Carolingian kings and emperors, especially Charlemagne (769–814), but also his father Pepin and his son Louis. Together they unified western Europe more successfully around shared rituals than common political structures. The rhetoric of their reforms favored Roman traditions, and they succeeded in making the Mass and certain elements of clerical and monastic culture, like chant, conform to Roman practice whether real or imagined. When it came to death and dying, however, Rome provided only one piece of the Carolingian ritual synthesis: the old Roman death ritual. Whether or not it was in use in Rome at the time, its triumphant psalmody and salvation theology struck a chord in a church supported by powerful and pious men who saw themselves as heirs to the kings of Israel and the Christian emperors of Rome. Other elements of their rituals had other sources. Carolingian rituals were deeply penitential, not just because of Augustine, but also because, in the rough-and-tumble world of the eighth and ninth centuries, even monks and priests were anxious about making it into heaven. Although reformers, following Caesarius of Arles, promoted the anointing of the sick on the grounds that there was no scriptural basis for anointing the dying, deathbed anointing came into general use, often via Irish texts and traditions. Carolingian rituals also drew liberally on the prayers of Caesarius of Arles and other fathers of the old Gallican and Visigothic churches.

The ritual experts of the Carolingian age did not just adapt older rites and provide a setting for their synthesis, however; they made their own contributions as well. In his classic 1908 study on ritual, the anthropologist Arnold van Gennep was surprised by the lack of elaboration of the first phase of death rites in the ethnographic reports he studied. People generally ritualized burial and commemoration, but gave little attention to the dying. Unlike other rites of passage, few rituals prepared people for death. Familiarity with European Christian traditions may be the source of van Gennep's surprise, for well-developed preliminal rites are one of their most characteristic features. Around the year 800 certain clerical communities introduced a ritual for the death agony. To aid the dying through the struggle of the soul's exit from the body, the community chanted the names of the

denizens of paradise. Rhythmically calling on the Trinity, Mary, the angels, the prophets and patriarchs, the martyrs and confessors, and all living holy men and women, they wove a web of sung prayer to aid the soul's passing. This practice quickly became part of a common tradition that also included rites of penance, absolution, anointing, and communion, each of which helped cut the ties that bound the dying to this world, ritually preparing them for entry into paradise.

Like most human groups, Christians had always used rites of transition to allay the dangers of the liminal period after death before the corpse was safely buried and the soul set on its journey to the otherworld. The same was true of post-liminal rites of incorporation, which accompanied the body into the earth, the soul into the otherworld, and the mourners back into normal society. But medieval Christians placed the ritual commemoration of the dead at the very center of social life. Between 760 and 762, a group of churchmen at the Carolingian royal villa of Attigny committed themselves to mutual commemoration after death. Not long afterward, monastic congregations began to make similar arrangements with other houses and with members of secular society. They also began to record the names of participants in books, which grew to include as many as 40,000 entries. When alms for the poor were added to the psalms and masses sung for the dead, the final piece was in place in a complex system of exchange that became one of the fundamental features of medieval Latin Christendom. Cloistered men and women, themselves "dead to this world," mediated these exchanges. They accepted gifts to the poor (among whom they included themselves) in exchange for prayers for the souls of the givers and their dead relatives. They may have acted more out of anxiety than out of confidence in the face of death, as the scholar Arno Borst has argued, but whatever their motivations, their actions, like the actions of the saints, helped bind together the community of the living and the dead.

The Carolingian reformers hoped to create community through shared ritual, but communities shaped ritual as much as ritual shaped communities, and the synthesis that resulted from their activities reflected not just their official stance but all the myriad traditions of the local churches that flowed into their vast realm. By the end of the ninth century a ritual process had emerged that blended the

triumphant psalmody of the old Roman rites with the concern for penance and purification of the early medieval world. A rite of passage that coordinated and accompanied every stage of the transition from this community to the next, it perfectly complemented the social and architectural landscape. Taken up by the reform movements of the tenth and eleventh centuries, this ritual complex reached its most developed form at the Burgundian monastery of Cluny. At Cluny, the desire to have the whole community present at the death of each of its members was so great that infirmarium servants were specially trained to recognize the signs of approaching death.

The Modern Age

Christian death rituals changed in the transition to modernity, historians like Philippe Ariès and David Stannard have detailed in their various works. But while Protestants stripped away many of their characteristic features, Catholics kept them essentially the same, at least until the Second Vatican Council (1962–1965). Like the Carolingian reformers, the fathers of Vatican II moved to restrict ritual anointing to the sick, but they may be no more successful in the long run, for the symbolic power of anointing as a rite of preparation for death seems hard to resist. And while the secularization of society since the 1700s has eroded the influence of Christian death rites in Western culture, nothing has quite taken their place. Modern science and medicine have taught humankind a great deal about death, and about how to treat the sick and the dying, but they have been unable to give death the kind of meaning that it had for medieval Christians. For many people living in the twenty-first century death is a wall against which the self is obliterated. For medieval Christians it was a membrane linking two communities and two worlds. In particular, Christian rites of preparation for death offered the dying the solace of ritual and community at the most difficult moment in their lives.

Reconnecting with the Past

The Chalice of Repose Project at St. Patrick Hospital in Missoula, Montana, is applying ancient knowledge to twenty-first-century end-of-life care. Inspired in part by the medieval death rituals of Cluny, the Chalice Project trains professional music thanatologists to serve the physical, emotional, and

spiritual needs of the dying with sung prayer. With harp and voice, these “contemplative musicians” ease the pain of death with sacred music—for the dying, but also for their families and friends and for the nurses and doctors who care for them. While anchored in the Catholic tradition, music thanatologists seek to make each death a blessed event regardless of the religious background of the dying person. Working with palliative physicians and nurses, they offer prescriptive music as an alternative therapy in end-of-life care. The Chalice of Repose is a model of how the past can infuse the present with new possibilities.

See also: ARS MORIENDI; CHARON AND THE RIVER STYX; JESUS; RITES OF PASSAGE

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FREDERICK S. PAXTON

CIVIL WAR, U.S.

Between the years 1861 and 1865, the United States engaged in a civil war, one of the most significant military confrontations in the young republic's life. The conflict dramatically altered the course of American society, eradicating the institution of slavery from the land and accelerating a number of social, economic, and political trends originating in other regions of the country. It also made lasting cultural impressions across imaginative and material American landscapes, including the gradual growth of a complex tourist industry built upon memory, patriotism, and consumerism, and the immediate expression of a deeply rooted, though politically sensitive, religious attachment to a distinctly southern way of life.

The Civil War, however, was a major turning point in American history for another reason as well: it transformed attitudes toward death and

practices surrounding the corpse in the United States. While antebellum America demonstrated marked preoccupations with the reality of death in literature, material culture, religion, diaries and letters, and early medicine, the war led to the extreme escalation of certain tendencies emerging on the social scene, as well as to the production of entirely new views on death and the dead. The incredible numbers of young men who died during the war, the problems associated with disposal of their bodies, and the rhetorical and symbolic efforts to make sense of the lives lost had profound consequences for American sensibilities and institutional structures.

The Presence of Death

During the war years, death was a pervasive element of social life in both the northern and southern sections of the country. Up until the war, Americans were quite familiar with the presence of death, intimate with its consequences in their own homes and local communities. Some estimates suggest that in the North, where more accurate records of the period are available, the crude death rate in the antebellum period was around 15 per 1,000 in rural areas, and between 20 and 40 per 1,000 in more populated cities. Most people lived into their late thirties if they survived the exceedingly dangerous early years of life. Chances of dying in childhood were also quite high, according to many studies. Infant mortality hovered around 200 per 1,000 live births, and roughly 10 percent of individuals between one year and twenty-one years died from a wide range of causes.

Despite this close and personal awareness of human mortality, Americans during the Civil War had a radically different set of experiences with death than previously. First and foremost, this conflict produced more deaths than any other war in U.S. history. The total number of deaths for both the North and the South, in the four-year period, was over 600,000. World War II is the only other major conflict that comes close to this number, when over 400,000 individuals died in battles across the ocean.

More demographic information is available for the Northern armies than for the Confederacy, which did not have the resources to keep accurate records on soldiers. According to some historians, roughly one out of sixteen white males in the North

between the ages of sixteen and forty-three lost his life during the war. Even more astonishing than the overall mortality rates for the entire conflict are the number for particular battles: During the three-day battle at Gettysburg, for example, 3,155 Union soldiers died; at Antietam, during one day of fighting, the Union lost over 2,000 young men.

The carnage left on these and other sites, for both sides, boggles the mind, and must have been overwhelming to Americans viewing photographs, visiting battlefields, or reading detailed accounts in newspapers. Another significant difference between this war and other wars after the Revolution is the proximity of the battles to American communities. The Civil War not only took place on American soil, it pitted neighbor against neighbor, family against family, countrymen against countrymen.

More threatening to American soldiers during the war than mortal wounds on the battlefield was the presence of disease and infection, which had the potential to seriously reduce the number of fighters on both sides. Nearly twice as many men died as a result of poor health in camps and hospitals than from wounds inflicted during combat. What did soldiers die from? Afflictions such as diarrhea, malaria, smallpox, typhoid fever, pneumonia, and measles wiped out large numbers of men on both sides of the conflict. The deadly power of disease swept through the ranks because of the incredibly poor conditions in camps, resulting from inadequate shelter, contaminated water supplies, unhealthy diet, and a limited knowledge about proper sanitation and safe hygienic practices. As the war progressed, the Union forces worked especially hard to improve the living conditions of soldiers and patients—death became an urgent public health issue that could be combated with sound, rational decisions about such simple things as clean water, healthy food, and adequate sanitation.

Under wartime conditions, Americans in general, and soldiers in particular, acquired a unique familiarity with human mortality. Regardless of the formidable presence of death in life during the antebellum years, the Civil War posed a series of new challenges for those affected by the carnage—which is to say nearly every American at the time—and produced new attitudes that reflected distinct modifications in how these Americans made sense of death and disposed of their dead. In the midst of war, unorthodox views on death and the dead

body emerged out of the entirely unparalleled experience with human violence, suffering, and mortality in U.S. history. On the other hand, some perspectives demonstrated a degree of continuity with more traditional views on the meaning of death, and reinforced deeply rooted religious sensibilities circulating before the onset of the conflict.

Disposing of the Dead

The Civil War forced Americans to reconsider what counts as appropriate treatment of the dead, as well as to reconceptualize the symbolic meanings of the dead body. The confrontation, with brutally slaughtered masses of bodies or hopelessly diseased soldiers dying in hospitals or camps, upset conventional patterns of disposal, as well as established attitudes about communal duties, religious rituals, and personal respect in the face of death. What counted as proper and appropriate action to usher the dead from the land of the living in an earlier time often proved impossible during the conflict, though in some cases efforts were made to treat the dead with a dignity that evoked prewar sensibilities.

In both the Union and Confederate armies, soldiers attempted to provide some kind of burial for fallen comrades who perished during a battle, even if this meant simply covering bodies with dirt, or placing the dead in common graves. The details of burial depended on a variety of circumstances, including which side won a particular battle, and which unit was assigned burial duty. Victors had the luxury of attending to their own dead with more care and attention, if time permitted. On the other hand, the losing side had to retreat from the battlefield, which meant leaving the fate of the dead and wounded to the winning side, who treated them as most enemies are treated, with indifference and disrespect.

If the Union forces controlled the field after a fight, for example, the dead were often buried without ceremony somewhere on or near the site, either individually in separate graves or collectively in common graves. In many cases, those assigned to burial duty—often African Americans, who performed a variety of noxious duties for the Union army—left the dead in their uniforms or placed a blanket around them before interment. If such resources as pine coffins or burial containers were available, and time permitted, soldiers would be

placed in them before being put in the ground, a procedure that rarely occurred in the early years of the war. Many soldiers on both sides expressed a great deal of fear that their bodies would be left to the enemy, which was understood as a fate worse than death.

The federal government and Union soldiers themselves tried to ensure that bodies were identified with at least a name, a desire that led some soldiers to go into battle with their names and positions pinned onto their uniform (foreshadowing the popular use of dog tags in subsequent wars). Again, when time allowed and when burial units were available, Union forces made an effort to avoid anonymous burial, identify graves, and keep records of who died during a battle, an effort that grew increasingly more sophisticated as the war dragged on.

In contrast to the lack of ceremony surrounding the disposition of the dead on or near fields of battle, conditions in Union camps and hospitals allowed for more conventional burial practices that maintained older traditions. Reasons for this difference had nothing to do with smaller numbers of dying soldiers in these settings. More men died from disease than wounds inflicted in battle, so there were ample corpses in these locations. Camps and hospitals simply had more resources, personnel, and time to take care of these matters. Many also had space singled out for use as cemeteries, which provided a readily available and organized location for disposal.

General hospitals in larger towns seemed to be settings where more formal funeral observances could be carried out, especially for the Union. In addition to the presence of hospital nurses in these locations, members of the Sanitary Commission and the Christian Commission made burial of the dead more humane, respectful, and ritually satisfying. According to some firsthand accounts of Union hospitals in Virginia and elsewhere, the dead were given proper burials, which included religious services, the use of a coffin, a military escort from the hospital, the firing of arms, and an individual headboard with information about the deceased.

Regimental hospitals much closer to battlefields, on the other hand, could not offer the kind of attention that larger hospitals provided the dead. Descriptions of death and dying in these locations can

be found in a number of soldiers' letters and diaries, anticipating the shifting scenery of expiration from home to hospital. The presence of corpses, as well as other reminders of human mortality like piles of amputated limbs, did not evoke images of order and solemnity. Instead, death and burial had many of the same characteristics as found on fields of battle, though a rudimentary graveyard next to these hospitals allowed for a slightly more organized space for disposing of remains.

In addition to hospitals and battlefields, another location where Civil War dead could be buried included prisons. According to one account of prison burials by a Union soldier incarcerated in Georgia's Andersonville Prison, treatment of the dead followed a fairly regimented set of procedures. These procedures included pinning the name of the deceased on his shirt, transportation to the prison "dead-house," placement on a wagon with twenty to thirty other bodies, and then transfer to the cemetery, where a superintendent overseeing the burial ground would assume responsibilities for ensuring as adequate a burial as possible. Dead prisoners were placed in trenches, usually without any covering, and buried under prison dirt. The location of each body was then marked with a stake at the head identifying the soldier and the date of death.

For family members and friends in the North, the prospect of loved ones dying far away from home, and being interred in what most considered to be profane Southern soil, led to a great deal of anguish and outrage. Indeed, many Northerners were deeply disturbed by this prospect because it upset normal social scripts ingrained in American culture when a family experienced a death. In normal times, death occurred in the home, people had a chance to view the body before it disappeared forever, and burial took place in a familiar space, which usually included previously deceased family members and neighbors. These were not normal times for sure, so some families, particularly the more affluent families in the North, would do whatever they could to bring the body of a loved family member's home, either by making the trip south on their own, or paying someone to locate, retrieve, and ship the body north.

As a result of these desires—to maintain familial control over the final resting place and, if possible, to have one last look before the body



Union soldiers prepare to bury dead soldiers that are underneath tarps. Excluding the Vietnam War, Civil War deaths nearly equaled the number of deaths in all other wars in U.S. history combined. LIBRARY OF CONGRESS

vanished—a new form of treating the dead appeared on the social scene, and paved the way for the birth of an entirely modern funeral industry. Undertakers who contracted with Northern families began to experiment with innovative means to preserve bodies that had to be shipped long distances on train cars, often during the hot summer months. The revolutionary practice that emerged in this context, embalming, provided both the military and Northern communities with a scientific, sanitary, and sensible way to move bodies across the land.

Making Sense of Death

In peaceful times, death is often experienced as a painful, disruptive, and confusing moment that requires individuals to draw on strongly held religious convictions about the meaning of life, the fate of the soul, and the stability of an ordered cosmos. During war, when individuals are called to sacrifice their lives for the good of the nation and

prepare for an early, violent end, the religion of nationalism makes a distinctive mark on meaning-making efforts circulating throughout public culture. Indeed, the religion of nationalism becomes an integral frame of reference when war breaks out, setting earthly, political conflicts in a cosmic realm of ultimate good battling ultimate evil. In the Civil War, two conflicting visions of American national life came into sharp relief against the backdrop of fields of bloodied bodies and widespread social anguish over the loss of sons, brothers, fathers, and husbands fighting for God and country.

Both Northerners and the Southerners believed God was on their side, and the nation envisioned by each a fulfillment of distinctive Christian commitments and values. Indeed, the blood of martyrs dying in the fight over slavery, and their sacrifices for the preservation of a sacred moral order ordained by God, had curative powers in the mind of many leading figures precisely because the nationalist ideologies of each side relied on Christian imagery and doctrine to justify killing, and being killed, in the service of a higher good. Although certain dead heroic figures had been intimately linked to the destiny of the nation from the Revolutionary War to the attack on Fort Sumter, the U.S. Civil War dramatically altered that linkage, and established a context for imagining innovative ways of making sense of death in American culture.

One concrete example of this innovation was the creation of military cemeteries, a new form of sacred space that gave material expression to religious sensibilities tied to both Christianity and nationalism. First established during the war by the federal government, military cemeteries gave order to death by placing bodies of fallen soldiers in a tidy, permanent, and sacrosanct space that glorified both the war effort and the Christian virtues associated with it. In the midst of the war and in the immediate aftermath these cemeteries made profoundly political statements about Northern power, resources, and determination.

After Congress approved the purchase of land by the government in 1862, twelve new cemeteries located on or near major battlefields, Union camps and hospitals, and other military sites were authorized. Most of them, including Robert E. Lee's estate near the Potomac, were on Southern soil, thereby enhancing the political and sacral weight of each.

President Abraham Lincoln articulated the essential meanings undergirding these cemeteries during his dedication speech at Gettysburg. Here Lincoln transformed the bloodied ground and buried lifeless bodies into the rich symbolic soil nourishing Union ideology and American traditions. In the brief speech, Lincoln successfully integrated the fallen soldiers into American mythology, giving them a permanent, holy spot in the physical landscape and assigning them a pivotal, transcendent role in the unfolding of American history. He also gave voice to the incalculable national debt living American citizens owed to the dead.

After the war, the victorious federal government began to ensure that as many Union soldiers as possible were identified and interred in the sacred space of national cemeteries. One of the first postwar national cemeteries was established on the grounds of Andersonville, a site that held profound symbolic meaning for Northerners who, by the end of the war, were outraged by the treatment of federal soldiers there. More than sixty cemeteries owned and operated by the government appeared across the North and South, and within the next decade nearly 300,000 bodies were reinterred. Trumpeting republican values and Christian morality, these cemeteries provided American citizens with an accessible space—in time, many became popular tourist destinations—that imposed a victorious national identity and promoted collective revitalization.

Northern and Southern leaders also gave meaning to the war dead through public pronouncements, in religious services, and by glorifying individual stories of heroism and sacrifice during and after the conflict. Unprecedented levels of social grief and mourning throughout American communities required extraordinary efforts at meaning-making that spoke to the profound emotional pain of individual citizens as well as created a shared sense of loss that could only be overcome through ultimate victory.

Many saw the battle in apocalyptic terms, with the very salvation of American society, and indeed the entire world, at stake. Millennial notions about the impending return of Christ, the role of the nation in this momentous event, and the demonization of the enemy transformed the blood of fallen soldiers into a potent source of social regeneration

that would eventually purify the sins of the nation. Leaders on both sides, for example, publicly encouraged citizens to keep the cosmic implications of the war in mind, rather than stay focused on the tragedy of individual deaths on the battlefield. In this rhetorical context, mass death became meaningful because it forcefully brought home a critical realization about the life and destiny of the nation: It occasionally requires the blood of its citizens to fertilize the life-sustaining spirit of patriotism.

On the other hand, however, Northerners committed to democratic ideals and individual rights also took great pains to glorify, and sentimentalize, the deaths of certain soldiers who embodied at the time of their death national virtues like courage in the face of injustice, spiritual preparedness with an eye toward heavenly rewards, and concern about stability at home with one foot in the grave. Numerous accounts of individuals dying a heroic death on the battlefield or in hospitals were anchored with abundantly rich symbol systems relating to Jesus Christ, America, and home. Indeed, whether death became meaningful in collective or personal terms, a reinterpretation of what it meant to die triumphantly and heroically took place over the course of the war, and was animated by one, two, or all three of these symbolic systems.

Both Northerners and Southerners kept certain deaths in mind and used them as a symbolic and inspirational resource throughout the fighting. For the Confederacy, one of the critical figures in the pantheon of heroic leaders was Stonewall Jackson. A paragon of Christian virtue and piety, Southern honor and pride, Jackson died after being accidentally wounded by one of his own men at the battle of Chancellorsville in 1863. The example of his death, with a chaplain close at hand, his wife singing hymns, and a calm, peaceful demeanor during his last hours, aroused many downhearted Confederates and, in time, attained mythological standing in Southern culture. After the war, Jackson, along with other venerated Southern heroes who eventually passed on like Robert E. Lee and Jefferson Davis, played an important role in the creation of a cultural system of meaning that transformed defeat into the basis for a regionally distinctive southern identity. The southern historian Charles Reagan Wilson argues that this identity embodies a peculiar religious system, the religion of the Lost Cause. This cultural religion, still vital and strong in

the twenty-first century, can be characterized as a cult of the dead since much of its mythological and ritual dimensions focus on deceased Southern martyrs who died during the war.

While many responses to the Civil War conveyed a belief in the regenerative powers of violent death, and that redemption of both the individual and society followed in the wake of mass sacrifices by young men, some grew hardened to the savagery and suffering taking place on American soil. For these people, including soldiers themselves who witnessed fighting firsthand, the meaning of death had nothing to do with religious notions like regeneration or redemption. Rather than being swept away by the emotional resonance of responses that glorified the dead and focused on the life of the spirit, certain individuals grew more and more disenchanted with the symbolism of death. Soldiers on the battlefield, military and political leaders guiding the troops, and citizens back home reading eyewitness accounts or seeing visual depictions of the fighting assumed a more pragmatic, disengaged posture, and became indifferent to scenes of human carnage and the deaths of individual men. The question first raised by these attitudes—Does overexposure to death and violence lead to desensitization?—continues to plague twenty-first-century American society.

Advances in Weaponry

Finally, one of the more long-lasting social changes associated with American experiences in the Civil War has to do with the emergence of a particularly strong cultural and political obsession with guns. During the war, technological advances in weaponry, and the wide distribution of rifles and pistols among the male population, transformed the way Americans related to their guns. After the war, a gun culture took shape that to this day remains anchored by both the mythic and social power of owning a weapon, threatening to use it in the face of perceived danger (a danger often understood as jeopardizing the three symbol systems mentioned earlier, Christian virtues, national security, or more commonly, home life), and using it as an expression of power. This fascination with guns, coupled with an ingrained historical tendency to experience violence as a form of social and religious regeneration, has contributed to making violent death in America a common feature of daily life.

See also: BROWN, JOHN; CEMETERIES, MILITARY; CEMETERIES, WAR; LINCOLN IN THE NATIONAL MEMORY; WAR

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CLINICAL DEATH

See BRAIN DEATH; DEFINITIONS OF DEATH.

COMA

See ADVANCE DIRECTIVES; DEFINITIONS OF DEATH; DO NOT RESUSCITATE; LIFE SUPPORT SYSTEM.

COMMUNICATION WITH THE DEAD

Distant communication has been transformed since ancient times. People can bridge the distance between absent loved ones by picking up a cellular phone, sending e-mail, or boarding a jet that quickly eradicates physical distance. Nevertheless, technology has not improved communication when it is death that separates individuals. The rich and varied history of attempts to communicate with its tantalizing melange of fact and history continues into the present day.

Attracting and Cherishing the Dead

John Dee fascinated Queen Elizabeth in the middle of the sixteenth century when he provided valuable service to the Crown as a navigational consultant, mathematician, and secret agent. What especially piqued the Queen's interest, though, was Dee's mirror. It was an Aztec mirror that had fallen into his hands—along with its story. Supposedly one could see visions by gazing into the mirror in a receptive state of mind. The Queen was among those who believed she had seen a departed friend in Dee's mirror.

Some claim that the dead choose to communicate with the living and the living can also reach out to them by using special techniques and rituals. These propositions have been accepted by many people since ancient times. Greek religious cults and the Aztecs both discovered the value of reflective surfaces for this purpose.

Raymond A. Moody, best known for his pioneering work on near-death experiences, literally unearthed the ancient tradition when he visited the ruins of a temple known as the Oracle of the Dead. There, on a remote and sacred hilltop in Heraclea, priests could arrange for encounters between the living and the dead. Moody recounts his visit:

The roof of the structure is gone, leaving exposed the maze of corridors and rooms that apparition seekers wandered through while waiting to venture into the apparition chamber. . . . I tried to imagine what this place would have been like two thousand years ago when it was dark as a cave and filled with a kind of eerie anticipation. What did the people think and feel during the weeks they were in here? Even though I like to be alone, my mind boggled at the thought of such lengthy and total sensory deprivation. (*Moody 1992, p. 88*)

The apparition chamber was the largest room. It was also probably the most majestic and impressive room the visitors had ever seen. After weeks in the dark, they were now bathed in light. Candles flickered against the walls as priests led them toward the centerpiece, a cauldron whose highly polished metal surface glittered and gleamed with reflections. With priestly guidance, the seekers gazed at the mirrored surface and the dead appeared—or did they? No one knows what their eyes beheld. This ritual was persuasive enough,

though, that it continued until the temple was destroyed by the conquering Romans. It is reasonable to suppose that some of the living did have profoundly stirring experiences, for they believed themselves to be in contact with loved ones who had crossed to the other side. Dee's Aztec mirror may also have been the stimulus for visions in sixteenth-century England. People thought they were seeing something or somebody.

The crystal ball eventually emerged as the preferred intermediary object. Not everybody was adept. Scryers had the knack of peering into the mystical sphere where they could sometimes see the past and the future, the living and the dead. Meanwhile, in jungle compounds thousands of miles away, there were others who could invoke the dead more directly—through the skull. Bones survived decomposition while flesh rotted away. The skull was, literally, the crowning glory of all bones and therefore embodied a physical link with the spirit of the deceased. It was a treasure to own a hut filled with the skulls of ancestors and perhaps of distinguished members of other tribes. The dead were there all the time and could be called upon for their wisdom and power when the occasion demanded.

Moody attempted to bring the *psychomanteum* (oracle of the dead) practice into modern times. He created a domestic-sized apparition chamber in his home. He allegedly experienced reunions (some of them unexpected) with his own deceased family members and subsequently invited others to do the same. Moody believed that meeting the dead had the potential for healing. The living and the dead have a second chance to resolve tensions and misunderstandings in their relationship. Not surprisingly, people have responded to these reports as wish-fulfillment illusions and outright hallucinations, depending on their own belief systems and criteria for evidence.

Prayer, Sacrifice, and Conversation

Worship often takes the form of prayer and may be augmented by either physical or symbolic sacrifice. The prayer messages (e.g., "help our people") and the heavy sacrifices are usually intended for the gods. Many prayers, though, are messages to the dead. Ancestor worship is a vital feature of Yoruba society, and Shintoism, in its various forms, is organized around behavior toward the dead.

Zoroastrianism, a major religion that arose in the Middle East, has been especially considerate of the dead. Sacrifices are offered every day for a month on behalf of the deceased, and food offerings are given for thirty years. Prayers go with the deceased person to urge that divine judgment be favorable. There are also annual holidays during which the dead revisit their homes, much like the Mexican Days of the Dead. It is during the Fravardegan holidays that the spirits of the dead reciprocate for the prayers that have been said on their behalf; they bless the living and thereby promote health, fertility, and success. In one way or another, many other world cultures have also looked for favorable responses from the honored dead.

Western monotheistic religions generally have discouraged worship of the dead as a pagan practice; they teach that only God should be the object of veneration. Despite these objections, cults developed around mortals regarded as touched by divine grace. The Catholic Church has taken pains to evaluate the credentials for sainthood and, in so doing, has rejected many candidates. Nevertheless, Marist worship has long moved beyond cult status as sorrowing and desperate women have sought comfort by speaking to the Virgin Mary. God may seem too remote or forbidding to some of the faithful, or a woman might simply feel that another woman would have more compassion for her suffering.

Christian dogma was a work in progress for several centuries. By the fourth century it was decided that the dead could use support from the living until God renders his final judgment. The doctrine of purgatory was subsequently accepted by the church. Masses for the dead became an important part of Christian music. The Gregorian chant and subsequent styles of music helped to carry the fervent words both to God and the dead who awaited his judgment.

Throughout the world, much communication intended for the dead occurs in a more private way. Some people bring flowers to the graveside and not only tell the deceased how much they miss them, but also share current events with them. Surviving family members speak their hearts to photographs of their deceased loved ones even though the conversation is necessarily one-sided. For example, a motorist notices a field of bright-eyed daisies and sends a thought-message to an old friend: "Do you see that, George? I'll bet you can!"

Mediums and Spiritualism

People often find comfort in offering prayers or personal messages to those who have been lost to death. Do the dead hear them? And can the dead find a way to respond? These questions came to the fore during the peak of Spiritualism.

Technology and science were rapidly transforming Western society by the middle of the nineteenth century. These advances produced an anything-is-possible mindset. Inventors Thomas Edison (incandescent light bulb) and Guglielmo Marconi (radio) were among the innovators who more than toyed with the idea that they could develop a device to communicate with the dead. Traditional ideas and practices were dropping by the wayside, though not without a struggle. It was just as industrialization was starting to run up its score that an old idea appeared in a new guise: One can communicate with the spirits of the dead no matter what scientists and authorities might say. There was an urgency about this quest. Belief in a congenial afterlife was one of the core assumptions that had become jeopardized by science (although some eminent researchers remained on the side of the angels). Contact from a deceased family member or friend would be quite reassuring.

Those who claimed to have the power for arranging these contacts were soon known as *mediums*. Like the communication technology of the twenty-first century, mediumship had its share of glitches and disappointments. The spirits were not always willing or able to visit the *séances* (French for “a sitting”). The presence of even one skeptic in the group could break the receptive mood necessary to encourage spirit visitation. Mediums who were proficient in luring the dead to their darkened chambers could make a good living by so doing while at the same time providing excitement and comfort to those gathered.

Fascination with spirit contacts swept through much of the world, becoming ever more influential as aristocrats, royalty, and celebrities from all walks of life took up the diversion. The impetus for this movement, though, came from a humble rural American source. The Fox family had moved into a modest home in the small upstate New York town of Hydesville. Life there settled into a simple and predictable routine. This situation was too boring for the young Fox daughters, Margaretta and

Kate. Fortunately, things livened up considerably when an invisible spirit, Mr. Splitfoot, made himself known. This spirit communicated by rapping on walls and tables. He was apparently a genial spirit who welcomed company. Kate, for example, would clap her hands and invite Mr. Splitfoot to do likewise, and he invariably obliged.

The girls’ mother also welcomed the diversion and joined in the spirit games. In her words:

I asked the noise to rap my different children’s ages, successively. Instantly, each one of my children’s ages was given correctly . . . until the seventh, at which a longer pause was made, and then three more emphatic raps were given, corresponding to the age of the little one that died, which was my youngest child. (*Doyle 1926, vol. 1, pp. 61–65*)

The mother was impressed. How could this whatever-it-is know the ages of her children? She invented a communication technique that was subsequently used throughout the world in contacts with the audible but invisible dead. She asked Mr. Splitfoot to respond to a series of questions by giving two raps for each “yes.” She employed this technique systematically:

I ascertained . . . that it was a man, aged 31 years, that he had been murdered in this house, and his remains were buried in the cellar; that his family consisted of a wife and five children . . . all living at the time of his death, but that his wife had since died. I asked: “Will you continue to rap if I call my neighbors that they may hear it too?” The raps were loud in the affirmative. . . . (*Doyle 1926, vol. 1, pp. 61–65*)

And so started the movement known first as Spiritism and later as Spiritualism as religious connotations were added. The neighbors were called in and, for the most part, properly astounded. Before long the Fox sisters had become a lucrative touring show. They demonstrated their skills to paying audiences both in small towns and large cities and were usually well received. The girls would ask Mr. Splitfoot to answer questions about the postmortem well-being of people dear to members of the audience. A few of their skeptics included three professors from the University of

Buffalo who concluded that Mr. Splitfoot's rappings were produced simply by the girls' ability to flex their knee-joints with exceptional dexterity. Other learned observers agreed. The *New York Herald* published a letter by a relative of the Fox family that also declared that the whole thing was a hoax. P. T. Barnum, the great circus entrepreneur, brought the Fox girls to New York City, where the large crowds were just as enthusiastic as the small rural gatherings that had first witnessed their performances.

Within a year or so of their New York appearance, there were an estimated 40,000 Spiritualists in that city alone. People interested in the new Spiritism phenomena often formed themselves into informal organizations known as "circles," a term perhaps derived from the popular "sewing circles" of the time. Many of the Spiritualists in New York City were associated with an estimated 300 circles. Horace Greeley, editor of the *New York Tribune*, and a former Supreme Court judge were among the luminaries who had become supporters of the movement. Mediums also helped to establish a thriving market developed for communication with the beyond. The movement spread rapidly throughout North America and crossed the oceans, where it soon enlisted both practitioners and clients in abundance.

Table-rapping was supplemented and eventually replaced by other communication technologies. The Ouija board was wildly popular for many years. This was a modern derivative of devices that had been used to communicate with the dead 2,500 years ago in China and Greece. The new version started as the *planchette*, a heart-shaped or triangular, three-legged platform. While moving the device over a piece of paper, one could produce graphic or textual messages. The belief was that the person who operates the device really does not have control over the messages, which is up to the spirits.

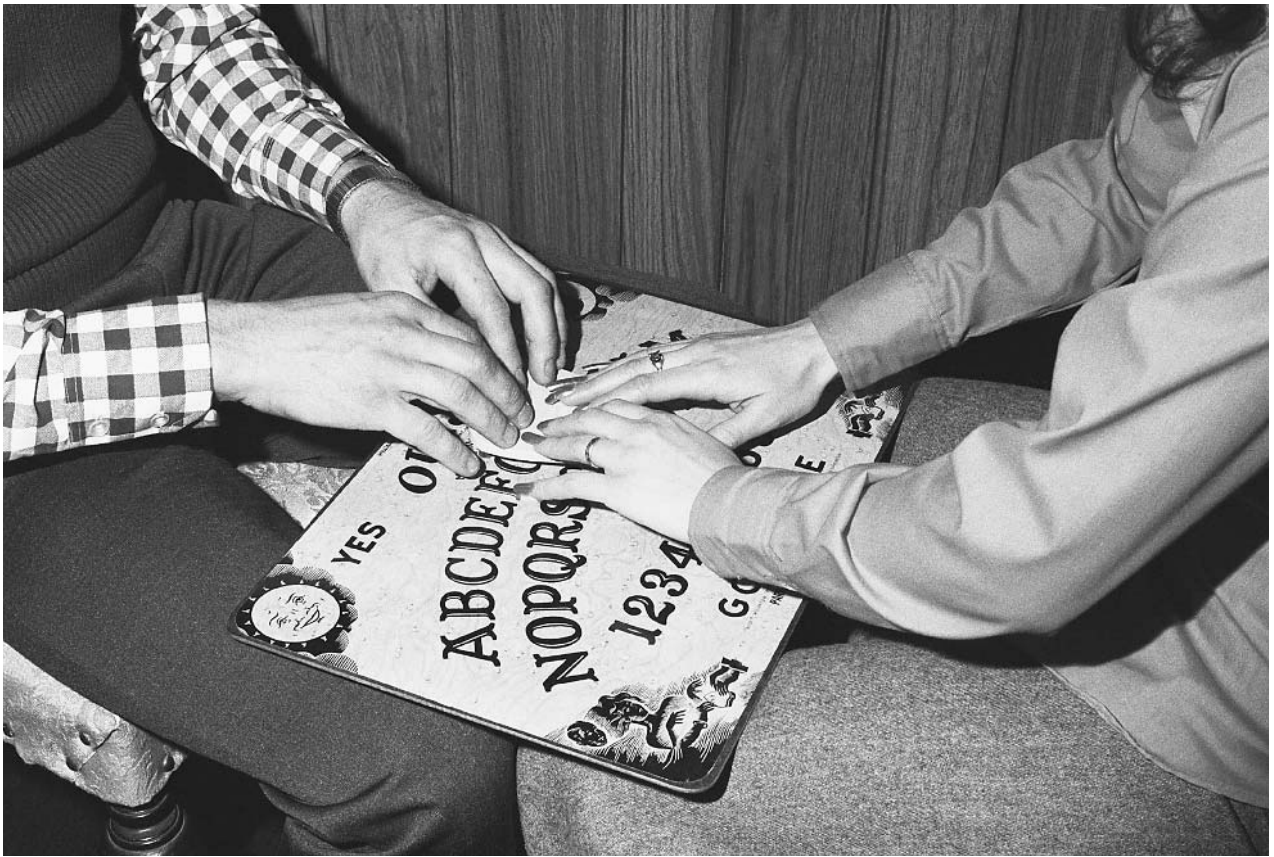
The Ouija board was criticized by some as too effective, and, therefore, dangerous. Believers in the spirit world feared that evil entities would respond to the summons, taking the place of the dearly departed. Other critics warned that the "manifestations" did not come from spirits of the dead but rather had escaped from forbidden corners of the user's own mind and could lead to psychosis and suicide.

Fraudulent Communication with the Dead

The quest to communicate with the dead soon divided into two distinct but overlapping approaches. One approach consisted of earnest efforts by people who either longed for contact with their deceased loved ones or were curious about the phenomena. The other approach consisted of outright fraud and chicanery intended to separate emotionally needy and gullible people from their money. Examples of the latter were so numerous that those searching for the truth of the matter were often discouraged. At the same time that modern investigative techniques were being developed, such as those pioneered by Pinkerton detective agency, there was also the emergence of spirit sleuths who devoted themselves to exposing the crooks while looking for any possible authentic phenomena. The famed illusionist Harry Houdini was among the most effective whistle-blowers during the Spiritism movement. Calling upon his technical knowledge in the art of deception, he declared that astounding people with entertaining illusions was very different from claiming supernatural powers and falsely raising hopes about spirit contact.

The long list of deceptive techniques included both the simple and brazen, and the fairly elaborate. Here are a few examples from spirit sleuth John Mulholland:

- A match-box sized device was constructed to provide a series of "yes" and "no" raps. All the medium had to do was to ask a corresponding series of questions.
- A blank slate placed on one's head in a darkened room would mysteriously be written upon by a spirit hand. The spirit was lent a hand by a confederate behind a panel who deftly substituted the blank slate for one with a prewritten message.
- Spirit hands would touch sitters at a séance to lend palpable credibility to the proceedings. Inflatable gloves were stock equipment for mediums.
- Other types of spirit touches occurred frequently if the medium had but one hand or foot free or, just as simply, a hidden confederate. A jar of osphorized olive oil and skillful suggestions constituted one of the easier ways of producing apparitions in a dark



Redesigned and renamed, the Ouija (combining the French oui and German ja for “yes”) was used by vast numbers of people who hoped to receive messages from the beyond. BETTMANN/CORBIS

room. Sitters, self-selected for their receptivity to spirits, also did not seem to notice that walking spirits looked a great deal like the medium herself.

- The growing popularity of photographers encouraged many of the dead to return and pose for their pictures. These apparitions were created by a variety of means familiar to and readily duplicated by professional photographers.

One of the more ingenious techniques was innovated by a woman often considered the most convincing of mediums. Margery Crandon, the wife of a Boston surgeon, was a bright, refined, and likable woman who burgeoned into a celebrated medium. Having attracted the attention of some of the best minds in the city, she sought new ways to demonstrate the authenticity of spirit contact. A high point was a session in which the spirit of the deceased Walter not only appeared but also left his fingerprints. This was unusually hard

evidence—until spirit sleuths discovered that Walter’s prints were on file in a local dentist’s office and could be easily stamped on various objects. Unlike most other mediums, Margery seemed to enjoy being investigated and did not appear to be in it for the money.

Automatic writing exemplified the higher road in attempted spirit communication. This is a dissociated state of consciousness in which a person’s writing hand seems to be at the service of some unseen “Other.” The writing comes at a rapid tempo and looks as though written by a different hand. Many of the early occurrences were unexpected and therefore surprised the writer. It was soon conjectured that these were messages from the dead, and automatic writing then passed into the repertoire of professional mediums. The writings ranged from personal letters to full-length books. A century later, the spirits of Chopin and other great composers dictated new compositions to Rosemary Brown, a Londoner with limited skills

at the piano. The unkind verdict was that death had taken the luster off their genius. The writings provided the basis for a new wave of investigations and experiments into the possibility of authentic communication with the dead. Some examples convinced some people; others dismissed automatic writing as an interesting but nonevidential dissociative activity in which, literally, the left hand did not know what the right hand was doing.

The cross-correspondence approach was stimulated by automatic writing but led to more complex and intensive investigations. The most advanced type of cross-correspondence is one in which the message is incomplete until two or more minds have worked together without ordinary means of communication—and in which the message itself could not have been formulated through ordinary means of information exchange. One of the most interesting cross-correspondence sequences involved Frederick W. H. Myers, a noted scholar who had made systematic efforts to investigate the authenticity of communication with the dead. Apparently he continued these efforts after his death by sending highly specific but fragmentary messages that could not be completed until the recipients did their own scholarly research. Myers also responded to questions with the knowledge and wit for which he had been admired during his life. Attempts have been made to explain cross-correspondences in terms of telepathy among the living and to dismiss the phenomena altogether as random and overinterpreted. A computerized analysis of cross-correspondences might at least make it possible to gain a better perspective on the phenomena.

The Decline of Spiritism

The heyday of Spiritism and mediums left much wreckage and a heritage of distrust. It was difficult to escape the conclusion that many people had such a desire to believe that they suspended their ordinary good judgment. A striking example occurred when Kate Fox, in her old age, not only announced herself to have been a fraud but also demonstrated her repertoire of spirit rappings and knockings to a sold-out audience in New York City. The audience relished the performance but remained convinced that Mr. Splitfoot was the real thing. Mediumship, having declined considerably, was back in business after World War I as families grieved for lost fathers, sons, and brothers. The

intensified need for communication brought forth the service.

Another revival occurred when mediums, again out of fashion, were replaced by channelers. The process through which messages are conveyed and other associated phenomena have much in common with traditional Spiritism. The most striking difference is the case of past life regression in which it is the individual's own dead selves who communicate. The case of Bridey Murphy aroused widespread interest in past-life regression and channeling. Investigation of the claims for Murphy and some other cases have resulted in strong arguments against their validity.

There are still episodes of apparent contact with the dead that remain open for wonder. One striking example involves Eileen Garrett, "the skeptical medium" who was also a highly successful executive. While attempting to establish communication with the recently deceased Sir Arthur Conan Doyle, she and her companions were startled and annoyed by an interruption from a person who gave his name as "Flight Lieutenant H. Carmichael Irwin." This flight officer had died in the fiery crash of dirigible R101. Garrett brought in an aviation expert for a follow-up session with Irwin, who described the causes of the crash in a degree of detail that was confirmed when the disaster investigation was completed months later.

The Psychic Friends Network and television programs devoted to "crossing over" enjoy a measure of popularity in the twenty-first century, long after the popularity of the Spiritualism movement. Examples such as these as well as a variety of personal experiences continue to keep alive the possibility of communication with the dead—and perhaps possibility is all that most people have needed from ancient times to the present.

See also: DAYS OF THE DEAD; GHOST DANCE; GHOSTS; NEAR-DEATH EXPERIENCES; NECROMANCY; SPIRITUALISM MOVEMENT; VIRGIN MARY, THE; ZOROASTRIANISM

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ROBERT KASTENBAUM

open family communication in facilitating the positive processing of a death loss. In the 1990s, attention started to be given to communicative issues with reference to dying individuals, especially with regard to the need for improved communication between dying persons and their families, their physicians, and their nurses.

For many people, the thought of dying evokes as much or more fear and apprehension as does the thought of death itself. Consequently, discussing the dying process, as well as thinking about how one's last days, weeks, and months might be spent, can be very beneficial. Otherwise, the process of dying becomes a forbidden topic. It is in this context of fear, apprehension, and denial that dying persons are often viewed as persons whom one might feel sorry for, yet as individuals whose very presence makes caretakers and family members feel uneasy and whose feelings, attitudes, and behaviors are hard to relate to. In this light, it is not surprising that Sherwin Nuland wrote the best-selling *How We Die* (1993) to "demystify" the dying process.

Coincidentally, a focus on relief of symptoms and increased attention to the patient's and family's conception of a good quality of life has emerged in medical care, particularly in the context of life-threatening illness. For example, in "The Quest to Die with Dignity," a 1997 report published by American Health Decisions, a nonprofit group, people not only reported fears of dying "hooked to machines," but also did not feel that the health care system supported their conception of a "good death," that is, a "natural" death in familiar surroundings. Such findings were based on 36 focus groups totaling nearly 400 people.

Furthermore, a study commissioned by Americans for Better Care of the Dying reported that most Americans view death as "awful," and that dying persons are often avoided and stigmatized because of their condition. In 1987 the researchers Peter Northouse and Laurel Northouse found that 61 percent of healthy individuals stated that they would avoid cancer patients, and 52 percent of dying persons believed that others generally avoided them. Significantly, the project SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks for Treatment), which studied 9,000 patients with life-threatening illnesses in five teaching hospitals over a two-year

COMMUNICATION WITH THE DYING

Interpersonal communication regarding death, dying, and bereavement has become an increasingly important area in the field of thanatology, wherein research has addressed the critical role of

period, reflects the difficulties patients have in communicating with their physicians at the end of life, where such persons' wishes regarding end-of-life care were largely ignored. Indeed, efforts to improve communication by educating physicians were not successful.

Why People Have Difficulty Communicating with Dying Persons

Researchers have suggested several reasons for the difficulty many individuals have in communicating with dying persons: not wanting to face the reality of one's own death, not having the time to become involved, and not feeling emotionally able to handle the intensity of the situation. For some people, the grief that they experience in anticipation of a loved one's death may help to explain their difficulty in interacting with terminally ill individuals. For others, dying may have "gone on too long," and thus the dying person experiences the pain of being isolated from those whose love he or she needs most. Likewise, loved ones' beliefs about whether they could have somehow prevented the death or not may evoke more guilt in such persons, causing them to avoid interacting with a dying loved one.

Uneasiness in being with the dying can manifest itself via outright avoidance, or in difficulty in speaking or maintaining eye contact with such persons. It can also be expressed in maintaining a physical distance, uneasiness about touching the dying person, or an inability or unwillingness to listen. This may result in overconcern, hyperactivity, or manipulative, impersonal behavior (e.g., "Aren't we looking good today!"), or changing the subject. Significantly, this uneasiness is likely to be perceived by those who are already sensitive to being rejected because they are dying.

Efforts to measure fears about interacting with dying persons have been reflected in the Communication Apprehension Regarding the Dying Scale (CA-Dying), which operationalizes apprehension related to such communicative issues as talking to and making eye contact with a dying individual and the level of perceived closeness to this person. CA-Dying is independent of general communication apprehension, and positively related to overt fears regarding one's own death and another's dying, while negatively related to death acceptance

and covert death fear. In 1986 and 1987, the creator of this scale, the psychologist Bert Hayslip, found that scores on the CA-Dying scale decreased among a group of hospice volunteers enrolled in a training program relative to age-matched controls. In this respect, age relates negatively to CA-Dying scores, most likely due to increased death experience. Such apprehension does not vary with the nature of the dying person's illness; it is universal.

Characteristics of dying individuals also may affect one's apprehension about communicating with such persons. Because pain frequently accompanies terminal illness, its presence often affects simple communication. Such pain often preoccupies dying individuals' thoughts and may contribute to, along with intense emotional conflict and the effects of medication, an increase in contradictory messages between the individual and others. In addition, those dying violate several of the social standards in place in American society: They are often nonproductive, unattractive, not in control of themselves and of their life situation, and provoke anxiety in others.

Not all dying people are alike. Thus, some may evoke more avoidance than others, depending upon whether their death is expected or not, what they are dying of, where they die, and whether their deaths are seen as "on-time" (i.e., the death of an older person), or "off-time" (i.e., the death of a child, adolescent, or young adult). Additionally, some dying individuals are more able to deal with everyday demands than are others, and some prefer to talk or remain silent on matters related to death. Some individuals have more support from friends and families than do others, and some are more tolerant of pain. Some are more willing to communicate their awareness of dying than other dying individuals, and others are more able to discuss what it is they need in order to die peacefully.

Important Steps in Communicating with Dying Persons

For those dying and their families, the prospect of their own or a loved one's imminent death can be a terrifying experience. Indeed, dying produces anxiety, leading to both dependence upon other people and defensiveness based upon fears of rejection. Consequently, being able to communicate honestly about the quality or length of one's life, the disease process, and one's feelings about

loved family members or friends is of utmost importance. This communication (both verbal and nonverbal) is two-way—each individual is both giving and searching for cues about each person's acceptability to the other. Because preconceptions as "dying person," "hospice patient," or "caregiver" (professional or otherwise) govern or limit what aspects a person reveals about him- or herself, being open, genuine, empathic, and understanding allows this two-way dynamic to evolve beyond these "labels."

The benefits of open communication are clear. Relationships that allow for communication about death often precede healthy adjustment. Researchers have found that the emotional impact of being labeled as "dying" is directly related to quality and openness of the communication between the dying individual and others, wherein if open communication is not achieved caregivers operate on preconceptions rather than the dying individual's actual thoughts and feelings.

Communicative Difficulties among Health Care Professionals

It could be argued that those persons whose attitudes and actions most influence the quality of end-of-life care are physicians, principally because they have primary control of the information that drives medical decision making. Furthermore, both patients and physicians agree that physicians have the responsibility to initiate discussions regarding advance directives and the use of life-sustaining medical intervention.

Many have noted the difficulty physicians experience in communicating with the dying and their families. For example, in 1977 the researcher Miriam Gluck suggested that physicians may fear emotional involvement, feel a loss of what to say, or lack knowledge about what the patient has been told. Often physicians may feel that terminal patients are medical "failures," are preoccupied with medical equipment and technical skills, fear the patient's anger, or fear that the patient will die.

Physicians, for the most part, seem to view death as the ultimate enemy, and many medical practitioners, when called upon to provide patient-centered palliative care, feel ill prepared. Personal and professional anxiety and occasionally even defensiveness often result. These responses often lead to missed opportunities for the patient, family,

and the physician to share in a peaceful, natural rite of passage. The discomfort felt by the physician in broaching the topic of advance directives may well lead to outcomes not desired by the patient, such as unwanted continuation of life-sustaining medical treatment.

Discomfort in broaching the topic of advance directives, death, and symptom control may stem from a lack of confidence in providing palliative care or lack of understanding regarding the ethical and legal aspects of end-of-life decision making. Reluctance to discuss end-of-life issues with patients may also be caused by a fear of damaging their hope, a perception that the role of the physician is only to heal and preserve life, and feeling that such discussions should only occur in the context of an intimate relationship with the patient and family. Although physicians vary in the extent to which they are able to discuss sensitive end-of-life issues, such as the diagnosis or prognosis of a terminal illness, physicians' attitudes toward the care of the terminally ill, including the willingness to communicate about the end of life, are critical to ensuring an improved death for the majority of Americans who prefer to die "naturally."

In 1971 the researcher Samuel Klagsbrun found that, for nurses, fear of death to a certain extent affected responses to situations requiring interaction with the dying patient. Specifically, a higher fear of others' dying was related to increased uneasiness in talking about dying with the patient where the nurse did not have a "specific task" to perform. In addition, finding a terminally ill patient crying was also related to a high fear of others' dying. In cases where "appropriate behavior" was ill defined in caring for a dying patient, simple denial was used to cut short the interaction.

What Is Special about Communicating with Dying Persons?

Loma Feigenberg and Edwin Shneidman have discussed four types of interactions with persons who are dying, which include (1) ordinary conversation, (2) hierarchical exchanges, (3) psychotherapy, and (4) thanatological exchanges. While ordinary conversation indicates that two individuals of equal status are talking about what is actually being said (e.g., the weather, sports, news items), hierarchical exchanges involve conversations between persons

of unequal status, where one is more powerful or perceptually superior to the other (e.g., supervisor-subordinate, officer-enlisted man, oncologist-patient). Roles cannot be exchanged; that is, the patient cannot examine the oncologist. Clearly, hierarchical exchanges undermine genuine communication with dying persons. Psychotherapy focuses on feelings, emotional content, and the latent (unconscious) meaning of what is said, where the patient invests the therapist with magical powers or projects powerful emotions or qualities onto the therapist. As with hierarchical exchange, in psychotherapy therapist and patient are not equals. In thanatological exchanges, while participants are perceived as equals (as in ordinary conversations), thanatological interactions between persons are unique.

Dying is a distinctly interpersonal event involving a helping person and the dying patient; this "other" person may be a friend, neighbor, hospice volunteer, counselor, one's husband, wife, or one's child. Consequently, ordinary conversations with dying persons may be very "therapeutic" and, in fact, reflect many elements that are typical of formal psychotherapy, including active listening.

Active listening assumes the individuality of each dying person's needs, and stresses what is communicated both verbally and nonverbally. One's presence as well as questions that are asked say, "I am trying to understand how you feel." Reassurance and providing nonjudgmental support are critical. Moreover, using the dying person's name throughout the conversation, making eye contact, holding the person's hand, placing one's hand on a shoulder or arm, smiling, gesturing, and leaning forward all communicate genuine interest and caring in what the person is saying (or not saying) and feeling. Asking specific questions such as, "Can you help me understand?" as well as open-ended questions such as, "What is it that you need to do now?" are very important, as is being comfortable with silence.

Effective communication with dying people reflects comfort with one's own discomfort, to "do nothing more than sit quietly together in silence" (Corr, Nabe, and Corr 2000, p. 178). Indeed, communicating involves as much listening as it does talking and doing. Building good communication and listening skills, touching and maintaining eye

contact, and projecting a genuine sense of empathy all give the message, "I am here to help and support you. I care about how you are feeling." In short, effective, empathic, and timely communication is embodied in the statement, "Be a friend."

Being attuned to verbal and nonverbal signals that the person wants to talk give permission to share. Providing the opportunity to expand on what the person has said by repeating what has been stated, using the person's own words, opens up communication, as does disclosing one's own thoughts and feelings. Such disclosure can help the individual talk about his or her own feelings. Doing this with others' needs in mind, not one's own, is very important.

In understanding dying people's needs, it is important to realize that different illnesses and illnesses in various stages of progression create different "dying trajectories" that make different physical, psychological, and psychosocial demands on those dying and their families. For example, the dying person may initially search for information regarding insurance coverage, the nature of the illness and its progression, treatment, or what the family can do to help to care for him or her. He or she may want to know about the side effects of pain-relieving medications. As the condition worsens, more intimate needs for reassurance and support may surface, and concerns about funeral planning, wills, or life without a loved one may be expressed. Near death, people may be less expressive about what they need, and emotional support may be all that they require. Rather than "doing" something, the caring persons may meet this need by simply "being there."

Dying people's and their families' feelings of being overwhelmed or of feeling vulnerable directly affect their behavior and willingness to talk. What passes for open, friendly conversation one day can change suddenly. One may be angrily rebuffed, rejected, or totally ignored because the person is in pain or because the person has had a fight with a child or spouse. The individual who is more aware of his or her disease and its impact on future relationships and plans may be more angry or depressed than usual; communication may cease altogether or be severely curtailed. No appreciation for time spent or help given (however unselfishly) may be expressed. On other days, this

same person may be very open or psychologically dependent on the professional caregiver. Fears, hopes, or secrets may be willingly shared. Such fluctuations are to be expected and are characteristic of the “ups and downs” of the dying process. One must be attentive to not only the dying individual’s words, but what words and actions may symbolize.

Critical to understanding dying persons’ concerns is understanding both the patient’s and the family’s needs in a variety of areas. These needs cut across many domains—physical (pain control); psychosocial (maintaining close relationships with others); spiritual (integrating or resolving spiritual beliefs); financial (overcoming the costs of medical or hospice care, having adequate funds to cover other financial obligations unrelated to care); and psychological (knowing about the illness and its course over time, talking over emotional difficulties, knowing that one’s family is informed about the illness and that family members will be cared for well). Attending to as many of these needs as one can contributes to both the patient’s and family’s quality of life.

See also: DYING, PROCESS OF; GOOD DEATH, THE; LESSONS FROM THE DYING; SYMPTOMS AND SYMPTOM MANAGEMENT

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CONFUCIUS

Confucius (551–479 B.C.E.) was one of several intellectuals who started questioning the meaning of life, and the role of the gods and the spirits. During the Warring States Period, Confucius developed a system of ethics and politics that stressed five virtues: charity, justice, propriety, wisdom, and loyalty. His teachings were recorded by his followers in a book called *Analects*, and formed the code of ethics called Confucianism that has been the cornerstone of Chinese thought for many centuries.

Confucius's guiding belief was that of the philosophy *Tien Ming* (or the influences of fate and mission). Tien Ming states that all things are under the control of the regulatory mechanism of heaven. This includes life and death, wealth and poverty, health and illness. Confucius believed that understanding Tien Ming was his life's mission. He encouraged people to accept whatever happened to them, including death.

Confucius affirmed that if people do not yet know about life, people may not know about death (Soothill 1910). Without knowledge of how to live, a person cannot know about death and dying. However, Confucius was criticized for avoiding discussions of death. He did not encourage his followers to seek eternal life, nor did he discuss death, gods, ghosts, and the unknown future or afterlife in detail. He maintained that ghosts were spirits and were not easy to understand. Confucius concluded that these issues were complicated and abstract, and that it was better to spend time solving the problems of the present life than to look into the unknown world of death and afterlife. He wanted to convey the importance of valuing the existing life and of leading a morally correct life according to one's mission from heaven.

Confucius considered righteousness to be a basic requirement of a good person, stating that such a person would not seek to stay alive at the expense of injuring virtue. He encouraged people to uphold these moral principles and care for each other until death. His followers were exhorted to be loyal and dutiful toward family, kin, and neighbors, and to respect their superiors and the elderly. Filial piety to parents and ancestors is fundamental to these beliefs. Far from being characterized by fear, the attitudes of the living toward the departed

members of the family or clan are one of continuous remembrance and affection.

These beliefs may partially explain why Qu Yuen and other students killed in the 1989 Tiananmen Square massacre in Beijing, China, were prepared to give up their lives to advocate the values of justice and goodness for their country. Those who follow such beliefs would have no regret when confronted with their own death and would accept death readily. This is regarded as a high level of moral behavior of family or social virtue. Although Confucius did not express it explicitly, to die for righteousness is an example of a good death for the individual as well as the nation.

See also: CHINESE BELIEFS; GHOSTS; GOOD DEATH, THE

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MUI HING JUNE MAK

CONTINUING BONDS

The phrase "continuing bonds" was first used in 1996 to refer to an aspect of bereavement process in the title of the book, *Continuing Bonds: Another View of Grief*, which challenged the popular model of grief requiring the bereaved to "let go" of or detach from the deceased. It was clear from the data presented that the bereaved maintain a link with the deceased that leads to the construction of a new relationship with him or her. This relationship continues and changes over time, typically providing the bereaved with comfort and solace. Most mourners struggle with their need to find a place for the deceased in their lives and are

often embarrassed to talk about it, afraid of being seen as having something wrong with them.

A spontaneous statement by Natasha Wagner, whose mother, the actress Natalie Wood, drowned when Natasha was a teenager, summarized this well: “I had to learn to have a relationship with someone who wasn’t there anymore” (1998). More than a decade after the death of his first wife, playwright Robert Anderson wrote about her continued place in his life: “I have a new life. . . . Death ends a life, but it does not end a relationship, which struggles on in the survivor’s mind toward some resolution which it never finds” (1974, p.77). With this statement, he legitimized his own experience and that of other mourners as well.

Detachment Revisited

Until the twentieth century, maintaining a bond with the deceased had been considered a normal part of the bereavement process in Western society. In contrast, in the twentieth century the view prevailed that successful mourning required the bereaved to emotionally detach themselves from the deceased. The work of Sigmund Freud contributed significantly to this view, largely as a result of the paper *Mourning and Melancholia*, which he wrote in 1917. Grief, as Freud saw it, freed the mourner from his or her attachments to the deceased, so that when the work of mourning was completed, mourners were free to move ahead and become involved in new relationships. When one looks at Freud’s writing regarding personal losses in his life, one learns that Freud understood that grief was not a process that resulted in cutting old attachments. Nonetheless, his theory took on a life of its own, and the mourners were advised to put the past behind them. This practice still continues into the twenty-first century.

Many practitioners observed that mourners often developed an inner representation of the deceased by internalizing attitudes, behavior, and values associated with the deceased. They saw this as a step in the process that eventually led the mourner to detach from the deceased and move on. The psychiatrist John Bowlby wrote that a discussion of mourning without identification—that is, finding a place for the deceased in one’s sense of self—will seem like Hamlet without a prince. Like most observers of the bereavement process,

he was aware of the ways in which mourners identify with the deceased, but he concluded that when attachment to the deceased is prominent, it seems to be indicative of psychopathology.

Another factor promoting the view of a necessary detachment was that most observers were basing their work on clinical practice. People came to them with serious emotional problems, many of which derived from connections to the deceased that were out of the bereaved’s awareness. These connections focused on negative consequences of the relationship and anchored the bereaved’s current life inappropriately in the past. The clinician/researcher then generalized to the larger population of the bereaved, most of whom had a different experience.

Researchers Dennis Klass and Tony Walter contend that this view of grief, in which the dead were banned from the lives of those surviving them, gained popularity as interest in the afterlife waned in Western society. The growing influence of the scientific worldview in the twentieth century led to death being viewed as a medical failure or accident rather than as an inevitable part of the human condition. The physician George Lundberg wrote about the difficulties caused by the expectations of both physicians and those they serve that they can keep death away rather than accepting that death is both natural and inevitable.

The twentieth-century Western approach to human behavior that valued individuation and autonomy also supported the focus on detachment. Bowlby’s development of the theory of attachment behavior in children focused on the individual and how his or her needs could be met. As this theory was subsequently applied to bereavement theory, the interactive, relational aspects of the process were not clearly spelled out. In the “letting go” model, a linear lens is applied, as if one experience can lead to one outcome, and this is how attachment theory was often applied as well. Yet psychologist Jerome Bruner noted that people can rarely be put into a simple cause-and-effect model. There are simply too many intervening variables reflecting the complexity of real life. In a linear model, bereavement is seen as a psychological condition or illness from which people could recover with the right treatment. In fact, bereavement does not go away but is a difficult and expected part of the normal life cycle; it is a

period of loss, of change and transition in how the bereaved relate to themselves, to the deceased, and to the world around them.

At the beginning of the twenty-first century views of bereavement continue to evolve. There is a growing recognition of the complexity of the human condition and the importance of relationships in people's lives. Humans now recognize that the goal of development is not independence but interdependence. Relationships with others, living or dead, frame one's sense of self and how one lives. More and more we appreciate that there is continuity between the past and the present. Without a sense of the past and an understanding of its place in people's lives, it is difficult to move ahead.

Various Expressions of Continuing Bonds

It is important not only for the individual but also for the community to find a way to relate to the deceased. Just as an individual's personal life is disrupted in a profound way by a death, so too is the larger social world. Ritual can play an important role in finding a place for the dead in the reconstituted world of both the bereaved and the community. In many cultures, religious beliefs and views of life after death govern the experience of the relationship.

In Catholicism, for example, mourners are expected to have a memorial mass on the anniversary of the death. In Judaism, mourners are obligated to remember family members who died by participating in synagogue memorial services five times during the year, including the anniversary of the death. Klass described the rituals practiced in the home in Japan to honor the deceased and their role in the family's ongoing life. He describes the Buddha altar where spirits of the deceased are venerated in daily prayer. In some societies, dreams in which the deceased appeared as well as other experiences of the deceased served to keep the deceased present in the survivors' lives. There are societies where there is no reference to the deceased after their death. In some communities, such as Native American communities, there is fear of the deceased returning to disrupt the lives of those left behind, and in other communities, like the aboriginal communities of Australia, there is a concern that talking about the deceased disrupts the soul's journey to the next life. This silence in

the community does not mean that there is no bond with the deceased; it is simply a relationship of a different sort that is unfamiliar to Westerners.

Constructing a Bond

An understanding of the nature of the continuing relationship presupposes a specific knowledge of the deceased whether he or she was a young person, an old person, a parent, a child, a friend, or a member of the extended family. All of these roles reflect the relationship between the mourner and the deceased. What did the mourner lose? On what is the continuing connection being built? What part did the deceased play in the mourner's life? In the community's life? What did he or she contribute? What will be missing? All of these issues affect the connection.

The development of a bond is conscious, dynamic, and changing. Mourners' faith systems can affect the way in which they incorporate the departed into their lives. Some people believe that the deceased live in another dimension. Many believe the deceased are there to intervene and support them. Others do not depend on a faith system but rather build the connection out of the fabric of daily life and the sense of the deceased they carry within them.

Individuals can learn a good deal about continuing bonds from children and adolescents. They build a new relationship with the deceased by talking to the deceased, locating the deceased (usually in heaven), experiencing the deceased in their dreams, visiting the grave, feeling the presence of the deceased, and by participating in mourning rituals. The researchers Claude Normand, Phyllis Silverman, and Steven Nickman found that over time the children of deceased parents developed a connection to the departed that they described as "becoming their parent's living legacy" (Normand 1996, p. 93). They began to emulate their parents in ways that they believe would have pleased them, thus confirming social worker Lily Pincus's thesis that mourners identify with the deceased, adopting aspects of the deceased's behavior and feeling that the deceased has become part of their current identity.

Adults also find themselves dreaming, talking to, and feeling the presence of the deceased. Some

see the deceased as a role model from whose wisdom and learning they can draw. They sometimes turn to the deceased for guidance. They also tend to adopt or reject a moral position identified with the deceased in order to clarify their own values. Finally, they actively form their thoughts in ways that facilitate their remembering the deceased.

Psychologist Lora Helms Tessman describes the dilemma an adult child experienced trying to reconcile her father's Nazi background while maintaining a "liveable" memory of him. Psychiatrist Ann Marie Rizzuto observed that the process of constructing inner representations involves the whole individual and that these representations grow and change with the individual's development and maturation. The role of the other person is very important so that construction is partly a social activity. Parents play a key role in helping their bereaved children relate to the deceased and in keeping him or her in their lives.

One sees that grief is never finished, that the way the bereaved relate to the deceased changes as they develop over the life cycle, whether they be young or old mourners. Yet there seems to be a lack of appropriate language for describing mourning as part of the life cycle. People need to stop thinking of grief as being entirely present or absent. People rarely just "get over it," nor do they ever really find "closure." The phrase "continuing bonds" is one contribution to a new language that reflects a new understanding of this process.

A continuing bond does not mean, however, that people live in the past. The very nature of mourners' daily lives is changed by the death. The deceased are both present and absent. One cannot ignore this fact and the tension this creates in the bereavement process. The bond shifts and takes new forms in time, but the connection is always there. Mourners, especially children, may need help from their support networks to keep their bonds alive or to let the deceased rest. Connections to the dead need to be legitimized. People need to talk about the deceased, to participate in memorial rituals, and to understand that their mourning is an evolving, not a static, process. In the words of a nineteenth-century rabbi, Samuel David Luzzatto, "Memory sustains man in the world of life" (Luzzatto, p. 318).

See also: FREUD, SIGMUND; GRIEF: THEORIES; GRIEF COUNSELING AND THERAPY

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PHYLLIS R. SILVERMAN

CORPSE

See CADAVER EXPERIENCES.

CREMATION

Cremation is the burning of the human body until its soft parts are destroyed by fire. The skeletal remains and ash residue (cremains) often become the object of religious rites, one for the body and one for the bones. The anthropologist Robert Hertz has described this as a double burial, with a "wet" first phase coping with the corpse and its decay, and a "dry" second phase treating the skeletal remains and ash. The chief difference between cremation and burial is the speed of transformation: Corpses burn in two hours or less, but bodies take months or years to decay, depending upon methods used and local soil conditions. The method of body disposal least like cremation is mummification, which seeks to preserve the body rather than destroy it.

Ancient Cremation

Archaeological evidence shows cremation rituals dating back to ancient times. In classical antiquity, cremation was a military procedure and thus was associated with battlefield honors. Both cremation and the interment of cremated remains are described in Homer's *Iliad* and *Odyssey*, both dating from the eighth century B.C.E. The seventeenth-century French painter Nicolas Poussin echoed another classical story in his masterpiece *The Ashes of Phocion*, perhaps the most famous of all cremation-linked paintings, in which a faithful wife

gathers the ashes of her husband, an improperly shamed leader who was cremated without the proper rites.

The ritual cremation of Roman emperors involved the release of an eagle above the cremation pyre to symbolize his deification and the passing of the emperor-god's spirit. The reasons for shifts between cremation and burial in classical times are not always apparent; fashion or even the availability of wood may have been involved.

Cremation Cultures

It was in India and in the Indian-influenced cultures of Buddhism and Sikhism that cremation developed into a central and enduring social institution. Basic to Hinduism is the belief that the life force underlying human existence is not restricted to one life but undergoes numerous transmigrations that may involve nonhuman forms. Hence the "self" and the identity of an individual are not simply and inevitably linked to any one body. Cremation became an appropriate vehicle for expressing the ephemerality of bodily life and the eternity of spiritual life.

Hinduism. For traditional Hindus, cremation fit into an overall scheme of destiny. Symbolically, the human embryo resulted from the combination of male seed forming bones and female blood providing flesh. In this account the spirit enters the fetus through the cranial suture of the skull, with the growing embryo in a sense being "cooked" by the heat of the womb. At the end of life, a symbolic reversal sees the heat of the funeral pyre separating flesh from bones; the rite of skull-cracking frees the spirit for its ongoing journey, which is influenced by *karma*, or merit accrued during life. The fire itself is the medium by which the body is offered to the gods as a kind of last sacrifice; cremation should take place in Banaras, the sacred city through which the sacred Ganges River flows. It is on the banks of the Ganges that cremations occur and cremated remains are placed in its holy waters. Hindus living in other parts of the world also practice cremation and either place cremated remains in local rivers or send the remains to be placed in the Ganges. While rites are also performed for set periods after cremation, there is no monument for the dead, whose ultimate destiny lies in the future and not in some past event.

Buddhism. Cremation is the preferred funeral rite for Buddhists as well and is reinforced by the fact that the Buddha was himself cremated. Tradition tells how his funeral pyre self-ignited, but only after many followers had come to pay respects to his body. When the flames ceased, no ash remained—only bones. These remains were divided into eight parts and built into eight stupas in different territories. This is a good example of how cremation makes possible a greater variety of memorializing the dead than does burial. Contemporary Buddhists practice both cremation and burial.

Evil and Emergency Cremation

Cremation is not only an established social custom but has also been used on battlefields to save the dead from the ravages of the enemy and as an emergency measure during plagues, as in the Black Death of the seventeenth century. The most inescapably negative use of cremation in human history was during the Holocaust, the Nazi regime's mass murder of millions of Jews and others, including Gypsies, homosexuals, and the mentally ill, all deemed culturally unacceptable to Hitler's Third Reich during World War II. The Nazi concentration camps came to symbolize the inhumanity of killing men, women, and children and then disposing of their bodies by cremation or mass burial. In this case, cremation was a kind of industrial process necessary to deal with the immense number of corpses that attended Hitler's "Final Solution."

Modern Cremation

With the increasing predominance of Christianity in Europe after the fifth century C.E., cremation was gradually abandoned in favor of earth burial as a symbol of the burial and resurrection of Christ. Charlemagne criminalized cremation in the Christian West in 789 C.E. There were subsequent countercurrents, including the unusual seventeenth-century treatise of Sir Thomas Browne on urn burial, *Hydriotaphia* (1658), and the brief French revolutionary attempt to foster cremation as a rebuke to Christianity in the 1790s.

It was not until the nineteenth century, however, that a widespread interest in cremation resurfaced, prompted by a variety of social, philosophical, and technological factors. The major social

elements related to massive increases in the population of industrial towns and major cities, whose cemeteries were increasingly hard-pressed to cope with the volume of the dead in an era of heightened concern with public hygiene—corpses buried near the surface of the ground were seen as a potential health risk. This was also a period of considerable interest in freedom of thought and creative engagement with ideas of progress. Traditional religious constraints were not viewed as impossible barriers to progress. Societies were established to promote cremation in many influential cities, including London and The Hague in 1874, Washington, D.C., in 1876, and New York in 1882. Central to these interest groups lay influential people as with Sir Henry Thompson (surgeon to Queen Victoria), whose highly influential book on cremation, *The Treatment of the Body after Death*, was published in 1874, followed shortly by William Eassie's *Cremation of the Dead* in 1875.

Italy was a major force in the renaissance of cremation; Brunetti's model cremator and display of cremated remains at the Vienna Exhibition of 1873 are credited with having prompted Sir Henry Thompson's interest. There was also a congress on cremation in Milan in 1874. These groups often existed for years before they achieved the goal of cremation as a legal and established practice. In Holland, for example, the 1874 group did not actually open a crematorium until 1914. Often there were objections from a variety of Christian churches, which contended that cremation would interfere with the resurrection of the body or that cremation spurned the example of the "burial" of Jesus. Sometimes the reasons were political rather than theological. Catholics in Italy, for example, found cremation unacceptable because it was favored and advocated by the anticlerical Freemasons. Indeed, it was not until the mid-1960s that the Roman Catholic Church accepted cremation as an appropriate form of funeral for its members.

The preoccupation with technological advancement in the nineteenth century also spurred the fortunes of cremation. It had become relatively easy to contemplate building ovens for the combustion of human bodies as well as architectural features to house them. Machines like the cremulator, for grinding larger bone fragments into dust, are similarly industrial in nature. The early crematoria were temporary, little more than ovens or grandly designed landmarks. In the late nineteenth and

early twentieth centuries they began to resemble church buildings; in the late twentieth century there was more scope for architects to reflect upon life and death in these unique structures.

In the late twentieth century cremation became a serious topic of academic study. It was only at the turn of the twenty-first century that serious academic interest in cremation—sociological, theological, and historical—emerged. The numerous journals published by many cremation societies have also made important contributions, systematically recording cremation rates, new crematoria, and technical developments. The Archives of the Cremation Society of Great Britain, held at the University of Durham, is one example, as is the Fabretti Institute of Turin in Italy.

Christian Traditions and Cultures

The most interesting aspect of the relationship between cremation and society within Western societies derives from the relative influence of the Orthodox, Catholic, and Protestant traditions. Greek and Russian Orthodoxy stand in firm opposition to cremation, and cremation rates are very low in strict Orthodox societies such as Greece. During the communist era in the former USSR and Eastern Europe, cremation was often pressed in an ideological fashion, which in turn spurred stronger opposition from various Christian denominations.

In Western Europe cremation rates vary with the degree of Catholic or Protestant influence in each country's tradition. In 1999 the cremation rate in Great Britain and Denmark was 71 percent and 68 percent in Sweden. In Finland, by contrast, with equally strong Protestant, Catholic, and Orthodox churches, the rate was only 25 percent. The Netherlands, roughly equally divided between Protestant and Catholic traditions, stood at 48 percent. The Catholic influence is more evident in Hungary (30%), Austria (21%), France (16%), Spain (13%), Italy (5%), and Ireland (5%).

The United States presents an interesting picture of mixed religious traditions with an overall cremation rate of approximately 25 percent. This may seem an unusually low figure, but it encompasses a wide variation in local practices. Washington, Nevada, and Oregon, have cremation rates of approximately 57 percent while Alabama, Mississippi, and West Virginia are about 5 percent.

Social Change and Cremation

In the West, the turn of the twentieth century saw the rise of strongly motivated individuals, often coalescing into small pressure groups that were ideologically committed to cremation. After World War II cremation began to be incorporated into social welfare provisions in numerous countries. Just as the urban growth of the middle and late nineteenth century had led to the establishment of many large cemeteries in European cities, so the later twentieth century was marked by the growth of crematoria. Cremation was a symptom not only of massive urbanization and the drive for social hygiene but also an increased medicalization of death. With more people dying in hospitals rather than at home, their bodies were collected by funeral directors and might be kept in special premises away from their home. Indeed the very concept of the “funeral home” developed to mark a place where a body could be kept and visited by the bereaved family. Cremation thus was another example of a rising trend of commercialization and professionalization of various aspects of life in the West. Cremation was but one aspect of a broader tendency toward efficiency, scientific technology, and consumer choice. It also served the psychological function of allaying the fears of those who were haunted by irrational fears of decay or of being buried alive. Cremation is also often less expensive than burial.

Although the upward trend in cremation continued unabated through the late twentieth century, there was a slight ripple of concern emanating from the environmental community, which pointed to the deleterious effect of industrial and domestic emission of gases—many communities have adopted more stringent laws for the running of cremators. On a populist front, this raised a question mark over the desirability of cremation. In Great Britain some minority groups have raised the idea of “green” woodland burials in which individuals are buried without elaborate coffins or caskets and in full recognition that their bodies would soon return to the earth in a form of earth-friendly decay.

Cremation, Privatization, and Secularization

As Christianity achieved dominance in Europe in its first millennium and firmly established itself geographically in the second, it imposed a much more formal theology and ritual, not least over

death. Catholic Christianity’s funerary rites included preparation of the dying for their eternal journey, along with masses and prayers for their migrant souls. Cemeteries were closely aligned with churches, and death rites were under ecclesiastical control.

With the advent of cremation, there arose a new possibility disengaging death rites from ecclesiastical control. For much of the late nineteenth century and the first two-thirds of the twentieth century, the great majority of cremation rites were set within a religious ritual framework overseen by the Protestant clergy. Catholic priests were also freed to do so from the mid-1960s, but by the late twentieth century clerical involvement in cremation was on the wane. Traditional burial was conducted under the control of a Christian church, and though remains might later have been removed to a charnel house (a place for storing human bones), the transfer was often a nonceremonial affair. Burials in some places could also be conducted without church rites, but it was with modern cremation that a secular process appeared more acceptable. Often the emphasis on what came to be called “life-centered” funerals was celebratory, with a focus on the past life of the deceased and not, as in traditional Christian rites, on the future hope of resurrection.

Cremated Remains

In contrast to the traditional practice of placing cremated remains in urns and storing them in columbaria (buildings containing niches in their walls), late-twentieth-century practices in the West have included the removal of cremated remains from crematoria by family members and their placement in locations of personal significance. This was the birth of a new tradition as individuals invented ways of placing remains in natural environments: mountains, rivers, gardens, or places of recreation and holiday where the survivors acknowledged that the deceased had spent pleasant and memorable times.

See also: FUNERAL INDUSTRY; GENOCIDE; GRIEF AND MOURNING
IN CROSS-CULTURAL PERSPECTIVE; WIDOW-BURNING

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DOUGLAS J. DAVIES

CRUZAN, NANCY

On January 11, 1983, Nancy Cruzan, then twenty-five years old, was involved in an automobile accident. Her body was thrown thirty-five feet beyond her overturned car. Paramedics estimated she was without oxygen for fifteen to twenty minutes before resuscitation was started. As a result she experienced massive, irreversible brain damage. However, she could breath on her own. Attending doctors said she could live indefinitely if she received artificial nutrition and hydration, but they agreed she could never return to a normal life. Cruzan had not left advance directives—instructions how she wished to be treated should such a physical and mental state occur. A feeding tube enabled her to receive food and fluids. Over the ensuing months, Cruzan became less recognizable to her parents. They began to feel strongly that if she had the opportunity she would choose to discontinue the life-supporting food and fluids. After five years of artificial feeding and hydration at the annual cost of \$130,000, and with increasing physical deterioration, Cruzan's parents requested that the feeding tube be removed so that their daughter could die a "natural death." In early 1988 their request was granted by Judge Charles E. Teel of the Probate Division of Jasper County, Missouri.

Judge Teel's decision was met by a very strong reaction from persons who expressed concern that removal of the feeding tube would not be in accord with Cruzan's wishes under the doctrine of "informed consent." Others argued that removal of the life-support feeding tube would constitute an act of homicide. The state of Missouri appealed Judge Teel's decision. In November of the same

year, the Missouri Supreme Court overruled Judge Peel's decision and therefore refused the Cruzan petition to make a decision on behalf of their daughter by stating that the family's quality-of-life arguments did not have as much substance as the state's interest in the sanctity of life. The Cruzan family appealed the Missouri Supreme Court decision to the U.S. Supreme Court. In their pleading to the U.S. Supreme Court, the state of Missouri asked that they be provided clear and convincing evidence of a patient's wishes regarding a will to die before granting the request to discontinue life support for persons in a persistent vegetative state. On June 25, 1990, the U.S. Supreme Court recognized the right to die as a constitutionally protected civil liberties interest. At the same time, the U.S. Supreme Court supported the interests of Missouri by declaring that it was entirely appropriate for the state to set reasonable standards to guide the exercise of that right. Thus, the U.S. Supreme Court sided with the state and returned the case to the Missouri courts.

Following the Supreme Court hearing, several of Cruzan's friends testified before Judge Teel, recalling that she stated preferences for care if she should become disabled. In addition, the doctor who was initially opposed to removing her feeding tube was less adamant than he had been five years previously. On December 14, 1988, the Jasper County Court determined that there was sufficient evidence to suggest that Cruzan would not wish to be maintained in a vegetative state. The following day the feeding tube was removed and she died before the end of the year.

See also: ADVANCE DIRECTIVES; DO NOT RESUSCITATE; EUTHANASIA; NATURAL DEATH ACTS; PERSISTENT VEGETATIVE STATE; QUINLAN, KAREN ANN

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WILLIAM M. LAMERS JR.

CRYONIC SUSPENSION

James H. Bedford is the first person known to have been placed in a state of cryonic suspension under controlled conditions. This event occurred in 1967

after a physician certified his death. Decades later his body remains in a hypothermic (supercooled) condition within a liquid nitrogen cylinder. Decades from now, perhaps he will be the first person to be resuscitated after this episode of biostasis, or what earlier generations called suspended animation. This hope is what led Bedford to arrange for cryonic suspension as an alternative to cremation and burial.

Why Cryonic Suspension?

Through the centuries some people have accepted the inevitability of death while others have devoted themselves to finding ways of prolonging life or, even better, living forever. These efforts have included bizarre and dangerous practices compounded of superstition and magic, but also increasingly effective public health measures that have resulted in a significant increase in life expectancy throughout much of the world. The cryonics approach is intended to take another step. It asks the question: Because biomedical science has already accomplished so much, why should humankind assume that people still have to die and stay dead?

The case for cryonics made its public debut with Robert C. W. Ettinger's best-selling book, *The Prospect of Immortality* (1966). He notes that in the past many people have died of disorders and diseases that have since become treatable. Medical advances are continuing, which means that people are still being buried or cremated even though their present fatal condition will eventually be healed. People should therefore give themselves the chance for a renewed and healthy life. This can be accomplished by immediately taking measures to preserve the "dead" body until such time as a curative procedure has been devised. The body would then be resuscitated from its state of suspended animation and the restorative procedure would be applied. From Ettinger's perspective, it is better to be alive than dead and human beings have the right to self-preservation. Furthermore, because so many gains have already been made in extending human life, it would be foolish to stop.

The Process of Cryonic Suspension

How it is done has changed somewhat in detail over the years, but still requires the following basic elements:

1. An adult who has consented to the procedure.
2. Financial provision for the services to be performed.
3. A physician and hospital willing to allow the procedure to be done.
4. Prompt certification of death (to limit post-mortem deterioration).
5. Injection of cryoprotective fluid (composed of liquid nitrogen) to replace water and other body fluids. This fluid is disseminated throughout the body with a heart-lung pump. Technicians continue to monitor temperature and other signs.
6. Bathing in a deep cooling bath until the desired temperature (about -79° centigrade) is reached.
7. Placement inside a sealed bag that is then immersed in a storage vessel filled with liquid nitrogen. The supercooled temperature is maintained indefinitely.
8. A cure for the individual's once-fatal disease or condition is discovered by medical science.
9. The body is removed from storage and carefully warmed.
10. The condition that had resulted in the person's "death" is healed and life begins anew.

Critical Response

Many criticisms have been made regarding the process of cryonic suspension. There is no dispute about the general proposition that refrigeration and freezing can preserve organic materials. A variety of industrial, research, and medical procedures rely upon this phenomenon. There has been some success in thawing out tissues and organs from liquid nitrogen storage. All of this, though, is a long way from resuscitating a person and, especially, the complex and fragile human brain upon which memory and personality appear to depend. The engineering and biomedical sciences have not come close enough to inspire confidence that such a feat could be accomplished at any foreseeable point in the future.

In addition to the limited state of success, other significant criticisms include: (1) Much tissue loss and damage occur whenever there are deviations from the ideal situation; for example, certification



Doctors prepare a patient for cryonic suspension. As of 2001, an estimated ninety people have been placed in cryonic storage. AP/WIDE WORLD PHOTOS

of death is delayed; medical or other authorities prove uncooperative; equipment or human failure is involved in carrying out the first crucial procedures; (2) ice formation will damage cells and tissues despite protective efforts; and (3) additional extensive damage will occur during the attempted resuscitation process. Many neuroscientists doubt that an intact and functional human brain can survive both the freezing and the rewarming processes, even if the neural structures had not suffered irreversible damage at the time of death.

The reasons for cryonic suspension have been criticized on moral and practical grounds. Some hold that it is immoral to defy God's will by reaching back over the life/death border. Others focus on the prospect of cryonics becoming one more elitist advantage. While some people barely have the necessities for a hard life, others would enjoy the unfair opportunity to play another round. A related criticism is that an already overcrowded world would be subject to an increased growth in population. Additional misgivings are expressed by questions such as:

1. What will happen to marriage, remarriage, and family structure in general if the dead

are not necessarily dead? How will people be able to go on with their lives?

2. How could loved ones complete—or even begin—their recovery from grief and mourning?
3. What formidable problems in adjustment would occur when a “Rip Van Winkle on Ice” returns after many years to a changed society?
4. Will people become less motivated and more careless with their “first lives” if they expect to have encore appearances?

Conclusions

As of 2001, there have been no known attempts at resuscitation because cryonicists judge that the technology has not yet been perfected. Since the 1980s there has been a trend to preserve only the head. The theory behind these “neuro” preparations is that (a) this form of storage is less expensive and (b) science will eventually make it possible to grow a new body from DNA. More conservative cryonicists, however, continue to favor the whole-body approach. Even more recently

there have been announcements that future efforts will switch from cryonic storage to vitrification—converting body tissue to a glasslike stone material. Advocates (including at least one cryonic suspension organization) believe vitrification would avoid the tissue damage associated with freezing and resuscitation. There are no known previous examples of vitrification having been applied above the level of isolated tissues and organs.

Along with the big question—Could cryonic suspension ever work?—there is also the unanswered question: Why in America’s high technology society have the cryonic storage vessels received fewer than a hundred people since 1967? At present, cryonic suspension remains a controversial and seldom end-of-life option. Future prospects are difficult to predict.

See also: BRAIN DEATH; BURIED ALIVE; DEFINITIONS OF DEATH; LIFE SUPPORT SYSTEM; NECROMANCY; RESUSCITATION

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ROBERT KASTENBAUM

CULT DEATHS

In the past several decades, a handful of cults have been associated with mass deaths, either through murders, suicides, or standoffs with the government that ended tragically. These highly publicized cases have convinced the public that many or all

cults are extremist groups that are highly dangerous; in fact, there is little understanding by many people of what constitutes a cult, how they recruit, or what turns a small number of these groups toward violence.

Defining cults and deciding which groups should be labeled as such is sometimes a difficult task because of the variety of groups that exist outside of the mainstream. However, in their *The Will to Kill* (2001), James A. Fox and Jack Levin define cults as being “loosely structured and unconventional forms of small religious groups, the members of which are held together by a charismatic leader who mobilizes their loyalty around some new religious cause—typically a cause that is at odds with that of more conventional religious institutions” (Fox and Levin 2001, p. 141). Part of the difficulty of defining what groups are cults is that cults may move to mainstream status over time by becoming conventional institutions. The Church of Jesus Christ of Latter-Day Saints made just such a transition since their founding in 1830.

Many groups can be categorized as cults under the previous definition, although the vast majority of them are harmless (Richardson 1994). However, society has a negative view of groups labeled as cults and typically treats such groups as dangerous. Furthermore, the public often views religious commitment “as properties of the lunatic fringe” and views cult members as fanatics (Miller 1994, p. 7). The negative connotation of the term *cult* resulted in many scholars avoiding its use and instead using “new religious movement” or “minority religions” (Lewis 1998, p. 1).

The anti-cult movement feeds part of the negative view that the public holds toward cults. A number of groups are part of this movement: Their common tasks are “disseminating information, offering advice and counseling, and/or lobbying those in authority to take action to curb the activities of cults” (Barker 1986, p. 335).

Recruitment

There are different viewpoints as to how cults procure new members. The anti-cult position takes a negative view of the groups’ activities, often assuming that people join cults because they were brainwashed, or were the victims of other mind control procedures that rendered them “helpless victims” (Barker 1986, p. 335). However, many

researchers view brainwashing as a stereotype of actual cult practices: It represents society's attempt at a "simplistic explanation of why people adopt strange beliefs" that are at odds with conventional wisdom (Wessinger 2000, p. 6). In her studies of cults, the sociologist and cult expert Eileen Barker notes that empirical evidence supporting the use of brainwashing is lacking.

Another explanation of cult membership focuses on deficiencies within the people themselves. This view, also popular within the anti-cult ranks, treats cult members as "abnormally pathetic or weak" (Barker 1986, p. 336). Yet evidence gathered through psychological testing does not support this position (Barker 1986).

In 1965 the sociologists John Lofland and Rodney Stark proposed a model of cult conversion by studying a millenarian cult interested in returning the world to "the conditions of the Garden of Eden" (Lofland and Stark 1965, p. 862). Their model is comprised of an ordered series of seven factors, all of which are necessary and sufficient for a person's decision to join a cult. The model focuses on how situational factors influence people who are predisposed, due to their backgrounds, to join such groups. Each step in the model reduces the number of potential converts, leaving only a few people eligible for conversion. Lofland updated the model in 1977 to reflect a more sophisticated effort on the part of the group they studied to obtain converts. He notes that the characteristics of the converts changed over time: The group attracted young people from "higher social classes," rather than the "less than advantaged" people they attracted in the past (Lofland 1977, p. 807).

Lofland's later explanation of conversion does involve persuasion on the part of cult members. For example, of the group he studied, weekend workshops were used to help potential converts form "affective bonds" with group members while avoiding "interference from outsiders" (p. 809). During these weekends a group member constantly accompanied potential converts; furthermore, people were discouraged from leaving the event, although physical force was never used to encourage them to remain.

Although the use of persuasion has been noted in conversion, and "coercive measures" have sometimes been used to prevent defection, it is

incorrect to say that converts are universally victims of brainwashing (Wessinger 2000, p.7). In fact, many people who join cults ultimately choose to leave them, with many groups experiencing high turnover rates. One argument against brainwashing is that cults appeal to people more during "periods of rapid social change, at times when individuals are feeling a lack of structure and belonging . . . and when the credibility of traditional institutions is impaired" (Fox and Levine 2001, p. 142). This explanation of membership emphasizes social as well as life circumstances.

When Cults Become Dangerous

Despite the fact that most cults are harmless, some groups do become dangerous either to themselves or others. A particularly dangerous time for cult activity coincides with the ending of a century or millennium. During these times, groups sometimes "prophesize the end of the world" (Fox and Levine 2001, p. 143). This belief is originally rooted in biblical tradition predicting a cataclysmic event followed by a period of a thousand years of perfection on the earth. However, the original meaning of millennium has now come to "be used as a synonym for belief in a collective terrestrial salvation" involving the formation of a "millennial kingdom" in which suffering does not exist (Wessinger 2000, p. 3). Some groups expect the paradise to be earthly, while others, like the group Heaven's Gate, expected it to be "heavenly or other-worldly" (Wessinger 2000, p. 3). Still others, like the Branch Davidians, are ambiguous on this issue.

Just because a group is a millennial group does not necessarily mean that violence will result. For example, in 1962 the scholars Jane Allyn Hardyck and Marcia Braden followed the activities of an Evangelical Christian group that prophesized an impending nuclear disaster. Despite moving into fallout shelters for forty-two days and emerging to find that their prophecy was incorrect, the group's core beliefs withstood the ordeal and no violence resulted. However, in rare circumstances violence does erupt. The scholar Jeffrey Kaplan notes that groups that become violent follow a specific pattern, with a key factor involving a leader who begins to feel persecuted for his or her beliefs. This combined with a tendency to withdraw from society and to develop "an increasingly idiosyncratic doctrine" may push the group toward violence (Kaplan 1994, p. 52).

The violence from millennial groups arises when they begin to play an active part in bringing about the prophesized apocalypse. One of the most dangerous of these groups was the Aum Shinrikyo, who released sarin nerve gas in the Tokyo subway on March 20, 1995, killing 12 people and injuring 5,500. They also released sarin gas in 1993 in Matsumoto, Japan, injuring 600 and killing 7. The group's leader, Shoko Asahara, was a self-proclaimed Buddha figure claiming psychic powers, including the ability to prophesize future events. In creating his religion, he hoped to bring about the creation of Shambhala, "the Buddhist Millennial Kingdom" that was to be populated with converts who were themselves psychic (Wessinger 2000, p. 142).

Asahara predicted that a worldwide nuclear Armageddon would occur in 1999, but said that the world could be saved if their group grew to 30,000 members. Although membership grew to as many as 10,000, it was clear that he had not reached his recruitment goal. As a result, Asahara began to move the date of the apocalypse closer and closer in an attempt to increase recruitment while also enhancing loyalty of group members. The date was finally moved to 1995, forcing his inner circle to launch their own Armageddon in order to preserve the illusion of his prophetic powers (Wessinger, 2000). The Tokyo subway attack was to be one step in their attempt to "overthrow the Japanese government" and then later "initiate a worldwide nuclear disaster that only he and his disciples would survive" (Fox and Levine 2001, p. 147).

The Solar Temple represents another example of a millennial group that resulted in the deaths of seventy-three people in multiple locations across Switzerland, France, and Canada between 1994 and 1997. The deaths involved both current and former members of the Temple. Letters left by group members note that the deaths were a combination of executions of "traitors," murders of weaker members who lacked the strength to "transit to a higher world," and suicides (Wessinger, 2000, p. 219). Group members believed that they must transit to "a higher realm of existence and consciousness" in order to find salvation: The destination of this transit appears to have been a star or one of several planets (Wessinger 2000, p. 219).

Membership in the Solar Temple reached as high as 442 people worldwide in 1989 but internal

strife began in 1990, leading to a steady decrease in membership during the following years. Former members began demanding reimbursements for their contributions. Even the son of one of the founders proved disloyal when he revealed to others that cofounders Joseph DiMambro and Luc Jouret used electronic devices to create illusions to fool Solar Temple members. Though the original position of the group merely involved bringing about an age of enlightenment involving "an evolution of consciousness on Earth," this position changed when internal problems as well as "persecutory" external events caused a shift in theology: The new theology justified leaving the earth since it could not be saved (Wessinger, 2000, p. 224).

Other millennial groups have been involved in mass deaths since 1990, including an incident that occurred in early 2000 in several remote locations in Uganda. Members of the Movement for the Restoration of the Ten Commandments of God were either murdered or engaged in mass suicide, leaving more than 500 people dead. Their leader, Joseph Kibwetere, had long prophesized an imminent end to the world. The truth surrounding the deaths as well as a final death toll may never be known because there were no survivors (Hammer 2000).

See also: DEATH SYSTEM; HEAVEN'S GATE; JONESTOWN; WACO

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D



DANCE

Dance, like other forms of art, has treated the subject of death continually throughout history and will continue to be used as a vehicle to express human fascination with this eternal unanswered question. Rituals have surrounded the mystery of death from prehistoric times. Repeated rhythmic movements become dance, and the solace of rocking and keening can be therapeutic. Funeral processions are an example of organized movement to music, expressive of grief.

Death Dances in the East

The aboriginal peoples of Australia sing and dance to evoke the clan totems of a dying man and two months after death dance again, recreating the symbolic animals to purify the bones and release the soul of the deceased. The Sagari dances are part of a cycle performed on the anniversary of a death on the islands of Melanesia, New Guinea. Dancing by a female shaman is an important element of Korean ceremonies to cleanse a deceased soul to allow it to achieve *nirvana*, closing the cycle of birth and rebirth. At Kachin, Upper Burma, funeral rites include dances to send back death spirits to the land of the dead. Dayals (shamans) of Pakistan fall into trances to imitate the spirits of the dead.

Death Dances in Africa

In Africa the Kenga people perform Dodi or Mutu (mourning dances) on burial day. The Yoruba dance wearing a likeness of the deceased, and the

Dogon of Mali perform masked dances to confront death and pass on traditions after death. The Lugbara people of Uganda and the Angas of northern Nigeria also include dance in their rituals surrounding death.

Death Dances in the Americas

The Umutima Indians of Upper Paraguay, South America, possess seventeen different death cult dances. Mexico celebrates All Souls' Day with masked street dancers dressed in skeleton costumes. The Ghost Dance of the Plains Indians of North America reaffirms an ancestral tribal continuity and has recently been revived after prohibition by the U.S. government, which deemed the dance subversive.

Death Dances in Europe

The Danse Macabre (Totentanz, or Dance of Death) of the European Middle Ages was portrayed many times on the walls of cloistered cemeteries as a dance of linked hands between people of all levels of society and the skeletal figure of death. These painted images were executed in a period of anxiety caused by the bubonic plague which swept the continent, killing a large percentage of the population.

Death in Western Stage Dance

In the Romantic period of the nineteenth century, a morbid fascination with death and the mysterious produced ballets such as the *ballet des nonnes* in Giacomo Meyerbeer's opera, *Robert le Diable* (1830), *Giselle* (1841), *La Peri* (1843), and *La*

Bayad Ère (1877), all of which present scenes with ballerinas dressed in white, vaporous costumes representing spirits after death, floating on their toes or suspended by invisible wires and illuminated by moonlight fabricated by the technology of gas lighting. Many of these ballets are still performed, providing the ballerina with the artistic challenge—roles in *Giselle* or *La BayadÈre*—of a dramatic death scene followed by the difficult illusion of phantomlike, weightless spirituality.

Twentieth-century dance has used death as the inspiration for many dance works; the most perennial is Mikhail Fokine's *Le Cygne* (1905), commonly known as *The Dying Swan*. Created for the dancer Anna Pavlova to express the noble death struggle of a legendarily silent bird who only sang at death (thus the idiomatic "swan song"), it remains in the repertory in twenty-first-century performances. The great dancer and choreographer Vaslav Nijinsky set the shocking theme of a virgin dancing herself to death by violent, percussive movements as a sacrifice for a fecund harvest in prehistoric Russia, matching composer Igor Stravinsky's iconclastic score for *The Rite of Spring* (1913).

In post-World War I Germany, Mary Wigman, high priestess of *ausdruckstanz* (the expressionistic modern dance style), used expressionist movement and masked ensembles to great effect in *Totenmal* (1930), showing the devastating impact of death on society. Another choreographic masterpiece from Germany is Kurt Jooss's *The Green Table* (1932), inspired by the medieval *Danse Macabre* paintings. This work shows Death himself taking, in different ways, the people caught up in a war; in essence, only Death is the victor.

The choreographer Martha Graham created *Lamentation* in 1930, which is portrayed through minimal rocking movement, the anguish and despair of mourning. In this dance she retained a passive face, only rising once from a sitting position, her movements stretching the fabric of a jersey tube, yet producing a profound image of distraught motherhood.

The Mexican choreographer Guillermina Bravo treated the subject of death in several modern dance works, influenced by Mexico's folk traditions. In *La Valse* (1951), George Balanchine, choreographer and director of the New York City Ballet, created an ominous image of death in the guise of a man dressed in black, offering a black dress

and gloves to a young girl at a ball, thereby claiming a victim.

In Canada, choreographer James Kudelka exorcised the pain of his mother's death from cancer in his ballet *In Paradism* (1983). This piece shows the stresses placed on a dying person by family and friends, and the encounter with a guide (nurse, priest, angel) who leads the protagonist from denial to acceptance. In this work the dancers all wear skirts and roles are interchangeable, eliminating references to gender. Kudelka composed two other works, *Passage* (1981) and *There Below* (1989), giving his vision of an afterlife. The choreographer Edouard Lock projected prolonged films of the dancer Louise Lecavalier as an old woman on her deathbed in his piece *2* (1995), showing her life cycle from childhood to death.

Since the 1980s many choreographers have responded to the AIDS (acquired immunodeficiency syndrome) epidemic by making deeply felt statements through dance. After the death of his partner, Arnie Zane, choreographer Bill T. Jones used performers with terminal diseases who recounted their experiences confronting death in *Still Here* (1994). Maurice Bejart, choreographer and director of the Ballet du XXIeme Siecle, after showing *Ce que la mort me dit* (1980), a serene vision of death, presented an evening-long piece, *Ballet For Life* (1996), in memory of the dancer Jorge Donn and the singer Freddie Mercury, both deceased from AIDS-related illnesses.

The list of dance works treating the subject of death is very long, and the symbolic figure of death appears in many choreographic works. Titles like Andrée Howard's *Death and the Maiden* (1937); Frederick Ashton's dances in Benjamin Britten's opera, *Death in Venice* (1974); Erick Hawkins's *Death is the Hunter* (1975); Flemming Flindt's *Triumph of Death* (1971); and *Death* by the Indian choreographer Astad Deboo are numerous and underline the continuing fascination of dance creators for the subject.

See also: DANSE MACABRE; FOLK MUSIC; HOW DEATH CAME INTO THE WORLD; OPERATIC DEATH

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This woodcut print of *A Dance of Death* from *Liber Chronicarum* shows the “band” of four skeletons following their leader, Death; thus began the personification of death. HISTORICAL PICTURE ARCHIVE/CORBIS

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VINCENT WARREN

DANSE MACABRE

The band consists of four skeletons performing on bagpipe, portable organ, harp, and small drum. The dancers move in a low, stately procession. It is clearly a ritualistic rather than a social dance. All the participants are following their leader—Death.

The Danse Macabre made its first appearance during the plague (Black Death) years of the fourteenth century. In Germany it was the *Todtentanz*; in Italy, *danza della morte*; and in England, the Dance of Death. In the Danse Macabre, the personified figure of Death led dancers in a slow,

stately procession that was clearly a ritualistic rather than a social dance.

Danse Macabre images served several purposes, including to help people express and share their grief; to remind each other that death is not only inevitable, but also the great equalizer, claiming the high and mighty as well as the humble; and to provide the opportunity for indirect mastery. When vulnerable mortals could depict, narrate, and enact the Dance of Death, they gained a subtle sense of control. In fact, as the Danse Macabre became an increasingly familiar cultural element, the figure of Death was also increasingly subject to caricature. The resilient human imagination had made Death a character—often dignified, sometimes frightening, and, eventually, even comic.

The earliest known appearances of the Danse Macabre were in story poems that told of encounters between the living and the dead. Most often the living were proud and powerful members of society, such as knights and bishops. The dead interrupted their procession: “As we are, so shall you be” was the underlying theme, “and neither your strength nor your piety can provide escape.” A haunting visual image also appeared early: the Danse Macabre painted on the cloister walls of The Innocents, a religious order in Paris. This painting no longer exists, but there are woodcut copies of early depictions of the Danse Macabre.

The origin of the term “macabre” has invited considerable speculation. Perhaps the best-founded explanation was that offered by the historian Philippe Ariès. He noted that the Maccabees of the Biblical period had been revered as patrons of the dead. *Macchabe* became a folk expression for the dead body, and Ariès found that the term still had that meaning in the folk slang of the late twentieth century.

There is sometimes confusion between the grave and measured gestures of the Danse Macabre and the much more violent and agitated phenomenon known as either St. John’s or St. Vitus’ dance. Both phenomena appeared at about the same time, but could hardly be more different. The Dance of Death was primarily the creation of storytellers and artists and only secondarily enacted in performance. St. Vitus’ dance was primarily a performance carried out often to the point of frenzy or exhaustion by masses of people joined

in a circle dance. Interestingly, municipal officials recognized some value in these proceedings. Musicians were hired and instructed to play faster and louder. The fallen dancers were swathed and comforted until they recovered their senses. It was as though the delirious participants had cast out the devil or at least reduced the tension of those desperate years not only for themselves but also for the bystanders.

Danse Macabre images have continued to appear throughout the centuries, each generation offering its own interpretation. Striking examples include the German painter Hans Holbein’s classic woodcuts, first published in 1538, and German artist Fritz Eichenberg’s visual commentary on the brutality of more modern times, published in 1983.

See also: ARS MORIENDI; BLACK DEATH; DANCE; GHOST DANCE; PERSONIFICATIONS OF DEATH

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ROBERT KASTENBAUM

DARWIN, CHARLES

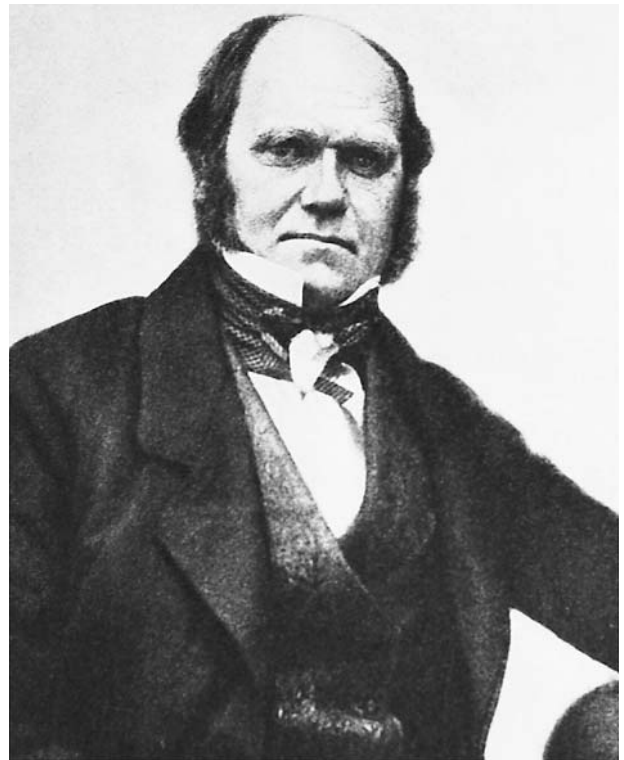
Charles Robert Darwin (1809–1882) is widely considered the greatest naturalist of the nineteenth century. His pioneering work in the theory of

evolution wrought a revolution in the study of the origins and nature of plant and animal life.

The son of Robert Darwin, a prominent English physician, Charles had an early interest in natural history, especially hunting, collecting, and geology. At his father's urging, Darwin attended medical school at Edinburgh, but found that he had little interest in medicine and returned home after two years. Wanting his son to have a respectable career, Darwin's father suggested that he should become an Anglican clergyman. Because the quiet, scholarly life of the clergyman appealed to him, Darwin agreed. He completed his degree at Cambridge in 1831. While awaiting an assignment, he was recommended for the job of naturalist on the survey ship *Beagle*, a voyage of nearly five years. In 1859 Darwin published *The Origin of Species by Means of Natural Selection* based on his discoveries during this voyage.

This seminal work contained three major discoveries. First, it presented an overwhelming amount of physical evidence of Darwin's evolutionary thesis. Naturalists had observed evolutionary change since the time of the ancient Greeks, and by the mid-1800s the idea of evolution was "in the air." But it was not until Darwin published *Origin* that a body of empirical evidence supported the idea of evolution. Because of Darwin's thorough and compelling work, almost no biologists today doubt the reality of evolution. Second, Darwin discovered descent from common ancestry, demonstrating that all living things are related. Tracing the lineage of any two species back far enough, one can find a common ancestor. The modern fossil record and biochemical comparisons among species verify this observation. Earlier theorists such as Jean Baptiste de Lamarck had assumed that life had originated many times and that each lineage was unique and unrelated to all others. Third, Darwin discovered and described the basic mechanism by which evolution works: natural selection. Natural selection is the differential reproductive success of some individuals in a population relative to that of others.

The Darwinian mechanism is based on differential reproductive rates. First, natural populations exhibit variation in phenotype (physical makeup) from one individual to the next, and this variation is genetically determined. For example, there is



Modern biologists recognize other evolutionary processes not known to Darwin, but natural selection remains the basic mechanism. BETTMANN/CORBIS

considerable variation in human height, skin color, and so on, within a population.

Second, organisms are genetically programmed to reproduce. Reproduction is a very powerful biological urge, and animals will risk or even sacrifice their lives to accomplish it. Humans feel this genetic programming in several ways, as a ticking "biological clock," as parental instinct, or as an attraction to children. As a result, natural populations have a tendency to overpopulate. Biologists define "overpopulation" in terms of limiting factors that may include food, space, mates, light, and minerals. For example, if there is enough space on an island for 1,000 deer but only enough food to sustain a population of 100, then 101 deer constitutes overpopulation. The result of overpopulation is competition among the individuals of the population for the limited resources. If there are no limited resources, there is no competition. Competition results in "survival of the fittest," an unfortunate phrase that Darwin borrowed from contemporary social theorists who are now known as "social Darwinists." In Darwinian terms, however, fitness

refers only to reproductive success, not to strength, size, or (in humans) economic status.

Third, some of the variants in the population are more efficient than others in exploiting the limited resources. Success in obtaining limited resources is due largely to inherited phenotype. These individuals channel more of the limited resource through themselves and are therefore able to reproduce more successfully than individuals that compete less successfully. Thus, these selected variants pass on their genes for their genotype with greater frequency than do other variants.

Fourth, the result of this selectively favored breeding is a modification of population gene frequencies over time that may cause a change in phenotype. That is, the average state of a given character undergoing selection changes from one generation to the next. If, for example, predators feed on slower antelope, the average running speed of the population will gradually increase from generation to generation. This is observed as evolution.

And lastly, the losers, those individuals less successful at exploiting limited resources and at reproduction, may die in greater numbers (if, for example, they do not find enough food) or may find an alternative to the limited resource. Galapagos finches (Darwin's finches) with thinner beaks that were less successful at eating heavy seeds often found alternative foods such as insect larvae, which are more accessible to thinner beaks. Over time, this process results in evolutionary diversification of an ancestral species into two or more progeny species, the divergence from common ancestry recognized by Darwin.

Darwin had three great accomplishments with the publication of *Origin of Species* in 1859. He produced an overwhelming body of physical evidence that demonstrated the fact of evolution. Darwin also discovered descent from common ancestry and, lastly, the basic mechanism by which evolution operates—natural selection based on differential reproductive rates of individuals in a breeding population. The implications of Darwin's discoveries have profoundly influenced almost every area of knowledge from science to religion to social theory.

See also: EXTINCTION

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ALFRED R. MARTIN

DAYS OF THE DEAD

Days of the Dead, a religious observation celebrated throughout Mexico on November 2, honors the memories of departed family members. The farther south one travels in Mexico, the more elaborate the celebration becomes. It is mainly in southern and central areas where Mexicans decorate their *panteones* (cemeteries) and the nearby streets with vivid imagery of death, usually skeletons and skulls. Families make altars in their homes, where the photos of departed souls are prominently placed alongside religious icons, *ofrendas* (offerings) of food such as *pan de muertos* baked in shapes of skulls and figures, and yellow marigolds, the symbol of death. On the eve of November 2, All Saints Day, some families spend the night at the cemetery in a *velada* (wake), lighting candles and making offerings at the tombs of their loved ones.

Some communities organize a *desfile* (parade) with participants dressed up as ghouls, ghosts, mummies, and skeletons carrying an open coffin with an animated corpse played by a villager. The skeletal representations are given feminine nicknames such as *la calaca* (the skeleton), *la pelona* (baldy), *la flaca* (skinny), and *la huesada* (bony). This most likely originates in the pre-European practice of assigning a female characteristic to the deity overseeing death. The Aztecs called this goddess Mictecacihuatl.

The traveler in the northern or urban areas of Mexico will find no such colorful observances.



Observers of Days of the Dead gather to commemorate departed family members in a ritual that has been interpreted as evidence of a cultural acceptance of death, a sharp contrast to the death-denying conventions of the United States.

AP/WIDE WORLD PHOTOS

While *El Día de los Muertos* (Day of the Dead) is marked in these regions, the activities are usually more sedate, consisting of placing marigolds at the tombs or either cleaning or refurbishing these resting places. But even here, a festive air surrounds the cemeteries as vendors peddle food, flowers, and religious relics.

There is no doubt that Mexicans demonstrate a unique devotion to a day that all Christians in varying degrees observe. The reasons for this are varied. In areas that retain a vibrant indigenous tradition, this Christian religious holiday is a part of a syncretic process, a blend of pre-Columbian beliefs in the return of the ancestors to their villages and the Christian belief that only the flesh decays but not the soul.

During the Days of the Dead, Mexicans deploy mockery and fraternization to openly confront and

accept the inevitability of death that is so feared and hidden in modern Western culture. Considering that contemporary and past pre-industrial cultures deal with death in a similar fashion—there are examples in India, Asia, or Africa—such conviviality in the face of death is a lively tradition in a country where the modern competes with a vigorous traditional past.

In the late nineteenth century, Chicanos and other Americans in the United States have taken to celebrating Days of the Dead with much fanfare. While these projects incorporate the most colorful and interesting features from Mexico, they are usually bereft of the religious dimension of authentic Mexican rites. Interestingly, in the San Francisco Bay area, the homosexual community has taken on this day of observation as a method of coping with the AIDS epidemic.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE;
COMMUNICATION WITH THE DEAD; GHOSTS; GRIEF
AND MOURNING IN CROSS-CULTURAL PERSPECTIVE

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F. ARTURO ROSALES

DEAD GHETTO

The concept of the “dead ghetto” derives from Jean Baudrillard (b. 1929), a contemporary French philosopher, in his book *Symbolic Exchange and Death* (1993). Baudrillard’s work is formed primarily from the concepts of the French sociologist Marcel Mauss (1872–1950) and the Swiss philologist Ferdinand de Saussure (1857–1913). Mauss wrote a slim volume on the gift, arguing that gift exchange (giving, receiving, counter-giving) is never voluntary, always obligatory, and reflects the totality of societal aspects. De Saussure described language as a social phenomenon, a structured system of signs or symbols. Baudrillard extended and combined these two concepts, creating the concept of how the dead are viewed by society and the living, and within that the concept of the dead ghetto.

According to Baudrillard’s philosophy, in primitive societies a sign represented an object, the signified. As society became more complex the sign became more and more divorced from reality, and itself became a new reality. In the twenty-first century, for example, a television newscast of an event becomes the reality itself, although the observer never gets close to the initial objects or reality. Because society can be described entirely as a system of exchanges, Baudrillard argues that society’s members are dealing with symbolic exchanges, in which a concept and its opposite become reversible. The living and the dead are such a pair,

and death serves as the boundary between them. If a concept such as the afterlife, introduced for example by the Christian churches, becomes paired with life, then death, no longer having something to be paired with and exchanged, disappears.

Baudrillard continues by saying that death can also be denied, or, in a sense, abolished, by segregating the dead in graveyards, which become “ghettos.” Following an analysis of Baudrillard’s concept by Bradley Butterfield, one may begin with primitive societies in which life and death were seen as partners in symbolic exchanges. As society evolved the dead were excluded from the realm of the living by assigning them to graveyards, the ghettos, where they no longer have a role to play in the community of the living. To be dead is to be abnormal, where for primitives it was merely another state of being human. For these earlier societies it was necessary to use their resources through ritual feasts and celebrations for the dead in order to avoid a disequilibrium where death would have a claim on them. In more evolved societies focused on economy, death is simply the end of life—the dead can no longer produce or consume, and thus are no longer available for exchanges with the living.

However, Baudrillard argues that the “death of death” is not complete because private mourning practices still exist. Baudrillard makes a similar argument on old age: “Old age has merely become a marginal and ultimately a social slice of life—a ghetto, a reprieve and the slide into death. Old age is literally being eliminated,” as it ceases to be symbolically acknowledged (Baudrillard 1993, p. 163).

Baudrillard presents an intellectual construct founded on the concepts of de Saussure and Mauss which, by contrast, are derived from a factual basis. Thus Baudrillard’s construct is one step removed from reality. The majority of real people, even in the complex societies of the twenty-first century, however, have not banished death to a ghetto where the dead no longer play a role in their lives. The presence of the deceased continues to play a role in their lives on an ongoing basis (Klass, Silverman, and Nickman 1996). Because the deceased are still important to the living, Baudrillard’s concept represents an interesting intellectual exercise—a *hyperreality*, to use his own term—but not an accurate representation of reality.

See also: CATACOMBS; CEMETERIES AND CEMETERY REFORM;
FUNERAL INDUSTRY; TOMBS

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SAM SILVERMAN

DEATHBED SCENES

See DEATHBED VISIONS AND ESCORTS; GOOD DEATH, THE.

DEATHBED VISIONS AND ESCORTS

Deathbed visions are apparitions; that is, appearances of ghostly beings to the dying near the time of their death. These beings are usually deceased family members or friends of the one who is dying. However, they can also be appearances of living people or of famous religious figures. Usually these visions are only seen and reported by the dying, but caretakers and those attending the dying have also reported witnessing such apparitions. In the majority of these cases, the apparition came to

either announce the imminent death of the individual or to help that person die. In the latter situation they act as escorts to the dying in the process of passing from this life to the next.

Visions at the time of death and announcements or omens of impending death, as well as escorts for the dead, are part of many cultures and religious traditions stretching back through antiquity. The religious motif of the soul making a journey from this life through death to another form of existence, whether it be reincarnation or to an eternal realm, is commonly found in many religions throughout history.

Shamans from many native cultures were adept at journeying from the land of the living to the land of the dead and were thus able to act as guides for those who were dying. Hermes, the Greek god of travel, was also known as the Psychopompos, the one who guided the soul from this life to Hades, and the realm of dead. Certain religious traditions have elaborate rituals of instruction for the soul at the time of death. *The Egyptian Book of the Dead* and the coffin texts of ancient Egypt gave detailed instructions for the soul's journey to the next life. Similarly, by use of the *Bardo Thodol*, or *Tibetan Book of the Dead*, Tibetan Buddhist monks have guided the souls of the dying through death to their next incarnation. In the Christian tradition it has been guardian angels that have acted as the soul's guide to paradise. The ancient hymn, "In Paradisum," invoking the angels to escort the soul to heaven, is still sung at twenty-first-century Roman Catholic funerals.

Christianity's belief in resurrection and the concept of a communion of saints, that is, the continued involvement of the dead with the spiritual welfare of the living, is reflected in the historical accounts of deathbed visions in the West. Third-century legends about the life of the Virgin Mary recount Christ's appearing to her to tell her of the approaching hour of her death and to lead her into glory. In the hagiography of many early Christian martyrs and saints, impending death is revealed by the visitation of Christ, Mary, or another saint who has come to accompany the dying into heaven. This tradition is carried over into early historical records. The eighth-century English historian Bede wrote of a dying nun who is visited by a recently deceased holy man telling her that she would die at

dawn, and she did. Medieval texts such as the thirteenth-century *Dialogue of Miracles* by the German monk Caesarius of Heisterbach recount similar stories, but always within a theological framework.

In the seventeenth century treatises began to be published specifically on the phenomena of apparitions and ghosts. By the nineteenth century specific categories within this type of phenomena were being described. For instance, apparitions began to be distinguished between those seen by healthy people and those seen by the dying. It was noted that when the dead appeared to the living, it was usually to impart some information to them such as the location of a treasure, or the identity of a murderer. However, when an apparition was seen by a dying person, its intent was almost always to announce the impending death of that individual, and often to be an escort for that death.

Early in the twentieth century, the doctor James H. Hyslop of Columbia University, and later Sir William F. Barrett of the University of Dublin, researched the deathbed visions of the dying. They were particularly interested in what became known as the "Peak in Darien" cases. These were instances when dying persons saw an apparition of someone coming to escort them to the next world whom they thought to be still alive and could not have known that they had preceded them in death.

In 1961 the physician Karlis Osis published *Deathbed Observations of Physicians and Nurses*. In it he analyzed 640 questionnaires returned by physicians and nurses on their experience of observing over 35,000 deaths. Osis refers to the deathbed visions of the dying as hallucinations because they cannot be empirically verified. He categorized two types of hallucinations: visions that were nonhuman (i.e., nature or landscapes), and apparitions that were of people. His work confirmed previous research that the dying who see apparitions predominantly see deceased relatives or friends who are there to aid them in their transition to the next life. With the assistance of another physician, Erlundur Haraldsson, Osis conducted two more surveys of physicians and nurses: one in the United States and one in northern India. The results of these surveys confirmed Osis's earlier research on deathbed hallucinations with the exception that there were more apparitions of religious figures in the Indian population.

These studies and the extensive literature on this subject confirm that throughout history and across cultures, the dying often experience apparitional hallucinations. What significance these deathbed visions have depends on the worldview with which one holds them. In this data those with religious or spiritual beliefs can find support for their beliefs. Parapsychological explanations such as telepathy or the doctrine of psychometry, whereby environments can hold emotional energy that is received by the subconscious of the dying, have all been advanced to explain apparitions at the time of death. The Jungian psychoanalyst Aniela Jaffe viewed apparitions, including those of the dying, as manifestations of Carl Jung's transpersonal views of the psyche and, therefore, a validation of Jungian metapsychology. Indeed both the visions as well as the apparitional hallucinations described by Osis can be attributed to a number of medical causes, including lack of oxygen to the brain. Ultimately the research into the phenomenon of deathbed visions, while confirming that such events are common, offers no clear explanations.

See also: COMMUNICATION WITH THE DEAD;

COMMUNICATION WITH THE DYING; EGYPTIAN BOOK OF THE DEAD; GHOSTS; NEAR-DEATH EXPERIENCES; OMENS; REINCARNATION; TIBETAN BOOK OF THE DEAD

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THOMAS B. WEST

DEATH CERTIFICATE

A death certificate is the official document that declares a person is dead. Death certificates serve two purposes: they prevent murder cover-ups by restricting those who can complete them for non-natural deaths to trained officials who generally have great latitude on whom they perform post-mortem examinations, and they provide public health statistics. Death registration was first required in the United Kingdom in 1874. Before then, it was not even necessary for a physician to view the corpse. In the United States, Great Britain, and most industrialized countries, physicians must now sign a death certificate listing the presumed cause of death. Otherwise, a medical examiner (forensic pathologist) will intervene with an autopsy to determine the cause of death in the event that a case requires police investigation.

People use death certificates in multiple ways. Survivors need death certificates to obtain burial permits, make life insurance claims, settle estates, and obtain death benefits. Public health departments look for patterns that may signal specific health problems, such as clusters of cancers that may reveal unknown toxic waste dumps.

There are three types of death certificates in the United States, including a standard certificate, one for medical/legal cases, and one for fetal or stillborn deaths. All but two states require a death certificate for fetal deaths. However, the majority of states only require a certificate if the fetus was past twenty weeks of gestation. All are based on the international form agreed to in 1948 (modified for clarity in the United States in the 1990s). This form lists the immediate cause of death (e.g., heart attack, stroke), conditions that resulted in the immediate cause of death (e.g., gunshot wound to the chest), and other significant medical conditions (e.g., hypertension, atherosclerotic coronary artery disease, or diabetes). The form also includes a place to record whether an autopsy was performed and the manner of death such as natural, accident,

suicide, homicide, could not be determined, or pending investigation.

Death certificates are occasionally used to fake a person's death for insurance fraud and to evade law enforcement officials or irate relatives. "Official" Los Angeles County death certificates, for example, were readily available in the mid-1990s for between \$500 and \$1,000 each. For fraudulent purposes, people have often used death certificates from remote nations and from countries in turmoil.

To complete death certificates, funeral directors first insert the decedent's personal information, including the name, sex, date of death, social security number, age at last birthday, birth date, birthplace, race, current address, usual occupation, educational history, service in the U.S. armed forces, site and address of death, marital status, name of any surviving spouse, parents' names, and informant's name and address. They also include the method and site of body disposition (burial, cremation, donation, or other) and sign the form. The responsible physician must then complete, with or without using an autopsy, his or her sections of the certificate. These include the immediate cause(s) of death; other significant conditions contributing to the death; the manner of death; the date, time, place, and mechanism of any injury; the time of death; the date the death was pronounced; whether the medical examiner was notified; and his or her signature. The death certificate then passes to the responsible local and state government offices, where, based on that document, a burial permit is issued. The death certificate, or at least the information it contains, then goes to the state's bureau of vital statistics and from there to the United States Center for Health Statistics.

Funeral directors often struggle to obtain a physician's signature on a death certificate. In an age of managed-care HMOs and multispecialty clinics, they must not only locate the busy practitioner for a signature, but also identify the correct physician. Survivors cannot bury or otherwise dispose of a corpse until a licensed physician signs a permanent death certificate or a medical examiner signs a temporary death certificate. Medical examiners (or coroners) list the cause of death as "pending" until further laboratory tests determine the actual cause of death. Except in unusual cases, disposition of the remains need not wait for the

final autopsy report, which may take weeks to complete.

After the death certificate has been signed, local authorities usually issue a certificate of disposition of remains, also known as a burial or cremation permit. Crematories and cemeteries require this form before they will cremate or bury a body. In some jurisdictions, the form is combined with a transportation permit that allows the movement or shipment of a body. The need for regulation of death certificates became evident in 1866. When New York City first installed an independent Board of Health in March 1866, city police inspected the offices of F. I. A. Boole, the former city inspector. According to the *New York Times*, police found a large number of unnumbered burial permits, which Boole had already signed. They claimed that Boole had been selling these to murderers who used them to legally bury their victims' bodies.

Public health policies depend heavily on the mortality data from death certificates because they are the only source of information about the causes of death and illnesses preceding death. For example, when Italy's Del Lazio Epidemiological Observatory reviewed 44,000 death certificates, it found that most diseases divided neatly along class lines. The poor died of lung tumors, cirrhosis of the liver, respiratory diseases, and "preventable deaths" (appendicitis, childbirth complications, juvenile hypertension, and acute respiratory infections). Well-to-do women had higher rates of breast cancer. It also found that the incidence of heart disease, strokes, and some cancers did not vary with income level. These findings have had a significant impact on how the Italian government funds its health care system.

Yet the accuracy of death certificates in the United States is questionable, with up to 29 percent of physicians erring both as to the cause of death and the deceased's age. About the same number incorrectly state whether an autopsy was done. Less significant discrepancies occur in listing the deceased's marital status, race, and place of birth. Death certificates of minority groups have the most errors. Only about 12 percent of U.S. physicians receive training in completing death certificates, and less than two-thirds of them do it correctly. Several do not appear to believe that completing death certificates accurately is very important.

Many certificates are meaningless because physicians complete them without knowing the real cause of death. Listing "cardiopulmonary arrest" signifies nothing—everyone's heart and lungs eventually stop. The important point is why? An autopsy is often needed to answer this question. Occasionally, autopsy, pathology, or forensic findings appear after a death certificate has been completed. If it is within three years of the death in many jurisdictions, the original physician-signer need only complete an amended certificate to correct the record.

Disguising deaths from alcoholism, AIDS, and other stigmatizing causes of death on death certificates is widespread. This practice appears to be more common where medical examiners' autopsy reports are part of the public record. For this reason, some states may eliminate the cause of death from publicly recorded death certificates.

Physicians obscure information on some death certificates to protect a family's reputation or income, with listings such as "pneumonia" for an AIDS death or "accidental" for a suicide. Even before the AIDS epidemic, one researcher found that in San Francisco, California, socially unacceptable causes of death frequently were misreported—the most common being alcoholic cirrhosis of the liver, alcoholism, syphilis, homicide, and suicide.

A similar problem with the accuracy of death certificates has been reported in Great Britain. The Royal College of Physicians of London claims that 20 percent of British death certificates incorrectly list the cause of death. In one instance, for example, the number of reported suicides at Beachy Head (a popular spot at which to commit suicide by jumping into the sea) diminished by one-third simply with a change in coroners.

Physicians who complete death certificates in good faith are not liable to criminal action, even if the cause of death is later found to be different from that recorded. Fraudulent completion to obscure a crime or to defraud an insurance company, however, is a felony.

Occasionally, fake death certificates appropriate real people's identities. Such false death certificates are especially distasteful to victims of this fraud who are still alive and whose "death" causes officials to freeze their assets, cancel credit, revoke licenses, and generally disrupt their lives.

Deaths that occur aboard ships are handled very differently. For example, British captains register any crew or passenger death in the ship's log, the information approximating that on a death certificate. On arrival at a British port, the captain must report the death to harbor authorities, who then investigate the circumstances.

Death certificates and other standard legal papers surrounding death normally cost between \$1 and \$5 each. The funeral director usually obtains these forms and itemizes their costs on the bill. In cases where a body must be shipped to a non-English-speaking country, the forms must often be translated at an additional cost.

See also: AUTOPSY; CAUSES OF DEATH; SUICIDE

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KENNETH V. ISERSON

DEATH EDUCATION

The term *death education* refers to a variety of educational activities and experiences related to death and embraces such core topics as meanings and attitudes toward death, processes of dying and bereavement, and care for people affected by death. Death education, also called education about death, dying, and bereavement, is based on the belief that death-denying, death-defying, and death-avoiding attitudes and practices in American culture can be transformed, and assumes that individuals and institutions will be better able to deal

with death-related practices as a result of educational efforts.

There are two major reasons for providing death education. First, death education is critical for preparing professionals to advance the field and accomplish its purposes. Second, it provides the general public with basic knowledge and wisdom developed in the field. The overarching aims of death education are to promote the quality of life and living for oneself and others, and to assist in creating and maintaining the conditions to bring this about. This is accomplished through new or expanded knowledge and changes in attitudes and behavior.

Death education varies in specific goals, formats, duration, intensity, and characteristics of participants. It can be formal or informal. Formal death education can involve highly structured academic programs of study and clinical experience. It can be organized into courses, modules, or units taught independently or incorporated into larger curricular entities. It can be offered at the elementary, middle, and high school levels, in postsecondary education, as professional preparation, and as short-term seminars or workshops for continuing professional and public education. Informal death education occurs when occasions arising in the home, at school, and in other social settings are recognized and used as "teachable moments." In the home, the birth of a sibling or the death of a pet may naturally lead to interactions that answer a child's questions about death. At school, a student's sudden death may trigger educational follow-up, in addition to crisis counseling.

Two distinct methodological approaches to structured death education are the didactic and the experiential. The didactic approach (involving, for example, lectures and audiovisual presentations) is meant to improve knowledge. The experiential approach is used to actively involve participants by evoking feelings and thereby permitting death-related attitudes to be modified. This approach includes personal sharing of experiences in group discussion, role-playing, and a variety of other simulation exercises, and requires an atmosphere of mutual trust. Most educators use a combination of the two approaches.

Death education can be traced back to the death awareness movement, which unofficially began with Herman Feifel's book, *The Meaning of*

Death (1959). He and other scholars noted that the subject of death had become “taboo” in the twentieth century and challenged individuals to acknowledge their personal mortality, suggesting that to do so is essential for a meaningful life. Feifel pioneered the scientific study of attitudes toward death and pointed to the multidisciplinary nature of the field. At about the same time other pioneers focused on more specific issues concerning dying persons and their care and the experience of grief.

General Academic Education

Reflecting the broad-based academic beginnings, courses on death and dying were developed by Robert Kastenbaum, Clark University, Robert Fulton at the University of Minnesota, Dan Leviton at the University of Maryland, and James Carse at Yale University, among others. In 1969 Fulton established the Center for Death Education (now the Center for Death Education and Bioethics at the University of Wisconsin, La Crosse). In 1970 Robert Kastenbaum founded *Omega: The Journal of Death and Dying*, the first professional journal in the field. In the same year the first conference on death education was held at Hamline University in St. Paul, Minnesota. In 1977 Hannelore Wass founded the journal *Death Education* (later renamed *Death Studies*).

College Courses

As the field developed, a course or two on death became popular offerings in many colleges and universities across the country (in such areas as psychology, sociology, health sciences, philosophy, and education). These courses varied somewhat in perspective, depending on the disciplines in which they were offered. Courses in sociology focused more on cultural and social influences and customs, whereas courses in psychology emphasized the experiences and dynamics of dying, bereavement, and attitudes toward death. Leaders in the field recommended an approach that embraced both foci. From suggestions for course content, a common core of topics emerged, including historical, cultural, and social orientations and practices; attitudinal correlates of death and dying; coping with bereavement; controversial issues; and personal confrontation with death.

Through the years, college courses increasingly have come to reflect the multidisciplinary nature of

the field. As more knowledge was generated, college level courses with a multidisciplinary focus have tended to function as introductory or survey courses. Although popular introductory textbooks vary in approach and style, with the considerable similarity in the topics, a degree of standardization, at least in course content, has been achieved. At least one course on death is offered at most colleges across the country.

Along with an accelerating rate of publications in professional journals, books were published on various aspects of death, for professionals and the general public, including juvenile literature. Additionally, a wealth of audiovisuals was developed. Audiovisuals are used to facilitate group discussions and the sharing of personal experiences.

Academic Concentration and Certificate Programs

A number of special tracks/areas of concentration have been developed in academic units at colleges and universities, especially at the graduate level, where they may be part of the curricular offerings in psychiatric/mental health and other nursing programs, counseling, clinical or health psychology, human development and family studies, and other specializations. One of the earliest, at Brooklyn College, is a thirty-three-credit-hour master's degree in a health science program with a concentration on care of the dying and bereaved. Similar programs in operation for two decades are offered at the New Rochelle College of Graduate Studies, New York University, and Hood College in Frederick, Maryland, among others. A unique comprehensive program, developed at King's College and Western Ontario University in Canada, is an undergraduate “Certificate in Palliative Care and Thanatology,” which involves a thirty-six-credit-hour interdisciplinary program with a focus on palliative care, bereavement, suicide, and ethical, religious, and cultural issues. Many colleges and universities allow for individualized programs of concentration in death-related studies.

Education for Health Professionals

In addition to the more general academic approach to the study of death, a number of pioneers concentrated on more specific issues. Several, including Jeanne Quint Benoliel, Cicely Saunders, and Elisabeth Kübler-Ross, focused on dying

patients and the effects of institutional environments, the process of dying, and pain management, and they articulated the need for change in the care of dying people.

Benoliel began her pioneering work in death education for caregivers by designing a graduate course for nursing students, which she began to teach in 1971. Course topics included social, cultural, and psychological conditions that influence death-related attitudes and practices; concepts of grief; and ethical, legal, and professional issues concerning death. The course became a model for others. In her 1982 book, *Death Education for the Health Professional*, Benoliel comprehensively described several courses on death for undergraduate and graduate students in nursing and medicine.

Many colleges of nursing developed courses or modules in death education as electives and often as required courses, as well as continuing education programs, with content reflecting the broader framework that Benoliel recommended together with palliative and other caring skills required to work effectively with dying persons and their families. Several medical educators developed courses specifically for medical students. Despite these efforts, however, medical schools largely have failed to incorporate death-related knowledge and skills into their curricula.

Education was critical for the development of hospice care. Hospices relied largely on the leadership of professional organizations. A major concern of the International Work Group on Death, Dying, and Bereavement (IWG) has been to develop standards of clinical practice. IWG documents, identifying basic assumptions and principles of death-related programs and activities, are published in professional journals and periodically reprinted as collections by IWG. The "Assumptions and Principles Underlying Standards of Care of the Terminally Ill," developed by IWG members from the United States, the United Kingdom, and Canada, first published in 1979, became an important guide for hospice organizations.

The National Hospice and Palliative Care Organization, founded in 1981, grew out of the efforts of pioneers in hospice care. Among its main purposes has been the continuing education of its membership through annual conferences and the development of resources. Other professional

organizations with similar priorities and information sharing are the Hospice Foundation of America, the International Association of Hospice and Palliative Care, and the American Academy of Hospice and Palliative Medicine (publisher of the *Journal of Palliative Medicine*). Related journals for health professionals are *Palliative Medicine* (in the United Kingdom) and the *Journal of Palliative Care* (in Canada), among others.

Developments in Physician Education

A four-year study of seriously ill patients in hospitals, released in 1995, confirmed substantial shortcomings in palliative care and communication. Another study, conducted by George E. Dickinson and A. C. Mermann and released in 1996, found that except for a few occasional lectures or seminars at the clinical level, little instruction on death and dying occurred in medical schools. Not surprisingly, an examination of medical textbooks in multiple specialties by Michael W. Rabow and his colleagues in 2000 revealed that, with few exceptions, content in end-of-life care areas is minimal or absent.

With funding from various sources, however, comprehensive initiatives have been launched to educate physicians in end-of-life care. In 1996 the American Academy of Hospice and Palliative Medicine developed Unipacs, a program in hospice and palliative training for physicians that consists of six modules and is designed for physicians and physician educators. The program includes such topics as assessment and treatment of pain and other symptoms, alleviating psychological and spiritual pain, ethical and legal decision-making when caring for the terminally ill, and communication skills. A similar program, the National Internal Medicine Residency Curriculum Project in End-of-Life Care, is now a requirement for internal medicine residency training. In 1998 the American Medical Association announced the Education for Physicians on End-of-Life Care Project. Its first phase has been curriculum development including lecture sessions, videotape presentations, discussions, and exercises, organized into portable two-day conferences. Next, physician educators have been trained in using the curriculum. It will be published as a self-directed learning program and made available for physicians across the country. The American Academy of Family Physicians, in its "Recommended Curriculum Guidelines for Family Practice Residents on

End-of-Life Care" (2001), adds to the knowledge and skill components a third on attitudes that include awareness and sensitivity to such issues as "breaking bad news"; psychosocial, spiritual, and cultural issues affecting patients and family; and physicians' personal attitudes toward death.

Nursing Education

Nurses spend far more time with critically ill patients and their families than do other caregivers. They have been better prepared for this aspect of their profession than physicians in that many nursing schools have been offering courses or modules at the undergraduate and graduate levels. Still, a 1999 study by Betty Ferrell suggested that end-of-life education in nursing schools is inconsistent. In response, the American Association of Colleges of Nursing (AACN) developed "Peaceful Death: Recommended Competencies and Curricular Guidelines for End-of-Life Nursing Care." Reflecting these guidelines, the AACN in 2001 developed the End of Life Nursing Education Curriculum (ELNEC). ELNEC is a comprehensive curriculum of nine modules to prepare bachelor's and associate degree nursing faculty who will integrate end-of-life care in basic nursing curricula for practicing nurses, and to provide continuing education in colleges and universities and specialty nursing organizations across the country. Among other efforts to improve nursing education in end-of-life care is the Tool-Kit for Nursing Excellence at End of Life Transition (TNEEL), a four-year project developed by six prominent nursing educators and researchers. TNEEL is an innovative package of electronic tools distributed to nurse educators in academic and clinical settings and eventually will be offered as a web-based self-study course.

Preparation of Grief Counselors

Scientific writing on grief began in 1917 with the renowned physician and psychiatrist Sigmund Freud's essay on mourning and melancholia, and continued with the first empirical study of acute grief reactions by Erich Lindemann in 1944, John Bowlby's studies on attachment and loss in 1960 and 1961, and Colin Murray Parkes's investigations of spousal bereavement in 1970. In the next thirty years the study of grief became the most active area of research in the field. Differences in conceptualizations and methodological approaches

led to diverse findings. The diversity in results may explain, in part, why findings from this literature were not immediately incorporated into the academic curricula in psychology, sociology, or the health sciences, except as occasional seminars, and lectures, or as topics for independent study and research.

These findings did stimulate the development of various mutual and self-help organizations for bereaved adults. Later, when studies on childhood bereavement showed that children also grieve and can benefit from support, programs for bereaved children were established. The Dougy Center in Portland, Oregon, a community-based volunteer program founded in 1985, became a model and training center for professionals across the nation interested in setting up grief support programs for children. In addition, leaders in the field pioneered community-supported crisis intervention programs in the public schools in the 1990s.

Hospices have become increasingly involved in community-oriented educational outreach and clinical services for bereaved adults and children and the public. Colleges of mortuary sciences have begun offering courses or modules in after-care counseling. Some basic information on grief and bereavement has also been incorporated into training of personnel for disaster relief organizations, of airline companies, and in some police departments.

The professional preparation of grief counselors has relied heavily on training in more non-traditional settings. Mental health practitioners and other health professionals have been offered continuing education seminars, workshops, and institutes. Leaders suggest that while well-trained and experienced mental health practitioners can learn the basics of grief counseling in a two- or three-day intensive workshop, the issues in grief therapy are too complex to be addressed in such abbreviated fashion.

Professional organizations have been vital in educating their members about grief. The Association for Death Education and Counseling (ADEC), in particular, concerned itself early with the question of education for professionals and was the first organization to develop professional standards and certification programs for death educators and counselors. In addition to its annual conferences, ADEC for many years has been offering a sequence of preconference basic and advanced academic

courses and experiential workshops taught by leading professionals, as well as resources to assist members in preparing for certification. ADEC is at present revising its certification programs to certify professionals as grief counselors.

At colleges and universities today, many departments of health psychology, counseling and clinical psychology, human development and family studies, and other academic units offer areas of concentration that include courses and independent studies in death and bereavement at the undergraduate level. At the graduate level, an increasing number of departments support theses and dissertations on the subject. Increasingly more sophisticated and up-to-date death and grief-related content appears in the textbooks in relevant specialties in psychology, sociology, and gerontology. As hospitals begin to include bereavement follow-up services in their end-of-life care programs, content about grief will become part of medical and nursing education.

In addition to *Death Studies* and *Omega*, several other professional journals deal with grief, including *Illness, Crisis, and Loss* and *Journal of Loss and Trauma*. A large number of books are in print on various aspects of grief, including scholarly treatments, personal accounts, and, most of all, practical guidelines for support. An exploding number of profit and nonprofit Internet web sites offer information, resources, and support as well.

Death Education for the Public

As the field of death and dying evolved and the subject became acceptable for discussion, the print and electronic media reported on new developments and presented interviews and panel discussions with increasing frequency. Public information about end-of-life issues that evolved with medical and technological advances was instrumental in the establishment of citizens' advocacy groups, the public debate regarding patients' rights, and subsequent legislation.

Funding from generous philanthropies, designed to educate professionals as well as the general public, has been instrumental in recent educational activities. One of the stated goals of the Project on Death in America of the Open Society Institute is to "understand and transform the culture and experience of dying and bereavement in America." Among recent educational efforts are the

National Public Radio series "The End of Life: Exploring Death in America" and the PBS television series "On Our Own Terms: Moyers on Dying in America." There are thousands of web pages on end-of-life issues, various aspects of dying, funerals, and grief, as well as online support services. Most professional organizations concerned with death offer a wealth of information and resources on their web sites. Citizens' organizations present their views and perspectives in print and on the web.

Many communities periodically offer adult education programs, lecture series, seminars, and similar formats. And many colleges, universities, hospices, and hospitals either design programs for the community or invite the public to conferences.

Death Education in Public Schools

Daniel Leviton, a pioneer in the field of death and dying, first articulated the rationale for teaching children about death. In 1977 Leviton, and in 1979 Eugene Knott, redefined early goals. Over the years numerous instructional guidelines and resources were developed for incorporating the study of death and dying into various subject areas taught in public schools.

A 1990 national survey of U.S. public schools conducted by Hannelore Wass, Gordon Thornton, and David Miller, however, found that only a fifth of the high schools, 15 percent of the middle schools, and less than a tenth of the elementary schools incorporated the study of death into their curricula. Those who did tended to include it in health science or family life. Goals were to better prepare for life, to appreciate life and health, and to be less afraid of death.

While most schools have established protocols for crisis intervention (grief counseling and support), preventive education through the study of death, dying, and bereavement has remained a controversial issue. Some parents say it infringes upon their and the church's domain. Some critics point to inadequate teacher preparation. There has been a concern that such study would induce anxiety and heighten fears in students. These concerns combined with increasing pressures to teach complex technological concepts and other basic skills, make it unlikely that the subject of death will be viewed as a part of the school's curriculum. But proponents of death education insist on the need to also address the life and people problems of

today and help students to learn skills to solve them. Understanding and appreciating oneself, others, and life, learning ways to manage anger and frustration; developing attitudes of tolerance, respect, empathy, and compassion all contribute to a high quality of life. These may be basic ingredients of long-term primary prevention of destructive behavior and serve as an antidote to the distorted perceptions children form from the entertainment media.

Reduction of Death Anxiety As a Goal in Death Education

Professionals disagree on the question of death anxiety reduction as a desirable or appropriate general goal for efforts in death education. Some leaders believe it is unrealistic to expect that a one-semester-length course of instruction in large classes can alleviate the negative affect of death. Instructors seldom know anything about individual students' feelings and personal experiences with death at the beginning of the instruction. Unless time is provided for sharing of experiences and concerns in class (or out of class), it may be difficult to assess students' attitudes and gauge affective changes. Additionally, changes may be too subtle to notice, or may be dormant for many months.

In continuing professional education, the concern has been whether a short-term workshop for health professionals—often not more than twenty hours in length—provides sufficient time to address the complex issues of death attitudes and to bring about attitude changes. Nonetheless, for students preparing to become health professionals, caring for dying and bereaved persons and their families, it is considered essential that they confront their own death-related feelings and learn to cope with them. There is evidence and a firm belief among thanatologists that negative feelings interfere with a person's effectiveness in helping others.

The concern that teaching children about death will induce or heighten death fears and anxieties may need reconsideration as well. Adults tend to be protective of children. At the same time, they also seem confident that children can withstand the onslaught of cultural and actual violence in their environment. This may be wishful thinking, however. Children do have fears and concerns about death. Studies of older children with life-threatening illness have shown that being given

detailed information about diagnosis, prognosis, and treatment options lowered their death anxieties, suggesting that knowledge may give children a measure of control. This may be true for healthy children as well. Improved and specific information about the consequences of risk-taking behavior in adolescents, or even the process of discussing these matters, may reduce death anxiety children already have and help prevent risk-taking behaviors. Considering the complexity of the issues, it is important to include study of death-related attitudes in the curricula of prospective teachers at any level.

Evaluation

While basic assumptions and goals of death education may be agreed on, wide variation in specific objectives, populations, and settings have made it difficult to establish general standards and to evaluate the overall effectiveness of the diverse efforts. Because thanatology (the study of death) has become a complex multidisciplinary field with a considerable amount of research, scholarship, and practice, and because the subject is personal and intimate, death education is challenging and requires solid qualification. There seems to be agreement on a number of basic competencies of an effective death educator:

- confrontation of personal mortality and comfort with the topic of death;
- knowledge of the subject matter and commitment to keep up with new developments;
- ability to develop objectives consistent with the needs, interests, and educational levels of learners;
- familiarity with basic principles of learning and instruction;
- knowledge of group dynamics; and
- skills in interpersonal communication and, when necessary, in identifying students' needs for support and counseling.

ADEC is currently developing standards for training death educators based on teacher competencies.

Numerous empirical studies have been conducted to provide objective data on the effects of death education. Most of these are done with college students taking a semester-length course or with health care professionals participating in short

courses or workshops. Joseph A. Durlak and Lee Ann Reisenberg conducted a meta-analysis of forty-six controlled outcome studies. They concluded in 1991, reevaluated by Durlak in 1994, that death education was fairly successful in achieving cognitive learning goals, in changing cognitive attitudes on death-related issues and death-related behaviors (e.g., making out a will, talking with dying patients). Findings on changes in affect (death fears and anxieties), however, were inconsistent, depending in part on the teaching methods employed: Emphasis on experiential methods was more likely to result in slight decreases in fears, and emphasis on didactic methods had no or slightly negative effects.

Conclusion

Education about death, dying, and bereavement has been instrumental in educating professionals and significant in informing the public. In general, substantial progress has been made identifying broad goals and specific objectives, designing curricula, developing resources, and reaching the populations to be addressed—college students, health care professionals, and the general public. Death education is minimal in the public schools. Leaders in the field, however, consider it an important component of the schools' curricula. Such education could be part of children's preparatory cultural education and could serve as primary prevention of violence by promoting life-affirming and constructive attitudes and behavior toward self and others.

Professional organizations concerned with death, dying, and bereavement demonstrate leadership by developing, expanding, or refining standards of practice and providing educational resources. The concerted efforts to educate physicians and nurses in end-of-life care are impressive. They also illustrate the importance of financial resources in bringing about change. Modest progress has been made in evaluating death education. The challenge of achieving an overall objective evaluation of educational outcomes remains. State-of-the-art death-related content needs to be reflected in the educational curricula for professionals. All groups can benefit from studying the larger social and cultural contexts in which they live and work. Advances in the communications technologies enabling rapid information gathering—and sharing—and the increasing use of these

technologies for online distance learning and teaching can greatly facilitate and enhance death education at all levels.

See also: CADAVER EXPERIENCES; CHILDREN AND ADOLESCENTS' UNDERSTANDING OF DEATH; FEIFEL, HERMAN; GRIEF COUNSELING AND THERAPY; TABOOS AND SOCIAL STIGMA

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HANNELORE WASS

DEATH INSTINCT

The pioneering Austrian psychoanalyst Sigmund Freud was a person with few illusions about human nature and civilization. In fact, he had been relentlessly exposing what he saw as the hidden strivings and conflicts beneath the mask of civilization. Even Freud, though, had not expected such a catastrophic violation of the values of civilization. Entering the sixth decade of his life, Freud had observed too much self-destructive behavior both from his psychoanalytic patients and society at large. He had grown dissatisfied with some of his own theories and felt the need to address more decisively the human propensity for self-destruction. His version of the question of the times became: Why do humans so often act against their own best interests—even the desire to survive?

It was in 1920 that Freud offered his death instinct theory. This was an uncertain time both in Freud's own life and in European culture. World War I, “The War to End All Wars” (unfortunately, misnamed), had finally concluded. Both the victorious and the defeated had experienced grievous loss. Parents had been bereaved, wives widowed, and children orphaned. Many of the survivors of

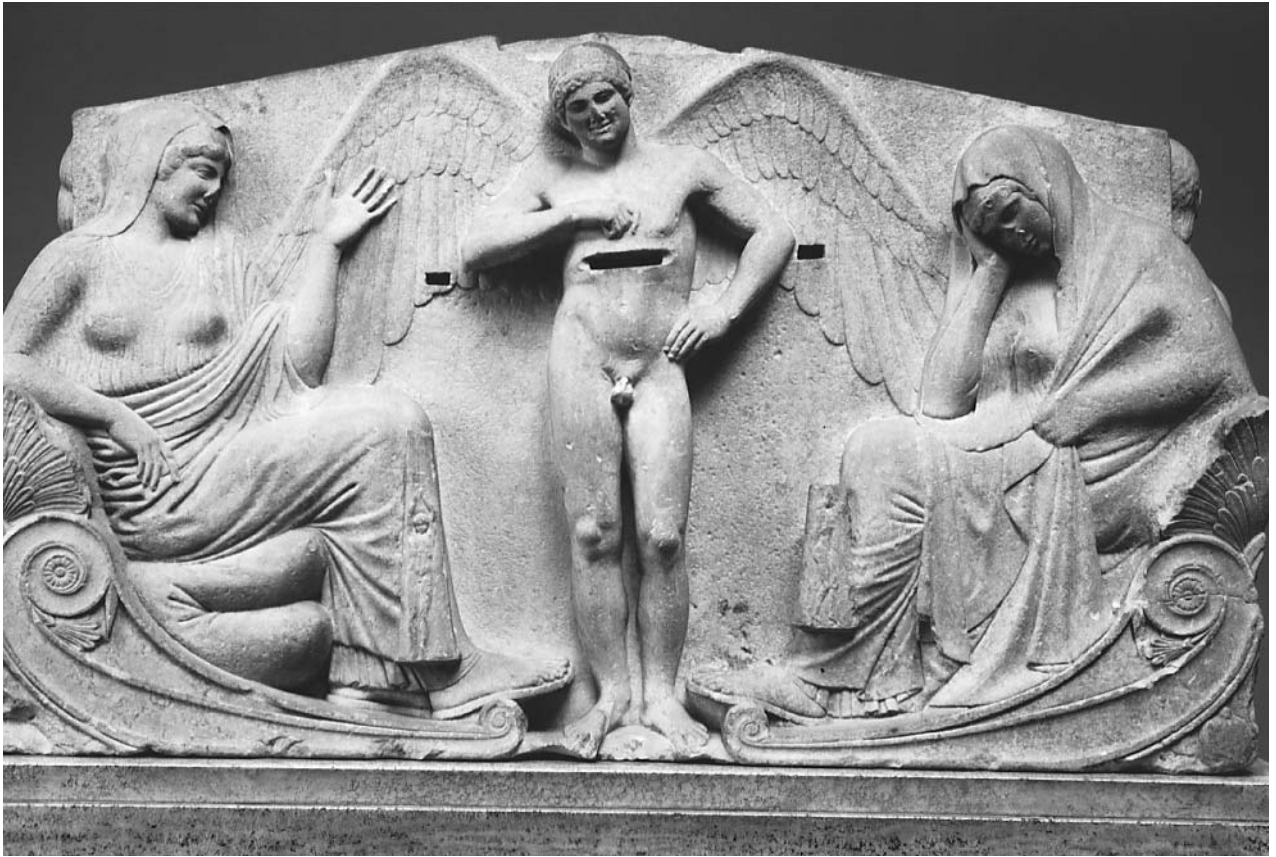
combat would never be the same again, physically or mentally. In Austria and Germany the devastation of war and the terms of the surrender had produced not only economic hardship but also a debilitating sense of hopelessness and frustration.

Thoughtful people found even more to worry about. World War I seemed to be much more than a tragic ordeal for all involved. In the minds of many observers, this protracted period of violence and upheaval had shattered the foundations of Western culture. Western civilization with its centuries-old traditions appeared to have been dealt a deathblow. Classical concepts of honor, beauty, glory, truth, and justice had been mutilated in the killing trenches and the casual brutalities of war. The visual, musical, and performing arts were contributing to the unease with disturbing new forms of expression. Science was increasingly seen as a threat to humanity through such routes as dehumanizing workplaces and ever-more lethal weaponry. The life sciences, through the theories of Charles Darwin, the nineteenth-century English naturalist, had already sounded one of the most troubling notes: *Homo sapiens* can be regarded as part of the animal kingdom. Humans were primates with superior language and tool skills. Where was the essence of humankind's moral being and the immortal soul? The physical and spiritual devastation of World War I seemed to have confirmed the gradually building anxieties about the future of humankind.

Freud introduced his new theory in *Beyond the Pleasure Principle* (1920). Most philosophers and psychologists had assumed that people are motivated by the desire to experience pleasure and avoid pain. This was not, however, always the case. Some of Freud's patients, for example, were masochistic—seekers of physical or emotional pain. The more he thought about it, the more connections Freud perceived between masochism, suicide, war, and the inability to love. Was there something in the very nature of humans that prompted them to override the self-preservation instinct and bring about harm both to themselves and others?

Life and Death: Eros and Thanatos

Freud came to the conclusion that humans have not one but two primary instincts. He called the life-favoring instinct *Eros*, one of the Greek words



Sigmund Freud claimed each human had a death instinct, called Thanatos, the Greek word for “death.” This Greek relief sculpture shows Thanatos positioned between Aphrodite and Persephone, who are thought to be competing for the soul of Adonis. BURSTEIN COLLECTION/CORBIS

for “love,” and the death instinct *Thanatos*, the Greek word for “death.” It was characteristic of Freud to invoke Greek literature and mythology, but it was also characteristic of him to ground his ideas in the biomedical and physical sciences. He suggested that all living creatures have an instinct, drive, or impulse to return to the inorganic state from which they emerged. This *tottrieb* (drive toward death) is active not only in every creature, great or small, but also in every cell of every organism. He pointed out that the metabolic processes active in all cells have both constructive (anabolic) and destructive (catabolic) functions. Life goes on because these processes work together—they are opposing but not adversarial.

Similarly, Eros and Thanatos function in a complementary manner in the personal and interpersonal lives of humans. People seek out new experiences, reach out to others, and expend energy in pursuit of their goals. Eros smiles over ventures

such as these. There are times, though, when humans need to act aggressively on the world, protect their interests, or withdraw from overstimulation and exertion and seek quietude. Thanatos presides over both these aggressive and risky ventures and the longing for “down time.” Humans function and feel at their best when these two drives are in harmony. Sexual love, for example, may include both tenderness and thrill-seeking.

Effects on Children

Unfortunately, though, these drives are often out of balance. Children may be punished or shamed for their exploratory and aggressive, even destructive, actions (e.g., pulling a caterpillar apart to see what is inside). A particular problem in Freud’s generation was strong parental disapproval of exploratory sexual expression in children. As a consequence, the child might grow into an adult who is aggressive and destructive where affection

and sharing would be more rewarding—or into a person with such thwarted and convoluted sex/death impulses that making love and making war are dangerously linked.

Suicide and Homicide

Suicide and homicide often have roots in a confused and unbalanced relationship between the life and the death instincts. The destructive impulses may be turned against one's own self (suicide) or projected against an external target (homicide). Wars erupt when society at large (or its leaders) have displaced their own neurotic conflicts to the public scene.

Later Views of the Theory

Death instinct theory has not fared well. In his influential 1938 book *Man against Himself*, American psychiatrist Karl Menninger stated that he found this theory helpful in understanding suicide and other self-destructive behaviors. Critics have dominated, however, both within the circle of psychoanalysis and the larger professional and academic community. Two of the criticisms are especially powerful: that the theory relies on vague and outdated scientific knowledge, and that it is seldom very useful when applied to specific individuals and situations. For the most part, counselors, therapists, researchers, and educators have found that they could get along just as well without making use of the death instinct theory.

Nevertheless, there is still vitality in this failed theory. Evidence of confused connections between sexuality and destructiveness remains plentiful, as do instances in which people seem to be operating against the principle of self-preservation of self or others. Furthermore, within the correspondence between Freud and the German-born American physicist and philosopher Albert Einstein, included in the 1932 book *Why War?*, was an ancient remedy that has yet to be given its full opportunity. Einstein had independently reached the same conclusion as Freud: "Man has in him the need to hate and to destroy." Freud replied with the emphasis on Eros: "Psychoanalysis need not be ashamed when it speaks of love, because religion says the same: 'Love thy neighbor as thyself.'"

See also: FREUD, SIGMUND; HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; SUICIDE

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ROBERT KASTENBAUM

DEATH MASK

A death mask is a wax or plaster cast of a person's face taken while he or she is alive or after their death. Usually the mask is created after the death of the person because of the danger imposed by its materials. The making of a reproduction of the face of a dead person is an ancient practice whose origins date from the periods of the Romans and Egyptians. The process served as a reminder of the deceased for the family, as well as a protector from evil spirits, and is associated with a belief in the return of the spirit.

In some cultures, mostly in African, Native American, and Oceanic tribes, death masks are considered an important part of social and religious life. Death masks facilitate communication between the living and the dead in funerary rites and they create a new, superhuman identity for the bearer. Death masks can take the form of animals or spirits, thereby allowing the bearer to assume the role of the invoked spirit or to fend off evil forces.

In some tribes death masks are used in initiatory or homage ceremonies, which recount the creation of the world and the appearance of death among human beings. For others, where the link to ancestors is sacred, they are used to make the transition from the deceased to his or her heir of the family. Death masks are also used as a tool to help the deceased's soul pass easily to the other life. The respect of the funeral rites of mask dancing can also protect from reprisals from the dead, preventing the risk of a wandering soul.

See also: HUMAN REMAINS; IMMORTALITY, SYMBOLIC

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ISABELLE MARCOUX

DEATH PENALTY

See CAPITAL PUNISHMENT.

DEATH SQUADS

Death squads are generally state-sponsored terrorist groups, meaning that the government advocates death by groups of men who hunt down and kill innocent victims. Death squads are often paramilitary in nature, and carry out extrajudicial (outside the scope of the law or courts) killings, executions, and other violent acts against clearly defined individuals or groups of people (Campbell 2000). Their goal is to maintain the status quo with special reference to power and to terrorize those supportive of economic, political, and social reform. An example is the private armies, mercenaries, and gangs whose goal was to terrorize the population to prevent their support of the revolutionary Sandinista National Liberation Front (FSLN) during the Contra war in Nicaragua in 1979-1990 (Schroeder 2000). The brutish civil war in El Salvador, 1979-1991, provides another example. The work of these death squads horrified the world. Some were brazen enough to identify themselves by carving the initials "EM" (Escuadrón de la Muerte, "Death Squad") into the chests of corpses (Arnson 2000).

Violence by death squads falls under concepts such as extrajudicial killing, state-sponsored terrorism, democide (murder of a person or people by the government), and "horrendous death." Examples of horrendous death are deaths resulting from war, including assassination, terrorism, genocide, racism (e.g., lynching), famine, and environmental assault. All are preventable because they are caused by people rather than God, nature, bacteria, or virus. Ironically, preventive policies exist

that would deal with underlying root causes as well as outcomes but are too infrequently implemented (Leviton 1997). For example, root causes that give rise to death squads include authoritarian, totalitarian, despotic, non-democratic governments, and economic and educational disparities that result in misery and despair. They, in turn, seed economic, social, and political reform and revolutionary movements that are the natural enemy of the totalitarian state.

State-sponsored violence has escalated since the end of World War II. According to Amnesty International in 2000, confirmed or possible extrajudicial executions (including children) were carried out in forty-seven countries. Yet this quantitative data masks the suffering of survivors and its detrimental impact upon the social contract between people and their government.

All people are vulnerable to intentioned deaths such as democide and horrendous death. Their prevention is in the best interests of those desiring a peaceful, global society. To that end, organizations have made specific, preventive recommendations to nation states. Organizations concerned with the elimination and prevention of death squads include the U.S. State Department's Bureau of Democracy, Human Rights, and Labor; United Nations; Amnesty International; and Human Rights Watch. An international surveillance and early warning system and policies that institute basic reforms are also necessary measures. The latter include the need for universal education, instituting democratic forms of government with strong adversarial parties, and an inquisitive and free media.

See also: TERRORISM; WAR

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DEATH SYSTEM

Death system, a concept introduced by Robert Kastenbaum in 1977, is defined as "the interpersonal, sociocultural, and symbolic network through which an individual's relationship to mortality is mediated by his or her society" (Kastenbaum 2001, p. 66). Through this concept, Kastenbaum seeks to move death from a purely individual concern to a larger context, understanding the role of death and dying in the maintenance and change of the social order.

Components of the Death System

To Kastenbaum, the death system in any given society has a number of components. First, *people* are connected to the death system. Because death is inevitable, everyone will, at one time or another, be involved with death—one's own or others.

Other individuals have more regular roles in the death system, earning their livelihood primarily by providing services that revolve around death. These include coroners and funeral directors, persons involved with life insurance, and florists. In other cases, Kastenbaum reminds society, the role may be apparent. Anyone, for example, involved in food manufacturing, especially meat, and food service, depends on the slaughter of animals. Clergy, police, firefighters, and health care workers all interact with the dying, dead, and bereaved and therefore have roles in the death system. Even statisticians who create actuarial tables play a role in the death system.

A second component of the death system is *places*. Places include hospitals (though they do not have the prominent role that they once had as places people go to die, at least in industrial societies), funeral homes, morgues, cemeteries, and other places that deal with the dead and dying. Memorials and battlefields are also places associated with death. Such places need not always be public. Family members may harbor superstitions or simply memories of a room or area where a loved one died.

Times are a third component of the death system. Certain holidays like Memorial Day or Halloween in U.S. culture, the Day of the Dead in Mexican culture, or All Saints' Day or Good Friday among Christian traditions are associated with a time to reflect upon or remember the dead. Again, different cultural groups, family systems, or individuals may hold other times, such as the anniversary of a death, battle, or disaster, as times to remember.

Objects and symbols are the remaining components of the death system. Death-related objects are diverse, ranging from caskets to mourning clothes, even to bug spray "that kills them dead." Symbols too are diverse. These refer to rituals such as Catholic "last rites" or funeral services, and symbols such as a skull and cross that warn of or convey death. Because language is a symbolic system, the words a society uses to discuss death are part of the death system as well.

Functions of the Death System

Kastenbaum takes a sociological approach, drawing from a broad, theoretical stream within sociology called "structure-functionalism." This approach

basically states that every system or structure within a society survives because it fulfills manifest and latent functions for the social order. Change occurs when the system no longer adequately fulfills its functions, due, for example, to changing social conditions, or until innovations emerge that better address these functions. To Kastenbaum, the death system fulfills a series of critical functions.

Warning and predicting death. This function refers to the varied structures within a society that warn individuals or collectivities about impending dangers. Examples of organizations that fulfill these functions include weather forecasting agencies that may post warnings, media that carries such warnings, and emergency personnel who assist in these events. It also includes laboratories and physicians that interpret test results to patients.

Caring for the dying. This category offers a good example of cultural change. The hospital was seen as ineffective by many in caring for the dying, so new cultural forms such as hospice and palliative care emerged to fulfill these functions.

Disposing of the dead. This area includes practices that surround the removal of a body, rituals, and methods of disposal. Being that every culture or generational cohort has its own meaningful ways to dispose of the dead, this can lead to strains when cultures differ.

Social consolidation after death. When an individual dies, other members of the society, such as the family or the work unit, have to adjust and consolidate after that death. In the Middle Ages, for example, the guild system that included masters (i.e., skilled and experienced professionals), intermediate-level journeymen, and beginning apprentices served to mediate the impact of often sudden death by creating a system that allowed for constant replacement. In industrial society, retirement removes workers from the system, lessening the impact of eventual death. In American society, funeral rituals and spontaneous memorialization, self-help and support groups, and counselors are examples of other structures that support consolidation.

Making sense of death. Every society has to develop ways to understand and make sense of loss. One of the values of funeral rituals is that they allow for a death to be interpreted within a given faith or philosophical viewpoint.

Killing. Every death system has norms that indicate when, how, and for what reasons individuals or other living creatures can be killed. There are international treaties that define what weapons and what killings are justifiable in war. Different cultures determine the crimes an individual can be executed for as well as the appropriate methods of execution. Cultures, too, will determine the reason and ways that animals may be killed.

Death systems are not static. They constantly evolve to deal with changing circumstances and situations. For example, the terrorist attacks of September 11, 2001, have led to the development of whole new systems for airline security that include new personnel, regulations, and places such as screening and identification. As causes of death have changed, new institutions such as hospice and nursing homes have developed. A series of social changes, such as demographic shifts, historical factors (i.e., the development of nuclear weapons), and cultural changes (i.e., increasing diversity), have led to the development of the death studies movement. Because it is a related system, changes in one part of the system are likely to generate changes in other parts of the system. For example, the growth of home-based hospice has led hospitals to reevaluate their care of the dying, contributing to the current interest in palliative care.

Thanatology is often more focused on the clinical, stressing the needs of dying and bereaved individuals. While the concept of the death system has not received widespread attention, it is a powerful reminder of the many ways that death shapes the social order.

See also: GENOCIDE; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; MEMORIALIZATION, SPONTANEOUS; SOCIAL FUNCTIONS OF DEATH

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KENNETH J. DOKA

DEFINITIONS OF DEATH

In the past, death has often been defined with a few confident words. For example, the first edition of *Encyclopaedia Britannica* informed its readership that “DEATH is generally considered as the separation of the soul and body; in which sense it stands opposed to life, which consists in the union thereof” (1768, v. 2, p. 309). The confidence and concision had dissolved by the time the fifteenth edition appeared in 1973. The entry on death had expanded to more than thirty times the original length. The earlier definition was not mentioned, and the alternative that death is simply the absence of life was dismissed as an empty negative. Readers seeking a clear and accurate definition were met instead with the admission that death “can only be conjectured” and is “the supreme puzzle of poets” (1973, v. 5, p. 526).

This shift from confidence to admission of ignorance is extraordinary not only because death is such a familiar term, but also because so much new scientific knowledge has been acquired since the eighteenth century. Actually, the advances in biomedical knowledge and technology have contributed greatly to the complexity that surrounds the concept and therefore the definition of death in the twenty-first century. Furthermore, the definition of death has become a crucial element in family, ethical, religious, legal, economic, and policy-making decisions.

It would be convenient to offer a firm definition of death at this point—but it would also be premature. An imposed definition would have little value before alternative definitions have been considered within their socio-medical contexts. Nevertheless, several general elements are likely to be associated with any definition that has a reasonable prospect for general acceptance in the early years of the twenty-first century. Such a definition would probably include the elements of a complete loss or absence of function that is permanent, not reversible, and useful to society.

These specifications include the cautious differentiation of “permanent” from “not reversible” because they take into account the argument that a death condition might persist under ordinary circumstances, but that life might be restored by extraordinary circumstances. Despite this caution there are other and more serious difficulties with

even the basic elements that have been sketched above. That a definition of death must also be “useful to society” is a specification that might appear to be wildly inappropriate. The relevance of this specification is evident, however, in a pattern of events that emerged in the second half of the twentieth century and that continues to remain significant (e.g., persistent vegetative state and organ transplantation). Competing definitions of death are regarded with respect to their societal implications as well as their biomedical credibility.

Attention is given first to some of the ways in which common usage of words has often led to ambiguity in the definition of death. The historical dimension is briefly considered, followed by a more substantial examination of the biomedical approach and its implications.

“Death”: One Word Used in Several Ways

The word *death* is used in at least three primary and numerous secondary ways. The context indicates the intended meaning in some instances, but it is not unusual for ambiguity or a shift in meanings to occur in the midst of a discussion. People may talk or write past each other when the specific usage of “death” is not clearly shared. The three primary usages are: death as an event; death as a condition; and death as a state of existence or nonexistence.

Death as an event. In this usage, death is something that happens. As an event, death occurs at a particular time and place and in a particular way. In this sense of the term, death is a phenomenon that stays within the bounds of mainstream conception and observation. Time, place, and cause can be recorded on a death certificate (theoretically, in all instances although, in practice, the information may be incomplete or imprecise). This usage does not concern itself with mysteries or explanations: Death is an event that cuts off a life.

Death as a condition. This is the crucial area in biomedical and bioethical controversy. Death is the nonreversible condition in which an organism is incapable of carrying out the vital functions of life. It is related to but not identical with death as an event because the focus here is on the specific signs that establish the cessation of life. These signs or determinants are often obvious to all observers. Sometimes, though, even experts can disagree.

Death as a state of existence or nonexistence. In this sense, it can almost be said that death is what becomes of a person after death. It refers not to the event that ended life nor the condition of the body at that time, but rather to whatever form of existence might be thought to prevail when a temporal life has come to its end.

Miscommunications and unnecessary disagreements can occur when people are not using the term *death* in the same way. For example, while grieving family members might already be concerned with finding someone to stay in contact with a loved one who will soon be “in death,” the physicians are more likely to focus on criteria for determining the cessation of life. In such situations the same word *death* is receiving functionally different definitions.

The secondary usages are mostly figurative. Death serves as a dramatic intensifier of meaning; for example, the historian’s judgment that the rise of commerce contributed to the death of feudalism, or the poet’s complaint that life has become death since being spurned by a lover. There are also extended uses that can be considered either literal or figurative, as when the destruction of the universe is contemplated: The issue open to speculation is whether the universe is fundamentally inanimate or a mega-life form.

Traditional Definitions of Death

Biomedical approaches to the definition of death have become increasingly complex and influential since the middle of the twentieth century. Throughout most of human history, however, death was defined through a combination of everyday observations and religious beliefs. The definition offered in the 1768 edition of *Encyclopaedia Britannica* is faithful to the ancient tradition that death should be understood as the separation of soul (or spirit) from the body. The philosophical foundation for this belief is known as dualism: Reality consists of two forms or essences, one of which is material and certain to decay, the other of which has a more subtle essence that can depart from its embodied host. Dualistic thinking is inherent in major world religions and was also evident in widespread belief systems at the dawn of known history.

Definitions of death in very early human societies have been inferred from physical evidence, a

limited though valuable source of information. Cro-Magnon burials, for example, hint at a belief in death as separation of some essence of the person from the flesh. The remains were painted with red ochre, consistently placed in a north-south orientation, and provided with items in the grave that would be useful in the journey to the next life. Anthropologists discovered similar practices among tribal people in the nineteenth and early twentieth centuries. The fact that corpses were painted red in so many cultures throughout the world has led to the speculation that this tinting was intended as a symbolic representation of blood. People throughout the world have long recognized that the loss of blood can lead to death, and that the cold pallor of the dead suggests that they have lost the physical essence of life (conceived as blood), as well as the spiritual (conceived as breath). A religious practice such as symbolically replacing or renewing blood through red-tinting would therefore have its origin in observations of the changes that occur when a living person becomes a corpse.

A significant element in traditional definitions of death is the belief that death does not happen all at once. Observers may clearly recognize signs of physical cessation; for example, lack of respiration and responsiveness as well as pallor and stiffening. Nevertheless, the death is not complete until the spirit has liberated itself from the body. This consideration has been taken into account in deathbed and mourning rituals that are intended to assist the soul to abandon the body and proceed on its afterlife journey. It was not unusual to wait until only the bones remain prior to burial because that would indicate that the spirit has separated, the death completed, and the living emancipated to go on with their lives.

Definitions of death as an event or condition have usually been based on the assumption that life is instantly transformed into death. (This view has been modified to some extent through biomedical research and clinical observation.) Historical tradition, though, has often conceived death as a process that takes some time and is subject to irregularities. This process view has characterized belief systems throughout much of the world and remains influential in the twenty-first century. Islamic doctrine, for example, holds that death is the separation of the soul from the body, and that

death is not complete as long as the spirit continues to reside in any part of the body. This perspective is of particular interest because medical sophistication has long been part of Islamic culture and has therefore created a perpetual dialogue between religious insights and biomedical advances. The question of reconciling traditional with contemporary approaches to the definition of death requires attention to recent and current developments.

Biomedical Determinations and Definitions of Death

For many years physicians depended on a few basic observations in determining death. Life had passed into death if the heart did not beat and air did not flow into and out of the lungs. Simple tests could be added if necessary; for example, finding no response when the skin is pinched or pricked nor adjustive movements when the body is moved to a different position. In the great majority of instances it was sufficient to define death operationally as the absence of cardiac activity, respiration, and responsiveness. There were enough exceptions, however, to prove disturbing. Trauma, illness, and even “fainting spells” occasionally reduced people to a condition that could be mistaken for death. The fortunate ones recovered, thereby prompting the realization that a person could look somewhat dead yet still be viable. The unfortunate ones were buried—and the most unfortunate stayed buried. There were enough seeming recoveries from the funeral process that fears of live burial circulated widely, especially from the late eighteenth century into the early years of the twentieth century.

A related development served as a foreshadowing of complexities and perplexities yet to come. Scientifically minded citizens of late-eighteenth-century London believed they could rescue and resuscitate victims of drowning; they could and they did. Not all victims could be saved, but there were carefully authenticated cases in which an apparent corpse had been returned to life. Some of the resuscitation techniques they pioneered have entered the repertoire of emergency responders around the world. They also tried (with occasional success) the futuristic technique of galvanic (electrical) stimulation. The impact of these experiments in resuscitation far exceeded the small number of

cases involved. The fictional Dr. Frankenstein would reanimate the dead by capturing a flash of lightning—and nonfictional physicians would later employ electric paddles and other devices and techniques for much the same purpose. The wonder at seeing an apparently dead person return to life was accompanied by a growing sense of uneasiness regarding the definition of death. It would not be until the middle of the twentieth century, though, that new developments in technology would pose questions about the definition of death that could no longer be shunted aside.

The accepted legal definition of death in the middle of the twentieth century appeared simple and firm on the surface. Death was the cessation of life as indicated by the absence of blood circulation, respiration, pulse, and other vital functions. The development of new biomedical techniques, however, soon raised questions about the adequacy of this definition. Cardiopulmonary resuscitation (CPR) had resuscitated some people whose condition seemed to meet the criteria for death. Furthermore, life support systems had been devised to prolong respiration and other vital functions in people whose bodies could no longer maintain themselves. In the past these people would have died in short order. The concept of a persistent vegetative state became salient and a disturbing question had to be faced: Were these unfortunate people alive, dead, or somewhere in between? This question had practical as well as theoretical implications. It was expensive to keep people on extended life support and also occupied hospital resources that might have more therapeutic uses. It was also hard on family members who saw their loved ones in that dependent and nonresponsive condition and who were not able to enter fully into the grieving process because the lost person was still there physically.

Still another source of tension quickly entered the situation. Advances were being made in transplanting cadaver organs to restore health and preserve the life of other people. If the person who was being maintained in a persistent vegetative state could be regarded as dead, then there was a chance for an organ transplantation procedure that might save another person’s life. Existing definitions and rules, however, were still based on the determination of death as the absence of vital functions, and these functions were still operational, even though mediated by life support systems.

Pressure built up to work through both the conceptual issues and the practical problems by altering the definition of death. The term *clinical death* had some value. Usually this term referred to the cessation of cardiac function, as might occur during a medical procedure or a heart attack. A physician could make this determination quickly and then try CPR or other techniques in an effort to restore cardiac function. "Clinical death" was therefore a useful term because it acknowledged that one of the basic criteria for determining death applied to the situation, yet it did not stand in the way of resuscitation efforts. This concept had its drawbacks, though. Many health care professionals as well as members of the general public were not ready to accept the idea of a temporary death, which seemed like a contradiction in terms. Furthermore, clinical death had no firm standing in legal tradition or legislative action. Nevertheless, this term opened the way for more vigorous attempts to take the definition of death apart and put it back together again.

Meanwhile, another approach was becoming of increasing interest within the realm of experimental biology. Some researchers were focusing on the development and death of small biological units, especially the individual cell within a larger organism. The relationship between the fate of the cell and that of the larger organism was of particular interest. Soon it became clear that death as well as development is programmed into the cell. Furthermore, programmed cell death proved to be regulated by signals from other cells. Although much still remains to be understood, it had become apparent that a comprehensive definition of death would have to include basic processes of living and dying that are inherent in cells, tissues, and organs as well as the larger organism. It has also provided further illumination of the lower-level life processes that continue after the larger organism has died. The person may be dead, but not all life has ceased. The cellular approach has still not drawn much attention from physicians and policy makers, but it has added to the difficulty of arriving at a new consensual definition of death. How many and what kind of life processes can continue to exist and still make it credible to say that death has occurred? This question has not been firmly answered as such, but was raised to a new level with the successful introduction of still another concept: brain death.

Technological advances in monitoring the electrical activity of the brain made it possible to propose brain death as a credible concept, and it quickly found employment in attempting to limit the number and duration of persistent vegetative states while improving the opportunities for organ transplantation. The electrical activity of the brain would quickly become a crucial element in the emerging redefinition of death.

A survey was conducted of patients who showed no electrical activity in their brains as measured by electroencephalograms. Only three of the 1,665 patients recovered cerebral function—and all three had been in a drug-induced coma. This finding led researchers to recommend that electrocerebral inactivity should be regarded as a state of nonreversible coma. Researchers suggested that this core determinant should also be supported by other types of observations, including inability to maintain circulation without external support and complete unresponsiveness. Researchers would later recommend that a distinction should be made between "coma" and "brain death." There are several levels of coma and a variety of possible causes; brain death refers to a state of such severe and irreparable damage that no mental functioning exists or can return.

The breakthrough for the new concept occurred in 1968 when an Ad Hoc Committee of the Harvard Medical School proposed that the nonreversible loss of brain should be the reigning definition of death. More traditional signs were still included. The person was dead if unresponsive, even to ordinarily painful stimuli, showed no movements and no breathing, as well as none of the reflexes that are usually included in a neurological examination. There were two new criteria, however, that were not measured in the past: a flat reading on the electroencephalogram (EEG) and lack of blood circulation in the brain. "The Harvard criteria," as they were known, soon became the dominant approach to defining death.

Subsequent studies have generally supported the reliability of the criteria proposed by the Harvard Medical School committee. The new definition of death won acceptance by the American Medical Association, the American Bar Association, and other influential organizations. A 1981 president's commission took the support to an even higher level, incorporating the concept into a new

Uniform Determination of Death Act with nationwide application. The basic Harvard Committee recommendations were accepted. However, some important specifications and cautions were emphasized. It was noted that errors in certification of death are possible if the patient has undergone hypothermia (extreme cold), drug or metabolic intoxication, or circulatory shock—conditions that can occur during some medical procedures and could result in a suspension of life processes that is not necessarily permanent. Furthermore, the status of children under the age of five years, especially the very young, requires special attention. (Task forces focusing on reliable examination of young children were established a few years later and introduced guidelines for that purpose.)

The most significant position advanced by the president's commission dealt with a question that as of 2002 is still the subject of controversy: whole-brain versus cerebral death. In the early 1980s there was already intense argument about the type and extent of brain damage that should be the basis for definition of death. The commission endorsed the more conservative position: The person is not dead until *all* brain functioning has ceased. This position takes into account the fact that some vital functions might still be present or potentially capable of restoration even when the higher centers of the brain (known as cerebral or cortical) have been destroyed. Death therefore should not be ruled unless there has been nonreversible destruction in the brain stem (responsible for respiration, homeostasis and other basic functions) as well as the higher centers. Others make the argument that the *person* is lost permanently when cerebral functions have ceased. There might still be electrical activity in the brain stem, but intellect, memory, and personality have perished. The death of the person should be the primary consideration and it would be pointless, therefore, to maintain a persistent vegetative state in a life support system.

Future Redefinitions of Death

The process of redefining death is not likely to come to a complete halt within the foreseeable future. Innovations in technology contributed much to the ongoing discussion. The EEG made it possible to monitor electrical activity in comatose patients and its application opened the way for the concept of brain death. Advances in life support

systems made it possible to maintain the vital functions of people with severely impaired or absent mental functioning—raising questions about the ethics and desirability of such interventions. Organ transplantation became a high visibility enterprise that is often accompanied by tension and frustration in the effort to match demand with supply.

Further advances in technology and treatment modalities and changes in socioeconomic forces can be expected to incite continuing efforts to redefine death. More powerful and refined techniques, for example, may provide significant new ways of monitoring severely impaired patients and this, in turn, might suggest concepts that go beyond current ideas of brain death. A simpler and less expensive method of providing life support could also reshape working definitions of death because it would lessen the economic pressure. Organ transplantation might be replaced by materials developed through gene technology, thereby reducing the pressure to employ a definition of death that allows for an earlier access to organs. Changes in religious belief and feeling might also continue to influence the definition of death. For example, the current biomedical control over death might face a challenge from widespread and intensified belief that all other considerations are secondary to the separation of soul from body. Cybernetic fantasies about virtual life and death might remain fantasies—but it could also be that the most remarkable redefinitions are yet to come.

See also: BRAIN DEATH; CELL DEATH; CRYONIC SUSPENSION; MIND-BODY PROBLEM; ORGAN DONATION AND TRANSPLANTATION

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ROBERT KASTENBAUM

DEHUMANIZATION

Dehumanization is the process of stripping away human qualities, such as denying others their individuality and self-esteem. With the rapid increase in medical technology many basic human qualities surrounding the care of the dying have been lost. Dehumanization is like a form of self-death that now often precedes physiological death owing to the institutionalization of the dying. For millennia the process of dying and the presence of death

were both close and familiar realities of everyday life. Many people died in the bed they were born in, surrounded by their family and friends. Called "tame death" by the French philosopher and death expert Philippe Ariès, it was natural, expected, and integrated into the rhythms of life. The Russian novelist Leo Tolstoy, in his epic work *War and Peace* (1869), comments that when a relative is sick the custom is to seek professional care for him or her, but when a loved one is dying the custom is to send the professionals away and care for the dying within the family unit. The naturalness to dying that Tolstoy describes has undergone a radical shift in the modern era.

The history of medicine was originally the art of personal caring and compassion. Since the Enlightenment, what was originally an art has become more clearly a science. In the twenty-first century the science of medicine focuses on curing disease and thus views death as a defeat. It is no longer natural or tame, but fearsome and strange. Increasingly it is the disease and not the individual being treated. The equally rapid development of medical technology has blurred the border between life and death. Life-sustaining machines have initiated new definitions of death, such as "brain death," into the medical lexicon. Medicine has become an increasingly technological profession. This has led to the modern phenomenon of dying when the machines are shut off or what the philosopher Ivan Illich calls "mechanical death." Illich states that mechanical and technical death have won a victory over natural death in the West.

H. Jack Geiger notes that the dehumanizing aspects of health care mainly deal with the loss or diminishment of four basic human qualities: the inherent worth in being human, the uniqueness of the individual, the freedom to act and the ability to make decisions, and the equality of status. While all people are worthy of the same care and attention from health care services, people instead receive it according to their social and economic status. Basic human services and all aspects of the health care are distributed unequally throughout society depending on economic and political power and status. This implicit loss of human worth is especially dehumanizing for the poor and marginalized in society.

The medicalization of the dying process, enhanced by increasing technology, has resulted in

increased isolation and dehumanization of the dying. People are surrounded by machines in intensive care units rather than by their families at home, and often people are treated as objects without feeling. The scholar Jan Howard notes this often occurs with acute care patients who are seen not as unique individuals but as extensions of the life-sustaining machines they are attached to at the end of their lives. Dehumanization of the dying acts to lessen the impact of death for survivors in a death-denying culture.

These trends are reinforced by advances in technology and by larger and more impersonal systems of health care that have developed. What has become known as the “tyranny of technology” has forced those involved in health care to become more technologically sophisticated. This in turn has led to an increased sense of professionalism and specialization within all aspects of medicine. Such professionalism has been characterized by a growing detachment from the unique concerns of individual patients and a loss of personal relationship to them. Physicians and other health care workers now react less as individuals in relationship to other individuals and more as representatives of their professions and their health care organizations. This results in a loss of autonomy and decision-making ability on the part of the patients and sometimes of their families as well. The policies and procedures of insurance companies and health maintenance organizations (HMOs) determine many critical health issues facing people in the twenty-first century. This loss of freedom is yet another dehumanizing effect of modern technology.

The advances in the scientific and technical aspects of medicine have increasingly made people dependent on strangers for the most crucial and intimate moments of their lives. Health care professionals and health care organizations have become more impersonal and bureaucratic. There is an obvious inequality of status between those in need of medical care and those whose profession it is to respond to that need. This inequality coupled with the impersonal quality of care they are offered leads to mistrust and a feeling of dehumanization.

The rise of hospice organizations, holistic medicine curricula in medical schools, and in-service programs in hospitals has attempted to address these dehumanizing aspects of modern medicine. Dying is one of the most personal and intimate

times in a person’s life. At that time, more than any other perhaps, people need their inherent worth valued, their uniqueness affirmed, and their ability to make decisions honored by those who care for them.

See also: DYING, PROCESS OF; WAR

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THOMAS B. WEST

DEMOGRAPHICS AND STATISTICS

Julius Richmond, the former Surgeon General of the United States, is purported to have said, “Statistics are people with their tears wiped dry” (Cohen 2000, p. 1367). While it is true that statistics, and quantitative data more generally, have a “dry face” to them, they have important uses in research and public policy. Statistical and demographic data are not meant to provide understanding on the felt circumstances of individuals. By their very nature these data deal with social aggregates.

Although people think that quantitative data give an objective portrayal of a phenomenon (the facts), this is not correct. What researchers choose to be measured and the methods they employ reflect the biases and values of those who collect data. Mortality data are almost always collected by

official or government agencies; thus to greater or lesser degree they reflect their perspectives. However, some measures of mortality, in particular causes of death, have been “internationalized” by such bodies as the World Health Organization and therefore reflect a consensus, albeit a Western-based one. In addition, some developing countries do not have the resources to acquire very much data on demographic events such as deaths; if they did have the available resources, it is not known what kind of information they might collect.

What is chosen to be measured and how it is measured is only part of the bias in quantitative data, however. How data are interpreted is also subject to bias and value judgments, clearly seen, for example, in the debate about the factors leading to maternal deaths and how to reduce maternal mortality.

Apart from biases, users of quantitative data on deaths need to be aware of a number of limitations. A large limitation, globally, is simply lack of information. Many statistics are estimates only. Another limitation concerns lack of knowledge regarding how statistics are calculated, which can lead to misinterpretations. A good example of this is with statistics on life expectancy which, although hypothetical, are not always interpreted as such.

Statistical data provide important information that is useful for a number of purposes, despite their limitations, problems with bias, and an inability to convey individual experiential phenomena. Scientists and researchers need to know how many people are dying and at what ages, of what gender, and for what reasons, in order to know how to target resources to reduce those deaths. Unlike the case with other demographic topics such as fertility and migration, there is worldwide consensus that reducing deaths is a worthwhile goal; thus statistical data on mortality can be corroboratively used in attempts to reach that goal. Data provide the raw materials needed for plans to be made (and implemented) aimed at enhancing the well-being of persons and tackling social inequalities in the risk of death.

See also: CAUSES OF DEATH; MORTALITY, INFANT

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DISASTERS

Disasters are stressful life situations that result in great terror, property damage, physical harm, and often death. Calamity and catastrophe, synonymous terms for these traumatic events, often involve extreme forces of nature like earthquakes, fires, floods, hurricanes, and tornadoes. Sometimes, though, people's behavior is the causal factor behind a disaster, or is contributory to higher losses of property and lives from events that were clearly avoidable. This happens through human error (a pilot's engineering mistake in an airplane crash), human carelessness and indifference (lax building practices), and intentional acts of cruelty and violence by some individuals against others (incidents of terrorism). Whatever the cause, disaster victims must struggle to resolve their losses and rebuild their lives, a process that generally takes longer than anyone initially imagines.

Natural Disasters

Devastating acts of nature have led to some of the world's most memorable disasters. Earth, air (wind), fire, and water, the original four elements named by the noted Greek philosopher Empedocles, are key ingredients in the recipe for many disasters. For instance, storms often bring a combination of damaging winds, flooding rains, and lightning that sparks fires. Disturbances within the earth's crust can trigger eruption of volcanoes, the severe ground cracking and shaking of earthquakes, and the flowing walls of water that become damaging tidal waves.

Cyclones and anticyclones. Cyclones are large, swirling windstorms. Though people sometimes refer to tornadoes as cyclones, meteorologists generally consider cyclones to be much larger systems

with lower air pressure at their center than is present outside the weather system. Anticyclones have the opposite trait in that the air pressure at their center is higher than is present outside the system. The airflow also differs, with cyclones turning counterclockwise in the northern hemisphere and clockwise in the southern hemisphere and anticyclones doing the opposite.

When these storms occur in the tropics they are known as tropical depressions and, in addition to the wind, they often have associated heavy rains. If the storms grow to a point that they reach certain sustained wind speeds, they will be classified as hurricanes or typhoons.

East Pakistan was hit by the world's worst cyclone in November 1970—200,000 people died and 100,000 others were missing from the storm and a related tidal wave. Southeastern Bangladesh lost 131,000 people (and millions of others died later due to storm-related hunger and disease) following an April 1991 cyclone.

Earthquakes. Rock formations sometimes shift within the earth's crust, a phenomena scientists refer to as plate tectonics. As the rock plates slide along fault lines (veins between the formations along which the shifting occurs), the resulting vibrations sometimes cause violent shaking of the ground. This surface activity may set off landslides, tidal waves on lakes or oceans, and volcanic eruptions. Taken together, these forces often result in building collapses and other damage to infrastructure (roads, bridges, dams, electrical power transmission lines, natural gas pipelines, etc.) that, in turn, injures or kills many people in the affected area. Even after the initial shaking ends, aftershocks may cause additional damage and continue to frighten residents of the area.

Shaanxi, China, suffered one of the worst earthquake losses in history with 830,000 deaths from a quake that occurred in 1556. San Francisco's 1906 earthquake took 500 lives and touched off a spectacular fire that consumed four square miles of the city. Most memorable to many readers, though, is the more recent San Francisco area quake that occurred on October 17, 1989, as many baseball fans around the world were settling in to watch a World Series game on television. That one killed 67 people and caused billions of dollars in damage. Other countries tend to suffer far more serious loss of lives than the United States due to a

combination of high population density in cities with infrastructures not built to withstand the ravages of an earthquake.

Floods. Whenever unusually large amounts of water fall on dry land, or when water from oceans, lakes, rivers, and streams overflows onto dry land, the damaging result is flooding. Many people first learn that rushing water can easily cause extreme property damage and death by hearing the Old Testament story of Noah saving pairs of animals from the great deluge of forty days and nights of rain.

The worst recorded loss of life from flooding occurred in Kaifeng, China, in 1642. War was raging and rebel forces destroyed a protective seawall, resulting in the loss of 300,000 lives. The worst flood in the United States came as a result of a tidal surge that accompanied the September 8, 1900, Galveston Hurricane (Galveston, Texas) that took 6,000 to 8,000 lives. Another notable flood—the Johnstown, Pennsylvania, flood—occurred on May 31, 1889, causing 2,209 deaths. Heavy rains caused the Lake Conemaugh Reservoir dam to fail, allowing a devastating wall of water to slam the city. Debris from damaged property added to the losses when it jammed at a bridge in the downtown area that then caught fire.

In 1993 the midwestern United States was devastated by summer-long flooding. Torrential rains caused rivers and streams to wash over their banks and damage thousands of homes and businesses. Although there were only 46 deaths attributed to the flooding, the region suffered millions of dollars in financial losses. Farming was totally disrupted, as everyone waited for the water to recede and the fields to dry out. Adding to the misery was the fact that many caskets surfaced and washed away from cemeteries located next to waterways that were out of control, reopening emotional wounds and complicating bereavement for many flood victims. All of this led to a great sense of collective solidarity, as people throughout the country assisted in a mammoth relief effort.

Hurricanes and typhoons. The terms hurricane and typhoon come from words that mean “big wind” (the West Indian word *huracan*) and “great wind” (the Chinese word *taifun*). As large tropical storms reach and sustain maximum wind speeds of at least 75 miles per hour, they officially become hurricanes (if occurring in the Atlantic Ocean or the eastern Pacific) or typhoons (if occurring in the

western Pacific). Some of the worst storms are able to reach wind speeds in excess of 180 miles per hour and drop over 10 inches of rain in one day. Oddly, at the center of these storms is a calm area known as the eye of the storm that has relatively light winds and blue sky overhead.

Summertime is hurricane season for the United States and many nearby islands. The worst loss of lives in the Western Hemisphere came when 20,000 to 22,000 people died in Barbados, the West Indies, Martinique, and St. Eustatius, as a result of the Great Hurricane of 1780. Since 1953 storms have received names from the National Weather Service. A storm named Hurricane Mitch (October 1998), killed 11,000 people in Central America, left 2 to 3 million people homeless, and caused \$5 billion in damage. Hurricane Andrew (August 1992) killed only 14 people when it ravaged southern Florida and the Gulf Coast, but it was the nation's most costly hurricane, causing \$15 to \$20 billion in damage. In some communities family residences sustained excessive damage because zoning rules had been ignored and the homes were not structurally able to withstand the easily foreseeable winds in that hurricane-prone area.

In September 1906, 10,000 lives were lost when a typhoon with a tsunami (tidal wave) struck Hong Kong. Typhoon Vera (September 1959) caused 4,464 deaths in Honshu, Japan. Thelma (November 1991) took 3,000 lives in the Philippines. Several thousand fishermen died in December 1949, when a typhoon caught Korea's fishing fleet in an offshore location.

Tornadoes. People often refer to tornadoes as "twisters" and know them as the tightly spiraling funnels of wind and debris that can destroy anything in their path. If they pass over water, they may form a waterspout, but generally waterspouts are less serious weather phenomena that can happen even when no storm is present. For many people who do not live in tornado-prone areas, the first knowledge of these devastating weather events often comes through media coverage or from movies. For instance, a famous big-screen twister carries a Kansas farmhouse to a mystical land on the other side of the rainbow in the classic 1939 film *The Wizard of Oz*.

Tornadoes are often spawned during severe thunderstorms, as cold weather fronts clash with



A trench holds coffins of the unidentified victims of Hurricane Audrey, which hit the coast of Louisiana in June 1957, killing an estimated 400 people. CORBIS

warm air systems ahead of them. They are classified on a scale known as the Fujita-Pearson scale that considers the touchdown path's length and width along with the maximum wind speed. Estimated speeds of 500 miles per hour are considered possible with the nastiest storms.

The worst single tornado event in U.S. history occurred on March 18, 1925, when Missouri, Illinois, and Indiana's Tri-State Tornado left 689 people dead and injured over 2,000. In March 1952 a two-day, six-state outbreak killed 343 people in Alabama, Arkansas, Kentucky, Missouri, Mississippi, and Tennessee. Another two-day event known as the Super Tornado Outbreak (April 1974) involved 146 twisters in 13 states. When it was all over, 330 people were dead and 5,484 were injured—the most in U.S. history.

Tsunamis. Ground-changing and ground-shaking events like earthquakes, volcanic eruptions, and

landslides sometimes generate large water waves known as tsunamis. This is especially common when the event occurs under the sea. Tsunamis are most common in the Pacific Ocean due to the frequency of seismic activity there. In 1883 an eruption of the Krakatoa volcano created a 120-foot wave that killed over 36,000 people in neighboring Papua New Guinea. That island is clearly prone to tsunamis. In 1998 three smaller waves killed over 2,000 people.

Volcanoes. Hot gas and lava (molten rock) sometimes explosively vent from deep inside the earth. The venting comes in the form of volcanic eruptions that push the ground upward, forming hills and mountains as they spew the magma (liquid, rock fragments, and gases) from openings at their tops. In the 1883 eruption of the Krakatoa volcano, the explosion could be heard 3,000 miles away and volcanic dust circled the earth.

In November 1985 the Colombian towns of Armero and Chinchina lost 25,000 persons during an eruption of Nevada de Ruiz. Italy's Mt. Vesuvius erupted in 79 C.E., killing thousands when it buried the cities of Herculaneum and Pompeii. The United States has also known active volcanoes. Washington State's Mt. St. Helens, for example, erupted in May 1980, killing 60 people along with countless animals, and damaging trees over a 500-kilometer area. The large island of Hawaii has Kiluea, which has become a tourist attraction thanks to an ongoing flow of lava. The Caribbean island of Montserrat also still has an active volcano, Soufriere Hills. During the summer of 1997 its eruption killed 20 people and left two-thirds of the island uninhabitable.

More extreme phenomena. Other extremes of nature also take their toll in property damage and lost lives. The central and eastern United States experienced a heat wave during the summer of 1980 that took 10,000 lives and caused \$20 billion in damage. The Blizzard of 1988 pummeled the East Coast with snow for three days, leaving 400 dead and \$20 million in damage from the 5 feet of snow it dropped in many areas. Another more recent blizzard, the March 1993 Storm of the Century, left 270 people dead and caused \$3 to \$6 billion in damage.

Drought is another weather extreme. In addition to obvious water shortages, a lack of precipitation can lead to crop damage or loss and then

unemployment among those who work in agriculture-related fields. The longest drought in U.S. history came in the 1930s, when many areas of the country were suffering through the Great Dust Bowl. John Steinbeck's novel *The Grapes of Wrath* (1939) details the struggles that farmers commonly faced during those very difficult times.

Human Complicity in Disasters

Many disasters have other than natural roots. The interplay of humans and machines sometimes results in accidents. Faulty design and/or engineering, unsafe building practices, and ignorance of safety procedures all cause many unnecessary injuries and deaths. Worse yet, people will sometimes intentionally cause a disaster in an effort to scare, control, and/or inflict harm on others.

Aircraft incidents. On March 27, 1977, a Pan Am 747 and a KLM 747 collided on an airport runway in the Canary Islands, resulting in the worst aircraft disaster in history. There were 582 deaths—all 249 on KLM and 333 of the 394 aboard Pan Am. The worst single plane incident occurred on April 12, 1985, when a Japan Air 747 crashed into a mountain in Japan—520 of the 524 passengers died. The loss of another jumbo jet, an Iran Air A300 Airbus on July 3, 1988, killed 290 people. Human error was the cause: While operating in the Persian Gulf, the U.S. Navy mistakenly identified the plane as an attacking enemy jet and shot it down.

Perhaps the most spectacular aviation disaster ever recorded on radio and film was the May 6, 1937, crash of the *Hindenburg*, a German zeppelin (passenger blimp). The incident happened as the blimp was about to moor at a docking mast on an airfield at the Naval Air Station in Lakehurst, New Jersey. Something sparked an explosion and fire that brought the flaming ship down. In a mere matter of seconds, thirty-six people died and many others suffered burns and other injuries. The radio commentator Herbert Morrison described the incident to a stunned audience. His most memorable and quoted line was "Oh, the humanity, and all the passengers screaming around here!"

Buildings and construction. Injuries and deaths often result from accidents involving structural failures. On March 12, 1928, the St. Francis Dam in Santa Paula, California, collapsed, killing 450 people. On June 29, 1995, the Sampoong Department

Store in Seoul, Korea, collapsed, leaving 206 people dead and 910 injured. On July 18, 1981, a skywalk collapsed during a dance being held at the Hyatt Regency Hotel in Kansas City, Missouri, killing 118 people and injuring 186. This event led to helpers offering well-documented emotional support for survivors and the family members of those lost. So did the November 17, 1999, deaths of 12 students from Texas A&M University in College Station, Texas. They were killed when a log pile structure that they were building for an annual pre-football game bonfire collapsed.

Ecological and environmental incidents. During the January 1991 Persian Gulf War, Iran intentionally spilled over 460 million gallons of crude oil into the Persian Gulf. It also dynamited and set ablaze 650 oil wells in Kuwait, making this the world's worst intentionally caused environmental disaster. On June 3, 1979, the Ixtoc 1 oil well in the Gulf of Mexico experienced an estimated spill of 140 million gallons of crude oil—the largest spill ever. Fortunately there was very low impact on the environment. On March 16, 1978, the *Amaco Cadiz* supertanker spilled 68 million gallons of crude oil off Portsall, France, damaging over 100 miles of coastline, making it the largest tanker spill in history. The worst U.S. event was the March 24, 1989, spill of over 10,000 gallons of crude oil in Prince William Sound, Alaska, by the *Exxon Valdez* supertanker. Wildlife suffers the most when these ecocatastrophes happen.

Explosions. Coal mine explosions around the world have taken many lives. Some examples include Courriæes, France (March 10, 1906), with 1,060 deaths; Omuta, Japan (November 9, 1963), with 447 deaths; Coalbrook, South Africa (January 21, 1960), with 437 deaths; Wankle, Rhodesia (June 6, 1972), with 427 deaths; and Bihar, India (May 28, 1965), with 375 deaths. The worst explosion in the United States occurred on May 1, 1900, in Scofield, Utah, when blasting powder ignited and killed 200 people.

Fires. A waterfront fire in Chongqing, China, took 1,700 lives on September 2, 1949, making it history's worst fire. The worst fire in U.S. history occurred on December 30, 1903, at the Iroquois Theater in Chicago, Illinois, where 602 people died.

Much more widely known, however, is the November 28, 1942, fire at the Coconut Grove

Nightclub in Boston, Massachusetts. That fire caused 491 deaths among a group of patrons that was heavily comprised of members of the military and their dates for the evening. Most notable there was the fact that many survivors were interviewed and helped by mental health professionals from a nearby hospital in what may have been the first documented use of disaster mental health techniques. Another major U.S. fire was the Chicago Fire of October 8, 1871, during which 50 people lost their lives and 17,450 buildings were burned. The damage estimate for that fire was \$196 million.

Industrial and nuclear accidents. On December 3, 1984, a toxic gas leak occurred at the Union Carbide plant in Bhopal, India, resulting in over 2,000 deaths and 150,000 injuries. The world's worst release of radiation was on April 26, 1986, when an accident occurred at the Chernobyl Nuclear Plant in Kiev in the former Soviet Union. The official death toll was 31, but estimates calculate that thousands may have died. When a partial meltdown occurred in the reactor at the Three Mile Island Nuclear Plant in Harrisburg, Pennsylvania, on March 28, 1979, no lives were lost. Nevertheless, there was a major, negative, and lasting psychological impact on residents of the area.

Shipwrecks. Two of the worst losses of lives in passenger shipping occurred in China during 1948. In November, a troop carrier sank with an estimated 6,000 people onboard. Then, the following month, about 3,000 refugees were lost when their ship sank. On December 12, 1987, the ferry *Dona Paz* collided with an oil tanker off the coast of Manila—over 4,000 people died. On December 12, 1917, a steam ship collided with the ammunition ship *Mont Blanc* in Halifax Harbor, Nova Scotia, and 1,600 people died as a result of the explosion that followed.

In the United States, the worst event occurred on April 27, 1865, when the *Sultana*, a Mississippi River steamboat carrying Union soldiers home from two infamous Confederate prison camps at the end of the Civil War, suffered an explosion in its boiler—1,547 people were killed. Another major shipping accident happened on April 16, 1947, in Texas City, when the *Grand Camp* caught fire. A large crowd formed to watch firefighters battle the blaze and no one realized that the ship's cargo was highly explosive ammonium nitrate fertilizer. When

it blew up, 600 people were killed by a combination of the shock waves, a small tidal wave, and several other resulting fires.

On April 15, 1912, one of the most famous accidents in shipping occurred when the British ocean liner *Titanic* sank after hitting an iceberg on its maiden, transatlantic voyage; over 1,500 people died. Three years later, another famous liner, the *Lusitania*, was sunk by a German submarine near the coast of Ireland. The deaths of 1,198 people there helped draw the United States into World War I. When the battleship *Arizona* and the rest of the Pacific fleet in Pearl Harbor, Hawaii, was bombed on December 12, 1942, 1,177 were killed, making it the worst loss in U.S. naval history.

There is also the July 25, 1956, collision of two ocean liners—the *Andrea Doria* and the *Stockholm*—off Nantucket, Massachusetts. This accident, in which 52 people died, is another disaster that produced early, well-documented emotional support for survivors.

Space exploration. Efforts to travel in space have resulted in their share of tragedies. On March 18, 1980, a Vostok rocket exploded during refueling at the Plesetsk Space Center in the former Soviet Union; 50 people were killed. The U.S. Space Shuttle program experienced its worst disaster on January 28, 1986, when the *Challenger* craft exploded in the air shortly after liftoff. A booster rocket fuel leak caused the explosion and fire that killed seven astronauts to their deaths just off Cape Kennedy, Florida. Many Americans, including most schoolchildren, watched the accident on live TV because Christa McAuliffe, America's first teacher in space, was aboard. Another tragedy for the United States was the *Apollo 1* fire on January 27, 1967. Three astronauts died at Cape Kennedy when an accidental fire erupted in their space ship during a routine launch pad practice exercise.

Sports. Disasters can happen anywhere, even at recreational events. On October 20, 1982, 340 soccer fans died in a sudden crush of people all moving about at the end of a match in Moscow's Lenin Stadium. Similar problems happened at a Peru versus Argentina soccer match in Lima, Peru, on May 24, 1964, when rioting occurred after a disputed call by a referee; over 300 people died and 500 were injured. In Sincelejo, Colombia, 222 people died on January 20, 1980, when the bleachers collapsed at the town's bullring.

Terrorism. Terrorism is the use of violence in an attempt to intimidate, control, and/or punish others in hopes of advancing a political agenda. On December 12, 1988, a terrorist bomb brought down a Pan-Am flight bound for New York City. The Boeing 747 crashed in Lockerbie, Scotland, killing all 259 passengers and 11 people on the ground. Two U.S. embassy bombings occurred on August 7, 1998, killing 243 people in Nairobi, Kenya, and 10 people in Dar Es Salaam, Tanzania; there were also 1,000 other people injured in these attacks.

The worst acts of terrorism on American soil came on September 11, 2001, when a coordinated group of terrorists commandeered four large commercial passenger jets and turned them into weapons of mass destruction. They crashed two of them into the twin towers of New York City's World Trade Center, causing both to collapse. They crashed the third plane into the Pentagon in Washington, D.C. Heroic passengers on the fourth plane had gotten word of the other hijacked planes and took action that resulted in the crash of their plane in a field in western Pennsylvania. This crash was far from any intended terrorist target, although the White House was the suspected objective. Although initial estimates of those lost were 6,000 people (or more), the current death toll from these four crashes is estimated to have been closer to 3,200 people.

Another major U.S. terrorist event was the April 19, 1995, truck bombing of the Federal Building in Oklahoma City, Oklahoma. The blast killed 168 people, including 19 children from a daycare center located in the building. In all, 221 buildings sustained damage. There had also been an earlier attack on New York's World Trade Center complex—a bombing on February 26, 1993, that resulted in 6 deaths and 1,040 injuries. Lessons learned in that attack helped save many lives during the September 11, 2001, tragedy.

Terrorism has also taken the form of product tampering. In September 1982 someone laced the pain medication Tylenol with cyanide poison and placed the packages in circulation in the Chicago area, leading to 7 deaths. That incident and other copycat behavior led drug manufacturers to place safety seals on each package. Similar seals quickly became standard on many other consumable foods and beverages.

Behavior and Psychological Changes in Victims

People are almost always changed by their disaster experiences, but they need not be damaged by those experiences. Victims and relief workers who have been traumatized generally will not stop functioning, but they will react in fairly predictable ways (with some differences due to age and level of maturity). By using various crisis intervention techniques, the victims and relief workers can be triaged, briefly counseled (or referred for formal services, if needed), and returned to predisaster levels of functioning as quickly as possible.

Persons and communities struck by disaster will often experience four distinct phases of response to the disaster. First, there is a *heroic phase* that may even begin prior to impact and that can last up to a week afterward. During this phase people struggle to prevent loss of lives and to minimize property damage. This phase is followed by the *honeymoon phase*, which may last from two weeks to two months. During this phase, massive relief efforts lift spirits of survivors, and hopes for a quick recovery run high. Sadly, for most people this optimism is often short-lived and, all too soon, the *disillusionment phase* begins. This phase may last from several months to a year or more. Social scientists sometimes call it the second disaster, as it is the time when the realities of bureaucratic paperwork and recovery delays set in. Outside help has often come and gone and people realize that they must do more themselves. Eventually, the *reconstruction phase* begins. This phase may take several years as normal functioning is gradually reestablished.

There are many more specific changes that people may experience. Disasters can cause behavioral changes and regression in children. Many react with fear and show clear signs of anxiety about recurrence of the disaster event(s). Sleep disturbances are very common among children and adults and can best be handled by quickly returning to or establishing a familiar bedtime routine. Similarly, school avoidance may occur, leading to development of school phobias if children are not quickly returned to their normal routine of school attendance.

Adults often report mild symptoms of depression and anxiety. They can feel haunted by visual

memories of the event. They may experience psychosomatic illnesses. Pre-existing physical problems such as heart trouble, diabetes, and ulcers may worsen in response to the increased level of stress. They may show anger, mood swings, suspicion, irritability, and/or apathy. Changes in appetite and sleep patterns are quite common. Adults, too, may have a period of poor performance at work or school and they may undergo some social withdrawal.

Middle-aged adults, in particular, may experience additional stress if they lose the security of their planned (and possibly paid-off) retirement home or financial nest egg, and/or if they are forced to pay for extensive rebuilding. Older adults will greatly miss their daily routines and will suffer strong feelings of loss from missing friends and loved ones. They may also suffer feelings of significant loss from the absence of their home or apartment, or its sentimental objects (paintings, antiques, Bibles and other spiritual items, scriptures, photo albums, and films or videotapes), which tied them to their past.

Timing of the onset of these changes varies with each person, as does duration. Some symptoms occur immediately, while others may not show until weeks later. Just about all of these things are considered normal reactions, as long as they do not last more than several weeks to a few months. The one commonality among disaster victims is that most everyone will be changed in some way by the experience, often marking time differently in its wake (speaking of what life has been like since the traumatic event).

The personal impact of disasters tends to be much worse whenever the disaster events are caused by intentionally destructive human acts than by natural causes (or pure accidents). Whenever inhumanity plays a major role in causality, survivors seem to need extra time to resolve their losses and move forward with their lives. This relates directly to the greater amount of anger involved, overexposure from repetitive media coverage, and the fact that any true sense of closure may not come until the perpetrators are found and prosecuted.

When disasters happen, the public demands answers and action. Mitigation efforts will often initiate social changes designed to prevent reoccurrences. Natural disasters prompt research to

improve early warning systems and enforce sturdier construction methods. Transportation accidents trigger investigations that lead to new safety regulations, improved operating procedures, and the redesign of problematic equipment. Acts of terrorism stimulate public debate over curtailment and/or abridgement of civil liberties, often resulting in legislative remedies and, in some cases, retaliatory military action.

Disaster Mental Health

Disaster mental health (DMH) is an expanding field of crisis intervention that addresses several aspects of traumatology, affecting both victims and relief workers who have experienced natural or human-caused disasters. Crisis workers strive to help people recognize, understand, and accept some of the common changes that often occur in the days, months, and years following any traumatic disaster event(s). The goal of DMH intervention is to help assure that the victims (and helpers) become survivors by doing whatever can be done to prevent long-term, negative consequences of the psychological trauma such as the development of posttraumatic stress disorder.

DMH work involves extensive use of outreach skills and simple approaches, including offering informal greetings, providing snacks/drinks, doing brief, supportive defusing interviews, to help people begin problem solving. For many people, DMH work also involves grief counseling to assist survivors as they begin to mourn their losses. For those who have experienced severe psychological trauma, formal debriefing interviews are the preferred method to begin helping people let go of the pain, face their losses, and prepare to begin moving forward with their lives.

Defusing and debriefing are two of the primary tools used in providing help. Both involve offering individuals or groups of people opportunities to talk things out in a safe and supportive atmosphere. Both are voluntary offerings made to those who are ready and willing to tell their upsetting disaster stories and learn ways to cope with the residual stress.

Defusing is the term given to the initial process during which DMH workers begin helping traumatized people talk things out. It works like taking the fuse out of a bomb (or an explosive situation), by allowing victims and workers the opportunity to

ventilate about their disaster-related memories, stresses, losses, and methods of coping in a safe and supportive atmosphere. The defusing process usually involves informal and impromptu sessions that help release thoughts, feelings, and fears which might not otherwise be appropriately expressed.

Debriefing is longer and more formally structured interview process that has grown from the researcher Jeff Mitchell's 1983 Critical Incident Stress Debriefing (CISD) model. The CISD model was designed for use with first responders (including police, firefighters, and emergency medical technicians), to help them overcome the emotional aftereffects of critical incidents (line-of-duty deaths). Sessions were usually held within the first twenty-four to seventy-two hours after the traumatic event, with follow-up sessions as needed. Given the nature of disasters, it is not always possible to identify all of the victims that quickly. Fortunately, the debriefing process is still beneficial, even when the sessions are held long after the event.

Disaster Preparedness and Disaster Relief

Local, state, and federal government officials play a major role in both disaster preparedness and disaster relief. The Federal Emergency Management Agency (FEMA) is an independent agency of the federal government that reports directly to the president. Since it was founded in 1979, FEMA workers have coordinated both the nation's planning for disasters and the mitigation efforts that are needed once they occur. States and most local communities also have emergency management agencies that take responsibility for coordinating disaster preparedness and relief efforts in their areas.

Providing relief services since 1881, the American Red Cross (ARC) has been chartered by the U.S. Congress to provide disaster relief services and it is the best group to call for initial advice about preparedness and emergency assistance. ARC workers, many of whom are volunteers, provide predisaster education programs, as well as postdisaster damage assessment, mass care sheltering and feeding, health services, and emergency assistance to families. By offering support and replacing some lost items (clothing, food, and health care items), relief efforts jump-start the recovery process.

Since 1989 ARC has taken the lead in recruiting and training volunteers to serve on DMH service teams whenever and wherever their services may be needed. The American Psychological Association, the American Counseling Association, the National Association of Social Workers, the American Psychiatric Association, the American Association of Marriage and Family Therapists, several professional nursing organizations, and many other such groups help supply the needed workers.

ARC is just one of over twenty relief organizations that work together as members of local, state, and national relief efforts, including the nationally run National Volunteer Organizations Active in Disaster (NVOAD). Each local Volunteer Organization Active in Disaster (VOAD) organization has its own area(s) of specialization, including feeding, sheltering, child care, ham radio communication, and construction/repair. Representatives of VOAD member organizations hold regular meetings to facilitate planning efforts and the sharing of resources.

Relief workers often put in twelve- to fourteen-hour days, sometimes doing so for weeks at a time, and thus need to be mindful of stress management and self-care. Burnout is a serious hazard for disaster workers. The use of peer support is the best method to cope with stress. Health care professionals urge relief workers to take breaks, schedule time off, use humor, maintain a proper diet, exercise, and get generous amounts of restful sleep. Keeping a personal journal (a log of what was seen, thought, and felt) and writing a narrative at the end of the assignment often help many relief workers.

See also: GRIEF: ACUTE; GRIEF COUNSELING AND THERAPY; HINDENBERG; TERRORISM; TERRORIST ATTACKS ON AMERICA; TITANIC

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JOHN D. WEAVER

DO NOT RESUSCITATE

Do Not Resuscitate (DNR) orders are medical directives to withhold efforts to revive a patient who has a cardiac or respiratory arrest. DNR orders came into use in the 1970s as a response to the widespread practice of cardiopulmonary resuscitation (CPR). CPR is an emergency intervention that uses a variety of techniques to restore the heartbeat and breathing. CPR includes such basic life support as external chest compression and mouth-to-mouth ventilation, as well as advanced cardiac life support such as electrical defibrillation and cardiac medications. A DNR order tells medical professionals not to perform CPR if the patient's heartbeat or breathing stops.

When it was first introduced in the early 1960s, CPR was a heroic, life-sustaining act. It was a technique used on only a select group of acutely ill but otherwise relatively healthy patients. By the end of the following decade, however, CPR had become a

routine intervention for all patients facing imminent death. With this widespread use of CPR came a growing recognition that it was neither effective nor desirable for some patients. For example, patients with aggressive cancer or serious infection had almost no chance of recovery after CPR. Other patients who did survive after CPR often ended up with brain damage or permanent disabilities. At the same time that poor outcomes from CPR were being recognized, patients were demanding to be more involved in medical decisions. The result was the institution of DNR orders.

Participation in the DNR Decision

An ongoing debate about DNR has involved the extent to which patients or their surrogate decision makers must agree to such orders. Through the late 1970s and early 1980s, some hospitals routinely created DNR orders without any discussion with the patient or the patient's family, and they did not clearly document the DNR order in the patient's chart. But these practices were abandoned as the bioethics movement and the courts emphasized the right of patients or their surrogate decision makers to refuse medical treatment, including life-sustaining therapies such as CPR. Most health care providers and well-recognized health professional groups and accrediting bodies began to support DNR policies that require the patient to be informed of the risks and benefits of CPR and to give consent that CPR not be used. Some well-respected physician ethicists and medical groups, however, advocate that physicians should have the ability to write DNR orders without a patient's consent in situations in which it has been determined that CPR would have no medical benefit.

Communication and Knowledge about CPR and DNR Orders

Despite policies that require consent to a DNR order, informed discussions between patients and physicians about CPR and other life-sustaining treatments occur infrequently. Only about one patient in seven reports having discussed personal preferences for life-sustaining treatment with a physician. Even when patients have life-threatening illnesses such as AIDS, cancer, and congestive heart failure, such discussions occurred less than 40 percent of the time in some studies. In many cases, the decision about a DNR order is broached only after

extensive procedures have been attempted and at a time when patients are no longer capable of making an informed decision.

This lack of communication contributes to three concerns. First, many people have unrealistic expectations about the likely success of CPR. When CPR was first described in 1960, it referred to heart massage by the exertion of pressure on the chest. The success rate of 70 percent survival to hospital discharge was quite high, largely because it was applied to a small group of patients who experienced a cardiac arrest in the operating room or postoperative recovery rooms. By the early twenty-first century, CPR included not only heart compression and mouth-to-mouth resuscitation but also a host of advanced supports such as electrical defibrillation paddles, powerful drugs, and an assortment of mechanical breathing devices. This range of interventions is generally referred to as a “code” in which a special team responds to resuscitate a patient. But success rates are nowhere near those reported in original studies.

Research in the 1980s and 1990s showed that for all patients undergoing CPR in the hospital, just under one-half survived the code itself and one-third survived for twenty-four hours. Approximately 15 percent of patients undergoing CPR in the hospital survived to discharge. About 30 percent of those who survived suffered a significant increase in dependence and required extensive home care or institutionalization. Survival to discharge from the hospital was much poorer when certain diseases or conditions were present. In some studies, for example, no patients with metastatic cancer and only 3 percent of patients with sepsis (a widespread infection) survived to discharge. Outcomes in some studies of frail, elderly patients in long-term care facilities showed survival rates of 5 percent or less, prompting some health care providers to suggest that CPR should not even be offered to residents of nursing homes and other long-term care facilities.

The general public, however, often has an overly positive impression about the success rates of CPR. As portrayed on popular television medical shows, CPR is much more effective than in real life. According to one study, two-thirds of CPR patients survive on television, a much higher percentage than any published medical study. The same study

reported that on television only 17 percent of patients getting CPR were elderly. In reality cardiac arrest is much more common in older people than in any other age group. Furthermore, three-quarters of cases of cardiac arrest on television resulted from accidents, stabbings, lightning strikes, and other injuries, whereas in the real world 75 percent or more of cardiac arrests were triggered by underlying heart disease.

Knowledge about the outcomes of CPR is especially important because it has been shown to affect preferences for care. Surveys have shown that as many as 90 percent of elderly outpatients and a range of 44 to 88 percent of hospitalized elderly desire to have CPR in the event of a cardiac arrest. Even when elderly patients were asked whether they wanted CPR if they had a serious disability, 20 to 45 percent said they would. Clinicians at one geriatric practice asked patients about their preferences for CPR if they were acutely ill and if they were chronically ill. These patients were then educated about the probability of surviving to discharge under these conditions. Once they were given prognostic information, preferences for CPR dropped nearly 50 percent.

A second area of concern is that the lack of communication about CPR results in common misunderstandings about DNR orders. Many patients believe incorrectly that having a living will or other type of written advance directive automatically means that a patient will have a DNR order written. Instead, while an advance directive may express a patient's desire to have a DNR order written under certain circumstances, DNR orders—like all medical orders—must be authorized by a physician who is treating the patient. Also, some patients assume that a DNR order directs that all medical treatments be stopped and only comfort care provided. In some circumstances, however, other aggressive therapies—including staying in an intensive care unit—are continued for patients with DNR orders.

Moreover, there are circumstances in which restricted or limited DNR orders are appropriate. For example, if it is determined that further attempts at CPR would not benefit a patient who is on a ventilator or a breathing machine, then an order might be written not to give cardioactive medications should a cardiac or pulmonary arrest

occur. On the other hand, it might also be determined that a patient would want cardioactive medications and chest compressions but would not want to be intubated and put on a breathing machine. Because there are multiple options, it is essential that physicians thoroughly discuss DNR options with patients or their surrogate decision makers and that decisions are carefully documented in the patient's medical record.

Third, the lack of genuine communication means that physicians are often unfamiliar with patients' preferences about CPR and must rely on family members to help decide whether a DNR order is appropriate. Family members, however, also are very poor predictors of what patients would actually want, answering wrongly up to 40 or 50 percent of the time in some scenarios. Uncertainty about patient wishes concerning CPR also means that decisions about DNR orders are often delayed until the patient is near death.

A major, multihospital, longitudinal study of these issues focusing on more than 9,000 patients—the Study to Understand Prognosis and Preferences for Outcomes and Treatment (SUPPORT)—discovered that 79 percent of the patients who died in the hospital had a DNR order but that almost half of these orders had been written in the last two days before death. Almost 40 percent of these patients had spent at least ten days in the intensive care unit, and, of those able to communicate, more than half were in moderate or severe pain at least half of the time in their final days. About one-third of the patients expressed a desire not to be resuscitated, but less than half of their physicians understood this desire.

Other Issues

An issue of special concern involves the patient with a DNR order who needs to have surgery or some other medical intervention that requires the use of anesthesia or other agents that affect resuscitation. At some hospitals, it is institutional policy to automatically suspend a DNR order while a patient is undergoing procedures that may require resuscitative measures. The rationale for such policies is that if the procedure requires a patient to be artificially resuscitated through the use of a ventilator or chemical agents, then a DNR order would be illogical. Some hospitals, however, forbid the practice of automatically suspending a DNR order

during surgery. Rather, they require the need for resuscitative measures during surgery or other procedures be discussed with the patient and that agreed-upon circumstances for using or not using resuscitative measures be put in writing.

Some states have authorized the use of "durable" DNR orders. Such orders can travel with the patient and can be recognized by a wide range of health care personnel at different facilities and at the patient's home. Durable DNR orders eliminate the problem of patients needing to have a DNR order written each time they enter a health care facility and mean that patients at home can have their DNR wishes honored by emergency services personnel. Without a durable DNR order, emergency services personnel are required to resuscitate a patient at home, even if the patient had a DNR order recently written in the hospital.

See also: COMMUNICATION WITH THE DYING; CRUZAN, NANCY; END-OF-LIFE ISSUES; INFORMED CONSENT; PERSISTENT VEGETATIVE STATE; QUINLAN, KAREN ANN; RESUSCITATION

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DROWNING

Drowning is defined by the American Academy of Pediatrics as death resulting from suffocation within twenty-four hours of submersion in water. Near-drowning applies to all other victims, whether or not they survive. For every child that drowns, four children are hospitalized for near-drowning, according to the National Center for Injury Prevention and Control. Children less than one year of age frequently drown in bathtubs and buckets; children aged one to four years most often drown in swimming pools; and children and adolescents aged five to nineteen years most frequently drown in natural bodies of water. Alcohol use in adolescents and adults is estimated to be associated with 25 to 50 percent of drownings.

Males comprise the overwhelming majority of drowning victims.

Although people can hold their breath underwater for a limited amount of time, rising carbon dioxide levels in the blood initiate the need to take a breath. Most drowning victims quickly lose consciousness due to lack of oxygen and then inhale water. Death is typically a result of brain damage due to lack of oxygen and/or acute lung injury from aspirated fluids. Both sea and fresh water affect a substance called surfactant that coats the tiny air sacs, or alveoli, in the lungs. Lack of surfactant activity causes elevated surface tension in the lungs. This increases the effort required to inflate the alveoli and thus decreases the amount of air that can fill the lungs and the extent of oxygenation of the blood.

Treatment of a drowning victim is to restore breathing and circulation as soon as possible, because irreversible brain damage or death may occur in four to six minutes after breathing stops. Artificial respiration (mouth-to-mouth resuscitation) and cardiopulmonary resuscitation (CPR) are techniques used for this purpose.

See also: CAUSES OF DEATH

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DURKHEIM, ÉMILE

Émile Durkheim (1858–1917) is considered one of the most influential figures in the founding of modern sociology. Born in the eastern part of France, Durkheim descended from a long line of rabbis and trained to follow in their footsteps. As a young man, he turned away from organized religion and became an agnostic. While studying in Germany,

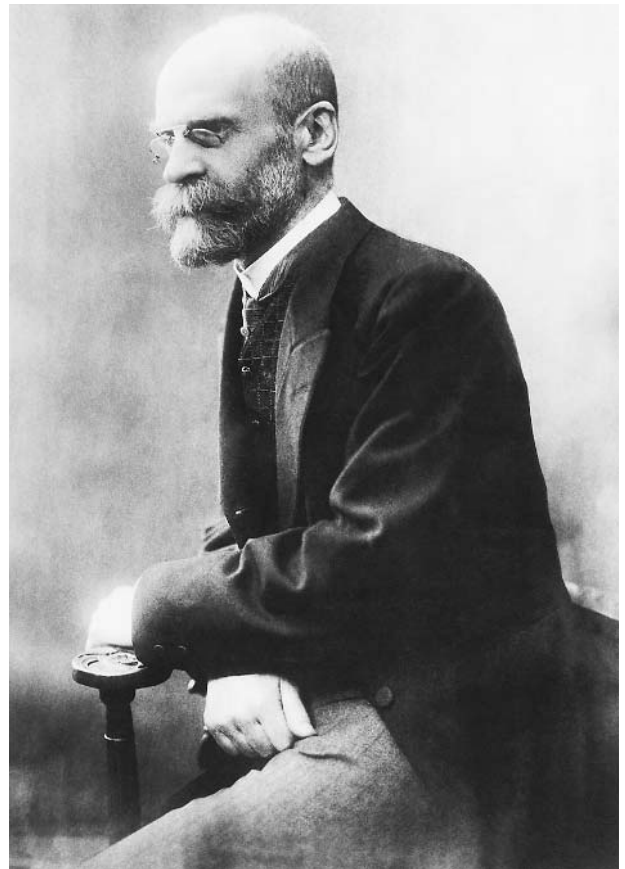
he became convinced of the value of using scientific methods, properly modified, in the study of human behavior. Recognized as a promising scholar, Durkheim wrote several important works on the methods of sociology, the division of labor, the scientific study of religion, and how imbalances in the relations between self and society can lead to death.

One of Durkheim's most influential books is a detailed study of suicide. When it was published in 1897, *Le Suicide* not only changed the way in which suicide was understood, it fundamentally transformed the way sociological research was subsequently conducted. In that work, Durkheim created what became the standard structure for sociological research. On the first page of the book's introduction, he began defining the central term under discussion and proceeded to sketch out the tentative outlines of an explanation for suicide that would be informed by social science, replete with tables of suicide statistics.

In critically reviewing the existing suicide literature, which largely viewed acts of self-destruction as having physiological or psychological origins, Durkheim wondered why people from similar genetic origins did not have similar rates of suicide. Why did rates vary within one region over time? If it was related to weakness of character, why was it unrelated to levels of alcoholism? Utilizing logic and statistics, Durkheim challenged both popular and academic explanations. In doing so, he indicated that the tentative sociological approach he had begun to develop in the book's introduction offered greater explanatory power. The majority of the book lays out what became a classic sociological explanation for suicide. There are four major types, all related to group cohesion or solidarity.

Egoistic suicide, Durkheim argued, was most common among groups of individuals with few connections to social groupings of any kind. Thus, loosely bound liberal Protestant groups had higher suicide rates than Catholics and Jews, for whom regular religious participation was expected; married people committed suicide at lower rates than singles; and nations undergoing political crises experienced lower rates because competing interests and parties became tightly integrated under stress.

While egoistic suicide made sense to most readers, Durkheim's second category, that of *altruistic* suicide, was more controversial. Durkheim argued



Training given to workers on suicide hotlines in the twenty-first century is largely based on the conclusions and categories originally introduced by Émile Durkheim in 1897. CORBIS

that certain types of suicide occurred among tightly knit groups when they came under severe threat and their members were prepared to die in the group's defense. Because suicide was widely understood as the act of sick or disturbed individuals, Durkheim's argument that soldiers who knowingly gave up their lives for their country were committing suicide appeared to diminish the valor of those actions. Durkheim delineated three types of altruistic suicide, based largely on a group's expectations that its members would undertake self-destruction in its defense.

The third type of suicide, *anomic*, was identified with an abrupt shift in an individual's circumstances, shifts that removed him or her from membership in what had been a well-integrated group. Durkheim showed that nations where divorce was common experienced higher suicide rates than nations where the practice was illegal. Similarly, economic crisis could lead to personal crises for

individuals who once thought of themselves as important providers for their families, but when confronted with persisting unemployment found themselves evicted from their homes, their credit rejected, and prospects for improvement dim. If these individuals and their friends were accustomed to thinking of poor people as responsible for their circumstances, then they found themselves condemned by their own categories of thought. Faced with humiliation and a lack of connection with groups who might ease their self-doubts, such individuals might commit anomic suicide.

Durkheim's final category of suicide, *fatalistic*, is relegated to a footnote. This type of suicide occurred within tightly knit groups whose members sought, but could not attain, escape, whose "futures are pitilessly blocked and passions violently choked by oppressive discipline" (Durkheim 1951, p. 276). Prisoners of war or slaves who were bound into distinct groups dominated by other groups might commit suicide in order to escape group membership or to demonstrate control over their lives.

Suicide concludes by moving from what had been a taxonomy of suicide types toward an explanation of how social, political, and economic forces produced those types. For instance, Durkheim explored links between suicide and urbanization, developing how cities atomize individuals, producing egoistic suicides.

Sociologists admire Durkheim's book for a variety of reasons. Not only does the work present a clear understanding of what a sociological perspective was and how it differed from the perspectives offered by other emerging academic disciplines, it provides a clear and well-documented argument advocating the practical value of that discipline's perspective. Durkheim's reliance on statistics for calculating and comparing suicide rates was innovative for the time, as was his realization that the effects of some variables had to be controlled. Although he recognized problems in the comparability of data drawn from different regions or within one region in different periods, his work contributed to an emerging body of scholarship in comparative historical sociology.

Several sociological studies have been conducted in the century since *Suicide's* original publication, and while some have qualified

Durkheim's observations, none has seriously challenged his overall approach or conclusions. While his earlier work contains some optimism about the potentially liberating effects of industrialization and urbanization, it also reveals concerns for disruptions caused by change that occurs too rapidly. As time went on, Durkheim saw these strains become more frequent and troubling. The Dreyfus affair led him to doubt the hearts and consciences of the French citizenry, and the outbreak of World War I revealed how destructive the potentially liberating forces of industrialization can be. The war claimed the life of his only son and intellectual heir in late 1915, a blow from which Durkheim never recovered. He died in 1917, his writing having shifted from scientific objectivity to the study of ethics.

See also: SUICIDE TYPES: THEORIES

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DYING, PROCESS OF

It might seem self-evident that death is the outcome of the process of dying. The reality, however, is not so simple. Consider a few examples: Two people are experiencing the same life-threatening emergency. One person receives prompt and competent treatment; the other does not. Were both dying if one recovers? Or say that laboratory tests show that a person has a progressive condition that sooner or later will result in death. At the moment, though, the person has only the early symptoms and can continue with all normal activities. Is this person dying? What about a person clinging to life in a case where doctors have devised a last-ditch intervention atop more standard treatments that have already failed? Is this person dying if there is another treatment that offers

hope of remission or cure? And what of a comatose patient, dependent on tubes and respirators with no sign of improvement? Is this person in a state of suspended dying? Or is this person already dead?

Such quandaries have become increasingly commonplace because of medical and technological advances. Continuing changes in the definition of death have also affected discourse about dying. This familiar term no longer seems entirely adequate when applied to a variety of situations, some of them shifting and ambiguous.

“Dying”: Historical Origin and Current Usage

Digbe, (also spelled *dye*) was a word in common usage in the Friesland province of northern Holland in the fourteenth century at the time when Europe was devastated by the Black Death, a plague that annihilated perhaps as much as a third of the population. Old Friesian derived from an early Indo-European language group and became a Low German dialect that is still spoken. The Icelandic *deyja* and the Danish *doe* are cognates. *Die* and *dying* became established words in the English language during the plague years.

Poetic imagination soon turned “dying” to additional uses. “Die-away ditties,” popular with Renaissance singers, were songs that ended in a subtle and suggestive manner. Elizabethan poetry often played with dying as a sexual metaphor, and lovers routinely spoke of dying when separated from their beloved.

Metaphorical uses persist, sometimes to the confusion of young children who hear that a runner at second base or a car battery has died. Members of a dwindling group are also characterized in this manner: “Phonograph record collectors are a dying breed.”

Because of the “sensitive” nomenclature fostered in the early twentieth century by unctuous funeral directors, the literal usage of the term “dying” gave way to euphemisms such as “expire,” “pass away,” or “go to one’s reward.” By the middle of the twentieth century, *dying* and *death* had become taboo words in the United States and Europe, even in physicians’ consultations with families or patients.

Communication started to improve with the emergence of the death-awareness movement in the 1960s, which introduced palliative care, death

education, and other advances. It was a breakthrough to have books published with “death” and “dying” in their titles. This period of more direct and open communication did not long endure, however. The medical establishment, although slow to give priority to the care of dying people, became more active on this front. But the term *dying* was still deemed too abrasive—*terminal illness* is the preferred clinical euphemism, connoting an aggregation of symptoms rather than a real, suffering human being in the twenty-first century.

End-of-life (EOL) has become another key term. Unlike *terminal illness*, EOL calls attention to the many sources of potential concern and support. Decisions about financial affairs and funeral arrangements, for example, are among the included topics. Nevertheless, EOL has also become the professional and bureaucratic rhetorical surrogate for *dying person*.

Perhaps the most useful addition to current terminology has been *end-phase of life*, the period in which major body systems have failed and the individual has become dependent on others for total care. The term is more specific than either *dying* or *terminally ill*. Some terminally ill people can continue with their family activities and careers, and look after much of their own care. People in the end-phase have lost much of their functional capacity and are likely to be receiving specialized care in the hospital or at home.

The Dying Person in Society

The onset of ill health is often accompanied by a change in social status, however temporary and reversible upon recovery. Lowered expectations or even outright aversion—if the condition is disturbing or contagious—account for much of the patient’s lowered social esteem—one that either disturbs (e.g., a burn victim whose injuries are painful for the viewer as well as the patient) or is feared as contagious. A similar reduction in social standing affects those who cannot make a full recovery—in such cases of the “chronically impaired,” the patient is often shunted to the periphery of social influence and interaction.

Research and observation have clearly established that society tends to isolate dying people. Both professionals and nonprofessionals spend less time with dying people, relying on various

evasive patterns of behavior. The growing awareness that dying people often experience social isolation and loneliness became a strong motivation for the development of palliative care and death education. Even today, however, the status change to “dying person” often signals a major alteration in the individual’s relationship with society.

When does dying begin? This question becomes important in light of the major changes that often occur when a person is regarded as a dying person. In a strict sense, it could be said that given the mortal nature of humans, dying begins at birth. But such an abstract philosophical perspective yields little concrete guidance in confronting the suffering and fears of real humans whose demise is not a distant endpoint but an imminent prospect. Neither is there much practical utility in the equally broad notion that dying begins with the onset of aging, especially because many people enjoy good health well into old age.

In the most common formulations, dying begins when a fatal condition is recognized by a physician; the patient is informed of the fatal condition; the patient realizes and accepts the facts; everybody in the situation (e.g., family, friends) realizes and accepts the facts; and nothing more can be done to reverse the condition and preserve life.

Each of these possibilities has its own set of implications. For example, a person might incur a life-threatening condition but remain unaware of it because of “silent” or seemingly trivial symptoms (i.e., digestive problems, fatigue)—hence the victim’s social image and self-image are not those of a dying person. Communication and interpretation are crucial to all the other possibilities. One person might suspect that a condition is fatal but resist that conclusion pending a physician’s confirmation, while another might resist the reality of impending death no matter how bluntly the physician conveys it; sometimes this denial might come from family members rather than the patient. It is not unusual for some time to elapse until physician, patient, and family all accept the prognosis.

The dying person is vulnerable to the additional stress of familial discord, which often takes the form of mixed messages, with some family members urging a pitched battle against the disease and others counseling resignation and acceptance in the face of the inevitable. Physicians are

often caught in the middle of such family dissonance, especially if the relatives’ attitudes shift with each new turn in the patient’s condition. In some cases a doctor’s zeal in pursuing every conceivable treatment strategy, no matter how difficult or futile, can override the patient’s own wishes to abandon an all but fruitless struggle and face the end placidly.

Caregivers often emphasize the importance of open communication and trust. Several studies have revealed that interactions with the dying person are often hedged by fears of excessive bluntness toward the patient and the relatives’ anxiety about their own mortality. Such circumspection leads to patients and relatives to deny to each other the knowledge that each possesses privately about the terminal nature of the illness. In the mutual-pretense situation, for example, both the dying person and the caregiver or family member know the truth, but both also act as if they are not aware in order to spare each other’s feelings. Experts suggest that it is more useful to attune to the dying person’s immediate needs instead of applying a predetermined resolve to skirt or confront sensitive topics. Sometimes dying people want to discuss heartfelt feelings about impending death, while others relish diversionary gossip. Experienced caregivers often encourage relatives to view the dying person as a human being rather than as a “case.”

The Medical Side of Dying

“We die the death of our disease,” observed the poet Rainer Maria Rilke. This statement echoes clinical realities. The patient’s overall life history and personal disposition can have as great an impact on the dying process as the nature of the illness. The physician Sherwin B. Nuland offers illuminating examples of the influence of biomedical factors: “When a would-be suicide hooks up one end of a hose to an automobile’s exhaust pipe and inhales at the other, he is taking advantage of the affinity that hemoglobin has for carbon monoxide, which it prefers by a factor of 200 to 300 over its life-giving competitor, oxygen. The patient dies because his brain and heart are deprived of an adequate oxygen supply” (Nuland 1994, p. 159).

What is significant about this pathway to death is the rapid loss of consciousness and therefore the inability to communicate or change one’s mind. By

contrast, some people recover from cancer or go into long periods of remission where they are at risk of terminal illness but not really dying. Should the cancer start on a terminal course, there is not usually a rapid loss of consciousness. Unlike the carbon monoxide suicide, the person with terminal cancer has time to be with friends and relatives, look after business matters, and reflect on life's values and meanings.

The end phase of life also differs markedly from that of the suicidal person attached to an exhaust tube hose. A prolonged struggle with cancer is likely to leave the patient emaciated and weak, subject to infection because of a compromised immune system—hence pneumonia, abscesses, and infection often become the immediate causes of death. Blood pressure drops, and various organ systems fail. During this “lingering trajectory,” family members can provide emotional support to one another as well as to the dying person.

Kidney failure also tends to have a lingering terminal course as excess potassium and other substances build up in the body, compromising brain functioning and often leading to a coma and then fatal cardiac instability. As Nuland observes, “Only rarely are there any last words or deathbed reconciliations” (1994, p. 54). There is a need to be with the dying kidney patient while there is still time for consoling and memorable interactions. In these and many other instances, the nature of the disease—and the type and quality of care—are usually decisive factors in the course of the dying process.

Conditions That Resemble Dying

The supposed uniqueness of the dying process engenders a good deal of the anxiety and confusion that typically attend it. Actually, many aspects of the process are akin to a wide array of feelings and experiences familiar to all from everyday life. The lessons gleaned from such similarities can aid in an understanding of the stress experienced by dying people. Here are some typical experiences of this kind:

- Restricted activity— “I can do less and less”;
- Limited energy— “I must conserve what is left of my strength”;
- Body image— “I don't look and feel like the person I used to be”;

- Contagion— “You act like you might catch something bad from me”;
- Disempowerment— “I have lost the ability to influence you”;
- Attributional incompetence— “You think I can't do anything right any more”;
- Ineffectuality— “I cannot make things happen the way I want them to”;
- Stress response— “My defenses have become so intense that they are causing problems of their own”;
- Time anxiety— “I fear it is too late to do all I must do”;
- Loss and separation— “I am losing contact with everything that is most important to me”;
- Disengagement— “I feel ready to withdraw from interactions and responsibilities”;
- Journey— “I am going some place I have never been before”;
- Closing the book— “I am doing everything for the last time; it will soon all be over”;
- Performance anxiety— “How am I doing? How do you think I am doing?”
- Endangered relationship— “I fear I am losing your love and respect”;
- Struggling brain— “My mind is not working as it should. The world is slipping away from me”;
- Storytelling— “I must come up with the best possible story of all that has happened, is happening, and will happen.”

These experiences of living can help individuals prepare for the experience of dying, which is more than restricted activity, limited energy, and doom-laden depression. Like many other key formative experiences, it is also the adventure of passage from the known to the unknown.

See also: COMMUNICATION WITH DYING; DEFINITIONS OF DEATH; GOOD DEATH, THE; INJURY MORTALITY; LAST WORDS; MOMENT OF DEATH; PAIN AND PAIN MANAGEMENT; TERRORISM

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ROBERT KASTENBAUM

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EGYPTIAN BOOK OF THE DEAD

There is probably no text in the popular imagination more closely associated with the ancient Egyptian beliefs about life after death than the work popularly known as the Egyptian *Book of the Dead*, also referred to as *The Book of Coming Forth by Day*. This work received its name from the fact that many of the earliest specimens to reach Renaissance Europe—centuries before Champollion deciphered the hieroglyphs in 1824—had been found next to mummies in burials, a practice that also gave rise to the misconception that the *Book of the Dead* was an authoritative scripture equivalent to the Bible. However, the actual Egyptian title, *The Chapters of Going Forth by Day*, offers a more accurate picture of purpose and orientation of this composition. The *Book* was essentially a collection of prayers and magical speeches primarily intended to enable a deceased person to overcome the trials and dangers of the next world and emerge safely from the tomb in a spiritualized form. Although there is no one ancient Egyptian work that contains the complete range of Egyptian postmortem beliefs, let alone the totality of their complex and constantly changing religious ideas, the *Book* does offer the modern reader insights into the wide range of ancient Egyptian concepts involving both the afterlife and the afterworld—it is not, however, in any sense an Egyptian Bible.

The *Book of the Dead* assumed many forms. It occurs primarily on papyri, but it is found as well on tomb walls, coffins, scarabs, funerary stelae, and

other objects. Perhaps the best-known *Book* is the famous papyrus that was inscribed for a certain Ani, “the Accounts-Scribe of the Divine Offerings of all the Gods,” and his wife Tutu. This profusely and beautifully illustrated scroll was made during the early Ramesside period (c. 1300 B.C.E.) in Ani’s home town, the southern religious capital at Thebes, modern Luxor. It was purchased there by its curator, E. A. Wallis Budge, in 1888 for the British Museum where it is displayed today. Extending more than seventy-five feet, it is one of the best examples of the *Book* papyri of the New Kingdom and Ramesside periods. Ironically, for all its splendor, this scroll was actually a template papyrus roughly akin to a modern preprinted lease or standard will, with Ani’s name and titles being inserted into the appropriate blank spaces at the last minute. Ani, or his survivors, purchased what was deemed appropriate (and what they could afford) from a funerary workshop for his safe journey into the next world; then the sheets with those relevant spells were pasted together to form the final product.

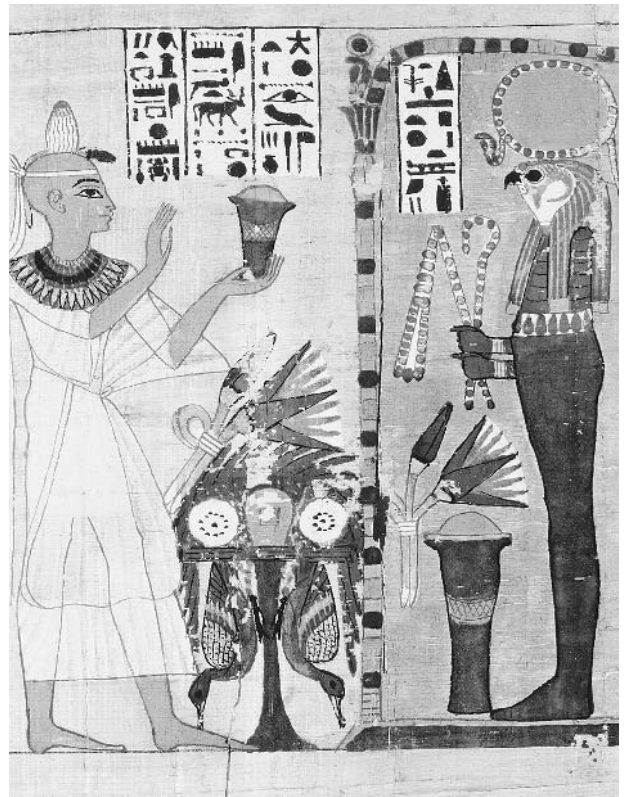
The *Book of the Dead* represents the acme of the illustrated book in ancient Egypt. The text itself represents a continuation of an ancient tradition of afterworld guides that began with the royal Pyramid Texts in the Old Kingdom and continued with the more “democratized” Coffin Texts for wealthy individuals of the Middle Kingdom. These, in turn, provided the material on which many chapters of the *Book of the Dead* were based. This pattern of rewriting old religious texts and adopting them to new beliefs was to continue after the *Book* throughout pharaonic history. At no time did any group of texts become canonical in the sense of having a

definitive text or a fixed sequence and number of chapters. The first spells that can be definitely associated with the *Book of the Dead* began appearing in the late Middle Kingdom, but it was not really until the Eighteenth Dynasty (c. 1500 B.C.E.) that this new work became the standard afterlife text for the Egyptian elite. In order to enhance its appeal to the conservative religious sense of Egyptians, the *Book of the Dead* preserves many archaisms in script, vocabulary, and dialect. The main innovations of the *Book of the Dead* were that nearly every spell was accompanied by a vignette—an illustration—and that the work, designed for the relatively cheap medium of papyrus, was affordable for a much wider audience of Egyptians.

Probably only a miniscule percentage of Egyptians had the means to include a *Book* papyrus among their burial equipment. In fact, because the *Book* describes a lavish funeral, an elaborate, well-outfitted tomb, and other expensive burial equipment, some scholars have surmised that these scrolls were partially intended to provide by magic various things that the average Egyptian official could not afford.

All Egyptian religious texts such as the *Book* were fundamentally collections compiled from several different sources or local traditions, so that the final versions often contained contradictory concepts and statements, occasionally within the same spell or sentence. Consequently, for modern readers, many of whom have been influenced by the uncompromising strictures of monotheism, reading the *Book* often evokes confusion, even shock. In the profoundly polytheistic environment of Egyptian religion, however, there was never was a need to reconcile differences or to compel uniformity; one should more properly speak of Egyptian religions in the plural rather than the singular. Yet, despite this seeming lack of consistency, the fundamental concepts concerning life after death remained essentially stable.

Above all, the Egyptians had an essentially optimistic conception of the afterlife. For them death may have been inevitable, but it was survivable. However, unlike the modern view of death as the great leveler that reduces all humanity to the same status before the deity, a profound class-consciousness permeated the Egyptian view of the next world. Earthly status was transferable into the world beyond. The chief objective of their vast



Departed souls make an offering to Horus in this illustration from the Egyptian Book of the Dead. Such images have become more widely known than the text itself.

CORBIS

mortuary culture was not only to ensure survival after death but to preserve one's earthly station, presumably as a member of the elite. Therein lay the elaborate nature of Egyptian tombs and burials, which were intended to provide the deceased with a comfortable material existence in the next world, an existence that would in part be an idyllic version of earthly life, an Egyptian Elysian Fields. Egypt, the land of the living, was well ordered and governed under the principle of *Ma'at*, that is, roughly (rightful) order or universal guidance. *Maat* prevailed in the coherent, cosmic universe.

Consequently, travel through the world beyond the grave meant that the deceased would have to confront irrational, chaotic forces. The *Book of the Dead* joins together two views of the afterlife—a chthonic underworld where Osiris, a deity who had died and been resurrected, presided and a stellar-solar realm where the blessed dead eventually hoped for an eternal celestial existence in the company of the sun god Ra. Once one entered the next

world in the West or traveled with the god Ra below the horizon into the netherworld, one encountered the forces of primordial chaos and irrationality prevailed. Magical spells such as those in the *Book of the Dead* were considered the appropriate means for protecting the traveling soul against these dangers.

The key afterlife trial that everyone faced took the form of a judgment of one's soul on a set of scales like those the Egyptians used in their earthly existence. After the deceased had ritualistically denied a list of forty-two misdeeds, the so-called negative confession—his or her heart was put on one scale-pan, while a feather symbolizing the principle of Ma'at was placed on the other. According to this beautiful metaphor, one's heart had to be as light as a feather in relation to sin. Thereafter, one was deemed "true-of-voice" and worthy of an eternal existence. Despite this, dangers remained. The chief purpose of the *Book of the Dead* was to guide the deceased through those afterlife perils; one might draw an analogy with a traveler's guide to a foreign land. The *Book* provides for many eventualities yet not all of these would arise, nor was it expected that the various dangers would occur according to the sequence in which they appear on any given scroll.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE;
CHARON AND THE RIVER STYX; MUMMIFICATION

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OGDEN GOELET JR.

ELVIS SIGHTINGS

For decades following his death, reported sightings of Elvis Presley, the acclaimed "King of Rock and Roll," persist. As is the case with religious

saints, it is Elvis's death day and not his birthday that receives ritual attention, attracting tens of thousands of individuals to Memphis, Tennessee, for Elvis Week. To understand his "immortality" one must know something of the man, his time, music, and the transcendence power of late-twentieth-century media celebritydom.

Death shaped Presley's fate from the moment of his birth in 1935, when his identical twin brother died in delivery. His parents—poor and originally from Mississippi—became extremely protective of their surviving son and supportive of his singing talents, which were nurtured in an Assembly of God choir and at church revivals. Following his graduation from a Memphis high school, Presley drove trucks during the day and took vocational classes at night. One day he happened across the Sun City recording studio, where he paid four dollars to cut two disks for his mother. Sun president Sam Phillips, looking for a Southern disc jockey, talent scout, and record producer long inspired by Memphis blues, happened to hear a copy of Presley's rendition of an Ink Spots song. Thus began a legendary career as he went on to record 149 songs that made it to *Billboard's* Hot 100, spending more weeks at the top of the charts (eighty) than any other performer.

Presley's career coincided with the beginning of the rock and roll movement, which itself was part of a broader social phenomenon—an emerging teenage culture made possible by postwar prosperity. The rapidly developing recording and television industries saturated popular culture with his image and sounds at a time when the massive baby boom generation passed through childhood and adolescence. As baby boomers sought their generational identity, rock and roll became their identifying music and this singer their own icon (as Frank Sinatra was for the preceding generation). Presley's death at age forty-two shocked a generation often accused of never having had to grow up.

In adolescence and early adulthood this generation asserted itself by challenging the values and lifestyles of its parents, including their death taboos and denials. Boomer music was to develop a dark side with its associations with death, in its lyrics and in the untimely deaths of its performers, often because of "noble excess" (Pattison 1987, p. 123).

Thanatological (death-related) themes came to be embedded within the very names of the performing groups, such as the Grateful Dead and the Dead Kennedys.

Parodies of such connections between rock and death were inevitable. A decade before Presley's death there were rumors of Paul McCartney's demise, with some critics claiming that the intent was to increase sales of the first album released by the Beatles' Apple Records company. This coupled with the climate of conspiracy suspicions of the 1960s and 1970s supported beliefs that Elvis was not dead.

The music industry found death to be a formidable marketing tool, often inflating the value of deceased performers' works. During the late 1970s and early 1980s, the posthumous releases by dead rockers often outsold the recordings of the living. In 1983, nearly three decades after their release, seven of Presley's songs were among the top forty-nine best-selling singles, according to the Recording Industry Association of America.

Elvis sightings began almost immediately after his death from a drug overdose on August 16, 1977. There were many interests served and many places where he could be seen. In capitalist economies, particularly in the performing industries, one can now remain "alive" as long as one generates revenue. In the case of Presley, those having an interest in his immortalization included the city of Memphis, where the Presley home was one of the largest generators of tourist dollars; the Presley estate, which profited from rereleases, greatest hit anthologies, and reformattings of the singer's performances with new music technologies (e.g., stereo LPs to cassettes to CDs); and even the U.S. Postal Service, whose revenues were bolstered with the 1993 release of its Elvis stamp. For decades after his death, Elvis impersonators abounded, given a high demand for their appearances at various social and commercial functions for midlife boomers nostalgic for their youth. In 2000, according to the March 19, 2001, issue of *Forbes* magazine, Elvis was the king of deceased performers, earning \$35 million for his estate, including \$15 million from admissions to his Graceland mansion.

Americans really do not believe that Elvis is alive. A 1997 Gallup poll found that only 4 percent

of Americans believed such was the case, whereas 93 percent were certain he was dead. So why the publicity given to reports to the contrary? The same poll found that nearly half of Americans still considered themselves "fans" of his twenty years after his demise, with the highest rate occurring among baby boomers. Two years later, the Gallup organization found that one-third of Americans viewed Presley as the greatest rock and roll performer of all time—six times the proportion of the second most-mentioned star. Indeed, Elvis "lives" in the American collective memory, particularly in that of baby boomers.

See also: CELEBRITY DEATHS; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; IMMORTALITY, SYMBOLIC; ROYALTY, BRITISH

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MICHAEL C. KEARL

EMBALMING

See FUNERAL INDUSTRY.

EMERGENCY MEDICAL TECHNICIANS

The struggle between life and death is the fundamental responsibility of the Emergency Medical Services (EMS) professional; EMS systems provide a medical safety net for the public. Since the inception of the EMS profession, paramedics have received billions of calls from Americans in need of emergency care.

Each one of these calls generates a complex chain reaction that started in the 1960s. In the early 1970s, paramedics first appeared in the public eye when the series *Emergency* appeared on television. However, the development of the paramedic profession predates the television program by several years.

Before the 1960s, funeral home personnel were a major source of care given the sick and injured with the first ambulances doubling as hearses. Only a small number of ambulance services existed; and of these, only a few employed properly trained attendants. With the resurgence of mouth-to-mouth resuscitation in the 1950s and discovery of closed-chest cardiac massage in the 1960s, cardiopulmonary resuscitation (CPR) became available to professionals and lay persons. Consequently, public interest grew in the ambulance industry, and more people looked toward a career in the EMS profession.

In 1966 the National Academy of Science published a report entitled *Accidental Death and Disability: The Neglected Disease of Modern Society*. This paper shaped the future of the EMS profession by showing that trauma care could reduce morbidity and mortality. About the same time, Congress passed the Highway Safety Act of 1966. From this Act, the Department of Transportation (DOT) was created. The DOT improved EMS systems by designing and implementing standards for the training of all EMS providers. Additionally, Congress passed the Emergency Medical Services Act of 1973, making federal funds available to regional and local communities to develop EMS programs. With federal funds available, EMS systems grew dramatically in the 1970s.

Since the 1990s EMS professionals have become part of a complex multifaceted Emergency Medical Service System nested with the overall health-care system. EMS systems are “planned configurations of community resources and personnel necessary to provide immediate medical care to patients who have suffered sudden or unexpected illness or injury” (Henry and Stapleton 1992, p. 4). The attributes of EMS systems include integration of health services, legislation and regulation, system finance, human resources, medical direction, education systems, public education, prevention, public access, communication systems, clinical care, information systems, and evaluation.

Types of EMS Providers

Many different levels of Emergency Medical Technicians (EMTs) exist in the United States; however, the DOT recognizes only four levels: first responder (FR), EMT-basic (EMT-B), EMT-intermediate (EMT-I), and EMT-paramedic (EMT-P). The EMT-B is the basic EMT level and provides skills such as CPR, bandaging, splinting, oxygen administration, and automatic external defibrillation. The EMT-intermediate (EMT-I) receives additional training beyond that of the EMT-B to include advanced airway and cardiac pacing. The paramedic (EMT-P) is the most skilled and, of all the EMTs, provides the most advanced prehospital care. First responders are the first individuals to arrive at the scene. First responders have a variety of credentials and function as assistants to other EMTs. During an emergency response, EMTs receive their medical direction from local emergency room physicians and previously established protocols.

Training Standards, Roles, and Responsibilities of EMTs

The federal government provides standard curriculums for EMS professionals; however, each state sets the practice regulations and training standards for the different levels of EMS providers. Training standards did not exist until 1971, when the DOT published the first EMT national curriculum. The DOT approved the EMT-paramedic curriculum in 1976 and the EMT-intermediate curriculum in 1985. In general, the 1970s were an era of expansion for EMS training. Currently, the DOT is moving away from standardized curriculums and specific lesson plans to a more comprehensive and flexible education model. This model will use a less prescriptive method yet still employ a systems approach to integrate the following components: core content, scope of practice model, education standards, EMS certification, and education program accreditation.

The primary goal of the EMS system is to provide acute care; additional roles are accident and injury prevention, treatment of chronic conditions, and assisting in improvements to the overall health of the community. EMTs' responsibilities include scene assessment, emergency management, emergency transport, record keeping, and equipment and vehicle maintenance. However, an EMT's role is to save lives, to lessen pain, and to reduce the extent of disability. EMTs achieve these lofty goals



Attempting to save a heart attack victim, this paramedic uses a defibrillator machine that applies an electric shock to restore a regular heartbeat. PHOTO RESEARCHERS, INC.

by rapidly and safely treating and transporting the sick and injured.

Challenges of Death

All EMS professionals must face death. The need for coming to terms with death is universal; death is part of an EMT's everyday duties. These professionals must not only learn how to respond to death, but also how to react to it and integrate it into everyday life. EMS professionals employ several strategies to control the stressful effects of death. The most frequently used defense mechanisms are educational desensitization, humor, language alteration, scientific fragmentation, escape into work, and rationalization. Many paramedics, when asked about their role, will respond that they hope to truly make a difference. One of the personality features common to EMS professionals is

altruism. Altruism provides them a special spot in the hearts of most Americans. "Always ready to serve others in time of need, the paramedic has become a most respected person in contemporary America" (Page 1979, p. 49).

The second challenge for EMS providers is the public perception of paramedics as lifesavers. Most of society anticipates that a paramedic will save the life of their loved one. Television programs such as *Emergency* and *Rescue 911* perpetuate these views by portraying paramedics as lifesaving heroes, as robbers of death. As the medical community increases the chances of surviving death, the public will expect the EMS profession to provide similar results.

Third, the primary death-related training afforded to EMS professionals is often inadequate.

EMS programs train paramedics to recognize the technical aspects of death with only a minimal amount of instruction covering the psychological or social aspects of death. Furthermore, this training often does not cover helping families at the moment of death or issues unique to prehospital death. The National Curriculum for Paramedics provides only a few grief-related objectives based on Elisabeth Kübler-Ross's stages of dying. There are no objectives specific to making death notifications or handling postmortem arrangements with newly bereaved persons. Because paramedics receive limited training in cultural and religious sensitivity, cultural and religious diversity further hinder a paramedic's ability to provide immediate support to the bereaved. The paucity of training may contribute to paramedics who feel that conversations with bereaved persons are problematic, stressful, and uncomfortable. Furthermore, conversations with bereaved persons may be harder for paramedics who have not come to terms with their own mortality.

The prehospital environment in which EMS professionals practice creates many obstacles during incidents involving death. When EMS professionals respond to an emergency, they request the right of way with their lights and sirens; consequently, they increase the risk for accidents and injury. After arriving on scene, EMTs provide care with limited equipment (compared to hospitals), with the public looking on, in adverse weather conditions, in hostile environments, and at all hours of the day and night. It is a formidable task to resuscitate a patient under these circumstances, yet EMTs do this every day as a routine part of their daily work. Death from AIDS and SIDS or deaths involving young children, coworkers, and other public service professionals (e.g., police officers) also aggravate the stress associated with responding to a death.

Legalities surrounding death also pose hurdles for EMTs. In the 1980s the greatest legal challenge for the EMS community was determining when to start CPR. This issue challenged not only the EMS profession but also the medical community as a whole. Initially, EMS providers started resuscitation on all patients, even if this conflicted with the patient's wishes or the personal views of the paramedic. For example, in the early 1980s, many terminally ill patients went home to die, but when the family called the paramedics to pronounce death,

the paramedics arrived and resuscitated the patient. The lack of Do Not Resuscitate (DNR) protocols required EMTs to do their best to bring these patients back to life. This duty often came at an emotional expense to the EMTs who responded to the incident, as well as to the families of the victims. By 2000 every U.S. state had its own Do Not Resuscitate protocol for EMTs. Despite these protocols, EMTs still resuscitate terminally ill patients. Many terminally ill patients are unaware of their local EMS agencies' policies to not recognize living wills and require official EMS-DNR forms.

In the early 1990s most EMS systems were challenged to create new guidelines for EMS providers detailing when to stop CPR and other resuscitative actions. Despite common social belief, most cardiac-arrest patients die. The medical community now recognizes the enormous impact of cardiac-arrest patients on the health care system. These patients require precious EMS resources, often at the expense of other less critically ill patients. Through research and experience, doctors can identify which patients are viable patients and separate them from patients with no chance of survival. Paramedics declare death and stop CPR on the nonviable patients while still providing the most aggressive treatment for those patients who may have a chance to survive. Pronouncing death, EMS professionals provide the initial psychosocial support for newly bereaved families. Providing this support and mitigating the traumatic effects of death to the families is another area where EMS professionals truly make a difference.

See also: DEATH EDUCATION; FUNERAL INDUSTRY;
RESUSCITATION; TERRORIST ATTACKS ON AMERICA

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TRACY L. SMITH

EMPATHY AND COMPASSION

The word *compassion* comes from Latin and means "to bear with" or "to suffer with." Compassion and empathy are essential human qualities that allow one to feel, understand, and respond to the suffering of others. They enable individuals to enter into and maintain relationships of caring. The ability to care has been identified by Martin Heidegger as a fundamental aspect of the human condition. In every society the sick and the dying have been treated with compassionate care. This is a universal human response. Many of the world's major religions hold compassion as one of the highest spiritual virtues.

Dynamic compassion, or *Abimsa* in Hinduism, is known as the God quality within a person. It is an open-hearted active response of respect, service, and care for those in need. It was a prime

aspect of Gandhi's nonviolent liberation movement. Compassion is also a central tenet of Buddhism. The Buddha manifested absolute compassion for all creation. Buddhist compassion, or *karuna*, is seen as the appropriate human response to understanding the interdependence and mutual welfare of all beings. In the Judeo-Christian tradition, compassion is a manifestation of God's love and mercy. It is the way God interacts with creation and is, therefore, the way people should interact with one another. In all of these spiritual traditions, directly addressing the suffering of others through compassionate care is a religious obligation. In such responses we can see the hallmark of our shared humanity.

To have compassion or to "suffer with" another implies a quality of imagination and an identifying with the other's pain as something we can vicariously feel along with them, however tangentially. Compassion is an active choice to want with others and to want for others the alleviation of their suffering. In acting compassionately we acknowledge that we all share the same conditions of mortality; we all suffer and we all die.

Empathy derives from a Greek root word meaning, "in feeling" or "feeling into." A component of compassion, empathy is the recognition and understanding of the other's suffering. It is a deep appreciation for what it is truly like to be in the other's situation from his or her perspective. Empathy requires an openness to receiving and holding the other's experience without reservation or judgment. Empathy is passive but absolutely attentive. It involves entering into and staying present in the painful experience of the other without moving away from that experience by trying to change it. Empathy establishes a deep connection of mutual vulnerability and intimacy.

The dying are often subject to feelings of isolation, loneliness, and helplessness. Some of their suffering can be ameliorated by the strong sense of connection to the other that empathy brings. For the caregiver as well, an empathetic connection to another person nearing the end of life can offer the gratification of a uniquely intimate relationship.

Compassion encompasses empathy. Empathy is that aspect of compassion that opens one to a deep understanding of the other's suffering. Compassion also involves an active concern for and

effort to alleviate that suffering. That is why compassion is sometimes called “love in action” by Mother Teresa. Compassionate action is a willingness to go beyond self-interest and give of oneself for the good of the other. In this regard it is similar to altruism, letting go of one’s own needs to attend to the needs of another so that one can meet one’s own deepest need: to feel a part of a larger shared humanity.

Compassion is a key aspect of care of the dying. K. R. Eissler, in his seminal work on caring for the dying, *The Psychiatrist and the Dying Patient* (1955), sets the tone when he advises caregivers to give themselves selflessly to the dying as a free gift of love. Other researchers and those writing from their personal experience of being with the dying have echoed Eissler’s advice.

A terminal illness deepens one’s need for empathy and compassion in physicians and caregivers. Unfortunately, it has often been found that it is just at this stage that physicians, family, friends, and caregivers can emotionally distance themselves from the dying. Those attending and caring for the dying, in such cases, have the opportunity to receive from them. By being open, empathetically present, and compassionate, they can themselves be healed in their humanity and experience the gift of an extraordinary intimacy.

Compassionately attending to the dying is often deeply rewarding. Elisabeth Kübler-Ross felt that a loving and caring commitment to the dying would help heal the isolation and division that is so destructive in modern life. She saw such commitment as helping to build broader forms of commitment within society that would benefit all of humanity. In being open and compassionately present to the dying, caregivers share the burden of suffering and of anticipatory grief with them. They also share with the dying the solidarity of their committed relationship together and the joy that intimacy can bring. This is what Stephen Levine (1979) calls the experiences of “cosmic humor” in their last journey together.

Someone mourning the death of an acquaintance, friend, or loved one also needs the support of compassionate care and the empathetic presence of others. Cultural and religious rituals of dying, death, and mourning can help one find meaning and comfort in loss. Compassion and

empathy are gifts that people can share throughout their lives.

See also: COMMUNICATION WITH THE DYING; HINDUISM; KÜBLER-ROSS, ELISABETH; LESSONS FROM THE DYING; MOURNING; SYMPATHY CARDS

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THOMAS B. WEST

END-OF-LIFE ISSUES

Before the 1950s, end-of-life decisions were simpler than they are today. Most people died in their own homes, surrounded by family and loved ones. Illnesses such as scarlet fever, cholera, measles, diarrhea, influenza, pneumonia, and gastritis killed quickly. Medical science had not yet learned how to keep people with such chronic diseases as heart disease and cancer alive. Lifesaving technology, such as respirators and feeding tubes, was not available. Nature, not medicine, controlled the timing of one’s death.

This began to change in the 1950s as medical technology increasingly became able to thwart death through an array of technical tools that could keep hearts beating, bodies nourished, and lungs breathing despite the ravages of disease, illness,

and time. Advances in pharmacology and other medical procedures made it possible to prolong the life of even the seriously ill. Lengthened lives, however, did not always mean quality lives. On the extreme end of the spectrum, it meant that patients existing in a persistent vegetative state could be kept alive for an indeterminate time. Other patients, while conscious, were debilitated and in pain, confined to bed and dependent on machines, for weeks, months, and even years. When the end did come, it was usually in a hospital room. Unlike in the past, when only a third of patients died in medical institutions, in the early twenty-first century four out of five patients died in institutions such as hospitals and nursing homes. Instead of embracing the phalanx of medical machinery that could forestall death, these patients and their families began to focus on the quality of death rather than the prolongation of life.

Defining Death

In direct response to the development of life-sustaining technologies, the medical profession began to expand the definition of death. Traditionally, the loss of circulatory and respiratory function signaled death. But with the advent of technology that could sustain breathing and heart functioning through mechanical means this definition became less useful. A new definition that incorporated brain death—the irreversible loss of brain activity—into the definition of death was proposed and adopted. This meant life supports could be removed from those patients who were brain dead but were being kept alive through mechanical means. Still controversial is whether the definition of death should be expanded further to include those patients who have lost their higher brain functions but who continue to have lower brain functions, such as breathing. This new definition of death would include people who can no longer interact with their environment but are not totally brain dead.

However, medical definitions did not address the many spiritual, ethical, and legal questions that arose. Should patients be able to hasten their own death by refusing a respirator, feeding tube, or other life supports? If patients are unable to decide, should others be able to decide for them? If so, who should make the decision—family members, medical professionals, or both? Does it matter if

the patient is young or old? What if the individual is not terminally ill, but severely and chronically ill? Is there a difference between refusing life supports and asking for medical intervention that would hasten death?

These and other questions spawned a national dialogue on the quality of death and the rights of dying patients. A physician, Elisabeth Kübler-Ross, in the classic text, *On Death and Dying*, explored the stages of death for both the dying and the bereaved. Medical ethicists, such as Robert Veatch and Tom Beauchamp, began exploring the ethical issues involved. A presidential commission was appointed to study the ethical problems in deciding to forgo life-sustaining treatment.

Quinlan Case

It was the legal system, however, that provided the primary guidance on how to address the knotty problems that accompanied the advent of life-sustaining technologies. The first case involving what is now referred to as the “right to die” was the Karen Ann Quinlan case, decided by the New Jersey Supreme Court in 1976. Quinlan was twenty-one when, while attending a party, she stopped breathing, for unknown reasons, for at least two fifteen-minute intervals. She was brought to a hospital where she slipped into a coma. She was unable to talk or see and was kept alive by a respirator and fed through a feeding tube. Her physicians predicted that she would never regain consciousness. Her father, a devout Catholic, asked her physician to disconnect her respirator. When the doctors and hospital refused to honor the request, Quinlan’s father turned to the courts for assistance.

Quinlan’s physician argued that because she was not brain dead, both medical standards and ethics required him to continue treating her, with the respirator being part of that treatment. The government also intervened, arguing that the state’s interest in protecting the sanctity of life must be protected and that removing the respirator was tantamount to criminal homicide.

The New Jersey Supreme Court rejected both arguments, deciding that Quinlan’s right to privacy, protected by the Constitution, was violated when her physician and the hospital refused to remove

the respirator. Although the court recognized that the state had an interest in preserving life, it found that interest “weaken[ed] and the individual’s right to privacy [grew] as the degree of bodily invasion increases and the prognosis dims.” The court also rejected the idea that the medical profession was required to use all means at its disposal to keep patients alive. Rather, the “focal point of the decision [to terminate treatment] was whether the patient would return to a ‘cognitive and sapient life’ or remain in a ‘biological vegetative existence.’”

As to who could make the decision to remove life supports because Quinlan was unable to, the court held that it could be her father. Practically, according to the court, Quinlan’s right to privacy would be rendered meaningless unless her father could exercise it on her behalf. Central to the court’s decision was its belief that Quinlan’s father was of “high character” and very “sincere, moral, ethical, and religious.” The court rejected the argument that her father’s grief and anguish would distort his decision-making process, making him unable to make life-and-death decisions concerning his daughter. Quinlan was removed from the respirator, and to the surprise of her physicians and family she did not die until nine years later.

Cruzan Case

The *Quinlan* decision, issued by the New Jersey Supreme Court, was applicable only in that state. But it became the template for later court decisions and helped frame the social, legal, and policy issues underlying the right to die. Fourteen years later, the U.S. Supreme Court, in *Cruzan v. Director, Missouri Department of Health*, directly addressed the issue. *Cruzan* involved a young woman in a persistent vegetative state who had suffered severe brain damage in an automobile accident and had no hope of recovery. Nancy Cruzan was being kept alive by artificial hydration and nutrition that her parents wanted withdrawn. The Court found that the Fourteenth Amendment to the Constitution, which provides that persons may not be deprived of their liberty without due process of law, included a liberty interest in refusing heroic medical measures. The Court also relied on a common-law tradition that recognizes the right of individuals to control their own body, thus requiring that they consent before anyone, including a physician, touched them. The Court also

found that withholding food or water was no different than withholding other forms of life supports, such as a respirator, would be.

Unlike the court in the *Quinlan* case, however, the Supreme Court did not find Cruzan’s parents capable of making the decision to withdraw hydration and nutrition from their daughter. What was important to the Court was not what the parents wanted, but what the daughter would have wanted if she were able to decide for herself. Under Missouri law, where Cruzan lived, clear and convincing evidence of the patient’s wishes regarding life support was required. For that evidence, the Court looked back to statements made by Cruzan, which included comments made to a housemate about a year before her accident that she would not want to live should she face life as a “vegetable.” The Court did not find that these statements satisfied the clear and convincing standard, and it refused to grant her parents’ wish to terminate life supports.

Determining Patients’ Interests

Thus, while the *Cruzan* case established a constitutionally protected “right to die,” it also highlighted the difficulty in applying that right. Many people on life supports are unable to communicate their wishes. Past statements, often made in the course of casual conversation, may not be specific or serious enough. There is the risk that a decision made while healthy may not be the same decision one would make when ill. And while the law does not distinguish between withholding food and withdrawing a respirator, a patient might want to. Questions also arose about whether to distinguish between persons who were terminally ill and those suffering from severe and chronic illnesses that were not imminently life threatening.

Leaving it to the family to accurately reflect the patient’s interests also has its pitfalls. As the Court in *Cruzan* said, “even where family members are present, [t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient.” Expense and inconvenience may cause family members to advocate for the termination of life supports. Religious views may also differ within families, with, for example, a religiously devout parent resisting the preferences of a more secular child. On the other hand,

it is often the family who best knows the patient and who has the patient's best interests at heart.

Advance directives. The response to many of these dilemmas was to encourage people, both through law and custom, to clearly record their preferences while they were still able to make those decisions. All fifty states have passed laws, referred to as Natural Death Acts, clarifying the right to refuse life-sustaining treatment. These laws provide for various forms of advance directives, which are statements, usually in writing, that outline an individual's end-of-life preferences. It includes a living will, which is a written statement expressing a person's willingness, or not, to accept life-sustaining technology. Another form of advance directive is a health care proxy, which is a written statement that delegates decision making to another individual when the patient is no longer competent. Many states also have Do Not Resuscitate laws, which govern a narrowly tailored type of advance directive that permits patients to refuse cardiopulmonary resuscitation if they suffer cardiac arrest. States have also passed laws that provide for the appointment of a surrogate decision maker (usually a family member), who is designated to make health care decisions when the patient has failed to complete an advance directive. These laws typically require the surrogate to consider the values and beliefs of the patient.

Bioethics and other issues. The medical profession has also responded, setting up hospital bioethics committees that establish policies and advise health professionals, patients, and their families of their rights and alternatives. Despite these laws, and the existence of bioethics committees, problems still remain. It is estimated that only one out of five adults has completed an advance directive. This means, as in the *Cruzan* case, that the patient's preferences must be ascertained, if possible, from past statements, unless the state has a law providing for a surrogate decision-maker to be appointed. For those who have executed advance directives, it may be too vague or ambiguous to be of use. Distraught family members may also try to persuade physicians not to follow a patient's preference for the withdrawal of life supports.

Other issues have also emerged as the right to die has become more firmly established. Evidence indicates that physicians sometimes ignore a

patient's advance directive, administering life supports when the patient does not want them. This may be because they are unaware of the directive or do not agree with it. This has spawned a new type of legal action that attempts to recover monetary damages from the physician or health care provider for, in essence, keeping the patient alive against his or her will. Several of these lawsuits have been successful, but the law is still evolving in this area. Another emerging area of concern is whether a health care system focused on cost cutting and rationing of medical services under managed care will discourage patients from choosing expensive life-sustaining technology. Here, the issue may be who decides—the patient or the physician—whether such intervention is futile or inappropriate.

Assisted Suicide and Euthanasia

Whether the right to die should be extended to a more active role in hastening death, such as physician-assisted suicide, is also a controversial issue. Physician-assisted suicide is when a physician provides medications or other interventions to a patient to enable the patient to commit suicide. Proponents of assisted suicide have argued that there is no distinction between ceasing or not accepting medical treatment and taking affirmative steps to hasten death. They contend that the right to control one's own body means the right to control one's death, with the help of others if necessary. Opponents argue that permitting assisted suicide is a slippery slope, and that the right to die will turn into the "duty to die." They contend that the old and infirm will feel an obligation to hasten their death because of the burden they create on society. The U.S. Supreme Court, in the 1997 case of *Vacco v. Quill*, has held that there is no constitutional right to assisted suicide. This does not mean, however, that states cannot pass laws legalizing assisted suicide. One state, Oregon, has already done so, passing the Death with Dignity Act in 1994.

Still more controversial is euthanasia, or "mercy killing." Voluntary active euthanasia involves one person asking another to cause the first person's death by, for example, administering a lethal injection. Such an act was not legal at the start of the twenty-first century, although many people supported the honoring of a terminally ill person's

request for voluntary active euthanasia. Involuntary active euthanasia means ending patients' lives without their consent. There is little or no public support for this type of euthanasia.

Wills and Estates

Another less controversial, and more routine, category of end-of-life decisions is how property is disposed of when someone dies. This area of law, commonly referred to as "wills and estates," is carefully regulated. A will is a written document that provides for the disposition of all of a person's property upon the person's death. An *estate* is the legal term used for this property. Without a will, state law determines how the property will be distributed. A surviving spouse gets half, while the children get the other half. Wills cannot be made by persons who have become *incompetent*, a legal term referring to persons who are unable to manage their own affairs because they cannot communicate or are suffering from other cognitive or psychological impairments. Thus, like advance directives, wills should be completed and updated before a person becomes ill or incompetent.

Decisions at the end of life have become more complex as modern technology conflicts with people's desire to die a more natural death. While a patient's right to refuse life-sustaining medical interventions is firmly embedded in the law, the full contours of this right are still evolving. Individual values of autonomy and self-determination must be balanced with medical progress and the government's interest in protecting life.

See also: ADVANCE DIRECTIVES; CRUZAN, NANCY;

DEFINITIONS OF DEATH; INFORMED CONSENT; LIVING WILL; NATURAL DEATH ACTS; QUINLAN, KAREN ANN; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE; WILLS AND INHERITANCE

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VICKI LENS

EPICURUS

Should we fear death? A very famous argument of why we should not was offered some 2,300 years ago by the philosopher Epicurus. Epicurus (341–271 B.C.E.) authored around 300 scrolls, but only three letters and a few fragments have survived, being passed down in a biography by Diogenes Laertius four centuries after Epicurus's death. Born of Athenian parents and raised on the island colony of Samos, Epicurus was introduced to philosophy as a teenager when he encountered followers of Plato and Democritus. Democritus's philosophy was to have a lasting effect on Epicurus's mature thinking. In 306 B.C.E., Epicurus began his own school in an area known as the "Garden." The school was unique in accepting women and even slaves—a point ridiculed by aristocratic critics. The school flourished and soon rivaled the established Academy (founded by Plato) and Lyceum (founded by Aristotle). Students came to deeply revere Epicurus, who became known for cultivating friendship. After his death, they began to celebrate his life with monthly feasts. His ideas spread quickly and with profound effects. The Roman poet Lucretius (95–55 B.C.E.) espouses Epicurean philosophy in his "On the Nature of Things."

Epicurus was interested in how one could achieve happiness. He believed that unhappiness is a kind of "disturbance in the mind," caused by irrational beliefs, desires, and fears. Among human desires, he argued, some are "natural and necessary," others are "vain." Among the vain are desires for a life of luxury and indulgence. This fuels the myth that epicureanism condones the maxim, "Eat, drink, and be merry." Although Epicurus was the father of hedonism (from the Greek word *hedone*, meaning "pleasure"), he did not encourage every kind of pleasure, as expressed in his *Letter to*

Menoceus: "We do not mean the pleasures of profligates and those that consist in sensuality . . . but freedom from pain in the body and trouble in the mind." The chief pleasure sought after was pleasure of the mind—tranquility (*ataraxia*)—which can be produced by "banishing mere opinions to which are due the greatest disturbance of spirit" (Bailey 1926, p. 127ff). Epicurus concentrated on two fears: the gods and death. How can these fears be banished as irrational and vain?

Arguing in his *Principal Doctrines* that "without natural science it is not possible to attain our pleasures unalloyed" (Bailey 1926, p. 97), he turned to Democritus's atomism, which held that the universe and everything in it is the product of accidental forces and composed of small bits of matter called atoms (*atomoi*). Epicurus accepted this as a reasonable explanation of life, and also saw in it the solution to human fears. As he puts forth in his *Letter*, in death the subject simply ceases to exist (the atoms are dispersed) and is therefore touched neither by the gods nor the experience of death itself:

. . . death is nothing to us. For all good and evil consists in sensation, but death is deprivation of sensation. And therefore a right understanding that death is nothing to us makes the mortality of life enjoyable, not because it adds to it an infinite span of time, but because it takes away the craving for immortality. For there is nothing terrible in life for the man who has truly comprehended that there is nothing terrible in not living. [Death] does not then concern either the living or the dead, since for the former it is not, and the latter are no more. (Bailey 1926, pp. 124–125)

Many scholars have objected to this argument by noting that it is often the anticipation of death, not the event itself, that disturbs humankind. For example, the scholar Warren Shibles points out that Epicurus's argument amounts to showing that "we cannot fear the state of death because we will not be conscious after death. But we certainly can fear losing consciousness" (Shibles 1974, p. 38). But Epicurus would most likely reply, as he did to similar concerns, "That which gives no trouble when it comes, is but an empty pain in anticipation" (Bailey 1926, pp. 124–125).

See also: PHILOSOPHY, WESTERN; PLATO; SOCRATES

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WILLIAM COONEY

EPITAPHS

For hundreds if not thousands of years, the epitaph has been a significant part of the death ritual. Before the development of written language and adequate tools for carving, the grave was marked with such items as sticks and rocks. In his *Death and Dying in Central Appalachia* (1994), the scholar James K. Crissman notes that in the first one hundred years of Central Appalachian society, marking a grave using any form of language involved taking a sharp-pointed rock and carving the initials of the deceased on another rock. Most likely, this was the way the first human societies expressed themselves when they developed the ability to use language symbols.

Archaeological evidence and written and pictorial records show that memorials were an important part of ancient societies such as the Egyptians, Greeks, and Romans. The Greeks used eight forms of grave markers including round columns, rectangular slabs, stelae (carved or inscribed stones), shrine-shaped stones, huge rectangular stone blocks, marble vases, square or round receptacles for cremains, and sarcophagi (stone coffins) (Bardis 1981). Many of these early societies employed sepulchral iconography or the use of beautiful, elaborate, and detailed scenes or panoramas portraying the life of the decedent, as well as written inscriptions such as "farewell" (Crissman 1994).

The epitaph, or inscription at a grave or memorial in memory of someone deceased, exists for a variety of reasons and in a multiplicity of forms. While the use of epitaphs predates the modern era, the French thanatologist Philippe Ariès states that "the practice of marking the exact site of

a grave by means of an inscription did not become widespread until the end of the eighteenth century" (Ariès 1982, p.78).

Grave markings usually act to provide information about the deceased, to memorialize, and to relay a message to the living. In the twenty-first century most tombstones contain some sort of biographical information about the deceased, including the name of the decedent, the date of birth, and the date of death. In addition to this information, many markers include an inscription in verse or prose upon a marker. There is clearly a memorial aspect contained in some epitaphs. For instance, the grave of the American reformer Susan B. Anthony states, "Liberty, Humanity, Justice, Equality" and epitaphs of soldiers killed in war often include lines such as, "He gave his life for his country" or "Who died in the service of his country." Another function of epitaphs is to attempt the establishment of symbolic immortality by relaying a message to the living. One of the more famous epitaphs states:

Remember friend as you passby
As you are now so once was I.
As I am now you will surely be
Prepare thyself to follow me.
(Gazis-Sax 2001, p.1)

Depending on the culture in which the deceased lived, the epitaph can take on several forms, ranging from the religious to the humorous. Some of the most common epitaphs contain only one line such as, "Gone but not forgotten," "Rest in peace," and "In remembrance of." Many epitaphs contain a religious theme emphasizing comfort and future reunions in heaven. Some examples of these include, "Precious Lord take my hand," "Prepare to meet me in Heaven," and "The Lord is my Shepherd I shall not want." In contrast to the religious messages, humorous epitaphs focus more on the manner of death, or relationships with the living, such as, "I told you I was sick," "Gone, but not forgiven," and "Here lies a father of twenty-nine, he would have had more but didn't have time." (Spiegl 1982).

The practice of using long epitaphs, whether religious or humorous, has not been as widely practiced in the United States as it has been in Europe. Furthermore, twenty-first-century epitaphs are much simpler than those of the past. Even though the practice of lengthy epitaphs has fallen



This stone epitaph for St. Monica, in the Museo di Antichità, Ostia, Italy, is one method used to mark graves—a practice that dates to ancient times. PUBLIC DOMAIN

out of favor, there is still the desire to have some information about the deceased. For example, a computer engineer has developed a solar-powered headstone with a sensor. When a visitor approaches the headstone, a recording device and a video display screen are utilized to reflect biographical information, a genealogy, and/or words of admonition, along with pictures of the deceased (Gumpert 1987). Although, in general, such technology is still unused, there are other ways in which technology continues to influence the use of epitaphs. There are numerous web sites that offer help writing a meaningful epitaph for those who are planning ahead, or want to memorialize a loved one or pet. Another future use of epitaphs is a web site where messages can be stored on the Internet and accessed only after the death of the

writer. All of these new forms of epitaphs help provide information about the deceased, memorialize their lives, and relay messages to the living.

See also: CEMETERIES AND CEMETERY REFORM; FUNERAL ORATIONS AND SERMONS; MEMORIAL, VIRTUAL

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EUGENICS

See BIOETHICS; BLACK STORK.

EUTHANASIA

The word *euthanasia* translates from Greek roots as "good death." The *Oxford English Dictionary* states that the original meaning, "a gentle and easy death," has evolved to mean "the actions of inducing a gentle and easy death." This definition is consistent with contemporary use of the term. For example, the Canadian Senate Special Committee on Euthanasia and Assisted Suicide defined euthanasia as "the deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person's suffering where that act is the cause of death" (Senate of Canada 1995, p. 15). Euthanasia is generally classified in terms of certain subcategories, depending upon whether or not the person who dies by euthanasia is considered to be competent or incompetent and whether or not the act of euthanasia is considered to be voluntary, nonvoluntary, or involuntary.

Definitions of Euthanasia

Euthanasia is considered to be *voluntary* when it takes place in accordance with the wishes of a competent individual, whether these wishes have been made known personally or by a valid advance directive—that is, a written statement of the person's future desires in the event that he or

she should be unable to communicate his or her intentions in the future. A person is considered to be competent if he or she is deemed capable of understanding the nature and consequences of the decisions to be made and capable of communicating this decision. An example of voluntary euthanasia is when a physician gives a lethal injection to a patient who is competent and suffering, at that patient's request.

Nonvoluntary euthanasia is done without the knowledge of the wishes of the patient either because the patient has always been incompetent, is now incompetent, or has left no advance directive. A person is considered incompetent when he or she is incapable of understanding the nature and consequences of the decision to be made and/or is not capable of communicating this decision. In the case of nonvoluntary euthanasia, the wishes of the patient are not known. An example of nonvoluntary euthanasia is when a doctor gives a lethal injection to an incompetent elderly man who is suffering greatly from an advanced terminal disease, but who did not make his wishes known to the physician when he was competent. Another example would be a father who asphyxiates with carbon monoxide a congenitally handicapped child who was never considered to be competent.

Involuntary euthanasia is done against the wishes of a competent individual or against the wishes expressed in a valid advance directive. Examples of involuntary euthanasia include a son who gives a lethal overdose of medication to his father who is suffering from cancer, but the father does not want the overdose. Another example is a physician who, despite the advance directive of a patient indicating that he or she does not want any actions to hasten death, gives a lethal injection to the patient who is now unconscious and suffering from the final stages of a terminal illness.

Although the above definitions may seem clear, there is much confusion in the words used to describe euthanasia and other actions that result in hastening death. The term "mercy killing" is often used to describe situations of nonvoluntary and involuntary euthanasia. In several European countries, for example the Netherlands, the difference between euthanasia, homicide, suicide, and assisted suicide appears to be relatively clear. However, in the United States and Canada there is

much confusion concerning the use of the term *assisted suicide* and *physician-assisted suicide*.

Definitions of Assisted Suicide

Assisted suicide is usually defined as a specific situation in which there is a suicide, that is, an act of killing oneself intentionally. Adding the word “assisted” to suicide implies that another person provided assistance by supplying the means (e.g., giving the person a gun or prescribing lethal medication), the knowledge (information about the use of the gun or how to take a lethal dose of medication), or both. In North America, assisted suicide has also been used in the media to refer to situations that appear to have been direct acts to end the life of a person intentionally initiated by another person. This is because assisted suicide has lesser legal sanctions than the act of killing another person even if the homicide is for the relief of pain and suffering in a terminally ill individual and can be called “euthanasia.” For these reasons, Jack Kevorkian (the pathologist who made media headlines in the 1990s for his involvement in the deaths of over 130 individuals) claimed that his participation in the deaths of several patients was assisted suicide rather than euthanasia.

Sometimes there may be a fine line between what is considered assisted suicide and euthanasia. For example, during the period between July 1996 and March 1997, when euthanasia was legal in the Northern Territory of Australia, a machine was invented whereby a physician attached the patient to a computer-operated pump that contained lethal substances. Although the physician hooked up and turned on the apparatus, the lethal injection was only given after the patient responded to a question on the computer screen by pressing on a key.

Arguments in Favor of Euthanasia

Arguments in favor of euthanasia are generally based upon beliefs concerning individual liberty, what constitutes a “good” or “appropriate” death, and certain life situations that are considered unacceptable. These arguments are generally based upon moral or religious values as well as certain beliefs concerning the value and quality of human life. They also often suppose that people are capable of making rational decisions, even when they are suffering and terminally ill.

The good death. According to this view, certain ways of dying are better than others. Usually a good death is described ideally as drifting into death in a pleasing environment as one falls asleep. The ancient Roman orator and statesman Cicero said that a good death is the ideal way of respecting natural law and public order by departing from the earth with dignity and tranquility. Euthanasia can be seen as a way to assure that a person dies in a dignified and appropriate manner.

Individual liberty. In his *Essay on Suicide*, the eighteenth-century Scottish philosopher David Hume stated that all individuals in a free society should be able to choose the manner of their death. Some people, for example, feel that this right must be tempered by the obligation to not cause harm to others.

Right to maintain human dignity. This argument is similar to the concept of the good death, except that the objective is to *avoid* a poor quality of life during the dying process rather than seek out a particular idealized way of dying the good death. There are great individual differences in what constitutes a dignified way to live and die. Commonly mentioned indignities to justify premature death include: being a burden to others, living a deteriorated state incapable of normal daily activities, having to be placed in a hospital or a nursing home, and being dependent upon intrusive medical apparatus to continue living or engaging in everyday tasks. The general public often assumes that certain chronic and terminal illnesses inevitably result in a poor quality of life. However, research suggests that the psychosocial environment determines quality of life as much or more than the nature of the illness, per se.

Reduction of suffering. In 1516 the English statesman and author Sir Thomas More described euthanasia to end suffering in his book *Utopia* as “those that are ill from incurable diseases they comfort by sitting and talking with them, and with all means available. But if the disease is not only incurable but also full of continuous pain and anguish, then the priests and magistrates exhort the patient saying that he has become . . . irksome to others and grievous to himself; that he ought to . . . dispatch himself out of that painful life as out of a prison or torture rack or else allow his life to be ended by others” (More 1964, pp. 186–187). In 1994 the philosophy professor Margaret Battin

wrote that euthanasia to reduce suffering has two components: to avoid future pain and suffering and to end current pain and suffering. This definition generally assumes that the pain is not only intolerable but interminable.

Justice. Gerald Gruman described euthanasia in order to achieve “justice” in society as “thrift euthanasia,” where decisions are made to end lives of certain patients in situations where there is competition for limited resources in medical care. When there is a scarcity of certain medical resources in a society, not all people who are ill can continue to live. In such situations, one can suggest that “less valuable” individuals should give up their places to persons who contribute more to society; if they are unwilling, others should decide who should live and who should die. An extreme example is the eugenics programs based upon Darwinian concepts, such as those proposed by the German biologist Ernst Haeckel in 1904. Haeckel proposed that in order to reduce welfare and medical costs “hundreds of thousands of incurable lunatics, lepers, people with cancer” be killed by means of morphine or some other “painless and rapid poison” (1904). This approach inspired the National Socialists led by Adolf Hitler in their eugenics program.

Even if one disagrees with any form of eugenics program for economic reasons, one may still consider the fact that social pressure often exists in situations where medical resources are limited. The concept of “distributive justice” involves looking at the collective good or general welfare as something to be shared among the total membership of society. When resources are limited, society may question, for example, if it is worth expending tremendous resources to maintain the life of one incurably ill individual in a vegetative unconscious state rather than using those resources to help cure those who have promising prognoses for recovery.

Avoiding botched suicides. Molloy states that if euthanasia remains illegal, some people will be forced to attempt suicide or try to kill loved ones without any help. He contends that in some instances unsuccessful suicide attempts and botched euthanasia by others may result in a life situation that is worse than before. It can be argued that legalization of euthanasia will avoid suffering from botched attempts and the prosecution of loved ones who are acting sincerely at the request of a family member.

Control of existing practices. In countries where euthanasia is illegal there are clandestine practices by physicians and family members regardless of the laws. Proponents of euthanasia in the Netherlands often state that as long as euthanasia remains illegal in a country, physicians and other citizens will camouflage those activities and there will be no monitoring or control of what occurs. An advantage to legalizing euthanasia would be to control existing practices and ensure that there are fewer abuses.

Arguments against Euthanasia

The arguments against euthanasia include religious and ethical beliefs about the sanctity of life as well as a number of arguments allowing for euthanasia that will inevitably lead to a situation where some individuals will risk having their deaths hastened against their will.

Sanctity of human life. This belief, based upon religious values, considers human life sacred and inviolable. No person may take the life of another. For example, St. Augustine interpreted the biblical precept against killing as being absolute, even including the taking of one’s own life. Another argument for the sanctity of human life is that this constitutes one of the pillars of social order that must be maintained to avoid social breakdown. For example, St. Thomas Aquinas condemned suicide because it goes against one’s obligation to oneself, the community, and God.

Wrong diagnoses and new treatments. According to this point of view, where there is life there is hope. It is possible that a terminal diagnosis is in error; some people thought to be dying from an incurable disease are victims of a mistaken diagnosis or may miraculously continue to live. Also, because of the rapid pace of advances in medical science, there may soon be a cure for diseases that are at the time of the euthanasia considered to be incurable. Thus, euthanasia may be a mistake if there is a possibility, however slight, that the person is not really going to die. For example, it can be said that many persons with AIDS (acquired immunodeficiency syndrome) who ended their life prematurely because of impending death may have continued to live for a long time because of the development of new treatments for the disease.

The Wedge or Slippery Slope. This argument maintains that when one accepts killing upon demand in

certain situations, despite the best controls and regulations, there is a risk of abuses. Furthermore, there is concern that once the door is opened to justify murder under some intolerable circumstances, there is the possibility of developing broader criteria and making euthanasia more widespread. For example, in the Netherlands euthanasia and assisted suicide was first only available to those who were terminally ill. Since 1998 the regulations for euthanasia have been used to permit access to euthanasia and assisted suicide to persons who are not terminally ill but who suffer hopelessly from chronic physical or even psychological illnesses.

Protection of the weak, incompetent, and disadvantaged. This argument is similar to the Wedge or Slippery Slope argument. The concerns with the Protection of the Weak argument are that people who may be unable to make informed choices concerning euthanasia may be forced to opt for a premature death or may become victims of non-voluntary or involuntary euthanasia.

The value of suffering. Suffering may be seen as good for the soul, a heroic act, or the price to pay for one's sins in order to guarantee a better life in the hereafter. Jesus' suffering on the cross may be considered an example of an appropriate way to die. If suffering is admirable, then seeking to end suffering by euthanasia cannot be condoned.

The option of suicide is always available. Because suicide is always available and not illegal in most countries, one can argue that legalization of euthanasia is not necessary because a person can always find some means of committing suicide. Because of the dangers in legalizing euthanasia, one might instead encourage people to commit suicide rather than involving others in their deaths. One may further argue that those who "do not have the courage" to end their own lives may be too ambivalent and should not be put to death by others.

The impossibility of competent and rational decision making. The seventeenth-century philosopher Spinoza felt that the desire to survive is such an essential part of human nature that humans may not rationally prefer not to survive and kill themselves. According to this view, anyone who wants to die may not be acting rationally. Furthermore, one may question if it is possible when experiencing pain and suffering to make a rational decision before the pain and suffering is controlled. Finally, one may question whether or not most important

human decision making is rational and why one should expect a person to be more rational when terminally ill. Major decisions such as choice of career, marriage partners, where to live, and whether or not to have children may be more emotional than rational. Also, there are no generally accepted criteria of what constitutes a rational argument in favor of euthanasia: What is logical and rational for one person may constitute reasons for continuing to fight against death in another person in a similar situation.

Choosing death for the wrong reasons. Many people consider euthanasia because they are experiencing pain and suffering. Ignorance of the availability of interventions to reduce pain and suffering may lead to a choice to end life. People involved in palliative care programs that focus upon reducing the suffering of terminally ill patients contend that better pain control and improvement of the psychosocial situation can alleviate a large proportion of the suffering and reduce the desire for euthanasia.

Undiagnosed clinical depression. It may be considered appropriate for people who are dying to feel sad and unhappy. However, some terminally ill persons may suffer from a more severe and potentially treatable psychiatric syndrome of clinical depression. In some instances, the depression may be a side effect of treatment of the illness or may be related to the psychosocial environment of an institution. According to this view, accurate diagnosis and treatment with antidepressant medication and/or psychotherapy is a preferable option to euthanasia.

Erosion of confidence in physicians. According to this argument, if physicians are allowed to kill some terminally ill patients then confidence in physicians may be diminished. Medical practitioners and proponents of this argument have suggested that only "specialists" should practice euthanasia if it is legalized so that physicians can maintain their reputation as advocates in the fight against death and the reduction of pain and suffering.

Compromising the right to choose by involving others in one's death. Brian Mishara has argued that humans generally experience tremendous ambivalence about ending their lives by suicide, so much so that most highly suicidal people change their minds before an attempt and the vast majority of persons who initiate a suicide attempt do not die

from their attempt. He questions whether the involvement of a physician in ending a person's life may create a social situation where there is tremendous pressure to complete the suicidal act and die rather than exercising the choice to continue to live. Once a physician has been convinced that euthanasia is acceptable and appropriate, it is not easy for a person to admit to the doctor that he or she is feeling ambivalent or scared and would like to put off the decision for a while. This analysis suggests that involving others in death can compromise people's rights to change their minds because of the social pressures to complete the act.

The Situation in the Netherlands

In the Netherlands, the practice of euthanasia and assisted suicide was legalized by legislative decree in November 2000. However, the practice of euthanasia has been tacitly condoned by jurisprudence since 1973. In 1973 a doctor was found guilty of giving her seventy-nine-year-old mother a lethal injection after repeated requests to end her suffering. The doctor was placed on probation for a year but this case generated considerable sympathy for the doctor and resulted in the Royal Dutch Medical Association producing a working paper on the topic. Furthermore, the Supreme Court of The Netherlands set out a number of considerations that would have to be met before an accused would be exonerated of euthanasia. Subsequently, the practice developed to not prosecute cases of euthanasia that respected those court guidelines. They include:

- The request for euthanasia must come from the patient and be completely voluntary, well considered, and persistent.
- The patient must have adequate information about his or her medical condition, the prognosis, and alternative treatments.
- There must be intolerable suffering with no prospect for improvement, although the patient need not be terminally ill.
- Other alternatives to alleviate the suffering must have been considered and found ineffective, unreasonable, and unacceptable to the patient.
- The euthanasia must be performed by a physician who has consulted an independent colleague.

- The physician must exercise due care, and there should be a written record of the case.
- The death must not be reported to the medical examiner as a natural death.

There is tremendous popular support in the Netherlands for the practice of euthanasia and the legal precedents have now been passed into law by Parliament. Several studies have been conducted on the nature of the practice of euthanasia and assisted suicide as well as possible abuses. Most cases of euthanasia occur among terminally ill persons in the advanced stages of their disease and it is rare that the criteria are not respected. However, in the Netherlands there are no monetary considerations concerning the cost of health care because there is a socialized medical program. Furthermore, the society in the Netherlands is very different from many other societies because of the strong emphasis upon individual freedom of choice and limited government control.

The Euthanasia Act in the Australian Northern Territories

The parliament of the Northern Territory in Australia passed the Rights of the Terminally Ill (ROTI) Act in May 1995, which was in effect for nine months from July 1, 1996, to March 25, 1997, when the act was repealed by legislation passed by the parliament of Australia. The ROTI Act allowed a terminally ill patient who was experiencing what he or she deemed to be unacceptable levels of pain, suffering, and/or distress to request the medical practitioner to end his or her life by euthanasia, if the requirements of the law were met. The law stipulated that besides suffering and being terminally ill, the patient must be at least eighteen years old, there must be no cure available, no other palliative care options to alleviate the suffering available, and a second opinion as well as a psychiatric assessment to confirm that he or she is not suffering from a treatable clinical depression.

After the law was passed, five persons who officially sought to use the act received extensive media attention. Although the intention of the law was to allow for a patient's personal physician to provide assistance to terminate life as part of their care, only one physician in the territory accepted to participate in euthanasia practices: Philip Nitschke. During the period that the act was in effect, seven cancer patients applied for euthanasia with

Nitschke. Four of the seven died by euthanasia; one committed suicide; one died a natural death; and another died from the effects of pain relief sedation.

The Oregon Death with Dignity Act

In November 1994 the Death with Dignity Act was adopted by a referendum vote of Oregon residents of 51 percent against 49 percent. Soon after the act was passed, the act was contested on the grounds that it presumably threatened the lives of terminally ill persons and did not afford them equal protection. A judge granted an injunction on the grounds that the act put people at risk. However, in 1997, the injunction was lifted by the Ninth Court of Appeals, which dismissed the case. The law went into effect in 1997 after the U.S. Supreme Court declined to hear an appeal of the case. A second referendum in November 1997 found 60 percent in favor and 40 percent against this law. In November 2001 the U.S. Attorney General John Ashcroft issued a directive that would have prohibited doctors from prescribing lethal doses of controlled drugs to terminally ill patients. Immediately after issuing the directive, the U.S. District Court in Portland issued a temporary restraining order blocking Ashcroft from punishing physicians who wrote lethal prescriptions. In April 2002 the same court ruled that Ashcroft had overstepped the authority of the Federal Controlled Substances Act when he declared that writing lethal prescriptions was not a legitimate medical purpose and threatened to revoke the license of physicians who wrote lethal-dose prescriptions to patients who requested one. This decision made the restraining order on Ashcroft permanent; however, as of this writing, the decision may be subject to appeal.

According to this law there are four criteria necessary for an assisted suicide to be conducted in the state of Oregon: (1) the person must be at least eighteen years old, (2) a legal resident of Oregon, (3) able to communicate his or her decisions about medical care, and (4) in the terminal phase of an illness that is defined as having a life expectancy of less than six months. If the patient is eligible, the request must be made twice in less than fifteen days and the request must be made in writing to a physician who then establishes that all the conditions have been met. A second physician must be consulted, and the first physician must inform the patient of all alternatives available. The physician can request that the person inform family members about the request, but this is not obligatory. The

physician may then prescribe a lethal medication, which he or she must declare to the Oregon Health Division. This physician has no obligation to participate in the assisted suicide and is protected against any criminal liability under this act.

During the first four years since the law was applied (1998–2000), 140 prescriptions for lethal doses of medication were written, mainly to cancer patients, and 91 persons died after taking these medications. This constitutes fewer than one-tenth of 1 percent of terminally ill Oregonians dying by physician-assisted suicide.

Conclusions

Arguments for or against active euthanasia that are based upon moral or religious beliefs are impossible to resolve on the basis of empirical facts or logical arguments; these arguments are related to cultural values and practices. However, values and practices can change over time. Some practices that were considered barbaric at one time in history have become acceptable in the twenty-first century. The practice of euthanasia, its legalization, and acceptance in various societies is also influenced by public debate and media reports. With the increased acceptance and legalization of euthanasia in different societies, researchers are gaining more information about the practice of euthanasia and its effects. One of the central issues in the acceptance of euthanasia is weighing society's obligations to provide an easier access to death against society's obligations to provide the means for diminishing pain and suffering among those who may want to die prematurely by euthanasia.

See also: BIOETHICS; BLACK STORK; GOOD DEATH, THE; INFORMED CONSENT; KEVORKIAN, JACK; NATURAL DEATH ACTS; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE

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BRIAN L. MISHARA

EXHUMATION

Cemeteries exist as "resting places," and the norm of many cultures is that the dead should not be disturbed. However, for a variety of reasons, they are disturbed through the process of exhumation (removal of a corpse from the earth). Many early groups placed the corpse in the ground and exhumed it at a later date for religious rituals, a practice still undertaken by some traditional societies. In fourteenth-century France, "it became common procedure to dig up the more or less dried-out bones in the older graves in order to

make room for new ones" (Ariès 1982, p. 54). The high death rate from the European plagues coupled with a desire to be buried in already-full church cemeteries led to old bones being exhumed so that new bodies could be placed in the graves.

In times past, on rare occasions prior to embalming, the body was removed from the ground. This happened when burial professionals or the authorities suspected that the person might have been buried alive. The French philosopher and death expert Philippe Ariès discussed necrophiliacs who disinterred dead bodies for sexual purposes and scientists who dug up corpses to conduct scientific experiments. It is common knowledge that for centuries until cadavers were legally provided, medical schools exhumed dead bodies for teaching purposes. One of the reasons the use of the wake was enacted in many societies was to deter those who might steal corpses.

In contemporary America corpses are disinterred when there is a need to identify a body or to establish cause of death like in the case of suspected homicide. For example, President Zachary Taylor was exhumed in 1991 to determine whether or not he had been poisoned, and the famous outlaw Jesse James's grave was excavated to prove that it was his body in the coffin. In addition, archaeological investigations often involve exhumation.

Under modern law, courts usually do not allow exhumation unless there are substantial and compelling reasons to do so. In a landmark U.S. Supreme Court decision (*Dougherty v. Mercantile Safe Deposit and Trust Company* 1978), Justice Cardozo stated, "The dead are to rest where they have been lain unless reason of substance is brought forward for disturbing their repose." Three general principles govern the law of disinterment in the United States. First, it is presumed that a "decently buried" body should remain undisturbed where it was placed unless good reason is given to do so. Second, disinterment is considered the private concern of the immediate family and the cemetery. Third, if there is disagreement among the close relatives regarding a proposal for exhumation the matter is adjudicated by a court of equity. The court considers (in order of importance) the wishes and religious beliefs of the deceased (if these can be determined), the wishes of the spouse of the deceased, the opinions of other close relatives, and

the policies and regulations of the cemetery when determining if exhumation should be allowed. California Labor Code stipulates that if it is suspected that a person has died as a result of injuries sustained in the course of his employment, the investigating appeals board may require an autopsy and, if necessary, the exhumation of the body for the purposes of autopsy. However, in accordance with the rules of equity, the close relatives can, if they wish, prevent the state (i.e., California) from either exhuming the body or performing the autopsy.

Scientists have long sought to understand life in early civilizations through the excavation of burial grounds and exhumation of human remains. In the United States the attempt to understand early cultures led to the exhumation of the remains of Native Americans, many of which ended up in the nation's museums and archaeology labs. In an attempt to prevent the desecration of Native American graves, the Native American Graves Protection and Repatriation Act was introduced in Congress in July 1990 and subsequently passed into law. The bill states that any human remains and objects found on federal or tribal lands after the date of enactment are to be considered owned or controlled by lineal descendants, the tribe on whose land it was found, the tribe having the closest cultural affiliation, or the tribe which aboriginally occupied the area. Anyone who discovers items covered by the bill must cease his or her activity, notify the federal land manager responsible and the appropriate tribe, and make a reasonable effort to protect the items. Anyone who violates the provisions of the bill may be fined, imprisoned not more than one year, or both. The penalty may increase to five years for a second violation. The act further states that all federal agencies and museums receiving federal funds that have control over any of the items covered in the bill are to, within five years, inventory and identify the items, notify the affected tribes, and make arrangements to return such items if the appropriate tribe made a request. If an item was acquired with the consent of the tribe or if the item was part of a scientific study which was expected to be of major benefit to the country, the request for repatriation (i.e., return) could be denied.

See also: AUTOPSY; CEMETERIES AND CEMETERY REFORM;
CHARNEL HOUSES; FORENSIC MEDICINE; HUMAN
REMAINS; NATIVE AMERICAN RELIGION

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EXPOSURE TO THE ELEMENTS

Although humans are among the most adaptable of the earth's creatures with one of the broadest territories of settlement, their ability to survive extreme temperatures is limited. Death can occur by exposure to extreme heat or cold. A person who falls through the ice into water will typically die within twenty to thirty minutes because of heart standstill or heart fibrillation. By then, his or her internal or core body temperature will have fallen to approximately 77 degrees Fahrenheit. Often death is a combination of stresses to the body such as hypothermia and starvation as in the case of the Donner party, the ill-fated group of emigrants that was caught in the Sierra Nevada Mountains during the winter of 1846. The decrease in core body temperature is compensated for by shivering, constriction of surface blood vessels to direct the blood to internal organs, and behavioral actions such as increasing voluntary exercise or putting on more clothes. As hypothermia sets in the rate of all metabolic processes slows down,

leading to loss of judgment, apathy, disorientation, and lethargy. Breathing becomes slower and weaker, the heart slows, and disturbances in cardiac rhythm occur, leading to death. Many symptoms of hypothermia were evident in the oral and written accounts of the Donner party, adding to the inability to supplement their rapidly decreasing food supply.

The limits for hot air temperature that one can stand depend on whether the air is wet or dry. The core temperature of a nude body can remain within normal range (97 to 99 degrees Fahrenheit) for hours when exposed to dry air ranging from 55 to 130 degrees Fahrenheit. However, if the humidity of the air approaches 100 percent or if the person is submerged in water, the core temperature will rise whenever the environmental temperature rises above 94 degrees Fahrenheit. The body responds to heat stress by sweating, dilating surface blood vessels to expose more of the internal heat to the outside, and behavioral actions, such as removing clothes. In extreme situations, especially in hot arid environments, the body can lose enough water and salts in sweat to cause heat exhaustion, a condition consisting of muscle cramps, impairment of the cardiovascular system, unconsciousness, delirium, and death. Symptoms of heat exhaustion are increasing fatigue and weakness, excessive sweating, low blood pressure, cold, pale, and clammy skin, anxiety, and disorientation. A person with heat exhaustion can be helped by laying his or her body flat, or by tipping the head down to increase the blood supply to the brain while administering small amounts of sugar water to increase blood volume. Heat exhaustion can be prevented by adequate hydration before, during, and after physical activity.

Heat stroke (or sunstroke) can be induced by overexertion with prolonged exposure to a hot, humid environment, at environmental temperatures as low as 85 to 90 degrees Fahrenheit. In this case the body is unable to sweat due to the malfunctioning of the thermoregulatory control center in the brain. Tissue damage to the nervous and cardiovascular systems occurs when the core temperature rises above 109 degrees Fahrenheit, causing death. Symptoms of heat stroke may include headache, dizziness, fatigue, and awareness of the rapidly rising temperature. The person increases his or her rate of breathing to expel the excess

heat and the heart races but the blood pressure is not affected. Sweating is typically decreased so the skin is hot, flushed, and usually dry. Treatment is aimed at cooling the person down and hospitalization is recommended to ensure that the thermoregulatory control center regains normal functioning. Heat exhaustion can quickly and unexpectedly lead to heat stroke and death even of the most physically fit, as was the case with offensive tackle Korey Stringer, who died in a Minnesota Vikings 2001 summer preseason practice. Although the body is well equipped to handle normal changes in body temperature, extreme changes in environmental conditions may not be able to be compensated for and can lead to irreversible damage and death.

See also: CAUSES OF DEATH

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ALLISON K. WILSON

EXTINCTION

Humans are the only species aware of not only of their own eventual personal deaths but of their collective demise as well. This latter insight came late in human history—a product of evolutionary theory and of paleontological and archaeological research.

The West still deals with the twin “cognitive shocks” from the mid-nineteenth-century discoveries that extinction was the fate both of creatures very much like human beings and of cultures as articulate as those in the West, whose people can still speak directly to Western civilization because of their writing systems. On top of these are the twentieth century’s scientific end-of-world scenarios, predicting the inevitable extinction of not only all life forms on Earth when the sun goes supernova, but of the entire universe, when entropy is complete and the last nuclear fires flicker out.

Since WWII—particularly following the publications of Rachel Carson’s *Silent Spring* (1962) and Paul Ehrlich’s *Population Bomb* (1968)—sensitivities toward extinction have heightened with cold war fears of nuclear war, the obvious diminishment and degradation of the natural order owing to industrialization and burgeoning human numbers, and with millennial apocalyptic fears. With increasing regularity the news brings scientific findings of global warming, of a rapidly growing list of endangered and newly extinct life forms, of “earth-killer” asteroids lurking nearby, and of lethal pollutants in the air, soil, and water. The polar ice caps are melting as are the famed snows of Kilimanjaro. The blubber of orcas from the American Pacific Northwest found to contain PCB (polychlorinated biphenyls) concentrations up to 500 times greater than those found in humans. In the extreme, such phenomena are interpreted as symptoms of the beginning of the end of not only the planet’s entire ecosystem but human beings as well.

Extinction as the consequence of natural selection and the fate of the “unfit” was to become the metaphor for understanding not only natural but social phenomena as well, whether it be the success or failures of businesses or of entire cultural orders. It also found expressions in the justifications for war, exploitation, and forced sterilizations and genocides of human populations.

Scientific Perspectives

The law of life from scientific perspectives holds that all life forms, ecosystems, planets, stars, and galaxies come and go. Personal death and collective extinction are the debts for life—on the individual, species, genus, family, order, class, and phyla levels. Since life first appeared on Earth 3.5

billion years ago, over 10 billion species have come into existence (and this figure is the roughest of estimates). Somewhere between 10 million and 30 million species (of which scientists have counted only about one-eighth) currently reside on the planet. In other words, for every 1,000 species that have ever existed probably fewer than 10 are alive in the twenty-first century.

Challenging the conventional idea that “species were immutable productions,” the naturalist Charles Darwin wrote *On the Origin of Species by Means of Natural Selection, or the Preservation of Favoured Races in the Struggle for Life*, explaining how life is a continuous process of modification and current life forms are descendants of extinct ancestral species. Natural selection is “the process by which genes change their sequences” (Ridley 2000, p. 35), by which those organisms best adapted to their environment survive to pass on their genetic code while those (previously “successful”) life forms unable to make adaptive modifications to varying conditions perish. Species’ billing on the stage of life is relatively short in terms of geologic time, with most becoming extinct within a few million years after their evolution. Most leave no related descendant species but rather become evolutionary dead ends.

Life is a continuous process of extinction and diversification, where only the fittest life forms survive in a world where, according to Darwin, they are “bound together by a web of complex relations” (1963, p. 54). Central to these “relations” are the ecological niches, the millions of different “fits” and functional interdependencies that plants and animals have with each other in their ecosystem. While various creatures may share a habitat, generally a niche can only be occupied by one species of animal or plant. When two different organisms compete for a particular niche, one will invariably lose out. If a niche should become empty, such as through extinction, other life forms will rush in and compete to fill the vacuum. In the case of a mass die-off, evolutionary explosions of new life forms occur as plants and animals adapt to take advantage of the abundance of newly opened niches.

Another factor affecting the rate of extinction and differentiation of life forms is the extent of biodiversity in an ecosystem. These natural systems comprising the biosphere do such things as cycle

oxygen and carbon, purify the water, and decompose waste. Diminish the genetic variation in individual species and they become more vulnerable to extinction. Homogenize the biotas in human-dominated ecosystems and biodiversity declines.

The diversity of life used to be considerably richer than is the case in the twenty-first century. For instance, based on the fossil record of the Cambrian Period over 500 million years ago, there may have been four to five times the number of phyla as exist today. Given present trends, this multiplier may be even greater in the near future as the site of the planet's greatest biodiversity, the tropical forests where between 50 and 90 percent of species reside, are rapidly disappearing. Worldwide, tropical forests four times the size of Switzerland are cut down annually, replaced with fields for cash crops and to make room for burgeoning human populations—which, in turn, pollute the water and land, further diminishing the variety and size of natural habitats.

Though humans may be one of the only species to have adapted to nearly all environments on Earth, their existence nevertheless remains dependent upon the complex systems of interdependent life forms.

Periodic Mass Extinctions

The rate of extinction is far from constant. In addition to the routine processes of Darwin's natural selection, various terrestrial and extraterrestrial catastrophes have profoundly altered the course of evolution. Paleontologists report historic cycles of mass death, dooming or marginalizing a portion of previously well-adapted species, followed by steep increases in the diversity of new life forms.

At least five periods of mass extinction have been identified, eliminating over half of the world's species at the time of their occurrence (although, in total, causing less than 5% of all extinctions). Scientific debate centers not on whether these mass die-offs have occurred but rather if they happened quickly, such as due to asteroid impact or a nearby star going supernova, or more slowly, such as due to glaciations, volcanic activity, changes in seawater oxygen or salinity, or epidemics. The time required for the species diversification to rebound to pre-catastrophe levels is estimated to be roughly 25 million years.

Asteroids are suspected in at least the three most recent mass die-offs. Most publicized is the suspected 10-kilometer-wide meteorite that slammed into what's now the Gulf of Mexico and the Yucatán Peninsula 65 million years ago, leaving the 180-kilometer-wide Chicxulub Crater, wiping out the dinosaurs, and ending the Cretaceous period. Another is believed to have concluded the Permian period with even more devastating results, when 250 million years ago some 96 percent of marine and 70 percent of land fauna disappeared. Ironically, shortly after *Jurassic Park's* release, the world witnessed over twenty parts of Comet Shoemaker-Levy collide with Jupiter. At least nine of these could have been Earth-killers, one forming a crater the planet could easily fit within. As of 2000, according to the British National Space Center, 284 asteroids have been located with the size and orbits to be deemed "potentially hazardous" to Earth.

There is evidence that mass extinctions may number in the dozens, with up to three-quarters of all species disappearing every 26 to 30 million years. One explanation for this cyclical regularity is the possible existence of a companion star to the sun. Called Nemesis, when this star reaches its perigee every 26 million years, it shakes loose and hurls a comet storm from the Oort cloud on the fringe of Earth's solar system. Every 50,000 years or so, for over a period of 2 million years, one of these comets collides with Earth, producing ecological catastrophes that lead to periodic global deaths.

Among biologists there is broad consensus that human beings are witnessing the sixth mass extinction, with anywhere from 10,000 to 20,000 species of animals and plants disappearing annually—a rate conservationists estimate to be 1,000 to 10,000 times greater than would be the case under natural conditions. A 1998 American Museum of Natural History survey of 400 experts in the biological sciences found approximately 70 percent expecting up to one in five of all living species on the planet disappearing within thirty years. What makes this different from the five other known periods of mass extinction—which were linked with asteroids, ice ages, and volcanoes—is the human complicity involved. We are death and are responsible for this "species holocaust" (Day 1981). In a sense, all creatures have become our miner's canaries and their disappearance means that the

TABLE 1

| The five greatest mass extinctions | | | | | |
|---|--|--|---|--|--|
| | Ordovician-silurian | Late Devonian | Permian-triassic | Late Triassic | Final Cretaceous |
| When Occurred | 439 million years ago | 365 million years ago | 251 million years ago | 199–214 million years ago | 65 million years ago |
| Casualties | Up to estimated 85% species and 45–60% of marine genuses killed. | 70–80% of all species and 30% of families vanish; marine life more decimated than freshwater and land fauna. | Most devastating of all, eliminating 85–90% of all marine and land vertebrate species, 95% of marine species. End of trilobites and many trees. | More than three quarters of all species and one quarter of families disappear. End of mammal-like reptiles and eel-like conodonts, leaving mainly dinosaurs. | 47% of marine genuses and 18% of land vertebrates wiped out, including the dinosaurs, leaving mainly turtles, lizards, birds, and mammals. |
| Hypothesized Cause(s) | Unusually fast plate movement; glaciation leading to sharp declines in sea levels. | Unknown if one catastrophic event or several smaller ones—possibly large asteroid or asteroid shower over time; possible glaciation and lethal temperature declines; oceanic anoxia (oxygen-lacking) | Possible asteroid; volcanic eruptions; dropping sea levels and oceanic anoxia | Little known but suspected fall in sea level, oceanic anoxia, major increase in rainfall. Possible comet showers or asteroid impact. | Suspected asteroid 10 km. in diameter hitting near Yucatán peninsula, coinciding with Siberian eruptions and dramatic climatic cooling. |

SOURCE: Adapted from A. Hallam, and P. B. Wignall, 1997; David Raup, and John J. Sepkosi Jr., 1986; and Lee Siegel, 2000.

health of the ecosystem is endangered and that we are running out of biological room

Human complicity in the Pleistocene extinction of large game animals remains a subject of debate, as there is a coincidence of receding glaciers, human migrations, and the extinction of many large game animals. The moa, a 400-pound flightless bird that thrived in New Zealand until about the year 1250, totally disappeared within 60 to 120 years of the first human arrival. Using fire as a weapon and tool, these settlers also burned into extinction an entire forest that was to become grassland. Similarly, woolly mammoths, camels, horses, saber-toothed tigers, and more than 120 other Pleistocene mammalian species all disappeared within a few hundred years after humans arrived in the New World roughly 11,000 to 13,000 years ago.

Perhaps the most poignant of recent extinctions is the passenger pigeon, which was to be hunted into oblivion. At the beginning of the American Civil War, this was one of the most successful bird species in North America, comprising an estimated 40 percent of the entire bird population. In 1870, a single flock one mile wide and 320 miles long flew over Cincinnati. In 1974 the last surviving pigeon died in that city's zoo. As of 2001, conservationists estimated that one in every six species of birds is in decline on the continent and could wane by half by the year 2030.

But the major cause of animal demise is the destruction of natural habitats as human populations

exploded, tripling just between 1930 to 2000, leading to urban sprawl, overfishing, overgrazing, deforestation, overuse of pesticides and herbicides, strip mining, and pollution of fresh water systems. Human introduction of non-native "invasive" species has also taken its toll. Fungus carried by North American ships, for instance, led to the Irish potato famine. Of those who fled migrated to Australia with rabbits and cats, many of which went wild and decimated indigenous plants and animals.

In Africa, the deserts annually expand thousands of square miles as a rapidly growing human population strips its indigenous vegetation for fuel (wood remains the chief energy source for many of its inhabitants) and to make room for profitable crops or livestock. Here the removal of ground cover leads to a greater runoff of rain, reducing evaporation into the clouds and thereby contributing to the severity of the region's routine droughts.

The loss is not confined to wild, undomesticated plants and animals but includes domesticated ones as well. During the twentieth century, because of the rise of cash crops and farmers' cultivation for maximum yield, three-quarters of the genetic diversity of the world's agricultural crops was lost. Roughly half of all domestic animal breeds in Europe became extinct. Gone are about 6,000 apple varieties that grew on U.S. farms 100 years ago. In the mid-1990s, the United Nations Food and Agriculture Organization reported that nearly one-quarter of the 3,882 breeds of 28 species of farm

animals around the world were “at risk”—meaning fewer than 1,000 females or 20 breeding males.

What worries experts most is the prospect that farmers will have a shrinking pool of breeds to draw upon to keep up with changing soil conditions, pests, and new diseases.

In other words, concerns are for preserving biodiversity, particularly in light of cash crops and humanity putting its proverbial eggs in fewer and fewer baskets.

Two groups of extinctions have intrigued humans over the past two centuries: the demise of the dinosaurs and of human ancestors. Over the final two decades of the twentieth century there was considerable research and public interest in the instantaneous (in geological time) demise 65 million years ago of dinosaurs, among the most successful (in terms of their length of reign on Earth) animals known. This interest coincided with the cold war, which was not coincidental. Humanity’s ability to equally quickly make itself extinct through thermonuclear devices became a widely accepted fact. Another factor heightening cultural receptivity was the rapid disappearance of its own social past—for example, old crafts, buildings, social etiquette—producing a sense of irretrievable loss. Modernity had come to mean impermanence in a culture of obsolescence where the only certainty had become change.

Unearthed in a quarry by Germany’s river Neander in 1856 as an unusual humanlike skeleton with a beetled browed skull. This discovery of the Neanderthals, a tool-making creature very similar to *Homo sapien*, ultimately led to the unsettling insight that extinction has also been the fate of all branches of the hominid family and of the *Homo* genus except for human sapiens. Modern humans’ complicity in the demise of these archaic humans remains a matter of speculation, with evidence indicating that humans shared the planet with at least the Neanderthals as recently as 26,000 years ago in Europe.

Social Reactions to Extinctions of the Natural Order

Only in modern times has there been the realization that the planet’s living resources are neither infinite nor always replenishable—and the scientific understanding of how precarious the interdependencies between all life forms are. People were

surprised in the 1860s when human artifacts were first found with extinct species in Europe. Severely challenged were biblical allusions to some “steady-state” or regenerative natural order, the fauna descendents of passengers on Noah’s ark, all of which were to be dominated by humans. Only later did people come to learn how the overkilling of “keystone species” could lead to an environmental collapse and the extinction of even non-hunted creatures.

For those living within largely manmade environments and within a highly individualistic culture, appreciation of life’s thorough interdependencies comes hard. Further, Cartesian conceptions of human’s biological essence—the body-as-machine metaphor that has long predominated in medicine—complicates more holistic understandings.

Limited is any acknowledgment of human complicity in the sixth mass extinction. According to 1993 and 1994 surveys of the American adult public conducted by the National Opinion Research Center, only 16 percent of American adults believe it is “definitely true” that “human beings are the main cause of plant and animal species dying out.” Four in ten agree with the statement, “We worry too much about the future of the environment and not enough about prices and jobs today.” And only one in three was “very” or “fairly” willing to accept cuts in his or her standard of living in order to protect the environment.

The perspective from the scientific community is less benign. Several scientists have likened human effects on the ecosystem to cancer. If people take the Gaia perspective of Earth functioning like one mega living organism, aerial views can show striking similarity to melanomas attacking healthy tissue.

The Economics of Extinction

The rise of the world economic order and its capitalist structure has accelerated the decimation of species. If, as Martin Luther King Jr. observed in 1967, capitalism has a tendency to treat profit motives and property rights as more important than people, one can easily surmise the importance it gives to the natural order. The system produces a bias toward short-term gains at the cost of long-term consequences. As mentioned, cash crops in the international marketplace have accelerated the

end of many species. The price tag of the resultant reduction of biodiversity rarely enters into the market system's cost-benefit equation. This absence is due, in part, to the fact that people really don't know how to calculate the worth of such endangered species as snail darters or white spotted owls.

In 1976 Daniel Bell wrote of the cultural contradictions of capitalism, perceiving them as seeds for change—or the death knell for entire social orders. One contradiction of relevance here is the economics of extinction, how the growing scarcity of a life form can increase its value and thereby accelerate its disappearance. For instance, in the 1980s when the market value of rhino horns exceeded the per ounce value of silver by ten times, this reduced the number of black rhinos in the Tanzanian Ngorongoro Crater from seventy-six to twenty-six in a single year. Pathetically, as their numbers declined the value of their parts hyperinflated, encouraging further exploitation. Another contradiction is how farmers will have a shrinking pool of breeds to draw upon to keep up with changing soil conditions, pests, and new diseases.

With the remnants of endangered species increasingly likely to only be preserved within zoos, research institutes, and parks, matters of cost and utility enter. Consider, for instance, the perspective of zoos. To garner public support, animal collections must attract audiences. The most popular animals are often those that are “cute,” furry, and large-eyed. Consequently, with time, Darwin's thesis of the survival of the fittest may have to be modified to be the survival of the cutest, like the black and white colobus or the arctic seal. Also saved will be those creatures that enhance humankind's own longevity, such as apes or pigs for xenotransplantations. Concerns over the loss of the tropical rainforests are often expressed in terms of human needs. One-quarter of prescription drugs are extracted from plants, including 70 percent of anti-cancer agents, and most of these come from tropical forests—where less than 1 percent of the flora has been examined for its pharmacological utility.

The Politics of Extinction

At the beginning of the twenty-first century, decisions as to whether the needs of humans ultimately outweigh those of endangered species are largely the monopoly of political regimes. However, the planet's greatest biodiversity largely exists within

developing nations where fertility rates are the highest, people the poorest, population pressures on nature the greatest, and unstable political regimes the least likely to resist powerful corporate and population encroachments on natural habitats.

Even in developed nations the accelerating rates of extinction have proven difficult to resist. The Green movement remains a minority voice. In the United States, awarenesses have become politicized. National surveys of 1993 and 1994 show Republicans are, for instance, 50 percent more likely than Democrats to disagree that “human beings are the main cause of plant and animal species dying out.”

And just when environmental causes have entered the public consciousness, ecoterrorism (or threats thereof) has become a new weapon of disenfranchised and antiestablishment groups. During the summer of 2000, soon-to-be-laid-off chemical workers in Northern France dumped 3,000 liters of sulfuric acid into a tributary of the Meuse River.

Religion and Extinction

The notion that humans are programmed by only 40,000 or so genes and descended from a chain of earlier life forms profoundly challenged traditional religious beliefs that life and death are acts of divine will. From the scientific method came the possibility that the cosmos was not divinely constructed around humanity but rather is the product of random chance, and that the same natural forces controlling the fates (and inevitable extinctions) of animals shape human fate as well. Also assaulting people's sense of specialness is the evidence that human beings and their fellow thinking mammals are not the “fittest,” as 95 percent of all animal species are invertebrates.

According to the Bible, God made human beings in his image and gave them dominion over all other creatures, whose existence was to serve their needs. To this day religion maintains this subordination of the natural order. When a random sample of Americans were asked whether “animals should have the same moral rights that human beings do,” their agreement decreased with increasingly religiosity. When asked if “it is right to use animals for medical testing if it might save human lives,” agreement increased with increasing religiosity.

Accused of causing “speciesism,” Christianity has played a limited role in the war against extinction. Instead, the scientifically prompted ecological movement has come to assume some quasi-religious characteristics of its own.

The Battle against Extinction As Part of the War against Death

So why the extensive attempts to save the California condor, whose diet at its peak 1 million years ago consisted of such currently extinct creatures as dead mastodons, or the Kemp’s Ridley turtle that, with a brain cavity the size of a pencil-width hole, is unable to learn a thing from experience and whose existence is totally hardwired? The reason may be largely symbolic.

The cultural war against death has expanded beyond the medical front to include battles against extinction in the natural order—and even resurrection of the extinct, as when in 2000 scientists awakened dormant 250-million-year-old bacteria encased in a salt crystal. Through human intervention, creatures extinct in the wild, like the Arabian oryx, are preserved in species preservation programs in zoos, ideally to be reintroduced to their native habitats. (In fact, there are cases where animals presumed extinct have been “discovered” in zoos, such as the Cape Lion, which was rediscovered in zoos in Novosibirsk, Serbia, and in Addis Ababa, Ethiopia.) In addition, genetic repositories, the contemporary “Noah’s Arks,” have been established by the Museum of Natural Science at Louisiana State University and the American Museum of Natural History to preserve in liquid nitrogen tissue samples from thousands of different creatures. In 2001, tissue frozen for eight years was used to successfully clone a gaur (a large type of cattle).

Perhaps in reaction to the extinction of the passenger pigeon, considerable press has been given to attempts to rescue the whooping crane from oblivion. This cause célèbre is a white crane with a seven-foot wingspan, mistakenly believed to be extinct in 1923. The victim of overhunting, its numbers had dwindled to about fifteen in 1941—this, despite the Migratory Bird Treaty Act of 1918, which brought market hunting of the cranes and other migratory birds to an end, and the 1937 creation of the Arkansas National Wildlife Refuge on the Texas coast to protect the crane’s last wintering ground.

The U.S. Fish and Wildlife Service began a whooping crane recovery program in 1967, relying initially on captive breeding to build up the population. As of 2002, there are roughly 300 of the birds.

The Environmental Movement

In the broader cultural war against death, battles against extinction have assumed numerous fronts, such as conservation biology, gene banks, attempts to clone endangered species, and habitat restoration. Numerous new social solidarities have arisen, crosscutting the stratifications of class, gender, and age, in such groups as Friends of the Sea Otter, Sea Turtle Restoration Project, and Trees for the Future.

Growing concern over “ecocide” and “biological meltdown” has given rise to increasingly politicized environmental groups (Greenpeace, the Sierra Club, the National Wildlife Federation, Friends of the Earth, and various animal rights organizations). This social movement has quasi-religious trappings in its demands for ecojustice and concerns for leaving a legacy for future generations.

On the extreme fringe of this movement are the so-called ecoterrorists, such as the Earth Liberation Front and the Animal Liberation Front. Radical environmentalists, such as Finland’s Pentti Linkola, see mass human death as the only way to save the planet’s fragile ecosystem. This Voluntary Human Extinction Movement has the slogan “May We Live Long and Die Out.” In addition to his hope for war, Linkola recommends ending capitalism, abolishing aid to the third world, and requiring mandatory abortions.

Cultural Extinction

Analogous to people’s interest in extinct creatures is their curiosity about extinct civilizations, such as the mythical Atlantis or the Anasazis and Mayans of the New World, and the causes of these cultures’ doom. As paleontologists study life forms of the past so archaeologists study past cultural orders, investigating whether their demise was due to avoidable factors with lessons that can be applied to the present. The archaeologist Richard Hansen, for instance, argues that deforestation produced an ecological disaster precipitating the collapse of the Maya civilization in approximately 800 C.E. To produce the stucco for their huge limestone pyramids, the Mayans leveled forests to fuel the hot fires required for transforming limestone into lime. Or

was the fate of these doomed cultures sealed by unforeseen and uncontrollable calamities, such as epidemics, earthquake, or drought?

The human war against death extends from battles against the extinction of biological to cultural systems. Memes are to anthropologists what genes are to biologists—carriers of life’s organizing principles, ways of doing this, that are passed down generation to generation. And as biologists worry about diminishing biodiversity, cultural scientists worry about the abatement of cultural diversity and endangered languages. Of the 6,800 languages spoken worldwide in 2001—cultural DNA, if you will—only 600 are robust enough to be in existence at the end of the twenty-first century. The last speaker of Ubykh, for instance, died in Turkey in 1992 at the age of eighty-eight.

As the fossilized remains of extinct creatures are the rage of affluent collectors so too are artifacts of extinct cultures. So lucrative is the market and so environmentally damaging are the attempts to satisfy demands that laws have had to be passed to ensure that remnants of the extinct themselves do not disappear.

See also: APOCALYPSE; DARWIN, CHARLES; DISASTERS;
NUCLEAR DESTRUCTION

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FAMINE

Every historical era has suffered the Four Horsemen of the Apocalypse mentioned in the Bible—famine, death, war, and the plague. Famine in the modern era is thought to be caused as much by other factors than food shortages due to nature. Famine involves a severe eruption of acute starvation and a sharp increase of mortality affecting a large segment of the population. Chronic hunger is characterized by sustained nutritional deprivation on a persistent basis.

Famine and chronic hunger are part of a food-availability–food-deprivation continuum. Either may be due to (1) forces of nature such as drought, plant diseases, or flood; (2) human conditions resulting from war, civil strife, genocide, market forces (e.g., hoarding, graft, and profiteering), and other exploitive governmental or corporation policies (where the goal is profit at all cost); or (3) both. Famine may be an intentional tactic or unintentional outcome of human behavior.

Estimates of excess death (i.e., actual famine mortality minus pre-famine mortality) due to hunger and hunger-related diseases of children, women, and men is around 40 million per year. During the famine of China, from 1958 to 1961, between 23 and 30 million people died. However, the greatest proportion of people died—one-eighth of their population, or 1 million people—during the Irish “Great Hunger” of 1845 to 1852. Dysentery, typhus, typhoid fever, and other infectious diseases, more so than literal starvation, were the primary causes of death.

Thomas Robert Malthus, an eighteenth-century British economist, theorized that famine, along with war and disease, was an adaptation to the imbalance between available food and population size. The neo-Malthusian view remains influential. Preventive policies would include increased food production capitalizing on technology (including improved fertilizers and transgenic food), and population growth restraints. Other conservationists and economists argue that high food production cannot be, and is not, maintained because a growing share of land and water used for crop production is unsustainable due to the various forms of pollution, increasing population growth in at-risk geographic areas, and global warming.

The Nobel Prize–winning economist Amartya Sen’s entitlement theory sees famine resulting not from the unavailability of food, but the lack of means to purchase or otherwise obtain food. Prevention is rooted in (1) global, coordinated public policies that control exploitive local and global market forces and that provide import of surplus food and (2) entitlements that allow obtaining food such as free food at distribution centers, money, jobs, education, and health care in at-risk geographic areas such as states in sub-Saharan Africa, South America, and Asia.

Other scholars, like Jenny Edkins, lecturer in international politics at the University of Wales, see famine as essentially resulting from modernity, including poverty, violence, and the bio-politicizing of famine. These scholars would re-politicize the issue of famine with the goal of preventing violence, war, genocide, and enhanced human rights.

For example, the genocidal policies of the Stalinist regime resulted in the Ukraine famine during 1932 and 1933 that caused the deaths of some 6 to 7 million people. Periodic genocidal wars and drought combine to produce famine and chronic starvation in many of the countries of southern Africa.

In the twenty-first century, food security is declared a basic human right by the United Nations Universal Declaration of Human Rights. It is defined as access by all people at all times to enough food for an active, healthy life. Food is a basic need. If unmet by institutions and structures designed to provide for the general welfare, then food insecurity is a threat to any social system. Can global food security be attained? The crucial issue is whether the wealthy nations and the political and economic forces involved in the globalization process have the will to implement the preventive policies suggested by social scientists and humanitarians.

Specific, international measures to increase food security include a structure (especially legislation with enforcement powers) that guarantees a livable wage which enables workers to live healthily and well. Other measures include maintaining environmental security, implementing strong human rights laws, implementing safe and sane food technologies with special reference to transgenic foods, providing an international food distribution system to at-risk locations and people, instituting a famine early warning system such as the one developed by the U.S. Agency for International Development, and encouraging democratic and open societies with special emphasis on a free and inquiring press, educated public, and adversarial politics.

See also: DISASTERS

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DANIEL LEVITON

FEIFEL, HERMAN

American psychologist Herman Feifel was born in Brooklyn, New York, on November 4, 1915. He is internationally recognized as a pioneering figure in the modern death movement. His personal and research efforts helped break the prevailing taboo that discouraged scientific study of death and dying. His work transformed the way people think about death, treat the dying and bereaved, and view their own lives.

Feifel was educated in the New York City school system. His interest in psychology was stimulated during his undergraduate years at the City

College of New York by John Gray Peatman, and later by Irving Lorge at Columbia University, where he received his master of art's degree in 1939. World War II became a reality before Feifel could finish his doctorate. He enlisted in the Army Air Corps (now, the Air Force) in 1942, where he worked first as an aviation psychologist and later as a clinical psychologist treating combat soldiers overseas. While assigned to the Island of Tinian in 1945 he watched the *Enola Gay* take off to bomb the Japanese city of Hiroshima, an event that ushered in the age of atomic warfare. Feifel later reflected that this event and the death of his mother in 1952 were the two most important influences that catalyzed his interest in thanatology.

When the war ended Feifel resumed his studies at Columbia University, and finished his doctorate in 1948. He joined the Winter General Veterans Administration (VA) Hospital/Menninger School of Psychiatry group in Topeka, Kansas, in 1950, an event that marked the beginning of a long and illustrious association with the VA.

In 1954 Feifel accepted an invitation to join the Los Angeles VA Mental Hygiene Clinic. In 1960 he assumed the position of chief psychologist, an office he held until his retirement in 1992. Since 1958 he has additionally held an appointment at the University of Southern California School of Medicine, where he is emeritus clinical professor of psychiatry and the behavioral sciences.

Feifel's dissatisfaction with psychology's neglect of the existential richness of life, including the everyday matters of death and dying, coalesced in the 1950s. A major consequence was his focus on what has since become known as the field of thanatology. In 1959 he edited the book *The Meaning of Death*, which authorities agree was the single most important work that galvanized the scholarly community concerning dying, death, and bereavement. In this and related areas (e.g., gerontology, personality, psychotherapy, religious experience) his publications encompass more than 125 articles and chapters, as well as two books. Many of his literary contributions are focused on dispelling myths held by scientists and practitioners about death, the most injurious of which is a denial of its importance for human behavior.

Feifel's empirical contributions are most influential in the areas of death attitudes, death anxiety, and coping with life-threatening illness. By the late

1990s scholars identified over 1,000 published studies in these areas, and recognized Feifel as being the only person to contribute seminal papers in five consecutive decades. He shaped the direction of this research by arguing for reliable and valid measures that acknowledge the multidimensional, multifaceted nature of death attitudes and fears, the importance of death attitudes in shaping a wide variety of behaviors, and the need to study death issues among those actually facing life-threatening circumstances. His research demonstrated that fear of death can exist differently on conscious and nonconscious levels, and helped establish that people may use different coping strategies when faced with life-threatening versus non-life-threatening situations.

For his work in thanatology, Feifel has received numerous accolades, including an honorary doctorate from the University of Judaism (1984), a Distinguished Death Educator Award (1990), the Distinguished Professional Contributions to Knowledge Award by the American Psychological Association (1988), and a Gold Medal for Life Achievement in the Practice of Psychology by the American Psychological Foundation (2001).

See also: ANXIETY AND FEAR; PSYCHOLOGY; TABOOS AND SOCIAL STIGMA; TERROR MANAGEMENT THEORY

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STEPHEN STRACK

FIREARMS

The availability of firearms is clearly associated with an increased risk of homicide, suicide, and deaths from firearm-related accidents. However, there is an active debate in the United States on the right to own and bear arms and the government's role in controlling access to firearms. Apart from the opinions on both sides, there are numerous studies on the topic. For example, countries with very restrictive legislation, including strict licensing of owners, have many fewer nonhunting fatalities from accidental shootings than countries with less restrictive firearm legislation. The United States is the Western country with the least restrictive firearm legislation; the accidental death rate by firearms in the United States is .7 people per 100,000 per year (compared to Sweden, which has restrictive legislation and one-tenth the number of nonhunting fatalities from accidental shootings).

When one factors in the variables of sex, age, income, ethnicity, education, previous violence in the home, and drug use, the presence of a firearm in the home greatly increases the likelihood of a homicide or a death by suicide. In the case of homicide, evidence shows that in many killings the offender did not have a single-minded intention to kill, and thus the lethality of the instrument used in the crime affected the outcome. Because homicides in the home usually follow altercations, and situational factors such as alcohol or drug consumption are often present, the presence of a lethal weapon increases the risk that a death will occur. Unsafe storage is also a risk factor, although the presence of a firearm has been found to be more critical than its accessibility.

In the case of suicide, studies have found that having access to a firearm in the home increases the risk of suicide; suicide rates are five or six times higher than in homes without guns. Restrictions on carrying firearms, enhanced sentences for the use of firearms in criminal offenses and legislation

(e.g., in Canada), and compelling firearms in the home to be guarded under lock and key have been associated with reduced deaths by suicide and homicide. According to a study conducted by Colin Loftin and colleagues, a widespread prohibition of handguns in the Washington, D.C., area in 1976 also appeared to be effective in decreasing mortality by 25 percent in the ten years following adoption of those restrictive laws, compared to no similar reductions in adjacent metropolitan areas in Maryland and Virginia where the law did not apply.

Persons opposed to legislative controls on firearms see criminals and suicidal individuals as being motivated by an intransigent need to harm others or themselves that is predetermined before any lethal event occurs. According to this view situational factors, such as the presence of a firearm, are irrelevant because these people will commit their premeditated acts irrespective of the means available. Opponents of gun control also feel that if "guns are outlawed only outlaws will have guns." These opinions ignore the reality that many homicides and suicides are impulsive and passionate acts where the presence of a lethal weapon immediately available greatly increases the risk of a lethal outcome. Furthermore, many people who commit acts of violence, including homicide, have no known history of criminal behavior. Research has shown that suicidal people have a much greater likelihood of not dying by suicide if a particular preferred lethal means is not available. Studies conducted since the mid-1970s have shown that situational influences, including the availability of firearms, can be critical in the outcome of an event.

See also: HOMICIDE, EPIDEMIOLOGY OF; SUICIDE

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BRIAN L. MISHARA

FOLK MUSIC

Folk music entertains, tells or supports a story, and is transmitted from generation to generation. It is the music of the common person as well as the wealthy. A significant number of American ballads were obtained from other societies such as Scotland, Ireland, Germany, England, and Wales, and the words were altered to fit the interpretation of the singer. Most often, the songs were obtained through oral tradition, rather than in written form, and the singer was left with the task of interpreting the meaning of the lyrics on the basis of his or her cultural milieu.

Most of the early folk songs were sung without instrumental accompaniment. According to folklorist Maude Karpeles, while collecting songs in the southern Appalachian Mountains during the years 1916 to 1918 with her colleague Cecil Sharp, found:

The songs were, with one exception, sung without instrumental accompaniment. This is in accordance with the older traditional methods of singing, both in England and in America. The present custom of singing to the accompaniment of guitar or banjo, which has been adopted by some traditional singers, is fairly recent and is probably due to the influence of popular and pseudo-folk music heard on the radio. (*Sharp and Karpeles 1968, p. 9*)

The instrument used while singing a folk song varies with the culture, from the drum in Africa to the bagpipes in Scotland to the plucked dulcimer in the American Appalachians. In the folk music revival of the late 1950s and early 1960s, the major instruments were the guitar, five-string banjo, upright bass, and fiddle.

The durability of a folk song may be attributed not only to the song itself, but to the folklorists and collectors who accepted the task of obtaining songs in various sections of the world and tracing their origin. Folklorists such as Francis James Child, Cecil Sharp, Maude Karpeles, and Alan and John

Lomax have preserved a folk music legacy that might otherwise have been lost.

Folk music has been written and performed portraying every theme imaginable. There are love songs and silly songs. There are songs with religious themes and songs with secular lyrics. Folk songs portray the good life and they delineate hardship. Some of the most popular folk lyrics portray dying and/or death. Common themes are death and its relationship to accidents, the supernatural, trains, murder, natural causes, the elements, war, suicide, and religion.

Death by Accident

There are many forms of accident that can result in death. Vehicular death has been portrayed in folk songs on more than one occasion. "The Drunken Driver" tells the story of two small children who were killed as they walked along a state highway. One of the deceased children turns out to be the drunken driver's son. "The Fatal Wreck of Bus" is the true tale of mass death when a bus goes over a cliff.

The death of two small children via drowning is reflected in "Kiss Me Mamma, For I Am Going to Sleep," which originally appeared in sheet music form. Songs about the sea, such as "Asleep in the Briny Deep" and "The Sailor's Sweetheart," tell the story of maidens who have lost their lovers to the sea. "Mighty Mississippi" and "The Flood Disaster of 1937" are only a few of the folk songs about floods and death. In the popular ballad "The House Carpenter," a wife leaves her husband and children to run away to sea with her lover. They are both killed when the ship sinks.

"Companions Draw Nigh" (also known as "The Dying Boy's Prayer") provides an account of a young man crushed in a construction accident and destined to die without prayer, song, or Bible present: "I must die without God or hope of his son, covered in darkness, bereaved an' undone." The popularity of cowboy songs in the early 1900s produced "Little Joe, the Wrangler," the tale of a young boy killed in a cattle stampede. When an avid cave explorer named Floyd Collins was trapped in a sandstone cave in Kentucky, and died before rescue workers could save him, several songs were composed about the tragedy. Eric Clapton's commercial recording of "Tears in Heaven" (1992) is reminiscent of early folk songs of tragedy. It tells

the story of Clapton's son, who fell from a sixth-story window to his death. The song asks a question often found in folk music: "Would you know my name, if I saw you in Heaven?"

Sensational accidents involving a large number of people are especially likely to become popularized in musical literature. Train wrecks, mining disasters, airplane crashes, fires, cyclones, and sea disasters are a few of the themes in folk music. "Lost on the Lady Elgin" and "The Ship That Never Returned" are about separate ship wrecks. The most famous of all the sea disasters is probably the sinking of the Titanic, immortalized in songs such as "The Sinking of the Titanic" and "Just as the Ship Went Down."

"The Akron's Last Flight" is about an airplane disaster. "The Avondale Mine Disaster," "The Dying Miner," and "Dream of the Miner's Child" reflect the relationship between coal mining and death. "Bonnie James Campbell" and "Darcy Farrow" concern horseback riding accidents that result in death. Death via fire is delineated in songs such as "Baltimore Fire."

Trains and Death

Perhaps no machine has ever captured the imagination of Americans like the train. In the early 1900s adults and children alike were in awe of the steam locomotive. The so-called father of country music, Jimmie Rodgers, was known as "the singing brakeman" because of his obsession with trains and songs about trains. Many songs reflect the death of the hobo, the common man who was often without home and food, and content to ride the rails. A few such as "The Fate of Chris Lively and Wife" concern death resulting from being hit by a train. Most, however, are about train wrecks and the brave engineers willing to die with their trains. "Casey Jones" (a train engineer on the Chicago and New Orleans Limited in Vaughan, Mississippi, in 1900) became an American hero when he died refusing to abandon his engine when it was about to crash into another locomotive. In "The Wreck of the Old 97" the engineer is "found in the wreck with his hand on the throttle, a-scalded to death by the steam." The devotion of the railroad engineer is best exhibited in "Engine 143" when George Alley's last words are, "I want to die for the engine I love, One Hundred and Forty-three."



Jimmie Rodgers, the father of country music, was the first musician inducted into the Country Music Hall of Fame.
COUNTRY MUSIC FOUNDATION, INC.

The Supernatural and Death

One of the oldest folk songs containing a supernatural theme is "The Wife of Usher's Well" (commonly called "The Lady Gay"), an English ballad reflecting the view that excess grief will cause the dead to return. A woman sends her children away to get an education, they die, she grieves, and they return to her in a vision. As a woman walks by the side of a river, her dead lover, "Lost Jimmy Whalan," returns to her in an apparition. In "Lily Lee," a sailor has a death vision involving his true love. When he returns years later she is dead. In the classic "Grandfather's Clock," the clock stops and never works again when its owner dies. Elements of the supernatural appear in the popular "Bringing Mary Home." The singer picks up a little girl walking along a highway and takes her home. When he opens up the door to let her out of the car, she is gone. The lady of the house explains that her daughter died thirteen years previously in an automobile wreck, and states, "You're the thirteenth one who's been here, bringing Mary home."

Death from Natural Causes

Death from natural causes is a common subject in musical literature. When the song involves a child, the title of the song often contains the word “little” followed by the first name (e.g., “Little Bessie,” “Little Mamie,” and “Darling Little Joe”). The listener does not know what the cause of death is, but the last hours of the child are sometimes emotionally portrayed. For example, in “Put My Little Shoes Away,” the dying child’s major concern is that the parents will give his or her prized shoes away. “Darling Little Joe” focuses on what others, both human and inhuman, will do after he is dead. The dying soldier in “Break the News to Mother” is worried about the welfare of his mother when she receives the news of his death, and “Little Bessie” experiences auditory hallucinations common among those who are dying:

There were little children singing,
Sweetest songs I ever heard.
They were sweeter, mother, sweeter,
Than the sweetest singing bird.

(McNeil 1988, pp. 172–173)

Death from the Elements

The plight of orphans frequently appears in folk music, often coupled with death from the elements to provide a more pathetic story. In “The Two Orphans,” “The Orphan Girl,” “Poor Little Joe,” and “Little Paper Boy,” children are discovered frozen to death at the end of the song. “Mary of the Wild Moor” and her child die from the cold weather and are discovered the next morning on the doorstep at the home of Mary’s father.

The fact that failure to heed the advice of parents can end in death is emphasized in “The Frozen Girl” (also “Young Charlotte”), the true story of a young girl who froze to death on her way to a ball on January 1, 1840, after failing to heed her mother’s warning:

“Oh, daughter dear,” her mother cried, “This
blanket ‘round you fold,
Tonight is a dreadful one, you’ll get your
death of cold.”
“Oh, nay, oh, nay!” Charlotte cried, as she
laughed like a gypsy queen,
“To ride in blankets muffled up I never would
be seen.”

(Sandburg 1927, pp. 58–59)

Children As Victims in Murder Ballads

Murder stories involving children have been very popular in musical literature. While mothers are generally portrayed as gentle and kind, there are songs that portray their violent side. Feticide/infanticide may be found in “Mary Hamilton” and “The Cruel Mother” (also known as “Down by the Greenwood Sidie”), and rejection/neglect is delineated in “Lady Gay” (“The Wife of Usher’s Well”).

Drunken fathers are factors in songs like “The Drunkard’s Child.” “Little Blossom” goes to the bar to find her father and in a drunken rage he murders her. Poisoning is the variable in death for “Lord Randall.” Revenge against the father for failure to pay a debt leads to the murder of his son in “Lamkin.”

Several of the child murder ballads popular in America were transplanted from Europe. Sir Hugh tells the story of a little boy murdered by a Jew’s daughter, and “Dunbar the Murderer” is the tale of a man who murders two children left in his care by the parents. However, most child murder ballads are original to the United States. Surprisingly, sensational cases, such as the murder of fourteen-year-old Bobby Franks by Nathan Leopold and Richard Loeb on May 21, 1924, and the murder and cannibalism of Grace Budd by Albert Fish in the 1930s, never made their way into musical literature. However, the killing of “Little Mary Phagan” at the pencil factory where she worked in 1913, the murder and beheading of “Little Marian Parker” on December 14, 1927, and the kidnapping and murder of the Lindbergh baby in 1932 were popularized in the media, commercial records, and folk music. Mass murders such as the “Ashland Tragedy” in 1883 (two children and a neighbor in Ashland, Kentucky, were murdered and the bodies burned) and the “Murder of the Lawson Family” (the father killed his wife, six children, and himself) made their way into the folk music tradition.

Women As Victims in Murder Ballads

The common theme in ballads involving the murder of women is the luring of the woman by the man to the place of her demise under false pretenses. Most of the songs are English ballads or altered forms of English ballads.

The victim dies when she refuses to marry her murderer in “Banks of the Ohio” and “Poor Ellen Smith.” Money appears to be a factor in “Down in

the Willow Garden” (also known as “Rose Connelly”). Jealousy on the part of the killer is extant in songs like “Lord Thomas and Fair Eleanor” (the name of the woman changes with the singer). Pregnancy sometimes exists as a variable. For example, when Scott Jackson and a fellow dental student murdered Pearl Bryan at Fort Thomas, Kentucky, in 1896, both pregnancy and jealousy were factors. Jonathan Lewis drowned “Omie Wise” in Deep River in 1888 for dual reasons: She was pregnant and he preferred a local girl. “Knoxville Girl,” a British broadside (single-sheet ballads sold for a penny or half-penny on the streets of towns and villages around Britain between the sixteenth and early twentieth centuries) written in the early 1700s, contains some of the most violent lyrics in any folk song.

Men As Victims in Murder Ballads

Few songs feature the murder of a man by a woman. Outstanding are the English ballad “Young Hunting” (known in America as “Loving Henry” and “Lord Henry and Lady Margaret”) and American ballads such as “Frankie and Albert” (also known as “Frankie and Johnny”) and “Frankie Silvers.” In all these songs the homicide is the result of jealousy.

Men kill men for many reasons and under varied circumstances in folk songs. There are heroes (e.g., “Pretty Boy Floyd” and “Jesse James”) and anti-heroes such as “Stagger Lee.” Murder may be committed for wanton cruelty or economic remuneration. An act of homicide may involve the killing of one man (“Jesse James”) or many (“The Golden Vanity”). The killing can be the result of jealousy and/or hatred. Whether the song is simply to tell a story or entertain, it is popularized and transmitted from generation to generation.

Suicide

Parental opposition to a love affair is a major theme in songs concerning suicide. In “Silver Dagger,” both the boy and girl commit suicide when her parents oppose their love. Death due to grief is a factor for women (“Barbara Allen” and “Earl Brand”) and men (“The Two Sisters”). In “It’s Sinful to Flirt” the boy kills himself because the girl won’t marry him, while the reverse is true in “The Butcher Boy.” The girl commits suicide in “Johnny

Doyle” because she is being forced to marry someone whom she doesn’t love. The man dies from a self-inflicted wound in “The Last Letter” when the girl marries someone else.

War

Songs about war are fraught with death and dying. There are lyrics portraying the grief (and death from grief) of those left behind. In “The Cruel War” the girl refuses to be left behind, dresses as a man, and goes off to war with her lover. The horror and violence of the battle are often portrayed in folk songs. Reflections of the dying soldier are quite poignant in folk music. Most of the final thoughts involve mother and/or the sweetheart left to mourn. In “Legend of the Rebel Soldier,” the dying Confederate is concerned with whether his soul will pass through the Southland one last time on the way to the hereafter.

Religion

Songs concerning religion have three major themes. First, there are songs that provide a blueprint for living prior to death. Second, the means of conveyance to the hereafter is occasionally a subject. For example, it might be by train (“Life’s Railway to Heaven”), a band of angels (that may carry the soul to Heaven as in “Angel Band”), boat (“The Gospel Ship”), or chariot (“Swing Down, Sweet Chariot”). Third, there are lyrics that denote what the afterlife is like. It is portrayed as a place of “Beautiful Flowers” and an “Uncloudy Day.” It is a realm where there is no suffering or pain, loved ones may be greeted, and “The Soul Never Dies.”

Folk songs provide helpful insight into the cultural traits related to death and dying in a specific society at a particular point in time. They also allow for comparisons of traits over a period of time. The provision of entertainment and knowledge at the same time makes folk music an integral part of any society with a music tradition.

See also: MAHLER, GUSTAV; MUSIC, CLASSICAL; OPERATIC DEATH

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JAMES K. CRISSMAN

FORENSIC MEDICINE

Forensic medicine deals with the application of scientific medical knowledge to the administration of law, to the furthering of justice, and to the legal relations of the medical practitioner.

Forensic medicine addresses the physiology of dying, the cause and time of death, and postdeath phenomena. Practitioners of this branch of medicine assist the law in assessing the liability of medical practitioners in issues including consent to treatment, therapeutic intervention, emergency treatment, legal procedures, tissue and organ removal and transplantation, unnecessary surgery, cosmetic surgery, scientific experimentation, and sexual procedures, as well as questions regarding maternity, paternity, murder, malpractice, the development and gathering of evidence, and the application of statutory law to medicine.

Forensic medicine deals with offenses against the person or patient. Practitioners of forensic medicine assist in medical-legal investigations by offering expert opinions to help legally authorized individuals understand the medical implications of pathological examinations, including postmortem examinations (autopsies) of bodies, tissues, organs, and laboratory specimens. They offer expert scientific opinions on the cause and time of death. They may offer interpretations of DNA (genetic tissue) analysis. In criminal cases, the coroner (often a physician) provides investigators and the court

expert opinion on wounds, injuries, intoxication, poisoning, infections, and the proper handling of pathologic specimens.

Practitioners of psychiatric forensic medicine provide the court with expert opinions on mental illness, diagnosis, treatment, and mental competency, competency to stand trial, and questions regarding responsibility for actions under the law. Experts in forensic medicine make use of medical science to inform the law. They offer opinions on the validity and interpretation of medical examinations and testing.

The earliest antecedent of forensic medicine was recorded in the Code of Hammurabi (Babylonian Empire, approximately 2200 B.C.E.). Paragraph 19 of that document deals with the matter of compensation for the death of a slave, ostensibly killed by a treating physician. For several thousand years there were no comparable records. Then, in the fourteenth century, physicians began to perform autopsies to investigate the cause of death through careful dissection and examination of the body of a deceased person. The first formal medical-legal inquest into the death of a person in the United States took place in New Plymouth, Massachusetts, in 1635. Forensic medicine has come a long way since its inception. Contemporary post-mortem examination is an integral part of criminal investigations and involves both gross and microscopic analysis of organs and tissues for the development of legal records and, if indicated, testimony in a court of law.

The term *forensic medicine* is often confused with the term *medical jurisprudence*. In fact, the terms mean the same thing in some countries. In the United States, the terms are not synonymous. Medical jurisprudence encompasses the legal aspects of medical practice as they involve risks to society, negligence, and unlawful and/or unethical practices. Medical jurisprudence deals with the codes, ethics, and laws that guide the practice of medicine. Forensic dentistry and forensic anthropology are closely related to the field of forensic medicine. Like forensic medicine, they rely on specially trained and experienced practitioners who help to inform the law with interpretations of the results of specialized examinations testing.

See also: EXHUMATION; HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; HUMAN REMAINS

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WILLIAM M. LAMERS JR.

FRANKL, VIKTOR

Viktor Frankl, founder of logotherapy, also known as the Third Viennese School of Psychotherapy, developed a paradigm in psychology that focuses on the importance of meaning in life. Viktor Frankl was born in 1905 in Vienna, Austria. He earned his M.D. in neurology and psychiatry and his Ph.D. in philosophy from the University of Vienna. During World War II he was sent to Theresienstadt and then Auschwitz. His book *Man's Searching for Meaning* (1963) is well known. Frankl was inspired by the existentialism of the twentieth-century German and Swiss philosophers Martin Heidegger, Karl Jaspers, and Ludwig Binswanger. Frankl died in 1997.

Mindful of the finitude of human existence, Heidegger's thinking dwells on death as humanity's final boundary. Clearly death is a reality for all human beings and poses a challenge to humans' coping skills. "Logotherapy, unlike other existential systems, is basically an optimistic, future-oriented system, focusing on human freedom and the multitude of possibilities for human beings to find meaning" (Bulka 1998, p. 114). Logotherapy emphasizes the transitory nature of life and points to the meaning of the journey, thus avoiding the more negative aspects of existentialism by injecting hope, meaning, and values into the therapeutic dialogue.

In order to understand life's ephemerality, one must first understand the nature of time in the lives of human beings. It is critical to understand that

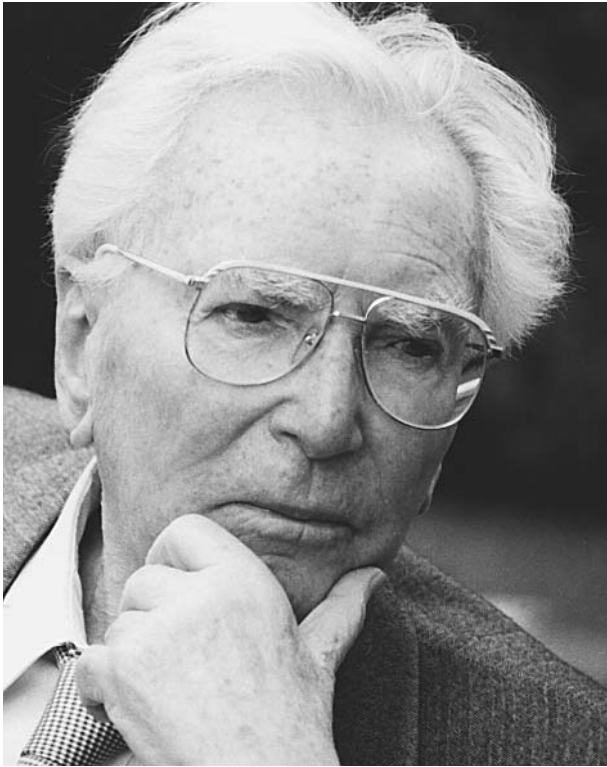
time only goes in a single direction. Thus, the gift of time from one person to another is a gift that cannot be exchanged at a department store but is a permanent expression of human potential. Frankl notes that, "The meaning of human existence is based upon its irreversible quality. An individual's responsibility in life must therefore be understood in terms of temporality and singularity" (Frankl 1986, p. 64).

Life is temporary, yet each life is unique. As his clients became aware of the nature of the transitory nature of life, Frankl would offer this advice: "Live as if you were living for the second time and had acted as wrongly the first time as you are about to act now" (Frankl 1986, p. 65). He notes that as an individual understands the full gravity of time, he or she will recognize the full responsibility for living.

Life, then, is a journey that reflects the experience of time. To face life only to reach the end of the day, the end of the task, the end of a journey is to live for the goal of dying. For Frankl, the focus is on the experience so that each event or task in life can become meaningful. He writes of the unconditional nature of meaning. Having lived through four Nazi death camps, Frankl offers the thought that all of life has meaning that can never be taken away from the individual. Only the individual can lose meaning. When this happens, the individual suffers feelings of meaninglessness that Frankl has identified as "existential vacuum."

For life to have meaning, it must offer the experience of transcendence. Frankl notes that the word *geistig* (the spirit) refers to the capacity for self-transcendence, which is basic to human nature. The most meaningful experiences in life are those that transcend the individual and offer caring moments with others. The human spirit can also be experienced in the form of suffering. Frankl notes that meaning can be found in suffering by transcending the moment to understand the fullest impact of the experience. Frankl points out that "life can be made meaningful (1) by what we give to the world in terms of our creation; (2) by what we take from the world in terms of our experience; and (3) by the stand we take toward the world, that is to say, by the attitude we choose toward suffering" (Frankl 1967, p. 37).

As a person faces mortality either in his or her own death or that of a loved one, the first thing he or she experiences is the story of the person. Each



Viktor Frankl's psychological approach focuses on the importance of meaning in life. His *Man's Search for Meaning* (1963) sold more than a million-and-a-half copies in the United States. VIKTOR FRANKL

person's story reflects both who she or he is and what she or he has done. A funeral eulogy is a time to tell the "story" of the person. However, the task of grief, according to Frankl, is twofold: The first aspect is to find meaning in the story. What is it about the story of this person that offers meaning to the person articulating the eulogy? Meaning is often found by asking the question, What is it about this story that would be important enough to you to want to share with someone else? Frankl notes, "This leads to the paradox that man's own past is his true future. The living man has both a future and a past; the dying man has no future in the usual sense, but only a past" (Frankl 1984, p. 127). In the hearts of friends, the stories of the person's life reflect shared meaning. In this way there is a future, even after the death of the loved one. Paradoxically, the real hurt in grief is the fact that stories have endings. Yet when the story is understood in meanings, there are no ends, only meanings that can be passed on from generation to generation.

The second task of grief is to understand the responsibility that is called for by the loss of a

loved one, particularly in incidents such as a car crash where one person lives and the other dies. Frankl suggests that to honor the life of the deceased is to move beyond survivor guilt, which often accompanies this type of situation. Frankl suggests that there should be no such thing as survivor guilt, but only survivor responsibility. Each person has responsibility to transcend the circumstances of the incident and cherish the memory of the deceased.

The work of Frankl offers a way of thinking about life as well as a therapeutic approach to being with persons who are dying and their loved ones. The goal of this process is the search for meaning. In meaning all of the transcendent life forces come together to offer more than mere existence as a human being.

See also: GENOCIDE; GRIEF COUNSELING AND THERAPY; GRIEF: THEORIES; PHILOSOPHY, WESTERN; THOU SHALT NOT KILL

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JAMES W. ELLOR

FREUD, SIGMUND

In 1856 Sigmund Freud, the founder of psychoanalysis, was born above a blacksmith shop in the Moravian town of Freiberg, his father an unsuccessful wool merchant. The family moved to Leipzig, then to Vienna, but continued to experience economic hardship. His mother—young, beautiful, and dynamic—was the center of his emotional life while his father was described as distant and ineffectual. Freud came of age during a renewal of anti-Jewish sentiment in Vienna after a

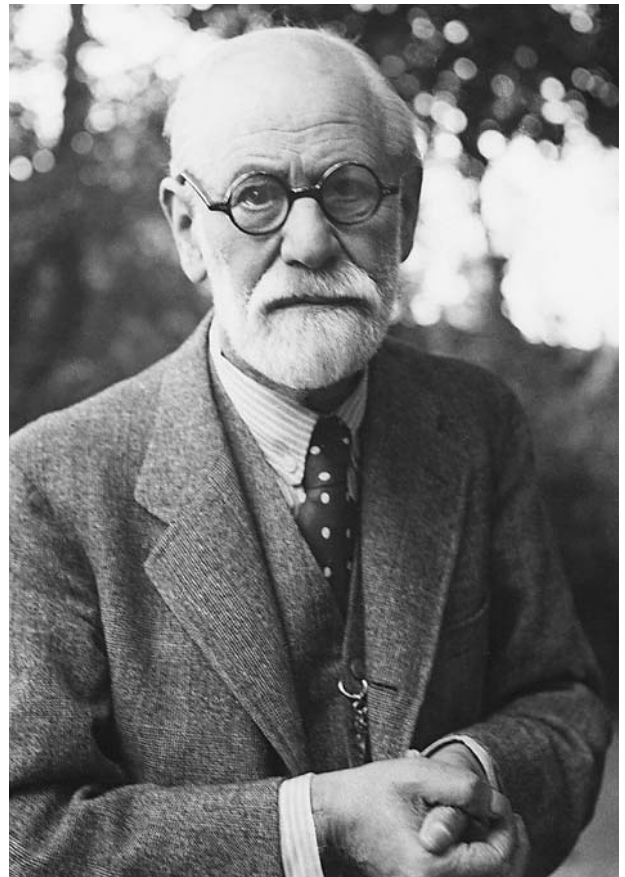
more liberal policy had encouraged the belief that people would be judged on their merits rather than their religion.

Freud earned his medical degree at the University of Vienna and became an adept neuroscientist whose research advanced knowledge of the nervous system and uncovered the anesthetic properties of cocaine. Nevertheless, his discoveries failed to win a secure position. Unable to support a wife, he corresponded daily with his beloved Martha Bernay while studying in Paris with a superstar physician and researcher, Jean Martin Charcot, who opened Freud's eyes to the importance of psychological factors (especially displaced sexuality) in producing physical symptoms. History has not been kind to Charcot's assertions, but he opened up a new world of possibilities to young Freud.

Setting himself up in clinical practice in order to support a family, Freud married Bernay and together they eventually had six children, including daughter Anna who became a distinguished psychoanalyst and child advocate in her own right. Freud's clinical practice started in a discouraging way. Patients were few and difficult to treat successfully. He used the methods then in vogue and also tried, but abandoned, hypnosis. Freud had expected much of himself, longing to be part of the new wave of scientists who were transforming medicine and society—and here he was, barely able to pay the bills. The death of his father was a further blow. The way out of these difficulties proved to be the way in—to the secrets of his own mind. Freud became both the first psychoanalyst and the first analysand (one undergoing psychoanalysis).

New Theory of the Human Mind

In *The Interpretation of Dreams* (1900) he reported (in a selective form) his self-analysis but also set forth an audacious new theory of the human mind. He elaborated, applied, and at times revised this theory over the years. Freud offered a complex vision of the human condition. He contended that adult personality is the outcome of experiences and conflicts beginning in early childhood. Neuroses result from difficulties in coping with fears, desires, and conflicts during the process of psychosexual development. Freud further held that conscious thought is a surface activity beneath



Austrian neurologist Sigmund Freud became, perhaps, the first major thinker to recognize both the importance and the pervasiveness of grief. CORBIS

which the unconscious operates according to its own rules. Much of the individual's emotional energy is tied up in an attempt to prevent threatening memories and conflicts from breaking through into consciousness. Furthermore, he believed that society itself has its own neurotic processes that often take the form of rituals and taboos. Mature persons are the ones who have become liberated from the hold of the past and accepted and integrated their basic impulses into a larger and more functional self.

Freud's new way of thinking about human thought and relationships led troubled people to seek his therapy and aspiring disciples to want to study with him. He was financially secure and in the midst of the international intellectual ferment for the remainder of his long life, but he was troubled throughout that life by a series of harrowing events: Friends died, some by their own hand; the brutality

of two wars intensified his concern about the future of civilization; physical pain tormented him for years; and the Nazis systematically destroyed his books and the works of other Jewish authors, leading to his reluctant departure from Vienna.

Freud on Death

At first Freud was dismissive of death concerns (thanatophobia). He believed that people who express fears of dying and death are—way deep down—actually afraid of something else, such as castration or abandonment. Humans could not really fear death because they had never had this experience and because finality and death are not computed by the unconscious. This view remained influential for many years after Freud himself started to take death more seriously.

It was grief that came foremost to Freud's notice. Not only had many died during World War I, but also many of Freud's family members and friends were suffering from depression, agitation, physical ailments, and suicidal thoughts and behavior. Later he realized that many people lived in grief for deaths not related to the war and that these losses might account for their various emotional and physical problems. Freud's grief-work theory suggested the importance of expressing grief and detaching emotionally from the deceased in order to recover full function.

His most sweeping—and controversial—suggestion took the form of death instinct theory, which postulated that all living creatures engage in an ongoing scrimmage between competing impulses for activity and survival on the one hand, and withdrawal and death on the other. This theory was associated with Freud's ever-intensifying fears that human destructive impulses would eventually destroy civilization if not all life on Earth unless they were rechanneled by improved child-rearing, psychoanalysis, and more effective societal patterns. To the last he hoped that acts of love could counteract the destructive impulses. It was not long after his death in London on September 23, 1939, that Anna Freud organized an effective mission to save the children of that city from Nazi rockets and bombs.

See also: ANXIETY AND FEAR; DEATH INSTINCT; GRIEF: THEORIES; PSYCHOLOGY

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ROBERT KASTENBAUM

FUNERAL INDUSTRY

The American funeral industry emerged in the aftermath of the Civil War, picking up steam at the turn of the twentieth century and gaining economic power by the middle of the century. Although the industry has long been the object of scathing public attacks, local funeral homes across the country have won respect as established and trusted places of business and as a source of comfort for families suffering from the loss of a close friend or relative. Variouslly called "undertakers," "funeral directors," and "morticians," America's new ritual specialists have transformed the twentieth-century experience of death and body disposal.

The foundation of the emergent industry was embalming, a practice that gained legitimacy during the Civil War years. Although medical schools before the Civil War relied on various European methods of preserving dead bodies for instructional purposes, most Americans had no knowledge of the procedure and abhorred any "unnatural" intervention into the body's organic processes of decomposition. In antebellum America, the integrity of the dead body, even one disintegrating in the coffin, had to be preserved at all costs. Even though it might be placed on a cooling board, the

interior of the corpse was generally not accessible to prying eyes, hands, or medical equipment.

During and after the Civil War, embalming became acceptable to more Americans who wanted to ensure that, no matter what, they could have a last look at their lost loved ones. Many Northern families who could afford it arranged to have the sacred remains of their fathers, sons, brothers, and husbands shipped home from Southern battlefields. They hired death specialists who found innovative methods, including arterial injection, to preserve bodies for the long journey home. Thomas Holmes, one of the pioneering founding fathers of the modern funeral industry, perfected his skills and made a dramatic impact on his fellow undertakers during the Civil War.

A critical turning point in popular awareness of embalming, and in legitimating it as a permissible American practice, was the cross-country journey of Abraham Lincoln's body after the war. Hundreds of thousands of people filed past the viewable body on display in cities from Washington, D.C., to Springfield, Illinois, and newspaper reports provided the public with graphic details about embalmers, whose methods were central to preserving a sacred relic that ritualistically united Americans after the divisive and bloody war.

After the Civil War, increasingly more undertakers began to experiment with embalming as an alternative to other modes of preservation. By the early decades of the twentieth century, embalming had become a standard practice in much of the country. American undertakers, many of whom had connections with the furniture industry and had a growing interest in the production of coffins, began to focus on the transformed appearance of the body.

Embalming assumed a central place in American burial practices for a number of reasons. First, instructors representing embalming chemical companies traveled the land, offering courses in the trade and conferring diplomas that signified professional expertise. In time, many of these companies established full-fledged mortuary schools. In addition, states began to recognize this modern professional occupation through licensing boards made up of established funeral directors and other civic leaders.

Second, the rhetoric surrounding embalming relied on contemporary theories about public

health and sanitation; many argued that embalmed bodies posed less of a threat to the health of a community than bodies left to rot in the ground naturally. Third, an entirely modern funeral aesthetic emerged in these early years, based in part on chemical company assertions about the value of providing mourners with a pleasing, well-preserved, and viewable corpse. Fourth, embalming proliferated because of an industry-inspired mythology that portrayed current practices as a technological culmination of ancient sacred rites dating back to ancient Egypt. Finally, embalming seemed to respond at some level to the needs and desires of Americans from a variety of ethnic, racial, and religious communities.

The rapid spread of embalming spurred the equally swift emergence of funeral homes across the country in the first few decades of the twentieth century, as American life was transformed by urbanization, medical advances, and the increasing prevalence of scientific attitudes and perspectives. Undertakers no longer traveled to the home of the deceased to prepare the body but instead transported corpses from the home or hospital to the funeral home. A melange of business, residence, religion, and consumerism, the funeral home rapidly became an American institution in local neighborhoods. Funeral directors lived with their families in these homes, and very often wives and children worked with the father in preparing services for people in grief. Whether they helped friends, neighbors, or acquaintances, everyone who walked into the home shared one thing in common: They were customers engaged in a financial transaction.

As funeral homes multiplied, so did a variety of professional associations organizing men at the national and state levels, trade publications exclusively catering to an emerging class of authorities of disposal, and educational institutions for the training of funeral directors. The funeral industry gradually emerged as an economically sophisticated, politically adept, and consumer-oriented institutional powerhouse that revolved around the embalmed, viewable body. But the industry encompassed much more than embalming chemical companies and national professional associations. Casket manufacturers, florists, cosmetic corporations, automobile companies, cemetery associations, insurance agencies, and other related businesses played a role in the financial triumph of



Lynch & Sons Funeral Home in Walled Lake, Michigan, has been a family owned and operated funeral home for over fifty years. The Lynch family, in its third generation of funeral directors, has chosen to remain privately owned while some others have sold to large multinational corporations. TIMOTHY LYNCH JR.

the industry, which was generating billions of dollars per year in economic activity by the end of the twentieth century.

While the changing nature of funerals created an industrial juggernaut over the course of the twentieth century, the public image of funeral directors has been constantly tarnished by bad press, ugly controversies, and negative stereotypes. Although they have referred to themselves as “professionals,” undertakers have had a difficult time convincing the public that this title should apply to an occupation that does not require a college degree—hence the gaping divide between the self-image of funeral directors as well-respected, active community members and the popular, media-fostered stereotype of the heartless, corrupt, and exploitative swindler.

Critics attacked modern American funeral traditions for a variety of reasons. The most obvious, and popular, line of attack was economic. The high cost of funerals seemed outrageous to many who

claimed that vulnerable families—especially poor families—consumed by grief and guilt had no choices and could not fully comprehend what they were purchasing when making funeral arrangements. Additionally, early on in the twentieth century many undertakers engaged in deceptive business practices, such as adding a range of costs for nonitemized services onto the price of the casket. Community and religious leaders, politicians, academics, and other public critics launched formal and informal investigations into the industry, and often produced lengthy, highly publicized reports that the media boiled down to accessible, reader-friendly stories that filled newspapers and popular magazines. Many reports tended to focus almost entirely on the economic angle, although explicit references to cultural and class differences frequently came into view. For example, many investigative reports claimed to have the interests of the lower classes in mind when making recommendations about curtailing the costs of funerals. According to these reports, the poorer segments of

American society, such as immigrants from Italy or Ireland, spent lavishly on extravagant funerals because they were ruled by irrational, emotional impulses that were manipulated by unscrupulous undertakers who encouraged them to spend beyond their means.

In addition to the economics of burial, many articles highlighted frequent religious criticisms of the American funeral. Not surprisingly, the focus in this regard was the embalmed, nicely dressed, presentable body displayed in an open casket for all to see. In the view of such critics, rather than expressing the highest values of an advanced civilization, this attention on the physical body was a debased form of paganism. They attributed this fixation on the corpse to a combination of irrational, primitive desires among the uneducated masses, and scandalous, dishonest practices by funeral men encouraging secular materialism.

The popular press frequently covered the high cost of funerals during the first half of the twentieth century, but one book published in 1963 made a dramatic, indelible impression on American public's perception of the funeral industry as nothing had before it: *The American Way of Death*, written by the English-born Jessica Mitford, simply restated earlier criticisms that were already familiar to most. But what made the book a runaway best-seller was Mitford's style of writing, an effective mixture of humor, muckraking, outrageous anecdotes, and exposé. The book struck a chord in American popular culture at a time when consumer consciousness and empowerment began to play a much larger role in the habits and tastes of the American buying public.

It also resonated because by the time of its release, the stereotype of the money-hungry, insensitive, buffoonish undertaker had already emerged in the American cultural imagination. One of the first was a hilarious, though brutal, episode in Mark Twain's *Life on the Mississippi* (1893), which depicted the author's encounter with an old friend who is now happily making a living burying people. A variety of subsequent similar representations gave shape to the popular, one-dimensional stereotype, including Thomas Wolfe's *Look Homeward, Angel* (1929); J. D. Salinger's *The Catcher in the Rye* (1951); the radio program *The Life of Reilly* with the famous character, Digger O'Dell, "the friendly undertaker"; the film *The Loved One*

(1965), adapted from Evelyn Waugh's 1948 book; and television shows all contributed to the vitality and familiarity of the stereotype by the early 1960s. Mitford's book reaffirmed, as well as revitalized, the stereotype. It resonated with Americans hooked on sensationalism and accustomed to the vile antics of modern death specialists.

Men and women in the funeral industry responded to Mitford in the same way that they had responded to earlier criticism. They engaged in intensive national public relations campaigns that included the production of numerous brochures and pamphlets, made efforts to educate their local communities through open houses and other events, and tried to defend the American way of death in the media when given an opportunity to present their case. In most instances, they claimed that the traditional American funeral—which included an embalmed body, cosmetic touches, an open casket, and a last viewing by mourners—expressed respect and honor for the deceased, represented patriotic American values, and responded to the deepest desires of the living who wanted to do right by their dead, regardless of what so-called experts might have said.

Industry representatives argued that most Americans did not want to handle their own dead and get them ready for burial. Any suggestion that the industry should be controlled by the government, these representatives warned, would lead to socialism and, ultimately, the destruction of democracy and the free market. Additionally, by the time Mitford's book was published, the industry had elaborated a theoretical basis for the modern funeral that relied on increasingly popular psychological language to justify its practices. In the early years of the industry, the reigning paradigm surrounding the professional duties of funeral directors was limited to his expertise in the area of embalming, running a successful business, and managing the funeral services. In time, another area of expertise that dominated industry rhetoric related to the psychology of grief, and, more specifically, the psychological value of viewing a pleasant-looking body in repose.

On the one hand, members of the industry asserted that the last look provided the bereaved with an undeniable message that death had occurred. On the other hand, gazing at the sacred remains initiated a much longer process of healing

because it offered those in grief a lasting image or “memory picture” that erased many of the negative images coming to be associated with dying (i.e., being hooked up to tubes and wires in an impersonal, antiseptic hospital setting or seeing cancer disfigure the body of a loved one). The funeral industry strongly promoted a psychology of grief that shaped public arguments and led to a range of additional services that many funeral homes began to offer their customers, such as after-death bereavement counseling.

In the wake of Mitford’s book and the recurring media reports on corruption within the funeral industry, a number of significant changes swept the country, although none really threatened the economic muscle and cultural authority of America’s funeral homes. The Federal Trade Commission began its own investigation of the industry in the late 1970s and issued a series of proclamations based on its findings, including the Funeral Trade Rule in 1984. Some of the regulations imposed on funeral directors included providing clients with a detailed price list of all goods and services, informing them that embalming is not required by law, and allowing families to plan alternative funerals that did not follow traditional patterns.

Governmental requirements of full disclosure, along with larger shifts in U.S. mores during the 1960s and 1970s, left a permanent imprint on American mortuary practices. For example, in response to growing popular desires to craft personal ceremonies that were unique to the life and personality of the deceased, the industry began to loosen traditional rituals invented and perpetuated by funeral directors in the first half of the century, encouraging an embrace of “adaptive” funerals that catered to individual and community needs.

In the midst of these changes, the funeral industry increasingly adapted to consumer demands, although funeral directors continued to play a central role in the interment of the dead. Even though many from the older generation resisted such changes and called for a return to tradition, younger, more progressive funeral directors simply changed with the times and expanded the range of services and goods available at local funeral homes.

By the early decades of the twentieth century, African-American, Jewish, Catholic, and other ethnic and religious communities had their own

funeral directors to take care of their dead. When a range of new communities sprang up in metropolitan areas after the change in immigration laws in the 1960s, many funeral directors began to offer services to Vietnamese, Latino, Eastern European, and other immigrant families that did not yet have their own funeral homes to which to turn. The funeral industry began to see a tremendous increase in Buddhist, Hindu, Confucian, and other non-Western religious rituals taking place in funeral homes across the country. In the first half of the twentieth century the industry had promoted cross-cultural knowledge of the world’s funeral customs throughout human history, but up until the later decades of the twentieth century, funeral directors never had hands-on experience with these traditions.

Perhaps the most important development to emerge after Mitford’s book was cremation. Although cremation had made its appearance on the American scene much earlier, it became a viable option in the late 1960s and grew in popularity in subsequent decades. At first, most imagined this option to be a mortal threat to the traditional funeral; the incineration of the body, with no embalming, no viewing, and no religious ceremony, posed an unprecedented dilemma for funeral directors around the country, who did not have the resources, technology, or tolerance for such an unusual mortuary practice. But as the cultural landscape began to shift, and as more Americans grew tolerant of the practice, the industry found ways to accommodate the growing numbers of people who desired burning bodies and ceremoniously disposing of the ashes. Cremation rates at the turn of the twenty-first century rose to 25 percent. As more funeral homes built their own crematoriums or contracted with independently owned facilities, the industry found ways to adapt to the popular practice. Cemeteries have built columbaria, merchandisers have produced a range of stylized urns, and funeral homes have established new ritual patterns, including some that retain more traditional elements, such as viewing an embalmed body before putting it to the fire.

Another significant trend to emerge in the closing decades of the twentieth century was the intrusion of multinational corporations into what has become known as “death care.” Inspired in part by the aging of the populous baby-boom generation,

big corporations like Service Corporation International and the Loewen Group have been buying up independent, family-owned funeral homes. Even though most funeral homes are independently owned and operated, these corporations will continue to play a major role in U.S. funerals well into the twenty-first century.

See also: BURIAL GROUNDS; CEMETERIES AND CEMETERY REFORM; CIVIL WAR, U.S.; CREMATION; DEATH SYSTEM; FUNERAL ORATIONS AND SERMONS; LAWN GARDEN CEMETERIES

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GARY M. LADERMAN

FUNERAL ORATIONS AND SERMONS

Since ancient times ceremonies and rites have been associated with the disposal of a corpse. The purposes of these rites were to honor the

deceased, to plead for divine favor, and to console the bereaved. Among the diverse customs that developed, funeral oratory emerged as a favorite means of responding to death, for it could, more than any other activity, highlight the personal characteristics of the deceased while serving as a means of reinforcing social bonds and status.

Roman Origins of the Funeral Oration

The Roman funeral oration (*laudatio funebris*) was typically utilized by the social elite. It provided the means for publicly reaffirming the continued authority of the Roman state, the power and prestige of the deceased's family, and the maintenance of cultural values and social hierarchies. Normally the son of the deceased or another close relative delivered the funeral oration in the city forum, following a variety of public and private rituals. During the oration, the deceased's meritorious deeds and virtues were recounted. The oration highlighted the moral strength and acts of charity performed by the dead. In addition, celebration of loyal service to Rome in public office or military rank reinforced the authority of the Roman state. Recitation of the achievements and legendary deeds of the deceased's ancestors showed continuity with the past.

In his works, the Roman chronicler Polybius described in his written works some of the benefits of a typical elite funeral for younger citizens, arguing that such orations and grand celebrations invoked pride and inspired young men to emulate the behavior and deeds of the deceased. The tone of orations was positive. Families kept these eulogies as reminders and enduring obituaries that acted as a kind of moral heritage.

Funeral Sermons of the Middle Ages

Funeral sermons of the Christian Middle Ages, often titled *de mortuis* sermons, originated with the works of Ambrose of Milan in the fourth century. His sermons combined Roman oration characteristics of praise and lamentation with Christian consolation. However, most surviving information on sermons dates from the fourteenth century. The medieval funeral sermon took place between the funeral mass and the burial, most likely given in the language that the majority of listeners would understand—Latin for a clerical audience, the vernacular for a lay audience. Sermons featured three

main themes: an extended discussion on death based on biblical scriptures; the presentation of the deceased as a praiseworthy role model; and a plea to the living to help the dead.

Many funeral sermons survived as models for preachers. Such model sermons were adapted to individual cases indicating use for a priest, knight, burgess, or matron. The existence of so many model sermons suggests that by the fourteenth century demand for funeral sermons had risen.

Sermons stressed that grief was natural but should be controlled, and that the bereaved should present a brave face to the world, easing the suffering of others. Indeed, funeral sermons often argued that grief should be rational, having an appropriate level of grief. Therefore, the status of the deceased and importance to the community was taken into account, with grief for a knight greater than for a burgess and greatest for a prince. In this way funeral sermons make clear the complexity of the social hierarchy beyond the notion of the three estates. Medieval funeral sermons usually strove to celebrate the person in his or her role, not as an individual. Thus, medieval funeral sermons did not convey a strong impression of the deceased's individuality, but instead gave a sense of the person's place in the community.

The Funeral Oratory and the Protestant and Catholic Reformations

The Protestant and Catholic Reformations caused the nature of the funeral oratory to gradually change. By 1550 Lutheran ministers had begun to emphasize sermons, which did not actually become central to burial services until 1600. Martin Luther had preached the first extant Lutheran sermons for the Saxon electors, Frederick the Wise and John the Constant, in 1525 and 1532, respectively. Focusing on the living rather than the dead, the intent of his biblical explication, Thessalonians 4:13–14 for both services, was to praise God and to console his congregation. He did not dwell on the personal qualities of the deceased. As these sermons increased in popularity, partly through the inclusion of models in church ordinances, their nature was transformed. Attached to their biblical exegeses and moral messages were lengthy eulogies of the deceased and their families. Because all funerals did not include sermons, the preaching of them served to highlight the deceased's prestige. They

generated widespread criticism because preachers inflated the qualities of the deceased and their families. Extremely popular, some 300,000 of them for both men and women were printed by 1770.

In other lands, extreme reformers, such as John Knox and some English Puritans, denounced the preaching of funeral sermons for fear that they would be interpreted as intercessory prayers for the dead or would be used to elicit those prayers. Many reformers, who also objected to them because of their Pagan origins, argued that burial of the dead was more appropriately a civil than a religious obligation. Ultimately, most English clergy chose to provide eulogies out of respect for the wishes of the bereaved who generally wanted to hear their beloved ones praised. Only a few Puritans failed to add commendations to their sermons. Justifying the praise on didactic grounds, their fellow ministers explained that they could hold up the praiseworthy lives of the departed as a pattern for members of their congregations to follow. Between 1670 and 1714, the sermons became increasingly popular; most of the 1,300 that were published in England appeared during that period. Some of the printed sermons were for women, who were extolled as models for all Christians, not just other women, to follow.

Moving between lamentation and praise, English preachers comforted the bereaved in oratory that was based on exegeses of scriptural texts, most often from the New Testament; a favorite was Revelation 14:13. With Greek and Latin allusions, ministers expounded on the brevity of life, on the difficulty of dying well, and on the blissful paradise awaiting Christians. They also attempted to rationalize the deceased's death and to offer ways in which members of their congregations should respond to their losses. Finally, they turned to the eulogies, which took up from one-fourth to one-third of the sermons and which, like the Lutheran ones, increasingly elicited criticism because of their flattering language. The more extreme Protestants tended to give stylized eulogies while other preachers offered ones that were somewhat more individualized in character. They all discussed personal matters, such as household relationships, private and public worship, and good works, as well as public careers. A detailed and sometimes lengthy description of the deathbed scene followed, in which the deceased played major roles

in religious meditations and struggled to overcome satanic temptations.

Post-Reformation Oratories

Orations continued in post-Reformation Protestant and Catholic countries. Universities in both areas might honor distinguished alumni with special memorial Latin oratory that extolled their public service and benefactions. Following the funeral mass in Catholic countries, such as France, priests also offered orations in which the eulogies were usually preceded by a lengthy meditation on death and the transitory nature of life. The death of the deceased, priests explained, was not simply the loss of relatives and friends but of all humanity.

During the Enlightenment, further changes occurred in Protestant and Catholic funerals. In Lutheran services the amount of clerical input was greatly decreased and often a secular oration replaced the sermon. In England the emphasis of the sermon shifted from the deceased's personal religious practices and household relationships to his or her public accomplishments and good works. Some Anglican preachers all but promised members of their congregations that if they followed the deceased's example they would be blessed financially in their earthly lives. Deathbed scenes were increasingly neglected. Although non-conformists continued to preach traditional sermons, criticism of their inflated eulogies soon led to their decline in popularity as well. In France, priests dwelt almost entirely on the deceased's life on the earth, leaving out extended religious meditations on death and the transitory nature of life.

Orations in the Eighteenth and Nineteenth Centuries

By the late eighteenth century, funeral orations had shifted firmly away from religious strictures and biblical exegesis to more secular topics. These eulogies emphasized the deeds of the citizen laboring in the state's service as well as private virtues. Republican France staged elaborate civic funerals that pointedly restricted religious content and reinforced republican ideals. This aspect became most clear at the graveside as orators, chosen by family members, spoke in praise and memory of the departed. The speeches dealt with the deceased's best qualities, but also touched on

political and social issues, providing an opportunity for reaffirming the prominence of the republic. England utilized state funerals for similar political and cultural affirmation.

In France and England, the religious portion of the funeral sermon dwelt on the threat of hell, though by the end of the nineteenth century the image of hell receded and the religious message became one of reassurance and comfort. In funeral sermons hell lost its terror, while heaven came to be a place that promised good things and reunion with loved ones.

Funeral Sermons in the Twentieth Century

Over the course of the twentieth century, funeral sermons further deemphasized the religious content as the entire funeral process became more professional and less dominated by family members. Although the clergy continued to provide sermons and commendations at funerals, especially in the reformed churches, by the late twentieth century the secularization of society had led to an increased lay participation in the services, with friends and family providing eulogies and services that often supplanted the religious services. Lay eulogies included film clips, recordings, oral reminiscences, poetry, and spiritual readings. The orators, unlike their predecessors, often recalled the foibles of the deceased as well as their finer moments. The total effect of the service was to celebrate the human spirit rather than to offer up the deceased as a religious model.

Funeral oratory has served vital social functions in Western culture, including commending the deceased and reinforcing religious beliefs, social hierarchies, and relationships. Funeral oratory in the twenty-first century will likely reflect a continuing secular emphasis, as well as the growing influence of the World Wide Web and advancing technology. Numerous religious organizations offer resources on the Internet for funeral sermons and eulogy. Virtual funerals on the Internet and videotaped funerals will increase access to funeral oratory. Access to oratory practices worldwide via technology and the Internet may both diversify and homogenize human death practices.

See also: EPITAPHS; FUNERAL INDUSTRY; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE

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GENDER AND DEATH

Males and females have different risks of dying with regard to both age at, and cause of, death. The male-female differential depends on level of economic development; however, there are some universal characteristics that appear to be biologically determined. These “universals” are most pronounced at young ages.

Biological Differences

It has universally been found that more male than female babies are born. While the magnitude of the sex ratio at birth (the number of male births per 100 female births) varies somewhat, it is almost always in the range of 103 to 107. There is some debate about why male births exceed female births, in part centered on the issue of sex differences in the number of conceptions. It has been argued that considerably more males are conceived, but that the male fetus is biologically weaker. The data available suggest that males do have higher mortality from around the third to the fifth month of gestation age. While it is extremely difficult to know about mortality risk during the first few months of pregnancy, the limited evidence suggests that there are more male embryos by the second month after conception. This means either that more males are conceived or that female embryos have higher mortality risk in the weeks after conception, or both.

While there is uncertainty about sex mortality differentials in the early gestational period, data for

the first year of life are very clear. In virtually all places and times infant mortality rates are higher for males than for females. Quite a bit of evidence points to biological factors playing an important role in the higher mortality of infant males. Despite their higher birthweights (a factor associated with infant survival), male babies are more likely to suffer from congenital abnormalities that lead to death and to have immune deficiencies associated with X chromosome-linked genetic defects and with exposure to testosterone prenatally and in early infancy. This latter factor may also contribute to greater activity levels associated with higher accident mortality.

Other biologically based factors contributing to gender differences in mortality include the protective effect of women's XX chromosome structure against heart disease, especially at ages under fifty-five, and a propensity to violence among men that can have lethal consequences. The degree to which men are more violence-prone than women and the reasons for it are, however, hotly debated and it cannot be stated if and how biology may be implicated. While biological factors can explain part of gender differences in mortality, these differences vary too much by time and place to be accounted for by biology to any great extent.

Gender Differences in Mortality in Less Developed Countries

According to the Population Reference Bureau, circa 2000 in less developed countries the life expectancy at birth of females exceeded that of males by three years (66 versus 63 years). In the

1950s the differential was approximately two years (42 versus 40 years). While considerable progress in life expectancy at birth has been made, and approximately equivalently for males and females, there is much concern that women in third world countries are disadvantaged in terms of mortality. In part, this concern stems from the gender mortality gap favoring females in developed countries that is interpreted to mean that, given more equal treatment, females will have lower mortality than males.

The clearest evidence of female disadvantage comes from demographic research on the third world, which estimates that between 60 million and 100 million girls and women are “missing.” They are missing as a combined result of female infanticide, sex-selective abortion and health care neglect, nutritional deficiency, and mistreatment that lead to death. Also, maternal mortality plays a role; the World Health Organization (WHO) and UNICEF estimate that more than half a million women die per year due to pregnancy-related problems, most in developing countries. Worldwide, women face a 1 in 75 lifetime risk of dying due to maternity-related causes. This risk varies from 1 in 4,085 in industrialized countries to 1 in 16 in the least developed parts of the world (see Table 1).

The female mortality disadvantage varies substantially across developing countries. For example, in substantial portions of the third world, mortality rates at ages one through four are approximately equal for girls and boys. However, populations of the Indian subcontinent and China have childhood mortality rates favoring males by a substantial margin. Indeed, it is likely that most of the world’s missing girls and women are from these two regions. It appears that the female mortality disadvantage in the third world is less the result of societal economic deprivation (as many countries are poorer than India and China) than it is the by-product of cultural values and practices that favor males. China’s one-child-only population policy also plays a role, given a pre-existing preference for sons in that patrilineal society.

Within the third world in general, there is not any systematic evidence that females are less well-nourished than males. However, research suggests that differential access to preventive and curative health care, such as vaccinations, favors males in

TABLE 1

| Maternal mortality, 1995 | | |
|---------------------------------|----------------------------------|--|
| Area | Number of Maternal Deaths | Lifetime Risk of Maternal Death 1 in: |
| World | 515,000 | 75 |
| Industrialized Countries | 1,200 | 4,085 |
| Developing Countries | 511,000 | 61 |
| Least Developed Countries | 230,000 | 16 |

SOURCE: Adapted from WHO, UNICEF and UNFPA. *Maternal Mortality in 1995: Estimates Developed by WHO and UNICEF*. Geneva, 2001.

much of the third world. Another factor that negatively affects female mortality relates to birth spacing. In countries with son preference, the birth of a daughter will be more quickly followed by another birth than is the case when a son is born. This disadvantages young girls because a short interval between siblings is related to higher mortality for the older child.

An aspect of gender inequality in death concerns cultural practices related to widowhood. In some societies it is cultural practice for widows to also die when their husbands pass away. A well-known case of this practice is *sati* in India, in which a widow is expected to commit suicide by throwing herself on his funeral pyre. A widow who resisted might be pushed into the pyre by her in-laws. While religious reasons are purportedly at the root of such practices, it is also argued that other motives can prevail, such as repossession of the widow’s inheritance by her husband’s family. While *sati* was legally banned in the 1800s by the British colonial rulers in India, it persists only in a few Indian states and other parts of south Asia.

Gender Differences in Mortality in Developed Countries

In developed countries, females outlive men by seven years: life expectancy at birth for females is 79 and for males it is 72. However, there is variation across the developed world in the magnitude of the sex difference in life expectancy. It ranges from a low of five years in many of the countries

that made up the former Yugoslavia (averaging 75 years for females and 70 years for males) to a high of twelve years in Russia (73 years for females; 61 years for males).

In mid-twentieth century the average difference in life expectancy at birth in more developed countries was approximately five years. At the beginning of the twentieth century, the difference was estimated at two to three years.

Trends in mortality favored women in the more developed countries from at least the beginning of the twentieth century to the early 1980s. Mortality trends in different age groups contributed differentially to this overall trend of widening the sex gap in mortality. Nearly two-thirds of the widening can be attributed to mortality among people aged sixty-five and over. In other words, death rates for older women declined more quickly than death rates for older men. One-quarter of the increase resulted from mortality trends among people aged fifty-five to sixty-four, for whom, as well, female death rates declined more than male death rates. Very little of the increase was due to mortality among children aged one to fourteen, less than 3 percent. (This is unlike the case in the third world, where death rates among children figure prominently in mortality trends and differentials.) In contrast, trends in infant mortality operated in opposite fashion, to narrow the sex difference in mortality. High male infant mortality was overcome to a considerable degree so that eventually, for the most part, only the genetically caused higher susceptibility of male infants to death remained.

Differential trends in various causes of death contributed to the widening of the sex mortality difference. By far the most important cause of death in the widening is diseases of the circulatory system, which include ischemic heart disease and strokes. While there is variation from country to country, the overall fact that male deaths due to circulatory disease declined less than female deaths is responsible for approximately three years of the widening gap. Of the different kinds of circulatory diseases, trends in ischemic heart disease played the biggest role in this three-year widening, with men's death rates increasing over most of the twentieth century while women's death rates were stable or declined. Rheumatic heart disease and strokes (for which

women and men have approximately equal risks of death) have decreased in importance as causes of death. Thus, the composition of the circulatory disease category—with an increasing prevalence of ischemic heart disease—played a role in widening the sex mortality differential.

The second most important cause of death in explaining the widening sex differential in mortality is malignant neoplasms (cancer). At the turn of the twentieth century, female mortality from cancer (especially due to breast cancer and cancers of the female genital organs) tended to be higher than male cancer mortality. However, over the course of the twentieth century increasing rates of male mortality due to respiratory (e.g., lung) cancers served to widen the male-female mortality difference. In the United States for the period from 1900 to the early 1980s shifts in the trends and pattern of cancer mortality accounted for more than one-third of the widening sex mortality differential; in other Western countries such as England and Australia, the contribution made by malignant neoplasms to widening the sex mortality ratio was even greater.

Other causes of death are much less important contributors to the widening sex mortality differential. For example, declines in maternal mortality, although very substantial, have had only a small effect. Trends in accident mortality and suicide—two causes of death that are higher for males—have not played a big role either. In contrast, declines in infectious and parasitic diseases, for which males in the West tended to have higher mortality than females, had an opposite effect, that is, to narrow the sex gap in mortality.

The increase in respiratory cancer among men and the slower decreases in circulatory system mortality among men have been attributed to smoking differences, in large part. Over the earlier years of the twentieth century, men (much more so than women) took up cigarette smoking, the effects of which show up in mortality statistics among older age groups being that cigarettes are slow killers.

Since the early to mid-1980s the sex differential in mortality has narrowed a bit in developed countries, although it is still the case that male mortality is higher than female mortality for every major cause of death. For example, in the United States, life expectancy at birth favored females by 7.6 years

in 1980; by 1990 and 2000, the difference was 6.7 years and 6.6 years, respectively. Trends in cancer, particularly respiratory cancers, account for some of the decrease. Since 1980 in the United States, men's rates of lung cancer mortality, although still increasing, have slowed down in pace; in contrast, women's rates of lung cancer mortality have skyrocketed. This trend reflects, in large part, the later adoption of smoking by women.

If the sex differential in mortality is to be reduced, the preferable route is by decreasing male mortality, not increasing female mortality. Smoking cessation is clearly required in order to achieve this. Also, research has shown that the sex gap in mortality is much smaller among the educated and economically advantaged segments of the U.S. population. This suggests that mortality level is, to a large extent, determined by social and economic factors, and that reductions in male mortality closer to female levels are attainable.

The topic of gender and death is one that is inherently political. On the surface it appears that in most populations in the world females are advantaged in that they live longer. One might wonder, then, why both international and national efforts are concentrated with women's health. Three issues are to be acknowledged in attempting to answer this question. One, there are clear indications that, at least in the area of the Indian subcontinent and in China that account for a large proportion of the world's population, females are treated in ways that risk their lives. Two, in most parts of the developing world females are not living as long as they could, given historical data from the West. Three, although females live longer in the developed countries, all evidence suggests that they are sicker than males, especially in adulthood and older adulthood. Efforts to combat premature mortality and morbidity should be cognizant of the often nuanced way that gender affects life and death.

Gender differences are also involved in matters associated with death, and not just death per se. In a classic work on cross-cultural aspects of grief and mourning, Rosenblatt and colleagues reported that men and women tend to vary in emotional expression of bereavement. Women are more likely to cry and self-mutilate whereas men tend to direct the anger associated with bereavement to others

and away from themselves. It is possible that this gender difference in expressivity reflects a more general pattern of gender inequality; that is, women, given their lower status, may be used as the persons who are expected, and perhaps coerced, to engage in activities that publicly symbolize a death that has occurred. Women are also often expected to publicly display their bereaved status much longer than men. For example, in many southern European countries, it was traditionally expected, and still is to varying degrees, that a widow wears black clothing for the rest of her life. Such rituals have the effect of silencing women and their sexuality.

Women tend to be more involved with death than men, given their role as "carers of others." Women, either as family members or as paid workers, are the ones who care for the dying in all societies. In Western societies, in which women outlive men by a substantial degree, elderly women are often the chief caregivers to their dying husbands, although they obtain assistance from other women, notably their daughters and daughters-in-law. They then face the prospect of their own death, typically partnerless because widows are not as likely to remarry as are widowers.

See also: INFANTICIDE; MORTALITY, CHILDBIRTH; SUICIDE
INFLUENCES AND FACTORS: GENDER

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ELLEN M. GEE

GENDER DISCRIMINATION AFTER DEATH

Does gender discrimination continue after death? A lifetime of inequality is arguably enough; how might inequality between the sexes perpetuate

itself beyond the grave? If one assumes that a posthumous obituary is a postself artifact that survives death, then one might ask whether or not obituaries are written and published in an unbiased manner. Scholars suggest that they are not, and that gender discrimination follows the individual beyond the grave.

Discussions of Gender Discrimination after Death

In 1977 the scholars Robert Kastenbaum, Sara Peyton, and Beatrice Kastenbaum were the first to raise the question of gender discrimination after death. They hypothesized that the "dominant male-prefering value system of the United States would carry over the threshold from life to death" (Kastenbaum, Peyton, and Kastenbaum 1977, p. 353). The authors used newspaper obituaries as a subtle, unobtrusive measure of society's value system, and they proposed that men receive greater public recognition after death than women. Their hypothesis was tested in two major metropolitan newspapers on the East Coast, the *New York Times* and the *Boston Globe*. They found that men receive four times as many obituaries as women, and that male obituaries are longer and are ten times more likely to be accompanied by a photograph. They concluded that the readers of these two publications are receiving "systematic, if subtle confirmation of the greater importance of men." They argued that if gender equality has won fundamental acceptance, one will expect it to "express itself in less visible, less pressured-by-advocacy areas such as obituaries" (p. 356).

Kastenbaum and his colleagues set the bar; others challenged it using a variety of methods and data sources. For example, in 1979 Bernard Spilka, Gerald Lacey, and Barbara Gelb examined obituaries in two Denver newspapers, the *Denver Post* and the *Rocky Mountain News*, arguing that the West is more progressive than the East. They sampled obituaries from July 1976 through July 1977 in both papers. Their findings provided weak support for gender bias favoring males. This is most pronounced in terms of obituary length, but there is evidence that women receive fewer obituaries and fewer photographs as well. They concluded: "Economic, political, and social factors within Western society continue to support a greater valuation of males and this is perpetuated even in the manner

in which one's death is marked and remembered" (Spilka, Lacey, and Gelb 1979, p. 232).

The next period of examination occurred in the mid-1980s. First, Michael Kearl looked at two national news magazines, *Time* and *Newsweek*, and sampled obituaries from 1923 to 1979. Men are six times more likely to receive an obituary than women and ten times more likely to receive a photograph; male obituaries are also longer. He found that individuals in the arts and business account for over 40 percent of the obituaries, and that women are underrepresented in all role categories except familial relation (being related to a famous person, almost always a man).

Next, Bernice Halbur and Mary Vandagriff examined death notices (as opposed to obituaries) in three Birmingham, Alabama, newspapers, the *Reporter*, the *World*, and the *News*, over an eighty-five-year period from 1900 through 1985. In their research they found no evidence of bias because they used death notices and not obituaries. Kastenbaum distinguished between death notices ("a single paragraph of basic information that is set in small type and included in an alphabetical listing of recent deaths") and obituaries ("more variable in length and somewhat more variable in style . . . printed in the newspaper's usual type size, with an individual 'headline' for each obituary, either the deceased's name or a more extended statement" (1977, p. 353)). Typically, death notices serve as a proxy for actual deaths and are not examined for gender bias because their content is highly standardized and they are submitted routinely to newspapers by funeral directors. On the other hand, obituaries represent "interesting" or "important" deaths selected for added recognition and, as such, are subject to possible gender bias. Because Halbur and Vandagriff relied on death notices, it is not unusual nor unexpected that they found no evidence of bias in the number of notices, nor in the presence of a photograph.

In the 1990s two more studies examined gender discrimination in obituaries. Karol Maybury examined obituaries in the *Boston Globe* and the *Sacramento Bee* for a two-month period from November 15, 1992, through January 15, 1993. Men are two and one-half times more likely to receive an obituary than women, their obituaries are longer, and their obituaries are four times more likely to be accompanied by a photograph. There are no

regional differences. Women related to famous men have the longest female obituaries, while men in entertainment/arts have the longest male obituaries.

Robin Moremen and Cathy Craddock examined gender differences in obituaries in four regional newspapers in the late 1990s, following the original Kastenbaum method. In Moremen and Craddock's study, the *New York Times* represents the Northeast and is included in the original study; the *Chicago Tribune* represents the Midwest, the *Los Angeles Times* the West, and the *Miami Herald* the Southeast. As in previous studies, men receive significantly more obituaries than women, however, unlike the Maybury study results, Moremen and Craddock's study found regional differences: Obituaries are 7.69 times more likely to be written about a man than a woman in the *New York Times* (compared to 4.02 times in the original study); 4.21 times more likely in the *Los Angeles Times*; 3.11 times more likely in the *Miami Herald*; and 2.47 times more likely in the *Chicago Tribune*. Male obituaries are longer (except for the *Miami Herald*), and significantly more likely to be accompanied by a photograph (except for the *Miami Herald*). The average age at death is seventy-nine for women and seventy-two for men, which is consistent with national averages. People in business and the performing arts receive the most recognition, with men dominating these categories. Women dominate categories like miscellaneous (including devoted to family, animals, and children; homemaker; volunteer; active with seniors), clerical/retail, and related to someone famous, usually a man.

These studies demonstrate little change over time in the recognition of women after death. Consistently, fewer obituaries are written about women, fewer obituary lines note the accomplishments of women, and fewer pictures of women appear on the obituary page. When women are recognized usually it is for domestic or caregiving roles, or for their relationship to a famous man. Why is this so, and why is there so little change over time? Certainly women have made inroads into the labor market in recent decades; why is this not being reflected in postself artifacts like obituaries?

Possible Explanations for the Findings

There appears to be five general explanations for the persistent inequality in obituary representation: a cohort effect, a period effect, a location effect,

a decision-making effect, and a social inequality effect.

Cohort effect. Men and women born in the early 1920s came of age in the 1940s and 1950s, prior to second-wave feminism. Most middle-class women of that generation were homemakers, performing tasks that did not register in the economic sphere. By the time the feminist movement left its mark on the workplace, most of these women were too old to benefit. Hence, this generation of women is dying with very little public recognition of their accomplishments. This is largely so because paid work counts in American society; unpaid work in the home does not register in the economic sphere, therefore it is not viewed as important. One might expect the situation to improve for the women who came of age during second-wave feminism in the 1960s and 1970s, but wage, occupational, and promotional barriers may still prevent them from receiving equal treatment in the workplace and, thus, equal treatment on the obituary page.

Period effect. In her best-selling *Backlash: The Undeclared War Against American Women* (1991), Susan Faludi wrote of a feminist backlash that is part of a conservative response to second-wave feminism. Women in the 1980s and 1990s were told by conservative ideologues in the New Right political and fundamentalist Christian movements that they had “made it.” The media took this ideology and translated it into sound bites; what is more apropos of this than an obituary that translates a person’s life into fifty-six lines of print? Kastebaum argued two decades prior that consumers of obituaries are receiving “systematic, if subtle confirmation of the greater importance of men” (1977, p. 356). Twenty-first-century consumers of obituaries are receiving systematic, if subtle, confirmation of a conservative ideology that is being promoted vigorously by New Right politicians and fundamentalist Christian groups.

Location effect. In locations where older women outnumber older men, there may be greater opportunity for posthumous recognition with an obituary. According to the Moremen and Craddock study, this is true in the *Miami Herald*. When a woman receives an obituary in the *Herald*, it is likely to be lengthy and to be accompanied by a photograph. Greater representation in the *Miami Herald* reflects greater awareness of senior issues

in Florida, where, in general, women over the age of sixty-five outnumber men three to two.

Decision-making effect. The obituary decision-making process may contribute to selection bias. Because major newspapers with huge circulation areas are studied in the past, none is able to run obituaries of everyone who dies (smaller newspapers are much better able to do this). Therefore, rules of thumb develop about who should receive obituary recognition. One such rule is that the person must be a “news maker” in his or her lifetime. A potential news maker might be brought to the attention of the obituary department by a relative calling the paper and reporting the death; by the wire services or the death notices submitted by family and funeral directors; by the editors of one of the news desks alerting the obituary department to the death of a notable person in his or her field; or by a corporation sending information to the paper about a distinguished businessperson who died. Once the “news maker” is identified, the individual is “researched.” This usually means looking back in the archives to see how many stories have been written about this person in the past. If time permits, other public sources are researched as well. If information is plentiful, then an obituary is written. In all cases, however, the obituary editor is the final arbiter of the page. The explanation most often offered by editors regarding unequal coverage of men and women is that obituaries reflect society as a whole; men have held higher positions historically and more has been written about them, therefore they receive greater obituary recognition.

One additional point is worth noting: Because women outlive men, more women are in the position of providing information to newspapers than men. When women die, there may be no one available to provide such information for them. More often women are the record keepers of the household. Therefore, even if men are in the position to provide information to newspapers, they may not have that information at their disposal.

Social inequality effect. Women’s inequality in obituary recognition most likely reflects their continuing inequality in society. When women receive equal salaries, equal access to all occupations, equal access to the top levels of management, and equal treatment in the home, then perhaps they will receive equal recognition after death.

Researchers have found lasting differentials between the average earnings of men and women. Women's salaries have increased more rapidly than men's, but women are still earning only seventy-five cents for every dollar that a man earns. Women continue to be excluded from some occupational categories. They are overrepresented in clerical, retail sales, and service occupations, and underrepresented in professional, managerial, and high-skill craft positions. Additionally, women are blocked from the highest ranks of management. While women readily advance into middle management, they seldom reach senior management; in 2000, women ran only three of the five hundred largest public companies. Meanwhile, women remain responsible for the majority of unpaid work in the home, whether or not they work for wages. They spend about thirty-four hours per week on household chores, while men spend about eighteen hours. When women undertake paid employment, housework amounts to a second, full-time job. Because women have not yet "made it" in American society, gender equality in "less pressured by advocacy" areas such as obituaries continues to allude them.

Suggestions for Change

Immediate, pragmatic suggestions for future change might include: contacting current obituary editors and making them aware of the bias on their pages; hiring obituary editors who desire a balanced page; suggesting that women write their own obituaries and direct the executors of their estates to submit them to obituary editors upon their death; writing letters to the editor demanding greater recognition of women on the obituary pages of their newspapers; suggesting that large corporations withhold advertising dollars until women are equally represented on all pages of the newspaper, including the obituary page. While these suggestions may effect some degree of local change, long-range efforts must be pursued as well.

These might include: continued pressure for equality in the workplace, including an equitable wage; an end to labor market segregation by sex; equal opportunity for women to advance into positions of authority that result in professional recognition; a demand for greater equality in the home so that women are not working a second shift in the unpaid sector; a greater valuation of women's

work in general; and a greater valuation of unpaid work that is not in the economic sphere.

See also: DEATH SYSTEM; MORTALITY, CHILDBIRTH

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ROBIN D. MOREMEN

GENNEP, ARNOLD VAN

Arnold van Gennep was born in 1873 and educated at the Sorbonne. He died in 1957 without ever having been accepted into Émile Durkheim's circle of sociologists, a neglect the anthropologist Rodney Needham speaks of as "an academic disgrace" in his preface to *The Semi-Scholars* (Gennep 1967, xi). Nevertheless, van Gennep's 1909 concept of "rites of passage" represents his prime contribution to thanatology, and subsequently became a major means of interpreting funerary ritual.

Rites of passage are transition rituals that move individuals from one social status to another in a

three-phased schema of separation, segregation, and incorporation. It is as though society conducts individuals from one status to another, as from one room in a house to another, always passing over thresholds. This spatial element is important since changed status often involves changing locality. The “magico-religious aspect of crossing frontiers” intrigued van Gennep. For him, religion meant abstract ideas or doctrine and magic meant ritual action, so magico-religious was his idiosyncratic description of practical religious action quite unlike Durkheim’s distinction between religion as collective and magic as privately selfish activity. According to van Gennep, in his book *The Rites of Passage*, the dynamic of rites of transition depends upon “the pivoting of sacredness” during the middle liminal phase, emphasizing why door and threshold (or *limen* in Latin), in both a literal and metaphorical sense, were important for him. Paradoxically he also thought that numerous landmarks were a form of phallus but devoid of “truly sexual significance.” The fear inherent in changing status and responsibilities was managed ritually even if they were not concurrent with biological changes in adolescence. These rites mark a journey through life reflecting physical changes and altering responsibilities. The anthropologist Ioan Lewis expressed this when he referred to rites of passage as “rites of way,” describing the phases in terms of thesis, antithesis, and synthesis (Lewis 1985, pp. 131–132).

Funerals both extend this journey to the other world in a series of transition rites and help structure the mourning process of survivors. Transition rather than separation is singled out as the predominating element of funerary rites, affecting both the living and the dead and involving potential danger for each as ritual changes in identity occur. Yet, almost as a law of life, these changes also involve a renewal of much-needed energy. One ignored element in van Gennep’s work concerns fear, for funerals may be “defensive procedures,” protecting against departed souls or the “contagion of death,” and helping to “dispose of eternal enemies” of the survivors. He was an early critic of the French anthropologist Robert Hertz’s overemphasis on positive aspects of funeral rites, and underemphasis on burial or cremation as effecting a dissociation of body and soul(s). Van Gennep’s energy model of society whose rituals periodically regenerated its power and gave sense to repeating pat-

terns of death and regeneration presaged both Durkheim’s basic argument on totemic ritual (made in 1912) and the British anthropologists Maurice Bloch and Jonathan Parry’s late-twentieth-century analysis of death and regeneration.

See also: DURKHEIM, ÉMILE; HERTZ, ROBERT; RITES OF PASSAGE

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DOUGLAS J. DAVIES

GENOCIDE

Raphael Lemkin, a Polish-Jewish legal scholar who escaped Nazi Germany to safe haven in the United States, coined the word *genocide* in 1944. The word originally referred to the killing of people on a racial basis. In *Axis Rule in Occupied Europe* (1944) Lemkin wrote, “New conceptions require new terms. By ‘genocide’ we mean the destruction of a nation or of an ethnic group. This new word, devised by the author to denote an old practice in its modern development, is made from the ancient Greek word *genos* (race, tribe) and the Latin *cide* (killing), thus corresponding in its formation to such words as tyrannicide, homicide, infanticide” (Lemkin 1944, p. 80). He also wrote about other elements that constitute the identity of a people that could be destroyed and hence the destruction of these, in addition to human lives, were aspects of genocide: political and social institutions, culture,

language, “national feelings,” religion, and the economic structure of groups or countries themselves.

Genocide is a criminological concept. Studying genocide involves an understanding of perpetrators/oppressors, their motives and methods, the fate of the victims and the role of bystanders. Lemkin went on to explain, “Genocide has two phases: one, destruction of the national pattern of the oppressed group; the other, the imposition of the national pattern of the oppressor” (1944, p. 80). So, while the general framework of genocide is to describe killing, the nuances of the definition, time considerations, and other aspects relating to politics and culture have made the term *genocide* highly charged with many possible applications based on interpretation. Lemkin’s categories of genocide were political, social, cultural, religious, moral, economic, biological, and physical. Lemkin was interested in describing contemporary crimes that might be prevented, rather than working as a historian and making judgments about whether past events qualified as genocide.

Genocide was both narrowed and expanded beyond its original racially based definition in the United Nations Convention on the Prevention and Punishment of the Crime of Genocide. This international agreement was approved and proposed for signature and accession by the United Nations General Assembly on December 9, 1948, and entered into force on January 12, 1951. Article 2, the heart of the Convention, outlines the qualifications for deeming an act a “genocide”:

- killing members of the group;
- causing serious bodily or mental harm to members of the group;
- deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
- imposing measures intended to prevent births within the group; and
- forcibly transferring children of the group to another group.

The most difficult and controversial part of the UN Convention is that the above acts are defined as genocide “committed with intent to destroy, in

whole or in part, a national, ethnical, racial or religious group” (Kuper 1981, p. 210). The controversies about the word genocide have come from the absence of the category “political,” which was eliminated because of the power politics of the General Assembly, especially the objections from the Soviet Union. The phrase “in whole or in part” is also problematic. Certainly, one can understand the meaning of “whole,” but an ongoing question being interpreted through international agreements and tribunals is the meaning of “in part.” There is the question of proving “intent,” which in the minds of some legal scholars demands a precise order of events as well as official pronouncements that indicate intentionality, while for others a general tendency of a state, party, or bureaucracy is sufficient.

The scholars Helen Fein and Ervin Staub have independently developed typologies for understanding victimization. According to Fein, there are five categories that help define victimization by stages of isolated experiences: *definition* of the group; *stripping* of rights, often by law; *segregation* from the bulk of the population; *isolation*, which has physical as well as psychological dimensions; and *concentration*, the purpose of which is extermination. Staub, who has written extensively about genocide, has created a structure of motivational sources of mistreatment that may end in genocide. This includes difficult life conditions of a group, the fear of attack on fundamental goals of the society that leads a group to become perpetrators, cultural and personal preconditions that create threats that result in responses to protect identity, and societal-political organizations that necessitate obedience to authority and submission to authoritarian tendencies. Staub places extreme importance on the role played by bystanders, who can create resistance to genocidal conditions, support genocide, or be neutral, which in itself becomes a form of support for the perpetrator.

Most genocides occur in an international war or civil war environment, as was the case with various people groups such as Jews, Roma/Sinti, Armenians, and Tutsis in Rwanda. The genocide of native peoples in North America and Australia, by contrast, occurred in the process of colonization of native lands. A related area to genocide, although less focused and involved with total killing, is the category of “crimes against humanity.” The phrase was first used in a 1915 when Allied declaration

that exposed what was later called the Armenian genocide at the hands of the Ottoman Turks. The more contemporary international meaning of “crimes against humanity” is derived from Control Council Law No. 10 (1945) (the basis for the prosecution of crimes committed by Nazis who were not tried for the major offenses in the International Military Tribunal at Nuremberg), dealing with Nazi crimes in the context of World War II: “Atrocities and offenses, including but not limited to murder, extermination, enslavement, deportation, imprisonment, torture, rape, or other inhumane acts committed against any civilian population, or persecutions on political, racial or religious grounds whether or not in violation of the domestic laws of the country where perpetrated” (Taylor, Control Council Law No. 10, Document).

In a retroactive sense, the United Nations Convention can apply to events that focus back on the destruction of Native American peoples in the western hemisphere; the mass killing of Herreros in Namibia in 1904–1905; the Armenian genocide from 1915 to 1922; the genocide in Cambodia at the hands of the Khmer Rouge from 1975 to 1979; Rwanda in 1994; and Bosnia in 1992.

Use of the “stable” categories of victim groups, who are victimized for things that cannot be changed, is critical to understanding genocide. “Crimes against humanity,” on the other hand, which can be equally devastating, can apply to both “stable” and “unstable” categories. Thus “race” is a stable and unchangeable category. “Political affiliation” or “religion” are “unstable” and can be changed. The crime of Jews during the Nazi era (from 1933 to 1945) was not that the Jewish people practiced an “illegal” religion, but rather that they had the misfortune of having “three or four Jewish Grandparents” (Nuremberg Law, 1935). The Nuremberg Law of 1935, therefore, allowed the perpetrators to define characteristics of the victim group.

Another term related to genocide and apparently first used to describe population transfers by the Yugoslav government during the early 1980s and more particularly in 1992 is *ethnic cleansing*. The term generally refers to removal of an ethnic group from its historic territory, purifying the land of “impure” elements perceived as a danger to the majority group. As the term was not in existence in 1948 when the United Nations Convention was

approved, it was not considered a form of genocide. Ethnic cleansing can be lethal and give an appearance of genocide, or it may involve involuntary transfer of populations. Forms of transfer, however, existed in the early twentieth century, such as the exchange of Greek and Turkish populations after the Greco-Turk War of 1920 and the transfer of millions of Germans out of Poland and other East European territories after World War II.

Three Examples of Twentieth-Century Genocides

The twentieth century was one of mass slaughter that occurred because of world wars, revolutions, purges, internal strife, and other forms of mass violence. Genocide, however, appeared as something new with greater ferocity, perhaps because of the availability of the technologies of industrialization to be used for mass murder and the willingness of regimes to use these methods. Above all, however, the willingness to embrace genocide as a formula for removing the “other,” a perceived enemy, represents the absolute opposite of the seeking of accommodation through diplomacy, negotiation, and compromise.

The Holocaust and Roma/Sinti Porrajmos. The Holocaust (*Sboah* in Hebrew) refers to the destruction of approximately 6 million Jews by Nazi Germany during World War II, from 1939 to 1945. The word existed before World War II and means “a burnt offering,” or something consumed by fire. The word *Holocaust* is considered by most authorities as specific to the Jewish destruction by Germany because of the cremation of the dead in ovens and because of the religious implications of the word for issues involving the presence and absence of God. *Porrajmos* (“The Devouring”) is the Roma word for the destruction of approximately half a million “gypsies” by the same German government. Jews and the Roma/Sinti were victims on a racial basis, a “stable” category invented by the perpetrators. Other groups were persecuted by the same regime but did not face inevitable destruction. Such groups included male homosexuals, Jehovah’s Witnesses, political opponents, priests, habitual criminals, and other national groups, such as Poles. Groups also persecuted and subjected to murder in many cases were those Germans who were handicapped or had genetic diseases. The Nazi T-4 killing program

began on September 1, 1939, and continued for several years, leading to the deaths of approximately 300,000 individuals in hospitals, wards, and gas chambers. The Holocaust produced the word *genocide*.

The mass destruction of both Jews and Roma/Sinti necessitated several steps. Gypsies were already regarded as social outcasts. Jews had to be removed from German society as an assimilated group. The first step was identifying and blaming the victim. Jews had received equal rights as citizens in the German empire and were full citizens when National Socialism came to power on January 30, 1933. The Roma and Sinti never received full rights and were the victims of varying restrictive laws and exceptional police surveillance. The rise of anti-Semitism associated with social Darwinism in the late nineteenth century helped define the Jew as the “non-Aryan,” which was part of a general campaign against the ideas of human equality being developed since the eighteenth century. Adolf Hitler’s *Mein Kampf* (1925–1927) focused on the Jew as the scapegoat for all of Germany’s and civilization’s ills.

The second stage of the Holocaust was identification of the victim group, which took place through use of bureaucratic, baptismal, church, and synagogue records. This permitted the removal of Jews from the German civil service in April 1933, and a gradual removal from German society over the next six years. Identification of the group permitted use of special internal documents marked with a “J” (“Jude”) by 1938 and the insertion of the middle names “Israel” for Jewish men and “Sara” for Jewish women. The immediate German plan for the Jews before 1939 was not extermination, but emigration. The solution for “the gypsy menace” was less dependent upon emigration, as the Roma/Sinti were equally despised in other countries, being identified as a “criminally inclined” group. Identification permitted the withdrawal of rights, “Aryanization” of property, and exclusion of Jews from the cultural and professional life of the country.

The issue of physical extermination started with the beginning of the German military offensive into Poland, which began on September 1, 1939, with the occupation of Poland and its 10 percent Jewish minority (approximately 3.5 million Jews). Military units (“Wehrmacht”) and SS

(“Shutzstaffeln”) began to carry out mass shootings of Jews, concentration in ghettos, and imposition of conditions of slave labor and starvation that accelerated the death rate. Mass killings in death camps began in 1941 using carbon monoxide gas and hydrogen cyanide. The first such killings marking “Endlösung,” or “The Final Solution,” began in the summer of 1941. The Wannsee Conference, held outside Berlin on January 20, 1942, was a bureaucratic meeting of the SS presided over by Reinhold Heydrich and designed to summarize and systematize the genocide. Mass extermination took place in six large death camps (*vernichtungslager*) in the borders of the partitioned Polish state: Auschwitz, Treblinka, Chelmno, Belzec, Sobibor, and Majdanek. Auschwitz became an identifier of genocide against the Jews because it claimed approximately 1.25 million victims.

The Holocaust and Porrajmos possess some unique aspects compared to other genocides. The genocidal killing was not conducted in one country but across Europe, from the North Sea to Mediterranean, from the French Atlantic coast to the occupied territories in the Soviet Union. Neither Jews nor Gypsies had their own state or historic territory within the boundaries of Europe. In both cases children were killed as a means to prevent reproduction of the group. The extermination of the Jews and Roma/Sinti ended only with the defeat of Nazi Germany.

In the aftermath of World War II, the International Military Tribunal at Nuremberg helped refine the legal concept of crimes against humanity and genocide. The trial of the surviving Nazi leaders, corporate leaders, doctors, General Staff and Wehrmacht officials, and *Einsatzgruppen* (mobile killing squads used on the Eastern front for genocidal actions) established the precedent for trials in the aftermath of genocides in Bosnia and Rwanda during the 1990s. The total military collapse of Germany allowed the full extent of the genocide to be known. In other genocides where there has not been a total military defeat of the perpetrator country, a consequence is denial of genocide.

The Jewish survivors of the Nazi genocide either sought immigration to democratic countries outside of Europe, such as Palestine (now Israel) or the United States, while a smaller number remained in Europe. The Roma/Sinti had no option

to emigrate, as no country was interested in taking them in. They returned to their countries of origin. The Israeli-Palestinian conflict may be regarded as a consequence of the anti-Semitism in Europe and the Holocaust, as the Zionist response to the Holocaust was to lobby and create a Jewish state.

The Armenian Genocide. The Armenians emerged as a people in the sixth century B.C.E. in Eastern Anatolia and lived there continuously until the twentieth century. They were the first national group to convert to Christianity in the year 301. The last Armenian kingdom collapsed in 1375. Thereafter, Armenia was part of the Ottoman Empire. Armenians were considered a loyal minority in the empire until the late nineteenth century. At the end of that century, Christian minorities living in the western part of the Ottoman Empire used the support of the Great Powers to achieve autonomy and later independence. The first attacks on Armenians occurred in 1881, in the aftermath of the Congress of Berlin that helped create Rumania, Bulgaria, Serbia, Macedonia, and Albania. In 1894 Kurdish attacks on Armenians occurred in the town of Sassun, leading to protests and reports by Christian missionaries and international interest. In 1895, as a response to a British, French, and Russian plan to create a single Armenian administrative district in the Ottoman Empire, Sultan Abdul Hamid II permitted more widespread attacks on Armenians in an effort to stifle Armenian nationalism and perceived separatist tendencies. Between 100,000 and 200,000 Armenians were killed in 1895 and many were forcibly converted to Islam.

The events that overtook the Armenians in 1895 are usually called “massacres.” However, in light of the subsequent massacres in Cilicia in 1909 and the beginning of the genocide in 1915, most historians have seen the entire period from 1895 through 1922 as possessing genocidal intent. The “stable” element of the genocide was Armenian nationality and language. Christianity represented both a stable and unstable element, as some Armenians were allowed to live if they accepted Islam. The genocide of 1915 started on April 24 and was connected with fears of Armenian separatism and disloyalty toward the Ottomans. Another theory relating to the genocide is that the Ittihadist Party, the ultranationalist faction of Young Turks—led by Enver Pasha, minister of war; Talaat Pasha, minister of internal affairs; Grand Vizir, military governor

of Istanbul; and Jemal Pasha, minister of marine—sought to create a great “Pan Turkish” empire with ties to the Turkish-Muslim peoples in the East. The Christian Armenians stood in the physical path of such a plan. The attack on the Armenians did not have the technological sophistication of the German genocide against the Jews, nor the extreme racial overtones. The Armenians were living on their historic homeland, as opposed to the Jews, who were a Diaspora people living in Europe.

The beginning of Armenian genocide witnessed the deportation and murder of the Armenian intelligentsia and leadership. Armenians in the army were murdered. Military units attacked communities in the Armenian heartland, men were killed, women raped and killed, and children sometimes kidnapped into Turkish families. Groups known as “Responsible Secretaries and Inspectors,” sometimes described as “delegates” (*murabhas*), organized and supervised the deportation and massacre of the Armenian convoys. The other was the “Special Organization” (*Teskilatı Mahsusa*), which comprised the bands in charge of the killings, the majority of whose members were criminals released from the prisons.

Those Armenians who survived the initial onslaught were subjected to forced marches into the Syrian Desert. A major destruction site was Deir Zor. The genocide witnessed the murder of 1.5 million Armenians, the destruction and obliteration of cultural institutions, art and manuscripts, churches, and cemeteries. The genocide also resulted in the creation through the survivors of the Armenian Diaspora, with large centers in Aleppo, Beirut, Jerusalem, Damascus, Baghdad, France, and the United States.

Unlike the Holocaust, the Armenian genocide was well covered in the American and European press. The United States was neutral in World War I until March 1917 and also had extensive missions, hence extensive reportage from eastern Turkey. First news of the genocide reached the Allies on May 24, 1915. Their response was a strong statement promising to hold the Turkish leaders accountable for the destruction of the Armenians. In May 1918, as a result of the destruction, Armenians in the Northeast section of Anatolia declared an Armenian Republic. At the 1919 Paris Peace Conference, the Allies agreed to sever Armenia and Arab lands from the Ottoman Empire. The United

States was offered a mandate over Armenia but it was rejected when the U.S. Senate refused to ratify the Paris Treaties. The independent Armenian Republic collapsed in May 1921 and became part of the Soviet Union.

In June 1919, the chief Turkish representative in Paris, Grand Vizir Damad Ferit, admitted misdeeds had occurred “that drew the revulsion of the entire humankind” (Dadrian 1995, p. 328). An American report by Major James G. Harbord concluded that 1.1 million Armenians had been deported.

Talaat Pasha, the main architect of the genocide, was assassinated on March 15, 1921, in Berlin by an Armenian student, Soghomon Tehlirian. Talaat had been condemned to death in absentia by the Turkish court martial on July 11, 1919. On July 24, 1923, the Treaty of Lausanne signed by Turkey and the Allies excluded all mention of Armenia or the Armenians. The new Turkish Republic was extended international recognition and the Ottoman Empire officially ended. In July 1926 the Swiss journalist Emile Hildebrand interviewed Turkish president Mustafa Kemal who blamed the Young Turks for the “massacre of millions of our Christian subjects” (1926, p. 1). Nevertheless, the Turkish government through the remainder of the twentieth century continued to deny that genocide had occurred. Armenians and academics have continued to press for recognition of the 1915 to 1922 events as “genocide.”

Rwanda. Rwanda was proclaimed a German colony in 1910. In 1923 the League of Nations awarded Rwanda to the Belgians. Before Rwanda achieved independence from Belgium, on July 1, 1962, the Tutsi, who made up 15 percent of the populace, had enjoyed a privileged status over 84 percent who were Hutu and 1 percent of a small minority called the Twa. The Belgians had favored the Tutsi because they came from the north, the “Great Lakes” region of Rwanda, and appeared lighter skinned and were taller, hence “more European.” Racial concepts based on eugenics were introduced by the Belgians, as well as an identity card system. After independence, the Hutu came to dominate the country and reversed the earlier discrimination imposed by the Belgians. The Tutsi were systematically discriminated against and periodically subjected to waves of killing and ethnic cleansing. Many Tutsi fled Rwanda into Uganda.

In 1963 an army of Tutsi exiles invaded Rwanda. The unsuccessful invasion led to a large-scale massacre of Tutsis. Rivalries among the Hutu led to a bloodless coup in 1973 in which Juvenal Habyaramana took power. In 1990 another Tutsi invasion took place, this time by the Tutsi-led Rwandan Patriotic Front (RPF). In 1993 the Hutu-dominated Rwandan government and the Tutsi rebels agreed to establish a multiparty democracy and to share power. After much resistance President Habyaramana agreed to peace talks in Tanzania. The Arusha Accords stipulated that the Rwandan government agreed to share power with Hutu opposition parties and the Tutsi minority. United Nations (UN) peacekeepers would be deployed to maintain peace in the country.

However, despite the presence of UN forces, a Hutu plot and arming of the Hutu civilian population took place during early 1994. In what is now referred to as the “Dallaire fax,” the Canadian lieutenant general and UN peacekeeper Romeo Dallaire relayed to New York the informant’s claim that Hutu extremists “had been ordered to register all the Tutsi in Kigali” (Des Forges 1999, p. 150). He suspected a plot of extermination of the Tutsi. Dallaire asked for more troops to stop any possible violence. Instead, his force was reduced from 3,000 to 500 men. This turned out to be the preplanning for genocide, which involved Hutus from all backgrounds, including the Catholic Church.

The genocide began on April 6, 1994, when an airplane carrying President Juvenal Habyarimana and President Cyprien Ntaryamira of Burundi was shot down, killing both men. From April 7 onward the Hutu-controlled army, the gendarmerie, and the militias worked together to wipe out Rwanda’s Tutsi. Radio transmissions were very important to the success of the genocide. Radio Mille Collines, the Hutu station, broadcast inflammatory propaganda urging the Hutus to “kill the cockroaches.” Killers often used primitive weapons, such as knives, axes, and machetes. Tutsi fled their homes in panic and were snared and butchered at checkpoints. The Hutus’ secret squads, the *interahamwe*, used guns and clubs. Women and younger men were especially targeted as they represented the future of the Tutsi minority. Women were raped in large numbers, and then killed. Hundreds of thousands of Tutsi fled to Tanzania and Congo to newly formed refugee camps.



In 1996 Rwandan Hutu refugees return home after having fled to Tanzania in 1994 fearing the retribution for a Hutu-planned genocide of the minority Tutsis. The Rwandan genocide stands as an event that could have been prevented had there been a will by the United Nations and other great powers to intervene. AP/WIDE WORLD PHOTOS

With international organizations helpless and both the European powers and the United States fearful of declaring events “genocidal,” the Tutsi RPF took the capital, Kigali, in early July 1994 and announced a new government comprised of RPF leaders and ministers previously selected for the transition government called for in the Arusha Accord. When the genocide finally ended, close to 1 million people had been killed. Further, 800,000 lives were taken in what is estimated to be a 100-day period, a faster rate of killing than during the Holocaust.

Early in December 1994 a panel of three African jurists presented a study of the murder of Tutsi to

the UN. It concluded, “Overwhelming evidence points to the fact that the extermination of Tutsi by the Hutu was planned months in advance. The massacres were carried out mainly by Hutus in a determined, planned, systematic and methodical manner, and were inspired by ethnic hatred.” Amnesty International concluded that “the pattern of genocide became especially clear in April, when frightened Tutsi were herded systematically into churches, stadiums and hospitals” (Amnesty 1998, p. 23).

Genocide trials began in Rwanda in December 1996. All experts have testified that a relatively small armed force could have stopped the massive killing. The Rwandan genocide lacked the larger

context of a world war, which was a factor in both Armenia and the Holocaust. The Holocaust represented more of a technologically based killing after initial shootings suggested negative side effects on the perpetrators. Nazi Germany also sought a solution through emigration before embarking on the “final solution.” The Armenian genocide seems similar to events in Rwanda, with hands-on killing and little lead time before the genocide actually began.

Genocide of the Plains Indians: North America

The issue of genocide in the New World is a contentious one for many reasons. First, there are vast variations from demographers regarding the population estimates of the New World in 1491, and North America in particular (the high being 18 million, the low 1.8 million). Second, there is no argument that perhaps 90 percent of the Native American population died between 1492 and 1525. However, while some populations were hunted down and subjected to cruel tortures, most seemed to have died because of immunological deficiencies that prevented resistance to European diseases. Third, while there was never a declaration of intent to kill all native peoples, removal policies by the United States and Canadian congresses, nineteenth-century federal bureaucratic agencies, and public statements created a popular perception that elimination of the Indian tribes was a necessary event for the success of European colonization. One of the consequences of the huge Native American population loss through disease was African slavery to replace necessary labor pools. Bacteriological warfare was used for the first time by Lord Jeffrey Amherst, who ordered smallpox-infected blankets be given to the Ottawas and Lenni Lenape tribes in Massachusetts, with catastrophic results (Churchill 2000). The aftermath of tribal reductions in the nineteenth century has been calamitous for remaining tribes and has been called genocide.

More to the heart of the definition of genocide are American and Canadian policies in the nineteenth and twentieth centuries. Native Americans qualify for categorization of a “stable” population under the guidelines for application of the United Nations Convention. Actually, the Native Indian tribes were identified as the barbaric “other” in the American Declaration of Independence. In the last

section of this historic document, Thomas Jefferson made the following accusation against the government of King George III: “He has excited domestic insurrections amongst us, and has endeavored to bring on the inhabitants of our frontiers, the merciless Indian Savages, whose known rule of warfare, is an undistinguished destruction of all ages, sexes and conditions.” It is no surprise, therefore, that the eighteenth and subsequent centuries witnessed a reduction of native populations through use of military forces, massacres, creation of reservation systems, removal of children from families through mission schools, and loss of native languages and significant aspects of culture. Jefferson’s description of the Indian tribes, largely propagandistic, might be likened to a charge that native peoples had declared war on the United States. However, it should be taken as the first step in a policy that ultimately saw ethnic cleansing of Indians and perhaps genocide.

The “Indian removal,” begun in 1830 by President Andrew Jackson’s policy, was implemented to clear land for white settlers. This period, known as the “Trail of Tears,” witnessed the removal of the “Five Civilized Tribes”: the Choctaw, Creek, Chickasaw, Cherokee, and Seminole. The Cherokee resisted removal, as they had established a written constitution modeled after the United States model. In 1838 the federal troops evicted the Cherokee under terms of the New Echota Treaty of 1835. Indian historians sometimes describe the result as a “death march.” Approximately 4,000 Cherokee died during the removal process. The Seminole were removed from Florida in ships and at the end of the process on railway boxcars, similar to deportations of Jews during the Holocaust. The Indian Removal Acts pushed more than 100,000 native peoples across the Mississippi River.

Forced assimilation for native peoples was first defined through Christianity as the answer to the paganism of the native peoples. A Christian worldview, linked with the sense of predominance of European (Spanish and Portuguese at first) civilization, necessitated an inferior view of the native “other” that could be modestly corrected through religion. Christian-based schooling provided a tool for the process of eradicating native languages. Boarding schools in particular, which lasted through the 1980s, were instrumental in this process. Captain Richard H. Pratt, founder of the

Carlisle Indian School in Pennsylvania, observed in 1892 that his school's philosophy was, "Kill the Indian to save the man" (Styron 1997). Boarding and mission schools forbade native children to speak their tribal languages and forced other assimilationist elements upon them: mandatory school uniforms, cutting of hair, and prohibitions on any native traditions. The result was that children who survived such treatment were aliens in two societies, their own as well as the world of the white man. Ward Churchill's writings have demonstrated the social impact, which was illiteracy, inability to work, high rates of alcoholism, chronic diseases, and low life expectancy. Accusations of forced sterilizations of Native American women have been advanced and many have been proven. Natives call this cultural genocide covered by the United Nations Convention.

An associated aspect of genocide of native peoples involves issues related to pollution of the natural environment. As native peoples lived in a tribal manner without large cities (except for the Aztec and Inca cultures that were extinguished earlier), their concern for nature was continual and they saw their own lives in a balance with nature. The earth was also seen as possessing a cosmic significance. The Native American ecological view of the earth sees it as threatened by industrialization and modernization generally, and explains environmental pollution in these terms as well as in the pursuit of personal profit.

Mass Murder in Ukraine: Crime against Humanity or Genocide?

There is no doubt that between 6 million and 7 million people died in Ukraine during the period of Joseph Stalin's plan to create a new and massive plan of social engineering by collectivizing agriculture (1928–1933). The results of collectivization may be called a crime against humanity, although the intentionality necessary to prove genocide is missing. Most of the killing and starvation involved a group defined by economic class rather than race. There was also a concerted attack on Ukrainian nationalism and culture that witnessed the killing of priests, and attacks on the Ukrainian Orthodox Church, intellectuals, and political opponents. During the nineteenth century there were various failed Tsarist plans to eradicate Ukrainian culture, all of which had failed.

Vladimir Ilyich Lenin's first application of Marxism in agriculture attempted a centralized policy of War Communism from 1918 to 1921. This policy, which focused on collectivization, failed miserably. Lenin followed with a compromise, the New Economic Policy (1921–1927), which, while successful, raised some fundamental questions about the future of Soviet agriculture. A debate erupted in 1924 within the Communist Party and became known as the "Industrialization Debates." Leon Trotsky argued for collectivization, while his opponent, Nikolai Bukharin, argued for maintaining private plots in the rural economy. Stalin, general secretary of the Communist Party, aligned himself and his supporters first behind Bukharin to defeat Trotsky, and then adopted Trotsky's position to defeat Bukharin. The result was the first five-year plan and the decision to collectivize agriculture. This decision assumed a vast transformation of the peasantry from a private to a collective society, and was undertaken based on the Marxist principle that human behavior could be changed.

Part of Stalin's logic for the agricultural sector was that, because the Union of Soviet Socialist Republics (USSR) was cut off from most foreign trade because of international blockade, a super-tax of sorts would have to be levied on the peasantry to help pay for industrial equipment that might be imported. Thus, private holdings were forced into collectives (*kolkhoz*) and the tax was imposed through forced deliveries of grain to the state. The kulak class of private peasants opposed the policy and fought back. Stalin's response for Ukraine, the most productive agricultural region of the USSR, was to seal it off, especially in 1931, and maintain grain exports even if it meant starvation of the peasantry. That the forced grain deliveries were coming extensively from the Ukraine was significant, as Ukrainian nationalism had a long history and an independent Ukraine had existed for a short time after the 1917 Revolution.

The forced grain deliveries of the first two years of the five-year plan produced a famine in 1932 and 1933 that claimed between 6 and 7 million lives. The famine happened in relative silence, as most reporters from foreign press agencies were kept out of the famine areas. The famine spread beyond the Ukraine into the North Caucasus and Volga River basin. Forced collectivization in Central Asia carried away as much as 10 percent of the

population in some areas. The famine affected not only crops, but also animals. The absence of fodder led to the massive death or slaughter of animals, and caused a massive reduction in farm animal population by 1933. Peasants who tried to flee or steal grain to survive were either shot or deported by the Soviet police, the NKVD.

The relationship between the question of genocide in Ukraine versus crimes against humanity is a complex one. Those who argue that it was a genocide see Stalin's actions as not only motivated by economics but as a pretext for the attack on Ukrainian nationalism, which paved the way for physical elimination by the police and military authorities of the Ukrainian elites. Leo Kuper, one of the founders of modern genocide thought that Stalin's actions against national and religious groups qualified as genocide under the UN definition. Other scholars have seen the events of the famine and collateral deaths through police action related to economics, class issues, and political forms of killing, which are excluded by the Genocide Convention. Using the information available since the collapse of the USSR in 1991, it appears that the intent of the Soviet government was to alter the economic basis of both agriculture and industry. The potential for resistance was greater in agriculture than industry because of its traditions of private holdings. Stalin's response to resistance was ruthless, and direct mass murder or permitting murder through famine was his response. While the debate about the Ukrainian famine may continue, there is no debate that it was a crime against humanity.

Genocide involves death and dying, not of individuals but of entire groups. The issue is never a comparison of numbers, but rather the intent of perpetrators and consequences for the victim group. The United Nations Convention aspires to both prevent and punish genocide. Thus far, it has been unsuccessful in preventing genocide. Trials begun in the period after 1992 in the Hague and Arusha related to events in Bosnia and Rwanda bear witness to the success or failure of war crime tribunals. Genocide remains a threat wherever national and ethnic tensions run high, when preconditions such as Helen Fein and Ervin Staub have suggested appear and trigger the use of violence. Genocide can be prevented by the willingness of outsiders, particularly powerful nations, to

act through intervention. However, such intervention seems easier to speak about in theory than in practice. The psychologist Israel Charny has called genocide "The Human Cancer." This disease of genocide, so prominent in the twentieth century, has the potential to reappear in the twenty-first century because of new technologies and smaller but more powerful weapons, often in the hands of both nation-states and substate groups.

See also: CAPITAL PUNISHMENT; FAMINE; GHOST DANCE; HOLOCAUST; MASS KILLERS; TERRORISM

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STEPHEN C. FEINSTEIN

GHOST DANCE

The Ghost Dance was the central rite of a messianic Native American religious movement in the late nineteenth century. It indirectly led to the massacre of some 250 Sioux Indians at Wounded Knee, South Dakota, in 1890, marking an end to the Indian wars. As a trance-enticing rite of a hybrid faith, it combined elements of Christianity with Native American religious traditions.

The Ghost Dance first emerged around 1870 in the Walker Lake area on the California-Nevada border. A Paiute mystic named Wodziwob, or "Fish Lake Joe," began to preach an apocalyptic vision in which a great flood or fire would eliminate the white man from the world and deceased tribal people would return alive to the earth. Wodziwob's assistant, a shaman named Tavibo, spread the new doctrine among Nevada tribes.

The original Ghost Dance fervor among far western American tribes gradually ebbed only to be rekindled in 1888 by Wovoka, Tavibo's son. The new prophet, also known as Jack Wilson, was said to practice miracles such as curing the sick, controlling the weather, and withstanding bullets shot at him. Wovoka claimed that while feverishly ill he saw in a vision all deceased Indians surrounding the throne of "the Great Spirit" God who told him to teach his people to love one another and to live peacefully with white people. Further, all deceased Indians would return to the earth and recover their ancestral lands. According to the vision, white men and women would retreat to their European homelands. The prophet taught his followers a five-day ritual of song and circle dances that would hasten the coming of this new millennium; hence, the Ghost Dance was born.

Wovoka's Paiute tribesmen became missionaries of this new messianic faith. It attracted many impoverished and unhappy western tribes who had been



This wood engraving from 1891 depicts a group of Sioux dancers performing, most likely, one of their last ghost dances before the arrest of the warrior chief Sitting Bull. CORBIS

herded by the United States military onto reservations, including the Arapaho, Bannock, Caddo, Cheyenne, Comanche, Kiowa, Sioux, Shoshones, and Utes. Each tribe adopted its own Ghost Dance songs and wore clothing painted with sacred symbols believed designed to ward off bullets.

The Ghost Dance movement came to a tragic end on Sioux reservations in South Dakota during the winter of 1890–1891. Sitting Bull, the famous Hunkpapa Sioux warrior chief, had become an enthusiastic follower of the new faith, along with his people on the Standing Rock Reservation in South Dakota. Their new religious fervor alarmed white United States government agents on the reservation who decided to arrest the chief as a means of restoring peace to the reservation. On December 15 Sitting Bull was shot and killed during a skirmish when Native American agency police tried to arrest him.

Some of Sitting Bull's followers escaped to the Cheyenne River Reservation to join Miniconjou Sioux who were also practicing the Ghost Dance under the leadership of Chief Big Foot. But on December 29, when American cavalry caught up

with Big Foot's group encamped along Wounded Knee Creek and tried to disarm them, rifle shots on both sides broke out. The American military, armed with four Hotchkiss machine guns, massacred the Sioux warriors and their unarmed women and children. The massacre marked the ending of the Indian wars in the American West.

See also: GENOCIDE; DANCE; NATIVE AMERICAN RELIGION

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KENNETH D. NORDIN

GHOSTS

Ghost lore has a long and colorful history. The word *ghost* has been in use since the late sixteenth century. It derives from a more ancient term, *gast*, in the language that evolved into modern German. For some time, *ghost* has usually signified the disembodied spirit of a deceased person. Earlier meanings still cling to this word, however. *Gast* originally referred to a terrifying rage. A person who experiences shock and terror can still be described as aghast (i.e., frightened by an angry ghost). Fear of angry ghosts is built into the word itself.

Etymology explains even more about the characteristics attributed to ghosts through the centuries. Ghost is created in part by way of spirit, and spirit by way of breath. The book of Genesis and many other world mythologies tell a similar story: God breathed into an inert form, and the creature then stirred with life. There has also been a widespread belief that each newborn becomes one of us in drawing its first breath. Each dying person leaves the world by exhaling the last breath, sometimes depicted as a soul bird. The breath is seen as life. Expelling the final breath is “giving up the ghost.” The spirit is on its way, the body stays behind. So in traditional accounts, spirit was breath, but more than breath: It became a subtle, immaterial essence that departs from a person at death. This idea is at the core of theological dualism, the belief that a person is composed of a material, perishable body and an immaterial, imperishable essence. Greek and Christian thought held that imagination, judgment, appreciation of beauty, and moral sense are functions of the spirit within humans. The spirit is an individual’s higher self, something of which survives bodily death in many religious accounts. In Western societies, people tend to speak of this surviving element as the soul.

Ghosts, however, do not necessarily emanate from the refined spirit of divinity within. It is fairly common among world cultures to believe in another spirit that accompanies them throughout life. This is a shadowy sort of spirit that could be thought of as a duplicate image of the physical body. The German term *doppelgänger* clearly conveys the idea of a second spirit that moves mysteriously through one’s life, sometimes serving as the ruthless Mr. Hyde to the everyday cultivated Dr. Jekyll. This shadow spirit is apt to leave the

body from time to time and linger around a person’s place of death and burial. A ghost, then, might either be a blessed spirit on a mission of mercy, or the tortured and malevolent image of a body that suffered an anguished death.

Varieties of Ghosts

Two sharply contrasting beliefs about ghosts have long coexisted, sometimes in the same society. The good ghost appears to be related to the higher spirit of a deceased person; the dangerous ghost, though, might be the shadowy doppelgänger or a higher soul that has turned evil. The two opposing ghostly prototypes are the angry ghost, dangerous because it is angry about being dead, having been killed in an unacceptable way, having been treated badly by family and community, or just plain inveterate nastiness; or the emotionally neutral ghost, the spiritual essence of the deceased that lingers or returns in order to warn, comfort, inspire, and protect the living, making its rounds amiably and harmlessly.

It is not unusual to have a mixed concept of ghosts because the influence of both traditions persists in the twenty-first century in popular media. Ghosts themselves can have mixed feelings. There are lost souls who cannot find rest, and others, like Wagner’s *Flying Dutchman*, who are condemned to a weary and aimless exile that can end only with the discovery of pure love. Such sad ghosts are capable of either good or evil, depending on how they are treated.

Funeral rites and prayers often have had the double function of providing safe conduct for the soul of the deceased while also preventing it from lingering or returning as a dangerous ghost. Candles or torches, for example, help guide the departing soul and at the same time discourage wandering evil spirits from entering the corpse or its attendants. Elaborate precautions are taken when the person has died by violence. An executed murderer, for example, might have all his body orifices sealed and his limbs amputated so the vengeful ghost cannot return to continue its evil career.

Ghost prevention remains a major concern in many world cultures. A Hindu ceremony conducted in Katmandu, Nepal, in June 2001 was intended to banish the ghost of the recently slain monarch. The ashes of the late King Birendra were

mixed into the luncheon food, and a Brahmin priest, dressed to impersonate the king, rode astride an elephant as crowds of people chased him and the monarch's ghost away.

Encounters with Ghosts

According to lore, there is more than one way in which a ghost can present itself. The visual visitation is most common. Visible ghosts are often elusive, appearing only in glimpses, but some linger. Specialists in folklore and paranormal phenomena tend to speak instead of apparitions (from Latin for "appearances" or "presentations"). Apparitions include ghosts of deceased persons but can also represent living people who are physically absent, animals, objects, and unusual beings that resist classification. Phantoms can also include visions of either a deceased or an absent living person. *Specter* and *shade*, terms seldomly used in the twenty-first century, refer to ghosts or spirits.

Some ghosts are heard rather than seen. *Poltergeists* (noisy ghosts) are notorious for dragging their chains, dropping dishes from a shelf, or even hurling objects across a room. Unseen spirits that communicated by rapping on walls or tables became especially popular during the heyday of Spiritualism. In reports of haunted houses, poltergeists are usually the chief perpetrators.

A more subtle type of ghost is neither seen nor heard. One "feels" its presence. This sense of presence is perhaps the most common type of ghost-related experience reported. Most common among the recently bereaved, these visitations often take the form of a sense of the deceased's uncanny presence. Interestingly, the pattern found in the late nineteenth century is much the same as in current reports: the more recent the death, the more frequent the incidents in which a ghostly presence was felt.

The "felt" ghost was encountered in a wider variety of situations at the end of Christianity's first millennium. Mystical experiences of an invisible presence were frequently reported and made their way into the historical record. A new liturgy for the dead had been introduced in which symbolism became inseparable from physical reality. Praying for the dead became a prime responsibility for Christians, and these intensified symbolic interactions with the dead seemed to attract ghosts.

Dream ghosts have been reported in many times and places. These nocturnal visitations often have been taken as revealing past, present, or future realities. Even in contemporary reports, a dream visitation from a deceased person is sometimes accepted as a "real ghost."

The famous confrontation between Hamlet the king and Hamlet the prince demonstrates the witness's quandary. Was the prince only dreaming that the ghost of his father had appeared to him? And how could he be sure that this was a reliable ghost and not a demon or deceitful spirit who had impersonated the king in order to urge Hamlet to murder—and therefore to damn the young prince's own soul? Whether ghosts have appeared in dreams, visions, or daily life, they have often suffered from a credibility problem. Are they a misperception, a trick of the mind, a hallucination, or the real thing?

Ghosts are most commonly reported as solo acts, but sometimes they bring a supporting cast. The medieval mind occasionally encountered hordes of ghosts arising from their graves. Witnesses have sworn that they have beheld the apparitions of numerous slain soldiers arising from a battlefield such as Gettysburg. By contrast, some people have met an entire family of ghosts ensconced comfortably in an ordinary home. Several women who reported having seen or heard domestic ghosts had this explanation to offer:

As they see it, the events and emotions of former residents' lives remain locked in the form of "energy" or "waves" or an "aura" in the house where they lived. If it is pleasant, the present resident can absorb and benefit from the atmosphere; the memories in the house will make those who live in it happy, healthy, and wise. If the spirit is malignant, however, and the memories violent, the energy may transform itself into a force which can throw or displace objects or echo the events of real life by sighing, walking about, switching lights on and off, closing doors, flushing toilets, and so on. (*Bennett 1999, pp. 47–48*)

These domestic ghosts have become, literally, "the spirit of the house," as Bennett adds.

The conjured ghost is a commercial product, brought forth in return for a fee. Some nineteenth-

and early twentieth-century mediums attracted participants to their séances by guest appearances from visual ghosts. After interest started to decline in spirit visitors, one could only hear ghosts. If the participants were sufficiently receptive and the ghost was in the right mood, they would be rewarded with the sight of a white ectoplasmic figure hovering, floating, or simply walking. (Ectoplasm is what ghosts wear or become when they allow themselves to be materialized; investigators discovered that the ectoplasm bore a remarkable similarity to the bladder of a goat.)

The Bible is almost devoid of ghosts. The strongest candidate for a ghost is the apparition that was conjured from the grave of Samuel by the necromancing Witch of Endor. Whether or not this figure was truly the ghost of Samuel remains a subject of controversy. Early Christian belief was not receptive to ghosts, in contrast to many of the popular cults of the time. Hamlet's chronic uncertainty was inculcated by a long tradition that cautioned against taking apparent ghostly visitors at face value.

Ghostly Functions

What is the ghost's vocation? "To haunt" is the answer that first comes to mind. Many reports tell of a ghost that appears in a particular location, sometimes repeatedly for generations. In some instances the witnesses identify the apparition as a person who once lived in that home or vicinity; in other instances the ghost is unknown to the witnesses, but the same assumption is made. Ghosts have also been encountered in the wilderness—along the Cumberland Trail, for example. Members of numerous folk cultures would not be surprised that ghosts have been observed both around the household and in the wilds. Some firmly believe that the spirit does linger for a while before undertaking its postmortem journey, and some may be unwilling or unable to leave until unfinished business has been completed. The roving ghost that might be encountered could be lost and disoriented because the person died far from home and has not been sanctified by purification and other mortuary rituals. The "skinwalkers" reported in Native American lore are among these restless souls.

Usually, then, ghosts have unfinished business to complete or an inability to move on. Being a ghost is usually a transitional status. When somebody or something succeeds in "laying the ghost,"



Visual ghosts, similar to this image (c. 1910), are the most common type of apparition; however, some ghosts tend to be "heard" clanking chains and making other noises rather than being seen. CORBIS

then this unfortunate spirit can finally desist from its hauntings and wanderings, and advance toward its fate.

There is another kind of ghost, however, whose origin is an unfortunate rebirth. Hungry ghosts (*e-kuei*) are Chinese Buddhist ancestors who are in constant torment because they are starving and thirsty but cannot receive nourishment. Whatever they try to eat or drink bursts into fire and then turns into ashes. There is hope for them, however. The Festival of Ghosts includes a ritual designed specifically to provide them with sanctified water that, accompanied by chant and magic, can release them from their terrible plight.

Fear of ghostly possession has haunted many societies. In these instances the disembodied spirit not only appears but also moves right in and takes over. Fortunately, the ghost often can be persuaded to leave once its demands are met. The ghosts of North India, for example, often require that they be given sweets. In the first phase of ghost possession, according to Freed and Freed,

“A victim shivers, moans, and then falls down unconscious” (1993, p. 305). Next, the victim engages in various dissociative actions such as talking nonsense, running around wildly, and even attempting suicide.

These functions of North Indian ghosts vary with the stages of the life cycle: different ones appear in childhood, adulthood, middle age, and old age. Because ghost possession is one of the expected hazards of life, North India villagers have developed first-aid techniques to reduce the disturbance until an exorcist arrives. The victims are wrapped in quilts, propped in a sitting position, guarded against suicide attempts, and administered a series of shock treatments (e.g., hair pulling, slapping, and placing peppers in their eyes and mouths). The intrusive ghost is also engaged in conversation while other villagers fling cow dung and incense on a fire so their fumes might help to dislodge the unwelcome spirit. Exorcism is the most dependable cure, however, if the ghost is to be banished without carrying off the victim’s soul.

One of the most learned scholars ever to devote himself to ghosts, phantoms, and survival has a different perspective to offer. Frederick W. H. Myers studied thousands of ghost-sighting reports. His conclusion: most ghosts do not do much of anything. This statement contrasts strongly with the usual belief that ghosts have intentions and missions. The typical sighting was of an apparently aimless, drifting entity that seemed to have nothing in particular on its mind. So the average ghost is not engaging in meaningful or purposeful behavior, according to Myers’s studies.

Explaining Ghosts

Myers offers two noncontradictory explanations for the do-nothing apparitions that were most commonly reported. First, he emphasizes their difference from the lurid ghouls described in many ghost stories. The more reliable human testimony seems to pertain to more pedestrian hauntings. Myers next tries to fathom the nature of these oddly lackadaisical apparitions. These are not ghosts at all, in the traditional sense of the term; rather, they are “a manifestation of persistent personal energy after death” (1975, p. 32). It is not an independent, free-roaming spirit, nor is it a hallucination or other trick of the mind. What we have

seen is a kind of after-image of the deceased person. We might compare these strange flashes with the light that comes to across from distant stars that have long since ceased to exist.

Myers’s views were later seconded by Hornell Hart, who had another half century of material to analyze. Hart observed that most apparitions were “tongue-tied” and exhibited no sense of purpose. This line of explanation has the merit of sticking close to witness reports. It does not satisfy either side in the controversy about the reality of ghosts that gathered steam when science and technology started to challenge folk belief and religious dogma. Staunch critics are reluctant to admit the possibility that even a sparkle of energy might persist after death. This highly attenuated form of survival does not include the personality of the deceased, and so it fails to support the faith and hopes of some traditionalists.

The crisis apparition offers a partial explanation that lies somewhere between the Myers/Hart thesis and the more traditional view. The image of an absent person suddenly appears to a friend or family member. This is not a vague, wispy apparition; it seems to be the very person. In some reports the phantom appears at the time of the person’s death, sometimes thousands of miles away. These reports could be taken as support for a personal form of survival, but this notion would not extend to all the legions of ghosts that have been perceived or imagined. Furthermore, a brief, one-time apparition offers no evidence of prolonged survival.

Ghosts have often been explained as hallucinations. Green and McCreery, for example, make an interesting case for the possibility that ghost sightings include hallucinations of the entire scene, not just the spirit figure. Defenders have tried to offer evidence that ghosts are not to be dismissed as hallucinations. So-called spirit photography was a popular effort in this direction. Thousands of photographs were produced in which deceased humans and animals appeared among the living. Several photographs even revealed a ghostly figure moving through a séance in all her ectoplasmic glory. Notwithstanding the adage that “seeing is believing,” the credibility of spirit photography succumbed rapidly to critical investigations into the wiles of trick photography.

The purported acquisition of unusual but accurate information from ghosts has also been offered as proof of their authenticity. Many of these examples pertain to prophecies of warning. For example, a ghost tells warns a family not to go on their planned trip or confides where they can find the old strongbox filled with money and valuable gems. If events prove the information to have been trustworthy, one might then feel entitled to reward the ghost with a vote of authenticity.

These and other possible contacts with ghosts invite skepticism and outright derision in the mainstream of a culture with an essentially rationalist, materialist worldview. But few contest the vividness and tenacity of ghostly visitations in the human imagination.

See also: AFRICAN RELIGIONS; COMMUNICATION WITH THE DEAD; GHOST DANCE; IMMORTALITY; SHAKESPEARE, WILLIAM; SOUL BIRDS

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ROBERT KASTENBAUM

GILGAMESH

Few poems are nobler in expression and content than the *Epic of Gilgamesh*. Its Sumerian hero was famous throughout the Near East from about 2000 B.C.E. to the seventh century B.C.E. when the epic was "written down and collated in the palace of Ashurbanipal, King of the World, King of Assyria." Gilgamesh was reckoned by Ashurbanipal as an ancestor—good reason for wanting his adventures preserved.

But this is a tale worth any king's attention, as relevant today as to the Sumerians of ancient Iraq. It tells of a man who finds a friend, loses him to death, and embarks on a quest for immortality. It speaks of earthy things given mythic status: felling trees, guarding sheep, baking bread, washing clothes, making wine, punting boats, diving in the sea. These amount to a celebration of life that gives poignancy to the poem's stark message: Death is the end of existence.

The Story

There was no greater city than Uruk, but Gilgamesh, its king, being two-thirds god, was driven by the relentless energy of divinity. Resting neither day or night, he took young men to labor on grandiose buildings, and carried brides off from their weddings. ("He is the first. The husband comes after.") Hearing the people's complaints, the

gods told Aruru, goddess of creation, to make a match for him, to divert his energies. She fashioned a wild man, huge, hairy and strong, who roamed the plains with the gazelle. His name was Enkidu.

When word of Enkidu reached Uruk, a temple prostitute was sent to seduce him, so that his animal companions would shun him. After this, she “made him a man,” teaching him human speech, and how to eat human food, drink alcohol, dress his hair, and wear clothes. Because of his strength, Enkidu was asked to stop Gilgamesh from abducting a bride and barred his way. They wrestled until Enkidu was thrown, but Gilgamesh acknowledged he had won because he was semi-divine: “In truth, you are my equal.” Here began their friendship.

Their first exploit was to go to the Cedar Forest to kill its giant guardian, Humbaba. Their second was to kill the Bull of Heaven (drought personified) sent because Gilgamesh rejected advances by Ishtar, goddess of love. The gods decreed that for the two slayings one of the friends must die. The lot fell on Enkidu.

The Gate of the Cedar Forest had seemed so beautiful to Enkidu that he could not hack it down, and instead pushed it open with his hand. But there was an enchantment on it, which blasted the hand, so that a fever spread from it and he dreamed of dying. He cursed the prostitute and the Forest Gate, and on the twelfth day fell silent. For seven days and nights Gilgamesh would not give him up for burial, and only when a maggot fell from his nose accepted his death.

Knowing that, like Enkidu, he would die. Gilgamesh set out to find Utnapishtim, the one man saved by the gods from The Flood. Making him immortal, they had placed him with his wife in Dilmun, the Garden of the Gods. Gilgamesh would ask Utnapishtim how to become immortal himself.

His quest led him through a gate guarded by Scorpion People with flaming aureoles into Mashu, the mountain into which the sun passes at night. He journeyed in darkness before coming out in the Garden of the Sun, where Shamash walked at evening. The sun god said his quest would fail: All mortals must die. Next he encountered Siduri, Woman of the Vine, beside her house making wine for the gods. She urged him to live from day to day, taking pleasure in food, wine, and the love of

wife and children, “for love was granted men as well as death.”

Seeing him undeterred, Siduri directed him to the Images of Stone, near which he would find Urshanabi, Utnapishtim’s boatman. To reach Dilmun, one must cross the deep, bitter Waters of Death, and the Images kept the ferryman safe on the crossing. In a fit of temper, Gilgamesh broke the Images of Stone and, when he found the boatman, Urshanabi said that it was now too dangerous to cross. However, he had Gilgamesh cut long poles from the woods, and they launched the boat on the sea. When they reached the Waters of Death that lay between it and Dilmun, Gilgamesh punted the boat along, dropping each pole before his hand touched the fatal Waters.

Reaching Dilmun, Gilgamesh told Utnapishtim why he had come there. Utnapishtim said first he must pass a test: not sleeping for six days and seven nights. But Gilgamesh was exhausted by his journey and he who had once needed no rest now fell into a profound slumber. Every day, Utnapishtim’s wife stood a fresh loaf of bread beside him. When Utnapishtim woke him, he saw six of them and despaired.

Utnapishtim now dismissed him, together with Urshanabi, who, having ferried a living man over the Waters, had broken the rule of the gods. Utnapishtim’s wife persuaded him to give Gilgamesh something in return for his suffering. So Utnapishtim told him of a place in the sea where grew the Flower of Youth, which would make the old young again.

Reaching the spot, Gilgamesh tied stones on his feet and jumped into the water. Down to the bottom he sank and, despite its thorns, plucked the flower. Cutting off the stones, he surfaced in triumph, telling Urshanabi he would give it to the old of Uruk to eat, and eventually eat it himself. But on their homeward voyage, they went ashore to rest and Gilgamesh bathed in a nearby pool, leaving the Flower of Youth on the bank. Deep in the pool lay a serpent that snuffed the fragrance of the flower, rose up, devoured it, and grew young again (sloughing its skin as snakes have ever since).

Then Gilgamesh wept. He had failed to win everlasting life, and with the Flower of Youth in his grasp lost even that. But presently he said they should continue to Uruk and he would show

Urshanabi his fine city. There at least his labors had not been fruitless.

The Background

The story of Gilgamesh comes from Sumer on the Persian Gulf. The Sumerians entered southern Iraq around 4000 B.C.E. and established city-states, each with its king. One of these was Gilgamesh, who appears in a king-list as the fifth king in Uruk (biblical Erech). Another Sumerian text tells of a conflict between Gilgamesh and Agga, king of Kish (c. 2700 B.C.E.). Some identify Gilgamesh as the “mighty hunter,” Nimrod son of Cush, mentioned in the Book of Genesis. Thus the epic may be based on traditions of real events.

But it has a mythic dimension. Gilgamesh was the son of Ninsun, a minor goddess residing in Egalmah, the “Great Palace” of Uruk, by “the high priest of Kullab” in the same city. Gilgamesh was regarded as superhuman. In the *Epic* he is said to be 11 cubits (approximately 18 feet) tall, and his punt poles were each 60 cubits long. The king-list says that he reigned for 126 years.

In about the fourteenth century B.C.E., Akkadians living north of Sumer established Babylon as their capital and took control of the whole area between Baghdad and the Gulf. The Babylonians preserved the Sumerian language as their language of religion, and with it Sumerian legends and myths.

The Hebrews may have learned Sumerian tales during their Babylonian exile. There are echoes of the *Epic of Gilgamesh* in the Bible: The flaming guardians of the Otherworld gate and the loss of immortality to a serpent are mythic themes that recur in the Expulsion from Eden in the Book of Genesis. Noah’s Ark also corresponds in some details to the *Epic’s* account of The Flood.

The Babylonians were succeeded in the region by the Assyrians. Originally the exploits of Gilgamesh were recounted in separate poems, such as “Gilgamesh and the Land of the Living,” a surviving Sumerian account of his quest. If Sumerians or Babylonians ever strung these poems together into an epic, it has been lost. The *Epic of Gilgamesh* exists only in the Assyrian version, written on twelve clay tablets in Ashurbanipal’s library at Nineveh and recovered at different times. From these the epic has been pieced together, breaks in the text

being supplemented from separate poems. Some mysteries remain. What were the Images of Stone?

The Meaning

Despite its enigmas, the *Epic* is one of the literary masterpieces of the world, at one level a swash-buckling adventure story; at another a “buddy” tale prefiguring the great friendships of David and Jonathan and Roland and Oliver; at another, a demonstration that the gods have an agenda independent of human interests (Enkidu is a toy for Gilgamesh, and expendable). At yet another level it is a contemplation of what it means to be human, in the figure of the wild man “tamed,” civilized by the prostitute to his undoing, for he responds to the Forest Gate as man not brute (which is why he curses both it and her).

At its most profound, the poem is a meditation on living in the knowledge of death. Enkidu tells Gilgamesh a fever-dream he has of dying. He is standing before a dark being whose talons are choking out his life. Then it turns his arms into wings and leads him to the house of the underworld queen, Ereshkigal. Everyone here has feathered wings and sits in eternal darkness, “dust their food and clay their sustenance.” This was the common lot in the ancient Near East. It is because “darkness is the end of mortal life” that Gilgamesh is desperate to learn Utnapishtim’s secret.

After failure comes resignation. He proudly shows Urshanabi his city—this much he has achieved. But his words before the Cedar Forest adventure return to haunt readers: “Only the gods live forever . . . As for mankind, numbered are their days; Whatever they achieve is but the wind!” One of the ironies of time is that Gilgamesh’s great city was long ago ruined; and it is the story of his heroic failure, written on brittle tablets of clay, that survives.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE;
GODS AND GODDESSES OF LIFE AND DEATH;
IMMORTALITY

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JENNIFER WESTWOOD

GODS AND GODDESSES OF LIFE AND DEATH

The One God of the Near Eastern monotheisms—Judaism, Christianity, Islam—is both the creator and stern but loving father of humankind. He cares for his creation from birth to death and beyond. This is somewhat exceptional among world mythologies. Many creator gods are unbelievably remote in time and space: Maheo in the myths of the Cheyenne of the U.S. Great Plains existed before existence, and numerous creators are sky gods, such as Olorun, or “Sky,” in the myths of the Edo and Yoruba peoples of Nigeria.

Although most peoples of the world preferred to believe that creation had a purpose, sometimes it was incidental or even accidental. Qamaits, warrior goddess of the Bella Coola people of the Northwest coast of Canada, killed off the primeval giants who ruled the earth, making room for other life forms merely as a by-product. Coniraya, one of the oldest of Inca gods, could not help but create: His mere touch made everything burst into life.

Such creators often take scant interest in their creation. Qamaits seldom concerned herself with the earth once she had killed the giants and perhaps humans as well; her rare visits caused earthquakes, forest fires, and epidemics. Other creator gods withdraw once the act of creation is over, leaving subordinates in charge. In Ugandan myth, the creator, Katonda, left his deputies Kibuka (war)

and Walumbe (death), along with others, to rule his new universe.

The War Gods

War and death are an obvious pairing. Almost no one embraces death willingly, unless seduced by the evil songs of Kipu-Tyttö, Finnish goddess of illness, into joining her in the underworld of Tuonela. To express most people’s sense of death as a battle lost, death is pictured in many myths as a warrior: Rudrani, the Hindu “red princess,” who brings plague and death, and gorges on blood shed in battle; and Llamo, Tibetan goddess of disease, riding across the world, clad in her victims’ skins, firing her poison arrows. Because warriors give protection too, the ancient Greeks were ushered out of life by a gentler psychopomp (soul guide) than in most mythologies, the warrior god Thanatos, brother of Sleep, who escorted the dead to the gates of the underworld.

If war and death seem obvious allies, war and life seem contradictions. Yet it is precisely on the patrons of war, and other gods and goddesses envisaged as warriors, that the business of human life often rests. In most mythologies, the divine energy of the gods is seen as the great motive force of the universe. This energy may be analogous to that of a storm or some other powerful natural force, as in Egypt where the desert wind was personified as the lion-headed goddess Sekhmet, who when angry became the Eye of Ra, a terrible war goddess who swept over the land, scorching the earth in her wake.

Just as human warriors are stronger and more active than most other people, war gods and goddesses generally embody pure energy: the Hindu goddess Durga is the anger of Shiva’s consort Parvati, just as Kartikeya (Skanda), Hindu god of armies, is the fierceness of Shiva himself. The divine vigor of these deities is barely contained: Sumerian Ninurta existed as power without form until his mother Ninhursaga confined it in the shape of an eagle-winged warrior. The same idea underlies the curious births of many war gods: Iranian Mithra, born from a rock; Greek Athene, springing from Zeus’s head; Kali, the Hindu death goddess, bursting from the forehead of Durga; and Kartikeya, born from the sparks that fell from Shiva’s eyes. They are eruptions into the universe of divine vitality.

Unsurprisingly, therefore, a number of war gods are themselves creators, like the Mesopotamian Marduk, Mithra in ancient Iran, Min in Egypt, Vahagn in Armenian myth, Unkulunkulu of the Amazulu people of South Africa, and (inadvertently) Qamaitis. Many more are deeply involved with the creative and intellectual growth of humankind, their myths saying something universal about the way civilizations develop. Except for the Greek Ares, portrayed as brawn without brain, the war gods are often great benefactors. Tools and weapons are the gifts of Gu, the blacksmith god of the Fon peoples of Dahomey, and of Ogun, venerated by the Yoruba as the power of iron. Craftskills are bestowed by Greek Athene and Sumerian Ninurta, healing and medical skills by lion-headed Sekhmet and by Unkulunkulu, the Amazulu creator. Magical knowledge is the legacy of Norse Odin, prophecy of Baltic Svandovit. Justice and fair dealing are the province of Norse Tr and Roman Mars, sovereignty and rule of Celtic Medb, Germanic Teutatis, and both Mars and the Roman war goddess Bellona.

It is very often the war gods, too, who oversee the continuance of the human race, and indeed the ability of all living things to reproduce themselves. The myths say this in different ways. Several war gods and goddesses, notably the Greek Ares and the Celtic Medb, were notorious for their sexual appetites. Just as Ares coupled for preference with Aphrodite, so in Haitian voodoo, Ogoun enjoys sex with the love goddess Erzulie. The Mesopotamian Ishtar, goddess of sex, was in Assyria also the war goddess, to whom were offered the flayed skins and severed hands of prisoners.

This is less a commentary on the rape and pillage historically associated with invading armies than a reflection of a link between war gods and a broader notion of generation and fertility. Gu, in Dahomey, oversaw both fertility and war; Cihuacóatl, Great Goddess of the Aztecs, had charge of war and women's fecundity. In particular instances, the link between war and fertility might arise from the war god's dual role as sky and weather god, by analogy with the life-giving rain, as with Mars and Svandovit. Another line of development is represented by Hachiman, who began as a protector of crops and children, came to protect the whole of Japan, and then became a war god.

Sex and Fertility

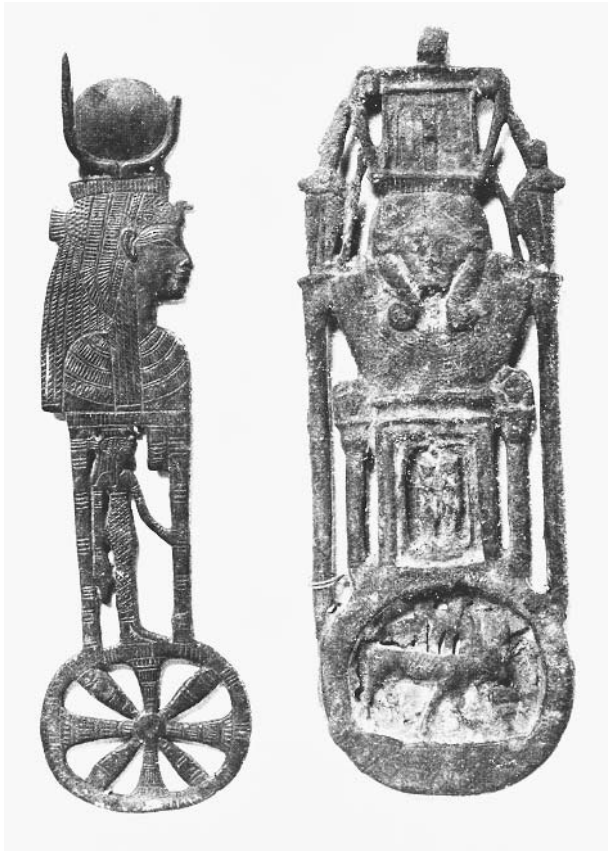
But war gods aside, a connection between sex/fertility and death is made in many mythologies from the most ancient past down to the present time. Nergal in Mesopotamia, embodied as a bull (a widespread symbol of virility), was notorious both for his sexual activity and also for dragging mortals off to the underworld; Sucellus, the "Good Striker," in Celtic myth had a hammer which he used both to strike plenty from the ground and to hit dying people on the forehead to make death easier; Ghede, originally the Haitian god of love, was in later voodoo belief amalgamated with Baron Samedi, the dancing god of death who was often questioned via blood sacrifice on questions of fertility.

This link between sex and/or fertility and death is epitomized by Hathor, originally a fierce blood-drinking Nubian war goddess who wore the same lion-headed form as Sekhmet. When introduced into Egypt, she became the cow of plenty whose milk was the food of the gods and kept them fecund. It was Hathor, too, who entertained the sun god Ra on his nightly voyage through the underworld, and also guided souls to the court of the judge of the dead, Osiris.

Life and death are two sides of the same coin: Innanna, Sumerian goddess of sex and fertility, is the twin sister of Ereshkigal, queen of the underworld. They are not two but one, a dual goddess, light and dark. Consider the Irish myths of the Daghdha. Wise, associated with magic, like the war gods he was master of arts and skills. But he was also the gluttonous god of abundance and of fertility, coupling with Boann, the spirit of the river Boyne, as well as his wife Dana, and with the war goddess the Morrigan (significantly on New Year's Day). He wielded a huge club—with the knobbed end killing the living, the other restoring the dead to life.

Other Aspects of Gods and Goddesses

Some mythologies have vanished; some have gone on to become world faiths. One of the survivors is Hinduism, which expresses its philosophy of life and death in the myth of Shiva, a warrior of vast strength, the most powerful being in the universe, armed with invincible weapons (including a bow made from the rainbow and a trident of thunderbolts). Like many war gods, he was born oddly,



The connection between fertility and death is made in many mythologies. The original Nubian war goddess turned Egyptian fertility goddess, Hathor, is characterized by these labor amulets. CORBIS

from a slit in a vast penis that appeared in the universe. (He is still honored in the form of a phallic stone column, the lingam.) At the same time, his titles include Kala (“Death”) and Nataraja (“Lord of the Dance”), because of the terrible dance he dances at the end of each cycle of the universe, when he opens his fearful third eye and unmakes the whole of creation. He is one of the three supreme deities: He destroys, Vishnu preserves, Brahma maintains balance. Together, they order the universe.

Though many ancient mythologies explained how death came into the world, comparatively few promised a better life to come. Their underworlds were mostly gloomy places, into which the dead were thrust by hideous demons or fierce warrior-deities, and there either forgotten by their creator or made to stand trial before some dread underworld lord such as Osiris in Egypt or in Chinese Buddhist myth the Four Kings of Hell, who guard

the Scrolls of Judgment in which all past lives are recorded. No wonder that many underworlds are filled with unhappy souls, like the spirits led by Gauna, death in the myths of the Bushmen of Botswana, who are so miserable in the world below that they keep trying to escape and take over the world above.

But several societies evolved myths of death and resurrection gods built on the analogy with plant life, which springs up and dies in an annual cycle. The Greeks told the story of Adonis, loved by both Aphrodite and the underworld goddess Persephone. When he was killed by a jealous Ares, scarlet anemones sprang up from drops of his blood. Zeus solved the rivalry between the goddesses by decreeing that Adonis should spend half his year with Aphrodite, half with Persephone in the underworld.

Death and resurrection gods form the background to the emergence in the Near East of mystery religions, so-called because only initiates knew their secrets. These extended the chance of a better hereafter beyond a close circle of special people, such as the pharaohs and nobles in Ancient Egypt afforded a kind of immortality by mummification; Greek heroes taken to the happy Isles of the Blest instead of gloomy Hades; and Norse warriors carried off the battlefield by Odin’s battle-maidens, the valkyries, to the everlasting feast in his mead-hall Vallhalla, whereas those who died in their beds were consigned to the dismal realm of the goddess Hel.

The mystery religions promised life after death to all believers. In Egypt, Aset (Isis), sister and consort of Osiris, by her magical skills reassembled the corpse of Osiris, after he was dismembered by his brother Set. However, the gods decreed that Osiris (perhaps because he could no longer function as a fertility deity, Aset having been unable to find his penis) should henceforth serve as judge of the dead in the underworld. From this evolved the Mysteries of Isis, a popular cult in Ptolemaic Egypt and Rome, from the first century B.C.E. to the fourth century C.E. At their initiation, devotees were told the secret name of the sun god Ra, which Isis won from him in order to revivify Osiris. They believed that knowing this name empowered them to conquer age and sickness, even death.

From Iran came the cult of the creator and war god Mithra who fought and killed the primeval

bull, from whose blood and bone marrow sprang all vegetation. He eternally mediates on humankind's behalf with his father, Ahura Mazda, the god of light, and combats the dark lord, Ahriman, the evil principle. This battle will end on Judgment Day with Mithra's triumph. In ancient Rome, where he was known as Mithras, Mithra became the focus of a mystery religion practiced especially by soldiers. Initiation into his cult, as into that of Isis, was believed to ensure immortality. The cult never became widespread, partly because it was secret, partly because it was austere, but chiefly perhaps because it was closed to half the population—the women.

By contrast, Christianity spoke to both sexes. It outlasted both the Mysteries of Isis and those of Mithras, perhaps because the answer it gave to the question "What happens to me after death?" was the same for everyone, king or subject, master or slave, soldier or farmer, man or woman. Moreover, the bodily death and resurrection of Christ himself, prefiguring the triumph over death of all who believed in him, was said to have happened to a historical person within or almost within living memory, rather than to a god in some remote mythical time.

See also: AFRICAN RELIGIONS; GILGAMESH; OSIRIS

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JENNIFER WESTWOOD

GOOD DEATH, THE

What is the good life? Most people would prefer health to illness, affluence to poverty, and freedom to confinement. Nevertheless, different people might have significantly different priorities. Is the good life one that is devoted to family affection or individual achievement? To contemplation or action? To safeguarding tradition or discovering new possibilities? There is a parallel situation in regard to the good death. Not surprisingly, most people would prefer to end their lives with ease of body, mind, and spirit. This unanimity dissolves, however, when one moves beyond the desire to avoid suffering. Societies as well as individuals have differed markedly in their conception of the good death. The long and eventful history of the good death has taken some new turns at the turn of the millennium, although enduring links with the past are still evident.

Dying is a phase of living, and death is the outcome. This obvious distinction is not always preserved in language and thought. When people speak of "the good death," they sometimes are thinking of the dying process, sometimes of death as an event that concludes the process, and sometimes of the status of "being dead." Furthermore, it is not unusual for people to shift focus from one facet to another.

Consider, for example, a person whose life has ended suddenly in a motor vehicle accident. One might consider this to have been a bad death because a healthy and vibrant life was destroyed along with all its future possibilities. But one might also consider this to have been a good death in that there was no protracted period of suffering. The death was bad, having been premature, but the dying was merciful. Moreover, one might believe that the person, who is now "in death," is either experiencing a joyous afterlife or simply no longer exists.

It is possible, then, to confuse oneself and others by shifting attention from process to event to status while using the same words. It is not only possible but also fairly common for these three aspects of death to be the subject of conflict. For example, the controversial practice of physician-assisted suicide advances the event of death to reduce suffering in the dying process. By contrast,

some dying people have refrained from taking their own lives in the belief that suicide is a sin that will be punished when the soul has passed into the realm of death. It is therefore useful to keep in mind the distinction between death as process, event, and status. It is also important to consider perspective: *who* judges this death to be good or bad? Society and individual do not necessarily share the same view, nor do physician and patient.

Philosophers continue to disagree among themselves as to whether death can be either good or bad. The Greek philosopher Epicurus (341–270 B.C.E.) made the case that death means nothing to us one way or the other: When we are here, death is not. When death is here, we are not. So why worry? Subsequent philosophers, however, have come up with reasons to worry. For example, according to Walter Glannon, author of a 1993 article in the journal *Monist*, the Deprivation of Goods Principle holds that death is bad to the extent that it removes the opportunity to enjoy what life still might have offered. It can be seen that philosophers are talking past each other on this point. Epicurus argued that death is a matter of indifference because it is outside humans' lived experience. This is a focus on process. Glannon and others argue that the "badness" of death is relative and quantitative—it depends on how much one has lost. This is a focus on death as event.

A World Perspective

From terminology and philosophy, one next turns to the rich heritage of world cultures as they have wrestled with the question of the good death within their own distinctive ways of life. Many of the world's peoples have lived in fairly small groups. People knew each other well and were bonded to their territory by economic, social, and religious ties. These face-to-face societies often contended with hardships and external threats. Community survival was therefore vital to individual survival. Within this context, the good death was regarded as even more consequential for the community than for the individual.

The good death was one that did not expose the community to reprisals from angry spirits or stir up confusion and discontent among the survivors. Personal sorrow was experienced when a family member died, but the community as a whole

responded with a sequence of rituals intended to avoid the disasters attendant on a bad death.

The Lugbara of Uganda and Zaire do not practice many rituals for birth, puberty, or marriage, but they become intensely involved in the funeral process. Death is regarded as an enemy, an alien force that raids the village. Nobody just dies. Much of Lugbara life is therefore devoted to controlling or placating evil spirits. The good death for the Lugbara encompasses the process, the event, and the state.

- **The Process:** Dying right is a performance that should take place in the individual's own hut with family gathered about to hear the last words. The dying person should be alert and capable of communicating, and the final hours should flow peacefully without physical discomfort or spiritual distress. The dying person has then prepared for the passage and has settled his or her affairs with family and community. It is especially desirable that a lineage successor has been appointed and confirmed to avoid rivalry and perhaps violence.
- **The Event:** The death occurs on schedule—not too soon and not too much later than what was expected. The moment is marked by the lineage successor with the *cre*, a whooping cry, which signifies that the deceased is dead to the community both physically and socially, and that the people can now get back to their lives.
- **The State:** The deceased and the community have performed their ritual obligations properly, so there is little danger of attack from discontented spirits. The spirit particular to the deceased may linger for a while, but it will soon continue its journey through the land of the dead.

A death can go bad when any of these components fails. For example, a person who dies suddenly or away from home is likely to become a confused and angry spirit who can become a menace to the community. A woman who dies in childbirth might return as an especially vengeful spirit because the sacred link between sexuality and fertility has been violated. The Lugbara deathbed scene shows compassion for the dying person and

concern for the well-being of the community. Nevertheless, it is a tense occasion because a bad death can leave the survivors vulnerable to the forces of evil.

In many other world cultures the passage from life to death has also been regarded as a crucial transaction with the realm of gods and spirits. The community becomes especially vulnerable at such times. It is best, then, to support this passage with rules and rituals. These observances begin while the person is still alive and continue while the released spirit is exploring its new state of being. Dying people receive compassionate care because of close interpersonal relationships but also because a bad death is so risky for the community.

Other conceptions of the good death have also been around for a long time. Greek, Roman, Islamic, Viking, and early Christian cultures all valued heroic death in battle. Life was often difficult and brief in ancient times. Patriotic and religious beliefs extolled those who chose a glorious death instead of an increasingly burdensome and uncertain life. Norse mythology provides an example made famous in an opera by the nineteenth-century German composer Richard Wagner in which the Valkyrie—the spirits of formidable female warriors—bring fallen heroes to Valhalla where their mortal sacrifice is rewarded by the gods.

Images of the heroic death have not been limited to the remote past. Many subsequent commanders have sent their troops to almost certain death, urging them to die gloriously. The U.S. Civil War (1861–1865) provides numerous examples of men pressing forward into withering firepower, but similar episodes have also occurred repeatedly throughout the world. Critics of heroic death observe that the young men who think they are giving their lives for a noble cause are actually being manipulated by leaders interested only in their own power.

Some acts of suicide have also been considered heroic. The Roman commander who lost the battle could retain honor by falling on his sword, and the Roman senator who displeased the emperor was given the opportunity to have a good death by cutting his wrists and bleeding his life away. Japanese warriors and noblemen similarly could expiate mistakes or crimes by the ritualistic suicide known in the West as *hara-kiri*. Widows in

India were expected to burn themselves alive on their husbands' funeral pyres.

Other deaths through the centuries have earned admiration for the willingness of individuals to sacrifice their lives to help another person or affirm a core value. Martyrs, people who chose to die rather than renounce their faith, have been sources of inspiration in Christianity and Islam. There is also admiration for the courage of people who died at the hands of enemies instead of betraying their friends. History lauds physicians who succumbed to fatal illnesses while knowingly exposing themselves to the risk in order to find a cause or cure. These deaths are exemplary from society's perspective, but they can be regarded as terrible misfortunes from the standpoint of the families and friends of the deceased.

The death of the Greek philosopher Socrates (c. 470–399 B.C.E.) shines through the centuries as an example of a person who remained true to his principles rather than take an available escape route. It is further distinguished as a death intended to be instruction to his followers. The good death, then, might be the one that strengthens and educates the living. The modern hospice/palliative care movement traces its origins to deaths of this kind.

With the advent of Christianity the stakes became higher for the dying person. The death and resurrection of Jesus led to the promise that true believers would also find their way into heaven—but one might instead be condemned to eternal damnation. It was crucial, then, to end this life in a state of grace. A new purification ritual was developed to assist in this outcome, the *ordo defunctorum*. The last moments of life now took on extraordinary significance. Nothing less than the fate of the soul hung in the balance.

The mood as well as the practice of Christianity underwent changes through the centuries with the joyful messianic expectation of an imminent transformation giving way to anxiety and doubt. The fear of punishment as a sinner darkened the hope of a blissful eternity. Individual salvation became the most salient concern. By the fifteenth century, European society was deeply immersed in death anxiety. The *Ars Moriendi* (“art of dying”) movement advised people to prepare themselves for death every day of their lives—and to see that their children learned to focus on the perils of their



The hospice environment is one in which a patient, such as the elderly person here, can be comforted by family and friends in moments leading up to death. This type of “good death” gives individuals a chance to say their good-byes to loved ones. TERRY WILD STUDIO

own deathbed scene rather than become attached to the amusements and temptations of earthly life. The good death was redemption and grace; everything else was of little value.

This heavy emphasis on lifelong contemplation of mortality and the crucial nature of the deathbed scene gradually lessened as the tempo of sociotechnological change accelerated. Hardships continued, but earthly life seemed to offer more attractions and possibilities, drawing attention away from meditations on death. And by the seventeenth century a familiar voice was speaking with a new ring of authority. Physicians were shedding their humble roles in society and proudly claiming enhanced powers and privileges. In consequence, the nobility were more likely to be tormented by aggressive, painful, and ineffective interventions before they could escape into death. The emerging medical profession was staking its claim to the deathbed scene. It was a good death

now when physicians could assure each other, “We did everything that could be done and more.”

The Good Death in the Twenty-First Century

In the early twenty-first century, as in the past, humans seek order, security, and meaning when confronted with death. It is therefore clear that not everything has changed. Nevertheless, people’s views of the good death have been influenced by the altered conditions of life. To begin with, there are more people alive today than ever before, and, in technologically developed nations, they are more likely to remain alive into the later adult years. The most remarkable gains in average life expectancy have come from eliminating the contagious diseases that previously had killed many infants and children. The juvenile death rate had been so high that in various countries census takers did not bother to count young children. Parents mourned for their lost children then as they do

now. The impact of this bad death was tempered to some extent by the knowledge that childhood was perilous and survival in God's hands. The current expectation that children will certainly survive into adulthood makes their death even more devastating. Parental self-blame, anger at God, stress disorders, and marital separation are among the consequences that have been linked to the death of a child.

Childbirth was a hazardous experience that many women did not long survive. Graveyards around the world provide evidence in stone of young mothers who had soon joined their infants and children in death. Such deaths are much less expected in the twenty-first century and therefore create an even bigger impact when they do occur.

In the late twentieth and early twenty-first centuries, many Mexicans died while attempting to cross the desert to find employment in the United States in order to feed and shelter their families. Are these "good deaths" because of the heroism of those who risked—and lost—their lives, tragic deaths because of their consequences, or senseless deaths because society has allowed this situation to develop?

It is far more common to assume that one has the right to a long life and therefore to regard an earlier demise as unfair or tragic. Paradoxically, though, there is also more concern about not dying young. Many people remain vigorous and active through a long life. Nevertheless, gerontophobia (fear of growing old) has become a significant problem in part because more people, having lived long, now die old. Younger people often fear that age will bring them to a lonely, dependent, and helpless preterminal situation. The distinction between aging and dying has become blurred in the minds of many people, with aging viewed as a slow fading away in which a person becomes less useful to themselves and others. It is a singularly prolonged bad death, then, to slide gradually into terminal decline, in essence having outlived one's authentic life. This pessimistic outlook has been linked to the rising rate of suicide for men in older age groups. In reality, many elders both contribute to society and receive loving support until the very end, but the image of dying too long and too late has become an anxious prospect since at least the middle of the twentieth century.

Two other forms of the bad death came to prominence in the late twentieth century. The aggressive but mostly ineffective physicians of the seventeenth century have been replaced by a public health and medical establishment that has made remarkable strides in helping people through their crises. Unfortunately, some terminally ill people have experienced persistent and invasive medical procedures that produced suffering without either extending or restoring the quality of their lives. The international hospice movement arose as an alternative to what was seen as a futile overemphasis on treatment that added to the physical and emotional distress of the dying person. The hospice mission has been to provide effective symptom relief and help the dying person maintain a sense of security and worth by supporting the family's own strength.

Being sustained indefinitely between life and death is the another image of the bad death that has been emerging from modern medical practice. The persistent vegetative state arouses anxieties once associated with fears of being buried alive. "Is this person alive, dead, or what?" is a question that adds the pangs of uncertainty to this form of the bad death.

The range of bad death has also expanded greatly from the perspective of those people who have not benefited from the general increase in life expectancy. The impoverished in technologically advanced societies and the larger part of the population in third world nations see others enjoy longer lives while their own kin die young. For example, once even the wealthy were vulnerable to high mortality rates in infancy, childhood, and childbirth. Many such deaths are now preventable, so when a child in a disadvantaged group dies for lack of basic care there is often a feeling of rage and despair.

A change in the configuration of society has made it more difficult to achieve consensus on the good death. Traditional societies usually were built upon shared residence, economic activity, and religious beliefs and practices. It was easier to judge what was good and what was bad. Many nations include substantial numbers of people from diverse backgrounds, practicing a variety of customs and rituals. There is an enriching effect with this cultural mix, but there is also the opportunity for misunderstandings and conflicts. One common

example occurs when a large and loving family tries to gather around the bedside of a hospitalized family member. This custom is traditional within some ethnic groups, as is the open expression of feelings. Intense and demonstrative family gatherings can unnerve hospital personnel whose own roots are in a less expressive subculture. Such simple acts as touching and singing to a dying person can be vital within one ethnic tradition and mystifying or unsettling to another.

Current Conceptions of the Good Death

The most obvious way to discover people's conceptions of the good death is to ask them. Most studies have focused on people who were not afflicted with a life-threatening condition at the time. There is a clear preference for an easy death. The process should be mercifully brief. Often people specify that death should occur in their sleep. Interestingly, students who are completing death education courses and experienced hospice caregivers tend toward a different view. When their turn comes, they would want to complete unfinished business, take leave of the people most important to them, and reflect upon their lives and their relationship to God. These actions require both time and awareness. Drifting off to sleep and death would be an easy ending, but only after they had enough opportunity to do what must be done during the dying process.

Women often describe their imagined deathbed scenes in consoling detail: wildflowers in an old milk jug; a favorite song being played; familiar faces gathered around; a grandchild skipping carefree in and out of the room; the woman, now aged and dying, easy in mind, leaving her full life without regrets. Conspicuous by their absence are the symptoms that often accompany the terminal phase—pain, respiratory difficulties, and so on. These good deaths require not only the positives of a familiar environment and interpersonal support but also a remarkably intact physical condition. (Men also seldom describe physical symptoms on their imagined deathbed.) Men usually give less detailed descriptions of their imagined final hours and are more likely than women to expect to die alone or suddenly in an accident. The imagined good death for some men and a few women takes place in a thrilling adventure, such as skydiving. This fantasy version of death is supposed to occur despite the ravages of a terminal illness.

What is the good death for people who know that they have only a short time to live? People dying of cancer in the National Hospice Demonstration study conducted in 1988, explained to their interviewers how they would like to experience the last three days of their lives. Among their wishes were the following:

- I want certain people to be here with me.
- I want to be physically able to do things.
- I want to feel at peace.
- I want to be free from pain.
- I want the last three days of my life to be like any other days.

This vision of the good death does not rely on fantasy or miracles. It represents a continuation of the life they have known, and their chances of having these wishes fulfilled were well within the reality of their situation. Religion was seldom mentioned as such, most probably because these people were secure in their beliefs.

Society as a whole is still reconstructing its concepts of both the good life and the good death. Studies suggest that most people hope to be spared pain and suffering, and to end their days with supportive companionship in familiar surroundings. Dramatic endings such as heroic sacrifice or deathbed conversion are seldom mentioned. There are continuing differences of opinion in other areas, however. Should people fight for their lives until the last breath, or accept the inevitable with grace? Is the good death simply a no-fuss punctuation mark after a good life—or does the quality of the death depend on how well people have prepared themselves for the next phase of their spiritual journey? Questions such as these will continue to engage humankind as the conditions of life and death also continue to change over time.

See also: ARS MORIENDI; COMMUNICATION WITH THE DYING; DEATH SYSTEM; DYING, PROCESS OF; EPICURUS; HOSPICE OPTION; JESUS; MARTYRS; SOCRATES

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ROBERT KASTENBAUM

GRAVESTONES AND OTHER MARKERS

Tracing the development of differing objects of memory provides a general background for understanding the development of gravestones and other markers from colonial times to the present in North America. Based on this overview, three broad traditions emerge: *memento mori* markers, markers that evoke the phrase, "in memory of," and *ignotatio mori* markers.

Memento Mori

The *memento mori* (remember death) tradition, which began with colonization and continues into the present, emerges from and belongs to a set of values that insists on both a devaluation of the body (indeed, all things temporal) and a valorization of the spirit or soul. The most obvious and significant consequence of such insistence is that markers belonging to this tradition discursively and iconographically encourage viewers to remember death as a means of reminding the living to prepare for judgment.

Gravestones and markers belonging to the *memento mori* tradition tend to be relatively modest structures (between one and five feet in height and width and between two and five inches thick). Characteristically, marker inscriptions provide only the deceased's name, age, date of death, and, less frequently, date of birth, cause of death, and family or community status, with by far the largest number providing nothing more than a brief inscription. Mottos such as the Latin phrases *Memento mori* and *Fugit hora* ("time flies" or, more literally, "hours flee") appear on countless early markers from this tradition and leave little room for doubt as to what viewers are to remember. To restate and reinforce the lesson, markers also continually confront viewers with time- and death-related icons.

In Memory Of

A second tradition, which began to emerge during the early years of the eighteenth century and also continues into the present, identifies a particular individual as the object of memory. Initially, proponents of this tradition, which we may designate the "in memory of" tradition, borrowed heavily from the *memento mori* tradition by producing markers nearly identical in size, shape, and general appearance. However, rather than instructing viewers to "remember death," these new markers discursively and iconographically emphasized the deceased, often drawing attention to emotions occasioned by the individual's death.

With the introduction of rural cemeteries, which specifically reflect the values of this tradition, came a remarkably increased facility for patrons to produce an enormous variety of gravestones and markers. Despite that variety, such markers fall into two general categories.

The first category abides principally by the creed that memorials are, or ought to be, works of art insofar as they serve primarily to draw attention either to the memorial as a work of art or to the work of art as a memorial. Typically, markers belonging to this category borrow heavily from Egyptian, Greek, Gothic, and Roman sources.

The second category draws attention not only to the memory of the deceased and to the work of art as a memorial (or to the memorial as a work of art), but also to pathetic sentiments. Some of the more common focal points for this kind of marker are the faithful animal, the poised angel, women

and children, and replicas of nature or natural phenomena. In all, markers within this tradition generally serve not as a means of reminding viewers of their urgent need to bring order out of chaos in order to prepare religiously for death, but as a means of encouraging viewers to live aesthetically, homeopathically, and naturally in the moment.

Ignoratio Mori

A third tradition, which we may designate the *ignoratio mori* ("ignore death") tradition, began to appear in gravescapes as early as the mid-eighteenth century and continues into the present. This tradition initially borrowed heavily from previous traditions. However, rather than replicating themes indicative of those traditions, this tradition sets death aside and focuses heavily on the lived accomplishments of the deceased. In general terms this tradition developed in three divergent but complementary directions.

The first direction produced markers that explicitly emphasized the deceased's worldly achievements, social or cultural standing, and heroic actions. The second direction produced memorials specifically designed to be erected in towns and cities, which afforded the double advantage of allowing proponents to construct memorials of sufficient size and of dissociating their tradition from the gravescape (and, thus, death). The third direction emerged as a consequence of the introduction of the lawn cemetery, a gravescape explicitly designed to reflect and articulate the values underlying this tradition. Here, markers (and again death) are flush with or slightly depressed into the ground so that the only immediately visible memorial efforts are those selected by adherents to this tradition and thus can insure that all memorials contained within this funerary environment conform to appropriate values.

See also: BURIAL GROUNDS; CEMETERIES AND CEMETERY REFORM; EPITAPHS; LAWN GARDEN CEMETERIES

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RICHARD MORRIS

GREEK TRAGEDY

Greek tragedy, created in the city-state of Athens in the last thirty years of the sixth century B.C.E., is the earliest kind of European drama. Its subject matter is normally drawn from mythology, except that for the ancient Greeks "mythology" was a kind of historical saga, often perfectly credible oral history, including stories about gods and other supernatural beings, handed down from generation to generation by word of mouth. Because history raised to the sphere of legend only remembers milestones crucial to the life of the community, sometimes contemporary events viewed as critical for the survival of a people could provide the material for a tragedy. The *Persians* of Aeschylus, describing the invasion of Athens by a huge Persian fleet in 480 and its defeat in the naval battle of Salamis, is such a play. However, tragedy is, strictly speaking, neither historical nor mythological; it is a poetic drama in the sense that poetry rises above the particulars of history and expresses human truths of a universal kind.

This is achieved by a combination of heroic characters (rising above the ordinary in terms of social status, moral qualities, and intensity of emotions) and plots illustrating the impotence of

humans in regard to divine powers. Greek gods did not profess to love humanity, promised no salvation after death, and administered a harsh justice not only to sinners but also to unsuspecting innocents because of crimes perpetrated by their forebears. Tragic characters often suffer and die for crimes they committed unwittingly, or because they were ordered to do so by a god (something possible in the context of Greek polytheism), or because they have to expiate an old sin, or fall under a family curse. When they fully realize the inevitability of their destiny, they act with dignity in accordance with their principles and proceed to do what they believe is right, often precipitating their dreadful end. This is considered a “tragic death,” although in modern languages the word *tragedy* is often used more loosely as a synonym for *disaster*—particularly a seemingly undeserved disaster that strikes unexpectedly powerful people and happy families.

Origins and Evolution

The term *tragedy* means the song of *tragōidoi* and *tragōidoi* means “he-goat singers.” Scholars do not know what may have been the relationship of goats to early tragedy, but possible explanations include (1) a goat was offered as a prize in a competition of predramatic choruses, or (2) the members of such choruses were disguised as half-animal demons in the service of Dionysus (such as satyrs) and used goat skins for that purpose.

According to Aristotle (*Poetics*, ch. 4), tragedy originated from the improvisations of the *exarchontes* (song leaders) of the dithyramb, while comedy originated with the leaders of the “phallic songs.” A dithyramb was a religious hymn in honor of Dionysus, and the Dionysiac origin of tragedy was in antiquity taken for granted, Dionysus being the god of theater as much as the god of wine, vegetation, and fertility. However, tragedy lost its Dionysiac associations very early, and only one of the preserved plays, indeed the very last tragedy of Euripides, *Bacchae*, has a Dionysiac content, namely the myth of resistance to the introduction of Dionysus’s cult to Thebes, and the god’s devastating revenge upon the city. Dithyramb, too, gradually lost its religious connection to Dionysus and developed into choral poetry that drew its subjects from mythology (like tragedy). Dithyrambs were also regularly performed in the Dionysiac festivals.

It is impossible to reconstruct with any certainty the stages of evolution from religious hymn to ritual enactment, and finally to a kind of secular play in which a great variety of myths were presented in dramatic form to a theatrical audience rather than a group of worshipers. The critical stage in this line of development was the transition from ritual to theater. Ritual must be repeated more or less exactly if it is to be a religious act. But once it metamorphoses into a playful act, its religious ties are loosened and a great potential for development in form and content becomes available to creative artists.

The first poet credited with the invention of tragedy was a minor, if semi-legendary, figure by the name of Thespis. His activity is dated to the 530s, although the introduction of tragic productions in the form of dramatic contests to the City Dionysia (c. 505) apparently did not take place before the establishment of democracy. Except for half a dozen titles of plays, nothing survives from his poetry.

However, once the first sparks were struck tragedy evolved swiftly by embracing and building on earlier forms of poetry. Choral lyric was a major poetic genre in Archaic Greece (700–500 B.C.E.), particularly among Dorian Greeks. It was incorporated into the new art of drama and retained not only its basic shape (division into strophic pairs and complex metrical structures), but even the Dorian dialect, invariably used by the Athenian poets in all choral parts of the plays. The personal lyric of the Ionians in iambic meter, particularly the style in which Solon, Athens’s own sixth-century poet and lawgiver, had written his emotionally charged accounts of self-justification and political advice, provided the model for the set-speeches of dramatic characters widely used in tragedy. Next, the tradition of epic poetry, shared by all Greeks, supplied the great pool of stories, often grouped in local cycles (e.g., Trojan and Theban) and family sagas (the Atréids, Theseus, Heracles). Finally came the actor, or *hypokrites*, which originally meant “interpreter” and/or “answerer” (before it came to mean “hypocrite” also, in late antiquity). The emergence of the actor suggests narrative and dialogue with the chorus on the part of the poet/actor, who could change masks and identities during the performance (both tragedy and comedy were always performed by masked male actors). When tragedy came to light, Aristotle notes, poets inclined to



Sophocles' Antigone, which dates to fifth-century B.C.E. Athens, contains themes that make its production still popular in the twenty-first century. PHOTOSTAGE/DONALD COOPER

compose serious poetry now turned to tragedy, and epic poets were thus succeeded by tragedians.

What made these developments possible and greatly accelerated them was the establishment of democracy in Athens right after 510. A large open-air theater on the south slope of the Acropolis accommodated a massive audience, consisting of the whole population of the city (including foreigners and slaves). In view of the size of this audience, and the participation of common men in it—the same citizens who voted for new laws and major political decisions in the assembly of (direct) democracy, and also served as jurors in the courts of law—it is hardly surprising that the chorus became an indispensable part of the dramatic performance. The chorus represented and spoke for a collective dramatic character at the level of myth (anonymous citizens, womenfolk, elders, sailors, slaves, and even minor divinities) who in the epic had remained speechless in the background of the action.

Further, the dramatists gave new accounts and interpretations of the traditional stories they represented and re-enacted. By doing so, they gratified

the contemporary Athenian audience that had made such great political progress from the time of a harsh oligarchy and widespread serfdom in the sixth century to democracy at the turn of the century, which was further consolidated by the victories in the Persian wars.

The Peak of Tragedy

The function of the poet, according to Aristotle, is to state the universal, “to tell, not what has happened, but what would have happened according to probability or necessity” (*Poetics*, ch. 9). But what is probable or necessary (outside of the domain of science) depends on what the audience is ready to accept. Was it necessary for Agamemnon to sacrifice his daughter, Iphigenia, in order to be allowed by goddess Artemis to set sail for Troy? Was he killed upon his return home by his wife because he had killed Iphigenia, or because he had destroyed the temples of gods in the sack of Troy, or because his wife had taken a lover whose father had cursed Agamemnon’s father? Was there a pattern of divine justice in these acts of revenge?

What made the discussion of these questions in public possible and indeed vital was that the Greeks had no religious book, like the Bible or the Koran, to explain the ways of the gods to them, and the level of the morality of gods, as depicted by the epic poetry of Homer and Hesiod (c. 750–700), was hardly superior to that of men. Men seemed and felt helpless in relation to gods—and likely to incur their envy or wrath—yet they thought that even the gods were subordinate to destiny. They dimly hoped that there was a world order contingent on divine providence that had been achieved by the harsh rule of Zeus. In reality men had done a lot better than the gods in pursuing social justice, and even oligarchic states like Sparta had developed constitutional forms of government and law administration already in the Archaic period (admired by later philosophers such as Plato).

In representing the human life of the past, the earliest of the great dramatists, Aeschylus, tried to make sense of the inconsistencies of mythology and arbitrariness of gods in relation to the perception of moral responsibility and justice current in Athenian political and judicial assemblies. He wrote trilogies of interrelated plays extending over successive generations of gods and men, and searched for reason and a just resolution of conflicts. Characteristic examples of his work are the Prometheus trilogy *Oresteia*. *Prometheus Bound*, the first and only surviving play of the former trilogy, depicts the punishment of Titan Prometheus by Zeus for stealing the fire from gods and giving it to humankind, along with many arts. Aeschylus made Prometheus the son of Themis (Custom, Law), and ended the trilogy with a reconciliation of Zeus and Prometheus, the benefactor of humankind. The *Oresteia* (the only surviving trilogy) deals with the bloody saga of the Atreids, which is resolved in the Athenian law-court, the Areopagus, by a jury of men who listen to divine litigants (the Furies) and witnesses (Apollo), and vote for acquitting Orestes, though not without the additional vote of Athena, the patron-goddess of the city. Aeschylus dominated the theater in the first half of the fifth century (produced the *Oresteia* in 458, died in 456). Only seven of his plays, out of approximately ninety written, have survived.

Sophocles (497–406 B.C.E.), although a deeply religious man, gave up trilogies of interconnected plays and the effort to untangle religious issues, and

focused on human characters, their motivation, their morality, and the uncompromising dignity with which they faced up to their predicaments. He perfected the art form in terms of plot construction and characterization, increased the number of speaking characters in a scene from two to three, and added painted scenery to the stage. Aristotle considers his *Oedipus the King* the perfect example of tragic composition, as it illustrates very well his concept of “tragic error” (a crime unwittingly committed, yet affecting family and city like a plague), and the sudden fall of a powerful man from happiness to disaster. However, Oedipus is neither a paragon of virtue nor immoral. The spectacle of a virtuous person suffering unjustly would be abhorrent, Aristotle writes, as the punishment of an immoral character would be pleasing to the spectator and thus untragic. Like Oedipus, the proper tragic hero should be of average moral stature: The downfall of such a person is felt to be tragic and stirs up the emotions of pity and fear in the audience. Sophocles reportedly wrote 120 plays, but only seven have survived, including *Antigone*, *Electra*, and *Oedipus at Colonus*.

Euripides (486–406) is the last of the great tragedians of the fifth century. If Sophocles represents the spirit and style of the Golden Age of Athens (480–430), Euripides (who as a young man had been a disciple of the physical philosopher Anaxagoras and the sophist Protagoras, an agnostic) belongs to the troubled period of the Peloponnesian War, which took place between Athens and Sparta between 431 and 404 B.C.E. He made no effort to account for the interference of gods in the life of humans; on the contrary, by having events that preceded and followed the action proper of the play merely reported or revealed in a prologue and an epilogue, spoken by a god (the *deus ex machina*), he seems to expose rather than explain the arbitrariness and cruelty of gods, which had made Socrates reject the validity of traditional myths and Plato pronounce epic and tragic poetry unacceptable to his ideal republic. He was less successful than either of his predecessors in his lifetime, but a lot more popular after his death. His plays were revived throughout the Greco-Roman antiquity, and no less than eighteen of his tragedies have been preserved into modern times. Although some of his plays have a happy ending (e.g., *Helen*, *Ion*, and *Iphigenia in Tauris*) and are considered melodramas rather than tragedies, others depict the human ineffectiveness to avert the fall

from a state of happiness to that of absolute misery and disaster. In fact, Aristotle calls Euripides “the most tragic of the poets” (*Poetics*, 13). Scholars consider *Medea*, *Hippolytus*, *Trojan Women*, and his last play, *Bacchae*, his greatest masterpieces.

Decline, Survival, Revival

Although one would not have guessed it by reading Aristotle’s analysis of tragedy as a poetic genre, the *Poetics* (c. 330), tragedy declined after the death of Sophocles and Euripides, and the humiliation of Athens at the end of the Peloponnesian War. Although several names (and some fragments) of poets who lived in the fourth century and in the Hellenistic era are known to modern-day scholars, intellectual and political developments, as well as the changing attitudes toward old gods and traditional religion, did not favor the kind of interpretation of the human past offered by tragedy. A new kind of drama, “New Comedy,” inherited Euripides’ realistic (comparatively speaking) style and Aristophanes’ preoccupation with contemporary life and social climate, and became the most important dramatic form in the later fourth and the following centuries.

However, tragedy won a different lease on life in the same period, initially as an Athenian cultural export. Several theaters were built in many cities in the fourth century, including the greatest of Greek theaters, that of Epidaurus in northern Peloponnese. After Alexander’s death in 323, which marks the beginning of the Hellenistic era, a veritable theatrical explosion took place all over the Greek-speaking world. Every city in Greece, Asia Minor, Syria, Egypt, and South Italy and Sicily established its own dramatic festival, and theater artists set up professional unions (in Athens, Peloponnese, Asia Minor, Egypt, and South Italy) in order to respond and profit from the new tremendous demand for their services. Dramatic festivals and contests became the mark of Hellenic culture, but despite all this activity the conditions for the creation of significant new tragedies did not exist anymore. Old religion had retreated under pressure from new oriental gods. Traditional Greek mythology had lost its value as oral history of the past, and Chance (personified as a goddess) had largely replaced Fate in the mind of ordinary people. Tragedy died out when the Eastern Roman Empire was Christianized in the fourth century.

Tragedy began to be revived on a modest scale in the Renaissance, and fertilized modern serious theater and the creation of the opera, which was conceived as a modern form of tragedy, not only in Italy and France, but also later in Germany. Productions of Greek tragedies have increasingly carved a considerable niche in contemporary Western (and Japanese) theater, so much so that one may wonder what it is that ancient tragedy has to say to modern audiences that have no familiarity with or belief in Greek mythology and religion. It seems that the basic shape of the stories, the examples of heroic defiance, and above all the uncompromising dignity with which tragic characters accept the predicament imposed on them by superior powers which they cannot overcome or avoid, hold a universal message of humanity that is as valuable for modern men and women as it was for ancient ones.

See also: FOLK MUSIC; GRIEF; TRAUMATIC; OPERATIC DEATH; SHAKESPEARE, WILLIAM

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G. M. SIFAKIS

GRIEF

OVERVIEW Robert Kastenbaum**ACUTE** Kenneth J. Doka**ANTICIPATORY** Joan Beder**CHILD'S DEATH** Reiko Schwab**DISENFRANCHISED** Kenneth J. Doka**FAMILY** Reiko Schwab**GENDER** Kenneth J. Doka**SUICIDE** Norman L. Farberow**THEORIES** Henk Schut, Margaret Stroebe, Wolfgang Stroebe**TRAUMATIC** Lillian M. Range

OVERVIEW

A suffering, a distress, a wretchedness, a pain, a burden, a wound. These were among the meanings associated with the word *grief* in its premodern French origin. The term also referred to

wrongs and injuries that have been inflicted upon an individual by others, thereby providing the related word *grievance*. There are still other associations: *greeffe*, *greffe*, and *gravis*—all denoting a heaviness that weighs one down toward the earth, the very opposite of levity. People who experience grief today are likely to feel many or all of the emotions that were inherent in the earliest definitions of the term.

Grief experts have also identified other facets of the grief response, such as a yearning for the lost person or state of affairs, a need to think repeatedly about past events, a sense of guilt, or even thoughts of suicide. As Kenneth Doka notes, the grief experience can begin even before the loss occurs; another useful distinction can be made between the immediate response to loss and the grieving that sometimes continues long afterward or which does not come to the surface until some time has passed since the death or other loss.

It is now recognized that grief is more than sorrow and emotional turmoil. Five dimensions are receiving particular attention in the mental health community. First, stress reactions include changes in physiological function that can increase one's vulnerability to illness and exacerbate preexisting physical problems. Secondly, perception and thought are also affected, with the increased possibility of making impulsive and potentially harmful decisions and becoming more at risk for accidents. Third, a spiritual crisis often occurs, in which the guiding assumptions and values are called into question. Fourth, family and communal response to loss, often neglected in the past, is a significant factor in grief and grief recovery. And lastly, although the pain of loss may be universal, cultural heritage and influences and current support systems have much influence on the way one expresses and copes with stress.

See also: GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; GRIEF COUNSELING AND THERAPY

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ROBERT KASTENBAUM

ACUTE

Grief is a type of stress reaction, a highly personal and subjective response to a real, perceived, or anticipated loss. Grief reactions may occur in any loss situation, whether the loss is physical or tangible—such as a death, significant injury, or loss of property—or symbolic and intangible, such as the loss of a dream. The intensity of grief depends on the meaning of that loss to the individual. Loss, however, does not inevitably create grief. Some individuals may be so disassociated from the lost object that they experience little or no grief or their response is characterized by intense denial.

Acute grief is different from bereavement or mourning. Bereavement is an objective state of loss: If one experiences a loss, one is bereaved. Bereavement refers to the fact of loss, while grief is the subjective response to that state of loss. Mourning has two interrelated meanings in the scholarly literature on the subject. On one hand, it describes the intrapsychic process whereby a grieving individual gradually adapts to the loss, a process that has also been referred to as “grieving” or “grief work.” Grief can also denote a social process, the norms, behavior patterns, and rituals through which an individual is recognized as bereaved and socially expresses grief; for example, wearing black, sending flowers, and attending funerals. Acute grief has also been described as the initial, intense reactions to a loss, differentiating it from later, less intense expressions of grief. Such a distinction, given the discussion that follows, is not made here.

Paradigms on the Origin of Acute Grief

Acute grief was first described by Eric Lindemann, a psychiatrist who studied survivors of the 1942 Coconut Grove fire, a blaze that swept through a

Boston nightclub, killing 492 people. Lindemann described grief as a syndrome that was “remarkably uniform” and included a common range of physical symptoms such as tightness of throat, shortness of breath, and other pain, along with a range of emotional responses (1944, p.145). Lindemann’s research was based on a sample of primarily young survivors of sudden and traumatic loss.

This medical model of grief was continued most clearly in the work of George Engel. In 1961 Engel asked if grief was a disease. He believed it could be described as one having a clear onset in a circumstance of loss, a predictable course that includes an initial state of shock; a developing awareness of loss characterized by physical, affective, cognitive, psychological, and behavioral symptoms; and a prolonged period of gradual recovery that might be complicated by other variables. Engel notes that other disease processes also are influenced by psychological and social variables. Even the fact that grief is universal and does not often require treatment, Engel argues, is not unlike other diseases. Engel also notes that whether or not a disease requires medical treatment or is, in fact, recognized as a disease is a social definition. Epilepsy, alcoholism, and many forms of mental illness are now recognized as diseases but were not at other times in human history or in other cultures.

Another paradigm that attempts to offer insight to the nature of acute grief is the psychological trauma model. This model, based on the work of Sigmund Freud, views grief as a response to the psychological trauma brought on by the loss of a love object. According to this view, acute grief is a normal defense against the trauma of loss. To Freud, grief is a crisis, but one that will likely abate over time and that does not usually require psychiatric intervention.

Perhaps one of the more influential theories of grief is the attachment model developed by John Bowlby. This approach emphasizes that attachment or bonding is a functional survival mechanism, a needed instinct, found in many of the social animals. Given humans’ prolonged periods of infancy and dependency, attachment is necessary for the survival of the species. When the object of that attachment is missing, certain behaviors are instinctual responses to that loss. These

behaviors, including crying, clinging, and searching, were seen by Bowlby as biologically based responses that seek to restore the lost bond and maintain the detachment. When these bonds are permanently severed, as in death, these behaviors continue until the bond is divested of emotional meaning and significance. A secondary purpose of these behaviors is that by expressing distress, they engage the care, support, and protection of the larger social unit. This psychobiological model sees grief as a natural, instinctual response to a loss that continues until the bond is restored or the grieving person sheds the bond. These early approaches continue to influence understandings of acute grief, though more contemporary models emphasize that grief is a natural response to major transitions in life and that bonds between the grieving individual and the lost object continue, albeit in different forms, after the loss. In addition, approaches of the 1990s emphasize that a significant loss may shatter assumptions, causing grieving individuals to reconstruct their sense of self, spirituality, and relationship to others and the world. While this may be a painful process, it also may be a catalyst for growth.

Manifestations of Acute Grief

Individuals can experience acute grief in varied ways. Physical reactions are common. These include a range of physical responses such as headaches, other aches and pains, tightness, dizziness, exhaustion, menstrual irregularities, sexual impotence, breathlessness, tremors and shakes, and oversensitivity to noise.

Bereaved individuals, particularly widows, do have a higher rate of mortality in the first year of loss. The reasons for this may include the stress of bereavement, the change in lifestyle that accompanies a loss, and the fact that many chronic diseases have lifestyle factors that can be shared by both partners; hence both partners share similar stress and patterns making them prone to similar diseases. It is important that a physician monitor any physical responses to loss.

There are affective manifestations of grief as well. Individuals may experience a range of emotions such as anger, guilt, helplessness, sadness, shock, numbing, yearning, jealousy, and self-blame. Some bereaved experience a sense of relief

or even a feeling of emancipation. This, however, can be followed by a sense of guilt. As in any emotional crisis, even contradictory feelings, such as sadness and relief, can occur simultaneously.

There can be cognitive manifestations of grief, including a sense of depersonalization in which nothing seems real, a sense of disbelief and confusion, or an inability to concentrate or focus. Bereaved individuals can be preoccupied with images or memories of the loss. These cognitive manifestations of acute grief can affect functioning at work, school, or home. Many persons also report experiences where they dream of the deceased or sense the person's presence.

Grief has spiritual manifestations as well. Individuals may struggle to find meaning and to reestablish a sense of identity and order in their world. They may be angry at God or struggle with their faith.

Behavioral manifestations of grief can also vary. These behavioral manifestations can include crying, withdrawal, avoiding or seeking reminders of the loss, searching, hyperactivity, and changes in relationships with others.

The reactions of persons to loss are highly individual and influenced by several factors, including the unique meaning of the loss, the strength and nature of the attachment, the circumstances surrounding the loss (such as the presence of other crises), reactions and experiences of earlier loss, the temperament and adaptive abilities of the individual, the presence and support of family and other informal and formal support systems, cultural and spiritual beliefs and practices, and general health and lifestyle practices of the grieving individuals.

The Course of Acute Grief

There have been a number of approaches to understanding the process or course of acute grief. Earlier approaches tended to see grief as proceeding in stages or phases. Researcher and theorist Colin Murray Parkes, for example, described four stages of grief: shock, angry pining, depression and despair, and detachment. Recent approaches have emphasized that grief does not follow a predictable and linear course, stressing instead that it often proceeds like a roller coaster, full of ups and

downs. Some of these more intense periods are predictable, such as holidays, anniversaries, or other significant days; other times may have no recognizable trigger.

Approaches during the 1990s have emphasized that acute grief involves a series of tasks or processes. Psychologist William Worden describes four tasks pertaining to grief: recognizing the reality of the loss, dealing with expressed and latent feelings, living in a world without the deceased, and relocating the deceased in one's life. Psychologist Therese A. Rando suggests that grieving individuals need to complete six "R" processes: recognize the loss, react to the separation, recollect and re-experience the deceased and the relationship, relinquish the old attachments to the deceased and the old world, readjust to the new world without forgetting the old, and reinvest. (While the language of both Worden and Rando is specific to death-related loss, their models can be adapted to other losses as well.) These and other similar models reaffirm the very individual nature of grief, acknowledging that these tasks or processes are not necessarily linear and that any given individual may have difficulty with one or more of the processes or tasks.

It is worth emphasizing that the course of acute grief is not linear. Nor is there any inherent timetable to grief. Acute grief reactions can persist for considerable time, gradually abating after the first few years. Research emphasizes that one does not simply "get over the loss." Rather, over time the pain lessens and grief becomes less disabling as individuals function at levels comparable to (and sometimes better than) pre-loss levels. Nevertheless, bonds and attachments to the lost object continue, and periods of intense grief can occur years after the loss. For example, the birth of a grandchild can trigger an experience of grief in a widow who wished to share this event with her deceased spouse.

Help and Acute Grief

Persons experiencing acute grief can help themselves in a number of ways. Since grief is a form of stress, the griever can benefit from various forms of stress management, especially adequate sleep and diet. Bibliotherapy (the use of self-help books) can often validate or normalize grief reactions, suggest

methods of adaptation, and offer hope. Self-help and support groups can offer similar assistance as well as social support from others who have experienced loss and respite. Others may benefit from counselors, particularly if their health suffers or their grief becomes highly disabling, impairing functioning at work, school, or home, or if they harbor destructive thoughts toward themselves or others. Parkes particularly stresses the value of grief counseling when other support is not forthcoming. Pharmacological interventions also may be helpful, particularly when the grief is so disabling that it severely compromises the individual's health or ability to function. Such interventions should focus on particular conditions—anxiety or depression—that are triggered or aggravated by the bereavement. Psychotherapy should accompany pharmacological interventions.

Most individuals seem to ameliorate grief; gradually they find themselves able to remember the loss without the intense reactions experienced earlier. Nevertheless, anywhere from 20 to 33 percent seem to experience more complicated grief reactions.

See also: DISASTERS; FREUD, SIGMUND; GRIEF COUNSELING AND THERAPY

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KENNETH J. DOKA

ANTICIPATORY

The concept of anticipatory grief was first described by psychiatrist Eric Lindemann at the end of a presentation to the American Psychiatric Association in 1944. Lindemann defined anticipatory grief as a progression through the stages of grief, including “depression, heightened preoccupation with the departed, a review of all the forms of death which might befall him, and anticipation of the modes of readjustment which might be necessitated by it” (Lindemann 1944, p. 148). He cautioned that there are advantages and disadvantages to anticipatory grieving, with the disadvantages including the possibility that the griever might pull away from the dying person prematurely (a circumstance referred to as deatathesis).

In the era of advanced medical technology, the phenomenon of anticipatory grief is particularly important. The experience of terminal illness has changed, and there is frequently an extended period between diagnosis and death. Because of medical advances, dying has become more of a gradual process; debilitation is extended and quality of life has been improved. There is a longer time during which families and the patient can experience anticipatory grief.

In a more current definition, psychologist Therese A. Rando defined anticipatory grief as “the phenomenon encompassing the processes of mourning, coping, interaction, planning, and psychosocial reorganization that are stimulated and begin in part in response to the awareness of the impending loss of a loved one” (Rando 1986, p. 24). According to Rebecca Ponder and Elizabeth Pomeroy, however, “persistent debate remains about whether anticipatory grief results in shorter and easier periods of grief when the actual death occurs or . . . may have adverse effects” (Ponder

and Pomeroy 1996, p. 4). Some argue that post-death grief may be intensified by anticipatory grieving as loved ones witness the debilitating aspects of the illness; in some cases, there may be the tendency toward premature detachment and abandonment of the patient as death approaches. Others find that anticipatory grief facilitates the leave-taking process as loved ones have time to complete the “unfinished business” of life and detach in a more orderly manner; in the presence of death, many people are able to rise above the past and make the amends necessary for a peaceful dying. Despite these contradictory beliefs, the concept initially suggested by Lindemann has endured.

Rando expanded the initial concept of anticipatory grief in several significant ways. She viewed it as a multidimensional concept defined across two perspectives, three time foci, and three classes of influencing variables. In Rando’s conceptualization, anticipatory grief is not confined to the experience of the caregiver or family alone: The dying patient also experiences this form of grief. In addition, she considered anticipatory grief to be a misnomer suggesting that one is grieving solely for anticipated losses. Rando asserted that there are three foci of losses that occur as part of the anticipated grief: past losses in terms of lost opportunities and past experiences that will not be repeated; present losses in terms of the progressive deterioration of the terminally ill person, the uncertainty, and the loss of control; and future losses that will ensue as a consequence of the death, such as economic uncertainty, loneliness, altered lifestyle, and the day-to-day moments in life that will no longer occur because of death. Variables influencing anticipatory grief, according to Rando, include psychological factors—the nature and meaning of the loss experienced; social factors—those dimensions within the family and socioeconomic characteristics that allow for certain comforts and discomforts during the illness period; and physiological factors—the griever’s energy and overall health.

In addition, Rando disagreed with Lindemann regarding the eventuality of a major deatathesis from the dying person. She not only did not see it as an automatic response but also redefined the pulling away in terms of deatathesis from the hopes, dreams, and expectations of a long-term future with and for that person, not from the person. Rando contended that “the future can be

grieved without relinquishing the present!" (Rando 1986, p. 13).

Phases of Anticipatory Grief

In a 1983 book called *The Anatomy of Bereavement*, Beverly Raphael discussed phases of anticipatory grief for both the dying person and those close to the person that parallel actual bereavement. Building on the work of Elisabeth Kübler-Ross, Raphael noted that for both the patient and caregiver(s) the first response to news of a fatal condition is shock, numbness, disbelief, and denial. In time, the news is faced, distressed feelings can no longer be fended off, and a period of fear, anxiety, and helplessness ensues. Bargaining and the anguish raised by the question "Why me?" mark this phase. Hope may fend off some of the anguish, but as the loss is acknowledged, the process of anticipatory grief may become pronounced. Anger, regret, resentment, a sense of failure, a feeling of being cheated, guilt, and depression are common responses. Some reach the calm and acceptance described by Kübler-Ross. The dying person may withdraw as the family/caregivers struggle with the opposing pulls to remain close to the dying person and to relinquish the bond to the person to mitigate the pain of the impending loss.

Both Raphael and Rando contended that anticipatory grief is a process—an experience that takes time to unfold and develop. During the process, the work is to slowly dispel the denial and to develop an awareness of what is happening. In this way, the griever(s) can begin to experience optimum amounts of anticipatory grief to reach a level of benefit.

For a terminal illness, researchers have repeatedly raised the question of whether there is an optimum length of time before the positive effects of anticipatory grief diminish. Rando, in a 1983 study, and C. M. Sanders, in a 1982 study, both found that there was an optimum length of time for anticipatory grief as it affected the survivor's postdeath adjustment: six to eighteen months.

The Impact of Special Situations

In several situations, the benefits and disadvantages of anticipatory grief can be questioned. One such situation is that of children facing the death of a parent. Given the child's developmental level

and the profound nature of the loss, the limited ability of children to understand death and its finality, and the reality that the dying parent is unable to attend to the needs of the child, the benefits of anticipatory grieving may be mitigated. In a 1999 study of parentally bereaved children conducted by Amy Saldinger and her colleagues, anticipated death was consistently associated with less adaptive outcomes and poorer mental health outcomes, using a variety of measures. According to Vanderlyn Pine and Carolyn Bauer, for parents who anticipate the loss of a child, "there is no way to know just how much anticipatory grief is too much. It does not appear that there is an optimum amount" (Pine and Bauer 1986, p. 86–87).

For those struggling with the varied losses imposed by Alzheimer's disease, there is a differential benefit to anticipatory grieving, depending on the duration of the illness. In a 1994 article for the *Journal of Gerontological Social Work*, Rebecca Walker and her colleagues attributed this to a combination of variables: the social stigma related to the disease as an illness of the aged, and the loss of cognitive ability and self-sufficiency; the progressive nature of the disease and the associated incapacitation; the multiple losses that the caregiver has to face; and the eventuality that the caregiver may have to relinquish care of the patient to others. From their 1996 study, Ponder and Pomeroy reported that for those dealing with patients with dementia and Alzheimer's disease, the benefits of anticipatory grief were limited, noting that this group of individuals is at high risk for complicated mourning.

Anticipatory grief in relation to AIDS is another area that shows differential benefit for the griever. Several variables, similar to those related to Alzheimer's disease and dementia, are operative for those with HIV/AIDS. The duration of the illness and the stigmatization that accompanies it are prominent factors. The course of HIV/AIDS often extends beyond the eighteen months designated as a beneficial length of time for anticipatory grief for the caregiver. In addition the multiple losses and the alternating periods of relative good health and battles with opportunistic diseases potentially abort the process of anticipatory grief. As a further complicating factor in the anticipatory grief trajectory is the relationship between the caregiver and the patient, a relationship that may not be sanctioned by society (i.e., homosexual relationships). In his

1989 book, Kenneth J. Doka used the term "disenfranchised loss" to describe a loss that is not recognized or validated by others. For those caring for the AIDS patient, completing some of the tasks of anticipatory grieving may be compromised by the lack of an official, socially sanctioned connection to the dying patient.

For practitioners working with patients and caregivers, the challenge is to combine the various elements of anticipatory grief. Practitioners must recognize that anticipatory grieving does not necessarily involve a pulling away from the patient; that there are multiple losses that span a period of time; that the process of anticipatory grieving goes through stages; and that it is a time of working on and working through the "unfinished business" for both patient and caregiver. Practitioners must be attuned to the tendency for premature detachment and diminishing communication between patient and caregiver and encourage discussion of fear, loss, and anger. Ideally, according to Walker and her colleagues, a practitioner "can help the caregiver both hold on to hope while letting go of the patient, thereby completing the very complicated work of anticipatory grief" (Walker et al. 1996, p. 55).

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JOAN BEDER

CHILD'S DEATH

The death of a child, regardless of age, is one of the worst possible losses adults can experience. Grief over a child's death is particularly severe compared to the loss of a spouse, parent, or sibling. The parent-child bond is uniquely strong and enduring. Children are extensions of parents; they hold parents' dreams, aspirations, and hopes for the future and promise the continuity of parents' life after their death. They define parents' sense of self and give meaning and a sense of purpose to their lives. When a child dies, parents feel mortally wounded; it is as though part of them is torn away by force. The family also loses its wholeness. A child's death is perceived as untimely at any age because parents are "supposed to" die before children. Moreover, miscarriage, stillbirth, and death in childhood and adolescence are often sudden and unexpected and in some cases violent, which traumatizes survivors.

The question of "why" haunts parents as they review the event to make sense of the death. Their sense of failure in protecting their child from harm evokes guilt feelings and diminishes their self-esteem. Out of their despair and urgent desire to be with the deceased child and to end their relentless pain, parents may entertain the thought of death. Parents' grief is not only their personal, intra-psychic experience but an interpersonal

process. A child's death affects all family members including extended members as well as others outside the family and their relationships and, in turn, others' responses to parents' plight affect parents.

Effects on Parents and the Spousal Relationship

A child's death can have a serious impact on parents and the spousal relationship. If a child is a victim of a serious illness, parents' anguish starts long before the child's death. Parents experience enormous stress emotionally, physically, and financially. They are confronted with conflicting demands between their work and the care of the ill child in addition to meeting the daily needs of well siblings. Typically, mothers assume the major responsibility of caring for the ill child while fathers fulfill their duties as providers, some holding two or three jobs to meet financial obligations. It is not uncommon that the relationship between husband and wife becomes strained. A mother's increased involvement with a sick child, often at the hospital, and a father's inability to accompany his wife and take an active part in the ill child's care may lead to the father feeling frustrated, excluded, and isolated. Physical exhaustion and emotional strain may affect a couple's sex life. As children become critically ill, fathers tend to withdraw and become unavailable to their families because of their inability to cope with the emotional ordeal, which angers their wives. Increased outbursts of anger and arguments often become part of family life. Strains in relationships that developed while children were ill may not easily be lessened after children die.

A review of research indicates that, regardless of the cause of death, a substantial number of marital relationships become strained after children die. The marital strain appears attributable to differences in couples' grief and ways of coping, which result primarily from differences in gender roles and personality and the singular relationship each parent has had with the deceased child. Soon after the child's death, parents' grief is so intense that they tend to withdraw into their own private world and minimally relate to others. They hesitate to talk to their spouses about the loss for fear of stirring up their spouses' emotions. In general, mothers express grief more openly and show more intense reactions to their child's death than do

fathers. Husbands tend to feel responsible for helping other family members, particularly their wives, cope with their grief while controlling their own, but feel helpless not knowing how to comfort their grief-stricken wives, who are incapacitated in their usual roles as wives and parents. Husbands' behavior, however, comes into conflict with their wives' desire for emotional sharing. Wives feel angry over what they perceive to be their husbands' unwillingness to share their grief, which they may see as an act of abandonment, compounding their sense of loss. It may take some time before wives realize that their spouses' behavior is their way of coping with their pain of grief.

Anger and rage, which are common in bereavement, are often displaced onto the nearest target: a person's spouse. Spouses are generally irritable toward each other over trivial matters and matters concerning the deceased child. Loss of sexual intimacy is common, and it may take even a year or two to restore a sexual relationship. Serious strain in marital relationships can lead to separation and divorce, especially if couples had marital problems prior to their child's death. In the majority of cases, however, the marital bond is strong enough to withstand this major ordeal and may even be strengthened.

Parents who are single as a result of divorce or the death of their spouses and unmarried parents are spared the kinds of problems that confront marital partners, but they grieve while carrying a myriad of responsibilities and demands placed on them without partners with whom to share the burden. If they lost their only child they are left alone without companionship and feel they are no longer needed. Their support system plays a particularly important role in coping with their experience of loss.

When adults who are responsible for managing and maintaining the household and promoting the welfare of the family are overwhelmed by their grief, unable to function adequately in their usual roles, and experiencing relational conflicts, their family naturally experiences varying degrees of disorganization and disequilibrium. Surviving children are a source of comfort, but their presence does not mitigate parents' distress. For the initial few weeks after the child's death, relatives, friends, and neighbors may offer not only emotional support but assistance with household chores and



A grieving couple in Warminster, Pennsylvania, arranges flowers at the grave of their teenage son who was killed during a video store robbery. Couples with strong marital relationships prior to their child's death appear to fare better in their bereavement. CORBIS

child care. When they leave to return to their own routines, parents are left alone to face the new reality of having to live with the void left by the deceased child. Much of the time parents feel like they are in a daze and later do not remember how they managed to get through those early days of bereavement.

Parents cope with their grief one day at a time with frequent setbacks. Coping involves a combination of action and cognitive activity for relieving stress and mastering stressful situations. There is no one right way to grieve or to cope. Parents usually adopt a combination of strategies. Seeking release of tension is a necessity for most parents, given the enormous emotional turmoil the loss engenders. Emotional tension, if kept inside, does not disappear and may surface in ways that are destructive to individuals and their relationships. Parents, especially mothers, may relieve their tension through talking about their loss and crying. Other strategies to which parents turn to relieve tension include engaging in physical activities, keeping themselves busy, and expressing their grief in writing, art, and other creative activities.

Many find relief in having something definite to do, which prevents them from becoming totally consumed by their grief and mired in depression. In general, coping strategies that direct parents' attention away from their tragedy appear essential and helpful during the initial weeks or months of acute grief. Total avoidance in facing the reality of loss and its pain, however, can complicate the grieving process. Parents also seek an understanding and validation of their experience through reading books about loss and learning about the experience of others in similar predicaments, which helps them diminish their sense of isolation and gain a perspective on their own experience.

Even though some parents may initially express anger toward God who they feel has betrayed them, for many, religious faith serves as a major source of comfort and strength and appears to lessen the intensity of grief. A number of parents participate in support groups, seek professional help, and/or make frequent visits to the cemetery in order to cope. Some parents become connected with other bereaved parents through the Internet. Parents' dominant coping strategies change in the course of their bereavement. Many parents transform their tragedy into something positive and find new meaning in life through their work, including work that changes the condition that contributed to their child's death, volunteer work to help others in need, and the establishment of scholarship funds in their child's name. Some parents whose child died due to murder or the negligence of others have transcended their tragedy through their courageous and generous acts of forgiveness.

Effects on Siblings

When a sibling is terminally ill, other children "live in houses of chronic sorrow" with "the signs of sorrow, illness, and death" everywhere, writes the researcher Myra Bluebond-Langner, who studied terminally ill children and their well siblings extensively (Bluebond-Langner 1995, p. 123). The signs are visible on parents' faces as well as the face of the ill child. The amount of parental attention well siblings receive diminishes; however, seeing the toll the illness takes on their parents, children try to be supportive toward them. Parents' relationship with each other is strained. Parents are irritable and their tempers are short and unpredictable. Family plans change frequently. Children can no longer engage in normal activities, such as having their

friends over to play. Their relationships with the ill sibling also change. Mutual give-and-take no longer exists. Well siblings try to get close to the dying sibling, but their efforts are often rebuffed. Instead, children not only help care for the sick sibling but parent their grieving parents, and yet they are not always kept abreast of the ill sibling's condition. Often they feel alone, confused, ambivalent, and neglected, but cannot express their feelings to distressed parents. After their sibling dies, many of the same conditions continue in the family for a period of time.

When children lose a sibling, they cope with their own grief and many consequent changes at home over which they have little control. Parents' diminished ability to function in their usual roles means the loss of a normal family life and many deprivations for children. Death in the family usually brings support for parents, but children's grief and need for support are often overlooked, increasing their sense of isolation and neglect. When children are young, parents tend to assume that their children are too young to be affected by the family tragedy and fail to talk to them about the circumstances of their sibling's death or provide them with opportunities to ask questions. There is, however, ample clinical evidence to indicate that even very young children are affected by the death. When children are not well informed, they resort to their imagination, distort reality, and experience an unnecessary sense of culpability over the death, resulting in a variety of developmental problems.

Furthermore, children face changes in relationships with their parents and hierarchical order among siblings with new parental expectations thrust upon them. Because of the centrality of the deceased sibling in the family during illness and after death, it may appear to surviving children that the deceased child is more important to parents than they are, making them feel insignificant. However, out of their loyalty and concern for distressed parents, children often become protective toward them, hiding their emotional and even physical pain so as not to burden their parents. They often become vigilant over parents' comings and goings. At the same time, parents, who fear that a similar tragedy may strike them again, become overprotective toward their surviving children. Parental overprotectiveness may be seen in their reluctance

to discipline children or to allow children to engage in normal growth experiences. In some cases, parents' unresolved grief and desire to keep deceased children alive may result in using surviving children or children born after the death as replacement children, who are expected to take over the identities of the deceased, denying them their own unique identities.

The Process of Healing

The impact of a child's death is pervasive and profound. The family and its members are irrevocably changed. Grandparents grieve for their grandchild whose life ended prematurely as well as their own loss, but often their grief is more focused on their adult child who has suffered a devastating loss. Other extended family members, friends, neighbors, co-workers, and sometimes even strangers are touched by the death directly or indirectly. Too frequently, what others say and do out of their own discomfort or lack of understanding about parental grief hurts and angers bereaved parents, creating a chasm between them and the bereaved, and thus diminishing the support networks to which the bereaved normally turn. On the other hand, those who stand by them and offer support and assistance while their child is ill and in their mourning are gratefully remembered by the bereaved.

The process of mourning is agonizingly long. It may be many months before parents restore their sense of equilibrium and become actively involved in daily life. Parents' willingness to openly share their grief with one another strengthens their relationship, and their ability to provide a secure and supportive environment for children facilitates the process of healing in the family. A child's death compels family members to reexamine their assumptions about the world, renew or question their spiritual or religious beliefs, and search for meaning in life. Realizing the fragility of life, survivors may develop a deeper appreciation of life and change their life priorities. Moreover, they discover inner strengths and resources they never knew they had.

A bond between deceased children and surviving family members continues for the rest of their lives. So does the pain of loss, which parents feel acutely from time to time throughout their

lives as special days approach; when something, perhaps a song, triggers thoughts of deceased children; and as deceased children miss each of the developmental milestones that they would have reached had they lived. As Robert Kastenbaum states, parents may not wish to relinquish their grief, for the pain is part of the precious memory that keeps a connection with the deceased. After a long and difficult journey, most parents learn to live with their pain of grief and move forward, finding once again some pleasure in life and hope for the future.

See also: GRIEF COUNSELING AND THERAPY; REPLACEMENT CHILDREN

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REIKO SCHWAB

DISENFRANCHISED

The professor and writer Kenneth J. Doka introduced the concept of disenfranchised grief in his 1989 book, *Disenfranchised Grief: Recognizing Hidden Sorrow*. Doka defined disenfranchised grief as "grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, socially sanctioned or publicly mourned" (p. 4).

The concept of disenfranchisement integrates psychological, biological, and sociological perspectives on grief and loss. Previous research has emphasized the variety of reactions in the grieving experience. While an individual may have an intense and multifaceted reaction to loss, that loss and the attendant responses may be unacknowledged by family, friends, or the surrounding society. Although the individual grieves, others might not acknowledge his or her right to do so. Such persons are not offered the "rights" or the "grieving

role” such as a claim to social sympathy and support, or such compensations as time off from work or diminution of social responsibilities.

In order to understand the social aspect of grief, it is important to remember that every society has norms that govern not only behavior but also affect and cognition. Every society has norms that frame grieving. These norms include expected behavior, in addition to feeling, thinking, and spiritual rules. Thus, when a loss occurs, these grieving rules include how one is to behave and how one is to feel and think. They govern what losses one grieves for, how one grieves for them, who legitimately can grieve for the loss, and how and to whom others respond with sympathy and support. These norms exist not only as folkways, or informally expected behavior, but also as “laws.” More formal statements of these grieving rules can be illustrated by company policies that extend bereavement leave to certain individuals, or regulations and laws that define who has control of the deceased body or funeral rituals.

In the United States and many other societies, these grieving rules limit grief to the deaths of family members. When a family member dies, one is allowed and expected to grieve, often in a specified way. Yet human beings exist in intimate networks that include both relatives and friends. They harbor attachment to fellow humans, animals, and even places and things. Persons experience a wide range of losses—deaths, separations, divorces, and other changes or transitions. When death or any other separation severs these attachments, the individual grieves for such loss in many ways, many of which might clash with the culture’s norms for grief. The person then experiences a loss, but others do not recognize his or her grief. That person has no socially accorded right to grieve that loss or to mourn it in that particular way. The psychologist Jeffrey Kauffman suggests that individuals internalize these grieving rules. Thus there can be an intrapsychic or self-disenfranchisement of grief whereby individuals believe that their grief is inappropriate, leading to feelings of guilt or shame.

The Disenfranchisement of Grief

There are a number of reasons that grief can be disenfranchised. In most Western societies, the family is the primary unit of social organization. Hence kin ties have clear acknowledgement in

norms and laws. While most individuals actually live their lives in intimate networks or associations that include both kin and non-kin, only kin have legal standing in making funeral arrangements and are accorded recognition as “mourner.”

Another principle of Western societies is rationality, which means that beyond the family, organizations such as businesses are expected to be organized along fair, functional, and rational lines. Grieving roles reflect such social norms. Extending grieving roles to non-death situations or to non-kin would create organizational burdens. Organizations would be forced to define “levels of friendship” or “types of loss.” They might be required to broaden the concept of bereavement leave, at considerable cost. Acknowledging only the death of kin conforms to rationalist organizational imperatives. It recognizes the grief of kin when a family member dies. By limiting the acknowledgement of loss to family members, it avoids confusion and potential abuse, affirming a single standard. This procedure prevents organizations from having to judge whether each individual case of loss is entitled to recognition. These policies, then, reflect and project societal recognition and support, again reaffirming and sanctioning familial relationships.

The policies also point to another significant factor—the relationship of grieving rules to ritual. The funeral becomes the vehicle by which grief is acknowledged and sanctioned, and where support is extended. The primacy of a family at the funeral reaffirms that these survivors have experienced a loss and that their subsequent grief needs sanction, acknowledgement, and support. The rite of the funeral publicly testifies to the right to grieve.

Naturally, in a diverse society, even those losses disenfranchised by society as a whole may be acknowledged within a smaller subculture. For example, the death of a gay lover may not be fully recognized by family or coworkers, but the grieving lover may be recognized and supported within the gay community. And as Eyetsemitan also notes, these grieving rules may change over time. Younger cohorts, for example, may be more supportive of the loss of an unmarried cohabiting couple. Thus, subcultures may mitigate the sense of disenfranchisement. Grieving rules differ between cultures and subcultures—what is disenfranchised in one may be supported in another.

Typologies of Disenfranchised Grief

What losses are disenfranchised? In *Disenfranchised Grief* Doka suggested three broad categories of loss and implied a fourth. These categories were developed inductively and clinically; certain types of cases suggested a series of broad categories.

The relationship is not recognized. Grief may be disenfranchised in those situations in which the relationship between the bereaved and deceased is not based on recognizable kin ties. Here, the closeness of other non-kin relationships may simply not be understood or appreciated. The roles of lovers, friends, neighbors, foster parents, colleagues, in-laws, stepparents and stepchildren, caregivers, counselors, coworkers, and roommates (e.g., in nursing homes) may be close and long-standing, but even though these relationships are recognized, mourners may not have full opportunity to publicly grieve a loss. At most, they might be expected to support and assist family members.

Then there are relationships that may not be publicly recognized or socially sanctioned. For example, nontraditional relationships such as extramarital affairs, cohabitation, and homosexual relationships have tenuous public acceptance and limited legal standing, and they face negative sanction within the larger community.

The loss is not acknowledged. In other cases, the loss is not socially defined as significant. Individuals experience many losses—some death-related, such as perinatal loss, or other non-death-related losses such as divorce, incarceration, the loss of a job or material possessions, or significant change in personality or temperament that may be unacknowledged by others. Some losses may be intangible. For example, a teenager aspiring to a career in sports is cut from a team, or parents discover that a beloved child suffers from a disability or grave disease. Similarly, the loss of reputation because of scandal, gossip, or arrest can be devastating. Even transitions in life can have undercurrents of loss. Aging, for example, leads to constant developmental losses such as the loss of childhood or other losses associated with different points of life.

The griever is excluded. There are situations in which the characteristics of the bereaved in effect disenfranchise their grief. Here, the person is not socially defined as capable of grief, therefore, there is little or no social recognition of his or her sense

of loss or need to mourn. Despite evidence to the contrary, both the old and the very young are typically perceived by others as having little comprehension of or reaction to the death of a significant other. Similarly, mentally disabled persons may also be disenfranchised in grief.

Circumstances of the death. The nature of the death may constrain the solicitation of the bereaved for support and limit the support extended by others. For example, many survivors of a suicide loss often feel a sense of stigma, believing that others may negatively judge the family because of the suicide. Similarly, the stigma of AIDS may lead survivors of an AIDS-related loss to be circumspect in sharing the loss with others.

The ways an individual grieves. The way in which an individual grieves also can contribute to disenfranchisement. Certain cultural modes of expressing grief such as stoicism or wailing may fall beyond the grieving rules of a given society, and thus contribute to disenfranchisement.

These examples and categories are not exhaustive, nor are they mutually exclusive. An individual's grief may be disenfranchised for a number of these reasons. And, of course, this particular taxonomy is attuned chiefly to contemporary Western culture.

Charles Corr offered another way to categorize disenfranchised grief. Corr approaches classification deductively, asking, "What is disenfranchised in grief?" He concludes that the state of bereavement, the experience of grief, and the process of mourning can all be disenfranchised.

The Special Problems of Disenfranchised Grief

Although each of the types of grief mentioned might create particular difficulties and different reactions, one can legitimately speak of the special problems shared by all disenfranchised grievers. The problem of disenfranchised grief can be expressed in a paradox. The very nature of disenfranchised grief creates additional problems for grief, while removing or minimizing sources of support.

Disenfranchising grief may aggravate the problem of bereavement in several ways. First, the situations mentioned tend to intensify emotional reactions. Many emotions are associated with normal

grief. These emotional reactions can be complicated when grief is disenfranchised. Second, both ambivalent relationships and concurrent crises have been identified in the literature as conditions that complicate grief. These conditions can often exist in many types of disenfranchised grief.

Although grief is complicated, many of the factors that facilitate mourning are not present when grief is disenfranchised. In death-related losses, the bereaved may be excluded from an active role in caring for the dying. Funeral rituals, normally helpful in resolving grief, may not help here. In some cases the bereaved may be excluded from attending, while in other cases they may have no role in planning those rituals or even in deciding whether to have them. Or in cases of divorce, separation, or psychosocial death (a significant change in another individual or relationship), rituals may be lacking altogether. In addition, the very nature of the disenfranchised grief precludes social support. Often there is not a recognized role in which mourners can assert the right to mourn and thus receive such support. Grief may have to remain private.

The Treatment of Disenfranchised Grief

Disenfranchised grief is treated by counselors as any form of grief. The psychologists Robert Neimeyer and John Jordan suggest that the key to treating disenfranchised grief lies in analyzing what they call "empathic failure," the factors that limit support and thus generate disenfranchisement. Once the cause of empathic failure is analyzed, therapists can devise interventions that develop or compensate for the lack of support. These interventions can include individual or group counseling, support groups, expressive therapies, or the therapeutic use of ritual.

See also: GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; GRIEF COUNSELING AND THERAPY; MOURNING

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KENNETH J. DOKA

FAMILY

Grief is a natural reaction to loss and a deeply personal experience. Its experience and intensity vary among individuals due to a variety of factors including who the deceased person was, the nature of the relationship with the deceased, the circumstances of death, and concurrent stress. The process of working through grief over a significant loss takes much more time than the public generally assumes. Often it takes many years to reach satisfactory resolution of the loss. Resolution, however, does not mean that an individual puts the experience of loss behind; it means that he or she has learned to live with the grief and is able to move on with life even though life has been irrevocably changed and the enduring sense of loss will remain. While the experience of grief is unique to each individual, grief is also an interpersonal process. People live in intricate networks of interdependent relationships inside and outside the family. Dying, death, and bereavement occur in this context. Individuals' distress over a loss is an interplay of their response to the loss, others' reactions, current and intergenerational family history of loss, and relational changes accompanying the loss. Therefore, grief can best be understood within the context of the family and its social environment.

The family is a social system in which members are interdependent and interact with one another in organized, predictable, and repetitive patterns. It is not a collection of individuals in isolation, but consists of individuals and their relationships. Because of interdependence among members, one member's behavior or whatever happens to one member affects the entire family. The family makes continuous adjustments in response to internal and external demands and

tries to maintain its equilibrium. The family, like individuals, develops over time. While every family experiences stresses as it moves through different phases of development, events that occur out of sync with normative development, such as the premature death of a member, disrupt the process and produce added stress.

Families may be conceptualized along three dimensions: cohesion, flexibility, and communication. Cohesion, emotional bonding among members, ranges from disengaged (very low) to enmeshed (very high), a moderate level of cohesion being optimal under normal circumstances. Moderately cohesive families are those with members who are able to be both independent from, and connected to, their families. In disengaged families, members are emotionally distant and unable to rely on one another for support or problem solving while in enmeshed families members are excessively close, demanding loyalty and lacking personal separateness. Flexibility refers to the family's ability to change structurally and functionally, its levels ranging from rigid (very low) to chaotic (very high). Moderately flexible families are able to make changes effectively while rigid and chaotic families lack an ability to change when necessary.

Central to family functioning is communication, verbal as well as nonverbal, by which members relate to one another. How members communicate is a good measure of the health of the family. Communication facilitates the family in making adjustments on the dimensions of cohesion and flexibility in order to maintain levels suitable to the situational demands and developmental needs of members and the family as a whole. Good communication is characterized by attentive and empathic listening, speaking for self, and an open expression of feelings about self and relationships.

In general, families with moderate levels of cohesion and flexibility supported by good communication make for optimal family functioning. Those families are able to cope more effectively with a family crisis. Too much or too little cohesion or flexibility tends to be dysfunctional. There is some research evidence to indicate that cohesive families deal with grief more effectively than those families characterized by conflict, low cohesiveness, low expressiveness, and poor organization.

When a family member has a serious illness, both the ill member and others in the family face the enormous challenge of living with the uncertainty of chronic illness from initial crisis through the terminal phase. They cope with an emotional roller coaster as they live with the uncertain trajectory of illness, the demands of illness and caregiving, exhaustion, financial burdens, and thoughts of their final separation. Family members lose their "normal" life and must learn to live with ambiguities over a long period of time, well members sometimes vacillating between a desire to be close to the ill member and a desire to escape from the unbearable situation.

An impending death is likely to intensify existing relational patterns in the family. When members communicate openly, they can share grief, set priorities, provide mutual support, resolve unfinished business, including old hurts, and grow closer together through their struggle. All members, regardless of age, can benefit from being part of this process. When communication is lacking, denial and avoidance create distance between the dying and the rest of the family as well as among well members, each feeling alone and isolated with issues unresolved when death occurs. Sudden death is likely to complicate survivors' grief, but death after a prolonged illness is also followed by difficult bereavement. Some of the factors that affect survivors' grief include: witnessing disfigurement and suffering of the ill member; ambivalence felt over the ill member's disease-related personality change; stresses of caregiving; and guilt over relief experienced after death.

The death of a family member disrupts individual and family equilibrium. It engenders emotional upheaval, often brings into question individual belief systems, interrupts the developmental process of individuals and the family, and changes the family and individual identity. It alters the family structure and relational patterns. Members try to restore a sense of equilibrium both in themselves and in their relationships by adapting to pervasive changes. Overwhelmed by their grief, however, adults' capacity to function in their usual roles as parents and/or spouses diminishes, which further affects the family structure and increases distress. Moreover, relational conflicts and past unresolved issues that have been dormant may resurface under the stress and complicate family relationships. The tasks of adapting to the new reality,

integrating the experience of the death into ongoing life, and moving forward developmentally are achieved through two overlapping and interrelated processes, family mourning and family reorganization. How these two processes are handled depends on the level of family functioning prior to the death as well as family resources.

The Process of Mourning

The finality of death touches the core of human vulnerability. Adults are confronted by their own and children's grief and daily demands of family life. For weeks, while they cope with their intense pain of grief and try to survive and restabilize the family, a discussion of the deceased may be kept to a minimum. Reacting to one another's attempt to manage intense grief, members frequently collaborate to protect severely distressed members, with spouses protecting their partners and children protecting their parents. In the case of a child's death, differences between spouses in their experience of grief and coping strategies often invite misunderstanding, leading to marital conflict and increased family difficulties. While adults are in distress, children must cope not only with their own grief over the death of their parent or sibling but the psychological absence of their surviving parent(s) who cannot adequately attend to their needs.

As adults gradually regain their equilibrium, members of a family whose functioning was optimal before the death are likely to restore communication and reestablish neglected relationships. Participating in rituals appropriate to the family's cultural tradition and mourning their loss in a supportive and cohesive family environment will not only promote the healthy resolution of grief but facilitate the reorganization of the family. Obstacles that block the mourning process vary, including unresolved losses in the current family or family of origin, disengaged or conflicted family relationships, unresolved conflict with the deceased, a desire to hide the nature of death which the bereaved deem undesirable, such as death due to suicide or AIDS (acquired immunodeficiency syndrome), and idealization of the deceased disallowing members to freely talk about the deceased. Excessive use of alcohol or other substances to numb the pain of grief also interferes with communication and jeopardizes health and family relationships. A desire to avoid what is painful is a natural human inclination; paradoxically, healing

comes through facing the challenge of giving the pain of grief the time and space that it requires. Even though there is no one way to cope with a major loss suitable for all, avoiding, inhibiting, or prohibiting talking about what everyone has in mind as though nothing has occurred hampers the mourning process. When members are deprived of opportunities to openly communicate and explore their own and the family's loss, the loss is compounded, resulting in a sense of isolation.

Through the process of mourning, the emotional center of the family gradually shifts from the deceased to the survivors and their future even though the deceased will continue to be psychologically present and serve as a source of support for members' ongoing development. Family members will establish their new sense of identity as widows, widowers, bereaved parents, fatherless or motherless children, children who have lost a sibling, and so forth. The change in identity also means a status change in social networks, requiring adjustments. When mourning is bypassed, the deceased individual remains as a "ghost" in the family, interfering with children's development as well as adults' developmental tasks, such as marriage, remarriage, or parenting, and places family members at risk for a host of physical and psychosocial problems. Those problems may not become evident until years later and may appear totally unrelated to the experience of loss.

The Process of Reorganization

A member's death changes the family's hierarchical structure, leaving a void and requiring not only an adjustment in relationships but an assumption of new roles and a reallocation of roles by surviving members. New employment and/or a change in residence may become necessary for some families. Emotional upheaval may precipitate some others to make drastic changes in their lives soon after the death, such as selling a home and/or business and moving to a new neighborhood. Decisions made under duress, however, may be regretted later on. Waiting a year or two, when possible, before making major decisions helps avoid additional disruption in the family. Under the stress of bereavement, even normally moderately cohesive and flexible families may show some degree of enmeshment and rigidity, which, if continued for an extended period of time, can restrict members' ongoing development and compromises children's

development toward increased independence and separation from the family.

The death of a member who performed a number of task-oriented roles presents adjustment difficulties if survivors are ill equipped to assume those roles. On the other hand, if the deceased member was dysfunctional and held a nonfunctional role in the family, adjustment may be minimally stressful. Rigid families with limited communication tend to allocate roles according to age and sex-role stereotypes with little negotiation. In flexible families roles are assigned through negotiation and based on member interest and competency. The death of children who played expressive roles leaves enormous psychic pain but does not necessitate task reassignment. Expressive roles, however, are also vital to maintaining family stability and cannot be left vacant for a long time. An empty space created by a child's death may exacerbate family problems that the child's presence kept at a distance. The death of a child who served to hold the parents' marriage together, for instance, can threaten the marital bond in bereavement. Sometimes a parent's continued attachment to the deceased child makes the parent inaccessible to others and poses problems in reorganization. Some parents start volunteer work or a project in memory of their child, which not only fills the void but brings new meaning to their lives.

Children who lost a parent or a sibling also confront changes in relationships with their parents as well as their siblings. With the death of a parent, older children may assume new roles to fulfill those roles formerly performed by the deceased or to support a depressed parent. Danger lies in children not only helping with household responsibilities or care of young siblings but assuming adult roles inappropriate to their age. Clear delineation of children's roles and responsibilities helps to prevent children from compromising their own normal development and possibly creating conflicts with siblings.

Family Resources

Families and their members differ in economic, personal, and social resources available to them in the process of family mourning and reorganization. Reduced socio-economic status due to death or a family's low material resources can negatively affect adjustment in bereavement. On the other

hand, personal resources including such individual characteristics as viewing life as a series of challenges and having pride, motivation, and a sense of control over life, help members make a better adjustment in bereavement.

Social support is a critical resource in coping with bereavement. The presence of others (kin, friends, neighbors, employers, coworkers, and even strangers in the community) who offer emotional and material support helps bereaved family members validate and mourn their immense loss and meet their daily needs when their ability to support themselves is seriously impaired. Those who are part of a cohesive cultural or religious group are likely to receive considerable support from others in the group. The types and amount of support the family needs differ depending on the family and the loss suffered, and family and individual needs change with time. Families isolated with minimal contact with others in the community and possessing limited resources are at risk for complications in bereavement. Families lacking social support due to stigma attached to their loved one's death as well as those whose needs are not adequately met through their usual sources of support may seek or augment support from outside the family. When the family faces serious difficulties in coping with the loss, assistance from professionals may be in order. Support groups designed to provide mutual support for those in a similar predicament are also found to be valuable sources of help for both bereaved children and adults. Often the most helpful emotional support comes from those who have experienced a similar loss.

Rebuilding

The process of integrating the experience of loss and rebuilding the family without the deceased is a gradual one, which can take months or years, depending on the circumstances. Adults who attend to their own grief and receive support from the extended family and community resources for reconstructing family life are in a better position to help children grieve and promote their healthy development. The effects of a member's death differ for each survivor and so do the ways of coping and the length of time it takes for members to resolve their grief and move on. The family mourning process, however, is a shared experience. Understanding and accepting the diversity in the family through mutual sharing facilitate the healing

process. New rituals may be created for cultural and religious celebrations and for special occasions, such as birthdays and anniversaries, to mourn and commemorate the deceased member and affirm the bond to the deceased in the ongoing family life. Troubling images associated with the death may continue to intrude into consciousness from time to time. The loss with its painful emotional and practical implications is revisited and grieved anew many times as the family and each member's life unfolds developmentally. Through embracing the past and reaffirming the continuity of life, members once again engage in life with hope for the future.

See also: COMMUNICATION WITH THE DYING; DYING, PROCESS OF; GOOD DEATH, THE; GRIEF COUNSELING AND THERAPY; MOURNING

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REIKO SCHWAB

GENDER

It has been suggested that because of different socialization experiences, or perhaps even biological differences, men and women exhibit distinct patterns in the way they experience, express, and adapt to grief. In much popular commentary it is further suggested that the male role inhibits grieving because it places emphasis on the regulation of emotional expression and constrains the seeking of support from others. Women, on the other hand, are seen as more ready to accept help and express emotions, both of which are seen as facilitating grief. Louis LeGrand, for example, stated in 1986 that this gender difference "does not mean that men are not grieving; it does indicate that they may not accomplish the task as successfully as women" (LeGrand 1986, p. 31). Allen Wolfelt, in a 1990 article in *Thanatos*, stated his belief that men's grief is

naturally more complicated because men cannot express emotion or seek help. Carol Staudacher in her book *Men and Grief* succinctly stated this bias toward emotive expressiveness: “Simply put, there is only one way to grieve. That way is to go through the core of grief. Only by expressing the emotional effects of your loved one’s death is it possible for you to eventually resolve the loss” (Staudacher 1991, p. 3). Yet the idea that men grieve poorly is clearly disputed by the research in the field of thanatology (the study of death).

Research Perspectives

Researchers have studied both therapists’ attitudes toward gender differences as well as the grief patterns and outcomes of men and women. The results have been mixed.

Therapists’ views. In 1997 Judith Stillion and Eugene McDowell reported the results of their study of certified grief counselors’ and grief therapists’ perspectives on gender differences in grief. The researchers found that the people in their sample did believe that men and women express grief differently. Men were perceived as less likely to express strong emotions and more likely to use diversions such as work, play, sex, or alcohol. Therapists reported that men were more likely to respond cognitively and to use anger as a primary mode of emotional expression. Women were seen as more likely to express grief affectively (emotionally) and to seek support.

The counselors in the sample also found differences in the expectations of others and the support men and women received from others. Others expected men to get over their loss more quickly and be able to function more effectively. Women were seen as needing and receiving more emotional support, but others also saw them as being more of a social risk—that is, being likely to break down in normal social situations. The result was that these therapists reported that their women clients received more comfort-oriented support but fewer opportunities for normal social activity than their male counterparts.

Despite these differences in the expression of grief, and the support men and women were likely to receive, the counselors surveyed did not report differences in outcomes. In fact these therapists saw different risks for each gender. In their view,

men were more at risk for certain types of complicated grief reactions, whereas women were more prone to depression or chronic mourning.

Gender-based studies of grief. The perspective of these therapists, explicitly or implicitly, is grounded in much of the research that does show a difference in the ways men and women grieve. In summarizing this research in 1999, Terry Martin and Kenneth J. Doka noted the following:

1. Research has shown that widows and widowers face different problems in grief. For example, many widows reported financial distress and noted the emotional support that had been provided by their spouse. Widowers were more likely to report disruptions of their familial and social networks. Widows were more likely to seek emotional support, whereas widowers found solace in exercise, work, religion, creative expression, or more destructively in alcohol.
2. Many of these same results are evident in the loss of a child. Mothers reported more emotional distress than fathers. Strategies in dealing with the loss differed by gender. Women tended to use more support-seeking and emotion-focused strategies, whereas men were more likely to intellectualize their grief and use more problem-focused strategies to adapt to the loss.
3. Studies of the loss of a parent also showed that middle-aged sons were less likely than daughters to experience intense grief, had fewer physical manifestations of grief, and were more likely to use cognitive and active approaches in adapting to loss.
4. Differences between genders seem less apparent in older age groups. This may reflect the idea that individuals become more androgynous as they age.
5. Differences in gender are also affected by other variables such as social class, generational differences, and cultural differences.
6. The research on differences in outcome is quite mixed. Some studies have shown men to have better outcomes, others show women to do better, and still other studies show no significant difference or mixed

results in outcome (i.e., men do better on some measures, women on other measures).

This research does have implications for counselors. Whether one sees these differences as due to gender or as patterns influenced by gender (see below), it does suggest that different responses to loss can affect relationships within the family as that family experiences a loss. Counselors will do well then to assist individuals in identifying and discussing the ways they deal with loss and in helping families to address how these differences affect each other's grief.

Beyond Gender: Patterns of Grief

Martin and Doka suggested that one look beyond gender to understand different patterns or styles of grief. Martin and Doka proposed that these patterns are related to gender but not determined by them. They suggested that gender, culture, and initial temperament all interact to produce a dominant pattern of grief. They viewed these patterns of grief as a continuum. Martin and Doka further acknowledged that patterns are likely to change throughout an individual's development, often moving more toward the center of the continuum as an individual moves to late adulthood. Based upon the underlying concept of emotion regulation, Martin and Doka proposed three basic patterns of grief: intuitive, instrumental, and dissonant.

Intuitive pattern. Intuitive grievers experience, express, and adapt to grief on a very affective level. Intuitive grievers are likely to report the experience of grief as waves of affect, or feeling. They are likely to strongly express these emotions as they grieve—shouting, crying, or displaying emotion in other ways. Intuitive grievers are also likely to be helped in ways that allow them to ventilate their emotions. Self-help and support groups, counseling, and other expressive opportunities that allow these grievers to ventilate feelings are likely to be helpful.

Instrumental pattern. Instrumental grievers are more likely to experience, express, and adapt to grief in more active and cognitive ways. Instrumental grievers will tend to experience grief as thoughts, such as a flooding of memories, or in physical or behavioral manifestations. They are likely to express grief in similar ways—doing something related to the loss, exercising, or talking about the loss. For example, in one case, a man

whose daughter died in a car crash found great solace in repairing the fence his daughter had wrecked. "It was," he shared later, "the only part of the accident I could fix" (Martin and Doka 1999). Instrumental grievers are helped by strategies such as bibliotherapy (the use of self-help literature) and other interventions that make use of cognitive and active approaches.

Dissonant pattern. Dissonant grievers are those who experience grief in one pattern but who are inhibited from finding compatible ways to express or adapt to grief that are compatible with their experience. For example, a man might experience grief intuitively but feel constrained from expressing or adapting to grief in that way because he perceives it as inimical to his male role. Similarly, a woman might also experience grief in a more intuitive way but believe she has to repress that feeling in order to protect her family. Counseling with dissonant grievers involves helping to identify their inherent pattern, recognizing the barriers to effective expression and adaptation, and developing suitable intervention techniques.

Where men and women are found on this continuum. Martin and Doka suggested that many men, at least in Western culture, are likely to be found on the instrumental end of this continuum whereas women are more likely to be found on the intuitive end. The researchers stressed, however, that while gender does influence the pattern of grief, that pattern is not determined by gender. Martin and Doka also noted that many individuals in the center of the continuum may show more blended patterns, using a range of emotional, behavioral, and cognitive strategies to adapt to loss.

Culture and Gender

It is critical to remember that any discussion of gender differences in grief, or even of patterns of grief that are influenced by gender, must take into account cultural differences. Culture influences grief in a number of ways. First, each culture has norms that govern the ways in which grief is appropriately expressed. In some cultures these norms can differ between genders. In a 1976 study, Paul Rosenblatt and his associates found that in the sixty societies they surveyed, thirty-two had no differences in the expectation of crying between men and women. In the remaining twenty-eight,

women were allowed more emotional expressiveness. Second, each culture defines relationships in different ways, which influences the level of attachment. These relationship definitions may also differ by gender.

See also: GENDER DISCRIMINATION AFTER DEATH; GRIEF COUNSELING AND THERAPY; SUICIDE INFLUENCES AND FACTORS: GENDER

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KENNETH J. DOKA

SUICIDE

The death of a loved one is almost always followed by a period of mourning and bereavement accompanied by many different feelings, including loss, grief, shock, denial, despair, depression, anxiety, helplessness, hopelessness, guilt, shame, relief, and anger. Physical symptoms are also common, among them fatigue, sleep and appetite disturbances, apathy, withdrawal, and agitation. Some scholars have contended that bereavement after a suicide is the most trying of all because of the suicide's presumed emotional suffering and the consequent voluntary decision to die. This factor, with its implication of rejection and desertion, has special impact on some survivors. Moreover, a suicide is often complicated by society's negative reactions toward both the decedent and the family, which make bereavement more difficult.

The variation in scholarly opinion on the nature and difficulties of bereavement reflects different methodological approaches in research in this area, such as the use of appropriate control groups for comparison, variability in kinship comparisons, time elapsed after death, and so on. Mark Cleiren, for example, found more differences between groups compared by kinship, such as parents versus spouses, siblings, or children, than between groups compared by mode of death, such as suicide versus accident, homicide, or natural causes. Nevertheless, many researchers report a greater risk of complicated bereavement after a suicide death than after other kinds of deaths, including less emotional support and more physical illness, depression, and anxiety. Other researchers have concluded that the feelings and reactions of survivors of suicide are really no different from the reactions that ensue from other modes of death and that the differences that do appear are more in intensity than in kind. The psychologist Sheila Clark has described the differences as "both minimal and mythical" and points to the relatively few quantitative differences when outcomes after different modes of death are compared. She argues the importance of dispelling the myth of this difference because she believes that it engenders the expectation of a more difficult bereavement.

The psychologist Albert Cain's early review of the literature, however, found that nearly all of the reports described more severe reactions to suicides, with greater severity of psychopathology and expression of vulnerability. A partial list included reality distortion, massive use of denial, confusion of memory, fantasy and misconception, guilt, a pervasive sense of complicity, rage, a disturbed self-concept, shame and worthlessness, intense frustration of needs, depression and self-destructiveness, incomplete mourning, and a gnawing belief that they might have played some role in precipitating the suicide or that they could have done something more to prevent it.

Survivors of a suicide are typically haunted by the question of "why" and are thus tormented by constant probing, rehearsing last contacts, reviewing all clues, and so on. Depression is probably the most common emotional syndrome of normal bereavement. It becomes pathological when the survivor grows progressively less able to function

and continues to sink further into despair, apathy, and emptiness. Trouble in concentrating, inability to think clearly, negative self-preoccupation, and self-reproach may appear. It is important to distinguish between the sadness of normal grief and pathological depression. One helpful distinction is that the psychiatrically depressed person is more likely to be preoccupied with himself than with the loss of the deceased loved one.

The suicide survivor's feelings of guilt and shame often go unrecognized to the extent that they surface in other emotional guises, such as self-blame, humiliation, failure, and embarrassment. Both guilt and shame refer to individual and social development in relation to oneself and others, and they indicate an awareness of what is deemed virtuous as well as what is deemed criminal and immoral. Shame and guilt have so many elements in common that distinguishing them is often difficult. An important element that helps in the differentiation is the direction of the attention: In shame, the attention is on some defect exposed in the self-image; in guilt, the focus is on the act or behavior and its consequences.

Anger may be more frequent and more intense for survivors of suicide. Many persons find anger difficult to deal with because of social and religious customs that make it unacceptable. The anger is directed in one or all directions—toward decedent, self, and others. The anger may be directed at the deceased because of strong feelings of desertion and abandonment; for his or her not having used or accepted available help, especially from the survivor; for having deprived the survivor of a shared future and forcing the discarding of cherished dreams; and for having left the survivor with a tangle of financial and legal problems. Sometimes the anger is experienced as a violation of trust, a dependency each had invested in the other that leaves the survivor not only bereft in the present but also hesitant to consider commitments in the future.

The anger may appear directed against the health and mental health professions who have failed to prevent the suicide, or it may be directed at their social network if it has withdrawn and offered less support than is ordinarily offered for survivors of a death by accident or natural causes. The anger may be directed at a society that condemns suicide and offers less compassion and

understanding because a taboo has been violated. David Lester remarks that official agencies in the community often function in such a way that it continually reminds the survivor that the death was not a natural one and creates "unpleasant experiences the bereaved are ill-equipped to handle." Anger with religion may occur when it fails to comfort or creates logistical problems during burial services. Anger at God may appear for his having "let" the suicide happen. Sometimes the anger may be directed at oneself for not having seen the "obvious" clues that the suicide was imminent or for not having prevented the death even though the signs were clear.

A suicide affects family members both individually and collectively. To the extent that suicide carries a stigma, many react to it with silence, secrecy, and even distortion (i.e., denial that death was a suicide). Kenneth Doka has called such deaths "disenfranchised" because their taboo status has resulted in social sanctions. As a result, there is reluctance to mourn openly or publicly. There may be scapegoating with accusations and blaming by other members of the family, fear of hereditary factors, anger at the medical and mental health professions, troublesome involvement of the police and insurance investigators, and possible intrusions by press and other media.

Bereavement for Children

The question of whether children can mourn depends on the definition of mourning. The ability to grieve develops as the child first comprehends the finality of death; the timing of this realization is a subject of debate among scholars. Some find it present in young infants, while others have concluded that it does not appear until adolescence. According to one researcher, Nancy Webb, young children can experience sadness, longing, detachment, and rage, but it cannot be considered mourning until the child is able to understand the finality of the loss and its significance. She argues that children of ages nine to eleven are just beginning to view the world logically and thus able to comprehend abstractions and hypotheses, with the full flowering of this ability developing during adolescence.

Karen Dunne-Maxim, Edward Dunne, and Marilyn Hauser feel that children react to suicide



Adolescents may manifest extremes of behavior such as withdrawal and social isolation, while others may become truant, delinquent, and openly aggressive when reacting to a suicide death of a family member or friend. A. TANNENBAUM/CORBIS

deaths with feelings very similar to those of adults but with very different behavior. The symptoms have been likened to those characteristic of post-traumatic stress after a disaster, with clinging and whining in small children, regression and collapse of some of the stages of development, and fears and anxieties about usually comfortable situations or people. Older children may become model children, fearful of any activity that might bring censure, possibly because of fears that they in some way have been responsible for the death. Some may try to become a parent to the remaining parent, trying to fill the gap and to assuage his or her grief.

Children, even when young, should be told the truth about the suicide. Experience has shown that the efforts to keep the nature of the death a

secret usually fail and that the truth, when revealed, is harder to integrate and to accept. Children and young adolescents can construct terrifying fantasies, such as unwarranted guilt for personally causing the death. The inevitable discovery increases the confusion if the secret emerges in childhood; if the revelation occurs in adulthood, the usual reaction is anger at the prolonged deception. The parent is most helpful when reassuring the child with words suitable to age and level of understanding, words that “normalize” the child’s feelings of guilt, shame, anger, or sadness. If signs of emotional disturbance continue, however (i.e., truancy, fighting, exaggerated grief), intervention by a trained child therapist might be in order.

Professional Caregivers As Survivors

Research has shown that therapists whose patients commit suicide often experience the same feelings as family members: shock, numbness, denial, anxiety, shame, grief, guilt, depression, anger, and others. However, there are also feelings that are inherent to the role of therapist: failure, self-doubts about therapy skills, clinical judgment, professional competence, and fear of litigation and professional ostracism. Grief reactions were correlated with the length of time in therapy. The effects of such reactions often led to changes in professional practice, like limiting practice only to patients who were not suicidal, avoiding undertaking treatment of severely depressed patients, hyperalertness to a patient’s suicidal ideas and/or self-destructive behavior, hospitalizing very low-risk patients, putting more inpatients on suicidal precaution, and canceling inpatient passes. For the therapist in training there is the additional stress that may stem from pressures of competition within the group, a feeling of being under constant observation and evaluation, and a desire to win approval from the faculty.

Research on clinician-survivors has been sparse, although it is not an isolated or rare event. Morton Kahne estimated that one out of every four psychiatrists will experience a suicide in his or her practice. Subsequent researchers have reported a frequency of patient suicides for therapists in private practice that ranges from 22 percent to 51 percent. Philip Kleespies found that one out of every nine psychology interns had to cope with a patient’s suicide attempt. The older the psychiatrist

and the greater the years of practice, the less the guilt and loss of self-esteem; for psychologists, there was no relationship between age or years of practice and intensity of reaction.

In-hospital suicide provokes the same feelings and reactions among the staff that have been reported for clinicians in private practice: shock, numbness, denial, guilt, insecurity, and so on. There is the added dimension of the impact on other patients, with anger frequently directed against the staff for not preventing the death and thus causing them to feel less secure and less protected against their impulses. Some showed a marked identification with the deceased and an assumption of inappropriate responsibility for the death.

Grief Relief

Grief, mourning, and bereavement are the natural consequences of the death of a loved one. The loss by suicide adds to the problems and difficulties experienced by the survivors in this process. The basic tasks in the relief of the grief that follows include accepting the reality and pain of the loss, adapting to a life in which the deceased is now missing, and relocating the deceased emotionally and moving on with life. The tasks also include detaching the hopes the survivor had of the loved one and developing a new and different relationship with the memories previously held about him or her.

For most survivors medical attention or psychological treatment is not required. Familial, social, and environmental support, along with personal coping mechanisms and passage of time, will bring about recovery. A small percentage of survivors may experience severe reactions that are crippling, persistent, and disruptive for both family and social relationships. When this occurs, professional treatment is in order. A larger percentage of survivors may experience continuing moderate difficulties in adapting to the loss. In such cases, help may be sought through family, friends, special groups (i.e., Compassionate Friends, Widow-to-Widow), peer and professional grief counselors, individual psychotherapy, group therapy, and suicide survivor groups. Individual psychotherapy with a mental health professional would probably include current information on suicide, descriptions of the grief process, efforts to normalize the

emotional reactions, discussions of disappointing or irritating social reactions, a determination of the survivor's social network and other sources of support, and an attempt to understand the role of any psychiatric illness that afflicted the decedent. The therapist would especially be alert for any evidence of suicidal thoughts and actions by the survivor or anyone in the family.

A survivor may also find help in group therapy led by a mental health professional. In such groups the process occurs within the context of frank discussion of the emotional problems of each member, with the interaction between the members of the group led by the therapist. Other forms of group treatment have been devised especially for suicide survivors. One is a form of family treatment that consists of sending trained nonprofessional volunteers to a family's home after a suicide to provide counseling and support. Another community provided counseling services by telephone along with visits to the home. In still another community a mental health professional accompanied the coroner's deputy so that support could be offered in the initial shock phase of the survivors' grief. Additional contacts occurred for a period afterward, depending on the needs of the survivors.

Probably the most common method for helping adult survivors of the suicide of a loved one is survivor groups in which all the members are survivors of a suicide. Models may be time-limited or continuous, open-ended or closed; they may be varied or limited in kinship, frequency and length of sessions, fees, and leadership (professional, trained survivor facilitators, or mixtures). The basic objective of the survivors' group is to provide a compassionate forum for discussion of the suicide, its impact on the survivors' lives, expression of emotions unique to suicide grief, negative affect, understanding of the grief process, exposure to alternative models of coping, and provision of mutual comfort and support.

Suicide survivor support groups are most often found among the services offered by local suicide prevention centers, crisis service centers, or community health centers. A directory of suicide survivor groups compiled by the American Foundation for Suicide Prevention listed and described 475 groups in the United States. The American Association of Suicidology and the World Health

Organization have published manuals on how to initiate and conduct survivor support groups.

See also: CHILDREN AND ADOLESCENTS' UNDERSTANDING OF DEATH; GRIEF COUNSELING AND THERAPY; LITERATURE FOR CHILDREN; MOURNING

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THEORIES

Theories of grief should deepen understanding of the phenomena and the manifestations of grief. A theory of grief should not merely describe but also explain. It should account for the decline in mental and/or physical health that often attends grief. Most importantly, a theory of grief should further the development of therapies to ameliorate or prevent complicated grief reactions.

Contemporary research on grief has grown out of psychoanalytic/attachment theories and stress/trauma theories. The classic psychoanalytic theory of grief focuses on the emotional reaction to loss (this incorporates a broader range of psychological reactions than depression alone), providing explanation of psychological symptoms of grief. By contrast, a tradition of research on the physical health effects of stress in general led to an extension of the application of stress theory to bereavement. This approach views bereavement as a form of stress that can lead to impairment of health.

Bereavement denotes the situation of losing a loved one through death, while *grief* is the emotional reaction to such a loss and typically involves psychological, physiological, social, and behavioral manifestations of distress. *Grieving* signifies the attempt to come to terms with loss and adapt to it. *Grief work* is the cognitive and/or emotional confrontation with loss, incorporating reflections on events surrounding the death. *Complicated grief* is a deviation from typical grief and grieving, taking cultural factors, the extremity of the particular bereavement event, and the duration of the bereavement into account. Different types of complication have been identified, including an absence of usual symptoms (absent grief), delayed onset of symptoms (delayed grief), or an exaggerated, chronic, more intense, or prolonged emotional experience (chronic grief). There is lack of agreement about how *traumatic bereavement* should be defined. It is useful to limit definition to those bereavements in which the death occurred in jarring, unnatural circumstances. *Mourning* is the social expression of grief actions and grief rituals that reflect one's culture and/or social group.

Psychoanalytic and Attachment Perspectives

Theories falling within the psychoanalytic/attachment framework owe much to Sigmund Freud's paper "Mourning and Melancholia." This approach has remained influential throughout the twentieth century, most notably in the work of major researchers, including John Bowlby, Eric Lindemann, Colin Parkes, Beverley Raphael, and Selby Jacobs, all of whom have developed their own lines of reasoning. According to psychoanalytic theory, when a significant person dies, the bereaved person faces the struggle to sever the tie and detach the libidinal energy (love) invested in the deceased person. The major cause of pathological grief is ambivalence in the relationship with the deceased, which prevents the normal transference of libido from that person to a new object. The psychological function of grief is to free the individual of the tie to the deceased and allow him or her to achieve a gradual detachment by means of a process of grief work. Since Freud, the notion that one has to work through one's grief has been central in major theoretical formulations and in principles of counseling and therapy. However, it has also met with considerable criticism. Dissatisfaction with the "working through" notion has led to further specification of ideas about adaptive coping in contemporary research and theorizing.

Departing in certain important respects from the psychoanalytic tradition, Bowlby's attachment theory emphasized the biological (evolutionary) rather than the psychological function of grieving. He argued that the biological function of grief was to regain proximity to the attachment figure, separation from which had caused anxiety. The observation of grieflike reactions to separation from attachment figures in primates and humans tends to support Bowlby's thesis that these responses have biological roots. It is indeed plausible that an adverse reaction to separation would increase the survival chances of animals that live in herds because predators tend to attack animals that are separated from their herds. Obviously, regaining proximity is not possible in the case of permanent loss, and such a response is therefore dysfunctional. Bowlby also argued for an active working-through of a loss. Like Freud, Bowlby saw the direct cause of pathological grief in the relationship with the lost person. However, the more distant cause was said to be childhood experiences with attachment figures—whether the child had been

securely or insecurely attached to the primary caregiver. Insecure attachment is assumed to result from parental rejection in childhood. These influences were assumed to have a lasting influence on later relationships. Unlike insecure individuals, secure individuals would be expected to display normal or healthy grieving, experiencing and expressing emotions to a moderate degree and being able to provide a coherent, balanced account of their loss-related experiences. Following this line of reasoning, there are effects of attachment orientation on ways of grieving.

The attachment theory has fostered much useful scholarship. John Archer has further examined the origin and adaptive significance of grief, deriving arguments from theoretical principles of modern evolutionary theory. He applied the principles of natural selection, reproductive value, and parental investment to grief, reasoning that these determine the strength of the relationship with the person who has died. This line of research provides predictions about patterns of grief toward different kin and at different ages for parent-offspring and offspring-parent grief.

By contrast, Simon Rubin has probed the relationship with the deceased person, specifically, a deceased child, in his two-track model of bereavement, in which intense preoccupation with the deceased sets the bereavement response in motion. Two tracks refer to related but not identical dimensions of loss: relationship and functioning. Track I describes the biopsychosocial reactions, or how people function in families and how this changes. Track II focuses on transformations in the attachment to the deceased, suggesting a dynamic mechanism in attachment.

Stress Perspectives

Cognitive-stress and trauma theories have proved most fruitful in investigations of bereavement. Stress theories are applicable to a broad range of life events (i.e., loss of a job, relocation, divorce), while trauma theories pertain more specifically to shocking, out-of-the-ordinary events (i.e., victimization, war, traffic accidents, violent bereavements). A basic assumption is that stressful life events play an important role in causing the various somatic and psychiatric disorders.

Cognitive stress theory, which emerged from the broader field of the psychophysiology of stress,

views bereavement as a source of serious stress that can endanger health and well-being. An individual's cognitive appraisal of the event (relating situational demands to available coping resources, like social support) determines the extent to which the bereavement is experienced as challenging or stressful. Cognitive-stress theory thus emphasizes the role of cognitive appraisal in adjustment to loss; it is a variable that is similar, though not identical, to subsequent "meaning-making" conceptualizations. Cognitive-stress theory provides a framework for a fine-grained analysis of the characteristics of the stressor (bereavement) itself, the coping process (styles, strategies such as confrontation versus avoidance and emotion versus problem-focused) and outcomes (well-being and mental and physical illness). It offers a theoretical explanation for the health consequences of bereavement and provides the theoretical basis for the so-called buffering model. According to this model, high levels of social support protect (buffer) the individual from the health risks of stress. Stress research has helped identify physiological mechanisms linking stress to various detriments to the immune, gastrointestinal, and cardiovascular systems.

A number of bereavement-specific stress-coping models have been developed that have (a) led to further specification of cognitive tasks and processes in coming to terms with bereavement, and/or (b) increased the emphasis on the impact of others on individual grief. These types of analysis form much of the basis of contemporary theorizing about bereavement. William Worden's, and Colin Parkes and Robert Weiss's task models were among the first to specify the prerequisites for coping with loss during bereavement. Worden's model represents coping with bereavement as an active, demanding process rather than an event to be passively experienced. He describes four tasks, which include accepting the reality of loss, experiencing the pain of grief, adjusting to an environment without the deceased, and relocating the deceased emotionally. Parkes and Weiss described three somewhat different tasks such as intellectual and emotional acceptance of a loss and forging a new identity.

Other investigators have focused on the way that the loss is appraised (e.g., whether these are guilt feelings or regrets and whether there is dwelling on or avoidance of grieving. Significant

theoretical developments have emerged from this work. For example, George Bonanno identified so-called dissociation between psychological and physiological reactions during episodes of disclosing emotions after bereavement. He showed that some persons who did not disclose verbally, thus suggesting denial, showed evidence of grief in high physiological arousal. In the long term, this pattern of dissociation was associated with good adjustment. This appears to contradict the idea that grief work helps and that denial is dysfunctional.

Alicia Cook's and Kevin Oltjenbrun's model of incremental grief examines the impact of others on individual grief. This describes how lack of congruence in grieving among bereaved persons (particularly families) leads to secondary loss, changing the relationship between survivors, and precipitation of further loss (e.g., breakup). Further specification of interpersonal influences on cognitive processing is provided in social construction models. Basic to this approach is the understanding that grieving is a process of meaning reconstruction, which is frequently negotiated between grieving family members and/or becomes established within the cultural context. This type of approach includes Robert Neimeyer's meaning-reconstruction model. According to Neimeyer, meaning reconstruction, which entails an understanding of the significance of the loss, is the central process of grieving, evidenced in six "propositions." Each of these propositions describes a type of cognitive process that affects the way a bereaved person adjusts to loss. For example, one of the propositions focuses on the way in which identities are reconstructed in negotiation with others. This proposition is based on the understanding that individual adjustment is affected by the way that grieving is done within its social context. Tony Walter's new model of grief focuses on the social context in a slightly different manner. Walter explains how biographies about deceased persons are created as the bereaved talk to each other about their loss and negotiate meaning and reality as part of the process of grieving. When a durable biography has been derived, such as when the grieving family members come to agree on the interpretation of the death, then the bereaved can find a place for the deceased, move on, and stop grieving. There are good reasons to argue that these meaning-reconstruction models are complementary to the cognitive-stress approaches. Among

the advantages of attempting integration of these perspectives is that combination would force understanding of grief within its personal, social, and cultural context.

Although trauma theories can be considered within a general stress framework, as noted above, they are more specifically directed toward understanding the impact of those events that are especially jarring and horrific. Trauma theory has emerged along three independent lines. Mardi Horowitz has analyzed phenomena in terms of “stress response syndromes”; the work of James Pennebaker has focused on disclosure in trauma management; and Ronnie Janoff-Bulman and Colin Parkes have both developed the conceptualization of “assumptive world views.” Common to these three perspectives is the notion that although the traumatic event itself has passed the person remains affected and still suffers psychologically and, perhaps, physically. The event needs to be assimilated, and/or inner representations accommodated, before the person can function normally again.

According to Horowitz, “Negative stress stems from experience of loss or injury, psychological or material, real or fantasized. If action cannot alter the situation, the inner models or schemata must be revised so that they conform to the new reality” (1979, p. 244). Control processes regulate the working-through process, which is often marked by a battle to fend off the intrusion of disturbing thoughts. Intrusion is the compulsive re-experiencing of feelings and ideas surrounding the event, including sleep and dream disturbance. Avoidance is the counterreaction, often involving amnesia, inability to visualize memories, and evidence of disavowal. Horowitz views the stress-response syndrome as a normal human reaction to traumatic events, one that can balloon into the more severe form of posttraumatic stress disorder.

Pennebaker has explored the role of emotional disclosure and sharing in assuaging the impact of traumatic experiences such as bereavement. The experimental research of Pennebaker and his colleagues showed that health benefits resulted from writing about traumatic events. Although these beneficial effects have been demonstrated for a wide range of traumatic experiences, the evidence is weaker in the case of normal bereavement. Pennebaker suggests that the benefit of written disclosure lies in helping the individual to organize

the experience, to clarify his or her psychological state to others, and to translate emotional experience into the medium of language.

Like Pennebaker’s approach, Janoff-Bulman’s is most applicable to traumatic bereavements. She emphasized the role of meaning in recovery, describing the changes in assumptive worldviews that occur following traumas. Fundamental assumptions people hold about themselves and their relationship to the world can be shattered by the death of a loved one. People normally hold the view that they are worthy, that the world is benevolent, and that what happens to them makes sense. With these assumptions shattered, the bereaved person struggles to integrate the experience. The process of achieving this integration involves rebuilding the inner world, re-establishing meaning, adjusting old assumptions, and/or trying to accept new ones.

Parkes’s psychosocial transition model is comparable in many respects to the model of Janoff-Bulman’s because he also argues for a gradual changing of assumptions and one’s internal model of the world. He specifies components in the process of changing assumptions, including preoccupation with thoughts of the lost person, painful dwelling on the loss, and attempts to make sense of it, either by fitting the experience into existing assumptions or by modifying those assumptions.

Stephen Fleming and Paul Robinson have analyzed how the process of meaning-making can go wrong and how it is possible for clinicians to use principles of cognitive behavior therapy for complicated grief. A bereaved person’s distress may be perpetuated in a cognitive-affective loop, in which beliefs (e.g., about the bereaved’s own responsibility for an accident causing the death) play on the emotions, which in turn prevent reconstruction of beliefs. They also cover the issues of attachment to the deceased, traumatic grief complications, and the impact of counterfactual thinking (the generation of imagined alternatives to actual events) on grieving.

Two Integrative Models

George Bonanno’s and Stacey Kaltman’s four-component model is an example of contemporary attempts to synthesize current research into an integrative model. These investigators describe

several components as fundamental in the grieving process and suggest ways in which they may interact during bereavement: (1) context of loss, risk factors such as type of death, gender, and cultural setting; (2) the continuum of subjective meanings associated with loss, appraisals of everyday matters as well as existential meanings; (3) the changing representations of the loss relationship across time, including the persisting bond with the deceased; and (4) the role of coping and emotion-regulation processes that can relieve or aggravate the stress of the loss. Emotion-regulation research has provided a theoretical framework to understand how adjustment in bereavement could be enhanced. The general theory suggests how the regulation or even dissociation of negative emotions and enhancement of positive emotions may foster adjustment to bereavement and, likewise, enable identification of spontaneous or automatic processes in grieving.

Margaret Stroebe and Henk Schut have attempted a different type of integration in their dual-process model of coping with bereavement. The dual processes refer to two different types of stressors: those associated with the lost person, so-called loss orientation, and restoration orientation, those associated with the secondary upheavals that are also consequences of bereavement. The focus of attachment theory on the nature of the lost relationship is consistent with loss orientation. Similarly, cognitive stress theory's identification of a range of substressors suggests the need to include the additional tasks of restoration orientation in the model, because these too are associated with distress and anxiety. For example, it may be necessary to acquire new skills (e.g., cooking or dealing with finances) that had been the domain of a deceased spouse. The model suggests that coping with the two types of stressors is a dynamic and fluctuating process, labeled "oscillation," that incorporates confrontation and avoidance of different components at different times, and includes both positive and negative reappraisals. For example, at any one moment a bereaved person may be dealing with new tasks (restoration-oriented) and feeling good about mastering these, only to be interrupted by a piece of music, perhaps, that is a reminder of the deceased (loss-oriented) and that brings on feelings of sadness. This perspective integrates the processes identified by Folkman and Nolen-Hoeksema, and is also consistent with Bonanno's emotion-regulation component.

Conclusions

Theorizing in the field of bereavement is still marked by a pluralism of approaches, but attempts at integration have begun. Investigators are also looking more to related bodies of research such as emotion theory to derive sound theoretical and empirical hypotheses. Further probing of the biological bases of grief and grieving is needed. Likewise, broadening of theoretical interest from the single stressor of bereavement to a general psychology of loss, focusing on diverse phenomena, could encourage the formation of general principles. Nevertheless, the understanding of grief has deepened significantly during the past few decades, in part because of the theoretical grounding of fine-grained empirical research on social and cognitive processing.

See also: CONTINUING BONDS; FREUD, SIGMUND; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; MOURNING

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TRAUMATIC

Traumatic grief is defined as profound emotional trauma and separation distress suffered after the death of a loved one. It includes yearning, searching for the deceased, and excessive loneliness resulting from the loss. Traumatic loss sometimes happens when a death is sudden, unexpected, preventable, or of a child. Traumatic loss shatters the bereaved person's worldview, leaving him or her feeling overwhelmed and helpless.

Diagnostic Considerations

There are four diagnostic criteria for traumatic grief: (1) Traumatic grief occurs after the death of a significant other and includes distress that intrudes into the victim's consciousness; (2) traumatic grief lasts at least two months; (3) traumatic grief symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning; and (4) traumatic grief includes eleven marked, persistent symptoms that include behaviors, thoughts, and emotions. These symptoms reflect the bereaved person's feelings of devastation as a result of the death. Behaviors include frequent efforts to avoid reminders of the

deceased (e.g., thoughts, feelings, activities, people, and places); and displaying excessive irritability, bitterness, or anger related to the death. Thoughts include purposelessness or feelings of futility about the future; difficulty imagining a fulfilling life without the deceased person; difficulty acknowledging the death; and a shattered worldview. Emotions include a subjective sense of numbness, detachment, or absence of emotional responsiveness; being stunned, dazed, or shocked; a sense that life is empty or meaningless; and feeling that part of oneself has died. Traumatic grief does not refer to the cause of the disorder or aspects of the death, but rather to the bereaved person's actual experience.

Two related forms of grief are delayed grief and complicated grief. Delayed grief is not apparent initially, but appears within the first six months of bereavement. Delayed grief might be particularly difficult to diagnose. Complicated grief occurs at least fourteen months after the death. The scholars who constructed this definition avoided twelve months because anniversaries often cause intense turbulence in the bereaved individual. Complicated grief includes intruding thoughts or avoidance behavior that is severe enough to interfere with daily functioning. The intruding thoughts may include unbidden memories or fantasies about the lost relationship, strong spells of severe emotion related to the lost relationship, and distressingly strong yearnings for the deceased. The avoidance symptoms include feeling far too alone or personally empty; excessive avoidance of people, places, or activities that remind the bereaved of the deceased person; unusual levels of sleep disturbance; and loss of interest in work, social activities, care taking, or recreational activities. These symptoms last for at least one month.

There are several differences between traumatic grief and complicated grief. One difference is in the duration of symptoms. For traumatic grief, the duration is at least two months, with no specification about the time since the death. For complicated grief, the duration is only one month, and the grief occurs within fourteen months of the bereavement. Another difference is in sleep disturbance. Only complicated grief includes sleep difficulty, which may be a result of the person being overly aroused. A third difference is that traumatic grief includes symptoms that reflect the devastation in the bereaved person's life caused by the death.

There are no closely related symptoms in complicated grief.

Although they are related, traumatic grief is distinct from depression, anxiety, separation anxiety disorders, and posttraumatic stress disorder (PTSD)—anxiety that develops when a person has a traumatic experience. Traumatic grief occurs among a significant minority of bereaved individuals, and lasts several years.

Origins

Persons who develop traumatic grief might do so in two ways. One way involves death that is sudden and violent, as in natural disasters, accidents, and criminal violence. The bereaved person might develop problems feeling close to loved ones because of a pervasive change in his or her view of the world, even when he or she was not vulnerable in the first place. In this case, in addition to traumatic grief, the bereaved person might also develop PTSD, as well as other psychiatric disorders. A second way involves loss of a significant other for a person with a vulnerable attachment style. The vulnerability might be the result of inherited characteristics, early nurturing experience, or some combination of the two. The person who was already vulnerable might develop other psychological disorders as well as traumatic grief.

An example of traumatic grief could be a mother who lost a beloved son in the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City. This mother makes strong efforts to avoid going through her son's belongings, and has excessive anger and bitterness about the death. Cognitively, she has no purpose, and has difficulty imagining a fulfilling life without her son, or even acknowledging his death. Her worldview is shattered. Emotionally, she feels numb and shocked that part of her life has died. Overall, she feels that life is empty or meaningless. These symptoms last for several months.

Another example of traumatic grief could be a father whose daughter is killed in an automobile accident, and whose mother dies six months later. He does not grieve immediately after the death of his daughter because he concentrates on caring for his sick mother. When his mother dies, both deaths "hit" him. Now, he is in a state of disbelief. Indeed, his chief complaint is that he still cannot believe what had happened. He feels overwhelmed by the

losses. He obsesses over the details of the daughter's accident, and can think of little else. He has frequent episodes of crying, provoked by any reminders of his daughter or mother. His work performance suffers, and his relationships with the rest of the family deteriorate. He feels useless to himself and others, at least partly because much of his life had been devoted to being a good father and son. He loses a sense of security, and no longer trusts the world he now views as unpredictable. These problems persist for the six months since his mother's death, and he dreads the anniversary of his daughter's death.

Clinical and Research Literature

Grief counseling has proliferated in the last decades of the twentieth century. Professionals provide conferences and workshops on grief. Institutions and communities provide programs for bereaved individuals conducted by grief therapists, or operated on a mutual support basis by lay leaders. Journals that publish research about grief include *Death Studies*, *Omega: The Journal of Death and Dying*, *Journal of Loss and Trauma*, and *Suicide and Life-Threatening Behavior*.

One thorough research project by Gabriel Silberman and colleagues that was published in *Psychological Medicine* looked at the quality of life among sixty-seven adults widowed four months earlier. Those with traumatic grief reported significantly impaired quality of life, more so than persons with major depression or PTSD. Another research project by Holly Prigerson and colleagues, published in the *American Journal of Psychiatry*, focused on a vitally important aspect of traumatic grief—suicidal ideas. Among seventy-six young adults who had a friend commit suicide, those with traumatic grief were five times more likely to consider suicide themselves compared to those who were depressed. Still other research has shown that violent deaths, more than anticipated deaths, lead to problems for bereaved persons. For example, reviewing a broad selection of different research projects on bereavement, George Bonanno and Stacey Kaltman in 1999 concluded that adults whose spouse died unexpectedly (i.e., from suicide, homicide, or an accident) experienced PTSD at a higher rate than those whose spouse died of natural causes (e.g., cancer, congestive heart failure). Apparently, violent deaths may not only lead to the development of trauma reactions, but they

also tend to exacerbate the more general grief response. Traumatic grief is different from other disorders and from general grief.

One major research project on grief analyzed twenty-three separate studies of bereaved persons. In each project, some participants were randomly assigned to receive some form of psychosocial intervention (psychotherapy, counseling, or facilitated group support). Others were randomly assigned to a control condition. Overall, treatment helped: Those who received treatment recovered more than those in the (nontreated) control group. However, the difference was small, which suggests that most people were helped, but some were not helped.

One reason for this finding could be time. Those people whose loved one died some time ago recovered more than those whose loved one died recently. Another reason could be age; younger clients fared better than older ones in grief therapy. Still a third reason could be the type of bereavement. Grief counseling for normal grievers had essentially no measurable positive effect, whereas grief counseling for traumatic grief was helpful. Apparently, grief therapy is particularly suitable for mourners experiencing protracted, traumatic, or complicated grief reactions. Conversely, grief therapy for normal bereavement is difficult to justify.

Theory

A useful theory to treating traumatic grief focuses on making meaning in the aftermath of bereavement. A counselor who uses this perspective might help a bereaved daughter to see that her father had lived a full life or accomplished his last major goal before he died. This daughter might find meaning in the fact that her father's life had some purpose, or had come full circle. This perspective to treating traumatic grief is different from a medical model, which might emphasize controlling the symptoms such as crying spells or depression. This approach is also different from the vague though well-intentioned assumption that sharing feelings in a supportive environment will promote recovery. Sharing feelings might help, but making meaning is an added step that involves reconstructing one's individual, personal understanding.

Supporting this view, one study found that for 70 to 85 percent of persons who experienced a

sudden, potentially traumatizing bereavement, the search for meaning played a compelling role in their grief. A significant minority, however, apparently coped straightforwardly with their loss, without engaging in deep reflection about its significance. For those who seek meaning and find none, the loss can be excruciating. These people report suffering intensely on a variety of dimensions. Conversely, bereaved persons who find a measure of meaning in the loss fare better, rivaling the adjustment of those who never feel the need to undertake a quest for meaning in the first place. In addition, many of those who find answers as to why the loss occurred revisit these answers in the months that follow.

Related to this emphasis on meaning is the assumption that describing one's thoughts and emotions about the traumatic grief promotes cognitive restructuring. Sharing with others allows bereaved individuals to restructure the difficult aspects of the loss, to explore ways of viewing themselves, and to regulate their own distressing emotions and bodily reactions.

Suggestions for Fostering Recovery

Traumatic grief does not respond to psychotherapy that is focused on interpersonal adjustment such as how the person gets along with others, whether or not this therapy includes antidepressant medicine. However, therapy that is oriented toward helping bereaved persons develop insight about their own lives, or to change their thoughts and behaviors, can be effective for those suffering from traumatic grief. Successful therapy includes a genuine, empathic, and compassionate relationship with the therapist and education about the bereavement.

Specific therapy for traumatic grief would focus on separation and traumatic distress. Treatment would include educating bereaved individuals about this type of distress, and helping them cope with it. Treatment would also include working with the person to lessen the distress in the first place. In addition, therapy should help the bereaved person to adapt to the new status caused by the bereavement and to the new roles required by that status.

Further, therapy would recognize that a quest for meaning plays a prominent role in grieving, at least for those who are bereaved by the sudden death of a loved one. When a bereaved person is

struggling for significance in the loss, a counselor should facilitate this process. Grief counselors should be cautious, however, about instigating a search for meaning in the minority of bereaved persons do not spontaneously undertake such a search. These individuals might be coping adaptively already. Further, making meaning is more an activity than an achievement. Early, provisional meanings of the death tend to be revisited as the reality of living with loss raises new questions and undermines old answers.

Simply disclosing oneself to others may or may not be helpful, depending in part on the receptivity of would-be listeners. Some potential listeners may be overwhelmed by repeated communication of intense negative states, such as sadness or distress. Talking to them about feelings may drive away people who might otherwise offer some interpersonal support. Therefore, bereaved individuals need to be selective in the persons with whom they share their thoughts and feelings.

A public ritual such as a funeral or memorial can offer powerful closure for traumatic grief. Other approaches include letter writing to the deceased person and/or empty chair work—going through an exercise in which one imagines the deceased person to be sitting beside him or her in an empty chair, talking to the person as if they were still alive. Several useful procedures revolve around the concept of forgiveness for both self and others.

See also: DISASTERS; GRIEF COUNSELING AND THERAPY; SUICIDE; TRIANGLE SHIRTWAIST COMPANY FIRE

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LILLIAN M. RANGE

GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE

Most contemporary writing about grief and mourning is based on research with people living in twentieth-century North America and Western Europe. The research uses theories and methods that grew from the same geographical area and historical period. Although reports about mourning and grief have come from many cultures, there is no consensus among bereavement scholars about what concepts explain the most about the ways in which individuals and communities respond to death in different cultures. The question here is: How might scholars develop more cross-cultural concepts of grief and mourning that can describe the thoughts, emotions, interpersonal interactions, myths, and rituals that follow significant deaths in other times and places?

Grief Varies with Culture

Cross-cultural study looks outward, seeking an opening to the varieties of cultural expression around the world; but it also looks inward, because an understanding of others can enrich our understanding of our own culture. All people are shaped to some extent by the culture into which they are born. The human expression of grief is no less a product of culture than marital or religious customs or symbols.

Many writers make a distinction between grief and mourning, saying that grief is a subjective state, a set of feelings that arise spontaneously after a significant death, whereas mourning is a set of rituals or behaviors prescribed by culture's tradition. In this distinction, thought, or cognitive meaning, is largely absent from both grief and mourning because the former is mostly feelings and the latter mostly action.

But this distinction between grief and mourning does not hold up to cross-cultural scrutiny. The concept of grief is an artifact of modernity. Grief as a real subjective state grows from a culture that prizes and cultivates individual experience. There is no equivalent to the term *grief* in some other languages; indeed, in some cultures, as in Japan, the concept of emotions that are only in the individual seems foreign. For the Japanese, individual identity is a function of social harmony. Emotions are part of family or community membership, sensed among the members so as to create a harmonized atmosphere.

The term *mourning* does have a Japanese equivalent, *mo*, which refers both to the ritual responses to death and the emotions—commonly defined in the West as “grief”—that attend them. *Hitan*, the Japanese word that comes closest to the English word *grief*, means “sadness and sorrow,” but the word does not imply that the emotions were brought about by death or loss. *Hitan* cannot be used in a way that refers to a self-evident inner reality. One translation into Japanese of the English phrase “She was in grief” might be “*Kanojyo-ba bitan no naka ni iru*,” (“she grief of inside being there”), but that is not a complete sentence. A complete sentence might be “*Kanojyo-ba bitan ni sizundeiru*.” (She grief to sinking.) An infinitive like “to sink” is needed because in Japanese *Hitan* cannot be a complete state on its own. With no

Japanese word available, writers introducing Western psychological ideas have transliterated *grief* as *guri-fu*. A rather simple bit of cross-cultural research is to ask how the English concepts of grief and mourning are translated in other languages and to look at how different words may change the way people might think about grief.

Grief As an Instinct

At the biological level it might seem that grief is universal. In every culture people cry or seem to want to cry after a death that is significant to them. Grief, then, could be conceived as an instinctual response, shaped by evolutionary development. Perhaps animals grieve. Primates and birds display behaviors that seem similar to humans' in response to death and separation. Instinctual response in this sense is a meta-interpretative scheme programmed into our genetic inheritance, much as nest building or migration is hard-wired into birds. The response is aroused by the perception of specific situations (i.e., harm, threat, success or failure, and breeding opportunities). Culture, of course, influences how people appraise situations, yet similar perceptions of events trigger similar instinctual responses. A significant death, then, might be regarded as a universal trigger of grieving emotions, although which death is significant enough spark such a response depends on the value system of a particular culture. Universal instincts, then, might provide the basis for concepts that could explain behavior in all cultures.

The model of grief based on the attachment instinct, propounded by John Bowlby and his followers, has generated a large body of research and advice for clinical practice. In this theory, a significant death triggers a response much like that which a child feels upon separation from his or her mother. First the child protests and tries to get back to the mother. Then the child despairs of returning to the mother but remains preoccupied with her. Finally the child loses interest in the mother and is emotionally detached from her upon her return. Grief after a significant death, this theory holds, follows the same preprogrammed sequence of behaviors. Attachment is instinctual behavior that has survival value because it keeps the child in close proximity to the mother for protection from predators. Humans are attached to individuals all through their lives. When they die, individuals



In Calexico, California, mourners attend the memorial service for a United Farm Workers (UFW) migrant worker who was killed at a lettuce farm during a strike to protest working and living conditions for migrant farmers. This kind of death may trigger questions for survivors, such as what does my life mean now that the person is dead? And what hope is there for our community? STEPHANIE MAZ/CORBIS

experience separation and loss, and so must reorganize their attachments to match the new reality. From observation one knows that human children develop different styles of attachment, depending on the mother's bond with the child. Some bereavement research indicates that attachment styles in childhood predict bereavement style in adulthood. Attachment theorists have claimed that attachment is biological and, though influenced by culture, nonetheless functions similarly in all cultures; therefore, attachment theorists claim, the attachment instinct undergirds a cross-cultural model of grief.

But attachment alone is not a sufficient basis for a meta-interpretative cross-cultural comparison. First, there is little cross-cultural research on attachment: "Core tenets of attachment theory are deeply rooted in mainstream Western thought" (Rothbaum

2000, p. 1094). Until experts can specify which attachment behaviors of parents and children are universal, which are cultural, and how both universal and cultural attachments behaviors are observed in grief, a cross-cultural theory based on attachment remains elusive.

Moreover, the template used in attachment bereavement theory is young children's responses when separated from their mothers. In grief, the theory holds, adults are all like children seeking reunion with the deceased person. The theory does not consider that as people mature their attachments become broader. The young child knows himself only in relationship with the mother. As the child matures, each level of social membership or identity is also an attachment (e.g., clan, village, tribe, nation, religious tradition). At each level, separation becomes a less plausible

explanation for grief because attachments to individual people become interwoven with social systems and cultural meanings that cannot be reduced to biological inheritance. In the individualistic culture of the modern West, with its eroding attachments to larger social systems, primary social relationships are limited largely to monogamy and the nuclear family. Such individualistic relationships approximate but do not duplicate the mother-child bond, so the latter is of limited value in explaining the former.

Death may arouse instinctual responses other than those that are labeled “grief” in Western culture. Some deaths in Western culture, for example, arouse a trauma response. It may be that the trauma response is as universal as the separation response in attachment. Trauma and loss are different meta-interpretative schemes. In the West, some deaths are traumatic; some traumas are not death; and some deaths are not traumatic. In modern Western culture, rape evokes a response similar to that of a traumatic death. Other cultures may have meta-interpretive schemes that apply to death (revenge, submission, and so on) but may not apply in the modern West. In traditional Chinese culture, for example, death presents the problem of pollution. One of the purposes of funeral rituals was to protect men from pollution while women took the pollution on themselves, thereby purifying the deceased for the next life. Whatever meta-interpretative schemes, other than mourning, are aroused by death, or by a particular death, would seem to be culture-specific, though the emotions aroused would be similar to those aroused when the meta-interpretative scheme was evoked in other circumstances. Death presents pollution or powerlessness in some cultural contexts as much as it presents separation, loss, and sometimes trauma in the modern West. As scholars develop a cross-cultural theory based on instincts, they will need to give as much attention to other instincts as they have given to attachment and trauma.

At a symbolic and metaphoric level, death is used to understand other realities in human life. One way to identify the instincts evoked by death might be to investigate a culture’s use of death as a metaphor. For traditional Chinese women, for example, death was like marriage. In the West the concept of grief is applied to other separations and losses, such as divorce, and to other traumas, such

as home invasion. Clearly the meanings ascribed to death in all cultures are not limited to separation, loss, and trauma. Students who are familiar with another culture might ask, “On what other occasions are themes from bereavement applied?”

Grief As Finding Meaning

Beyond instinctual responses lies the realm of thought or meaning, which has been excluded from many definitions of both grief and mourning. When a significant person dies, the issue of meaning is central for the survivors: What does this death mean? What does this life mean? What did this person mean to me and to this community? Western individuals who successfully come to terms with a traumatic death may change how they think about themselves, how they relate to others, and how they view life in general. Changes experienced by individuals in other cultures might be just as wide-ranging but cover spheres not experienced in the West.

The task of meaning making is done in the interchange between the individual and the culture. An individual seeks to make sense of his or her experience using cognitive or mental models that are supplied by that individual’s culture. When modern Western people look at sickness, for example, they see it in terms of germs and viruses. People in other times and places might have seen sickness in terms of witchcraft or magic. The movement between cultural models and mental models goes in both directions. Cultural models are objectifications formed over time from the inner experiences of a group of individuals in a community. Cultural forms, including models of grief, change as individuals in the culture accommodate their cognitive models to make sense of the deaths in their lives. Cross-cultural research in grief, therefore, may include studies in the same culture at different times in order to understand the factors that influence the changes.

The constructivist model grounds grief both in the interplay between cultural meaning and individual meaning and in concrete interpersonal relationships. By contrast, in attachment theory, the purpose of grief is to reconstruct the autonomous individual, who, in large measure, leaves the dead person behind in order to form new attachments, which he or she accomplishes by working through

and resolving negative feelings. Grief is conceptualized as an innate process that, if allowed to run its course, will bring the survivor to a new equilibrium in a changed world that no longer includes the dead person.

In the constructivist model the purpose of grief is the construction of durable biographies—individual and social narratives—of the dead person and of the survivors that enable the living to integrate the dead into their lives. Narratives are stories. People make sense of their lives by telling a story that makes sense of their past and present experiences. Whether they are aware of it or not, people have an autobiography that they are constantly revising in light of new experiences. If something like an important death does not make sense, it is “nonsense.” Both individuals and societies want to keep seeing the world the same way, but sometimes death forces one to see the world differently. When an individual sees the world differently, he or she constructs a new narrative, a new biography of themselves and of the person who has died.

In the constructivist model, the process by which people make sense of their world is social interaction. When something important happens in individuals’ lives, they do not just think about it; they talk about it with others. Grief and mourning do not just happen inside a person; they happen in the interactions between people. In most cultures over human history, myth and ritual provide the intersubjective space in which one can construct the meaning of the deceased’s life, death, and influence over the survivors’ lives. In contemporary Western culture, in which rituals and myths from earlier times have fallen into disuse, intersubjective space is characterized by informal verbal and nonverbal interaction aimed largely at communicating shared meaning. Often people see contemporary communities constructing their narrative by inventing new rituals that allow community members to feel a sense of togetherness.

Narratives, of course, are maintained within different kinds of social systems. Differences in mourning behavior might be attributable to structural differences in societies. It appears that mourning in small, closely knit societies is different from mourning in large, more loosely knit societies in which primary membership is in the nuclear family. In small networks such as a rural village, members

identify with people outside the nuclear family. When someone dies, people find substitutes for the deceased in their immediate social environment. For example, many adults already care for a child in a small network, so when a parent dies, other adults can easily move into the parent role. Death disrupts the social structure of small networks, so mourning rites focus on rehabilitating the damaged role system by reallocating roles. For example, when the elder dies, someone must be moved into the role of elder. In more complex, loosely knit networks, such as in an industrialized city, most individual deaths do not significantly affect the larger social system, so grief loses any larger social meaning and becomes a matter of individual family and psychic readjustment. As scholars move toward cross-cultural concepts, they might study grief in villages and cities in the same cultural tradition before asking whether or how grief and mourning are different in different cultures.

Each level of social system maintains narratives—individual narratives, family narratives, community narratives, media narratives, subculture narratives, and cultural meta-narratives. Each level of social membership is also a kind of attachment. Narratives from higher-level systems provide the materials from which the narratives at lower levels can be constructed. The narrative at any level is constrained by the structure of the level or levels above it. For example, the narrative in the family limits the narrative in individual constructs, and the narratives of the culture and religious traditions to which the family belongs limit the family narrative. Contemporary Western culture evinces a relative freedom of the individual from the constraints of cultural narrative. The price individuals pay for such freedom is a sense of inner loneliness that sociologists call “anomie.” One point of cross-cultural comparison is the degree of cultural or religious narrative constraint on individuals and families in their attempt to form their own meaningful response to a significant death.

Constructivist theory allows a definition of relative “normality” of grief within various cultural contexts. When the narratives are congruent within and between levels, grief may be stressful, but is not problematic. Grief becomes problematic when there is an incongruence of narratives within a level (e.g., an individual who is unable either to accept or reject contradictory stories). Did she die because it was God’s will or because the doctor

made a mistake? Grief also becomes problematic when narratives at different levels of the hierarchy are incongruent (e.g., when individual's thoughts and emotions are incongruent with the family's understanding of what thoughts and expressions of emotion are acceptable).

A community's grief becomes problematic to itself when there are contradictory or incongruent narratives, such as when there is a disagreement about whether the high school students who kill themselves after they have killed other students should be memorialized along with those whom they killed. A community's grief becomes problematic to other communities when the narratives are incongruent; for example, a gang's revenge narrative can be in conflict with the larger culture's narrative of the "rule of law" in which only the state can define and punish wrongful death.

The Grief Police

When an individual and family grieve within larger social narratives, larger political dynamics are in play. Society polices grief; it controls and instructs the bereaved about how to think, feel, and behave. All societies have rules about how the emotions of grief are to be displayed and handled. In some cultures, for example, those who grieve should talk to the dead, and in other cultures the name of the dead should never be spoken. Such coercion is, of course, a top-down matter. Those who do not conform to the social expectations are labeled aberrant. In contemporary psychotherapeutic culture, aberrant grief is deemed pathological. In other cultures the labels would be different—counterrevolutionary in communist cultures, sinful or idolatrous in monotheistic religions.

One cross-cultural project seeks to compare the rules about the emotional expression of grief. Anthropologist Unni Wikan, for example, compared the rules in Egypt and Bali, both Islamic cultures. She found that in that in Bali, women were strongly discouraged from crying, while in Egypt women were considered abnormal if they did not incapacitate themselves in demonstrative weeping.

When people understand that every society polices grief, they can use several cross-cultural studies that are otherwise misleading. The most common mistake in cross-cultural study of grief is to confuse the official worldview of the culture, its

dominant mythology or theology, with what individuals in the culture actually do. Research on grief and mourning is descriptive: people describe what they do, but official theologies are prescriptive—they dictate patterns or norms of behavior. In the cross-cultural study of grief, it will not do simply to explicate the beliefs of the culture's religious tradition as if those beliefs described the lived experience of individuals and communities. The stated beliefs of a culture are often the rationale for the rules by which grief is policed; they are often merely the directives for public performances that may or may not really express the mourners' private thoughts and feelings. If individuals understand the cultural basis of their own prescriptions, they will be better able to describe the cultural basis for prescriptions in other times and places.

The distinction between descriptive and prescriptive becomes somewhat muddy in contemporary Western society because psychology and sociology are the contemporary forms of myth. Often research hypotheses are drawn from cultural prescriptions, and researchers' findings pass quickly into popular culture as prescriptions and directives. It is common for those who do research on grief to find their descriptions of grief turned into counsel given by therapists and media personalities. Students might study grief in American culture by doing a serious analysis of the advice given on television talk shows; bilingual students could compare advice given on English and non-English language stations.

A potentially useful direction for the cross-cultural study of grief might be to compare rules about grief and to analyze how the prescriptions on grief coordinate with other prescriptions. For example, students could look at the rules for expressing grief as part of the rules for being a man or a woman. In traditional China, women wailed laments but men sat silently. A fruitful topic might be an investigation into the rigor of a culture's rule enforcement (e.g., the severity of the penalty, if any, that a weeping man would face in a culture that discourages male crying).

Continuing Bonds with the Dead

The resolution of grief often includes cultivating bonds of emotion and meaning with the dead. In other words, people who are important to us become part of our inner conversation and remain

there after they die. If someone says, "I would not do that because my mother would be disappointed in me," the mother is part of that person's inner conversation even though the mother is not present and may never find out if the person did it or not. People who are important to us may continue to play important roles in our lives and in the life of the community for many years after they have died. Throughout history this kind of persistent communion with the dead is a recurring behavioral pattern, far more common than an outright severing of all bonds. Indeed, Western psychologists and psychiatrists became interested in individual grief—the ways in which survivors live on after a death—precisely at the time when the cultural narrative about afterlife had begun to wane.

If students use continuing bonds as the focus of cross-cultural study, relatively straightforward methods can yield data that are useful in a comparison of the roles played by the dead in individual lives and cultural systems. Historian Ronald Finucane traces changes in Western history from ancient Greek culture to the present in various areas: how the dead appear to the living, what the dead want from the living, and what the living ask of the dead. Comparisons can be made between the changes in the relationship of the living and the dead during the mourning period.

Continuing bonds with the dead in individuals and families become integrated into the collective representations that mediate the culture to the individual. Emile Durkheim, one of the founders of sociology, said that collective representations play a major role in developing social solidarity and identity in tribes, ethnic groups, and nations. Grief and the rituals of mourning install the dead into collective memory as well as into the individual memories of those who knew them. The memory of soldiers who die in war, for example, are evoked during patriotic celebrations in every culture. Grief then takes on a political meaning because one of the functions of all cultural narratives is to uphold the legitimacy of those who hold economic and political power. Only a few centuries ago, cultural narratives said that kings ruled by divine right. Twenty-first-century narratives say that presidents rule because they are elected by the people. The political question is, however, which collective narrative controls the continuing bond with the dead? To what end or in whose interest is grief policed? In Chinese ancestor rituals, the dead

remain part of the family, defining the values by which the family lives and creating the shared identity of the living members of the family. The memories of martyrs energize living people who believe in the ideas or causes for which they died. A fruitful area of student study might be an analysis of the political, historical, or cultural meaning of deaths in which the grief is shared by the wider society, not just by family members.

Conclusion

The cross-cultural study of grief can apply to many levels of human life: at the biological level, the instincts aroused by a significant death; and at the linguistic level, the meanings and usage of the words that refer to what people call grief and mourning in the West. In the interchange between individuals and culture, grief and the resolution of grief happens in a series of nested cultural narratives—family, clan, tribe, community, subcultural, nation, religious tradition, and so on. At each level those narratives supply the plots for the construction of individual narratives that endow grief with meaning and manageability. Grief interacts with every level of this hierarchy, from family patterns to political legitimacy.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; CONTINUING BONDS; DEATH SYSTEM; GRIEF: THEORIES; MOURNING

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DENNIS KLASS

GRIEF COUNSELING AND THERAPY

How individuals and families cope with dying, death, grief, loss, and bereavement is as unique as a fingerprint. The response to the death of a family member, relative, or close friend places one in the category of "bereaved." Those who are bereaved experience grief, a person's response or reaction to loss, which encompasses physical, psychological, social, and spiritual components. How one copes with other life events and adapts to one's present and future is also part of the grieving process.

In the broadest context losses can be thought of as the loss of one's possessions, one's self, one's developmental losses, or one's significant others. Historically, many grief counselors and grief therapists have chosen to follow the popular "grief counseling theory of the time." However, in the twenty-first century there are constantly changing theories regarding grief and loss, and new challenges and questions raised by researchers, clinicians, and the bereaved themselves regarding what is or is not helpful during the bereavement process. In addition to counselors and therapists as defined in the more traditional sense, "grief and bereavement specialists" have emerged to help people deal with their grief, both before and after death.

What Is Grief Counseling and Grief Therapy?

In *Grief Counseling and Grief Therapy* (1991), the clinician and researcher William J. Worden, Ph.D., makes a distinction between grief counseling and grief therapy. He believes counseling involves helping people facilitate uncomplicated, or normal, grief to a healthy completion of the tasks of grieving within a reasonable time frame. Grief therapy, on the other hand, utilizes specialized techniques that help people with abnormal or complicated grief reactions and helps them resolve the conflicts of separation. He believes grief therapy is most appropriate in situations that fall into three categories: (1) The complicated grief reaction is manifested as prolonged grief; (2) the grief reaction manifests itself through some masked somatic or behavioral symptom; or (3) the reaction is manifested by an exaggerated grief response.

Does a person need "specialized" grief counseling or grief therapy when grief, as a normal reaction to loss, takes place? Are people not able to cope with loss as they have in the past or are individuals not being provided the same type of support they received in previous generations? Individual and family geographic living arrangements are different in the twenty-first century than in past years. People have moved from rural to urban centers, technology has altered the lifespan, and the health care decisions are becoming not only more prevalent but often more difficult. Cost and legal issues become factors in some cases. Today, ethics committees in hospitals and long-term care facilities are available to help families and health care providers arrive at common ground. Traumatic and violent deaths have also changed the bereavement

landscape. What had helped individuals and families in the past in many situations has eroded and the grief and bereavement specialist, or the persons, agencies, and organizations providing those services, is doing so in many cases out of default. Grief counseling is used not only by individuals and families, but in many situations by schools, agencies, and organizations, and in some cases by entire communities affected by death.

Can Sources Other than Professionals Act As Counselors?

Social worker Dennis M. Reilly states, “We do not necessarily need a whole new profession of . . . bereavement counselors. We do need more thought, sensitivity, and activity concerning this issue on the part of the existing professional groups; that is, clergy, funeral directors, family therapists, nurses, social workers and physicians” (Worden 1991, p. 5). Although there are professionals who specialize in grief counseling and grief therapy, there are still many opportunities for the bereaved to seek support elsewhere.

Churches, synagogues, community centers, and neighborhoods were (and in many cases still are) the “specialized” support persons. Cultural traditions and religious rituals for many bereaved persons did and still do meet their needs. In the past, friends, family, and support systems listened to one another and supported individuals through the death of their loved ones, during the rituals after the death, and during the days, months, and years after the death. Although American culture is used to having immediate gratification, not everyone processes grief at the same rate. Some cope and adapt to a death sooner, while others, based on similar factors and variables, may take a longer period of time.

Grief counseling and grief therapy are not for everyone and are not “cures” for the grieving process. Counseling and therapy are opportunities for those who seek support to help move from only coping to being transformed by the loss—to find a new “normal” in their lives and to know that after a loved one dies one does not remove that person from his or her life, but rather learns to develop a new relationship with the person now that he or she has died. In *A Time to Grieve: Meditations for Healing after the Death of a Loved One* (1994) the writer Carol Crandall states, “You don’t

heal from the loss of a loved one because time passes; you heal because of what you do with the time” (Staudacher 1994, p. 92).

Goals of Grief Counseling and Therapy

Professionals believe that there are diverse frameworks and approaches to goals and outcomes of the grief counseling and therapy process. Robert Neimeyer believes, “The grief counselor acts as a fellow traveler [with the bereaved] rather than consultant, sharing the uncertainties of the journey, and walking alongside, rather than leading the grieving individual along the unpredictable road toward a new adaptation” (Neimeyer 1998, p. 200). Janice Winchester Nadeau clearly reminds grief counselors and grief therapists that it is not only individuals who are grieving, but entire family systems. A person is not only grieving independently within the family system, but the interdependence within the family also affects one’s actions and reactions. According to Worden there are three types of changes that help one to evaluate the results of grief therapy. These are changes in: (1) subjective experience, (2) behavior, and (3) symptom relief.

Where Is Counseling Done and In What Format?

Grief counseling and grief therapy are both generally done in a private area (generally an office setting). These private areas may be within hospitals (for both inpatients and their families and for outpatients), mental health clinics, churches, synagogues, chemical dependency inpatient and outpatient programs, schools, universities, funeral home aftercare programs, employee assistance programs, and programs that serve chronically ill or terminally ill persons. Additional sites might include adult or juvenile service locations for criminal offenders. Private practice (when a counselor or therapist works for herself) is another opportunity to provide direct client services.

Treatment options include individual, couple, and family grief counseling or grief therapy, and/or group counseling. Sessions are approximately one hour in length, or longer for individual sessions. Groups are either closed (for a set period of time with the same small group of individuals attending each session) or open (offered once, twice, or several times a month and open to whoever attends

without previous registration or intake). Grief support groups are generally not therapy groups, but supportive therapeutic environments for the bereaved. Group sessions are generally ninety minutes long. Treatment plans are used by grief counselors in most individual and family counseling situations and in all grief therapy situations.

In some cases a grief counselor may be meeting with a person one time to help “normalize” what the person is feeling, while grief therapy requires multiple sessions. In most cases a fee is paid by the person utilizing the grief counseling or grief therapy service and is either paid on a sliding scale or by self-pay, third-party insurance, victim assistance programs, community charitable care programs, or some other type of financial arrangement. Some hospice/palliative care programs offer grief counseling and grief therapy services at no charge for a limited number of sessions.

Crisis intervention hotlines emphasize assessment and referral, and residential settings for children, adolescents, and adults are also locations where grief counseling or grief therapy is utilized. A number of grief therapists do consulting work with other grief therapists or grief counselors, or with agencies or organizations.

Approaches Used

There is not one method or approach. Each counselor or therapist has his or her own techniques that he or she utilizes because they are effective, although counselors often defer to other techniques that suit a particular person much better based on the individual's circumstances. Counseling and therapy techniques include art and music therapy, meditation, creation of personalized rituals, bibliotherapy, journaling, communication with the deceased (through writing, conversations, etc.), bringing in photos or possessions that belonged to the person who has died, role playing, bearing witness to the story of the loved one, confiding in intimates, and participating in support groups. The “empty chair” or Gestalt therapy technique is also an approach widely used by grief counselors and grief therapists. This technique involves having an individual talk to the deceased in an empty chair as if the deceased person were actually sitting there; afterward, the same individual sits in the deceased person's chair and speaks from that person's perspective. The dialogue is in first person, and a

counselor or therapist is always present. The Internet also provides a number of sites that address the topic of grief and provide links to counseling services and organizations.

When Is Grief Counseling or Therapy Needed?

According to many experts, including John Jordan, grief counseling and grief therapy approaches are challenged and redesigned by new research. In their article published in the journal *Death Studies*, Selby Jacobs, Carolyn Mazure, and Holly Prigerson state, “The death of a family member or intimate exposes the afflicted person to a higher risk for several types of psychiatric disorders. These include major depressions, panic disorders, generalized anxiety disorders, posttraumatic stress disorders; and increased alcohol use and abuse” (Jacobs, Mazure, and Prigerson 2000, p. 185). They encourage the development of a new *Diagnostic and Statistical Manual of Mental Disorders* (DSM) category entitled “Traumatic Grief,” which would facilitate early detection and intervention for those bereaved persons affected by this disorder.

Researcher Phyllis Silverman is concerned that messages dealing with the resolution of grief, especially a new category entitled “Traumatic Grief,” may do more harm to the mourner. She states, “If this initiative succeeds (‘Traumatic Grief’), it will have serious repercussions for how we consider the bereaved—they become persons who are suffering from a psychiatric diagnose or a condition eligible for reimbursed services from mental health professionals” (Silverman 2001). She feels the new DSM category may help provide the availability of more services, but believes it is important to consider what it means when predictable, expected aspects of the life cycle experience are called “disorders” that require expert care. When one thinks of grief counselors and grief therapists one is again reminded that grief and bereavement is a process, not an event.

How do persons cope and adapt? Grief counseling or grief therapy intervention can be useful at any point in the grief process, before and/or after a death. Consider the following story from a thirteen-year-old who was participating in a bereavement support group for teens, and wrote the following biography in response to her mother's death:

My mom was born on January 12, 1942, in Minnesota. She had a brother who was 11 years younger than her and she had a mother and father. . . . She was married in 1965. She then had two children. In 1981 my mom found out she had a brain tumor. She then got spinal meningitis and was in a coma for 3 weeks. She then was blind, but overcame blindness in a few months. One year later she was diagnosed with breast cancer. She had a mastectomy. She had chemotherapy for about one year. Then she had uterine cancer and had her uterus removed. Then she was diagnosed with lung cancer. She tried to hold on, but she was so sick. She went around in a wheelchair and was in and out of the hospital for weeks. But she got worse. On September 21, 1984, my mom died. I think that everyone who knew her will never forget her. (*Wolfe and Senta 1995, p. 218*)

In this case, anticipatory grief took place before the actual death occurred. It is the assumption that if one knows a person is going to die then the grief after the death is not as intense as if the death were a surprise. Grief counseling and therapy do not only begin after death. However, is this really true? According to clinician, researcher and writer Therese Rando,

Anticipatory grief is the phenomenon encompassing the process of mourning, coping, interaction, planning, and psychosocial reorganization that are stimulated and begun in part in response to the awareness of the impending loss of a loved one and the recognition of associated losses in the past, present, and future. It is seldom explicitly recognized, but the truly therapeutic experience of anticipatory grief mandates a delicate balance among the mutually conflicting demands of simultaneously holding onto, letting go of, and drawing closer to the dying patient. (*Rando 2000, p. 29*)

How Effective Is Counseling?

Various factors will determine the effectiveness of grief counseling or grief therapy. Some counselors and therapists utilize instruments to measure the effectiveness of the helping sessions. Others rely

upon subjective comments from the client, his or her family, behavior observations, cognitive responses, symptom relief, and spiritual discussions. Because grief is a process and not an event, what takes place along the grief journey may alter how one continues to cope and adapt to loss. One loss or multiple losses do not make a person immune to future hardships.

The clinical psychologist and researcher Nancy Hogan and her colleagues state, "Understanding this 'normal' trajectory of bereavement has been hampered, in part, by the use of questionnaires designed to measure psychiatric dysfunction, such as depression and anxiety, rather than instruments specifically developed to measure grief" (Hogan, Greenfield, and Schmidt 2000). The Texas Revised Inventory of Grief (TRIG), the Grief Experience Inventory (GEI), and the Inventory of Traumatic Grief (ITG) have been criticized by Hogan. She believes, "The lack of grief instruments with solid psychometric properties continues to limit the ability of researchers to study basic questions related to the bereavement process. To date, the normal trajectory of grief has still not been empirically defined" (Hogan, Greenfield, and Schmidt 2000, pp. 1–2).

Qualifications of Counselors and Therapists

Most grief counselors and grief therapists have advanced degrees in either social work, nursing, psychology, marriage and family therapy, medicine, theology, or a related field. Many have terminal degrees. Those with only undergraduate degrees may find employment doing grief counseling for various organizations or agencies, but any type of third-party reimbursement (in the United States) would be minimal if not impossible without a graduate degree. A number of universities around the world offer undergraduate course work on death-related topics and graduate courses drawing upon subjects related to grief counseling and therapy. Certification in the field of grief counseling and grief therapy is offered by the Association for Death Education and Counseling, while other organizations in death-related areas such as the American Association of Suicidology and the U.S. National Hospice and Palliative Care Organization, also offer certification specific to their subject areas. In the United States and Canada, there are no state or provincial grief counseling or grief

therapy certification requirements as of 2001. However, to practice in the United States in fields such as social work, psychology, or marriage and family therapy, a state license is required.

Rewards

Carl Hammerschlag, a Yale-trained psychiatrist, spent twenty years with Native Americans in the Southwest of the United States. While working as a family physician he was introduced to a patient named Santiago, a Pueblo priest and clan chief, who believed there were many ways for one to heal. In his book, *The Dancing Healers* (1988), Hammerschlag shares a time when Santiago asked him where he had learned how to heal. Hammerschlag rattled off his medical education, internship, and certification. The old man replied, "Do you know how to dance?" To humor Santiago, Hammerschlag got up and demonstrated the proper dance steps. "You must be able to dance if you are to heal people," Santiago admonished the young doctor, and then stated, "I can teach you my steps, but you will have to hear your own music" (p. 10).

Grief counseling and grief therapy are metaphorically, learning to dance. Each person looks at the world through a different set of lenses, and as a result, one's dances, steps, upbringing, hopes, dreams, and healing are dependent on many factors. Grief counseling and therapy are about sharing a person's journey before or after a death. The focus is on companioning them during difficult times and not rescuing or fixing them, and about listening to their stories and thoughts with an open mind and open heart. The grief counselor or therapist's role in helping others is about transitions and new beginnings for those with whom they work. There are many rewards for clients, counselors, and therapists.

See also: DEATH EDUCATION; GRIEF: ANTICIPATORY, FAMILY

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BEN WOLFE

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HEAVEN

Heaven is usually thought of as some sort of afterlife, a view provoking hopeful belief on the one hand and skepticism on the other. Yet heaven is much more complicated and diverse than that. Those influenced by Western civilizations generally think of heaven along Christian lines—or along caricatures of those lines, as in cartoons featuring harps, wings, and clouds. On a less crude level, heaven is often derided as part of a system of reward and punishment, a “pie in the sky” or “opiate” diverting people from attention to bettering their present, earthly lives. However, the essence of the word “heaven” worldwide is the transformation of chaos into order (from the Greek *kosmos*, meaning “ordered universe”), meaninglessness into meaning, and selfishness into compassion. Its attributes are usually joy, contentment, harmony, compassion, bliss, community, love, and a vision of God, or even union with God.

Different languages have different words for “heaven.” More than that, the concepts behind the words vary radically among different religions and even within each religion. Judaism, Christianity, Islam, Buddhism, Hinduism, and innumerable other religions display a panoply of beliefs. Heaven is not necessarily an afterlife. The most universal meaning of the concept is a joyful existence beyond the plane of human ordinary thought, feelings, and perceptions: a “new life” or “different life.” To be sure, that concept is frequently expressed as afterlife, but it is also expressed as timeless or eternal life, transcendent life, and even

as a state of existence in which humans can live a life free of illusion during their present lives. Heaven often means the realm of god(s), a distinctly different meaning from heaven as a goal for humans, but the two ideas readily merged.

Beliefs in a life different from what humans daily experience appeared at least as early as the Neolithic period. Primal religions number in the thousands and most were characterized by belief in a world other than, or beyond, physical life, a “place” or “time” (in Aborigine, “dreamtime”) of a different, often greater, reality than that of the physical world. Often this was accompanied by the belief that humans have contact with that other world both during life and after death. Shamans, oracles, and dreams could be consulted in order to be in touch with the other life. The spirits of the dead remained with us or else entered that other life where we would eventually join them. Burials included artifacts that the dead person would be able to use in the other world. The other world could be a place or a state of being. Often (but not necessarily) it was conceived as being “up” because of its early association with the sun, moon, and stars.

Another way of understanding heaven is what it is not. Many traditions worldwide affirmed that original cosmic order was somehow deformed by the actions of ignorant or malicious humans or deities. In Western religions this understanding was expressed in a chronological story: In the beginning was Paradise, where all was in harmony; a conscious choice was made by humanity (Adam and Eve) to reject that harmony, thereby disrupting



The Glory of Heaven by Francesco Maria Russo shows an angel pointing upward to the skies. Despite varying opinions about the afterlife, many agree on what heaven looks like. CORBIS

cosmos; at the end of time, harmony would be restored. In that sense, Paradise was where humankind begins and heaven where humankind ends, but often the two were blended and taken as synonyms. Most religions perceived a perennial tension between the world as it originally was and was meant to be (the Golden Age), the world as it was now, and the world as it would be when chaos and evil were overcome and cosmos restored.

Ancient Ideas

In ancient Egypt, cosmic order and justice (*ma'at*) prevailed, but it could be temporarily distorted by human evil. The *ka* (spirit of the dead person) descends into the underworld to be judged by the gods (specifically Anubis). The unjust were tormented in scorching heat, while those living in accordance with *ma'at* rose into the eternal realm of the gods. Ancient Mesopotamian religion had little idea of heaven: The dead were doomed to unending gloom and wretchedness in the darkness

beneath the earth, with the dubious consolation that the rich and powerful in earthly life would have a less miserable status in the afterlife.

In early Greco-Roman religion, the souls of the dead descended to the shadowy underworld of Hades; later, the spirits of heroes were believed to escape that fate and to rise instead into the Elysian Fields, which were variously located in an earthly garden, a mysterious “land” to the West, or among the stars. Elysium, wherever located, was a place of fulfillment of earthly delights. Greco-Roman philosophers focused on the virtue of intellect and on the perfect world of ideas, toward which humans attempt to strive but can never attain. Perfect being was always beyond human reach; still, Plato argued for the immortality of the soul, which consisted of a combination of the basic life force common to all creatures with mind (*nous*), which was unique to humans. Plato tended to view the fields of heaven as a temporary abode for the soul before it returned to the earth in a reincarnation. The cycle of reincarnation ended with the purification of the soul—losing its bodily needs and desires—and its final union with Being itself. Cicero (106–43 B.C.E.), the great Roman lawyer, linked the divine with justice and saw Elysium as a reward for those who served the Roman state. The Later Platonists of the third to fifth centuries C.E. taught that everything in the cosmos yearns for such union and that everything, once elevated beyond matter into pure spirit, will eventually attain that happy end.

Eastern Religions

The major Eastern religions (Hinduism, Buddhism, Taoism, and Confucianism) had less-defined concepts of heaven and hell than the Abrahamic, monotheist religions (Judaism, Christianity, and Islam), because their distinction between good and evil tended to be less sharp.

Hinduism. Hinduism is a modern name for a complex combination of traditions in India. The first great period of Hinduism was that of the Vedas, about 1500 to 1000 B.C.E. In Vedic religion, the dead, who retained personal consciousness, went to a lush green place with beautiful music. Those more devout and observant of ritual were closest to the gods; those lax in ritual farther away. Between about 700 and 100 B.C.E., the Upanishads (sacred scriptures) reshaped Hinduism. They

taught that the essence of heaven was to be freed from *maya* (illusion), with which humans surrounded themselves in this earthly life, which blocked them from reality, and immersed them in the desire, pain, and suffering inherent in this life. Freedom from *maya* was obtained through knowledge, love, labor, and the spiritual disciplines known as *yogas*. Hinduism affirmed that souls, having entered the world, were bound to a long series of rebirths. The deeds of their lives formed a tendency of character, which they could improve or impair in future lives. Heaven became merely a transitory state between rebirths. Ritual remained central, however, and in the early C.E., *bhakti* (the practice of devotion to a particular god, such as Vishnu) became a way of escaping the cycle of rebirth. For true heaven was union with Brahman (the ultimate divine principle), a union in which consciousness of self disappeared. In this state, known as *samadhi*, one's soul was reabsorbed into the unbounded "allness" of being as a drop of water being merged with the sea.

Buddhism. Buddhism, partly rooted in early Hindu culture, also posited a state of cyclical flux, *samsara*. *Samsara* might lead one into rebirth on the earth as a human or an animal, or it might pass one through a variety of temporary heavens. Until the cycle was broken, both the earth and heavens were intermediate states between one incarnation and the next, and each incarnation was characterized by *dukkha* (suffering), *tankha* (craving for worldly possessions), and *anicca* (impermanence). One's actions (*karma*) would bear fruit in future lives, which could be improved through meritorious, compassionate deeds. Ultimate heaven was escape from the cycle into union with the deepest reality. This required the extended practice of meditation and detachment—from objects, from people, and from oneself—that constituted enlightenment and, ultimately, *nirvana*. *Nirvana* was the extinction of all concerns, desires, and fears of one's finite self; it was complete union with ultimate reality beyond human comprehension.

Classical Buddhism had no concept of individual immortality: The *atman* ("soul") is immortal but only as part of the world soul. The individual is simply as one candle flame that is a part of fire itself. One form of Buddhism, "Pure Land Buddhism," originating about 500 C.E., resembled Western religions more by focusing on the saving

power of a *bodhisattva* (a perfectly wise person whose life was dedicated to compassion for all living, suffering beings) who brought the compassionate into a heaven ("pure land") with beautiful meadows, lakes, rivers, music, and ease. But even in this variety of Buddhism, the pure land was a prelude to the essential attainment of *nirvana*.

Taoism. Taoism was a syncretistic blend of philosophical, shamanistic, and popular religions, a tradition crystallized in the *Tao Te Ching*, a book attributed to Lao Tzu in the 600s B.C.E. Tao had three aspects: Tao as the ultimate underlying basis, reality, and wisdom of existence; Tao as the universe when it is in harmony with the higher Tao; Tao as human life on the earth in harmony with the other Taos. Virtue consisted in losing the false consciousness that the individual has any meaning apart from the whole society or even world. Philosophical Taoism, which believed in no other world beyond this one, influenced Confucianism (the teachings of Kung Fu-tzu in the 500s B.C.E.). Popular, religious Taoism had tales of journeys to heaven by immortal sages. Like Taoism, Confucianism (the dominant religion of China until it was replaced by Marxism), centered on harmony. Heaven was the underlying harmony of being, not a habitation for humans or even gods in the usual sense. The point of Confucian teaching was maintaining accord with that harmony in human society, particularly the family. Worldly as it was, however, Confucianism held an implicit belief in immortality in its worship of ancestors, who continued to be with their earthly family in their present life.

Secular Religions

A variety of modern secular religions arose in the past three centuries, including the Enlightenment cult of reason, the Romantic cult of nature, and, the most influential, Marxism. Marxism was a secular religion excluding all metaphysical realities (except, oddly, a semi-divine "history"). Marxist heaven, achieved through "socialism," was the classless society that would emerge at the end of history, a secularization of Judeo-Christian traditions of the Messiah and the millennium. Its success in China was largely owing to its compatibility with the Confucian tradition that the individual is unimportant. Reductionism or "Scientism," the belief that the only truth is scientific truth, suffused

twentieth-century thought, adding to skepticism, since heaven is not locatable in the space-time continuum.

Judaism. The three great Western monotheistic religions—Judaism, Christianity, and Islam—together accounted for at least one-third of the earth's population at the beginning of the twenty-first century. To treat them in roughly chronological order, ancient Hebrew religion (whose origins are at least as old as the thirteenth century B.C.E.) was founded on belief in a transcendent deity—Yahweh or Adonai (the Lord). Heaven was the dwelling place of the Lord, not a place in which humans lived; humans' only life was this earthly one. With extremely rare exceptions (such as the prophet Elijah) humans did not enter the transcendent plane. The "Kingdom of God," like human life itself, was worked out in this present, earthly existence. The essence of Hebrew religion was that the Lord had made a covenant (contract) with his chosen people, Israel. Only Israelites could participate in that covenant, and only those who were faithful to the covenant as expressed in Torah (the first five books of the Bible) could enter the Kingdom of God. Israel cemented morality into religion. Death brought for most humans a shadowy existence in Sheol (similar to Greco-Roman Hades); for vicious violators of the covenant pain in the fires of the hellish Gehenna; for Israelites faithful to the covenant a blissful existence at the end of the world in the *'olam ha-ba*, the kingdom of God on the earth.

Between 250 B.C.E. and 100 C.E., Hebrew religion shifted its focus. Incessant persecutions by Syrians, Romans, and other conquerors made justice and mercy seem remote or lacking in earthly life, so attention shifted to another sort of life where those qualities, which one expected of the Lord, ruled. Still, that life was not perceived as an afterlife for individuals but instead as the future coming of a Messiah establishing a Kingdom of the Lord at the end of time on this earth. The old division between the Qehel Adonai (those Israelites faithful to the covenant) and those violating the covenant came to imply a divine judgment on each person's life, either immediately at death or at the end of time. Those who lived at the time of the Messiah would live joyful lives together in the community of the Qehel. But what of the deceased? Justice seemed to require that the entire

Qehel Adonai, including the dead, should live in the Kingdom when the Messiah came. And since this Kingdom would be a bodily existence on this earth, the dead would be resurrected at the end time, in Jerusalem, and in their own, personal, earthly bodies. This remains the teaching of Orthodox Jews, while the more "liberal" or "secular" tend not to look beyond the present life. In any Jewish scenario, a human being had only the one earthly life.

Dualism. Quite different religions and philosophies appeared around the eastern Mediterranean during late pre-Christian and early Christian eras. The most influential philosophy of the ancient Greeks was that of Plato (c. 400 B.C.E.). Platonism was strongly idealist and dualistic, affirming a dichotomy between spirit and matter, spirit being more worthy, essential, and eternal than matter. In the Neoplatonist thought of the early Common Era, pure spirit was defined as real and matter as lacking existence, teetering on the verge of unreality. The Iranian religion Mazdaism (or Zoroastrianism), along with its later successor Manicheism, was based on the belief that there were two almost equally powerful spirit gods. One spirit, Ohrmazd, was the spirit of light and goodness and being; the other spirit, Ahriman, was the spirit of darkness and evil and the void. The two struggled for sovereignty over the cosmos. At last Ohrmazd would destroy Ahriman and bring about the *frashkart*, the end of the corrupted world, and the restoration of the cosmos to its pristine perfection—or better, for there was no longer any potential for spoiling the shining world. Ohrmazd would judge humans and assign the followers of darkness to annihilation and the followers of light to eternal bliss. Meanwhile, at death, bodiless souls ascended toward Ohrmazd and "The Singing House" to the degree that they had transcended earthly concerns.

At the end of the pre-Christian era, Platonic and Mazdaist ideas converged in a movement known as Gnosticism, a variety of religious views. Gnostics, like Mazdaists, posited an eternal struggle between good and evil; like Platonists, they posited the eternal opposition of spirit and matter. Combining the two, they affirmed an eternal struggle between good spirit and evil matter. Whereas Platonists tended to see matter primarily as essentially lack of being, or nothingness, Gnostics saw matter as loathsome evil. The human body was the

vile prison for the human spirit, which longed to escape its bondage in order to return to the spirit world with the triumphant Spirit of Good. Being that the Gnostics regarded the body as disgusting, they completely rejected the Jewish and Christian resurrection of the body, affirming instead the immortality of a “soul” defined as pure spirit.

Christianity. Early Christian thought, based in Hebrew religion yet influenced by the ambient Platonism of the time, found itself affirming the resurrection of the body yet also allowing for some sort of immortal “soul.” For Christian theology from Paul onward, however, “soul” did not mean pure spirit but rather a complete person, body and spirit inseparably together. The basic Christian idea of heaven derived from the Jewish idea of the Qehel Adonai, which Christianity translated and expanded into the salvation of the entire community (Jews and Gentiles together and alike) of those loyal to Christ. For Christianity, death became a moral matter more than a natural one, for the physical death at the end of one’s present life meant almost nothing in comparison to the “second death” or “inner death” of those rejecting the Lord. At the end time, the dead would all rise in the very same body they have today and would rejoice in the Kingdom of God announced by the Messiah, Jesus Christ, who would judge between those who love and those who reject love: the latter being in hell and the former in heaven. In some forms of Christianity, the Messiah would usher in and rule a thousand-year Kingdom of God on Earth before all time was dissolved. For Christians, like Jews, heaven meant essentially to be in the presence of the eternal God. Still, in popular belief Christians came to view it as a physical place other than on this earth.

Early Christian theologians bravely faced the problem posed by the undeniable delay between the physical death of an individual and the resurrection at the end of time. There seemed to be an interim period when spirit and body were separated while the spirit awaited resurrection. Once it was admitted that spirit and body could thus be separated even only temporarily, Christianity slid toward the concept (already promoted by Platonism) of an immortality of the “soul” defined as spirit. Even though theology always insisted on the resurrection of the body and downplayed the immortality of an incorporeal spirit, in popular

Christian thought the latter idea gradually became prevalent.

Christian theology also seldom focused on reward and punishment. The hope was not to have God punish sinners, but to have them change their lives so that they could participate in the community of the saved, a heaven of mutual, selfless opening up in love between humans and God and among humans themselves. Again, popular, legend-creating, storytelling, picture-making Christianity preferred more colorful, concrete visions of immortal spirits being either delighted in heaven or else tormented in a hell of darkness and fire. From such popular vision, literature sprang the most celestial poem ever written, *Paradiso*, in *Divine Comedy* of Dante Alighieri (1265–1321).

Islam. Founded in the 600s C.E., Islam was based upon the Qur’an (the written revelation to Prophet Muhammad). For Muslims the Qur’an was the dictated, “literal” word of God, yet influences of Judaism and Christianity were clearly present. Islam affirmed the judgment of individuals according to their deeds in this life and loyalty to the teachings of the Prophet, especially compassion and generosity. Islam focused on the formation of a just society on the earth, but the Qur’an was also explicit in affirming the resurrection of the body. At the end of the world, the resurrected dead were judged and then divided into the damned and the faithful, with the latter entering heaven. Heaven was another, better place than this earth, yet a distinctly physical one in its attributes, including elaborate gardens, carpets, banquets, cooling drinks, sex, and other bodily comforts. The Qur’an also permitted metaphorical readings, and al-Ghazali (Algazel) in the twelfth century C.E., along with other Muslim spiritual leaders and writers, such as the medieval Sufis, sensed a deeper reality, realizing that the human mind was incapable, even at its most sublime, of formulating concepts that, like heaven, were rooted in the ultimate and entire reality of the cosmos. For them, heaven meant being in the presence of the eternally just and merciful Allah (“the God”).

Concepts of heaven are thus so diverse that skepticism on the overt (literal) level is natural. Yet statements about heaven can be true if they are taken, not as scientific or historical statements about space-time, but rather as metaphors for

deeper and more diverse truths beyond that conceived by materialist reductionists (those maintaining that truth is exclusively to be found in the scientific observation of matter). Modern first-world affluence, encouraging faith in acquisition of objects and power, along with alienation from nature in huge urban conglomerations where the light of the stars and the green of the fields are blotted out, have caused heaven to fade. Yet it is the fulfillment of the deeply rooted human longing for meaning, for a greater understanding of the cosmos, of other people, and of the self, and for greater knowledge and love than are comprised in this present life. No human concept can possibly contain the fullness of reality, but truth is found more by opening out than by narrowing down. There is, and can be, no evidence against the existence of heaven, and hundreds of generations of wise, sensitive, and knowledgeable people have affirmed it and claimed to experience it.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE;
BUDDHISM; CATHOLICISM; HELL; HINDUISM;
IMMORTALITY; ISLAM; JUDAISM; NEAR-DEATH
EXPERIENCES; PURGATORY

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JEFFREY BURTON RUSSELL

HEAVEN'S GATE

Marshall Herff Applewhite and Bonnie Lu Nettles founded Heaven's Gate, which was a cult that "combined Christian and some Theosophical doctrines with beliefs in UFO's [and] extraterrestrials" (Wessinger 2000, p. 233). Applewhite and Nettles went by many aliases during their time together. They went by Guinea and Pig, Bo and Peep, Ti and Do, and collectively they were referred to as the "Two." Applewhite and Nettles met at a hospital where Nettles worked in 1972. After the meeting, the two became close friends and Applewhite felt that he had met the "platonic helper he had longed for all his life" (Balch 1995, p. 142). Although they met in 1972, the cult really did not form until they began attracting followers in 1975.

The psychiatrist Marc Galanter argues that Applewhite and Nettles may have suffered from "the psychiatric syndrome of *folie à deux*, in which one partner draws the other into a shared system of delusion" (Galanter 1999, p. 178). They believed that they had come from the Next Level (i.e., heaven) to find individuals who would dedicate themselves to preparing for the spaceship that would take them there (Balch 1995). Their belief that they were from the Next Level is evidenced by both their assertions that they were the two witnesses referred to in Revelation 11 who had risen from the dead after being killed for spreading the



Identified as “The Two,” Marshall H. Applewhite and Bonnie Lu Trusdale (sitting at table) hold a meeting in Waldport, Oregon, September 14, 1975, to recruit followers. Over twenty years later, thirty-nine Heaven’s Gate members committed suicide at the cult’s mansion in Rancho Sante Fe, California. BETTMAN/CORBIS

word of God, and their belief that Applewhite was the Second Coming of Jesus Christ incarnate, and Nettles was the Heavenly Father.

Applewhite and Nettles believed that evil space aliens called Luciferians had kept people tied to the human level, and therefore incapable of moving to the Next Level. Because Applewhite and Nettles were from the Next Level only they could provide the insight needed to prepare their followers, which made the followers extremely dependent upon their leadership. The process of preparing for the Next Level involved giving up all human attachments and was called the “human individual metamorphosis” (Balch 1995, p. 143). Some of the human attachments that cult members were expected to give up included family, friends, sexual relationships, and gender.

The Followers

Sociologists Robert Balch and David Taylor and religious scholar Catherine Wessinger have noted that the members led a very regimented, monastic

lifestyle within the cult. First, platonic male-female partnerships were formed, so each member could develop an “awareness of the human qualities each person had to overcome” (Balch and Taylor 1977, p. 842). Second, group members wore uniforms that were designed to conceal their human form in general and, in particular, their gender. Third, Balch notes that the cult had a number of rules and guidelines that “discouraged contact with the outside world” (e.g., do not contact parents or friends), “eliminate[d] old habits and identities” (e.g., no jewelry, no drugs), and “prevent[ed] the formation of interpersonal attachments within the group” (e.g., no sexual relationships) (Balch 1995, p. 149). Additionally, seven members, including Applewhite, had themselves castrated in order to control their sexual urges. Fourth, Applewhite and Nettles had group members engage in a series of activities or rituals that kept them busy for nearly all parts of the day. For example, Balch outlines an activity called “a tone,” where group members were to keep themselves focused on a tone produced from a tuning fork at all times while doing

other activities. The idea was to keep the group members focused on the Next Level, while ignoring human thoughts.

Many scholars provide commentary on the Heaven's Gate mindset. Marc Galanter points out that although the ideas that Applewhite and Nettles proposed are delusional and unreasonable, many of these concepts taken in isolation are relatively accepted by mainstream society. Balch and Taylor report that most of the people who joined Heaven's Gate accepted many of these ideas in isolation and were particularly intrigued by the way that Applewhite and Nettles had combined them. Moreover, Wessinger reports that those who left the cult still believed its ideas, but could not "adhere to the monastic discipline" (Wessinger 2000, p. 237).

The Suicide

In 1997 the Heaven's Gate members were living in a mansion in Rancho Santa Fe, California, where the group had been earning a living as web page designers. Applewhite became convinced that Nettles, who had died of cancer in 1985, was piloting a spaceship in the tail of the Hale-Bopp comet to take them to the Next Level. However, they could not go in their human form, so they committed suicide to shed their "physical containers" (Lewis 1998, p. 2).

The suicide began on March 22, 1997. On day one, fifteen members ate applesauce or pudding laced with Phenobarbital and drank vodka, and then other members helped fasten plastic bags around their heads to asphyxiate them. After their deaths, the plastic bags were removed and they were covered with a purple shroud. On the second day, the process was repeated for another fifteen members, followed by another seven members. Finally, the mass suicide was completed when the last two members killed themselves (Wessinger 2000).

In total there were thirty-nine people (20 women and 19 men) who committed suicide. The group members ranged in age from their twenties to age seventy-two. When the bodies were discovered, they were all dressed in black and covered with a purple shroud. On their left shoulders group members had a patch that read "Heaven's Gate Away

Team," which was an apparent reference to the television show *Star Trek: The Next Generation*. Additionally, "Each person had a \$5 bill and quarters in the front shirt pocket" (Wessinger 2000, p. 231).

Differences from Other Forms of Cult Violence

Wessinger notes that Heaven's Gate was different from other cults that have decided to commit violence (e.g., Solar Temple, Jonestown) in that there were no children involved. Heaven's Gate members believed that only adults were prepared to make the decision about whether or not to go to the Next Level.

In Jonestown, Guyana, it is unclear how many people committed suicide versus how many people were murdered. In the Solar Temple cult, primarily a European cult, a number of the members were killed if it was felt that they were too weak to make the decision to kill themselves (Wessinger, 2000). However, Wessinger (2000) argues that there are several lines of evidence that suggest the members of Heaven's Gate were highly committed to voluntarily taking their own lives. First, the highly coordinated suicide (i.e., a farewell tape, preparation of the bodies) suggests that this was a well-thought-out plan. Second, the suicide took several days, yet no one tried to escape, unlike Jonestown where some members hid or escaped into the jungle. Moreover, two group members of Heaven's Gate who did not commit suicide in March later killed themselves in a similar ritualistic manner.

See also: CULT DEATHS; JONESTOWN; WACO

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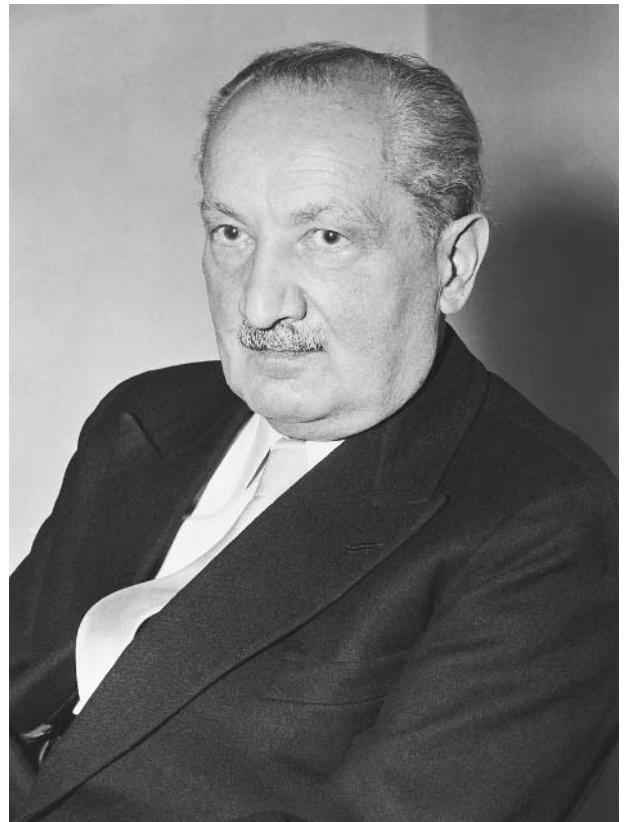
DENNIS D. STEWART
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HEIDEGGER, MARTIN

One cannot fully live unless one confronts one's own mortality. This hallmark of existentialist thought owes much to the works of Martin Heidegger. Heidegger (1889–1976) was born in Germany's Black Forest region. He held an early interest in theology and the priesthood, but soon shifted his attention to philosophy. At the University of Freiburg he studied under Edmund Husserl, and eventually succeeded him as chair of philosophy. Heidegger went on to become a leading exponent of phenomenological and existential philosophy, which he blends together in his *Being and Time* (1927).

In this monumental work Heidegger addresses issues related to death, exploring the human being in his or her temporality. This connection is important. For Heidegger, the human being cannot achieve a complete or meaningful life, or any kind of “authentic existence,” unless he or she comes to terms with temporality—a uniquely human awareness that a human being is a finite, historical, and temporal being. The awareness of death is a central beginning for understanding this temporality.

According to Heidegger, the human being must understand that he or she is a “being toward death” (*Being and Time*). “As soon as man comes to life,” he says, “he is at once old enough to die” (Heidegger 1962, p. 289). Therefore the awareness and acceptance of death is a requirement for authentic existence. Heidegger refers to the inauthentic self as the “they-self.” This is the self that is influenced by the crowd or the “they,” rather than by its own unique potentialities. The they-self sees death as a subject producing “cowardly fear, a sign of insecurity” (p. 298) and therefore a fit topic to be avoided. Avoidance of death can be achieved by an evasion technique Heidegger refers to as the “constant tranquilization about death.” In so doing, the they-self “does not permit us the courage for



Martin Heidegger (1889–1976) discussed his existential philosophy of humans as “beings toward death” in his seminal work Being and Time (1927). CORBIS

anxiety in the face of death” and promotes instead an “untroubled indifference” (p. 299) about death.

Death, the they-self argues, is something all human beings will experience one day in the undetermined and, therefore, easily ignored future. People experience death in the death of others, and draw conclusions about their own deaths. As Heidegger states, this is as if to say, “One of these days one will die too, in the end; but right now it has nothing to do with us” (p. 297). But for Heidegger death is not a shared experience at all; rather, it is one's “ownmost” and a “non-relational” experience. That is, death is something one can only do by oneself, as each person dies his or her own death.

What is the proper attitude toward one's death? Heidegger rejects the cowardly fear proposed by the they-self. The only proper mood, he argues, when one comes “face-to-face” with the “nothing” that death reveals, is a courageous “anxiety” (p. 310). This anxiety or dread, as the scholar

HELL

Michael Gelven points out, is different from fear in that fear attaches to some actual object, while anxiety focuses on freedom and possibility. Only such a mood, says Heidegger, will bring about an “impassioned *freedom towards death*” (p. 311). Heidegger’s reflections on death, therefore, are not obsessions with morbidity. Nor does he offer a religious hope of life after death. Rather, healthy anxiety about death provides courageous awareness and acceptance of death, and of one’s finitude.

See also: ANXIETY AND FEAR; KIERKEGAARD, SØREN;
PHILOSOPHY, WESTERN

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WILLIAM COONEY

HELL

Most ancient societies and religions had an idea of an afterlife judgment, especially understood as a “weighing of souls,” where the gods would reward the faithful worshipers, or honor the great and mighty of society. In later times this notion of afterlife was refined more and more into a concept of the public recognition of the worth of a person’s life, its moral valency. The three biblical religions—Judaism, Christianity, and Islam—all apply the notion of the afterlife judgment (and the ideas of heaven and hell which derive from this concept) as essentially a divine adjudication that assesses and pronounces on the worth of a human life. Such beliefs were to become among the most potent mechanisms of social control ever devised.

The classical Greek conception viewed Hades, the land of the dead, as a place of insubstantial shadows. The story of the “House of the Dead” in Homer’s *Odyssey* gives a harrowing version of how even heroes are rendered into pathetic wraiths, desperately thirsting after life, waiting for the grave offerings (libations of wine or blood or the smoke

of sacrifices) that their relatives would offer at their tombs. Such an afterlife was as insubstantial as smoke, a poetic evocation of the grief of loss more than anything else. There was no life or love or hope beyond the grave. By contrast the gods were immortals who feasted in an Elysian paradise, a marked contrast to the wretched fallibility of mortals whose deaths would reduce them one day, inevitably, to dust and oblivion. This resigned existentialism permeates much of classical Greek and Roman writing. It was not particularly related to the more philosophical notions, as witnessed in Plato, for example, of the soul as an immortal and godlike entity that would one day be freed when released from its bodily entrapment. However, both notions were destined to be riveted together, in one form or another, when the Christians merged the Hellenistic concepts of their cultural matrix with biblical ideas of judgment, as they elaborated the New Testament doctrine of hell.

The classical descriptions of Hades were borrowed and reused by Christians as one of the first popular images for hell. The earliest iconic images of the Resurrection, in Byzantine art, depict Christ descending into Hades, breaking down the doors and liberating the souls of all those who had been consigned to imprisonment in the House of Death before his incarnation. Having broken into the realm of darkness and powerlessness, the Risen Christ is shown stretching out a hand to Adam and Eve, to lift them from their tombs, while the other righteous men and women of the days before his coming all wait in line to be taken with Christ to the glory of heaven. In the Christian era, with common allegiance being given to the idea of the immortality of the soul, Hades was now no longer a place of fading away to nonexistence, but rather a place of permanent imprisonment and sorrow. So it was that Hades made its transition toward becoming hell.

Scriptural Images of Hell As Devastation

The concept of Hades, reappropriated in this way and set to the service of the proclamation of the Resurrection victory, however, was only one form of the Christian doctrine of afterlife. Both the *Egyptian Book of the Dead* and the Buddhist mythology of the afterlife speak clearly enough of the afterlife as a state of judgment and the punishment of the wicked. This aspect of doctrine eventually came to be part of late Judaism, influencing both rabbinic

teachings and the doctrine of Jesus, and thus coming to be a part of late classical Judaism and Christianity (not to mention Islam) to the present day. To chart the development of this stream of thought one needs to look at the prophetic view of God's justice in the world and how it came to be reassessed by the apocalyptic school.

The prophet Isaiah used the image of the fire that falls upon the wicked and established it for later use. The concept of enemy raids that inflicted destructive fires and terrible sufferings on ancient Israel was real enough to need little explanation. The invasion of enemies, however, was a major problem in the Hebrew theology of providence that was often explained by the prophets on the grounds that God only allowed infidel invaders to devastate his holy land because his covenant people had themselves been unfaithful. The image of punishing fire thus became associated in the prophetic literature with unfaithfulness as it was being corrected by God, whose anger was temporary, and who, after the devastation, would restore his people to peace and favor.

The association of ideas is seen clearly in Isaiah 66:24, which becomes a *locus classicus* for Jesus himself, and by this means entered into the Christian tradition as an authoritative logion, or dominical saying. In this passage the prophet speaks of a restored Jerusalem under the Messiah, when the true Israelites who have been restored by God will, in turn, go out to look upon the devastation that they have survived, and will see "those who rebelled against me, for their worm shall not die, and their fire shall not be quenched, and they shall be an abomination to all flesh." This is an image of the aftermath of devastation used as an apocalyptic sign, a theological statement about the ultimate vindication of God and his chosen people, functioning as if it were a rallying cry for the elect to retain trust in God even in times of difficulty, when the covenant hope might seem slight or politically ill-founded. From this stream of prophetic teaching the image of fires of judgment began to coalesce into a concept of hell.

Apocalyptic Ideas on God's Judgment

In the two centuries preceding the Christian era the prophetic theology of providence faltered. It was overtaken by a new mode of thought called apocalyptic, taken from the style of books that often

featured a chosen prophet figure who received special revelations (apocalypses) in the heavenly court, and who then returned to announce the word of divine judgment to his contemporaries. The Book of Daniel is the one great instance of such an apocalyptic book that entered the canon of the Hebrew scriptures, although there were many other instances of such literature that were highly influential in the period between the two testaments, and which colored the Judaism of the time, as well as primitive Christianity.

The image of God's anger against the evil ways of the earth is a common feature of this genre of scripture. The divine judgment is often depicted in terms of God deciding on a definitive end to the cycle of disasters that have befallen his elect people in the course of world history. The literature depicts the forces of evil as beasts, servants of the great beast, often seen as the dark angel who rebelled against God in primeval times. The earthly beasts are, typically, the great empires that throughout history have crushed the Kingdom of God on the earth (predominantly understood as Israel). In apocalyptic imagery the great battle for good and evil is won definitively by God and his angels who then imprison the rebel forces in unbreakable bonds. An inescapable "Lake of Fire" is a common image, insofar as fire was a common biblical idiom for the devastation that accompanied divine judgment. In apocalyptic thought the definitive casting down of the evil powers into the fire of judgment is coterminous with the establishment of the glorious Kingdom of God and his saints. In this sense both heaven and hell are the biblical code for the ultimate victory of God. So it was that in apocalyptic literature the final elements of the Judeo-Christian vocabulary of hell were brought together.

The Teachings of Jesus on Gehenna

Historically understood, the teachings of Jesus belong to the genre of apocalyptic in a particular way, though are not entirely subsumed by it despite many presuppositions to the contrary in the scholarship of the twentieth century. Jesus taught the imminent approach of a definitive time of judgment by God, a time when God would purify Israel and create a new gathering of the covenant people. It was this teaching that was the original kernel of the Christian church, which saw

itself as the new elect gathered around the suffering and vindicated Messiah. Jesus's own execution by the Romans (who were less than impressed by the apocalyptic vividness of his imagery of the Kingdom restored), became inextricably linked in his follower's minds with the "time of great suffering" that was customarily understood to usher in the period of God's Day of Judgment and his final vindication of the chosen people (necessarily involving the crushing of the wicked persecutors).

In his prophetic preaching, Jesus explicitly quoted Isaiah's image of the fire burning day and night, and the worm (maggot) incessantly feeding on the bloated corpses of the fallen and, to the same end as Isaiah, that when God came to vindicate Israel he would make a radical separation of the good and the wicked. The image of the judgment and separation of the good and the evil is a dominant aspect of Jesus's moral teaching and can be found in many of his parables, such as the king who judges and rewards according to the deeds of individuals in Matthew 23, or the man who harvests a field full of wheat and weeds, separating them out only at the harvest time in Matthew 13.

Jesus also used the biblical idea of Gehenna as the synopsis of what his vision of hell was like. Gehenna was the valley of Hinnom, one of the narrow defiles marking out the plateau on which Jerusalem was built. It was a biblical symbol of everything opposed to God, and as such destined to being purified when God roused himself in his judgment of the evils of the earth. It had been the place in ancient times where some of the inhabitants of Jerusalem had offered their own children in sacrifice to the god Moloch. The reforming King Josiah, as a result of "the abomination of desolation," made the valley into the place of refuse-burning for the city, a place where bodies of criminals were also thrown. In Jesus' teaching (as is the case for later rabbinic literature) it thus became a symbol for the desolate state of all who fall under the judgment of God. The burning of endless fires in a stinking wasteland that symbolized human folly and destructive wickedness is, therefore, Jesus' image for the alternative to his invitation for his hearers to enter, with him, into the service of God, and into the obedience of the Kingdom of God.

Christian disciples later developed the idea of Gehenna into the more elaborated concept of hell, just as they rendered the dynamic concept of the

Kingdom of God (obedience to the divine covenant) into the notion of heaven as a place for the righteous. The original point of the teachings was more dynamic, to the effect that humans have a choice to listen and respond to the prophetic call, or to ignore and oppose it. In either case they respond not merely to the prophet, but to God who sent the prophet. In the case of Jesus, those who listen and obey his teachings are described as the guests who are invited to the wedding feast; those who refuse it are compared to those who haunt the wilderness of Gehenna and have chosen the stink of death to the joy of life with God. It is a graphic image indeed, arguably having even more of an impact than the later Christian extrapolation of the eternal hellfire that developed from it.

Christian Theologians on Hell

Not all Christian theologians acceded to the gradual elision of the Hellenistic notions of Hades, and the apocalyptic imagery of the burning fires of Gehenna or the sea of flames, but certain books were quite decisive, not least the one great apocalyptic book that made its way into the canon of the New Testament, the Revelation of John, whose image of the Lake of Fire, where the dark angels were destined to be punished by God, exercised a profound hold over the imagination of the Western churches. The Byzantine and Eastern churches never afforded Revelation as much attention as did the West, and so the graphic doomsdays of the medieval period never quite entered the Eastern Orthodox consciousness to the same extent.

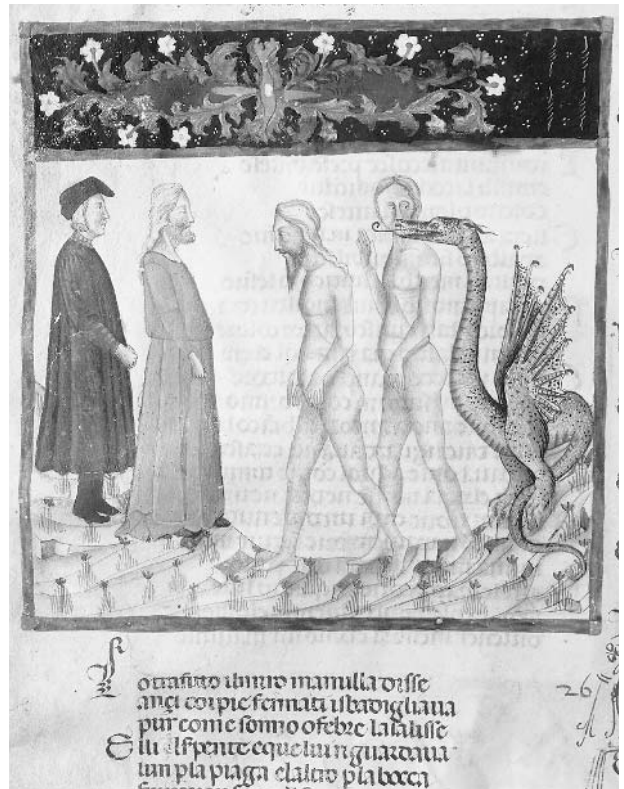
Some influential Greek theologians argued explicitly against the concept of an eternal hell fire that condemned reprobate sinners to an infinity of pain, on the grounds that all God's punishments are corrective, meant for the restoration of errants, and because an eternal punishment allows no possibility of repentance or correction, it would merely be vengeful, and as such unworthy of the God of infinite love. Important theologians such as Origen (*On First Principles* 2.10) and his followers (Gregory Nyssa and Gregory Nazianzen, among others) who argued this case fell under disapproval mainly because the Gospel words of Jesus described the fire of Gehenna as "eternal" even though it was a word (*aionios*) that in context did not simply mean "endless" but more to the point of "belonging to the next age."

But even with the unhappiness of the Christians with Origen's idea that hell was a doctrine intended only "for the simple who needed threats to bring them to order" (*Contra Celsum* 5.15), the logic of his argument about God's majesty transcending mere vengeance, and the constant stress in the teachings of Jesus on the mercifulness of God, led to a shying away from the implications of the doctrine of an eternal hell, throughout the wider Christian tradition, even when this doctrine was generally affirmed.

Major authorities such as Augustine and John Chrysostom explained the pains of fire as symbols of the grief and loss of intimacy with God that the souls of the damned experienced. Dante developed this in the *Divine Comedy* with his famous conception of hell as a cold, dark place, sterile in its sense of loss. Augustine aided the development of the idea of purgatory (itself a major revision of the concept of eternal punishment). Other thinkers argued that while hell did exist (not merely as a symbol but as a real possibility of alienation from life and goodness), it was impossible to conclude that God's judgments were irreversible, for that would be to stand in judgment over God, and describe eternity simply in time-bound terms; one position being blasphemous, the other illogical.

Because of the implications, not least because of the need to affirm the ultimate mercy and goodness of God, even when acting as judge and vindicator, modern Christian theology has remained somewhat muted on the doctrine of hell, returning to it more in line with the original inspiration of the message as a graphic call to moral action. It has probably been less successful in representing the other major function of the doctrine of hell; that is, the manner in which it enshrines a major insight of Jesus and the biblical tradition, that God will defend the right of the oppressed vigorously even when the powerful of the world think that to all appearances the poor can be safely tyrannized. Originally the Christian doctrine of hell functioned as a major protecting hedge for the doctrine of God's justice and his unfailing correction of the principles of perversion in the world.

In previous generations, when hell and final judgment were the subjects of regular preaching in places of worship, the fear of hell was more regularly seen as an aspect of the approach to death by the terminally ill. In the twenty-first century, while



Dante and Virgil are depicted walking in the cold, dark and sterile hell of the Divine Comedy. CORBIS

most world religions still advocate a role for the varieties of hell in their theological systems, the fear has substantively diminished even though popular opinion in modern America still expresses its widespread belief in the existence of hell. The change of attitude can be seen in media treatments of death and afterlife that commonly use images of the death experience as either a slipping into nonexistence, or as some form of returning to the welcoming light. Even modern American evangelicalism, strongly rooted in biblical sources, has shown a distinct move away from the doctrine of hell to a conception of final punishment as an "annihilation" of the souls of the unrighteous, a concept that is found in a few biblical sources as an alternative to the image of apocalyptic judgment.

Because of its vivid nature, and the increasingly static graphic imagination of later Christian centuries, hell came to be associated too much with an image of God as tormentor of the souls in some eternal horror. Such a God did not correspond to the gracious "Father" described by Jesus, but like all images packaged for the religiously illiterate, the dramatic cartoon often replaces the truer

conception that can be gained from the Gospels and writings of Christian saints through the centuries: that hell is a radical call to wake up and make a stand for justice and mercy, as well as a profound statement that God's holiness is perennially opposed to evil and injustice.

See also: CATHOLICISM; CHARON AND THE RIVER STYX; CHRISTIAN DEATH RITES, HISTORY OF; GODS AND GODDESSES OF LIFE AND DEATH; HEAVEN; JESUS; PURGATORY

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J. A. McGUICKIN

HERTZ, ROBERT

Robert Hertz was born to a Jewish family near Paris on June 22, 1881. As an anthropologist and politically active socialist, Hertz provided a new way of interpreting funerary ritual and sought to relate sociology to the practical flourishing of community life. At age nineteen he joined the *Année*

Sociologique group that included leading sociologists of the day such as Durkheim, Mauss, Hubert, and Halbwachs. Their approach stressed broad theories rather than the accumulation of voluminous cultural facts as in Frazerian anthropology. While volunteering for active service in World War I, he was killed in action on April 13, 1915.

The contemporary anthropologist Robert Parkin has highlighted Hertz's scholarly contributions to the symbolic significance of "right" and "left" classifications, to sin and expiation and to myth and death. Hertz's last and best-known essay—"*Contribution à une étude sur la représentation collective de la mort*"—was published in 1907 but largely forgotten in the English-speaking world until Rodney and Claudia Needham's English edition was published in 1960.

Echoing Durkheim's view of society as a moral community whose values are expressed as "collective representations," Hertz speaks of "society" and "collective representations" abstractly to explain how enduring values were related to concrete individuals. He demonstrated these links by analyzing death and funeral rites. Two paradoxical streams flow through his argument, one social and the other more psychological. Sociologically, he interprets society as perceiving itself to be immortal, transcending the lives of any individual members and conferring upon the dead a new status as ancestors. In this sense, members of society never die but change their relative relationships as they move from being living members of society to its dead "members."

The psychological stream concerns the relationship between the living and the dead and the experience of grief. Both social and psychological streams, however, relate symbolically to the state of the corpse. Indeed, Hertz was an early exponent of what would later be called "embodiment," interpreting the human body as a vehicle enshrining and expressing social values. Accordingly, he made a special study of "double-burial," distinguishing between "wet" and "dry" phases of ritual. The wet phase, often linked to temporary earth burial or containing the dead in pots, related to the rotting corpse and sociologically was the period when the identity of the dead was increasingly removed from his or her former living identity. Psychologically, this was a period when the living experienced the pain of early separation and might

have felt a sense of revulsion to the deceased. The dry phase of the ritual dealt with the bones and incorporated the dead into their new identity in the afterlife. At this time, a new sense of “reverent courage” might replace revulsion among the surviving kin. His reference to “internal partings” was an early form of attachment theory, just as his stress on transition and incorporation presages his friend van Gennep’s idea of rites of passage. Hertz’s influence increased significantly in the growing literature on death studies from approximately the 1980s.

See also: ANTHROPOLOGY; DURKHEIM, ÉMILE; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; IMMORTALITY, SYMBOLIC; RITES OF PASSAGE

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DOUGLAS J. DAVIES

HIDDEN GRIEF

See GRIEF: DISENFRANCHISED.

HINDENBURG

The *Hindenburg* was an 804-foot-long German dirigible and the largest rigid airship ever constructed. It was first launched in Friedrichshafen, Germany, in April 1936. The huge craft could lift a total weight of about 235 tons (215 metric tons). It carried fifty passengers and a crew of sixty, in addition to baggage, mail cargo, and its heavy load of fuel. It had a maximum speed of 84 mph (135km/h) and a cruising speed of 78 mph (126km/h). It was renowned not only for its size

but also for its luxurious two-deck passenger accommodations.

Commercial air service across the North Atlantic was inaugurated by the *Hindenburg*, carrying a total of 1,002 passengers on ten round-trips between Germany and the United States, was among the first lighter-than-air crafts, and certainly the most prestigious, to assure commercial air service across the North Atlantic. Then, on the evening of May 6, 1937, while landing at Lakehurst, New Jersey, the *Hindenburg* was destroyed in a massive, fiery explosion, killing thirty-five of the ninety-seven persons aboard and one ground worker. This disaster foreshadowed the end of the commercial rigid airship and the end of an era.

The disaster was generally attributed to a discharge of atmospheric electricity near a hydrogen gas leak from the zeppelin. There were some speculations that the dirigible had been the target of an anti-Nazi act of sabotage. More recent explanations disregard the bombing theory and the hydrogen leak problem, and lay the blame on a special fabric used for the outer skin which, when ignited, burns like dry leaves.

The importance of the event was magnified by a now-famous and often-replayed live radio broadcast of the disaster. This broadcast was the first to bring the drama of a major tragedy directly in the homes of Americans and helped ensure that this event would be considered one of the major disasters of the twentieth century.

See also: DISASTERS; TITANIC; TRIANGLE SHIRTWAIST COMPANY FIRE

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JEAN-YVES BOUCHER

HINDUISM

In India “death in the midst of life” is a literal, not figurative, notion. Along the Ganges River, for instance, bodies are regularly cremated, and the odor of burning flesh fills the air. And in the city of Calcutta, dead bodies become a problem to those responsible for keeping the streets clean. Thus, it is not surprising that in India’s sacred texts and stories, how one lives one’s life determines one’s fate after death.

Hinduism As a Religion

The roots of Hinduism go back to the Indus civilization in the third millennium B.C.E., but it is only with the migratory waves of Indo-European Aryans in the late second millennium B.C.E. that researchers have access to Hindu ideas about death and afterlife. The religious rituals that were brought by the Aryan pastoral nomads mingled with the customs of the native peoples, the Dravidians, and the culture that developed between them has come to be known as classical Hinduism. The word *Hindu* comes from the Sanskrit name for the river Indus. Hindu was not originally a religious term but was used by Persians and Greeks in the first millennium B.C.E. as a name for the people east of the Indus River. Muslims later borrowed the term *Hindu* to designate the non-Muslim population of India, and the British (who governed India in the eighteenth and nineteenth centuries) used it in much the same way. In its current usage, Hindu refers to those who follow the mainstream religious traditions of India and accept, at least nominally, the authority of the ancient priestly scriptures known as the *Vedas*.

Adherents of the Hindu path, or *sanatana dharma* (universal, eternal teaching), made up about 83 percent of India’s population, or about 808 million people, as of 1997. While a vast majority of Hindus reside in India, over the last several hundred years varied expressions of Hinduism have migrated to such places as Sri Lanka and Indonesia, in part because of the political and economic domination by England from the middle of the nineteenth century to the middle of the twentieth century. Beginning with Vivekananda’s (a disciple of Ramakrishna) attendance at the World Parliament of Religions in Chicago in 1893, held in

conjunction with the World Fair, about 1.3 million Hindus have emigrated to North America over the past century.

While Hinduism is not a religion in the familiar Western sense—it has no specific founder, no clear time of origin, and no organizational structure—at the core of its cumulative tradition are the three *margas*, or paths to spiritual liberation, which include ritual action (*Karma-marga*), the path of knowledge (*Jnana-marga*), and the path of devotion (*Bhakti-marga*). Each of these systems has its own justification, and each presents a distinctive view of death.

The Path of Ritual Action

Sacrificial celebration (*yajna*) was a central feature of the evolving Aryan religious tradition. By around 1200 B.C.E. a collection of hymns used for these sacrifices was brought together in the earliest scripture, the *Rig Veda*, and by the first millennium B.C.E. its complex rituals had come under the control of a class of priests or Brahmins. It was one of their special responsibilities to perform rituals correctly and to maintain and transmit the knowledge required for their proper performance.

Two major principles emerged in this period: the concepts of ritual knowledge (*veda*) and of ritual action (*karma*). At the center of these ritual celebrations was *Agni*, the lord of fire. It was to *Agni* that an offering was made, and by *Agni* that it was consumed and transformed. In the *Rig Veda*, one reads, “At *yajna* the prayerful community worships *Agni*, / Priest of all joy, blessed with youth, / He, untiring envoy for the Gods at the hour of offering, / He is the Lord of all treasure” (7.10.5). The Brahmins taught that fire sacrifices, properly conceived and correctly performed, reciprocally embodied the fundamental structures of the universe. Ritual action thus had cosmic consequences. Indeed, proper ritual action could produce desired results at a personal level.

The final sacrificial fire ritual is performed after one dies. In the Vedic view, early Hindus believed that cremation returned the physical remains of the deceased back to nature as smoke and ashes. Properly performed, the karma of this ritual established the departed in the “World of the Fathers.” To this early Vedic understanding was added the need for a special set of postcremation rituals to

complete a transition to the ancestral world. After-life is thus not only a matter of individual effort but also depends on correct ritual performances.

The Path of Liberating Knowledge

After about 800 B.C.E., the viewpoints and values of the Vedic ritual tradition were challenged by another system that emerged from within the Vedic system and developed into the classic scripture of Hinduism, known as the *Upanishads* (“Sitting near the feet of the teacher”). Upanishadic thinkers distinguished what is permanent and unchanging from what is transient and impermanent. At the cosmic level, the unchanging reality is *Brahman*, the absolute that underlies the transient names and forms of phenomena. At the personal level, this same reality is called the *atman*, or true self, the essential, unalterable being that underlies each person in the midst of activity.

The goal of the Upanishadic teachers was to escape from the ceaseless cycle of birth, death, and rebirth that was called *samsara*. Freedom from rebirth was made possible only by giving up one’s attachments to desires. In turn, this was only possible if one realized that true self, *atman*, was not part of the transient phenomenal world. The idea of *samsara*, including reincarnation (also called transmigration), refers to successive life embodiments of an individual soul (*jiva*). This life flux embodies a continual series of births, deaths, and rebirths. Reincarnation blends the natural evolution with a spiritual evolution toward awakening. For example, at the subhuman level, growth is automatic and progresses toward ever-increasing complexity from inorganic to organic to vegetative to human levels. At the human level, however, the soul has the opportunity to break out of this cycle of births, deaths, and rebirths.

To illustrate what happens at death from the Hindu standpoint, the outer or gross body (skin, bones, muscles, nervous system, and brain) is said to fall away. The subtle body sheath (composed of karmic tendencies, knowledge, breath, and mind) that coats the *jiva*, or psychic substratum, also begins to disappear. After death the *jiva* initially remains within or near the body before it completely departs from the body to eventually enter an otherworldly reality conditioned by one’s susceptibility to earthly sensual cravings. When these cravings have ceased, the *jiva* enters a temporarily

blissful existence until, at a karmically determined time, it takes on a new physical body and is reborn.

Upanishadic teachers agreed that *moksha*, the final liberation from a cycle of painful rebirths, is the goal of life. This final union with Brahman—which takes place before death—is described as a state of *sat* (being), *chit* (consciousness), and *ananda* (pure joy). The early Hindu sages, therefore, sought a realization that liberated the mind from the fear of death. This realization, or *moksha*, can be described as a spiritual death, a dying before dying, which accentuates at least four consequences: liberation (*moksha*) from the endless cycle of birth and death and birth and death; activation of *samadhi*, or the void, which is also absolute fullness and compassion; freedom from the effects of the reincarnation cycle at death; and a return to full identification with *atman*.

One of the most dramatic examples of this view occurs in the *Katha Upanishad* (800–500 B.C.E.), which relates the visit of Nachiketas to the Land of Death, Yama’s kingdom. In the story, a teaching dialogue occurs between an archetypal seeker and an immortal teacher. Nachiketas, the seeker, asks Yama, “What is the purpose of life, given the certainty of death?” Yama replies by affirming the way to freedom from attachments through realizing *atman* (the deathless Self): “Unborn is he, eternal, everlasting and primeval, / He is not slain when the body is slain. / Should the killer think ‘I kill.’ / Or the killed ‘I have been killed,’ / Both these have no [right] knowledge”(2.19). That is, for Yama, when the body dies, *atman* does not die. The secret of death, then, is realized not by preaching, not by sacrifice, but through meditation and grace. This realization of the supreme self hidden in the cave of the heart emancipates one from the vagaries of *samsara*.

The Path of Devotion

Both the Vedic rituals and the Upanishadic path of knowledge are products of the Vedic priesthood. The appeal of these paths was mostly confined to the elite social classes, and thus each path denied access to the majority of Hindus. In response to this limitation, by the second century B.C.E. a third path was emerging, one with both greater popular appeal and greater accessibility. This new path—devotional theism—was based not on Vedic rituals or Vedic knowledge, but on the worship of various

popular deities. The way of devotion (*bhakti*) is dramatically expounded in the *Bhagavad Gita*, or *Song of the Lord* (500–200 B.C.E.). Not a Vedic text, the *Bhagavad Gita* is a part of a long popular epic known as the *Mahabharata* that was accessible to the populace.

Devotional theism took root, expanded rapidly, and, by the early centuries of the common era, had become, in terms of numbers of followers, the dominant form of Hinduism. In this path, many gods and goddesses are worshipped (e.g., Vishnu, the protector, with his incarnations as Krishna and Rama; Shiva, the destroyer, the divine Yogi and cosmic Lord of dance; and Devi, the goddess in a variety of names and forms). Devotional theism, this third path within Hinduism, emphasized above all faith and grace. Release from rebirth was no longer viewed as a matter of knowledge alone but also could be received as a divine gift by faithful devotees. The sought-for afterlife, then, was not the sterile or abstract “World of the Fathers” but a life—or afterlife—of devotion to God.

The *Bhagavad Gita* presents a dialogue between Krishna, the divine teacher, and Arjuna, the warrior disciple. Unlike the Buddha (the awakened one), Krishna is the incarnation of *Vishnu*. Krishna, disguised as a charioteer, listens to Arjuna’s despair at the prospect of fighting his kinsmen to retrieve land that is rightfully his. Then Krishna speaks: “All things born must die,” and “out of death in truth comes life” (2:27). Echoing Yama’s words to Nachiketas, Krishna goes on to say that death is an illusion. Like those of the *Katha Upanishad*, Krishna’s teachings on death argue four basic attitudes: the death of one’s physical body is inevitable and should not cause prolonged grief; the subtle dimension of the person (*jiva*) does not die at death, rather takes on a new body; the eternal self (*atman*) is birthless and deathless, and cannot be destroyed; and one who realizes the eternal self while yet alive will not be reborn but, at death, will merge with ultimate reality, or Brahman.

Whereas the practice of sacrifice in the *Vedas* referred to an external ritual that included fire, drink, chants, stories, and grain or animal offerings, Krishna teaches devotional sacrifice. Performing all actions without attachment to the results, the devotee sacrifices even attachments to the divine. How-

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Vishnu, the Hindu god of protection, is illustrated by this eleventh-century sculpture. ST. LOUIS ART MUSEUM

ever, Arjuna is left with a significant question: How does one realize *atman*? Krishna provides several clues. Beyond *jnana yoga*, the way of knowledge (intuitive, single-minded awareness of the eternal self), Krishna emphasizes *karma yoga* (self-sacrificing, detached activity) and *bhakti yoga* (self-surrendering devotion to the divine). In fact, the highest secret of the *Bhagavad Gita* is most appropriately practiced at the time of death. Krishna teaches: “Let him [the dying person] utter [the sound] Om, *Brahman* in one syllable, / Keeping Me in mind; / Then when his time is come to leave aside the ody, / tread the highest Way” (8:13). And then Krishna promises that a person will be freed from the bonds of misfortune when “Armed with the discipline of renunciation, / Yourself liberated, you will join me . . . / Keep me in your mind and devotion, sacrifice / To me, bow to me, discipline yourself to me, / And you will reach me!” (9:28, 34). These verses express a constant refrain of devotional

Hinduism—not only to be freed from karma-caused traces of rebirth, but also to achieve a permanent union with one’s personal deity through a devotional relationship. While the Gita represents only one version of the path of devotion, its teachings are broadly typical with respect to both devotion and the afterlife.

Death Ritual

All of the views of afterlife outlined above became part of the continuing Hindu religious tradition, and they and their related systems of liberation—the three margas—have provided the basic framework of Hinduism for the past 2,000 years. What Hinduism offers with regard to death and afterlife is thus not a final decision that must be made in one’s present lifetime, but a process that leads through many cycles of death and rebirth until one is able to reach the goal of liberation.

Typically, as a Hindu approaches death, he or she is surrounded with religious rites and ceremonies that support the dying person. Before a Hindu dies, the eldest son and relatives put water taken, if possible, from the Ganges River into the dying person’s mouth. At this time, family and friends sing devotional prayers and chant Vedic *mantras* (sacred sounds). More than the words, which are themselves comforting, the tone of the communal chanting soothes the dying person and comforts relatives in their time of stress and grief.

Hinduism requires cremation as soon as possible (unless the deceased is less than three years old, in which case he or she is buried). In New Delhi alone, it is estimated that 50,000 bodies are cremated annually. In response to the depletion of forests caused by wood-burning cremations, the Indian government has begun building electric crematoriums throughout India. Some traditional Hindus, however, have argued that ending wood-burning cremations could violate their religious rights.

Prior to cremation, the body is washed and anointed, the hair (and beard) is trimmed, and the corpse is given new or clean clothes. During the procession, relatives and mourners, who carry the body to the cremation ground, chant verses that invoke Yama’s help. The body is then placed on a funeral pyre. The eldest son finally walks around the pyre three times, each time pouring sacred

water on the deceased. He then sets fire to the wood with a torch that has been blessed. Throughout the sacred ritual, relatives and mourners chant Vedic mantras to quicken the soul’s release.

See also: BUDDHISM; CHINESE BELIEFS; ISLAM; REINCARNATION; WIDOW-BURNING

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KENNETH P. KRAMER

HIPPOCRATIC OATH

The recitation of the oath attributed to Hippocrates is an integral part of medical school graduation in the Western world. Referred to as either the Hippocratic oath or the oath of Hippocrates, the oath exists in a variety of forms and has been translated and revised over the centuries. Early versions advised physicians to practice the art of medicine solely for the benefit of their patients. Twentieth-century versions emphasized that doctors abstain from practices that would harm their patients, and stress the ethical basis of medical practice.

The Hippocratic oath requires that medical graduates solemnly promise to adhere to a course of professional conduct that has guided physicians in ages past. It also requires that they promise to revere their instructors and to care for them should they ever require assistance; transmit (teach) the art of medicine to deserving persons; utilize good judgment to provide beneficial treatment for patients; abstain from providing any harmful or dangerous treatments; refrain from intervening in cases that require greater skill and training; remain pure and holy in the practice of the profession; limit involvement with patients solely to the benefit of the patient's health; give no cause for disrespect of the profession through word or deed; and keep confidential all that is learned through practice of the profession. The oath concludes with a statement that if the physician adheres to these precepts, he or she will enjoy happiness, success, and respect.

The Hippocratic oath is an anachronism. It is outdated and holds no power. There are no sanctions for those who violate its precepts, nor does it have status in a court of law. It is a historical document with unconscious, symbolic dimensions stemming from its 2,500-year-old historical tradition. Its persistent use during medical school graduation ceremonies does provide symbolic significance beyond words. In essence, it emphasizes the unique role and responsibilities of the physician in activities of a

high nature and establishes a basis for the guiding principles of medical care, which include autonomy, beneficence, justice, and nonmaleficence.

The most recent version of the oath is the product of collaboration between doctors from both the United States and Europe. It contains three guiding principles—primacy of patient welfare, patient autonomy, and social justice—and lists ten professional responsibilities. It stresses the centrality of altruism in the physician-patient relationship. It states that the quality of medical care must not be compromised by market forces, societal pressures, or administrative exigencies. It emphasizes that doctors must be honest with their patients and empower them to make informed decisions about their treatment. Patient decisions about their care must be recognized as paramount, as long as those decisions are consistent with ethical practice and do not contribute to demands for inappropriate care. It urges physicians to work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

See also: ADVANCE DIRECTIVES; EUTHANASIA; INFORMED

CONSENT; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE

WILLIAM M. LAMERS JR.

HOLOCAUST

The term *holocaust*, with origins in the Greek translation of the Hebrew Bible, translates the Hebrew expression *olab* as *holokauston*, meaning “a burnt sacrifice” (Berenbaum 2000, p. 31). Deeply imbued with religious meaning, the expression is presently most closely associated with the Nazi policy of mass murder directed against European Jewry. In a century when over 140 million people died in wars, the Holocaust may long be the ultimate symbol of inhumanity.

The meaning of Holocaust is itself fraught with great controversy. Some, like the historian Walter Lacquer, insist that the expression is “singularly inappropriate” because of its religious connotations (Lacquer 1980, p. 7). Elie Wiesel, a survivor of Auschwitz and the Nobel Prize-winning author of

Night (1960), is often credited with introducing the word into popular usage. In the face of this religious qualification, the term remains widely used by academics, the media, and the larger community. Wiesel has since expressed great concern over the abuse of the term applied to situations beyond the historical context of the Third Reich and the experience of mass destruction experienced by the Jews. Just as important, Wiesel reminds readers that the term *Holocaust*, like any expression from human language, invariably falls far short in encompassing the sheer horror and depth of tragedy behind the persecution and mass death inside and outside Nazi concentration and death camps. Poets and historians still search for words to explain the unfathomable atrocity.

The history of the Holocaust reflects the reality that Adolph Hitler and the Nazi movement did not invent anti-Semitic hatred against the Jews. What was unique in the Nazi experience was that the Third Reich was the first and only regime in modern history to define anti-Semitism in racial terms and, upon this basis, to use the full weight of the state to legitimize the *Ausrottung*, or eradication of the Jews. Racial bloodlines defined the essential difference between Aryan Germans and Jews. This distinction, in the words of Victor Klemperer, a philologist and shrewd observer of Nazi language, was everything. What set National Socialism apart from other forms of fascism “is a concept of race reduced solely to anti-Semitism and fired exclusively by it” (Klemperer 2000, p. 135). The racial state conceived by the Nazis as a foundation stone for the Holocaust defined citizenship in biological terms. As one prominent Nazi race eugenicist argued, “National Socialism is nothing but applied biology” (Baur, Fischer, and Lenz 1931, p. 417).

Part of the Nazi success in rising to power in 1933 was the union of racial science from the late nineteenth century with traditional religious and economic forms of anti-Semitism rooted in the Middle Ages. From its inception racial science took on an international character. Appearing only about six months into the regime, the Nazi Law on the Prevention of Hereditarily Ill Progeny, which legalized compulsory sterilization, drew from a notable legislative model in the numerous compulsory sterilization measures passed by twenty-four of the states of America under the aegis of the American eugenics movement, beginning with

Indiana in 1907 (Kühl 1994, p. 17). The Nazi policy of destroying “life unworthy of life” under the banner of “scientific objectivity,” of which sterilization was an early manifestation, would hold profound implications for others deemed racially undesirable, including Jews and Gypsies.

Furthermore, Nazi propagandists exploited the long tradition of religious anti-Semitism in the Lutheran and Catholic churches. Jews were considered outcasts by both religious communities because of their refusal to convert to Christianity and for the charge of deicide in killing Christ. Martin Luther became an especially popular historical reference for Nazi propagandists who liberally quoted the religious reformer’s incendiary pamphlet, “The Jews and Their Lies” (1543). Luther vented his rage against the Jews by drawing on old economic stereotypes depicting Jews as greedy moneylenders with an aversion to physical labor. The negative connotation of usury and lust for money, part of both Christian traditions, remained alive and well under the Third Reich. As vital as Jews were to the emerging market economy of Europe, they were still held as parasites and criminals. The social and economic power of anti-Semitic stereotypes like these was central to William Shakespeare’s play *The Merchant of Venice* (1596), which portrays the rejection and suffering of Shylock, the Jewish merchant. Under the Third Reich, the new anti-Semitism, steeped in the language of race biology and yet connected to traditional hatred for Jews in the marketplace and church, provided an even more powerful ideological justification for persecution of a distinct minority.

Anti-Semitism alone does not explain German Nazism and the Holocaust. Yet any serious consideration of what caused the Third Reich must take into account the dynamics of anti-Semitic thinking and their influence in shaping the formation and administration of Nazi social and political policies. Hitler’s anti-Semitic agenda and the reality of the Holocaust did not assume definite policy directions overnight. Other contemporary factors played a significant role in bringing Hitler to dictatorial rule. Buoyed by the social and political malaise engendered by the Great Depression and skyrocketing unemployment and inflation rates, Hitler ridiculed democratic institutions and the lack of political unity under the Weimar Republic. Hitler also exploited the legacy of the Treaty of Versailles, which stripped

Germany of pride and territories, and added the heavy weight of war guilt and reparations. All of these elements from World War I left a great deal of resentment among various elements in the German population. Here again, the Jews suffered from scapegoating and received blame for Germany's misfortunes. In what became known as the "stab in the back," Jews were even accused of causing Germany's defeat in World War I by working behind the scenes as betrayers on the home front.

Historians and social scientists still struggle to understand how a country with one of the highest literacy rates in the world and a culture which nurtured great scientists, musicians, and theologians could administer one of the biggest mass murders in history, carried out with the complicity of millions and with the aid of the most modern technological means available. Indeed, the Germans were to industrialize mass death and the disposal of their remains. Germany was not the only country with a culture marked by deep-seated anti-Semitic resentments, but it was the only one to transform this resentment into a policy directed toward annihilating the entire Jewish people.

Neither were the Jews the only group identified for total destruction because of racial reasons. The infamous "T-4" killings of the handicapped, the mentally ill, and those suffering from hereditary illness conducted by medical doctors under Hitler's orders preceded the formation of the death camps in the East. These were the first victims of mass murder. Under the guise of "euthanasia" and supported by the legal apparatus of the state, as many as 6,000 children and 70,273 adults met their deaths at the hands of medical professionals in asylums across the Reich. The vast majority of the victims died in gas chambers. The choice of method for this kind of murder was critically important for the future. The early Nazi elimination of "life unworthy of life" through the "T-4" killings foreshadowed the use of gas chambers in Auschwitz and other camps as well. Both the technology and many of the former medical personnel from this sordid experiment in mass murder would re-emerge with the SS, or *schutztaffel*, in helping to run the machinery of the death camps after 1941. The story did not end here. The intent to racially cleanse Germany of undesirable racial elements also extended to Sinti and Roma, called *Zigeuner* by the Germans and known traditionally as "Gypsies." Classified by the Nazis as "criminal"

TABLE 1

| Jewish casualties from the Final Solution | |
|--|-----------|
| German Reich (boundaries of 1938) | 130,000 |
| Austria | 58,000 |
| Belgium | 26,000 |
| Bulgaria | 7,000 |
| Czechoslovakia (boundaries of 1938) | 245,000 |
| France | 64,000 |
| Greece | 58,000 |
| Hungary and Carpatho-Ukraine | 300,000 |
| Italy | 8,000 |
| Latvia, Lithuania, Estonia | 200,000 |
| Luxembourg | 3,000 |
| Netherlands | 101,800 |
| Norway | 677 |
| Poland (boundaries of 1939) | 2,700,000 |
| Romania (boundaries prior to 1940) | 220,000 |
| USSR (boundaries prior to 1939) | 800,000 |
| Yugoslavia | 54,000 |
| | 4,975,477 |

Note: The numbers under discussion cannot embrace the full depth and scope of human loss which was the Holocaust. Controversy undoubtedly continues among scholars over the statistics representing the loss, of which Gerald Fleming's research is an important part.

SOURCE: Fleming, Gerald. *Hitler and the Final Solution*. Berkeley: University of California Press, 1984.

or "asocials" and forced to wear the black triangle on prisoner clothing, at least 250,000 Sinti and Roma died under Nazi rule. Whether the Nazis fully intended to wipe out the entire population of Sinti and Roma remains an issue of some dispute among scholars.

The Road to Auschwitz

There existed no doubt among Nazi policymakers regarding the scope of mass murder and the massive destruction of Jews in the wake of the attack on Russia in the summer of 1941. The Nazi intention was to kill every single Jewish man, woman, and child. Hitler vented his obsessive hatred for Jews in *Mein Kampf*, (*My Struggle*) originally written in Landsberg prison in 1924. The Jewish community stood in diametric opposition to his racial vision for a New Germany. Judeophobia, as the scholar Klaus Fischer calls it, reflected a paranoid distortion of reality and delusory thinking. After rising to power in 1933, Hitler wasted little time before moving against the Jews and other avowed enemies of the state. Dachau, the first of many concentration camps originally created to incarcerate political enemies of the regime, opened less than two months after Hitler came to office. The

SA, or *sturmabteilung*, brown-shirted storm troopers, rounded up Social Democrats and Communists. The Nazis followed on April 1, 1933, by boycotting all Jewish businesses. Even more devastating to the Jewish community was the dismissal of all Jews from civil service and the legal practice six days later.

The mass murder of Jews and others declared unworthy of citizenship did not take place overnight. State violence and terror, in order to be more fully institutionalized, required the legitimacy of a legal framework. Early on the perpetrators created a series of laws to legalize the oppressive actions taken against their victims. Compulsory sterilization laws appeared in July 1933 leading to the forced sterilization of over 320,000 people suffering from hereditary illnesses. Forced to wear the pink triangle and condemned under Paragraph 175 of the 1871 Reich Criminal Code, which made homosexual relations a criminal offense, at least 10,000 gays suffered imprisonment and deplorable treatment in at least eleven concentration camps.

The legal noose continued to tighten around the Jews. A public book-burning of works by Jewish authors like Heinrich Heine and Sigmund Freud along with other opponents of Nazism took place in May 1933. Signs declaring “No Jews” sprung up all over the country during the summer of 1935 outside restaurants, stores, and villages forbidding Jewish entry. A critically important racial development emerged in September of that year under the anti-Semitic Nuremberg Laws. These laws virtually stripped Jews of citizenship, legitimizing the huge social chasm between Jews and Aryan Germans. With the intent of preserving blood purity, Jews could not marry and have sexual relations with Germans or employ female employees under the age of forty-five in their households.

An equally ominous but perhaps lesser known aspect of the Holocaust regarded early reactions of the global community to the treatment of the Jews. At an international conference staged at Evian in France during early July 1938, diplomats representing thirty-two nations met to discuss solutions in answer to a growing refugee problem. The mounting number of Jewish refugees from Austria and Germany created pressure on the United States and other countries to raise immigration quotas. Little more than expressions of sympathy

for the Jews came out of the conference. In short, the conference results convinced Hitler that “no one wanted the Jews” and, moreover, implied that he had a free hand in dealing with the Jews without international interference.

A growing escalation of violence against the Jews occurred during *Kristallnacht*, or the Night of the Broken Glass, on November 9, 1938. That evening, over 1,000 synagogues across Austria and Germany were burned and many Jewish businesses looted and destroyed. Ninety-six Jews were murdered and 30,000 were arrested and sent to concentration camps in Dachau, Sachsenhausen, and Buchenwald. Eight days later, Jewish children were expelled from German schools. Economic pressures increased; the isolation of the Jews continued with the compulsory expropriation of their businesses, industries, and shops with the “Aryanization” of the economy in December of that year.

The Final Solution, the Nazi answer to the Jewish question, did not follow a direct path from Hitler’s obsessive hatred of Jews, as expressed in *Mein Kampf*, to the killing fields of the death camps. A major focus of Nazi policy from 1933 to 1941 was to use forced emigration to clear Germany of all Jews. At least as late as the closing days of 1938, the Nazi regime explored the possibility of organizing a wholesale migration of Jews to either Madagascar or Palestine. Some historians, like Gerald Fleming and Eberhard Jäckel, known in some quarters as intentionalists, claim a direct connection between Hitler’s anti-Semitic ideology and anti-Semitic practices. Karl Schleunes, representing a more functionalist point of view, argues that the Nazi leadership from the top down had not defined the scope and substance of the Final Solution.

Conditions of the war on the eastern front marked a critical phase in the Holocaust. Vast tracts of territory, along with huge numbers of Russian prisoners of war and Jews, fell under German control during the early phase of Hitler’s war with Russia. Christopher Browning’s research argues convincingly that Hitler gave the go ahead for the mass murder of the Jews in the fall of 1941, some four months after Germany attacked Russia. This distinction is important since it sheds new light on the old and misguided assumption that plans for the Final Solution were first instituted months later as part of the Wannsee Conference on January 20, 1942. Knowing when Hitler and his circle passed

the point of no return in regard to killing Jews remains important for students of the Holocaust for several reasons. As Browning reminds readers, this extreme case of genocide was different from other genocides in that the goal was to eliminate every single Jewish person in the entire Reich and occupied territories. This genocide remains unique as a turning point in history for another reason. The Nazi regime exploited the latest technology as well as considerable bureaucratic and scientific resources to achieve the most thorough and efficient killing process possible.

The Dynamics of Nazi Mass Murder

An important distinction existed between the formation of concentration as opposed to death camps within the Nazi racial state. Concentration camps originally imprisoned political opponents. Eventually, as racial enemies of the regime, Jews also became part of the prison population in the concentration camps. Death camps, of which there were six in number, were located in Poland. Their sole purpose was to kill as many Jews as quickly as possible. Auschwitz, Chelmo, Treblinka, Sobibor, Maidanek, and Belzec are places that will forever live in the memory of the Holocaust. Of these, Auschwitz was by far the largest. From at least 1.3 million deportees to Auschwitz, about 900,000 met their end very soon after arrival. Another 400,000 entered as camp prisoners and given identification numbers. About half of these people died of disease, hunger, or slave labor. Many of the remainder met their end by injection, medical experiments, or the gas chambers. Ninety percent of the victims in Auschwitz were Jews. Poles constituted the second largest group followed by Gypsies and Soviet prisoners of war.

The geographical location of the death camps in the East afforded a certain level of official secrecy and deceit in the administration of mass murder. The six camps were located close to the highest concentration of Jews in all of Europe. Pre-war Poland had a Jewish population of just less than 3 million. Auschwitz, which opened its gates as a death camp in 1942, was favorably situated because of its location at a confluence of major railroad lines. The railroads acted as major arteries to the death camps running from all parts of occupied Europe. Day and night Jews from twenty countries were shipped to their deaths.

The railroads, in order to operate as efficiently as possible, relied on armies of trusted bureaucrats who, with the stroke of their pens, determined the fate of hundreds of thousands of people. These same faceless figures rarely witnessed the lethal results of their orders. SS Officer Adolf Eichmann, as master bureaucrat, was a central figure in this process since he designed and administered the entire transportation system for the purpose of speeding up the process of mass murder. The memoirs of Rudolf Höss, SS commandant of Auschwitz, reveal a kind and dedicated family man who felt no hatred for Jews. In the banal language of the brutally efficient bureaucrat, he simply had a job to do.

The power of Nazi propaganda to work a language of deceit was an important factor in efficiently moving large groups of people to their unknown destinations. Victims were packed into cattle cars under the most inhumane conditions without food, water, or basic sanitation. To quell the threat of riots, Nazi officials informed passengers that they were part of a resettlement project. Showers, clean clothing, and hot soup were among those things promised at journey's end. Jewish musicians were pressed into service to play classical music at the gate of Auschwitz to soothe the anxieties of incoming prisoners. The real truth of the matter was hidden in an intricate language of deception. To make the situation even more precarious, Jews were required by law to wear the yellow star in September 1941. The Nazis developed no less than twenty-five expressions to mask the real meaning behind mass murder. *Sonderbehandlung* conveyed a literal meaning of special treatment. The expression really meant taking Jews through the death process in the camp. Arriving prisoners saw a welcome sign for *Badeanstalten*, or bath houses, which really were gas chambers.

Not all Jews were killed in the camps. To facilitate the killing operations, the Germans initiated the *Einsatzgruppen*, or mobile killing squads under the direction of the SS. This newly formed "police army" swept through areas newly conquered by the German army in Poland and Russia. Thousands of Jewish women and children were hunted down and shot on the spot. Males were either executed or deported. This massive killing campaign, carried out primarily in 1942, demonstrated the highly concentrated methods used by

the SS to eliminate as many people as possible within a relatively short timeframe. This was another face of the Holocaust which reflected the serious Nazi intent and purpose to carry out a war against the Jews.

The Voice of Survivors

Several years would pass after the horrific experience of the Holocaust before survivors began to write about and discuss the meaning of their experiences. Survivor literature teems with many volumes of memories and poignant observations about the problem of being human under Nazi persecution. The writing of Elie Wiesel and Primo Levi, both Jewish survivors of Auschwitz, remain among the most popular authors from this literary genre. Wiesel's *Night* continues to be the most widely read recollection of the Holocaust. He captures his own adolescent struggle with his father while offering poignant observations about the problem of retaining some kind of humanity in Auschwitz. Perhaps one of the most excruciating theological questions raised by Wiesel concerns the existence of God. For him, the question about the presence or absence of God in Auschwitz remains unanswered to this very day.

The sheer struggle for survival, also a powerful theme in Wiesel's writing, returned to Levi's experience in a most powerful way. His *If This Is a Man* (1986) recounts with great insight the culture of Auschwitz and the behavior of both perpetrators and victims. Under the shadow of hunger, disease, and fear, Levi describes the extent to which human beings regressed to the level of animal instinct to survive. There was for this man a larger lesson to be learned: "The story of the death camps should be understood by everyone as a sinister alarm-signal" (Wiesel 1986, p. 4).

The importance of the survivors as teachers of succeeding generations cannot be overstated. The late existential psychologist Viktor Frankl, a survivor of four camps, influenced many readers with his theory about the nature of meaning and its relationship to suffering. Art symbolized another legacy from the survivors, including Alfred Kantor's 1987 collection of drawings depicting his experiences as a survivor in Auschwitz and Theresienstadt. Szyman Laks takes readers into the world of a musician in the orchestra at Auschwitz. His

writing defies those who insist on finding a message of hope in the death camps. In *Music from Another World* (2000), Laks describes how the experience of being a musician, steeped in the classics and the daily smell of death, led some to despair. Until the 1980s the voices of women survivors were overlooked. A rich literature in poetry and verse relating the experiences of women in the camps by Carol Rittner (1993) and Ruth Schwetfeger (1989) offers readers new perspectives on the oppression of female populations. Another way of preserving the voices of survivors for future generations is being led by the pioneering work of the filmmaker Steven Spielberg and the Shoah Foundation. The group digitally recorded and indexed interviews with over 50,000 survivors. The realization is that, in only a few years, all survivors will pass into history.

The Accounting of Death

Exactly how many victims died in the Holocaust will never be known with great exactitude. Six million Jews lost their lives under the Nazi regime, a figure most commonly cited over the years by historians and social scientists. This statistical assumption continues to come under scrutiny. The historian Gerald Fleming argues with certainty that the figure reaches the 5 million mark (see Table 1). Raoul Hilberg proposes a slightly higher number of Jewish victims at 5.1 million. One important basis for determining the scope of human destruction in the death camps are the railroad passenger numbers and points of departure with dates carefully documented by the SS. While the toll of other twentieth-century disasters are often known to the single person, the loss of life from the Holocaust can only be estimated to within hundreds of thousands and millions. In some cases, entire Jewish communities in eastern Europe were wiped off the face of the earth.

More Competing Views

Noted earlier were the competing views of scholars regarding the intentional versus the functional nature of Nazi ideology and the Holocaust. Another voice, which emerged in the mid-1990s, sparked a firestorm of debate. Daniel Goldhagen's *Hitler's Willing Executioners* (1996) claims that anti-Semitic hatred, nurtured in the soil of Christianity, was *the* central cause for the Holocaust and

that such hatred was imbedded in German culture. Goldhagen attacks the cherished assumption that Germans were guilty only of obedience to authority. Like many other institutions under the fascist process of centralization, the churches participated in an already deeply rooted German tendency toward “eliminationist anti-Semitism” (Goldhagen 1996, p. 23).

Goldhagen’s thesis came under withering criticism by a host of historians. The prominent German historian Eberhard Jäckel accused Goldhagen of advancing “primitive stereotypes” while making wholly inaccurate contrasts between anti-Semitism in Germany and developments in Italy and Denmark. Christopher Browning’s scholarship emphasizes obedience to authority as a critical development leading to the Holocaust. He carefully contends that the demonization of an entire people with the charge of anti-Semitism explains nothing. Goldhagen’s reductionist argument did not sit well among many historians. The controversial nature of the Holocaust, deeply embroiled in the causes and motivations for mass murder, promises new and expanded debates in the future.

Appearing in the late twentieth century, certain revisionist historians like David Irving and Arthur Butz, members of the infamous Institute for Historical Review, exploited historical ignorance and nascent anti-Semitic prejudices by denying the Holocaust. Irving had long argued that Hitler remained ignorant of the Holocaust and Butz insisted that gas chambers did not exist at Auschwitz. The emergence of Holocaust denial as a cultural phenomenon, often reflecting an anti-Semitic agenda from elements of the Far Right, is not one to be overlooked or easily dismissed. A legal confrontation was inevitable. In 2000 a civil trial in London, where Irving sued the scholar Deborah Lipstadt for calling him a Holocaust denier, ended in disgrace for the plaintiff and a resounding public condemnation of Irving’s historical claims about Hitler and the Jews by the judge. The controversy is not over. The language of anti-Semitic hatred continues to find audiences on the Internet under a growing number of web sites. In the Federal Republic of Germany and Canada, public denials of the Holocaust are considered expressions of hate language, incitements to violence, and insults to the dead. As such, these actions are considered serious violations of federal law in both nations.

The long shadow of the Holocaust continues to shape world affairs. The tremendous sorrow, grief, and sense of betrayal from the Holocaust provided a powerful emotional and political thrust for Jews to create the state of Israel in 1948. Research protocols ensuring the protection of research subjects, growing out of the revelations of the Nuremberg trials, influences the way research is conducted today. Millions each year visit the extensive exhibits in the Holocaust and Memorial Museum in Washington, D.C. A new memorial in the center of Berlin, finalized after a protracted debate in the Federal Republic, will memorialize millions of Jews whose lives were lost in one of the most horrendous genocides in human history. The legal settlements over Swiss gold, which began in 1998 and continue into the twenty-first century, as well as reparations paid by German corporations who employed forced laborers raised a new awareness about the complicity of economic interests in the Nazi exploitation of minority populations. A deeper understanding about the human capacity for evil is an inescapable part of this legacy.

See also: BLACK STORK; GENOCIDE; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; JUDAISM; MASS KILLERS

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GREGORY PAUL WEGNER

HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF

Early legal codes, including English common law, defined homicide as the killing of a human being and included suicide. As the American legal system evolved, suicide was excluded and homicide became "the killing of one person by another" (Allen and Simonsen 1998, p. 615).

National and international definitions of homicide vary from society to society. Because most societies consider homicide to be the killing of one human being by another human being, both suicide and the murder of inhuman beings (beings "lower" than humans) are excluded from the definition. The differentiation between abortion and homicide has not always been so clear-cut. Some people consider a fetus to be a human being from the moment of conception, whereas others are more liberal in their beliefs. The debate over the line between human being and nonhuman being, with regard to abortion, is a continuous issue, but the U.S. Supreme Court's January 1973 *Roe v. Wade* decision eliminated the act, especially in the first trimester of pregnancy, from the definition of homicide. At the start of the twenty-first century, forty states and the District of Columbia prohibited (except in rare circumstances) abortions after the fetus becomes viable (i.e., capable of surviving outside the mother on its own)—generally after the twenty-seventh week of pregnancy. When the fetus becomes viable, it becomes a human being

and, unless legally permitted, its termination falls within the realm of homicide. An ongoing legal issue is “partial birth” abortion in relation to the subject of homicide.

Homicide is generally divided into two categories: criminal (unjustifiable) and noncriminal (justifiable or excusable). Noncriminal homicide involves the taking of the life of another in a manner that would not invoke criminal sanctions. The police officer who kills in the line of duty, the public executioner who is paid for the action, and the private citizen who kills to protect his or her own life and/or the life or lives of others may be justified or excused for their behavior.

Criminal homicide is an act that is *mala in se*. This means that it is behavior that is morally wrong in itself and is objectively and inherently criminal regardless of where it occurs. The killing of a person by another in a nonlegal manner is a violation of “natural law,” which Frank Schmalleger defined as “rules of conduct inherent in human nature and in the natural order which are thought to be knowable through intuition, inspiration, and the exercise of reason, without the need for reference to man-made laws” (Schmalleger 2001, p. 122). Homicide that is criminal is classified as a felony and is typically punishable by a year or more in a state or federal penal institution. In some circumstances, the death penalty may be administered.

Each state differs in the defining of criminal homicide. The Federal Bureau of Investigation’s *Uniform Crime Reports* uses the categories of murder and nonnegligent manslaughter (“the willful . . . killing of one person by another person”) and manslaughter by negligence (“the killing of another person by gross negligence”). It classifies justifiable homicide separately and excludes traffic fatalities. It is most helpful to simply divide criminal homicide into murder (first degree and second degree) and manslaughter (negligent, or involuntary, and nonnegligent, or voluntary).

First-degree murder consists of both premeditation and malice aforethought. Perpetrators of such murders possess *mens rea*, or criminal intent. They possess an “evil mind” or “depraved heart.” They are aware that they have no right to kill, but they intend to commit an act of murder anyway (malice aforethought), and they carefully plan the demise of their victim (premeditation). For example, Joe Jones is an heir to the fortune of his Uncle

John. Finding himself in need of money, Jones, after careful contemplation, decides that he wants his uncle dead and carefully plans to kill him via poisoning. Jones does not have to be present at the time of his relative’s death to be convicted for his action.

In second-degree murder there is malice aforethought without premeditation. In other words, the offender intends to kill the victim but does not plan the lethal act. Bill Smith buys a new car, drives it home, and parks it in his driveway. While Smith is in his home, a neighbor attempts to vandalize and destroy Smith’s new automobile. In a fit of rage and the full intent to kill, Smith returns to the driveway and murders his neighbor.

An act of voluntary or nonnegligent manslaughter is committed when a person attempts to hurt, but not kill, another human being—but the victim dies in the process. In a fit of drunken rage, Ray Wrong decides to teach his wife a lesson by banging her head against a wall. At the completion of his act, she is dead.

Negligent or involuntary manslaughter is characterized by accidental death. Some states distinguish between vehicular and nonvehicular accidental death and others do not. Jane Fast, while traveling through a school zone at an excessive rate of speed, hits and kills a pedestrian in a crosswalk. Her behavior would be considered an act of vehicular homicide. Mark Carpenter, while working on the roof of a new home, drops his hammer, which hits the head of a coworker working below. When the coworker dies from a skull concussion, the act becomes one of accidental, but not vehicular, manslaughter.

A number of studies have shown that the majority of homicides occur between people who know each other. “Non-stranger” or “acquaintance” homicide may range from individuals who encounter one another on one occasion and the death comes later, to persons who have been married for many years. In 2001 Freda Adler, Gerhard O. W. Mueller, and William S. Laufer reported on one study that indicated that 44 percent of the victims were in an intimate relationship with their killer, 11 percent were the children of the perpetrator, and 26 percent were friends and acquaintances. Only 7.5 percent of the killings involved strangers.

In a 1958 study of homicide in Philadelphia, Marvin Wolfgang found that a large number of the victims had initiated their own death. Wolfgang coined the term “victim precipitated” homicide to refer to those instances in which the victims’ actions resulted in their demise. In this form of murder, the deceased may have made a menacing gesture, was first to pull a weapon, or merely used words to elicit a deadly response from the killer.

A new term for an old form of murder is “hate” homicide. This form of killing involves taking the life of “victims who are targeted because they differ from the perpetrator with respect to such characteristics as race, religion, ethnic origin, sexual orientation, gender, or disability status” (Fox and Levin 2001, p. 128). Hate killers are usually members of extremist groups such as neo-Nazis, skinheads, and the Ku Klux Klan. Victims are most often African Americans or homosexuals, and the killings usually occur in the southern and western parts of the country. In June 1998 James Byrd, an African-American, while hitchhiking on a Saturday night in Jasper, Texas, encountered three white men who were members of the Ku Klux Klan. Byrd was chained to the back of a truck and dragged more than two miles to his death. According to the perpetrators of the crime, they wanted to send a message to other African Americans in the area. On another occasion, in October 1998 in Laramie, Wyoming, two men posing as homosexuals lured a gay college student from a gay bar. He was robbed, pistol-whipped, burned with cigarettes, tied to a fence in the desert, and left to die from exposure. He died five days later in a hospital.

On April 20, 1999, at 11:35 A.M., eighteen-year-old Eric Harris and seventeen-year-old Dylan Klebold entered the cafeteria at Columbine High School in Littleton, Colorado. Heavily armed with semiautomatic weapons, the teenagers went on a killing rampage that resulted in the deaths of twelve students and one teacher. At the end of their carnage, the murderers killed themselves. The Columbine incident was not the first time a student entered a school and committed an act of homicide, but it was the one that shocked the public conscience and created a new term in the American vocabulary—“school homicide” or “school killing.”

See also: CAPITAL PUNISHMENT; DEATH SYSTEM; FIREARMS;
HOMICIDE, EPIDEMIOLOGY OF

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HOMICIDE, EPIDEMIOLOGY OF

Homicide, the killing of one human being by another human being, has always been a concern in human society. It is a major social problem in the United States, where violence is endemic. The homicide rate in the United States peaked in 1980 at 10.7 per 100,000 population, but declined by 1997 to 6.8 per 100,000, the lowest number since

1967 when the murder rate was 7 murders per 100,000 (Adler, Mueller, and Laufer 2001).

Because various nations differ in their definitions of homicide and the manner in which they gather data, comparisons are difficult—statistics will vary from one data-gathering source to another. In 1989, in a comparison of nineteen industrialized nations providing information to Interpol (the international police agency), the United States possessed the highest homicide rate in the world at 7.9 per 100,000. Neighboring Canada's rate was only 2.7 per 100,000. A more recent comparison of nineteen industrialized nations, published in 1997, indicated that the United States still had the highest murder rate in the world. In 1998, according to Henry Tischler, the number hovered at around 7.4 per 100,000, which was three to four times the rate for most European nations. Tischler noted that although "Russia and other former Eastern-bloc countries have experienced a great deal of social upheaval since the fall of communism, causing their homicide rates to increase dramatically . . . these countries do not have rates that have been typical of the United States in the past 10 years" (Tischler 1998, p. 203).

Gender and Homicide

Richard Hernstein has noted that the more heinous the crime, the greater the disproportion between men and women. This certainly holds true for homicide. According to statistics published by the U.S. Department of Justice, men committed 87.5 percent of murders in 1999. The ratio of male to female homicides was approximately nine to one. Almost three-fourths of male homicides and 80 percent of female homicides were perpetrated against men. Males were more likely to choose a gun as their weapon, but women preferred a cleaner means of killing, such as arson or poisoning (Fox and Levin 2001).

Age and Homicide

According to Jay Albanese, writing in 2001, 46 percent of violent crime arrests (including those for homicide) involved people under the age of twenty-five. Individuals aged eighteen to twenty-four were the most likely to be arrested. In 1997 Sue Titus Reid found that children between the ages of twelve and fifteen were the most frequent

victims of violence, and the elderly were the least likely to be victimized. Department of Justice data for 1976 to 1999 showed that 63.7 percent of homicide offenders and 52.7 percent of victims were between the ages of eighteen and thirty-four. Only 7.5 percent of homicide offenders and 14.9 percent of homicide victims were fifty years of age or older. Variables in the high rate of homicide for young people included an increase in gang activity and the availability of guns and drugs. Additionally, Larry Gaines, Michael Kaune, and Larry L. Miller contended that an "environment of violence . . . permeates the daily life of many of our nation's youths," and "child abuse, which is difficult to measure, but is believed to be widespread, can also teach a youth the values of violence, which may lead to delinquent or criminal activity" (Gaines, Kaune, and Miller 2001, p. 27).

Race and Homicide

While African Americans constitute only about 12 percent of the U.S. population, they are overrepresented in the homicide category for both offenders and victims. Department of Justice statistics delineated that African Americans were seven times more likely than whites to commit homicides and six times more likely than whites to be murdered in 1999. Most homicides are intraracial. In a 2001 publication, James Alan Fox and Jack Levin stated that 86 percent of white homicide victims were killed by whites and 94 percent of African Americans were murdered by members of their own race.

Stranger killing tends to be intraracial, with 68 percent of whites and 87 percent of African Americans killing strangers within their own race. Data for 1976 to 1999 showed that 42.4 percent of African Americans and 55.5 percent of white victims were in an intimate relationship with the offender at the time of their demise. The murder of intimates was also intraracial.

African Americans were much more likely than whites to be the victims of hate crimes. According to Albanese, "Hispanics constitute a small but growing segment of victims of serious crimes" (Albanese 2001, p. 63).

Guns and Homicide

Perhaps the principal reason for the high rate of homicide in the United States is the gun mentality of American citizens. Americans led by the National

Rifle Association (NRA) argue that the Second Amendment of the U.S. Constitution gives them the “right to bear arms” and that that right should never be taken away. Gerald Robin, writing in 1991, stated that approximately one in every four families owned a handgun and that the average number of firearms in gun-owning families was about 2.34. Data from 1999 showed that in a comparison with France, Norway, Canada, New Zealand, Australia, Israel, Denmark, Scotland, the Netherlands, and England/Wales, the United States had an average annual rate of 13.6 per 100,000 population for deaths from firearms. This was more than twice the rate for the second highest country, France, which had a rate of 6.2 per 100,000.

Social Class and Homicide

Since the early 1900s, with the exception of Edwin Sutherland’s classic work on white-collar crime in the 1940s, criminologists and criminological theory have focused primarily on lower-class crime. Theories that the poor are more likely to commit a violent crime are supported by crime statistics. The highest crime rates are found in the low-income areas of the city. The National Crime Victimization Survey for 1997 showed that people in households with an income of less than \$7,500 experienced significantly more violent crime than persons in households at any other income level. The survey also showed that the greater the income, the lower the violent crime rate. Gaines, Kaune, and Miller stated that “a rise in one percentage point in male unemployment appears to increase the violent crime rate by 9 percent” (Gaines, Kaune, and Miller 2001, p. 49).

Drugs, Alcohol, and Homicide

Drugs and alcohol are definitely related to homicide. The National Center on Addiction and Substance Abuse at Columbia University in 1998 reported that 80 percent of prisoners in the United States were involved with alcohol or other drugs at the time of their crime. A study of murders in New York City discovered that more than half were drug related. Department of Justice statistics for 1997 showed that approximately 53 percent of state and federal prisoners incarcerated for murder were under the influence of drugs or alcohol when they committed their lethal act. Research performed by the Rand Corporation in 2001 found that most of

the violent prisoners studied had extensive histories of heroin abuse, often in combination with alcohol and other drugs. Also in 2001, Kurt Finsterbusch found in a study of homicide offenders incarcerated in New York State correctional facilities that 31 percent reported being drunk at the time of their crime, and 19 percent believed that their homicide was related to their drinking. The National Council on Alcoholism reported in 1997 that approximately 64 percent of murders may be attributed to alcohol misuse. Joel Samaha stated, “about half of all offenders have used alcohol within 72 hours of committing a violent crime” (Samaha 2001, p. 43).

Geographic Region and Homicide

Regional differences are evident with regard to homicide. Statistics published in 2001 showed that states in the southern and western regions of the United States had higher homicide rates than those in the Midwest and Northeast. The highest rates were in the South (8 per 100,000), and the lowest were in the northeastern section of the country (4 per 100,000).

There are several possible explanations for the high rate of southern homicide. First, there is the contention that the hot climate is more conducive to angry responses, which then lead to lethal consequences. Gaines, Kaune, and Miller provided partial support for this argument when they stated that crime data “show higher rates of crime in warmer summer months than any other time of the year” (Gaines, Kaune, and Miller 2001, p. 48). Second, there is the argument that a regional subculture of violence can be found in the South. Third, the prejudice and discrimination once prevalent in the South may still be a contributing factor in racial tensions and violence. Fourth, Steven Barkan noted in 2001 that the South has a high rate of economic deprivation and inequality, which are variables in homicide. Finally, there is a gun mentality in the South not found in other parts of the country.

Urban Status and Homicide

As reported by Freda Adler, Gerhard Mueller, and William Laufer in 2001, the largest U.S. cities have the highest homicide rates, while the smallest have the lowest homicide rates. According to Michael Rand, for the period 1993 to 1996, urban residents

had homicide rates significantly higher than suburban residents, who in turn had higher rates than rural residents. In 1997, however, metropolitan cities had a much higher rate of homicide than rural counties, but rural counties possessed a slightly higher homicide rate than small cities (i.e., suburban cities). According to Federal Bureau of Investigation statistics published in 2001, the homicide rate was 7 per 100,000 residents in U.S. metropolitan areas and 16 to 18 per 100,000 in some of the largest cities. In rural areas, the rate was 5 per 100,000.

Because homicide rates in the United States are the highest of all Western nations, it is logical that American cities would have a higher homicide rate than comparable large cities in other parts of the world. For example, Barkan, in a 2001 publication, reported that New York City had a homicide rate five to six times as high as London, another city with a large population. One study indicated that 25 percent of Boston's youth homicides, gun assaults, and drug offenses occurred in an area encompassing less than 4 percent of the city.

See also: HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; MASS KILLERS; SERIAL KILLERS; SUICIDE BASICS; EPIDEMIOLOGY

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HORROR MOVIES

According to the film critic William K. Everson, the horror film is the most unique of any film genre because rigid guidelines do not have to be followed as closely by the director or, for that matter, the screenwriter. The horror film's message of terror and death can be subtly communicated to the audience or conveyed in very intense (and ultimately disturbing) visual and auditory cues. While other film genres might use restraint and logical explanation as their overriding criteria, the horror film need not follow this standard formula; thus,

many cinematic tricks and techniques are available to filmmakers to employ at their discretion. The end result is that the audience can experience a wide range of negative effects, from minor irritation to overwhelming nausea, when viewing a film of the horror genre.

Based on Everson's remarks, one might conclude that the salient reason given as to why people watch horror films is that they want to be scared. In fact, this scare drive is so powerfully addictive to some viewers that they keep coming back to these films over and over again, desiring more terror and craving more thrills with each viewing. However, a deeper, more psychological explanation can be provided as to why humans have been fascinated with gore and bloodshed since the very beginning of recorded history.

To help one understand this motivating force in the human psyche, one must consider Carl Jung's psychoanalytic theory of archetypes. Jung believed that all humans have inherited a set of primordial images that are contained in the collective unconscious. For the most part, these archaic images (referred to as archetypes) remain buried within the unconscious; at significant moments of one's life, however, they can be realized and fully expressed through religion, philosophy, art, literature, and, more recently, the cinema. Jung noted that the most powerful and perhaps most dangerous archetype of the group is the shadow. By definition, the shadow contains all of humanity's unacceptable behavior, bestial impulses, and repressed desires. Using a horror theme analogy, the shadow is "the Mr. Hyde to our Dr. Jekyll . . . the side of our personality that wants to do all the things that we do not allow ourselves to do [normally]" (Fordham 1966, p. 49). Thus, human nature is really comprised of two selves: an outward, everyday persona and a dark shadow that people try to keep in check and hide from others as much as possible.

The neo-Jungian Carol Pearson labels the Jungian shadow as humanity's Destroyer. She explains that while people might be committed to promoting life and making the world a better place in which to reside, each and every person has a death wish that can ultimately hurt them and the much larger society. Pearson further adds, "Even the healthiest individual will do or say things that hurt

other people . . . Ultimately, the Destroyer turns us into villains when we refuse to acknowledge and take responsibility for the harm we do—and we all do harm of some kind" (Pearson 1991, p. 145). Given this description of the archetypal Destroyer, it seems only natural that humankind is drawn to horror films. Every aspect of death that the psyche tries to keep hidden from the conscious self is depicted on the screen. And even though most of the cinematic acts of destruction are rather extreme and exaggerated forms of everyday reality, people are still compelled to examine them if for no other reason than to remind themselves that they carry around this death-dealing nature.

This entry examines the various faces of death in this particular film genre, starting with the silent era and moving to the contemporary period. The dramatic changes in how death is portrayed on the screen across eight decades will be noted as well as how these images are related to the given sociocultural milieu of the times.

The Prototypic Faces of Death in the 1920s, 1930s, and 1940s

The silent era of horror films focused almost exclusively on the hideous, deathlike appearances of the monsters rather than the ghastly crimes they committed against society. The chief reason was that the grisly makeup had to compensate for the lack of sound in these features. And so any number of strange and bizarre bogeymen that populated the screen greeted the viewer. Take for instance John Barrymore's *Mr. Hyde* (1920), which depicts the counterpart of Dr. Jekyll as a creature with a Neanderthal, almost satanic visage. Or consider the very first vampire film, the German silent *Nosferatu* (1922), that turned Count Orlock into a "walking skeleton" of horror with "his pale skull-like face, his blazing eyes, pointed ears, and long tapering fingernails" (Preiss 1991, p. 267).

The Universal Studios period of horror films spanning the 1930s and 1940s continued to invest most of their special effects budget in the title creatures' features at the expense of adequate plot development, noteworthy musical scores, and prominent death scenes. Thus, the great works of literature like Bram Stoker's *Dracula* (1897) or Mary Shelley's *Frankenstein* (1818) were converted to one-dimensional productions with the ghoulish

monster once again occupying the central position on the screen. The 1930 Todd Browning version of *Dracula* cast the Hungarian actor Bela Lugosi in the role of the Count. His broken English, exaggerated hand gestures, pasty face makeup, piercing eyes, aquiline nose, and high cheekbones gave Lugosi a kind of cinematic immortality for recreating the image of the Old World nobleman into a mysterious, somewhat disturbing creature of the night. Interestingly, very few humans would die at the hands of this cinematic Count, unlike his literary predecessor.

The very next year Universal tried its hand at Shelley's *Frankenstein* (1931), giving the actor Boris Karloff his chance at fame for playing the Monster with a good deal of pathos. The film reviewer Byron Preiss describes Karloff in the following way: "tall, ill-clad, lumbering, with a square head and pegs sticking out from his neck, his face gaunt, his eyes baffled . . . he stands unsteadily with his arms upthrust toward the light which, with the innocence of the newborn, he tries to seize" (Preiss 1991, p. 243). And while the Monster executes some humans in the worst way imaginable (from drowning a child in the lake to hanging the hunchbacked servant with his own whip), these sequences take a backseat to the very realistic, corpselike appearance of Karloff that the viewer never tires from seeing.

Other Universal monsters populated the screen during this interval, such as *The Mummy* (1932), *The Bride of Frankenstein* (1935), and *The Wolf Man* (1941). However, few would ever reach the stature of Count Dracula or Frankenstein's Monster in looks or atrocities, overt as well as covert. It was not until the 1950s that the creature features would return to the screen in a never-before-seen blood-thirsty glory by the Hammer Film Studios in London, England.

The International Faces of Death in the 1950s, 1960s, and 1970s

More than anything else, the Hammer Studios wanted to attract a significant portion of the adult market to the horror film genre. Instead of banal scripts and terrible acting, the Universal story lines would be updated for that targeted audience with experienced actors like Christopher Lee (Count Dracula) and Peter Cushing (Dr. Victor

Frankenstein) at the helm, delivering lines with vigor and enthusiasm. Perhaps the most salient addition was the effective use of bloodshed and gore at key moments to illustrate just how despicable these characters were to their unsuspecting victims. The movies were shot in a Technicolor brilliance (unlike their monochromatic predecessors), which only exaggerated the death scenes. Now the viewer would gaze at streams of blood gushing out from chests, necks, and faces in a potpourri of deep reds and bright purples amidst softer blue and green backdrops. Some examples of Hammer Studios' seventeen-year tenure in the horror cinema (from 1957 to 1974) are included to show just how much the Destroyer archetype had been modified to satiate the public demand for more atypical and bizarre ways of killing on the screen.

The *Dracula* series of films began their run with some very striking scenes. In *Horror of Dracula* (1958) Van Helsing drives the stake into a recently converted vampire with a sickening relish. By the ending he traps Dracula in his own castle and, holding candlesticks in the sign of the cross, the good doctor forces the Count directly into the rays of the sun, thereby blasting the crumbling body to dusty remains. The follow-up movie, *Dracula—Prince of Darkness* (1965), involves the resurrection of the infamous monster by having his manservant brutally slit the throat of one of the guests at the castle in a Black Mass ritual. *Dracula Has Risen from the Grave* (1969) depicts one of the most graphic sequences of any vampire film to date. Here the Count survives a staking by pulling out the pointed object and throwing it at his attackers, but not before a significant amount of blackish-red blood comes streaming out of the rather large hole made in the vampire's chest. As the titles progressed, Dracula would be stabbed, burnt, poked and prodded atop a bed of stakes, and even shoveled to death (*Dracula A.D.*, 1972) before meeting his screen finale at the hands of Van Helsing once more in *The Satanic Rites of Dracula* (1973).

Like *Dracula*, the *Frankenstein* set had its share of memorable death moments. Beginning with *The Curse of Frankenstein* (1957), the Monster strangles a number of the local villagers with its bare hands before being shot directly in the face. The film critic John McCarty notes that Frankenstein is no better than his creation, "fondling brains, eyeballs, severed hands and other assorted

organs” throughout the film with an unusual coldness that would bring new meaning to the term “mad scientist” (McCarty 1990, p. 19). The series continues this bloody path by having new creations eat the flesh of their victims (*Revenge of Frankenstein*, 1959) as well as decapitate assorted bullies and store their heads in picnic baskets and atop bedposts (*Frankenstein Created Woman*, 1967). Perhaps the most tragic of all fates occurs for the Monster when it is literally torn apart by the inmates of an asylum who spurn it for being so different from themselves (*Frankenstein and the Monster from Hell*, 1974).

In addition to the Dracula and Frankenstein films, Hammer Studios also produced one *Wolf-man* picture. *The Curse of the Werewolf* (1961) ends on a sad note when the cursed creature’s father shoots it in the heart with a silver bullet. The metamorphosis back to the human state never transpires, and so the camera lingers on the werewolf’s face that has bloodstained tears dripping from the permanently open, yet forlorn, eyes.

Other British companies tried to emulate the Hammer horror treatments with some measure of success. The Amicus Company specialized in reanimated body parts that would seek out with a vengeance those parties responsible for their owners’ deaths (see *Dr. Terror’s House of Horrors*, 1965; *Tales from the Crypt*, 1972; *Asylum*, 1972; *And Now the Screaming Starts*, 1973). Elstree Studios, in conjunction with American International, gave a more human face to the Destroyer by casting horror film veteran Vincent Price in the title role of *The Abominable Dr. Phibes* (1971), who metes out justice to those physicians who could not save his beloved wife, Victoria. In 1992 Price disclosed in an interview with Stanley Wiater that he thoroughly enjoyed making *Dr. Phibes*, as it enabled him to throw a good deal of humor into the role so that the extent of his violent acts could be significantly diminished on the screen. And so one of Phibes’s victims is drained entirely of his blood, another has the flesh on her face consumed by locusts, and still another is eaten alive in the cockpit of his plane by ravenous rats while the doctor attentively listens to his assistant Vulnavia playing beautiful music upon her violin. The send-up formula would be employed at least three more times by Price (in *Dr. Phibes Rises Again*, 1972; *Theater of Blood*, 1973; and *Madhouse*, 1974) until the actor became

tired of the same old story line and eventually retired from the horror genre. But the violence-humor combination would remain a staple of the horror film from this point on.

The Faces of Death in Contemporary American Films

The American horror cinema was heavily influenced by the British faces of death, yet was able to impart originality to its less Gothic, more modernized tales of destruction. The mad slasher film became one of the most popular American products, starting with Alfred Hitchcock’s 1960 masterpiece, *Psycho*. Playing the dual role of a disturbed young man (Norman Bates) and his dead mother, Anthony Perkins gave a much needed pathos to the brutal slasher figure that killed unsuspecting women taking showers in their motel rooms. The three *Psycho* sequels that followed (*Psycho II*, 1983; *Psycho III*, 1986; and *Psycho IV: The Beginning*, 1990) continued to expand on the character of Norman Bates and were successful in large part due to Perkins portraying the aging madman as a misunderstood victim of his tragic upbringing. The statement Bates utters throughout the series, “We all go a little mad sometimes,” would allow viewers to identify with his insanity and perhaps their own latent fears of losing control in an abusive environment as well.

Other horror series throughout the 1970s, 1980s, and 1990s attempted to recreate the *Psycho* slasher, but their madmen ultimately lacked the charm, wit, and other human qualities of Perkins’s Bates. From *Halloween*’s Michael Myers, *Friday the 13th*’s Jason Voorhees, and *A Nightmare on Elm Street*’s Freddy Krueger all these slashers share a number of qualities: a distinctive attire (from hockey masks to green-and-red sweaters), heavy breathing, a lingering point-of-view toward their intended prey, and the ability to generate a high body count (i.e., dozens of corpses littering a single film). One noteworthy trademark of the slasher film, namely the Final Girl who survives and eventually kills the madman with anything readily available (e.g., axe, knife, even her own highly trained body), would come to be a widely accepted image for the horror queen. As the film study scholars Pat Kirkham and Janet Thumim note, male fans of the genre would be the strongest endorsers, especially when these Final Girls took the offensive and used



The 1982 horror movie *Poltergeist*, starring Craig T. Nelson, Heather O'Rourke (center), and Jobeth Williams featured scenes of paranormal activity and the undead, which originated from the family's television set. This successful film spawned its first sequel in 1986 and its second in 1988. KOBAL COLLECTION/MGM/UA

their brains to outthink their intellectually challenged foes. *Silence of the Lambs* (1991) and *Hannibal* (2001) are just two examples of how the Final Girl has evolved to the Amazon-worthy protagonist (Clarice Starling) to such powerful psychotics as Dr. Lecter.

Another type of horror film capitalized on earlier works both in the United States and abroad (*The Innocents*, 1960; *Rosemary's Baby*, 1968) and focused on a new death-dealer, the possessed child. William Peter Blatty's *The Exorcist* (1973) goes well beyond the limits of acceptable good taste and propriety by showing scenes of the satanic child Regan (played by Linda Blair) spraying vomit into the faces of the prostrate priests or masturbating with devilish delight using her crucifix. One reason that *The Exorcist* remains the highest-grossing horror movie ever made, setting the stage for many rip-offs (*Beyond the Door*, 1975; *The Omen*, 1976; *Damien—Omen II*, 1978; *Holocaust 2000*, 1978; *The Godsend*, 1979; *The Children*, 1980; *Children of the Corn*, 1984; *Child of Light*—

Child of Darkness, 1990) as well as its own inevitable set of sequels (*Exorcist II: The Heretic*, 1977; *The Exorcist III*, 1990), is that it preys on parents' fears that they could lose their children to uncontrollable outside forces. Clearly, *The Exorcist* is a film that has reshaped the horror genre and continues to do so, as seen in adult possession hits like *Stigmata* (1999).

The cannibalistic zombie image further pushed the envelope on what would be considered the conventional norms to a horror film. Starting with the cult classic *Night of the Living Dead* (1968), and continuing with *Dawn of the Dead* (1979) and *Day of the Dead* (1985), viewers are greeted by a more disgusting type of Destroyer—one that literally kills humans by devouring them—who dies then comes back to life (with whatever limbs or organs remaining) to join the ranks of the ravenous zombies, thus escalating the scale of the menace. Of all zombie movies made, the original *Night of the Living Dead* remains the most fatalistic. The film contains "dead relatives turning on living relatives, dead oldsters

turning on living youngsters (and vice-versa) . . . with the nightmarish cycle repeating itself [over and over again]" (McCarty 1990, p. 103). What *Night of the Living Dead's* screenplay writer George Romero wanted to do was show just how irrational the world had become with the breakdown of the nuclear family, wars waged without a just cause, and frequent assassinations of noteworthy, political leaders. While the zombie Destroyer has not been embraced to the same degree as the more traditional ones (e.g., the vampire and mad scientist), every so often a horror film surfaces with the hungry undead in it, reminding viewers that the worst hell on earth is never dying but living on indefinitely at the expense of destroying other souls.

Future Faces of Death in the Horror Cinema

Many scholars and film critics believe that the faces of death within the horror genre will undergo a major facelift in the twenty-first century and beyond. Referred to as techno-mythic Destroyers, these new figures will either be created by the technological advances available or use that very technology to kill people in even more unusual and imaginative ways than before. Some techno-mythic Destroyers have already appeared on the screen. In the 1980s when television sets and VCRs were becoming commonplace items in every household, there emerged a rash of related cinematic terrors. In *Halloween III: Season of the Witch* (1982), the villain of the tale broadcasts his demonic message across the national airwaves to unsuspecting children while *Videodrome* (1982) allows the viewer to imagine a wide assortment of sadomasochistic pleasures via cable programming until they take on a frightening and mind-bending reality. By the 1990s, video games were becoming all the rage, so naturally horror movies mimicked the popular culture trend. *Stephen King's The Langoliers* (1995) has evil Pac-Man creatures terrorizing a stranded group of airline passengers in an alternate time zone; *Phantasm III: Lord of the Undead* (1993) portrays the Tall Man unleashing his horde of living spheres on the world in a new stage of the *Phantasm* game; and *Lawnmower Man* (1992) shows the recreated Jobe seizing control of the virtual reality universe and all programs tapping into that dimension. Based on these films, it seems only a matter of time until HDTV and DVD technology will be utilized by similar fictional Destroyers to wipe out human existence on the planet.

Despite these changing faces of death in the horror film genre, one factor does appear to be constant—namely, the mythos of the human destructive potential. This dark half of human nature is filled with so many nasty images and sinister figures that eventually they will surface in full force. Humankind's hidden demons will continue to serve as fodder for future screenplay writers and directors in the film industry, and audiences will most assuredly see more of their inner selves on the screen in the decades ahead.

See also: GREEK TRAGEDY; OPERATIC DEATH; SHAKESPEARE, WILLIAM; VAMPIRES; ZOMBIES

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HOSPICE, ALZHEIMER PATIENTS AND

“Dying the good death” is a care-giving goal, regardless of the presumed immediate cause of death, site(s) of the dying process, or cultural and ethnic differences among the dying person, their family, the community, and the health care providers. At the close of life, the patient, family members, and clinicians face decisions regarding the degree of intensive medical care to be provided for treatment of diseases, withdrawal of invasive interventions, initiation of hospice, and treatment of a range of chronic medical conditions. A hospice philosophy or care provides palliative care with a goal of maximal comfort and not maximal survival of the person. In the beginning, hospices served mostly persons with advanced cancer who decided to forgo further aggressive therapies, but the success of the hospice movement led to inclusion of persons with other life-limiting conditions, such as patients with heart disease, pulmonary disease, and dementia. Despite the recommendation made sixteen years ago that hospice care is appropriate for individuals suffering from advanced dementia, a survey of hospice programs showed that less than 1 percent of hospice patients had primary diagnosis of dementia and seven percent had dementia as a secondary diagnosis in addition to having cancer.

Dementia of the Alzheimer type (DAT) is an acquired, progressive, life-limiting disorder for which the biggest risk factor is living to an old age. According to U.S. Census data from 1900 and projections through 2050, people over age eighty-five—the category at highest risk for developing dementia—constitute the most rapidly growing segment of the population. Between 2.5 and 4 million Americans are already afflicted with DAT and evidence suggests that about 47 percent of people age eighty-five and older may develop DAT, meaning that these numbers will continue to rise as the population ages.

Persons with DAT have both a chronic and terminal illness and ultimately will become completely dependent in all aspects of activities of self-care. Cognitive deficits in dementia occur in several spheres including memory impairment, aphasia, apraxia, agnosia, and disturbance in executive function. Although some symptoms of DAT

may be slowed by medications, there is no cure for DAT and ultimately the person will die either from a complication of DAT or from another age-related disorder. In either case, because new discoveries in medical science have the capacity to extend the typical dying process without restoring cognitive capacity or physical function, palliative care should be considered to provide comfort-promoting interventions and relief from aversive symptoms.

Hospice Care and DAT

Hospice care is an organized method of providing palliative care. Care can be provided in a hospital, nursing home, community setting, or as a free-standing program, but most hospice care is provided in homes. Making the hospice philosophy operational directs care-giving activities to strive for maximal comfort and not maximal survival of the person.

Persons suffering from DAT often develop behavioral problems in which different symptoms appear throughout the progressive stages. When patients with terminal cancer receive hospice care, pain relief is a focus of care. For persons with DAT, management of the challenging behaviors is a focus of care. Regardless of the pathological processes involved, both pain and behavioral symptoms cause suffering; pain can be managed for persons with terminal cancer and behavioral symptoms can be managed for persons with DAT. A two-year prospective cohort study found that caring for patients with advanced DAT on a Dementia Special Care Unit (DSCU) using a palliative care philosophy resulted in less patient discomfort and lower health care costs than when care was provided on a traditional long-term care unit. When patients with DAT are allowed to receive palliative care, their surrogate decision makers reject care that extends the dying process, and patients receive “high-touch” care provided by interdisciplinary health care team members who strive to promote patient comfort. The focus of high-touch care is not the withholding of invasive aggressive interventions, but providing specific, individualized, intensive nursing interventions.

Advance care planning is necessary to assure that individuals receive the types of health care they desire. Everyone should have an established health care proxy who would make a decision regarding health care if an individual becomes

incapacitated. If a person has not completed the health care proxy process before the diagnosis of DAT, the person should select a proxy and complete required legal forms as soon as possible. Early in the dementia process, persons have the cognitive capacity to make future plans, including choosing who should represent their health, legal, and financial affairs. If there is no health care proxy and the person no longer has the capacity to select one, the health care team should work with the surrogate decision maker to establish an advance care plan so that end-of-life decisions can be made in advance of crises.

Treatment Options

There is a palliative care program for veterans with advanced DAT at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts. The Bedford program has two central components: advance care planning and comfort care. Family members meet with the interdisciplinary health care team to discuss therapeutic options, explore previous wishes of the patient and their relevance to the veteran's current condition, and establish an advance care plan. The advance care plan specifies interventions to promote quality of life and comfort, and identifies aggressive medical interventions to be avoided. Aggressive medical care includes invasive diagnostic tests and treatment of coexisting medical conditions including transfer to an acute-care unit if indicated, and tube feeding if normal food intake is not possible. Treatment limitations that are more consistent with a comfort approach to end-of-life care include:

- no cardiopulmonary resuscitation;
- no transfer to an acute-care setting for technological interventions, which excludes intravenous therapy but includes transfer for an intervention required to prevent discomfort, such as to repair a fractured hip;
- no invasive medical or intravenous antibiotic treatment of intercurrent infections, but antipyretics, analgesics, and oral antibiotics may be prescribed for symptom management to treat discomfort; and
- no artificial feeding, which precludes the use of long-term feeding tubes.

Infections and eating difficulties are two inevitable consequences of terminal DAT. Changes in

immune function, incontinence, decreased mobility, and propensity for aspiration of food, liquids, and respiratory secretions predispose persons to life-threatening infections. Infections are the most frequent cause of death in the terminal stage of dementia. Even excellent intensive nursing care and high vaccination rates cannot eliminate the influence of risk factors that cause development of many infections, relapse after successful treatment, and infections that gradually become more difficult to treat. Because a life-threatening infection is highly probable in advanced DAT, clinicians should be prepared to help surrogates make decisions about palliative treatment options.

Under the leadership of Ladislav Volicer (who initiated hospice care for persons with dementia), the Bedford team conducted a series of studies to examine "treatment success," which has to be weighed against the risk benefit ratio of management strategies and the likelihood of successfully achieving positive outcomes for individual persons. Study one found no difference in the mortality rate for patients with severe DAT who received antibiotic therapy versus those who received palliative care—suggesting that aggressive treatment did not alter the survival of patients with severe DAT. Study two found that managing infections on a DSCU results in lower discomfort, even for patients treated aggressively.

Study three developed and tested a predictive model for short-term survival and found that older age and higher severity of DAT at the time of the infection, palliative care, and admission for long-term care within six months prior to the febrile event were positively associated with the likelihood of dying within six months following onset of a fever. Clinicians can consider this predictive model when making the decision whether or not to certify patients with DAT for Medicare hospice coverage. Study four found that an infection did not have its own effect on DAT progression; disease severity increased in most patients, but more so in patients who received aggressive medical treatment. Providing palliative care for infections: (1) prevents patients from undergoing invasive diagnostic workups and treatments, does not accelerate the progression of DAT; (2) is associated with lower observed discomfort; (3) is not associated with higher rates of mortality for more advanced patients; and (4) also conserves scarce health care resources.

Instead of aggressive “high-tech” care, strategies to prevent infections or decrease their severity should be provided by:

- offering meticulous nursing care to keep the skin clean and dry despite incontinence;
- avoiding urinary catheters;
- instituting therapy programs striving to maintain ambulation as long as possible; and
- minimizing aspiration of food and liquids through the adjustment of diet texture and by using thickened liquids and physiological positioning.

During the course of the illness, the main eating difficulties are food refusal and choking. Many late-stage patients also forget how to chew and swallow and the terminal stage is marked by swallowing difficulty due to brain pathology. Decreased appetite causing food refusal may be a symptom of depression or a sign of the dying process as the body goes through a physical shutting down. Using skillful hand feeding techniques with pleasing to the taste caloric-rich foods in a composition to prevent choking prevents the use of feeding tubes. There will come a time, however, when serious eating problems will lead to the person with DAT being unable to eat or swallow. At that time, the person may be kept comfortable by offering a single ice chip at a time under the tongue or in the cheek or by artificial saliva spray.

End-of-life care should be characterized by a sense of contentment and ease as the dying person makes the transition to death. For the very vulnerable group of persons with DAT, many health professionals believe foregoing aggressive interventions, which do not ultimately result in improvement of an underlying dementia and may cause discomfort, is more compassionate than striving to extend survival at all costs.

See also: HOSPICE IN HISTORICAL PERSPECTIVE; SAUNDERS, CICELY

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HOSPICE AROUND THE WORLD

Known initially as “palliative care,” the modern hospice movement began in the 1970s. Over time it has sought to provide end-of-life care in the home or a specially designated unit with a special focus on the patient’s physical, psychological, social, and spiritual needs. The movement has also

sought to provide inpatient care for acute symptom management and family respite.

With the advent of the palliative-medicine movement in the last decade of the twentieth century, the meanings of terms *palliative medicine* and *palliative care* expanded to refer to care provided in secondary- and tertiary-care facilities from the onset of symptoms. Hospice and palliative-care programs provide their services in a cultural and canonic context that influences where care is given and by whom. For example, in Poland, the cultural tradition of keeping persons in the home, with family and friends gathering around the bed at the time of death, influenced the type of services provided. Given the poor housing conditions of the area that make caring “for the terminally ill at home very difficult,” Hospicium attempted to meet those needs by being a home where relatives and friends could volunteer to care for the dying person (Tenner 1997, p. 159). Similar problems prevail in Russia and Japan, where the tight living quarters of most inhabitants make it difficult to care for terminally ill persons in the home. Such living conditions promote inpatient hospice programs. The first hospice in Russia was opened in September 1990 in Lachta, a village close to St. Petersburg.

The size of the living quarters does not always determine the locus of care. In Saudi Arabia the terminally ill are cared for in the home, with support provided by the King Faisal Specialist Hospital and Research Centre. The Malath Foundation for Humanistic Care in Jordan also provides professional and volunteer support for the family caregivers, although nonprofessional volunteers outside the family help by running errands. In such situations the family decides on a direct caregiver within the family.

In China, when all adult family members are employed outside the home, there is no one to care for the terminally ill; therefore, out-of-home care becomes necessary. Beijing Song Tang Hospice, an inpatient facility in China, has a nursing assistant's bed in the room with the patient in order to attend to a patient's needs twenty-four hours per day. The program survives on charitable contributions and the periodic assistance of foreigners who come to China to help provide care.

As in China, the availability of caregivers in the home in India dictates the form of hospice care. In

1999, Karunashraya Hospice, a fifty-five-bed free-standing hospice in Bangalore, was opened. Marie Coughlan states, “The ability to care for sick family members is compromised because there are often no family members at home to do the caring. In the poor families anyone who can work does so; thus, even when family members are together they may all be out working” (2000, p. 1). The staff consists of four registered nurses and seven nurses' aides, a retired volunteer physician, a consultant anesthetist, and a home care team of two nurses and one family counselor. The home care team sees three to five patients each day throughout the Bangalore metropolitan area.

The first hospice program in India, Shanti Avedna Ashram, was opened in 1986 in Mumbai. Since then, hospice programs have been established in Goa and Delhi. In 1995 Chennai opened a hospice program that provides limited community outreach. Access to morphine has been assured by collaboration with medical colleagues.

Human resources influence access to care as profoundly as economics. In countries like the Netherlands that have universal insurance, the individual's ability to pay is not an issue. This is not the case in countries like Ghana, where the ability to pay for care as well as medications determines access. Motivation to pay for care is also an issue. Professionals in Ghana are concerned that if families think there is no cure, they won't pay for care. For this reason, and to protect the patient from hurtful news, many Ghanaians do not know either their diagnosis or prognosis. In an environment in which truth-telling is not a value, it becomes difficult to obtain referrals of informed patients. Furthermore, if care without cure is not valued or affordable, this economic reality may dictate both access and provision of services. Given these realities, sub-Saharan Africa has developed some unique approaches to meeting the needs of the terminally ill.

Sub-Saharan Africa is beset with three epidemics: HIV/AIDS, malaria, and tuberculosis. The need for hospice and palliative care for individuals who are terminally ill with these diseases should not be understood as an alternative to treatment. Appropriate interventions to prevent the occurrence of these diseases or the onset of secondary or tertiary sequelae are also required.



Kenyans show support for the Nyumbani Hospice that will serve HIV positive children. GAMMA LIAISON NETWORK

The first hospice in Africa, Island Hospice and Bereavement Service in Harare, Zimbabwe, was organized in 1979. As of 2001 it has fifteen branches throughout Zimbabwe. Originally organized with a home hospice nurse or social worker providing direct care via home visits, the facility was too limited to meet the needs of the increasing numbers of persons with HIV/AIDS who required care. Consequently a model of hospice as facilitator was developed. In this model, hospice develops partnerships with other organizations and with the community to provide care. Rather than providing home visiting, the hospice facilitates the care given by volunteers.

Mabvuku/Tafara Hospice in Harare provides care through its trained volunteers, who render about 80 percent of the care. The hospice team consists of the health department, social services, churches, schools, police, and two hospice nurses. These two nurses facilitate the care given by the volunteers as well as seeing a limited number of patients.

These programs have moved from direct provision of care by professionals to facilitation of care by

volunteers as a primary mode of care delivery. This approach is a creative solution to the challenge of the AIDS pandemic in Africa. Yet even this approach may be inadequate given the numbers of individuals infected with HIV and the paucity of resources in many of the nations of sub-Saharan Africa.

Resources of space and available caregivers, as noted, affect care in Japan, China, and India. Most of the hospice care available in Japan is inpatient with little support for those who wish to die at home. The lack of space in most Japanese apartments makes it difficult to provide care at home.

Korea also faces resource challenges. There, hospice care is provided in both inpatient facilities and at home. Nonetheless, there is a lack of understanding of the nature of hospice/palliative care by citizens and physicians, a lack of insurance coverage, and a lack of availability of short-acting morphine.

Germany has several hospice/palliative care programs headed by physicians that focus on the physical, psychological, social, and spiritual aspects of care. Largely inpatient programs, these

services include a range of complementary/alternative therapies along with traditional medical care. Hospice care in Germany, however, is not a widespread phenomenon.

The hospice movement began in Israel in the early 1980s with the Tel-Hashomer Hospice, which opened in 1983 in Tel-Aviv. This program was based on the British model of hospice care. The first hospice home care program was established in 1984 in Tivon. In 1986 a fourteen-bed unit was created at the Hadassah University Hospital at Mount Scopus, Jerusalem.

Clinica Familia, in Chile, a hospice-hospital, contains forty beds and an outpatient clinic as well as a chapel, mortuary room, and a pharmacy. The Clinic is run largely by volunteers, including physicians, psychologists, nurses, assistant nurses, volunteers who provide administrative support, and four paid employees.

The key distinctions in hospice programs worldwide are the role of volunteers as either the predominant caregivers or as supports for professionals; the level of governmental and/or private support; the amount of home space and availability of family members for home care; and the availability of morphine and other drugs. Even more fundamental is the level of information provided to patient and families about diagnosis and prognosis.

See also: HOSPICE IN HISTORICAL PERSPECTIVE; PAIN AND PAIN MANGEMENT; SAUNDERS, CICELY; SYMPTOMS AND SYMPTOM MANAGEMENT

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HOSPICE IN HISTORICAL PERSPECTIVE

Some commentaries on hospice history, particularly from inside the hospice movement, are inclined to seek ancient roots for what is actually a modern phenomenon. The scholar Cathy Siebold, for example, notes: "The Crusades, which began late in the eleventh century and continued for several hundred years, are a milestone in hospice history" (Siebold 1992, p. 16). These connections between the past and the present contain a powerful symbolic message. They suggest that modern hospices are rooted in deep and ancient traditions of compassionate care that go back to earliest civilizations. Yet they tend to lack historical veracity. It is inaccurate, for example, to draw too close a parallel between places called hospices in early times and those carrying that name in the twenty and twenty-first centuries. The former contained a broad spread of the diseased, the poor and the downtrodden, cared for over the longer term. The latter have tended to focus on the relatively short-term care of those close to the end of life and especially those dying from malignancies. No doubt in human societies going back over two millennia or more there have existed individuals, such as Fabiola in the fourth century, who patronized and nursed the sick and dying; but scholars should be cautious in seeing her as someone who prefigured the charismatic leaders of the modern hospice approach, developed in the second half of the twentieth century.

A review of a more recent period reveals the first concentrated efforts to give institutional care to dying people. For this, the nineteenth century—a time of great hospital building, which produced in turn a diminution in concern for those at the end of life whose condition was beyond cure—is the place to begin. At this point in time, both the bereaved and the medical establishment noted the first signs of death as a medical failure. The dying were no longer welcome in the hospital, and therefore philanthropic and charitable endeavors led to the creation of special institutions, some of them called hospices, which sought to provide care and sanctuary to those nearing death.

The Nineteenth Century

From the beginning of the nineteenth century it is possible to identify certain important developments in the care of dying people, several of these led by women. The young widow and bereaved mother, Jeanne Garnier, together with others in similar circumstances, formed *L'Association des Dames du Calvaire* in Lyon, France, in 1842. The association opened a home for the dying the following year, which was characterized by “a respectful familiarity, an attitude of prayer and calm in the face of death” (Clark 2000, p. 51). Jeanne Garnier died in 1853, but her influence led to the foundation of six other establishments for the care of the dying between 1874 in Paris, and 1899 in New York. In both of these cities modern-day palliative care services exist that originated directly from the work of *L'Association des Dames du Calvaire*.

Mary Aikenhead was born in Cork, Ireland, in 1787. At age twenty-five she became Sister Mary Augustine and was established almost immediately as Superior of a new Order, known as the Irish Sisters of Charity, the first of its kind in Ireland to be uncloistered. The Order made plans to establish a hospital. Three of the sisters went to Paris to learn the work of the *Notre Dame de la Pitié* Hospital. In Ireland they opened St. Vincent's Hospital in Dublin, in 1834. Following many years of chronic illness, Mary Aikenhead died in 1858 at nearby Harold's Cross. Fulfilling an ambition that she had long held, the convent where Mary Aikenhead spent her final years became Our Lady's Hospice for the Dying in 1879. The Sisters of Charity followed it with others in Australia, England, and

Scotland, all of which exist in the twenty-first century and are run by the Order as modern palliative care units.

In the United States, Rose Hawthorne had experienced the death of a child and watched her friend, the poet Emma Lazarus, die of cancer. During the late 1890s she organized a group of women known as the Servants of Relief of Incurable Cancer. When her husband died she took religious orders in 1900, under the title Mother Alphonsa, and formed an order known as the Dominican Sisters of Hawthorne. They established St. Rose's Hospice in Lower Manhattan and then another in New York, followed by others in Philadelphia, Atlanta, St. Paul, and Cleveland.

Although unknown to each other, Jeanne Garnier, Mary Aikenhead, and Rose Hawthorne shared a common purpose in their concern for the care of the dying, and in particular the dying poor. Directly and indirectly they founded institutions which, in time, led to the development of other homes and hospices elsewhere. They also established base camp for what was to follow, for their achievements created some of the preconditions for modern hospice and palliative care development. The historian Clare Humphreys has shown how these early hospices and homes for the dying reveal three sets of concerns: religious, philanthropic, and moral. Such institutions placed a strong emphasis on the cure of the soul, even when the life of the body was diminishing. They drew on charitable endeavors, and were often concerned to give succor to the poor and disadvantaged. They were not, however, places in which the medical or nursing care of the dying was of any real sophistication. Rooted in religious and philanthropic concerns, which would diminish as the twentieth century advanced, the early homes for the dying represent the prologue to a period of subsequent development, which got underway in the decades after World War II.

The Twentieth Century

By the mid-twentieth century some important changes occurred in Western medicine and health care. Specialization was advancing rapidly, new treatments were proliferating, and there was an increasing emphasis upon cure and rehabilitation. At the same time death in the hospital, rather than at home, was becoming the norm, and medicine

critics viewed the dying patient or “hopeless case” as a failure of the medical practice. In a series of famous lectures published in 1935 the American physician Alfred Worcester noted: “. . . many doctors nowadays, when the death of their patients becomes imminent, seem to believe that it is quite proper to leave the dying in the care of the nurses and the sorrowing relatives. This shifting of responsibility is un-pardonable. And one of its results is that as less professional interest is taken in such service less is known about it” (Worcester 1935, p. 33). This vacuum in knowledge was one factor that contributed to alternative suggestions about care at the end of life. That same year the Voluntary Euthanasia Legalisation Society was formed in the United Kingdom, followed in 1937 by the organization that came to be known as the Euthanasia Society of America. Both sought to promote the deliberate ending of life when requested by the patient.

Concerns about improving care at the end of life began to surface in the 1950s. In Britain attention focused on the medical “neglect” of the dying, whereas in the United States a reaction to the medicalization of death began to take root. Four particular innovations can be identified:

1. A shift took place within the professional literature of care of the dying, from idiosyncratic anecdote to systematic observation. New studies by doctors, social workers, and social scientists provided evidence about the social and clinical aspects of dying in contemporary society. By the early 1960s leading articles in *The Lancet* and *British Medical Journal* were drawing on the evidence of research to suggest ways in which terminal care could be promoted and arguments for euthanasia might be countered.
2. A new view of dying began to emerge that sought to foster concepts of dignity and meaning. Enormous scope was opened up for refining ideas about the dying process and exploring the extent to which patients should and did know about their terminal condition.
3. An active rather than a passive approach to the care of the dying was promoted with increasing vigor. Within this, the fatalistic resignation of the doctor was supplanted by a determination to find new and imaginative

ways to continue caring up to the end of life, and indeed beyond it, in the care of the bereaved.

4. A growing recognition of the interdependency of mental and physical distress created the potential for a more embodied notion of suffering, thus constituting a profound challenge to the body-mind dualism upon which so much medical practice of the period was predicated.

It was the work of Cicely Saunders, first developed in St. Joseph’s Hospice in Hackney, East London, that was to prove most consequential, for it was she that began to forge a peculiarly modern philosophy of terminal care. Through systematic attention to patient narratives, listening carefully to stories of illness, disease, and suffering, she evolved the concept of “total pain.” This view of pain moved beyond the physical to encompass the social, emotional, and spiritual aspects of suffering—captured so comprehensively by the patient who told her, “All of me is wrong” (Saunders 1964, p. viii). But it was also linked to a hard-headed approach to pain management. Saunders’s message was simple: “Constant pain needs constant control” (Saunders 1960, p. 17). She believed analgesics should be employed in a method of regular giving that would ensure that pain was prevented in advance, rather than alleviated once it had become established; in addition, they should be used progressively, from mild to moderate to strong.

When Cicely Saunders founded St. Christopher’s Hospice in South London in 1967, it quickly became a source of inspiration to others. As the first “modern” hospice, it sought to combine three key principles: excellent clinical care, education, and research. It differed significantly from the other homes for the dying that had preceded it and sought to establish itself as a center of excellence in a new field of care. Its success was phenomenal and it soon became the stimulus for an expansive phase of hospice development, not only in Britain but around the world.

From the outset, ideas developed at St. Christopher’s were applied differently in other settings. Within a decade it was accepted that the principles of hospice care could be practiced in many settings—in specialist inpatient units, but also in home care and day-care services. Likewise, hospital units and support teams were established that

brought the new thinking about dying into the very heartlands of acute medicine. Modern hospice developments took place first in affluent countries, but in time they also took hold in poorer countries, often supported by mentoring and “twinning” arrangements with more established hospices in the West. By the mid-1980s, a process of maturation was evident.

In the United Kingdom, approximately 100 hospices had been formed, complemented by home support services and the first hospital palliative care teams; funding from the National Health Service and from the major cancer care charities started to become available. In the United States, growth was even more striking: 516 hospices existed just ten years after the foundation of the first initiative in New Haven, which had opened in 1974. Even more significant, a federal benefit was created in 1982 under Medicare for patients with terminal disease and a prognosis of six months. The legislation proved a stimulus to both not-for-profit and for-profit hospices. By the end of the twentieth century some 3,000 hospice organizations were operating in the United States.

Elsewhere, the potential for development varied enormously. Political instability, economic privation, and the absence of leadership limited possibilities for the development of hospices. In Eastern Europe, for example, there was little opportunity for hospice initiatives until communism began to break down. Thus in the Polish city of Krakow an informal society was first formed to support hospice developments in 1981, the year martial law was imposed. In Russia the first hospice was opened in St. Petersburg in 1992, with the support of the émigré journalist Viktor Zorza, who established Russian links with supporters in the United Kingdom in the wake of the new era of glasnost. The Island Hospice, which began in Zimbabwe in 1979, is generally acknowledged by medical professionals as the first hospice established in a third world country.

In several countries, for example India, the first hospices were modeled quite explicitly upon St. Christopher’s, but local variation was also common. In Spain the word *hospice* has negative cultural associations of poverty and incarceration, so a strong emphasis was placed from the outset on the integration of services within the mainstream health care system. Pioneers of first-wave hospice

development and some of their second generation successors have worked to promote their work in many countries of the world, building increasingly on international networks of support and collaboration, fostered by groups such as the World Health Organization, the International Association for Hospice and Palliative Care, and the European Association of Palliative Care.

By the early twenty-first century some form of specialist palliative care existed in an estimated ninety countries and there was clear evidence of continuing expansion in Asia, Eastern Europe, Africa, and Latin America. Within the professional lifetime of the founders of the modern hospice movement a remarkable proliferation had occurred; at the same time the definition of hospice and palliative care had come into sharper focus. The debates and discussions that followed saw palliative care preoccupied with many of the wider questions relating to the work of health care systems in the modern world.

In the 1970s and 1980s modern hospice and palliative care in the West had many of the qualities of a social movement supported by wider forces: consumerism and increasing discernment among the users of health and social care services; demographic trends that created substantial numbers of individuals able to volunteer their labor in local hospices; and greater affluence, which led to an increase in charitable giving. This movement may have contributed to a new openness about death and bereavement that was in evidence in the late twentieth century (in Britain, for example, the first person ever to be seen to die on television, was in the care of a hospice). Inspired by charismatic leadership, it was a movement that condemned the neglect of the dying in society; called for high quality pain and symptom management for all who needed it; sought to reconstruct death as a natural phenomenon, rather than a clinical failure; and marshaled practical and moral argument to oppose those in favor of euthanasia. For Cicely Saunders and her followers such work served as a measure of the worth of a culture: “A society which shuns the dying must have an incomplete philosophy” (Saunders 1961, p. 3).

In the late twentieth century in several countries, including Britain, Australia, Canada, the United States, there was professional recognition of

this emerging area of expertise. Specialty recognition occurred first in Britain, in 1987, and was seen by some scholars as a turning point in hospice history. It was part of a wider shift away from “terminal” and “hospice” care toward the concept of palliative care. Those seeking to further develop this work claim that specialization, the integration of palliative care into the mainstream health system, and the development of an “evidence-based” model of practice and organization are crucial to long-term viability. Others in the field mourn the loss of early ideals and regret what they perceive to be an emphasis upon physical symptoms at the expense of psychosocial and spiritual concerns. In short, there have been claims that forces of medicalization and routinization are at work or even that the putative “holism” of palliative care philosophy masks a new, more subtle form of surveillance of the dying and bereaved in modern society.

By the end of the twentieth century, however, a growing commitment to the evidence base was emerging. Two forces for expansion were also clearly visible. First, there was the impetus to move palliative care further upstream in the disease progression, thereby seeking integration with curative and rehabilitation therapies and shifting the focus beyond terminal care and the final stages of life. Second, there was a growing interest in extending the benefits of palliative care to those with diseases other than cancer, in order to make “palliative care for all” a reality. The new specialty was therefore delicately poised. For some such integration with the wider system was a *sine qua non* for success; for others it marked the entry into a risky phase of new development in which early ideals might be compromised.

Hospice care and palliative care have shared a brief history. The evolution of one into the other marks a transition which, if successful, could ensure that the benefits of a model of care previously available to just a few people at the end of life will be extended to all who need it, regardless of diagnosis, stage of disease, social situation or means.

See also: HOSPICE, ALZHEIMER PATIENTS AND; HOSPICE AROUND THE WORLD; SAUNDERS, CICELY

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DAVID CLARK

HOSPICE OPTION

Approximately 30 percent of people who die in the United States choose hospice care during the last weeks of life. The average length of enrollment in hospice care was forty-eight days in 1999. Many of these patients die from cancer, but others have chronic, life-limiting diseases, such as cardiovascular or lung problems. Hospice is a major provider of end-of-life care to patients with HIV/AIDS and Alzheimer’s disease. Hospice serves patients of all cultures and ethnicities, although barriers to general health care access may cause minorities to distrust hospice/palliative care as

a form of denial of needed services. Fear that providers will not respect customs and traditions may also affect acceptance of hospice care. In the United States, Medicare, Medicaid, and most managed health care and private insurance plans cover hospice care.

What Is Hospice?

Hospice is a humane and compassionate way to deliver health care and supportive services to patients and their families during the final weeks of life. Modern hospice care started, in part, as a reaction to the increasing use of technology to extend life and the increasing expectation that death would occur in an unsympathetic, unsupportive hospital. The picture was one of strangers in attendance and no choice about the medical procedures being performed. People longed for idealized earlier scenes of peace and dignity where the dying person is pain free and surrounded by caring family.

During the 1960s, Cicely Saunders, a British physician, began the modern hospice movement by bringing together scientific research with holistic care of the mind and spirit. Saunders proposed standards that still guide care in the more than 2,000 hospices in the United States and hospice/palliative care units in Canada. Hospice affirms the rights of the patient/family unit to control the final stages of life. The terminally ill person's own preferences and lifestyle are taken into account in the hospice plan. The focus changes to caring when a life-limiting illness no longer responds to cure-oriented treatments. Hospice is intended to help make the most of the final months of life by providing emotional and spiritual support along with pain and symptom control.

Hospice care is provided by a team. Included in the team are the patient, the family, and trained volunteers, as well as the usual health care providers—nurses, home health aides, social workers, therapists, counselors, and physicians. The physician may be the patient's own physician or one who is specially trained in palliative (comfort) care. Each member of the team brings specific knowledge of terminal illness to the holistic care of the patient.

Volunteers provide significant services by offering support to patient and families, assisting with child care, and working with professional staff on bereavement support programs. Volunteer activities

(such as transportation, shopping, and visiting) offer relief, referred to as respite care, to the caregiver from the work as well as time for self-care. The volunteers represent the wider community support for the patient in tangible ways.

One of the guiding principles for hospice is that patients, family, and staff all have legitimate needs and interests. The organization provides a mutual support network to discuss experiences and feelings engendered by emotionally charged care situations.

Care based on hospice principles can be provided in all of the settings where people die. Most people choose to die at home or in a relative's home with the help of hospice home health agencies. This choice is limited by the availability and abilities of caregivers, the technology that is needed, and the resources that are available in the community. Care is structured to keep patient and families together in the least restrictive environment possible. Other settings devoted to managing end-of-life care include freestanding inpatient hospices, nursing homes, and hospitals.

The hospice team coordinates a plan of care structured for just one person: the patient. A wide range of services may be provided, including nursing care, medical social services, physician services, spiritual support and counseling, home care aide and homemaker services, continuous care in the home, trained volunteer support service, physical, occupational, and speech therapy, twenty-four-hour on-call availability, hospice inpatient care, respite care, and bereavement support. In the United States Medicare, Medicaid, and most private insurance plans pay for much of this care. If insurance coverage is not available or is insufficient, most hospices provide services by relying on grants and community support through fundraising activities.

Health care expenditures are highest during the last month of life. Hospice is a cost-effective approach to end-of-life care. A 1995 comparison of average charges for a Medicare patient, prepared for the National Hospice Organization (NHO), indicated costs of \$2,177 per day for hospital inpatient care, \$482 per day for skilled nursing facility care, and \$113 per day for hospice care.

While cost savings with hospice care account for governmental and third-party payers' interest, it is public support that drives the success and

growth of hospice care availability. Much of the public wants to ensure that patient's wishes are enforced and that the patient is able to choose desired types of services.

Making the Decision to Receive Hospice Care

Even though there has been a significant death education movement in the United States and internationally since the 1960s, most Americans are still unwilling to discuss end-of-life care with the terminally ill. While the living will and advanced directives documents have been available since the late 1960s, only a quarter of Americans have put into writing the care they want at the end of life. Discussions with family about preferences for treatment continue to be avoided until a crisis occurs.

The first step is to explore one's own feelings about the end of life. This might best be accomplished through the answering of a series of questions, such as: What would you like the last three days of your life to be like? Where will you be? Who will be with you? Who will give you emotional and spiritual support? Do you have cultural and family traditions that will affect the care you wish to receive? Who would you like to have fixing your food? Would you like family to provide personal care, or someone who is trained for that care? Do you want everything done to keep you alive, such as cardiopulmonary resuscitation, breathing machines, and feeding tubes? Do you want to be alert and able to talk with your family or would you rather be unaware of the nearness of your death? If you were not able to make decisions for yourself, who would you like to have making those decisions for you?

The next steps include learning about the options available in the community and putting one's wishes in the form of advanced directives and a medical power of attorney. Discussions with family, doctor, and attorney can help make educated decisions and can also free loved ones from the anxiety and uncertainty of not knowing one's wishes and options.

When to Make the Hospice Care Decision

Ideally, the decision to enter hospice care is made when the patient and family decide that remembering, sharing, and bringing closure to life is more important than persisting in unpleasant and futile treatments to prolong life. In hospice care, the



The hospice option was not an entirely new concept to the twentieth century. Hôtel-Dieu in France was built in 1443 to house the poor and ill after the Hundred Year's War.

PATRICK WARD/CORBIS

patient and family are able to focus on management of pain and other symptoms and to find time to address emotional and spiritual issues. Unfortunately it is very difficult for patients and doctors to identify the end of the fight for cure and the beginning of the need for palliative hospice care.

As they reported in 2000, Nicholas A. Christakis and Elizabeth Lamont asked doctors to estimate their patients' length of life. The doctors predicted accurately within one month of the actual death for only 42 percent of the patients. Most (46%) of the time the doctors overestimated the length of time left to the patient. Although there are variations depending on patient diagnosis, the average survival after enrollment in hospice is approximately one month to six weeks. Many of the patients die within seven days of enrollment. Hospice workers feel that earlier recognition of the

need for palliative care would allow both patient and family more time to address end-of-life issues. Cultural, emotional, and socioeconomic factors all affect the accuracy of prognosis and the readiness for hospice care.

Ultimately the decision is a joint one, made between the patient/family and the doctor. Doctors certify that patients are terminally ill and probably have less than six months to live. Patients certify that they wish to enter a program that provides care, but that they no longer seek to cure illness. This is an emotional turning point that is difficult for all involved. The decision to enter hospice care should be an affirmative choice to live life to its fullest, supported by a comprehensive program of medical care. It should not be viewed as a failure for the doctor, the patient, or the family.

Once the decision is made, health care personnel can assist in identifying the resources available in the community. Questions about accreditation and licensure, available services, eligibility criteria, costs, payment procedures, and employee job descriptions may assist with the choice. Hospices may be freestanding or have close relationships with hospitals, skilled nursing facilities, or home health agencies. Hospices may be for-profit or non-profit agencies. References from hospital or community agency professionals may guide the choice. The final decision may be made in consultation with the hospice nurse in an evaluation interview. A key question is whether the philosophy and standards of the hospice are congruent with the needs and desires of the patient and family.

What to Expect from Hospice Care

Hospice care combines medical knowledge and research with a reverence for life. The philosophy emphasizes that appropriate care can allow the patient and family to live as fully and comfortably as possible with meaning and dignity. This was epitomized by an incident observed at St. Christopher's Hospice in England many years ago. An American nurse visiting this pioneering hospice noticed that none of the patients had intravenous fluids hanging by the bedside. Because almost every patient in the typical oncology ward at that time had continuous intravenous fluids, she asked Cicely Saunders, the pioneering hospice physician, about the lack at St. Christopher's. Saunders reply was, "Isn't it so much nicer to share a cup of tea?"

The nurse noted that no patients seemed dehydrated and that the staff did indeed share a cup of tea with the patients.

The hospice patient and family should expect a professional nurse or social worker to develop a plan for care. Consideration of the needs and wishes of the patient and family is uppermost as decisions are made. Palliation, or remission of pain and other troubling symptoms, was the subject of research leading to great improvement in care during the latter part of the twentieth century. The hospice physician and patient's doctor are consulted to assure that pain and symptom management orders are in place. Freedom from pain and from fear of pain allow the patient to fully participate in the business of living.

In addition to pain management, hospice provides social, psychological, emotional, and spiritual support. The patient and family should feel safe and secure knowing that they can depend on caregivers to communicate honestly, discuss concerns, answer questions, and function effectively. Patients and family need the opportunity and privacy to say goodbye.

Hospice care is intended to support family members, especially those who are the patient's caregivers and information about what is happening to the terminally ill person is given. Instruction about how to care for the person can be very reassuring to the caregivers. Assistance with household tasks such as meal preparation, shopping, and transportation may be needed. Sometimes what is needed is a good night's sleep or time for one's own health care appointment. This respite from duties can make it possible to continue caring. Some hospices provide inpatient respite services where the patient is cared for in a skilled nursing facility or hospital for a few days to allow the caregiver time to rest. Patients appreciate knowing that the burden of their care can be shared.

The birth or wedding that goes as it should seems to foretell a life or marriage that will go well. The same is true of a good death. Family members survive and grow from the experience. When the death is isolated and filled with pain, the memories that stay behind can be difficult. Hospice is committed to making the end of life a time of growth.

See also: GOOD DEATH, THE; HOSPICE AROUND THE WORLD; PAIN AND PAIN MANAGEMENT; SAUNDERS, CICELY; SYMPTOMS AND SYMPTOM MANAGEMENT

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BEATRICE KASTENBAUM

HOW DEATH CAME INTO THE WORLD

Traditional, mythic accounts of the origin of death extend back to the earliest hunter-gatherer cultures. Usually these stories are morality tales about faithfulness, trust, or the ethical and natural balance of the elements of the world.

According to an African Asante myth, although people did not like the idea or experience of death, they nevertheless embraced it when given

the choice, as in the tale of an ancient people who, upon experiencing their first visitation of death, pleaded with God to stop it. God granted this wish, and for three years there was no death. But there were also no births during that time. Unwilling to endure this absence of children, the people beseeched God to return death to them as long as they could have children again.

The death myths of aboriginal Australia vary enormously among clans and linguistic groups. Among most of them, however, death is often attributed to magic, misfortune, or to an evil spirit or act. Occasionally death is presented as the punishment for human failure to complete an assignment or achieve a goal assigned by the gods. Still other stories arise from some primordial incident that strikes at the heart of some tribal taboo. Early myths about death frequently bear these moral messages.

Among the Tiwi of Bathurst and Melville Islands in northern Australia, the advent of death is explained by the Purukapali myth, which recounts a time before death entered the world, when a man lived with his infant son, his wife, and his younger brother. The younger brother was unmarried and had desires for his brother's wife. He met her alone while she was gathering yams, and they spent the rest of the afternoon in sexual union. During this time, the husband was minding his infant son, who soon became hungry. As the son called for feeding, the husband called in vain for his missing wife. At sunset, the wife and younger man returned to find that the infant son had starved to death. Realizing what had happened, the husband administered a severe beating to his brother, who escaped up to the sky where he became the moon. His injuries can still be seen in the markings of the moon every month. The husband declared that he would die, and, taking the dead infant in his arms, performed a dance—the first ceremony of death—before walking backwards into the sea, never to be seen again.

The Berndts, Australian anthropologists, tell another ancient myth about two men, Moon and Djarbo, who had traveled together for a long while but then fall mortally ill. Moon had a plan to revive them, but Djarbo, believing that Moon's idea was a trick, rebuffs his friend's help and soon dies. Moon dies also, but thanks to his plan, he managed to revive himself into a new body every month,

whereas Djarbo remained dead. Thus, Moon triumphs over bodily death while the first peoples of that ancient time followed Djarbo's example, and that is why all humans die.

Death As a Being

None of these stories is meant to suggest that aboriginal people do not believe in spiritual immortality. On the contrary, their lore is rich in accounts of immortal lands. These are accounts of the origin of physical rather than spiritual death.

The idea of death as a consequence of human deeds is not universal. The image of death as a being in its own right is common in modern as well as old folklore. In this mythic vein, death is a sentient being, maybe an animal, perhaps even a monster. Sometimes death is disguised, sometimes not. Death enters the world to steal and silence people's lives. In Europe during the Middle Ages death was widely viewed as a being who came in the night to take children away. Death was a dark, hooded, grisly figure—a grim reaper—with an insatiable thirst for the lives of children. Children were frequently dressed as adults as soon as possible to trick death into looking elsewhere for prey.

The film industry produced two well-known films, the second a remake of the first, which examined this idea of death as a being who makes daily rounds of collecting the dead: *Death Takes a Holiday* (1934) and *Meet Joe Black* (1998), both of which portrayed death as perplexed at his victim's fear of him. In a wry and ironic plot twist, a young woman falls in love with the male embodiment of death, and it is through an experience of how this love creates earthly attachment that death comes to understand the dread inspired by his appearance.

But the idea of death as a humanlike being is mostly characteristic of traditional folktales that dramatize the human anguish about mortality. By contrast, in the realm of religious ideas, death is regarded less as an identifiable personal being than as an abstract state of being. In the world of myth and legend, this state appears to collide with the human experience of life. As a consequence of human's nature as celestial beings, it is life on Earth which is sometimes viewed as a type of death. In this way, the question of how death enters the world in turn poses the question of how to understand death as an essential part of the world.

The Garden of Eden

In the book of Genesis, the first man, Adam, wanders through the paradisiacal Garden of Eden. Pitying his solitary nature, God creates the first woman, Eve, from Adam's rib. Adam and Eve are perfectly happy in the Garden of Eden and enjoy all its bounty with one exception: God prohibits the couple from eating from the Tree of Knowledge.

The Garden of Eden is utopian. Utopia, in its etymological sense, is literally "no place." It is a perfect, probably spiritual domain for two celestial beings who, bearing the birthmarks of the God who created them, are immortal. These two beings eat from the Tree of Knowledge, which ironically, distracts them from their awareness of God and his omnipresence. As a result of this error, Adam and Eve become the embodiment of forgetfulness of the divine. In other words, they become material beings, as symbolized in their sudden awareness of and shame in their nakedness.

Adam and Eve thus "fall" into the flesh, into the world as it is known, with the entire legacy that embodiment entails: work, suffering, and physical death. Paradoxically, the Tree of Knowledge heralds ignorance of their divine nature, and the fall into flesh signals their sleepwalking indifference to that nature. Human beings therefore need God's help through the divine mercy of his Son or the sacred texts of the Bible to awaken them to their divine destiny. Without this awakening, the wages of sin are eternal death—an eternal darkness spent in chains of ignorance, a blindness maintained by humans' attachment to mere earthly concerns and distractions. This famous story thus embodies all the paradoxical elements of creation, implying that human life is actually no life at all, but its opposite: death.

In the kernel of this local creation story lies the archaic analogy of all the great stories about how life is death and death is the beginning of true life. The cycles of life and death are not merely hermeneutic paradoxes across different human cultures, but they are also the fundamental narrative template upon which all the great religions explain how death entered the world and, indeed, became the world.

In Greek mythology, as Mircea Eliade has observed, sleep (Hypnos) and death (Thanatos) are twin brothers. Life is portrayed as a forgetfulness that requires one to remember, or recollect,

the structures of reality, eternal truths, the essential forms or ideas of which Plato wrote. Likewise, for postexilic Jews and Christians, death was understood as sleep or a stupor in Sheol, a dreary, gray underworld in the afterlife. The Gnostics often referred to earthly life as drunkenness or oblivion. For Christians, the exhortation was also to wake from the sleep of earthly concerns and desire and to watch and pray. In Buddhist texts, the awakening is a concern for recollection of past lives. The recollection of personal history in the wheel of rebirth is the only hope anyone has of breaking this cycle of eternal return.

Sleep, then, converges with death. Both have been the potent symbols and language used to describe life on earth. It is only through the remembering of human's divine nature and its purpose, brokered during an earthly life of asceticism or discipline, or perhaps through the negotiation of trials in the afterlife, that one can awaken again and, through this awakening, be born into eternal life.

Modern Accounts

The humanistic trend of twentieth-century social science and philosophy has diverged from this broadly cross-cultural and long-standing view of death as earthly existence and true life as the fruit of earthly death. Contemporary anthropology and psychoanalytic ideas, for example, have argued that these religious ideas constitute a "denial of death." The anthropologist Ernest Becker and religious studies scholar John Bowker have argued that religions generate creation myths that invert the material reality of death so as to control the anxiety associated with the extinction of personality and relationships.

Like-minded thinkers have argued that philosophical theories which postulate a "ghost in the machine"—a division of the self into a body and a separate spirit or soul—are irrational and unscientific. But, of course, the assumptions underlying these particular objections are themselves not open to empirical testing and examination. Criticism of this kind remains open to similar charges of bias and methodological dogma, and tends, therefore, to be no less speculative than religious views of death.

Beyond the different scientific and religious arguments about how life and death came into the world, and which is which, there are several other traditions of literature about travel between the

two domains. Scholars have described the ways in which world religions have accounted for this transit between the two halves of existence—life and death. Often, travel to the "world of the dead" is undertaken as an initiation or as part of a shamanic rite, but at other times and places such otherworldly journeys have been part of ascetic practices of Christians and pagans alike.

In the past half century psychological, medical, and theological literature has produced major descriptions and analyses of near-death experiences, near-death visions, visions or hallucinations of the bereaved, and altered states of consciousness. Research of this type, particularly in the behavioral, social, and clinical sciences, has reignited debates between those with materialist and religious assumptions about the ultimate basis of reality.

Traditionally confined to the provinces of philosophy and theology, such debates have now seeped into the heretofore metaphysics-resistant precincts of neuroscience, psychology, and medicine. What can these modern psychological and social investigations of otherworldly journeys tell experts about the nature of life and death, and which is which?

The religious studies scholar Ioan Peter Couliano argues that one of the common denominators of the problem of otherworldly journeys is that they appear to be mental journeys, journeys into mental universes and spaces. But such remarks say more about the origin of "mental" as a term of reference than the subject at hand. The glib observation that otherworldly journeys may be mere flights of fancy may in fact only be substituting one ambiguous problem with yet another.

As Couliano himself observes, people in the twenty-first century live in a time of otherworldly pluralism—a time when such journeys have parallels in science and religion, in fantasy and fact, in public and private life.

Conclusion

Death has permeated life from the first stirrings of matter in the known universe—itsself a mortal phenomenon, according to the prevailing cosmological theory of contemporary physics. Death came incorporated in the birth of the first star, the first living molecules, the birth of the first mammoth, the first cougar, the first human infant, the first

human empire, and the youngest and oldest theory of science itself. Early cultures groped with the meaning of death and its relationship to life. The very naming of each, along with the attendant stories and theories, is an attempt to somehow define and thus master these refractory mysteries. All of the major myths about how death entered the world are, in fact, attempts to penetrate below the obvious.

Most have concluded that Death, like Life, is not a person. Both seem to be stories where the destinations are debatable, even within their own communities of belief, but the reality of the journey is always acknowledged—a continuing and intriguing source of human debate and wonderment.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; AUSTRALIAN ABORIGINAL RELIGION; GODS AND GODDESSES OF LIFE AND DEATH; IMMORTALITY

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ALLAN KELLEHEAR

HUMAN REMAINS

Archaeologists, anthropologists, and classicists seem unanimous in asserting that the values of every culture, ancient and modern, entail proper disposal of human tissue and dead bodies. Among many peoples, the obligation to put the body properly to rest has been extended to maintaining the places of disposal as sacred sites. For example, in seventeenth-century New France, now Quebec, the settlements were considered unsuccessful until cemeteries were established. Prior to that, members of the aristocracy who could afford to do so had the body preserved in alcohol or stripped to the skeleton and shipped back to the country of origin. Those of lower status were simply buried in unconsecrated ground and forgotten. Only when consecrated cemeteries were allowed was a parish established, thus allowing the second and third generations of New France to claim the land around the site as "home." The parishioners then had all of the rights of identity afforded their ancestors in the mother country, along with the obligations of maintaining the parish cemeteries as sacred ground.

It is taboo in most of the world to disturb the remains of deceased ancestors except under the most limited of circumstances. Nevertheless, cemeteries are sometimes subject to disturbance. Historically, destruction of burial sites has often been the first act of dominion a conqueror imposes on the vanquished precisely because of its demoralizing effect on the local population. To desecrate means to treat contemptuously, often in a way that demeans for the progeny the importance or values of their ancestor's remains and the sacred sites of disposal.

Groups of indigenous peoples around the world are working to encourage the United Nations to adopt a Declaration on the Rights of Indigenous Peoples forbidding the desecration of burial sites and the displaying of ancestral remains and grave artifacts as tourist attractions. Other international organizations seek to contain the rapidly expanding market for human organs taken from unsuspecting patients and the newly dead in order to cash in on demand in the organ transplant market.

Two major actions taken in the United States have influenced worldwide debate about the use

and abuse of human tissue, modern and ancient—the Vermillion Accord (1989) and the Native American Graves Protection and Repatriation Act (1990). The Vermillion Accord on Human Remains emerged out of the first Inter-Congress of the World Archaeological Congress at the University of South Dakota in Vermillion. Individuals from twenty countries, twenty-seven Native American nations, and indigenous people from other parts of the world—among them human osteologists, archaeologists, medical educators, and ethicists—discussed and debated the subject of respectful treatment of human remains. The result, a six-point agreement that has influenced subsequent efforts to bridge the interests of indigenous peoples and scholars, appeared in a 1990 issue of *Death Studies*:

1. “Respect for the mortal remains of the dead shall be accorded to all irrespective of origin, race, religion, nationality, custom, and tradition.”
2. “Respect for the wishes of the dead concerning disposition shall be accorded whenever possible, reasonable, and lawful, when they are known or can be reasonably inferred.”
3. “Respect for wishes of the local community shall be accorded whenever possible, reasonable, and lawful.”
4. “Respect for the scientific research values of skeletal, mummified, and other human remains (including fossil hominids) shall be accorded when such value is demonstrated to exist.”
5. “Agreement on the disposition of fossil, skeletal, mummified, and other remains shall be reached by negotiation on the basis of mutual respect for the legitimate concerns of communities for the proper disposition of their ancestors, as well as the legitimate concerns of science and education.”
6. “The express recognition that the concerns of various ethnic groups as well as those of science are legitimate and to be respected will permit acceptable agreements to be reached and honored.”

The accord was later expanded in the World Archaeological Congress’s First Code of Ethics.

The Native American Graves Protection and Repatriation Act, passed by Congress in 1990, established rules for returning Native American

remains and grave artifacts to appropriate indigenous populations. By November 1993 museums holding Native American materials containing human tissue were required to prepare written summaries of their collections for distribution to culturally affiliated tribes. By November 1995 museums were required to prepare detailed inventories of their Native American collections.

Since adoption of the accord and the passage of the act, legislation has been expanded to cover use of various tests, such as carbon dating and DNA, for identification of remains; control of sale of human tissue; and restriction of collection of ancient, indigenous artifacts associated with sacred areas.

See also: ANTHROPOLOGICAL PERSPECTIVE; CEMETERIES AND CEMETERY REFORM; KENNEWICK MAN; MUMMIFICATION

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GLEN W. DAVIDSON

HUNGER STRIKES

Hunger strikes as a means of protest have been traced to the pre-Christian era in Rome. They were revived in the early twentieth century in England by women suffragists. A global phenomenon, hunger strikes have been reported from Ireland to Beijing, Istanbul to New Delhi and the United States. Purportedly the longest hunger strike continued for seventy-four days, ending in the death of a Sinn Fein political party member in the 1920s.

Ireland was also the scene of the largest reported hunger strike, involving 8,000 political prisoners and internees in 1923.

A true hunger strike represents a competent individual's intentional refusal to eat and or drink for some specific purpose. Definitions vary, however, in the specificity of both fluid intake and the time interval required to certify such an act as a hunger strike. Occasionally hunger striking is an indication of mental illness that is tantamount to actual or attempted suicide. William Butler Yeats captured in verse what may be the primary aim of hunger striking, that is to "shame" those in authority to right a "wrong" or injustice. "Persuade him to eat or drink? / While he is lying there. Perishing there, my good name in the world / Is perishing also. I cannot give way, / Because I am king, because if I give way, / My nobles would call me a weakling, and, it may be, / the very throne be shaken." Most often it entails acts of nonviolent protest to prompt redress of structural or human rights violations, whether unjust imprisonment, objectionable living conditions for prisoners, or struggles against oppression by groups such as the United Farm Workers in California or the people of Tibet.

Prisoners, priests, students, suffragists, nationalists, pacifists, and activists have been emboldened to use fasting and hunger strikes to publicize and underscore their personal and political agendas. Mohandas Gandhi resorted to fasting at least fourteen times, but never for longer than twenty-one days. In 1981 Irish republicans initiated hunger strikes to demand status as political detainees, asserting the political nature of their claims. For the Irish, particularly northern Catholics, hunger strikes have both historical and mythological precedents. They are viewed symbolically as acts of religio-political martyrdom, linking the protagonist to the pantheon of Irish heroes and the cult of sacrifice, whose most notable exemplar was Jesus Christ.

The ability to accurately document and enumerate the incidence of hunger strikes, along with statistics on morbidity or mortality, is severely hampered by a lack of any systematic surveillance, so the reporting of such incidents remain haphazard. In 1991 the World Medical Association issued guidelines for physicians who treat hunger strikers; a key point of the paper is that care should not be contingent on the suspension of the strike but must be based on clear communication between

patient and provider in a context of respect, beneficence, and autonomy.

Hunger striking as a political tool has had mixed success. Court-mandated forced feeding, a controversial precedent set in the early suffragist movement in England, has since been used by governments to stifle or terminate hunger strikes, as in the case of Red Army Faction prisoners in Germany in the 1970s and 1980s. There have been several notable negotiated settlements of strikes; for example, the Bulgarian strikes of 1925–1929, which resulted in a partial amnesty for political prisoners. The 1978 hunger strike in Bolivia led to the downfall of the military regime. In some cases where demands have been ignored, the prolongation of the hunger strikes have led to the death of some strikers, as in the Irish strikes of 1981 and in Turkey in 1996.

In the case of Bobby Sands and the nine other Irish prisoners who died, world opinion seemed to support the British government's position during the strike. After the fatalities, however, mass sentiment began to shift in favor of the Irish Republican movement, whose candidates went on to win several seats in Irish and British parliamentary elections of 1983. In Turkey, the 1996 hunger strike of hundreds of political prisoners resulted in at least twelve deaths, and many surviving prisoners had residual neurologic and psychiatric effects. The death toll from the Turkish strike of 2001 stands at twenty and prompted the government to initiate some of the reforms in prisoner treatment sought by human rights groups.

While reports of hunger strikes reach far back into antiquity, the dawn of a new millennium brings evidence of their ongoing use. It appears that hunger striking will continue to represent a powerful form of protest as long as there remain the oppressive political and social conditions that seem to give rise to them.

See also: CAUSES OF DEATH; FAMINE; SOCIAL FUNCTIONS OF DEATH

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HUNTING

Social scientists report that humans have employed hunting as a subsistence strategy for at least 90 percent of *Homo sapiens*' history. The anthropologists Richard Lee and Richard Daly conceptualize hunting, the pursuit and killing of other animals, as one component of "foraging," a broader complex of subsistence activities that also includes the "gathering of wild plant foods, and fishing" (Lee and Daly 1999, p. 3). Hunting entails searching for and killing (or, on occasion, capturing and confining) a wild, unconfined animal. While humans hunt and kill animals primarily as a source of food, they also hunt in order to neutralize a threat (i.e., a tiger or leopard that preys on people), to remove a pest (i.e., rodents or birds that consume agricultural products), or to eliminate a competitor (i.e., predators that kill game animals).

As a human activity, hunting is magnified in its significance by a deceptively simple feature: the evasiveness or resistance exhibited routinely by prey. Because of the behavioral challenges that it presents, hunting has had far-reaching consequences for key aspects of human social, psychological, and cultural life. Since the mid-1960s, for example, anthropologists have argued that hunting may have been a powerful and fundamental force shaping the very nature of cooperation and sharing among early humans.

One such claim involves what the behavioral ecologist Bruce Winterhalder calls the "risk reduction hypothesis." The failure rate of hunters is notoriously high. Even among experienced, highly skilled subsistence hunters who pursue big game animals, any one hunt is much more likely to result in failure than in success. Studying the Hadza of Tanzania in 1993, the anthropologist Kristen Hawkes reported that when hunting big game, Hadza men failed to make a kill 97 of every 100 days that they hunted. When a large game animal is killed, it often represents a "windfall" in excess of what any one hunter and his or her immediate family can consume. These circumstances promote reciprocity and sharing among hunters. By sharing the meat provided by a successful kill, a hunter effectively "buys insurance" against failure in future hunts. When, in the future, he or she fails to kill prey, other successful hunters with whom meat has been shared previously will reciprocate and provide

meat to the unsuccessful hunter. The science writer Matt Ridley argues that the cooperation and reciprocity associated with hunting may help constitute the basis of systems of moral and ethical culture. In short, hunting is an activity that promotes cooperation and sharing because it entails the pursuit of a highly valued resource, access to which is unpredictable and risky.

Anthropologists report that while both men and women hunt, in the vast majority of human societies this activity is predominantly male. Yet, it is not self-evident why males are more likely to hunt than females. Scholarly interpretations of the 1990s link hunting to sexual activity and rewards. While the matter is debated among social scientists, some researchers argue that males are motivated to hunt not only because of the food they acquire but because of the social esteem and increased sexual opportunities enjoyed by successful hunters.

The extrinsic rewards of a successful hunt may provide clues about why hunting is intrinsically exciting and satisfying to many people, especially males. To the extent that a behavior confers significant survival and reproductive advantages, evolutionary psychologists like Leda Cosmides and John Tooby suggest that humans are likely to evolve specialized psychological mechanisms that promote such behavior. Accordingly, if hunting yields highly valued protein in the form of meat, promotes stable patterns of cooperation and exchange, and provides males with a currency that they can exchange for sex, it is reasonable to surmise that human males may have evolved psychological attributes that make hunting highly intrinsically satisfying and rewarding to them, whatever the accompanying risks. While this line of reasoning appears promising and compelling to evolutionary minded social and behavioral scientists, it may be too early to conclude that humans are psychologically equipped with specialized mental mechanisms that are the product of humans' Pleistocene history as hunters.

Despite the demise of the hunter-gatherer era about 12,000 years ago, hunting has maintained great significance in many human cultures. In *A View To a Death in the Morning* (1993), Matt Cartmill traces the symbolism and imagery of the hunt from the hunting-gathering era, through the agrarian era, and into modern, industrial times. Cartmill



Hunting, once reserved for socialites in the early twentieth century, has become popular sport for all classes.

BETTMANN/CORBIS

sees the symbolism of the hunt as rich with information about how human beings understand and assess their place in nature. In the Greco-Roman world, hunting was elevated to cosmological significance in the form of deities such as Apollo and Artemis/Diana. In later European art, literature, and philosophy, hunting themes became freighted with complex meanings about class relations and social justice. In contemporary industrial societies such as the United States, media products such as the animated film *Bambi* are said to express a view of nature in general and animals in particular as good, and humanity as evil, or at least “dubious.” Thus, writers like Cartmill see the human significance of hunting in the post-hunter-gatherer era as primarily semiotic, as pertaining to the symbolization of humanity and its relation to nature, and to itself.

In contemporary Western societies like the United States and Great Britain, it is conflict over the moral meanings attending hunting that has made it the focal point of intense and protracted political debate. Members of animal rights organizations such as People for the Ethical Treatment of Animals (PETA) and Friends of Animals vilify hunting. They also denounce hunters whom they see

as arrogant and insensitive for engaging in an activity that is described as “recreational” or “sporting,” and necessitates the death of a “sentient,” nonhuman animal. Yet many hunters themselves impose entirely different meanings on the hunt, and some, such as the naturalist Paul Shepard, even assign it spiritual significance, construing it as an activity that expresses a deep and profound reverence toward nature and living things. It is unlikely that these divergent views will be reconciled in the near future. If humans are, in fact, possessed of an evolved psychology that derives from a hunting-gathering past, it has yet to be determined if this evolved psychology and the contours of modernity are somehow reconcilable or, rather, are fundamentally incommensurable.

Finally, hunters and recreational shooters in modern societies like the United States have played a significant role in wildlife conservation. As members of various hunting and shooting organizations, such as Ducks Unlimited, the Rocky Mountain Elk Foundation, and the National Rifle Association, hunting enthusiasts have generated billions of dollars that have supported various types of game management programs, habitat protection and restoration, and conservation education. Some of this money takes the form of direct contributions to such programs, and other monies are generated indirectly by taxes on hunting equipment purchases and various license, tag, permit, and stamp fees. One of the oldest and most important among such hunting-based revenue sources is the Federal Aid in Wildlife Restoration Act of 1937 (also known as the Pittman-Robertson Act), and it has distributed more than \$3.8 billion to state fish and wildlife agencies since it became law. Thus, somewhat ironically, modern hunters contribute significantly to the survival of the very species whose individual members they hunt and kill.

See also: DEATH SYSTEM

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I



IATROGENIC ILLNESS

Literally meaning “physician-induced,” the term *iatrogenic* describes diseases inadvertently resulting from medical treatments or procedures. With more effective and powerful treatments have come side effects that may be more common and harmful. There are efforts by medical specialists and consumers to quantify and reduce iatrogenic side effects. These efforts are hampered by the natural reluctance of physicians (and other providers) to have their errors publicized and the prospect of malpractice lawsuits. Physicians rarely report iatrogenic events, even though most claim to have witnessed them. Efforts to make reporting mandatory are resisted by the medical profession; therefore, lack of such reporting makes it more difficult to identify and minimize hazards.

Despite these obstacles, the hazards of medicine are emerging in an increasing number of studies and reports. A 2000 presidential report described iatrogenic error and illness as “a national problem of epidemic proportions,” causing tens of thousands of annual deaths. The report estimated the cost of lost income, disability, and health care costs to be \$29 billion a year. The report concluded that half of adverse medical events were preventable.

The presidential report relied heavily upon another report by the Institute of Medicine, *To Err is Human: Building a Safer Health System* (2000). Issued by the most respected agency of American medicine, *To Err is Human* generated considerable attention and surprise by concluding that up to 98,000 Americans are killed annually by medical

errors. This number slightly exceeds the combined total of those killed in one year by motor vehicle accidents (43,458), breast cancer (42,297), and AIDS (acquired immunodeficiency syndrome, 16,516).

The Institute of Medicine utilized the findings of two large studies. One found that 2.9 percent of people hospitalized in Colorado and Utah experienced medical errors and 6.6 percent of those people died as a result of the errors. The second study found that 3.7 percent of people hospitalized in New York experienced errors and 13.6 percent of those people died as result. This led the Institute to conclude that a minimum of 44,000 Americans die annually due to error during hospitalization, making it the eighth leading cause of death in the United States. Even so, the report says that these numbers “offer only a very modest estimate of the magnitude of the problem since hospital patients represent only a small proportion of the total population at risk” (Institute of Medicine 2000, p. 2).

While important, these reports fail to address major iatrogenic controversies such as the undertreatment of people with chronic pain and the repetitive misclassification of physical illnesses as psychiatric disorders. (Diseases as wide-ranging as peptic ulcer, epilepsy, asthma, and migraine have been so classified, leading to ineffective treatments, suffering, and death.) However, another important source of iatrogenic illness, the increase of drug-resistant infections due to overuse of antibiotics, is otherwise being acknowledged and addressed.

The Centers for Disease Control and Prevention (CDC) estimate that each year nearly 2 million

people acquire infections while hospitalized and about 90,000 die from those infections. More than 70 percent of hospital-acquired bacterial infections have become resistant to at least one of the drugs commonly used to treat them. *Staphylococcus aureus* (staph), the leading cause of hospital-acquired infections, is resistant to 95 percent of first-choice antibiotics, and about 30 percent of second-choice antibiotics.

In New York City alone, treatment of people with hospital-acquired staph infections exceeds \$400 million, according to a study published in 1999. Researchers found that staph infections doubled the length of hospitalization, and more than doubled the patient death rate and per patient costs.

The CDC proposes several methods of reducing hospital-acquired infections. The most important include more discriminating antibiotic use and improved hygiene of hospital staff, the main source of infections.

The modern state is, as Thomas Szasz has described it in *Pharmacracy: Medicine and Politics in America* (2001), a “therapeutic state” in which medical providers have far more power than consumers. Such an imbalance of power may make consumers increasingly vulnerable to the factors that cause iatrogenic illness to be an important cause of illness and death.

See also: CAUSES OF DEATH; TECHNOLOGY AND DEATH

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NICOLAS S. MARTIN

IMMORTALITY

Western belief systems believe that there is life after death. William James waited until the final pages of his classic *Varieties of Religious Experiences* (1902) before trying to evaluate this belief. In those pages he endeavored to answer the question: Suppose that there is a God; What difference would humans expect God to make within the natural world? Although James believed that God was the producer of immortality, his far-ranging study of religious experience did not provide clear support for personal immortality. He could conclude only:

. . . that we can experience union with *something* larger than ourselves and in that union find our greatest peace. . . . Anything larger will do, if only it be large enough to trust for the next step. It need not be infinite, it need not be solitary. It might conceivably be only a larger and more godlike self, of which the present self would then be but the mutilated expression, and the universe might conceivably be a collection of such selves with no absolute unity at all. (*James 1992, pp. 570–571*)

Types of Afterlife Belief

It is doubtful that many believers have ever traded their faith in personal immortality for the speculations offered by James. A far more heartening prospect is eternal life under the auspices of an all-powerful, all-knowing, all-loving God. Nevertheless, personal immortality is only one of the answers that have been proposed over the centuries. This entry (1) surveys a variety of afterlife beliefs; (2) considers their foundation in faith, reason, and fact; and (3) explores some of the meanings and uses associated with these beliefs. Survival of death is not identical with immortality, and immortality is not identical with a continuation of

personality or individuality. These distinctions become clearer as several types of survival are identified and explored.

Afterflash. An “afterflash” refers to a force field or faded image of the person that occurs immediately after death, but soon vanishes. This afterlife belief holds that the afterflash might come and go so quickly that witnesses are left with the feeling that something happened or somebody was there, yet have no tangible evidence to show for it. The afterflash might also manifest itself briefly on a few occasions before disappearing forever. It is possible that even this minimal phenomenon is not what it seems. Perhaps what is perceived is only a record of what has perished, as the scholar F. W. H. Myers suggests. Myers cites the example of the streaming light from stars that perished before the earth was formed. Even if these phenomena do represent some type of survival it would be in a downgraded and fleeting form that does not express the individual personality of the deceased. Therefore, this philosophy is clearly a long way from personal immortality.

Fade away. One of the most prevalent views of the afterlife in the ancient world was a gradual dimming of the departed spirit, known as a “fade away.” In pre-Christian Mesopotamia, for example, the souls of the dead dwelled in a gloomy underworld. There they became dulled, miserable remnants of their former selves. Early Hebrew belief inherited this tradition. *Yabweh* (the Hebrew word for “God”) kept watch over the living; the shades of the dead were abandoned. Within this belief system, the fade-away type of survival did not preserve individual personality. According to some accounts, the piteous dead continued to become even weaker until the end of creation; others are inclined to believe that the spirits dissolved as their vital essence eventually gave way.

Cosmic melding. According to the philosophy of “cosmic melding,” the spark of life is not destroyed by death. Because it was never really the private property of the individual, it does not remain so after death. Rather, each person is like a drop of water that returns to the ocean of creation to become a continuing but transformed part of the universal flow. The philosophy of cosmic melding, although not termed this way, can be found in Hindu thought. Central to Hindu belief are the writings collectively known as the *Upanishads* (the

“Equivalences”). The individual soul (*atman*) is at one with the universal soul (*brahman*). Life and death are different aspects of the same reality. One hopes ultimately to escape the cycle of death and rebirth and achieve ecstatic union with the universal soul. This is a survival doctrine that seeks an end to personal survival.

The idea of cosmic melding has been expressed outside Hinduism. It has been suggested that the universe itself is alive with pulsations from the unimaginable subatomic to the unimaginable vast. Individuals pulsate as unique units for a brief time and then participate in the music of the spheres in different forms. This ancient idea has been kept alive in modern theoretical physics.

Reincarnation and rebirth. Besides the Hindu cycle of birth and rebirth, other reincarnation beliefs exist in many world cultures. These beliefs differ greatly in their details, but in 1958 a historian of religion, Mircea Eliade, observed that typically it is not just the life and death of the individual that is involved. Human society and the world itself can be regenerated through death. Many communal rituals are devoted to this purpose, including those that initiate novices into adulthood. There are many rites of passage in the course of communal life. One has experienced symbolic but intense death/rebirth experiences before encountering physical death. However, all of this does not guarantee that one will continue to survive death after death. The doctrine of reincarnation includes the belief that souls can perish because of individual misfortune or attack, and all souls can perish when the skies and mountains dissolve.

Conditional survival. The philosophy of continued survival holds that there is more than one possible outcome after death. A person might or might not survive death. This survival might be glorious or horrifying. Furthermore, survival might be everlasting or only temporary. According to this view, it should not be assumed that survival of death is identical with immortality. There is no guarantee that passing through death assures the spirit or soul of continued existence for all time or eternity. The possibility of more than one outcome after death has had numerous distinguished advocates. The philosophers Gustav Theodor Fechner and William Ernest Hocking are among those who believe that individuals develop more or less spiritual sensitivity and depth through their lives. The universe

itself is changing. Within this cosmic framework, the fate of the individual personality perhaps should also be considered as a set of possibilities.

According to this philosophical approach, the nature of the self is a key to what happens after death. In resonance with Eastern thought, these philosophers regard the self as always in process, always in the making. People become more real as they develop their spiritual selves to a higher level. What happens after death depends on how “real” the self has become. People who have gone through life without awakening their spiritual potential will have little or nothing that can survive death, but those who have sought and opened themselves to enlightenment will continue to develop after death.

An elitist view of survival was also known in the ancient world. The possibility of a spiritual survival was the privilege of the royal family, not the commoner. Immortality depended on status, and status either depended on the choice of the gods or political skill and good fortune. Furthermore, Islam as well as Christianity presents two contrasting paths for the soul after death. First there is the waiting for judgment. One is then either awarded salvation or condemned to damnation. Similarly, Muslims either cross the sacred bridge (*sirat*) safely, or are hurled into hell. Some of the impure are in torment forever; others may eventually repent sufficiently and join the blessed.

Data file. The concept of a “data file” has become widely known as the ability to register and store large quantities of information in electronic, computer-accessible form. The idea that survival of death might operate through data files does not appear in the sacred writings of the great religions and the rituals of world societies; however, it is a logical spin-off of the computer sciences. In *The Physics of Immortality* (1994), Frank J. Tipler offers a bold theory derived from concepts and findings in quantum cosmology. Tipler suggests that modern physics is supportive of the Judeo-Christian tradition, although in a nontraditional way. According to Tipler’s philosophy, the dead can exist as information and therefore be reconstituted or resurrected in the future. He does not use the term *data file*, but this perhaps conveys the central idea that one can continue to exist as a potential source of information. When effective retrieval and reconstitution techniques are developed, the souls on file

can be accessed and, in that sense, return to life. (There is a parallel here with developments in cryonic suspension since the mid-twentieth century.) But does this “information” know that it *is* information? Is self-awareness or consciousness part of this process, or is the surviving element more like a book that can be read, rather than a reader?

Symbolic immortality. The idea of something that represents a person can continue to survive in society after death is known as “symbolic immortality.” The person is dead, but his or her name or some important aspect of the personality has become part of ongoing human life. Other people, now deceased, live on in human memory. The living will also survive in this way. With continuing advances in communication technology people can survive as CD-ROMs with digitized audio and video, and perhaps in other forms still to come. This is the essence of the concept of symbolic immortality. Wealthy people can endow university buildings and the illustrious can have their names attached to a variety of programs and events, staying alive, then, in public memory. Louis Armstrong, Elvis Presley, and Frank Sinatra may be considered to have a share of symbolic immortality through their recordings and movies.

Helping others to stay alive has emerged as a relatively new form of symbolic immortality. Organ donation and efforts to rescue endangered species and protect the environment are ways in which people are contributing to the continued survival of others; thereby bringing something of their selves into the future.

Personal immortality. The concept of “personal immortality” is a core belief within the Christian tradition. Something of the individual survives death forever. Many people expect to enjoy a reunion with loved ones. This expectation obviously assumes the continuation of personal identity. Many other belief systems are ambiguous about personal immortality, however, and traces of this vagueness or discord can be found within Christianity as well. A key question here is the relationship between person and soul. Is the soul the essence of the individual? If so, then survival is personal. Or, Is the soul a sort of passenger-spirit that has very little to do with the individual’s unique life? If so, then there might be immortal survival, but not necessarily of the person.

Belief and Disbelief

Are humans immortal in any meaningful sense of the word? The history of religion is closely associated with beliefs in survival of death as James, the French sociologist Emile Durkheim, and other historians and philosophers have noted. Ancient burial pits, mounds, and tombs often included objects designed to be useful to the deceased in their next lives. From prehistory onward the available evidence suggests that survival belief has been widespread and dominant.

Disbelief also has its tradition, however. Early Chinese philosophy mostly saw death as the natural end to life. Because humans are all part of the cosmic process there is no reason to bemoan one's fate: It is best to become a good person and live well with others into old age. Ancestor cults did flourish, but the illustrious thinkers of the time discouraged people from investing too much in the prospect of immortality. Confucius himself replied to a disciple's question by saying, "If we do not yet know about life, how can we learn about death?" Wang Ch'ung, a scholar of the Han dynasty, scoffed at the presumption of immortality and called his followers' attention to other natural processes by saying:

Human death is like the extinction of fire. When a fire is extinguished, its light does not shine any more, and when man dies his intellect does not perceive any more. The nature of both is the same. What is the difference between a sick man about to die and a light about to go out? (*Overmyer 1974, p. 202*)

The world has not been divided neatly between believers and disbelievers. Many people have experienced doubt or uncertainty. It is not unusual for people of strong faith to have wrestled with their doubts from time to time, nor for skeptics to wonder if immortality, improbable as it seemed to them, might not yet be true.

Belief can be grounded on custom, authority, positive personal experience, inner knowledge, external fact, reason, or any combination thereof. By "faith" is usually meant a certainty of belief derived from personal experience and/or inner knowledge. Doubt and disbelief can be occasioned by weakened or conflicted custom, discredited authority, negative personal experience,

discredited or counter facts, and compelling alternative arguments.

Custom and authority, reinforced by impressive rituals, was probably enough for many people who lived in small face-to-face societies and worshiped local gods. Intense ritual experiences might also produce the inner conviction that one had touched the sacred. The truth was therefore felt as inside one's self as well as with the people and nature. Authority became a stronger force in religious belief as people organized themselves into larger organizational structures. Although the Egyptian dynasties with their central authorities took shape about 7,000 years ago, there were still many small societies worshiping local gods throughout the days of the Roman Empire. Politics, social action and control, and religion were tightly entwined in emerging civilizations. Judaism, Christianity, and Islam were all beset with internal dissonance on a variety of concepts and practices. Authorities, bolstered by canons of approved writings, systematically accepted a particular view of survival while rejecting others (e.g., reincarnation died hard and only temporarily in Christianity).

Questions about the existence and nature of God and the survival of death lingered despite the weight of Church authority and tradition. Medieval theologians and scholars debated these related issues with intensity and often ingenuity. Saint Thomas Aquinas, for example, argued that the soul is immortal despite its association with the vulnerable body because it comes from God who is the "necessary being" on whom all other creatures depend. This was an influential view, but there were dissenters who argued that "the immortal form" that survives death seems to have none of the characteristics of the actual person who dies—this kind of immortality was too abstract and distant for the critics of Aquinas. Elite scholars made repeated attempts to prove immortality by rational analysis and were regularly taken to task by other elite scholars.

Immortality became a keen issue for society at large as science emerged, challenging the order of the universe as conceived by theology. Astronomers in the sixteenth and early seventeenth centuries made observations that contradicted the Catholic Church's official beliefs about the nature and motions of earth, sun, and other celestial bodies. In the nineteenth century the English naturalist

Charles Darwin's theory of evolution led to a convulsive response on the part of established institutions. If humans are but another kind of animal, what then of immortality?

Philosophers and scientists lined up on both the side of belief and disbelief. Strenuous arguments pro and con continued well into the twentieth century. Meanwhile, academic philosophy quietly slipped away from what increasingly seemed like an outmoded and unrewarding debate, and only in the late twentieth century took the challenge up again.

Belief in a just God and personal immortality was shaken by calamitous events throughout the twentieth century. Two world wars, genocides, and a host of other disastrous events led many to reject the traditional assurances. Others devoted themselves to assuage their sorrows and affirm their beliefs through spiritualism and communication with the dead. Brought up within conventional churches, some set off on quests to find ways of life that might speak more directly to their needs. These quests sometimes took the form of exploring Eastern religions, sometimes in reshaping Judeo-Christian beliefs and practices (from which the New Age movement emerged).

Reports of near-death experiences were welcomed as another opportunity to affirm personal immortality. At the core of these reports is an absolute conviction: "This is what happened; this is what I saw, what I felt, what I experienced!" Logical arguments for or against survival of death are always vulnerable to powerful rejoinders. Scientific findings are always subject to modification, even rejection, by subsequent studies. What a person feels and experiences, however, can seem sufficient within itself. A sense of direct experience and inner knowledge is more convincing to many people than a survey of external facts or convoluted argumentation.

Thomas A. Kselman's 1993 analysis *Death and the Afterlife in Modern France* offers insights applicable to other contemporary societies as well. He notes that beliefs about death were of prime importance in establishing and maintaining social order. How people thought they should live was ruled to an appreciable extent by how they hoped to fare in the next life. In the meantime, public officials and the clergy often played upon this theme to achieve their own ends. By the waning years

of the nineteenth century, however, this long-standing social and moral order was rapidly crumbling. The pace of technology and commerce had picked up dramatically, shifting attention to the opportunities of the present life on the earth. The establishment had a difficult time in trying to keep the lid on simmering developments in all areas of society. Increasingly, death became a concern for individuals and their families and fell less under the control of church and state. The "market culture" had taken over, and ideas about survival of death would have to compete not only with each other but also with other, sometimes more compelling, possibilities.

At the turn of the twenty-first century an enormous range of ideas, attitudes, and practices coexist, including Margaret Wertheim's *The Pearly Gates of Cyberspace* (1999) and N. Catherine Hayles's *How We Became Posthuman: Virtual Bodies in Cybernetics, Literature, and Informatics* (1999). The survival of the survival question appears to be assured for some time to come.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; BUDDHISM; CHINESE BELIEFS; COMMUNICATION WITH THE DEAD; GHOSTS; IMMORTALITY, SYMBOLIC; NEAR-DEATH EXPERIENCES; REINCARNATION

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ROBERT KASTENBAUM

IMMORTALITY, SYMBOLIC

Among the numerous cultural mechanisms for allaying death's sting are envisionments for personal transcendence, such as resurrection, reincarnation, metempsychoses, or some disembodied spiritual existence. In addition to these relatively direct means for personal survival, there are more symbolic forms of immortality that exist. Collectively, there is the immortality obtained through assisting in the transmission of knowledge and precedent to succeeding generations; personally, the preservation of one's memory through eponym, legacy, photograph, or artistic creation. The holocaust survivor and Nobel Peace Prize recipient Elie Wiesel asked,

What does it mean to remember? It is to live in more than one world, to prevent the past from fading and to call upon the future to illuminate it. It is to revive fragments of existence, to rescue lost beings, to cast harsh light on faces and events, to

drive back the sands that cover the surface of things, to combat oblivion and to reject death. (*Wiesel 1995, p 150*)

Human beings live in two worlds: the natural and the symbolic. Ultimately governing human existence within both, according to thanatological determinists, are drives to transcend death. From the perspective of sociobiology, the central drive of the biological self is to pass on one's genetic code. Similarly, to counter death fears and the challenges death poses to the meaningfulness of existence, the symbolic self has a psychobiological drive to leave its mark and a psychological need to continuously feel there's something indestructible within itself.

Given that selfhood is a social phenomenon, negotiated through symbolic exchanges with others, this sense of personal immortality entails, according to psychiatrist Robert Lifton, the ability to symbolize one's own death and continuity thereafter. Death can, for instance, be perceived as but a transition, and one can "survive" through others' memories. And with this outlook, instead of expending life energies in death denials, like the art of karate where one uses the energy of one's adversary, the power of death is diverted to personal growth and social development as the living work on their post selves.

Just as the psychoanalyst Sigmund Freud's late-nineteenth-century model of the human psyche, based on the development of sexuality, arose during an era when sex was the great taboo, so Lifton's late-twentieth-century death-based psychological paradigm emerged from a culture of death denials and a world threatened by nuclear extinction. "While the denial of death is universal, the inner life-experience of a sense of immortality, rather than reflecting such denial, may well be the most authentic psychological alternative to that denial" (Lifton 1979, p. 13). Humans are the only creatures to be aware of their vulnerabilities and mortality, whose deadening imageries feature separation, disintegration, and stasis. To buffer themselves from the anxieties of such insights, these meaning-seeking primates employ the vitalizing imageries of connection, integrity, and movement through five distinct modes of experiencing that, according to Lifton, comprise the essence of symbolic immortality. These include the biological,

spiritual, creative, natural, and mystic modes, whose traditional and contemporary forms are detailed in this entry.

Modes of Symbolic Immortality and Their Contemporary Variations

Genetic, or biological, immortality was undoubtedly the first mode grasped by the human primate. It involves the sense of connection with one's parents and familial generations past as well as the sense of personal continuity through one's progeny. Further, given the nature of one's bonds with nonfamilial groups, these feelings of connection with something greater than one's self can extend outward to include one's tribe, culture, and nation.

Modern science has added new ways to biologically transcend death, such as through organ transplants (where at least a portion of one's self remains alive), sperm banks (allowing for the genetic immortality of anonymous and deceased donors), and cloning. In April 1999 a California woman gave birth to a child sired by her deceased husband. What made this news (after all, women have been impregnated with frozen sperm of the dead since the early 1990s) was that her husband's sperm was extracted from his epididymis, upon her request, thirty hours after he had suddenly died from an allergic reaction.

Religious/spiritual conceptions of immortality range from the resurrection-based beliefs of Christianity to the cycles of rebirths in such Eastern faiths as Buddhism and Hinduism. Members of the Islamic Jihad martyr themselves in performing terrorist acts, assured by leaders that their sacrifice will earn them a place in heaven. Practitioners of Santeria sacrifice animals to protect themselves against death. This mode is experienced as being released from one's biological finiteness, of living at a higher level of existence.

Americans are, it seems, more prone to experience this mode than those from most other developed nations. For instance, according to the National Opinion Research Center's General Social Surveys, four out of ten American adults believe that they have at least once been in touch with one who has died and more than seven in ten believe in an afterlife. Two-thirds claim to have had at least one *déjà vu* experience, and nearly three in ten

have seen future events occur as if they were happening at that moment in the present.

The creative mode entails the belief that one's endeavors are worthwhile because they can withstand the tests of time. Being symbolic creatures, human essence resides not in the physical body but rather in the minds of others. Thus one can "live on" in others through one's works, through memories of one's deeds, and in one's enduring influence on generations yet born. Sociobiologists refer to this as mimetic immortality, which may be more potent than genetic. As the scholar Richard Dawkins observed,

When we die we can leave behind genes and/or memes. The difference between them being that our genes will be forgotten in just a few generations. As each generation passes, the contribution of one's unique genes is halved. . . . But if you contribute to the world's culture, if you have a good idea, compose a tune, invent a spark plug, write a poem, it may live on, intact, long after your genes have dissolved in the common pool. (*Dawkins 1990, p. 214*)

The natural mode of symbolic immortality involves the continuance of the natural world beyond the individual's lifetime, as well with the feeling of being part of the eternal universe beyond oneself.

In a sense, the ecology movement can be seen as an immortality attempt of many individuals whose efforts lead to the preservation of some natural habitat or species of life. As the natural order disappears as human population burgeon, "nature" is increasingly preserved in parks and zoos. Technological innovation has contributed to this sense as well. The collectively produced spacecraft that has left the solar system and will continue to "fly on" even after the sun goes supernova.

The mystical or experiential transcendence mode features an altered state of consciousness so intense that one "looses oneself" in a timeless, deathless realm currently referred to as being "in the zone." As the scholar Jean-Louis Drolet noted, this differs from the other modes as it depends on a psychic state, one characterized by extraordinary psychic unity and perceptual intensity. It can occur with a number of activities, such as during orgasm, birth, athletic effort, ingestion of psychotropic substances, or contemplation. And having had such an

experience, according to Robert Lifton, “One never ‘returns’ to exactly the same inner structure of the self. Having once broken old forms, one senses that they can be broken again, or at least extended beyond earlier limitations” (Lifton 1979, p. 26).

Immortality Ideologies across History

Following the tradition of Franz Borkeu, Jean-Paul Sartre, and Otto Rank, Lifton cast history to ultimately be changes in immortality symbolizations (or ideologies). For instance, the rise of Darwinian thought not only weakened the theological mode but led to “man’s sense of biological continuity was extended back into the infinite past . . . [and] into the infinite future” (p. 286). Man’s imagery of his own history now came to include, in some important degree, the history of all his fellow species, not only animal but even plants—in other words, it produced a reactivation of the natural mode of immortality.

Modern medical technologies have enhanced the mystical mode by its ability to resurrect those “clinically dead.” By the late 1960s, stories of what it is like to die began to circulate widely in professional quarters, and in 1975 they were shared with the general public in the best-selling book *Life after Life*, by Raymond Moody, a physician and philosopher. Here, Moody reported tantalizing similarities among the reports of those having had “near-death experiences,” or NDEs, including out-of-body experiences, interactions with deceased others, and born-again outlooks. The results of an early 1980s national survey indicated that as many as 8 million Americans have had such experiences.

But modern times have also thwarted the perceived potency of these modes to overcome death. A central theme of Lifton’s work is how, for much of the latter half of the twentieth century, the possibility of nuclear war threatened cultural symbols of immortality while propagating deadening imageries of extinction. The suspected consequences of fearing that all transcendence modes will be vaporized range from the growth of religious fundamentalism and cults to the contemporary drug “epidemics.”

With the end of the cold war, one would expect a resurgence of transcendence interest. Indeed, since the 1980s the popular culture has witnessed a proliferation of halls of fame (ranging

from international, national, state, city, and occupational) and “Who’s Who” compilations, a significant increase in the percent of Americans believing in reincarnation and life after death, opportunities for being remembered through charitable donations, and even an affirmative action campaign for U.S. postage stamp immortalizations of such notables as rock-and-roll legend Elvis Presley.

In general, however, modernity’s effects on the traditional modes of symbolic immortality have been double-edged. When change has become life’s only certainty there’s been a severing of sensed connections between living generations and those of the future and past, hence the observed historic ignorance of American students. Changes in family structure and relationships, such as those wrought by the divorce revolution, have dampened members’ knowledge of (and interest in) familial generations past, possibly weakening the significance attached to the biological mode. Thus even though new recording technologies may be able to virtually preserve one’s image or voice, what difference does it make if no one knows or cares who you were? And with increasing secularization and the loss of religious monopoly over transcendence symbolizations, connections between desirous immortality and the moral worthiness of lives lived evaporated, as have images of hell from the Christian imagination.

Symbolic Immortality As Source of Evil

Symbolic immortality has its dark side; attempts to transcend oneself through heroism may also lie at the root of human evil. Being a “loser” in life, John Hinkley sought immortality through infamy by trying to kill the president of the United States. Nearly two decades later, Eric Harris and Dylan Klebold were to receive in death more attention than they did in life because of their murderous frenzy at Columbine High School. The Columbine gunmen sought immortality through a well-planned suicidal massacre, coming not only through the notoriety of their deed but also through their electronic legacies—from their web site and from a series of videos taped over the weeks before the massacre, wherein the nihilistic rationalizations for their revenge were developed. Their immortality would be further enhanced as their death day would occur on the birthday of Adolf Hitler, the twentieth century’s embodiment of evil. “Directors will be

fighting over this story,” Klebold said in one video. In another, made on the morning of the massacre, he said, “It’s a half hour before Judgment Day. I didn’t like life very much. Just know I’m going to a better place than here” (Associated Press, 1999).

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE;
IMMORTALITY; MEMORIAL, VIRTUAL

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MICHAEL C. KEARL

INCAN RELIGION

Like many ancient Andean people before them, the Incas viewed death in two ways. One was biological death, when the body ceased functionally and was cremated, buried, or mummified. The other was social death, when certain privileged individuals remained active in the minds, souls,

and daily lives of the living until they were forgotten or replaced by other prominent figures. Some ancestors were never forgotten, however. They were considered heroic figures who gave the Inca their identity. Their corpses were mummified, revered, and saved as sacred objects. Ancestor veneration frightened the Spanish crown and clergy, who destroyed the burial chambers, or *huacas*, of these corpses in an attempt to undermine the ancestral foundation of the Incan empire.

The ancient Inca Empire developed in the fourteenth and fifteenth centuries C.E. and spanned more than 2,000 miles from Ecuador to Chile at the time of the Spanish arrival in 1515. Hereditary lords ruled the empire. The basic social unit of the Inca was the *ayllu*, a collective of kinsmen who cooperated in the management of land and camelid herds. Common ancestors gave ayllus their ethnic identity. Ruling over the local ayllus were *karacas*. Lords and karacas claimed close kinship ties with important deities and ancestors and acted as intermediaries between heaven and the earth, interceding with the supernatural forces on behalf of their subjects’ well being. The countryside was viewed as being alive with supernatural forces, solar deities, and ancestral figures. Even today the indigenous Quechua and Aymara people of the Andes see the land animated with these figures.

The Incas believed they were the children of the sun, *Inti*. The exaltation of Inti was basic to the creation of an imperial cult. Inti became the deified royal progenitor, and his role as dynastic ancestor is described by early Spanish scholars. In each imperial city a temple to Inti was built and served by special priests.

Both in Cuzco, the capital of the empire, and the surrounding countryside, numerous sanctuaries and huacas were situated on *ceques*, or imaginary lines. Ceques were divided into four sections, or quarters, as defined by the principal roads radiating from the Temple of the Sun in Cuzco in the direction of the four quarters of the Inca Empire. The ceques played an important part in the calendrical system and in Inca religion in general, including child sacrifice.

In the mid-1500s, the Spanish scholar Bernardo Cobo reported that after the Incas conquered a town or province they would divide the cultivated land into three parts: the first for the state religion and temples, the second for the Inca ruler himself,

and the remaining third for the community itself. Temple lands were often used to cultivate corn, whose religious significance was important, and possibly other products required for ceremonial purposes, as well as provide food for the priests of powerful deities.

Inca rulers were extremely powerful and revered by most followers. Veneration of the rulers did not end with their death; they were mummified and displayed during special public rituals so their legends would be retained as a living presence. Their mummies were served by *panacas*, royal descendants of the dead lord endowed with great wealth. The panacas' role was to conserve the dead ruler's mummy and to immortalize his life and achievements with the help of chants and rituals performed on ceremonial occasions in the presence of the succeeding lord and the mummies of other dead Inca lords. These rites were passed on from generation to generation. Placed in the temporary tombs of the lord's were llama and women sculpted in gold, as well as different kinds of golden vessels, exquisite textiles, and other fine objects. Royal members of the lord's court and local karacas were not mummified but placed in elaborate tombs with lavish offerings. Most commoners were buried in simple surroundings.

See also: AZTEC RELIGION; MAYA RELIGION;
MUMMIFICATION

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TOM D. DILLEHAY

INFANTICIDE

Most societies agree that the drive to protect and nurture one's infant is a basic human trait. Yet infanticide—the killing of an infant at the hands of

a parent—has been an accepted practice for disposing of unwanted or deformed children since prehistoric times. Despite human repugnance for the act, most societies, both ancient and contemporary, have practiced infanticide. Based upon both historical and contemporary data, as many as 10 to 15 percent of all babies were killed by their parents. The anthropologist Laila Williamson notes that infanticide has been practiced by nearly all civilizations. Williamson concludes that infanticide must represent a common human trait, perhaps genetically encoded to promote self-survival.

Neonaticide is generally defined as “the homicide of an infant aged one week or less.” The psychiatrist Phillip Resnick further limits neonaticide to the killing of an infant on the day of its birth. *Infanticide* in general usage is defined as “the homicide of a person older than one week but less than one year of age.” *Filicide* is defined as “the homicide of a child (less than eighteen years of age) by his or her parent or stepparent.” For the purposes of this entry, the term *infanticide* will be used to describe the act of child murder by the child's parent(s) regardless of the age of the victim.

Changing Views of the Nature of the Child

The helpless newborn has not always evoked a protective and loving response, in part because the newborn was not always believed to be human. This belief legitimized an action that under other circumstances would be referred to as murder. For example, the ancient Romans believed that the child was more like a plant than an animal until the seventh day after birth. During the Middle Ages, children born with physical defects or behavioral abnormalities were often viewed as evil or the product of supernatural forces. Changelings were infants believed to be exchanged in the still of the night by devils or goblins who removed the real child and left the changeling in its place. To view the child as potentially evil, dangerous, or worthless, rationalizes the desire to eliminate the burden or threat without guilt or remorse.

Historically, birth was not necessarily viewed as a transition to life. Common law in England presumed that a child was born dead. According to early Jewish law, an infant was not deemed viable until it was thirty days old. During the 1950s the chief rabbi of Israel, Ben Zion Uziel, said that if an infant who was not yet thirty days old was killed,

the killer could not be executed because the infant's life was still in doubt. In Japan, a child was not considered to be a human being until it released its first cry, a sign that the spirit entered its body. Scientists and ethicists continue to disagree about when life begins, fueling the moral debate surrounding abortion and infanticide. The twenty-first-century moral philosopher Michael Tooley contends that neonates are not persons and as such neonaticide should not be classified as murder. Tooley has suggested that infanticide should be allowed during a brief (e.g., thirty-day) period after birth.

Several symbolic acts were indicative that the infant was indeed human and worthy of life. In many cultures, it was illegal to kill the child once the child was named, baptized, received its first taste of food, or swallowed water. Symbolic acts such as these afforded the child protection in the event that the child became an economic or emotional burden.

Legal Perspectives on Infanticide

Until the fourth century, infanticide was neither illegal nor immoral. Complete parental control of the father over the life of his child was dictated by both early Greek and Roman laws. *Patria potestas* refers to the power of the Roman father to decide the fate of his child, even before birth. However, if a mother killed her child she would be punished by death.

Legal sanctions against infanticide were introduced in the fourth century as Christianity infused secular laws. The Roman emperor Constantine, a Christian convert, proclaimed the slaying of a child by the child's father to be a crime. Infanticide was punishable by the death penalty by the end of the fourth century. Around the same time, the Christian emperor Valentinian declared that it was illegal for parents to fail to provide for their offspring. Thus, by the Middle Ages, infanticide was no longer condoned by either church or state in Europe. However, as a result of hard times and a high illegitimacy rate, infanticide was the most common crime in Western Europe from the Middle Ages to the end of the eighteenth century.

During the Renaissance period, the criminal justice system took a strong position against infanticide. Widespread poverty and political unrest throughout Europe resulted in high infant mortality

rates. Legislation in France demanded the death penalty for mothers convicted of this crime. In 1720 Prussia's King Friedrich Wilhelm I decreed that women who killed their children should be sewn into sacks and drowned. Infanticide has existed as a separate statutory crime in England since 1922. Under English legislation (the Infanticide Act of 1938), a mother who kills her child within the first year of the child's life is assumed to be mentally ill. The highest crime she can be charged with is manslaughter. English juries are reluctant to sentence women to prison for this crime, while fathers can be charged with homicide.

Early American parents found to be child killers were punished by death. In 1642 Massachusetts enacted a law making the concealment of a murdered illegitimate child a capital offense. Records indicate that executions for infanticide occurred as early as 1648.

Twenty-first-century America classifies infanticide as a homicide. Depending on state laws, those who commit infanticide may be eligible for the death penalty. Most of the mothers convicted are granted suspended sentences or probation. Fathers are generally not afforded the same leniency. Despite these laws, shame, illegitimacy, poverty, and the lack of effective birth control result in uncountable hidden infanticides.

Factors Leading to Infanticide through the Ages

In examining the numerous causes for infanticide, the physician and researcher Larry Milner contends that "infanticide arises from hardness of life rather than hardness of heart" (1998, p. 10). Perhaps the mother with the hardest of hearts was Medea who, according to Greek legend, killed her children as revenge against her unfaithful husband. The term *Medea syndrome* derives from this legend. The following factors represent examples of both hardness of life and hardness of heart.

Human sacrifice. Human sacrifice is one of the earliest recorded forms of infanticide. Archaeological evidence indicates that prehistoric children were sacrificed to the gods. In Germany, a mass burial grave dating back to 20000 B.C.E. was discovered, containing thirty-three skulls of children who appeared to be victims of sacrifice. Aztec children were sacrificed to the rain god Tlaloc. The Senjero tribe of eastern Africa sacrificed firstborn

sons to assure a bountiful harvest. As late as 1843, children were sealed in walls, foundations of buildings, and bridges to strengthen the structure. Evidence of this practice dates back to the walls of Jericho. Lloyd deMause states, "To this day, when children play 'London Bridge is falling down' they are acting out a sacrifice to a river goddess when they catch the child at the end of the game" (1974, p. 27). By offering a valued possession to the gods, humans have long attempted to appease a deity.

Population control. One of the most common factors leading to infanticide is population control. Poverty, famine, and population control are inter-related factors. Where safe and effective birth control was unavailable, infanticide was used to selectively limit the growth of a community. Infanticide allowed for selection of the fittest or most desirable offspring, with sick, deformed, female, or multiple births targeted for disposal. Greek philosophers accepted the use of infanticide to control the size of the state. With regard to practicality, infanticide was not a crime. In a 1976 review of 393 populations, the anthropologists William Divale and Marvin Harris reported that 208 tribes routinely practiced infanticide, particularly female infanticide, to control population. Females were targeted because this practice reduced the number of sexually active, fertile females.

Poverty. Even when population growth was not a factor, poverty was the most common reason why parents killed their offspring. In ancient Greece and Rome, parents who could not afford to raise their children disposed of them, particularly during times of war, famine, and drought. At times children were killed and even consumed by the starving parents. Eskimo children were eaten by the parents and older siblings during times of famine. Cannibalism was common during times of drought among the Australian aboriginals, a people normally fond of their children. During extreme droughts, every second child was killed and fed to a preceding child to ensure its survival.

Devaluation of females. Female infanticide is a problem rooted in a culture of sexism throughout antiquity. In many cultures girls have little value. Even when female children were not killed at birth, their needs were neglected, particularly if limited resources were needed to ensure the survival of male offspring. In tribal societies, male babies were preferred because males grew up to

be hunters and warriors. Young females were seen as a threat because they might attract males from neighboring tribes.

Data indicating high male-to-female population ratios indicate selective female infanticide. Sex-ratio evidence suggests that female infanticide dates back to Greco-Roman times. Men were more valuable as laborers and warriors. Females required a costly marriage dowry. A common Roman expression was, "Everyone raises a son, including a poor man, but even a rich man will abandon a daughter" (Milner 1998, p. 160). Unequal sex ratios have been reported throughout the Middle Ages and the Renaissance worldwide. Evidence from tribal societies also suggests that tribal peoples used female infanticide as the primary method to control population.

In China, a poor and overcrowded country, females are expendable. Evidence of female infanticide in China dates back to 800 B.C.E. Females are viewed as less desirable in Chinese culture due to the expense involved in the dowry system and the fact that only a son can perpetuate the family line. Additionally, when a girl marries she leaves her family and is unavailable to care for her aging parents. With the implementation of the "one child per couple" policy in 1978, Chinese parents are unwilling to invest their one opportunity for parenthood on a daughter. The policy provided for enforced abortions, sterilizations, and legal/economic sanctions against families who choose not to comply. Although illegal, sex-selective abortion is a common practice. Estimates based upon unequal sex ratios suggest that over 30 million females are missing in China.

In India, the practice of female infanticide is even more pervasive. As in China, the birth of a daughter is seen as a liability. Only sons are allowed to perform the funeral rites at the pyre of his father. The murder of female newborns is so common that it has a special name, *kuzhippa*, or "baby intended for the burial pit" (Milner 1998, p. 176). Selective abortion is also a common practice. In 1998 Milner reported that in one Bombay clinic, of 8,000 abortions, 7,999 were performed on female fetuses. In 1991 Nicholas Kristof estimated that nearly 30 million females were missing in India.

Birth defects. Deformed or defective newborns have been disposed of by most cultures across the ages. From an evolutionary standpoint, parents

decide whether to invest their energy in raising a deformed or sick child that may not survive to perpetuate the family lines. Aristotle declared that there should be a law that no deformed child should live. In the twenty-first century, medical advances present new challenges to parents who are forced to decide whether to use heroic measures to save the life of severely impaired newborns or to let them die.

Illegitimacy. Illegitimacy is another factor leading to infanticide through the ages. To avoid shame and censure, women have secretively disposed of illegitimate babies since early Roman times. Illegitimacy and poverty are the most common reasons for infanticide in the twenty-first century.

Superstition. Finally, superstitious beliefs regarding children and childbirth contributed to the practice of infanticide. In many cultures, twins were believed to be evil and were promptly killed. In some tribal societies, twins of the opposite gender were believed to have committed incest in the womb and were condemned. In some cases only one twin was killed. Other superstitions involve unlucky days of the week, breech presentations, the presence of baby teeth at birth, or atmospheric conditions during birth. Ignorance, fear, and legend have contributed to the deaths of infants throughout the ages.

Methods of Infanticide throughout the Ages

As the factors leading to the practice of infanticide vary from culture to culture and age to age, so do the methods of disposal. Clearly some methods reflect cultural beliefs regarding the value of children. Other methods reflect ignorance about the proper care of infants.

Abandonment and exposure. Abandonment or exposure represents one of the oldest methods of infanticide. History is replete with stories of babies abandoned and left to die as a result of starvation, dehydration, or animal attack. Despite the parent's naive belief that the child would be rescued, most abandoned children perished. Ancient Greeks and Romans readily accepted the practice of exposure to eliminate unwanted, deformed, or illegitimate children. Historians estimate that 20 to 40 percent of all babies were abandoned during the later Roman Empire. Abandoned babies were generally brought to a conspicuous place where they were left on display. Most of these babies were taken

and raised, while some were sold into slavery or prostitution.

During the Middle Ages, exposure was a prevalent practice due to overpopulation and the large numbers of illegitimate births. During the Renaissance in Italy, the abandonment rate was in excess of 50 percent of all babies. In seventeenth-century China, Jesuit missionaries reported that thousands of infants, mostly female, were deposited in the streets. In 1741 Thomas Coram, a retired sea captain, was so disturbed by the sight of infant corpses lying in the gutters and rotting on dung heaps that he opened Foundling Hospital in England to "suppress the inhuman custom of exposing new-born infants to perish in the streets" (Langer 1974, p. 358).

Suffocation. Suffocation has been one of the most common methods of infanticide throughout the ages. "Overlaying," the practice of suffocating or smothering an infant in bed, occurred in medieval England. Overlaying remained a problem in England into the twentieth century. In 1894 a London coroner reported that over 1,000 infants died as a result of overlaying. Subsequently, in 1909, overlaying was made a criminal offense. Differentiating accidental death from intentional suffocation continues to present a legal challenge. For example, distinguishing between Sudden Infant Death Syndrome (SIDS) and suffocation is a difficult yet critical diagnostic decision.

Drowning. The practice of drowning unwanted infants at birth is a long held practice in China. The anthropologist Steven Mosher describes how a bucket of water is readied at the bedside to drown female newborns. This practice was so prevalent in 1943 that an official government publication prohibited the drowning of infant girls. Unfortunately, the decree had little effect. Similarly, infant girls born in India were often drowned in a pit filled with milk, referred to as "making them drink milk" (Milner 1998, p. 175).

Ignorance, neglect, and abuse. Historically, children were subjected to mistreatment and death as a result of simple ignorance about proper care. For example, opium and liquor were commonly given to infants to calm and induce sleep. Godfrey's cordial, a mixture of opium, treacle, and sassafras available in the nineteenth century, proved as fatal as arsenic.

Infants also died of starvation, as a result of neglect, poverty, and punishment. Wet nurses were commonly hired throughout history. Maliciously, many of the wet nurses took on more infants than they could feed. It was a well-known fact to parents that infants died at a far higher rate in the care of wet nurses than with their parents.

Swaddling or restraining infants to calm or contain their movements has been a near universal practice, although it was almost entirely discontinued in the United States and England by the end of the eighteenth century. If performed improperly, swaddling can result in suffocation and permanent injury. Swaddled infants could be “laid for hours behind the hot oven, hung on pegs on the wall, placed in tubs and in general left like a parcel in every convenient corner” (deMause 1974, p. 37). DeMause describes how fatal accidents frequently befell children because little children were left alone for extended periods. Dating back to Roman times, infants were exposed to hypothermia through the therapeutic practice of dipping children in icy-cold waters to harden or toughen the character. DeMause reports that the eighteenth-century pediatrician William Buchanan stated that nearly half of the human species died in infancy as a result of ignorance and improper care.

In the twenty-first century the most prevalent methods of infanticide are head trauma, drowning, suffocation, and strangulation. Shaken-baby syndrome, brain injury as a result of violent shaking, is a common phenomenon.

Religious Beliefs

The newborn has been afforded some protection through the beliefs of God-fearing people. Judeo-Christian morals prohibited infanticide as the will of God. According to Jewish beliefs, one can never know whether the child conceived may be the long-awaited Savior. As a result, the Torah demanded that married couples procreate and Jewish law prohibited the killing of children. Abortion and neonaticide, however, were allowed.

The prevalence of infanticide in ancient Rome began to diminish around the time of Jesus Christ. The Christian Church condemned the practice of exposure, particularly if the exposed infant was unbaptized. It was believed that upon his or her death an unbaptized child would be prevented from entering the gates of heaven. As a result,

stricter penalties were given to mothers who killed unbaptized infants. Similarly, in Islam, Muhammad admonished parents for preferring male offspring and warned against the evils of infanticide. With the rise of Christianity and the fall of the Roman Empire, Judeo-Christian ethics were infused with secular law.

Infanticide in Modern America

Do murderous parents still act more out of hardness of life than hardness of heart? In a 2001 news report, a Texas woman confessed to drowning her five children in the bathtub. Her family stated that she had been suffering from postpartum depression. An Illinois woman who drugged and suffocated her three young children claimed insanity at the time of the murders. Both women were found guilty of murder and faced life in prison. The 1990s and early 2000s witnessed a rash of so-called trashcan moms who gave birth in seclusion, killed the newborns, and deposited their bodies in the trash. A teenage girl delivered a six-pound boy during her prom, disposed of the infant, and returned to the dance floor. In 2001 a Tennessee woman reportedly gave birth secretly, slashed her infant's throat, wrapped her in garbage bags, and left her in the car trunk to die.

In 1995 the U.S. Advisory Board on Child Abuse and Neglect estimated that nearly 2,000 infants and young children die each year from abuse or neglect. Fatal abuse may result from one incident (e.g., shaking the baby) or repeated abuse and neglect over a period of time. According to the FBI's Uniform Crime Reports, approximately 700 homicide victims under the age of six were reported in 1997; the majority (71%) of these children were murdered by a parent. Ten percent of these children were murdered during the first six days of their life.

Many researchers believe that child fatalities are underreported because some deaths labeled as accidents or SIDS are, in fact, homicides. Waneta Hoyt claimed to have lost all five of her children to SIDS, leading researchers to suspect SIDS ran in families and was caused by sleep apnea. In 1995 Hoyt confessed to suffocating all five of her children. As a result, researchers were forced to reexamine the causes of SIDS.

The risk of child homicide declines with child age. Children under the age of five are the most

frequent victims of fatalities. Children under the age of three account for 77 percent of all child fatalities. Male children are slightly more at risk than female. Five percent of these deaths occurred on the infant's first day of life. Nearly all of these infants were not born in a hospital. In fact, most neonaticides probably go undetected. Infants under one week of age are most likely to be killed by their mothers, whereas after the first week of life the perpetrator is more likely to be the father or stepfather. Researchers disagree as to whether mothers or fathers are more likely, in general, to kill their offspring.

Parents who kill are most often poor, single, and under the age of nineteen. They most likely live in rural areas and do not have a high school diploma. If female, they are likely to have an older child and have not received prenatal care. Female perpetrators show a variety of other risk factors including regular drug and alcohol usage, history of depression, childhood history of inadequate parenting and abuse, current involvement with an abusive partner, history of self-abuse, and lack of social support. Approximately 15 to 30 percent of all mothers who kill their children commit suicide. Of the fathers who murder their children, 40 to 60 percent commit suicide. Infanticide continues to be associated with difficult life circumstances.

Phillip Resnick argues that mothers who kill actually fall into two distinct groups. Mothers who kill their infant on the day of its birth (neonaticide) do not generally show signs of psychopathology. Mothers who commit neonaticide tend to be young, single, and immature, and kill to eliminate an unwanted child. Mothers who kill their older children (filicide) are frequently older, married, psychotic, depressed, or suicidal. Filicides tend to kill as a result of their psychosis, for altruistic reasons (to relieve child of suffering), accidentally (as in battered child syndrome), or to seek revenge on a spouse. Resnick notes that mothers who commit neonaticide are more likely to be incarcerated, whereas mothers who commit filicide are more likely to be hospitalized.

Legal debate centers on the use of postpartum depression as a legal defense in infanticide (homicide) cases. The American Psychiatric Association first recognized postpartum depression (PPD) in 1994. Since then, American courts have begun to recognize PPD as a legitimate defense, although it

has rarely been used successfully. Approximately 20 percent of all new mothers experience PPD, a serious and lasting depression. One out of every thousand new mothers will experience psychotic symptoms including delusions, hallucinations, and incoherent thinking. Because British law has long assumed that mothers who kill suffer from mental illness, British doctors treat PPD aggressively and British courts rule with more leniency than American courts. Many researchers suggest that the United States should follow the British approach.

Alternatives and Prevention

One of the earliest methods of saving illegitimate and abandoned babies was the formation of foundling homes (orphanages). The first foundling home was opened in 787 C.E. in Italy. Foundling homes were opened across Europe, quickly filling to capacity. Placing a child in a foundling home was little more than infanticide in a hidden form. In Dublin, the foundling hospital had a revolving basket placed at the front gate to provide parents anonymity as they deposited their unwanted children. Roughly 85 percent of infants placed in these homes died as a result of inadequate care. The orphanages in twenty-first-century China bear striking similarity to these early foundling homes. During a period of economic hardship in Hungary in 1996, a hospital placed an incubator by the hospital entrance to provide poor parents an alternative to killing their infants.

Several authors contend that the legalization of abortion has resulted in decreased rates of infanticide. Pro-life supporters counter that abortion represents nothing more than preterm infanticide. However, the so-called trashcan moms have access to both legalized abortion and birth control, yet fail to utilize either option. Resnick contends that the passive nature of these women contributes to denial of their pregnancy, preventing them from seeking an abortion. Perhaps the best form of prevention for young women most at risk for neonaticide comes from abstinence or effective contraceptive use.

The research by Mary D. Overpeck and her colleagues suggests early intervention strategies to prevent infanticide in high-risk individuals. For example, identification of women who are hiding their pregnancies can improve access to prenatal care. Screening parents for emotional problems

(including family history of postpartum depression) may increase access to mental health services. According to Overpeck, interventions targeting social support, completion of education, parenting training, contraceptive education, and substance abuse are critically needed. Finally, diagnosis and aggressive treatment for postpartum depression for all mothers constitutes an essential health care need.

With increasing reports of abandoned babies, legislators are searching for alternative methods to protect newborns. The U.S. Congress and over half of the states are considering legislation to decriminalize the abandonment of newborns in designated safe locations. Immunity from prosecution is afforded to those parents who leave the infant in designated locations. Critics contend that such legislation will result in encouraging parents to abandon their infants. However, baby abandonment legislation is a growing trend across the United States.

The reasons why parents choose to destroy their offspring are complicated and defy simple explanation. In the past, harsh conditions and lack of information contributed to the problem. In modern times harsh conditions continue to drive infanticide rates. Are these parents unfortunate, evil, selfish, or mentally ill? Perhaps the answer lies in a combination of these explanations. Understanding the causes of infanticide can only lead to better means of prevention.

See also: CHILDREN, MURDER OF; CHRISTIAN DEATH RITES, HISTORY OF; HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; HOMICIDE, EPIDEMIOLOGY OF; ISLAM; MORTALITY, INFANT

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INFLUENZA

Influenza is a respiratory infection caused by a family of flu viruses. Often confused with either the common cold or stomach and intestinal infections, most forms of influenza are characterized by a sore throat, headache, chills, body aches, exhaustion, fever, and coughing. Droplets carried from one person to another by sneezing and coughing spread the disease, and touching can also contract it. According to the National Institutes of Health, the disease runs its course in about a week, and can be especially dangerous to infants and toddlers, the elderly, and those with compromised immune systems. Children acquire influenza easily, and can spread it to others rapidly. Normally, peaks of high wintertime reporting and low numbers of cases in the summer characterize influenza trends. Chances of acquiring an influenza infection during the flu season, usually November through March, increase with age, and pneumonia-influenza rates for those over seventy-five years old are much higher than for the middle-aged.

Influenza has annually ranked as one of the ten leading causes of death in the United States. During a typical flu season, anywhere from 35 to 50 million Americans could show symptoms of influenza. About 100,000 of those cases might be hospitalized, and as many as 20,000 could die from influenza and its complications. Influenza is also a substantial threat to human lives in many parts of the third world due to both a lack of effective vaccine distribution programs and a wide range of factors lowering resistance to many viruses.

Because a virus causes influenza, only specific symptoms and some ensuing infections can be treated with antibiotics. Primary prevention in the form of inoculation is the best method of combating influenza. Immunity to particular strains is acquired either naturally by previous exposure or induced with a vaccine, and the variants of influenza change over time. While there are broad

categories of influenza A, B, and C that cause illness in humans, the A strains are by far the most lethal and hence the objective for focused vaccine development.

Some vaccines previously used are no longer effective because as the level of immunity in a population increases strains of influenza change genetically and propagate in those susceptible to the altered viral variants. The scholar W. I. B. Beveridge offers the explanation of how an influenza virus capsule has eight separate strands of ribonucleic acid (RNA) for its hereditary material. When a cell of a higher organism is infected by two different varieties of the virus, their sixteen RNA segments can combine to produce progeny with traits from both of the parent strains. New strains capable of evading the host's immunological defenses can thus emerge. Two of the eight viral genes code for protein-sugar complexes on the outer coat of the virus. These surface molecules, hemagglutinin (H) and neuraminidase (N), are antigens that can stimulate the host's immune system to make antibodies against the infecting virus. Subtypes H1, H2, H3, N1, and N2 are known to have caused human influenza epidemics and pandemics (worldwide epidemics) because of major shifts in the order of H and N antigens.

People have suffered from influenza for thousands of years. Written accounts date to the twelfth century, and the development of the printing press combined with changing worldwide travel patterns since the Age of Discovery created more knowledge about the disease. In his *Diffusion of Influenza* (1986), the influenza researcher Gerald Pyle documents pandemics that took place in 1580, 1732–1733, 1800–1803, 1847–1848, and 1889–1892. These and similar events that transpired during the twentieth century are greatly overshadowed by the catastrophic pandemic of 1918–1919. It was so lethal that historians estimate that 40 million people were killed worldwide; a half million of them had been clearly documented in the United States. While the origins of this pandemic are unclear, it emerged from the trenches of World War I in an apocalyptic fashion, leaving a wake of deaths in diffusion pathways extending into most inhabited continents in the world.

Subsequent pandemics have been measured against this event, and although hundreds of thousands in the United States died during pandemics

in 1957 and 1968, death tolls were far less than during the 1918–1919 episode. Since the 1950s, vaccine developments have kept pace with genetic shifts of influenza viruses. “Close calls” include a swine flu scare that was averted in 1976 and a contained outbreak of chicken flu in Hong Kong in 1997. According to Gina Kolata, researchers in the late 1990s uncovered the genetic makeup of the 1918–1919 virus from tissue samples stored in paraffin, but that mystery has intensified because the strain identified is unlike any other known influenza viruses. While the biological and geographic origins of the 1918–1919 pandemic remain unclear, it continues to serve as a landmark event in the annals of influenza.

See also: CAUSES OF DEATH

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Internet Resources

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GERALD F. PYLE

INFORMED CONSENT

Twenty-five hundred years of Western medicine, starting with Hippocrates, have been built on the preferred conception that physicians should protect their patients from information about their diseases or treatment options. The oath that has been repeated by physicians for thousands of years articulates clearly that the physician knows what is

best for his or her patients. For over two millennia, the culture has put the physician in an almost God-like position in terms of his or her wisdom to practice in the patient’s best interest. However, since the mid-twentieth century there has been a trend toward patients rights, that has included the right to know what the physician intends to do and why. This is the essence of informed consent.

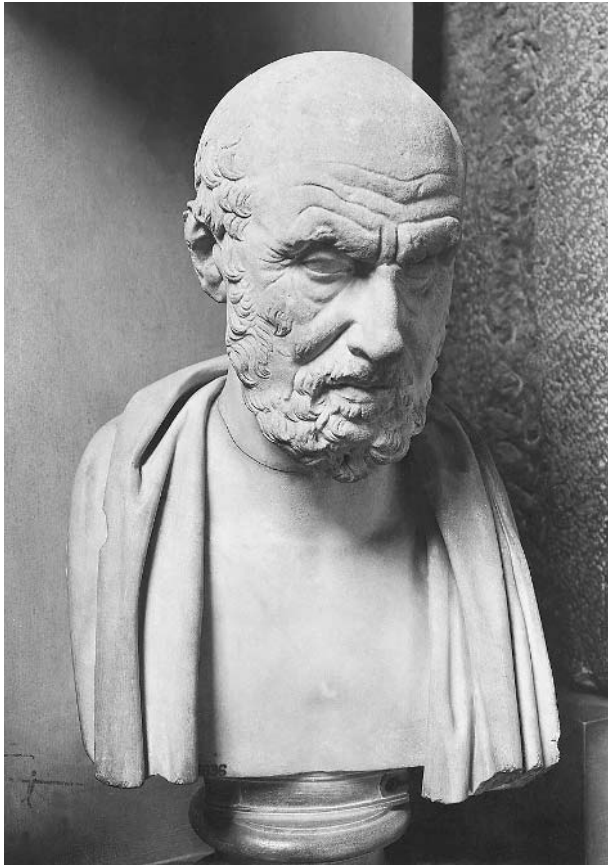
The Emergence of Informed Consent

In one form or another, the question of who gets to decide beats at the heart of the most difficult medical situations. Will it be the physician, the patient, or the family members? Whose values will ultimately be respected? What should a patient be told regarding the range of complicated life and death decisions commonplace in today’s medical arena?

The definition of informed consent is equally complicated. An informed consent is an autonomous authorization by an individual regarding a medical intervention or involvement in biomedical research. An individual must do more than express agreement or comply with a proposal for this to be considered informed consent. Informed consent is a process between physician and patient that must contain an information component and a consent component. The information component refers to the disclosure of information and comprehension of what is disclosed. The consent component refers to a voluntary decision and agreement to undergo a recommended procedure. Legal, regulatory, philosophical, medical, and psychological literature tend to favor the following elements as the necessary components of informed consent: (1) competence; (2) disclosure; (3) understanding; (4) voluntariness; and (5) consent.

If one is competent to act, receives thorough disclosure, has an understanding, and is voluntary in his or her consent, then informed consent is viable. For informed consent to be legally recognized in medical practice, the following steps need to be clearly articulated:

1. Preconditions: Includes competence (to understand and decide) and voluntariness (in deciding).
2. Information elements: Includes disclosure (of risks/benefits); recommendation (plan); and understanding (of information and plan).
3. Consent elements: Includes authorization (based on patient autonomy).



Hippocrates' oath, which granted physicians the right to practice in the patient's best interest, has conflicted with the twentieth-century trend toward patient rights. BRITISH MUSEUM

Physicians are obligated to disclose a core set of information including: (1) those facts or descriptions that patients usually consider material in deciding whether to refuse or consent to the proposed intervention; (2) information that the physician thinks is critical; (3) the professionals' recommendation; (4) the purpose of seeking consent; and (5) the nature and limits of consent as an act of authorization.

History of Informed Consent within Medical Practice

Civil litigation emerged over informed consent to include injury to one's person or property that is intentionally or negligently inflicted by a physician's failure to disclose the injury, measured in terms of monetary damages. With the medical advances that emerged in the beginning of the twentieth century, such as improved anesthesia

and surgical interventions, physicians began to disclose basic information without necessarily outlining all potential risks.

The first important introduction of the notion of informed consent is in the classic case of *Mohr v. Williams* (1905). In this case, a physician obtained Anna Mohr's consent to an operation on her right ear. While operating, the surgeon determined that the left ear needed surgery instead, and proceeded to operate on it. A court found that the physician should have obtained the patient's consent to the surgery on the left ear. The judge decided that a physician needs to advise a patient of all the information related to a particular procedure and must review all the risks and benefits. Only after this exchange does the patient enter into a contract, a contract that authorizes the physician to operate *only* to the extent of the consent given.

In the late 1950s a series of legal cases in California and the District of Columbia forever changed society's vision of the doctor-patient relationship. In California, radiation therapy went awry for a young woman, leaving her in much worse condition than prior to the treatment. After the therapy she was acutely fatigued and suffering from radiation burns. These side effects far exceeded the side effects described by the physician. She sued the physician, saying he never adequately explained the risks of her radiation procedure. The court found that unless such consent was based on full information, and that the patient fully understood all of the risks of the procedure, the doctor was not protected for liability. In several jurisdictions, beginning in 1972 in the District of Columbia, *Canterbury v. Spence*, informed consent emerged as a legal right with full legal redress equivalent to battery if informed consent was not provided.

With the mid-1970s came the introduction and growing utilization of extraordinary life-sustaining treatments such as dialysis, respirators, cardiac resuscitation, and a wide array of organ transplantation. To protect oneself from the automatic use of such heroic measures, patients and their family members experienced an urgent need to be fully informed of risks and benefits and to have the authority to protect their wishes. Legal methods, including advance directives, living wills, and health care proxies, came to the fore of patient's rights as mechanisms to articulate and protect the

patient's wishes over the imperative central tenet to medicine: If it can be done, it should be done.

Advance directives. The Patient Self-Determination Act (PSDA) was passed in 1990 and went into effect in December 1991. The essence of this legislation is to empower the public with the right to be fully informed and fully self-determining regarding end-of-life decisions. However, since its implementation there is little evidence of national acceptance by the health care industry. The law applies to all health care facilities that receive any federal reimbursement for services, and includes hospitals, nursing homes, home health agencies, and clinics. The PSDA requires a health care mechanism for disseminating information about advance directives with patients.

Advance directives have been available in parts of the United States since the late 1980s, but research shows that only a small percentage (5% to 25%) have some form of written advance directive. Advance directives allow a competent person to express who should be a decision maker and what preferences the patient may have.

Psychiatric advance directives are a legal means by which a person with mental illness, while competent to make health care decisions, may specify his or her preferences for treatment and may designate a surrogate decision maker to act on his or her behalf in the event of an incapacitating mental health crisis.

When informed consent is not viable for the patient, and he or she does not have advance directives, the process of surrogate decision making is initiated. Surrogate decision making refers to the process in which a loved one has to make a medical decision because the patient's judgment is incapacitated. Surrogate decision makers reach decisions for those with fluctuating decision-making capacity that is doubtful and thus need to be aware of all the side effects in order to make decisions on behalf of someone else.

Courts and legislatures have been actively involved in the right of surrogate decision makers and the various related ethical dilemmas. Within the context of advanced life-sustaining treatments, patients and their family members have been confronted with life and death choices. The questions regarding who is competent to make which decisions is still a much-litigated scenario. Many judgments about terminating or continuing treatment

are made daily for patients who are no longer able to choose for themselves—patients with HIV (human immunodeficiency virus), Alzheimer's disease, and Parkinson's disease, and those suffering from stroke effects, heart and kidney failure, dementia, and psychosis.

History of Informed Consent within Biomedical Research

A comprehensive movement toward informed consent began after World War II with the 1947 Nuremberg trials. In these war trials, it was revealed that physicians conducted abhorrent medical research experiments on concentration camp prisoners. The research included human experimentation with germ warfare, freezing individuals to learn what temperature kills individuals most effectively, and many more horrifying research trials. Between 1930 and 1945 Japan conducted human experimentation in biological warfare, including physical responses to infection and trauma, and thousands were killed. The Nuremberg Code, which emerged from the trials, abandons the earlier paternalistic perspective of medicine and research and replaces it with the centrality of patient self-determination by asserting that the voluntary consent of the human subject is necessary under all circumstances of medical research. With this, the modern era of ethics within biomedical research emerged with a particular emphasis on the patient's rights expressed by the practice of informed consent.

The term *informed consent* first received wide awareness and prominence in public health research, as well as in the practice of medicine, in 1972, in response to the public outcry regarding unethical practices in the Tuskegee research. In 1932 the U.S. Public Health Service initiated a study that examined the effects of untreated syphilis among rural black men in Tuskegee, Alabama. Thousands of men were kept in total ignorance of the experiment, their infection, and the seriousness of syphilis. They were consistently steered away from receiving effective treatment so the United States government could monitor how the disease progressed, its many serious side effects, and its rate of fatality.

Immediately following this disclosure, the first national government commission, the National Commission for the Protection of Human Subjects

of Biomedical Research and Behavioral Research was established. One of its primary goals was to initiate a variety of legislation to further ensure a patient's right to be fully informed regarding any medical research. A decade later, the President's Commission on the Study of Ethical Problems in Medicine and Biomedical Research and Behavioral Research was formed in 1983 to replace the first commission. Its mandate was to deal with the full range of medical and ethical issues, including the care of the dying, genetics, and issues of health care decisions such as informed consent and allocation of resources.

Informed Consent in the Managed Care Climate

With the era of cost-containment in the 1980s and managed care in the 1990s, informed consent became even more critical. Informed decision counseling (IDC) has been used to promote cost-effective care and provide over-the-phone medical information from twenty-four-hour-a-day clinicians. Designed to promote appropriate utilization and effective patient-provider communication, IDC is based on the premise that health care consumers make appropriate utilization decisions if adequately informed.

Informed consent will continue to evolve in response to continued advances in medical treatment, the shift toward partnership in patient-physician relationships, and new avenues of biomedical research. At the center of informed consent remains the critical primacy of the right for a patient to understand any medical treatment, medical procedure, or participation in medical research.

See also: ADVANCE DIRECTIVES; CRUZAN, NANCY; HIPPOCRATIC OATH; NATURAL DEATH ACTS; QUINLAN, KAREN ANN; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE

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INJURY MORTALITY

Around the world, about 16,000 people die every day as a result of injuries. For every death, many more people survive but suffer lifelong impairment. An injury is "a bodily lesion at the organic level resulting from acute exposure to energy (which can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some cases (e.g., drowning, strangulation, or freezing), the injury results from an insufficiency of a vital element. The time between exposure and the appearance of injury needs to be short" (Krug 1999, p.2). It is the acuteness of exposure that distinguishes injury from disease. Long-term exposure to relatively low levels of a harmful agent may cause disease, but acute exposure to the higher levels of the same agent (e.g., lead) may cause injury.

Injuries can be unintentional or intentional. Most traffic injuries, fire-related injuries, falls, and drownings are classified as unintentional. On the other hand, homicides, suicides, war, and most poisonings are classified as intentional. Aside from the degree of intentionality, there are classifications

of the purpose of the activity being undertaken (i.e., work-related, recreational), the nature of the injurious event (i.e., vehicle crash, fall, poisoning, drowning, fire), or the setting (i.e., home, workplace, road).

Basic Data on Injury Mortality

Accurate counts of the number of people who die as a result of injury are usually not available. Official mortality reports are often based on incomplete counts, biased sources, cursory or no investigation, or erroneous coding. This situation is common in developing countries and in remote areas of developed countries. Even in developed countries, many health information systems do not allow for easy identification of injury deaths. Among these poorly identified types of injury deaths are occupational fatalities, deaths resulting from the use or misuse of particular products, and falls where the cause of death may be coded as pneumonia occurring as a consequence of an earlier fall. Some types of injuries—child abuse, violence against women, and suicide—are likely to be underreported.

The World Health Organization has estimated that 5.8 million people worldwide died as a result of injuries in 1998, which corresponds to an injury mortality rate of 97.9 per 100,000 population. More than 90 percent of injury-related deaths occurred in low- and middle-income countries. The injury-related mortality rate in these countries was double the rate found in high-income countries.

Road-traffic injuries are the leading cause of injury mortality, resulting in over 1.1 million deaths per year worldwide and ranking tenth in the leading causes of death for both sexes in 1998 (see Table 1). Self-inflicted injuries result in about 950,000 deaths per year and were ranked as the eleventh-leading cause of death for both sexes in 1998. Other major causes of injury death in 1998 were interpersonal violence (more than 650,000 deaths), war injuries (more than 530,000 deaths), drowning (more than 400,000 deaths) and fires (more than 160,000 deaths).

The pattern of injury mortality differs between high-, medium-, and low-income countries. Road-traffic injuries rank tenth as the leading causes of death in each group of countries. However, self-inflicted injuries rank eleventh in the leading

TABLE 1

Estimated number of deaths worldwide resulting from fifteen leading causes in 1998

| Rank | Males | Females | Both sexes |
|------|--|--|--|
| 1 | Ischaemic heart disease 3,658,699 | Ischaemic heart disease 3,716,709 | Ischaemic heart disease 7,375,408 |
| 2 | Cerebrovascular disease 2,340,299 | Cerebrovascular disease 2,765,827 | Cerebrovascular disease 5,106,125 |
| 3 | Acute lower respiratory infections 1,753,220 | Acute lower respiratory infections 1,698,957 | Acute lower respiratory infections 3,452,178 |
| 4 | Chronic obstructive pulmonary disease 1,239,658 | HIV/AIDS 1,121,421 | HIV/AIDS 2,285,229 |
| 5 | HIV/AIDS 1,163,808 | Diarrhoeal disease 1,069,757 | Chronic obstructive pulmonary disease 2,249,252 |
| 6 | Diarrhoeal disease 1,149,275 | Perinatal conditions 1,034,002 | Diarrhoeal disease 2,219,032 |
| 7 | Perinatal conditions 1,120,998 | Chronic obstructive pulmonary disease 1,009,594 | Perinatal conditions 2,155,000 |
| 8 | Trachea/bronchus/lung cancers 910,471 | Tuberculosis 604,674 | Tuberculosis 1,498,061 |
| 9 | Tuberculosis 893,387 | Malaria 537,882 | Trachea/bronchus/lung cancers 1,244,407 |
| 10 | Road-traffic injuries 854,939 | Measles 431,630 | Road traffic injuries 1,170,694 |
| 11 | Interpersonal violence 582,486 | Breast cancers 411,668 | Malaria 1,110,293 |
| 12 | Malaria 572,411 | Self-inflicted injuries 382,541 | Self-inflicted injuries 947,697 |
| 13 | Self-inflicted injuries 565,156 | Diabetes mellitus 343,021 | Measles 887,671 |
| 14 | Cirrhosis of the liver 533,724 | Trachea/bronchus/lung cancers 333,436 | Stomach cancers 822,069 |
| 15 | Stomach cancers 517,821 | Road traffic injuries 315,755 | Cirrhosis of the liver 774,563 |

SOURCE: Violence and Injury Prevention, World Health Organization. *Injury: A Leading Cause of the Global Burden of Disease*, edited by E. Krug. Geneva: World Health Organization, 1999.

causes of death in high-income countries but thirteenth in low- and middle-income countries. Interpersonal violence is not one of the fifteen leading causes of death in high-income countries, but it ranks fourteenth in the leading causes of death in low- and middle-income countries. Intentional injuries are generally more prevalent in areas (or among groups) where there is political or social instability.

Around 70 percent of deaths from road-traffic crashes occur in developing countries. Developed countries report an annual road-crash mortality rate of about 2 deaths per 10,000 motor vehicles, compared to 20 to 70 deaths per 10,000 motor vehicles in developing countries. Some of the disparity in death rates is attributable to the differences in the traffic composition between developed and developing countries. Developing countries have high proportions of vulnerable road users such as pedestrians, bicyclists, and motorcyclists in the traffic stream. Trucks and buses also exist in greater proportions than in developed countries.

Transportation fatality rates differ substantially within and between modes. Overall, travel by air and rail results in fewer fatalities per billion passenger kilometers than travel by road. Within air travel, fatality rates are higher for general aviation than for scheduled passenger air services. About 90 percent of rail fatalities are occupants of road vehicles at railway crossings or railway employees involved in shunting and track maintenance. Within road transport, fatality rates are highest among motorcycle riders, pedestrians, and cyclists.

The number of deaths related to occupational injury is not well documented. It has been estimated that each year about 50,000 people die of occupational injuries in the Americas (North, Central, and South), and that about 100,000 people die of occupational injuries in India. In the developed world, many of the deaths from occupational injuries result from on- or off-road vehicles. In developing countries, most deaths occur in the workplace, resulting from factors such as old or poorly shielded machinery, toxic exposures, and minimal or nonexistent safety standards.

Trends in Injury Mortality

The trends in the numbers and rates of injury deaths differ among transport, occupational, and domestic injuries and between the developed and the developing countries. In developed countries, both the total number of fatalities and the fatality rates (as a function of distance traveled) have decreased for road traffic generally and for particular types of vehicles (e.g., passenger cars, large trucks, and so on) from the 1970s to the 1990s. The rate of railway-related fatalities has remained relatively stable. In the developing world, however,

the number of vehicles is growing faster than the physical, legal, and institutional infrastructure needed to safely contain them, with the result that the number of fatalities is increasing.

The number of deaths due to falls is likely to increase in the Western world as the population ages. In developed countries at least, occupational deaths have been decreasing with increasing sophistication of equipment.

Factors Affecting the Risk of Injury Death

The risk of injury death is affected by individual factors such as alcohol consumption, propensity to take risks, and socioeconomic differences. Alcohol consumption increases the risk of involvement in motor vehicle crashes, whether as a driver or as a pedestrian. Alcohol consumption is also implicated in substantial numbers of railroad and aviation crashes, falls, drownings, fires, homicides and suicides. Prior psychological and social characteristics have been found to predict young drivers' crash involvement. Sensation seeking, impulsiveness, and risky lifestyles are associated with risk-taking and crash involvement.

Deaths from traffic injuries are often higher among children and adults from lower social positions and in more deprived socioeconomic areas. The mechanism underlying these findings may be increased exposure to risk (high traffic volumes, lack of safe areas for walking or recreation) or less education about risk avoidance. Injury mortality from other causes, such as occupational injury, also appears to be greater among persons of lower socioeconomic status.

Age and Gender Factors

Deaths related to injury commonly involve people under forty-five years of age, whereas noninjury deaths commonly involve people forty-five or older. Thus injury mortality leads to a greater number of years of potential life lost than many other causes of death (e.g., ischaemic heart disease). European data show that road traffic crashes lead to an average loss of 40 years of life expectancy, compared to 10.5 years for cancer and 9.7 years for cardiovascular illnesses.

The most common causes of injury mortality differ across age groups. For example, drowning is the leading cause of injury deaths among children under five years of age, ahead of war injuries and

road traffic injuries. Road-traffic injuries are the leading cause of injury death for youths between the ages of five and fourteen, ahead of drowning, war injuries, fires, and interpersonal violence. Road-traffic injuries are the leading cause of injury death for individuals between fifteen and forty-four, ahead of interpersonal violence, self-inflicted injuries, war injuries, drowning, and fires.

About twice as many males as females die as a result of injury. This statistic may reflect both greater exposure (greater involvement in potentially injurious activities) and greater risk-taking by males. Road-traffic injury is the leading injury cause of death in males, but self-inflicted injury is the leading injury cause of death in females.

Intentional and Unintentional Injuries

Injuries are commonly categorized as intentional or unintentional. This categorization is satisfactory most of the time, but some injury events may be difficult to place into one category or the other. For example, some single-vehicle road crashes can be identified as suicides (e.g., if a note is left), but others may be unidentified suicides. Some poisonings may be clearly intentional or unintentional, but others may be difficult to classify.

How to Decrease the Risk of Injury Deaths

In the first half of the twentieth century, the main approach to decreasing injury and injury deaths addressed the shortcomings of the victims: bad drivers, lazy workers, and unaware children or parents. The emphasis was on educational measures such as posters and pamphlets and on training courses and materials.

It is now recognized that injuries, including fatal injuries, usually involve a complex series of events that include environmental factors and the interaction of human performance and the task to be performed. Intervention at any point in the causal chain can prevent the injury or reduce its severity. Prevention of injury is relatively more important than treatment because many deaths from injury occur so quickly or because the damage is so severe that death is unlikely to be prevented by treatment.

Injury prevention has become a sophisticated science with clearly defined steps of problem identification, countermeasure development, implementation, and evaluation. Evaluation is needed to

assess whether interventions have worked or not and to provide support for further implementation. The physician William Haddon Jr., who became the first director of the U.S. National Highway Safety Administration, developed a list of ten general strategies designed to prevent injury:

1. Prevent the creation of the hazard (e.g., stop producing particularly hazardous substances).
2. Reduce the amount of the hazard (e.g., package toxic drugs in smaller, safer amounts).
3. Prevent the release of a hazard that already exists (e.g., make bathtubs less slippery).
4. Modify the rate or spatial distribution of the hazard (e.g., require automobile air bags).
5. Separate, in time or space, the hazard from that which is to be protected (e.g., use sidewalks to separate pedestrians from automobiles).
6. Separate the hazard from that which is to be protected by a material barrier (e.g., insulate electrical cords).
7. Modify relevant basic qualities of the hazard (e.g., require a maximum distance between cot-slats to prevent children from being strangled).
8. Make what is to be protected more resistant to damage from the hazard (e.g., improve the person's physical condition by appropriate nutrition and exercise programs).
9. Begin to counter the damage already done by the hazard (e.g., provide emergency medical care).
10. Stabilize, repair, and rehabilitate the object of the damage (e.g., provide acute care and rehabilitation facilities).

Most of these general strategies apply to the prevention of both unintentional and intentional injury.

The specific interventions that have been identified as most effective in reducing deaths resulting from road crashes, include improvements in the ability of vehicles to protect occupants in a crash (both vehicle structure and safety devices such as seat belts and air bags), improvements to roads and roadsides to prevent crashes or reduce their severity, laws and enforcement to reduce drunk driving, and graduated licensing laws to allow

young drivers to gain experience under less risky conditions. The specific interventions to reduce deaths relating to other injury causes have been less well documented. The interventions that have proved effective include child-resistant closures for toxic materials, lifeguards, isolation fencing for swimming pools, fire-resistant nightwear for children, smoke detectors, bars on high residential windows, firearm restrictions, and technological improvements in workplace equipment (including farm machinery).

One of the most important issues in the prevention of injury deaths (and injury in general) has been the need to ensure implementation of effective interventions. There are many interventions that have not been adopted or have been adopted only partially and whose potential has therefore not been realized. Some examples from road safety include seat belts, bicycle helmets, and measures to prevent drunk driving.

The transfer of particular interventions across cultures has been uneven. Many engineering measures to improve road safety were developed decades ago in advanced industrial countries. The social, political, economic, and cultural contexts in which they were developed differ significantly from those of motorizing countries. The different contexts are likely to be reflected in different patterns and motivations of road-user behavior. Therefore the engineering measures may not be as effective or may even be counterproductive when applied in motorizing countries.

Conclusion

Injury is a leading cause of death to people under the age of forty-five. Road-traffic injuries are the most common type of injury death. Self-inflicted injury is a more common type of injury death among females than road-traffic injuries. While there is a downward trend in road traffic deaths in the developed world, these deaths are likely to continue to increase in the developing world. Some effective measures to prevent injury deaths have been developed but have not always been fully implemented. Measures that have proved effective in one culture are not always easily transferable to another culture. Evaluation of the effectiveness of measures to reduce injury mortality is crucial.

See also: CAUSES OF DEATH; DISASTERS; SAFETY REGULATIONS; SUICIDE TYPES: INDIRECT SUICIDE

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INTERNET

Traditionally, death has been a great taboo in Western culture, a topic delicately sidestepped in polite public company and private reflection alike. But since 1995, the taboo has been at least partially dispelled in the informational glut of the Internet, which has brought the subject of death within easy arm's reach of millions of the previously averse or oblivious—merely typing in the letters "d-e-a-t-h" in the window of a search engine (i.e., www.google.com) yields no fewer than 23,600,000 items, enough to daunt even the most avid scholar or morbid connoisseur of mortality.

However, these web sites provide far more than mere information: There is practical help in the form of bereavement support and information on organ donation and living wills, death in cultures around the world, hospice care, and numerous other areas.

General Sites

Some of the most useful sites guide the web surfer toward services as well as information. One such site is www.excite.com/family/family_in_crisis, which lists numerous links to social and medical services and information for those burdened with

grief or terminal illness. The site lists links to other sites regarding euthanasia, suicide, estate planning, and many other related topics. Those with more theoretical concerns might profitably consult www.tripod.lycos.com. There, the student, teacher, or researcher can find additional links to a wealth of other informational sites.

Because search engines often yield a dizzying plethora of responses, it is useful to narrow the range of responses by making the topic as specific as possible. For example, instead of merely typing in "grief," one might add "AND" plus another word to limit the search—say, "children's." Then only topics pertaining to children's grief will appear on the list of responses, saving the searcher a good deal of time and effort by reducing the number of items to several dozen rather than several thousand.

Another important watchword for web surfing on this or any other topic is "vigilance," a critical tool in distinguishing between the trustworthiness of a site produced by a distinguished scholar, such as Michael Kearl, and a personal site titled "Buffy's Death Page." "Caveat emptor" should be the watchword for every Internet surfer, where triviality and fraud are as common as the authentic and rewarding.

Demographics of Death on the Web

A number of web sites specialize in a statistical approach to death—its causes and demographics, life expectancies, social factors, and so on. The data on these sites are updated frequently and are usually culled from reliable government and scholarly sources. Some such sites are devoted to particular segments of society. For example, www.runet.edu provides information on life expectancy for African Americans compared to whites, along with other health-related data. Government sites, such as www.cdc.gov/nchs, give a broader range of data for many different segments of American society, including major causes of death in various age groups.

In other sites the accent is on the individual—for example, by entering a name, place of death, or Social Security Number at www.vitalrec.com, one can locate the death record of anyone in the United States. This site also provides links to sites that yield overseas records as well.

Cross-Cultural and Religious Information

For those interested in the religious dimension of death and dying, there is a wealth of sites that provide access to information on the death rituals, funeral customs, and mourning practices of nearly every known religion or cult, major or minor. Other sites dwell on a more broadly cultural approach to the meaning of death and attitudes toward the dying—a site might be devoted to a single culture such as that of the Cree Indians (www.sicc.sk.ca), while others might explore a broad range of cultures. One of the best is found at www.encarta.msn.com. Sites such as these also provide links to related web sites, as well as to printed material and reading lists.

Grief and Bereavement

The most numerous death-related web sites are those that deal with grief, both as a subject of analysis and as a topic for practical guidance to coping. The Griefnet web site (www.griefnet.org) provides one of the most extensive support systems online. It includes several web pages and over thirty small e-mail support groups. Griefnet posts a companion site for children and parents.

Some sites are designed to deal with specific categories of grievers. The Australian Widownet site (www.grief.org.au) provides information and self-help resources for widows and widowers of all ages, religious backgrounds, and sexual orientations. Suicide often evokes special issues of grief. One particular site that includes personal testimony by those who have experienced the death of a loved one by suicide is www.1000deaths.com. Tragedy Assistance Program for Survivors, Inc., a nonprofit group that provides support to those who have lost a loved one who met his or her end while serving in the armed forces, can be found at www.taps.org. The site provides peer support, crisis information, a variety of resources, and the opportunity to establish a virtual memorial.

Other bereavement web sites provide information not only for the bereaved but also for the professionals who are a part of the death system. Genesis Bereavement Resources (www.genesis-resources.com) provides a list of music, videos, and other material that may be helpful to grievers, health care professionals, funeral directors, and pastors.

No detail is too slight or awkward to escape the attention of web entrepreneurs. Bereavement

Travel at www.bereavementtravel.com allows one to make travel arrangements at the time of death at the special bereavement rates offered by many airlines and hotels. This service is primarily a convenience for the bereaved.

There are also special sites dedicated to unique bereavement responses, including www.aidsquilt.org/Newsite, which provides information on the AIDS quilt that has been shown all over the United States as a memorial to victims of the illness. In addition to bereavement support, some sites offer guidance on life-threatening illnesses, such as www.cancer.org for the American Cancer Society and www.alz.org for the Alzheimer's Disease and Related Disorders Association.

Compassionate Friends, the best known of the national bereavement support groups for parents who have experienced the death of a child, has a web site at www.compassionatefriends.org. Here, one can locate local chapters, obtain brochures, form a local chapter, and catch up with the latest related news. There are also organizations that help visitors locate or start a grief support group.

Finally, there are sites for many well-known organizations that are part of the thanatology field. The Make-A-Wish Foundation (www.wish.org) fulfills special wishes for terminally ill children. They send children to theme parks, arrange meetings or phone calls with celebrities, and perform other special services for ill children.

Pet Loss

Bereavement guidance on the web is not limited to those who have suffered the loss of human companions. Those dealing with the loss of a pet may go to the web site for the Association for Pet Loss and Bereavement at www.aplb.org. One of the most unique sites in this area is www.petloss.com, which provides online grief support and describes a special candle ceremony held weekly to commemorate the death of a pet. Also at this site, one can find reference to other related web sites, chat rooms, and telephone support.

End-of-Life Issues

The web offers a range of end-of-life issues, including care of the terminally ill, living wills, and hospice care. Choice in Dying (www.choices.org) is the organization that first devised a living will in

1967, long before states adopted a legal policy on this issue. This nonprofit organization and its web site provide counseling for patients and families, information on advanced directives, outline training resources for professionals, and serve as an advocate for improved laws. The American Institute of Life-Threatening Illnesses, a division of the Foundation for Thanatology, can be found at www.lifethreat.org. This organization, established in 1967, is dedicated to promoting improved medical and psychosocial care for critically ill patients and their families.

Funeral Arrangements

People have long complained about the high cost of funerals and related expenses. There are numerous web sites that offer online casket purchases and other related items. Such sites promise quick service and complete satisfaction, often at steep discounts. In addition to caskets, www.webcaskets.com offers urns, markers, flowers, and other funerary items. At www.eternalight.com one can purchase an “eternal” light, guaranteed to glow for thirty years. The light can be used at home as a permanent memorial to the loved one. The site donates 10 percent of the purchase price to a national support group of the customer’s choice.

It is possible to plan an entire funeral service online at www.funeralplan.com. One can actually watch a funeral service from many funeral homes by going to www.funeral-cast.com. The National Funeral Directors Association maintains a site at www.nfda.org. Here, one can locate funeral homes, obtain consumer information, and learn about careers in this field.

Unusual Sites

Some web sites defy easy classification. One popular site is www.deathclock.com. Here one can plug in one’s date of birth and gender, along with one’s attitudinal and philosophical propensities, and obtain the likely date of one’s demise. Visitors can watch the clock count down their time on Earth. Many college students find this to be a fascinating site and download a screen-saver version—every time they turn on their computers they watch their lives “tick away.” Other interesting sites include www.1800autopsy.com, where one can contact a mobile company to perform such an examination, and www.autopsyvideo.com, which

allows visitors to view autopsies online. These web sites are used by professionals and educators, as well as the curious.

The web is aswarm with jokes on all topics, and death is no exception. Some web pages specialize in bad-taste death jokes, many of which center on celebrities. One site in particular allows the visitor to “bury or cremate” someone. After entering a name and choosing a method of body disposal, one can watch as the casket burns up.

Obituaries and Last Words

Numerous web sites provide visitors with the opportunity to post memorial messages. Most of these sites charge a fee for permanent placement. At www.legacy.com, one can pay a fee of \$195 to place a memorial, including photograph, on the site.

Memorialtrees.com arranges for a memorial tree to be planted in any state in the United States or in the Canadian provinces. The fee is less than thirty dollars and includes a certificate of planting and a card that Memorialtrees.com sends to the survivor.

Near-Death Experiences

Much attention has been paid to the issue of the near-death experience. Two sites that are particularly useful include www.iands.org, the official web site of the International Association for Near-Death Studies, replete with research information, case studies, and resources; and www.near-death.com, which includes near-death experiences of people of various faiths along with the testimony of children and suicides who have had brushes with death.

Legal and Financial Issues

A number of sites offer guidance in the many practical and financial matters that arise after a death. One very comprehensive site is www.moneycentral.msn.com. Here, one can find answers to general questions regarding finances, collecting life insurance, and handling bills of the deceased. One can also obtain information on making a will without consulting an attorney. A site like www3.myprimetime.com includes information on estates as well as the impact of being a griever and executor.

Conclusion

The Internet has dramatically expanded the availability of resources in the field of thanatology, providing both useful and irrelevant sites. Anyone consulting web sites must be careful to sort through them to find those that are helpful and accurate.

See also: DEATH EDUCATION; GRIEF: OVERVIEW; GRIEF COUNSELING AND THERAPY; LAST WORDS; MEMORIAL, VIRTUAL; NEAR-DEATH EXPERIENCES; TECHNOLOGY AND DEATH

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DANA G. CABLE

ISLAM

Islam is an Arabic word meaning “surrender” or “submission.” It is a faith that encompasses approximately one-fifth of humanity. Its adherents reside in almost every country of the world and comprise majorities in large segments of Africa, the Middle East, the Indian subcontinent, and Asia. Approximately 6 million Americans follow Islam.

The Origins of Islam

The historical origins of Islam date back to seventh century Arabia. The Prophet Muhammad, an aristocratic Arabian born and raised an orphan in the sanctuary city of Mecca, experienced a revelation in his fortieth year. He began to preach to his own people, most of whom initially persecuted him. After thirteen years of suffering with patience and endurance, he migrated to the nearby city of Medina. For over twenty-three years, beginning in 610 C.E., the Prophet orally transmitted the Quran (Koran). Muslims believe the Quran was revealed from God through the archangel Gabriel. In it, a cosmology, a theology, and an elaborate eschatology are described. By the end of the Prophet’s life in 632 C.E., almost the entire Arabian Peninsula had

converted from paganism to Islam, and within a hundred years, its followers stretched from France to China.

Although considered the youngest of the three great Abrahamic faiths that include Judaism and Christianity, Islam does not view itself as a new religion but rather as a reformed Abrahamic faith. Muslims believe that the Quran corrects distortions of previous prophetic dispensations while not departing from the aboriginal faith of humanity, which according to the Muslims is Islam, or submission to one God. While Muslims believe all prophets have taught the unity of God and that their beliefs about God were the same, their actual practices have changed to suit various times and places. According to Muslims, this is why religions tend to differ outwardly, while retaining an essential inward truth common to them all. However, the Quran declares its message as uniquely universal applying to all people for all remaining time.

Basic Beliefs of Muslims

Islam is based upon five “pillars” that represent the bedrock upon which all else is based. The first pillar, which makes one a Muslim, is called the *shahadah*, meaning, “testimony” or “witnessing.” It is fulfilled by declaring to two witnesses the foundational creed of Islam: “*Asbhadu an la ilaha illa Allah wa anna Mubhammadan rasulullah.*” This means, “I witness that there is nothing worthy of worship except God and that Muhammad is God’s messenger.” The first part of the testimony is a belief that God is unique with no partners. Thus, nothing in creation can be associated with God, as creation has no real substantiation without the sustaining power of God. Indeed, creation is not God nor does it have any eternal qualities of the divine that are worthy of worship. Rather, creation is a theater of divine manifestations. Creation is seen as a place where analogies of the divine reveal themselves. The intellect of a person is the vehicle given by God to discern this truth about creation as indicated by several verses in the Quran.

The second part of the declaration, Muhammad is the messenger of God, acknowledges the means through which this understanding of God has come. All prophets are special human beings capable of refracting divine light, acting like prisms that allow others to see it. The intensity of direct divine light is something only a prophet can bear.

Muslims believe that the revelation given to Muhammad is like refracted green light, which lies in the middle of the light spectrum. Muslims consider Islam to be the most balanced of the prophetic dispensations, the “middle way.” The Prophet Muhammad’s life is considered to be moderate and exemplary for both men and women. He abhorred extremes saying, “Beware of extremism in your religion.” After the Quran, the Prophet’s practice, or *Sunnah*, is the second most important authority in Islam.

The second pillar of Islam is prayer. While people may supplicate anytime they wish to do so, there is a specific prayer every adult Muslim, female and male, is obliged to perform five times a day. The times are determined by the perceived movement of the sun as a way of reminding people of the temporal nature of the world. Thus, each day is considered to be a microcosm of one’s own life: the dawn prayer as one’s coming into the world, the midday prayer as the end of youth, the afternoon prayer as old age, the sunset prayer as death, and the evening prayer as the beginning of the descent into the darkness of the grave and returning to the dawn prayer as the awakening and resurrection of the dead. After the testimony of faith, prayer is considered the most important pillar.

The third pillar of Islam is paying *zakah*, an obligatory alms given once every lunar year from the standing capital of every responsible adult. It is not an income tax, as income tax is prohibited in Islamic law, but rather a capital tax on wealth that has been stagnate for at least a year. It is one-fortieth of a person’s liquid assets. According to the Quran, *zakah* is distributed among eight categories of people, the two most important recipients being the poor and the needy.

The fourth pillar is fasting the entire lunar month of Ramadan, and it begins with the sighting of the new crescent for that month. Fasting entails abstaining from food, drink, and sexual relations from dawn to sunset and is obligatory on adults healthy enough to do so.

The fifth pillar is the *Hajj*, or pilgrimage to Mecca. Muslims believe Mecca to be the site of the first house of worship built by the Prophet Adam and his wife Eve and then restored millennia later by the Prophet Abraham and his son, the Prophet Ishmael. At the end of his mission, the Prophet Muhammad restored its monotheistic purpose by

destroying the 365 idols in it that the Arabs had been worshipping prior to Islam. The rituals performed in the pilgrimage follow the footsteps of Abraham and his second wife Hagar. The Hajj culminates on a vast desert plain where approximately 3 million pilgrims from almost every country on Earth gather every year and prepare for standing before God on the Day of Judgment.

Customs and Practices of Muslims

Due to the broad cultural diversity in the Muslim world, Islam is a quilt of many colors rather than a monolithic faith etched in stone. The majority of Muslims have never considered Islam to be “straight and narrow” but rather “straight and broad.” The word in Arabic for the sacred law of Islam, *shariah*, literally means “the broad path to water.” The *shariah*, rather than being a rigid and inflexible law, is governed by a fluid and elastic set of principles, and Muslim legal theorists consider it rationally comprehensible and thus capable of being altered when the rationale is absent or the circumstances warrant.

Most Muslim cultures manifest their own characteristics. For instance, the Islam of Indonesia, while essentially the same in its skeletal form, is quite different culturally from the Islam of Senegal. Muslims are required to wear modest clothes, and women are required to cover their hair and entire body except for the hands and face when in the presence of unrelated males. However, the bright colors of the women of Nigeria contrast sharply with the moribund black of the Arabian Peninsula—both are considered acceptable. Food and merrymaking also differ greatly, and Muslims, like other peoples, have diverse ways of enjoying themselves and appreciating the milestones of life such as weddings, births, graduations, and religious holidays. Religious music and chanting are widespread in the Muslim world, and Quran reciters with beautiful voices have statuses in some Muslim countries.

Living and Dying in Islam

The German philosopher Goethe wrote, “If Islam means submission to the will of God, then in Islam we all live and die.” This succinctly summarizes the goal of Muslims: To live and die in accordance with God’s will as revealed in the Quran and practiced by the Prophet. Muslims attempt to adjust

their view of the world with the lens of the Quran. The will of God is expressed in the Quran through both expectations and examples. The expectations are usually descriptions of how a believer should live his or her life, and various stories in the Quran provide positive and negative examples. The epitome of a positive exemplar is Moses, whose story is dealt with in great detail in the Quran. Struggle is at the root of life on earth, a spiritual survival of the fittest. The fittest are those closest to God; they are those who are “steadfast in prayer and spend out of what We have provided for them” (Quran 2:3; Ali 1999, p. 17). The negative prototype is embodied in Pharaoh, who elevates himself above God’s law and makes his own law the only source of guidance. Moses is given the Promised Land for his perseverance and steadfastness, and Pharaoh is destroyed by his own hubris and rebellion against the divine will. The story of Moses is an example of submission (Islam), and Pharaoh’s is of rebellion and infidelity (*kuf̣ṛ*). Between these two lies the struggle of humanity.

Life is meant to be an arena whereby one struggles with good and evil. The Quran teaches that good and evil exist in the heart of every individual as well as in the society. The individual struggle is to act righteously in accordance with the Quran and prophetic example, and to shun one’s own evil and its impulses. The collective struggle is to work with others to make the world a more righteous place. In Arabic, this inward and outward struggle is called *jihad*. While it can mean a militant struggle against those who attack the Muslim lands, it also signifies a person’s struggle with the lower tendencies of the soul, the gravitational pull of self-destructive forces that lead to alienation from God and a state of spiritual disequilibrium. Because humans inevitably fall short morally and succumb to these destructive tendencies from time to time, a means of reestablishing spiritual balance is given, called *tauba* or atonement. This is done by experiencing a genuine sense of remorse for one’s transgressions and a removal of the unhealthy effects of that state by turning to God and seeking divine grace through prayer, charity, and a sincere resolution not to return to the destructive patterns of the past.

While life is seen as a spiritual test and journey, it is also seen as being filled with blessings from God to be enjoyed: “Eat and drink, but waste not by excess, for Allah loveth not the wasters.

Say: ‘Who hath forbidden the beautiful (gifts) of Allah which He hath produced for His servants, and the things, clean and pure, (which He hath provided) for sustenance?’” (Quran, p. 352). Thus, in Islam, marriage is highly recommended and celibacy is frowned upon. The Muslim savants of the past identified sexual relations between a wife and her husband as a foretaste of eternal bliss with God in the afterlife. The Prophet Muhammad encouraged marriage and stated, “There is no monasticism in Islam.” In Islam, children are highly esteemed and seen as one of God’s greatest blessings to humanity. The Prophet stated that humans were born innocent and later corrupted by their societies. Thus, parents are held responsible for maintaining that state of innocence and raising them with a sense of love and awe of the divine. Motherhood is highly regarded in the Quran and the prophetic tradition. The Prophet said, “Paradise lies at the feet of mothers.” In most Muslim societies, adult women are still predominantly mothers and housewives during their productive years.

Death and Its Relevance to Muslims

Death is a question of ultimate concern for every human being, and Islam has a very vivid portrayal of the stages of death and the afterlife. Death is likened to sleep in Islam; interestingly, sleep in Arabic is called “the little brother of death.” The Prophet spoke often of death, and the Quran is filled with warnings of the dangers of ignoring one’s mortality and of not preparing for death before it is too late. In one poignant passage, the Quran reads,

And spend something (in charity) out of the substance which We have bestowed on you before death should come to any of you and he should say, “O my Lord! Why didst Thou not give me respite for a little while? I should then have given (largely) in charity, and I should have been one of the doers of good.” But to no soul will Allah grant respite when the time appointed (for it) has come; and Allah is well-acquainted with (all) that ye do. (*Quran, pp. 1473–1474*)

Hence, the world is seen as an opportunity to cultivate for the hereafter, and time is seen as capital that human beings either invest wisely or squander, only to find themselves bankrupt in the

next life. Muhammad said, “One of you says, ‘My wealth! My wealth!’ Indeed, have any of you anything other than your food that you eat and consume, your clothes that you wear out, and your wealth that you give in charity which thus increases in return in the next world?”

The idea of mentioning death and reflecting on death is very important in a Muslim’s daily life, and attending any Muslim’s funeral, whether known or not, is highly encouraged; for such attendance, one is rewarded greatly by God. Muhammad advised, “Make much mention of the destroyer of delights,” which is death. He also said, “Introduce into your gatherings some mention of death to keep things in perspective.” This is not seen as a morbid exercise, and Muslims surprisingly accept death, resigned to what is called “one’s appointed time” (*ajal*). Like the telomere in biology that dictates how many times a cell may regenerate before dying, an individual’s appointed term, according to Islam, is inescapable and fated. When a Muslim survives a near-death experience, such as a serious car accident, an operation, or an illness, he or she will often remark, “My appointed time did not come yet.”

After Death

Once a Muslim dies, the people left behind must prepare the body by washing, perfuming, and shrouding it. The funeral prayer is then performed, and the deceased is buried in a graveyard without a coffin, simply laid in the earth and covered. A person, usually a relative, informs the deceased of what is happening, as Muslims believe that the deceased can hear and understand what is being said. Muslims believe the dead person is not always aware of the transition, and so the one giving instructions informs the deceased that he or she has died, is being laid in the grave, and that two angels known as Munkar and Nakir will soon come into the grave to ask three questions. To the first question, “Who is your Lord?” the deceased is instructed to reply, “Allah.” In answer to the second question, “Who is your Prophet?” the deceased should say, “Muhammad,” and the correct response to the third question, “What is your religion?” is “Islam.” If the individual passes this first phase of the afterlife, the experience of the grave is pleasant, and he or she is given glimpses of the pleasures of paradise. If however, the

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This sixteenth-century drawing, “Mubammad’s Ascent to Heaven,” illustrates Mubammad, the major prophet of Islam, on horseback escorted by angels. SEATTLE ART MUSEUM

deceased does not pass this phase, then the grave is the first stage of chastisement.

After this, the soul sleeps and does not awake until a blast from an angel at God’s command. According to Islamic tradition, this blast signals the end of the world and kills any remaining souls on the earth. It is followed by a second blast that causes all of the souls to be resurrected. At this point, humanity is raised up and assembled on a plain. The Quran states, “On that day We shall leave them to surge like waves on one another; the trumpet will be blown, and We shall collect them all together” (Quran, p. 735). From there, humanity will beg each of the prophets to intercede for them and hasten the Day of Judgment because the

waiting is so terrible, but the prophets will refuse. Finally, all of humanity goes to the Prophet Muhammad. He will agree to intercede for them and ask that the Judgment commence. This intercession is granted to him alone. Then, each soul is judged based upon its beliefs and actions, which are weighed in the scales of divine justice. At this point, the two guardian angels assigned to all people throughout their adult lives will testify for or against them. According to the Quran, the limbs of each person will testify, and the earth herself is resurrected and bears witness against those who caused her harm. Next, a person will be given a book either in the right or left hand. For those given a book in the right hand, they pass the Judgment and are given the grace of God. For those given a book in their left hand, they fail the Judgment and are condemned to hell. However, at this point, prophets and other righteous people are allowed to intercede for their relatives, followers, or friends among the condemned, and their intercession is accepted.

Once the Day of Judgment is over, humanity proceeds to a bridge known as the *sirat*, which crosses over hell. The saved cross it safely to the other side and are greeted by their respective prophets. The Muslims who make it safely across are greeted by Muhammad, who will take them to a great pool and give them a drink that will quench their thirst forever. The condemned fall into hell. The Quran states that some will only spend a brief time there, while others, the unrepenting and idolatrous ingrates, are condemned forever. Muslims see death as a transition to the other side. Islam is seen as the vehicle that will take one safely there. It is only in paradise that the believer finds ultimate peace and happiness.

Common Misconceptions about Islam

Perhaps the most common misunderstanding about Islam is its attitude toward women. In light of modern sensibilities, Islam, as practiced by most Muslims, does retain some pre-modern attitudes. Much of this is cultural; however, some is not. For example, although the home is generally considered the best place for a woman, Islam does not prohibit a woman from a career in the outside world. In fact, many early Muslim women including the Prophet's wife, Khadija, were scholars and merchants. While Islamic law does legislate some differences

between men and women, they are few in number. The majority of practicing Muslim women do not view them as demeaning because a woman is considered equal to a man before God. The Quran clearly states, "Whoever works righteousness, man or woman, and has faith, verily to him will We give a new life, and life that is good and pure, and We will bestow on such their reward according to the best of their actions" (Quran, p. 663).

Another aspect of Islam that tends to spark interest is the idea of Jihad, or holy war. Some people think Islam condones violence and even terrorism. In reality, Islam rarely permits Muslims to use coercive force and does so only for reasons such as self-defense. Moreover, with the exception of self-defense, only legitimate state authority can exercise coercive force. Although there is a religious duty to fight to defend the lands of Islam, strict rules of engagement apply. The Prophet specifically prohibited the killing of religious people, old people, as well as women and children. Later, Muslim legal theorists included any non-combatants in this prohibition. Sadly, like other religions, Islam has violent fanatics and extremists who justify their crimes by distorting Quranic verses and the sayings of the Prophet Muhammad for heinous ends.

Muslims are a racially diverse community, the majority of which are non-Arab. Although Islam began in Arabia, Arabs comprise less than 15 percent of Muslims. The largest Muslim population is in Indonesia, and the second largest is in Bangladesh. There are estimated to be over 60 million Muslims in modern China. Largely due to high birthrates in the traditional Islamic world, Islam is considered to be the fastest growing religion in the twenty-first century. In 2000 it was the third largest religion in the United States and is expected to be the second after Christianity.

See also: AFRICAN RELIGIONS; BUDDHISM; CHINESE BELIEFS; HINDUISM; ZOROASTRIANISM

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IVAN ILYCH

“The Death of Ivan Ilych” is widely regarded as one of the most powerful meditations on death and dying in world literature, at least in part because it anticipates modern psychological discussions of the stages of dying. Written in 1886, the novella was the Russian novelist and moral philosopher Leo Tolstoy’s first major work of fiction completed after his existential crisis of the late 1870s—a crisis that initiated the search for a new understanding of Christianity that was to preoccupy him for the remainder of his life. The story is

a fictional adaptation of Tolstoy’s autobiographical work “The Confession” (1879–1880), which recounts his personal struggle for meaning in the face of the terrifying inevitability of death. It is a classic literary case study of how awareness and acceptance of human mortality can and should change how people live their lives.

On the surface, “Ivan Ilych” is a simple story: A conventional family man and a successful judge, who is a member in good standing in high society, suddenly develops a mysterious illness that causes him agonizing pain and eventually kills him. Structurally, the story privileges Ivan’s death over his life. It begins with his funeral, thus introducing him as a character who has already died, and only then chronicles his life from childhood to the onset of his illness. The story increases in speed and intensity after Ivan becomes sick: The chapters shorten and the time period depicted in each decreases dramatically from a few weeks to, in the final chapter, just a few hours. In structuring the story in this way, Tolstoy suggests that Ivan is not really alive until he begins to die.

Ivan is depicted as Everyman. Explicit details link Ivan’s fate with the fate of all the characters in the story. The reader of the story is intended to learn the lesson that Tolstoy himself learned as a result of his spiritual crisis and that Ivan learns as the story unfolds: Death is an inevitable part of life, and active acceptance of this simple fact is a necessary precondition for leading a meaningful life. None of the characters in the story, with one exception, seem to understand this lesson; all treat the dying Ivan as an unpleasant and foreign intrusion into their comfortable world. The exception to this rule is Gerasim, the story’s energetic peasant-hero, who comforts his dying master and who says of death: “It’s God’s will. We shall all come to it some day” (Katz 1991, p. 129).

Tolstoy maps out Ivan’s struggle to accept death through a series of subtexts that run counter to the surface plot. The subtexts tell the story of a nineteenth-century man with all the traits of the modern, twenty-first-century self: one with no spiritual life, one alienated from others, and one compelled by his illness to seek and find true meaning. When well, Ivan could avoid the “unpleasant” and believe that death is something that happens only to other people. When dying, he is forced to confront life’s unpleasantness (physical discomfort, which

comes to symbolize a lack of spiritual meaning) and question the rightness of how he lived his life.

Ivan's reconsideration of his life is ironically facilitated by the intense pain he experiences as his illness progresses. The pain, the most unpleasant of all circumstances Ivan has ever endured, dismantles his comfortable world and turns his pleasant and decorous life into something horribly unpleasant and false, something that Ivan must struggle against in his quest for meaning. Ivan faces his mortality both figuratively and literally because the pain is personified as a gleaming light that peeks out at him from behind houseplants and shines through all the screens that he puts up in vain attempts to block it off.

By the end of the story, Ivan's pain has become not only the central fact of his existence but the vehicle of his salvation. The pain resurrects him by sharpening or heightening all of his senses. Ivan discovers that the pain that accompanies his death is a catalyst for self-knowledge and spiritual renewal: "His ache, that gnawing ache that never ceased for a moment, seemed to have acquired a new and more serious significance" (p. 143). In accepting the pain accompanying death, Ivan symbolically rediscovers life.

Ivan suffers not because he is being punished but because Tolstoy needs a vehicle for dramatically depicting the significance of death for life.

Ivan's fate, which is everyone's fate, suggests that the inevitability of death ought to have consequences for how one's life is lived. Tolstoy delivers this seemingly simple message in a story whose haunting symbolic power survives translation across both time and culture.

See also: COMMUNICATION WITH THE DYING; DEATH EDUCATION; DYING, PROCESS OF; LESSONS FROM THE DYING; LITERATURE FOR ADULTS; PAIN AND PAIN MANAGEMENT; PHILOSOPHY, WESTERN

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J



JAINISM

Jainism is an ancient religious and philosophical tradition that is thought to have originated in the Ganges River basin. There remain some 4 million Jains in India, spread mainly between five states, and there is also a small but influential community of emigrants in both Europe and the United States. The great philosophers of Jainism evolved a view of the universe as material and permanent, in strong contrast to the Buddhist view that everything is illusory and transient and *nirvana* or *moksa* means the merging or extinction of individuality in an undifferentiated final state. In contrast, in Jainism death leads ultimately to the liberation of the soul into an individual state of total knowledge and bliss, although this process may take several cycles of death and rebirth. In Hinduism, unlike Jainism, there is no possible form of transmitting conscious memory from one life to another, because its domain belongs to the world of illusions and dissolves at death.

The distinctive aspects of the Jain tradition are the belief in unending cycles and “half cycles” of time as well as of life and death; the spiritual model provided by twenty-four leaders (*jinās*) who regenerated the Jain tradition in the present “half cycle” of time; the five vows of noninjury or non-violence; speaking the truth; taking only that which is given; chastity; and detachment from place, persons, and things. The aim of Jain spiritual endeavor is to liberate the soul (*jīva*), which is believed to leave the physical body with one’s karmic matter. This matter supplies the energy for onward travel

to a new destiny in the cycle of death and rebirth (*karma*), which in the Jain tradition has a material nature. “Drier,” more dispassionate souls are not so easily polluted by negative karma, whereas karmic matter is more easily attracted to souls that are “moist” with desires that might contravene the five vows. The soul can leave the body through several orifices. The soul of a sinner is perceived as leaving an already decayed body through the anus. The suture at the top of the skull is the purest point of the soul’s exit, reserved for those who have led a life of renunciation, such as that of a dead ascetic. Just before the body of the deceased is cremated, the eldest son may help the soul of his father on its way by cracking the skull.

“First there must be knowledge and then compassion. This is how all ascetics achieve self-control” (*Dasavaikalika* 4:33). In Jainism, a good life through moral conduct (*abimsaa*, or non-violence and reverence for life in thoughts, words, and deeds) leads to a good death, one in which the body remains, to the last, under an ascetic type of control. Jain scriptures detail the destiny of the soul after death and the causes of physical death. These causes are classified as death because of old age or degeneration; death with desires; death without desires; the fool’s death; the prudent person’s death; a mixed death (i.e., the death of one who is neither a fool nor a prudent person, but one who is only partially disciplined); holy death, and (the highest state) omniscient death. “The concept of omniscience,” writes Natubhai Shah, “is the central feature of Jainism and its philosophy. . . . The ultimate goal of worldly life is to acquire omniscience” (Shah 1998, 2:114). Thus, by definition, the state of

perfect knowledge or omniscience (*kevala jnaana*) is the highest form of life before death.

“When a wise man, in whatever way, comes to know that the apportioned space of his life draws towards its end, he should in the meantime quickly learn the method of dying a religious death.” This extract from the Jain holy scriptures, known as *Sutra krtraanga*, identifies a ritual almost unique among the world’s religions (except in the most ascetic sects): a holy fast unto death, which through inaction rids the soul of negative karma and brings about death with dignity and dispassion (*sallekhanaa*). Within the Jain tradition, this is not regarded as an act of suicide (which involves passion and violence and is thus anathema) and is recommended only for a few spiritually fit persons and under strict supervision, usually in a public forum, with the approval of the family and spiritual superiors. People who die in this “death of the wise” (*pandita-marana*) are considered to be only a few births removed from final liberation from the painful cycle of death and rebirth. Two other forms of withdrawal from life are also practiced in conjunction with abstention from food. These are death through renunciation (*sannyasana marana*) and death through meditation (*samaadhi marana*).

At a Jain deathbed, the sacred mantra of surrender, obeisance, and veneration to the five supreme beings (*Navakara Mantra*) is recited and hymns are sung. The same mantra is recited after death, when hymns are sung and other prayers recited. In the Indian subcontinent, the dead person is normally cremated within twenty-four hours of death (though there may be a delay of up to a week among the diaspora in Europe and the United States). Before the body is consumed in the crematorium oven, there is a period of meditation for the peace of the soul, a sermon on the temporary nature of worldly life and advice to those present not to feel grief at the departure of the soul, which will be reborn in a new body. In the Indian subcontinent, the ashes of the deceased are dispersed in a nearby sacred river, or in the absence of a suitable river, a pit. The departure of the soul at death is part of a Jain worldview in which the concept of a living soul is thought to exist in all human beings, animals, insects, and vegetation, and even in the earth, stone, fire, water, and air. The distinctive Jain respect for life and refusal to kill animals, insects, and plants for food arises from this worldview.

See also: BUDDHISM; CREMATION; HINDUISM; IMMORTALITY; REINCARNATION; ZOROASTRIANISM

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JESUS

Jesus is the historical figure identified by the many forms of Christian tradition as its point of historical origin and the means of Christian believers’ eternal destiny. Jesus of Nazareth was a popular Jewish teacher who reflected the tradition of his day—often associated with the Pharisee group of Jews—adhering to a belief in a future resurrection of the dead associated with a day of judgment and a new form of the kingdom of God. After his death his disciples claimed that he had risen from the dead, a resurrection belief characterizing his disciple group that soon broke away from traditional Judaism to become the earliest Christian Church. This means that the person of Jesus became inextricably bound up with the idea of the conquest of death. Indeed, the novelty of the New Testament does not lie in a general belief in resurrection but in a commitment to the specific belief that it had already taken place in Jesus and, because of that, all who believe in him and are his followers will also be granted a resurrection to eternal life.

Christian Theologies

The significance of Jesus as far as death is concerned does not simply lie in the belief that he was resurrected, but that his death, in and of itself, achieved specific purposes. Here death becomes a symbolic vehicle for a number of ideas, largely grounded in the notions of sacrifice and salvation and traditionally spoken of as theories of atonement explaining how his death beneficially changed the relationship between God and humanity from hostility to reconciliation.

Sacrificial Death

The prime meaning given to the death of Jesus both in the New Testament and in subsequent theologies is that it was an act of atonement expressed as a sacrifice. It is important to appreciate the fullness of the extent of this symbolism and the way it has entered into many of the cultures of the world. The death of Jesus could not have been interpreted as a sacrifice without the long historical tradition of the pre-existing Hebrew Bible and the Jewish ritual practices conducted at Jerusalem's temple, especially animal sacrifices for Jerusalem was then a center for animal sacrifice in which the shed blood was the means of removing personal sin. This was a religion in which morality and sacrifice were closely bound together as a means of forgiving the sin engendered by the breaking of divine commandments. The life of the beast was reckoned to be in its blood and it was the ending of that life that made possible the forgiveness of sins.

Another important strand of this tradition regarded suffering as the means of atoning for sin as in the image of the suffering servant of God who would be an agent for the deliverance of God's chosen people, Israel. This perspective was developed by some of the rabbis in the early Christian period to argue that death was the most extreme form of suffering, one that was actually experienced by dying individuals who might thereby atone for their sins in and through their own death. The earliest Christian traditions tended to foster these ideas, emphasizing them to varying degree, but seeing in Jesus both the sacrificial lamb of God who takes away the sin of the world and the suffering servant.

Much has been made of the fact that Jesus did not die a natural death but died as a criminal by the appointed method of crucifixion. This raises an interesting issue over blood as a medium of sacrifice. Crucifixion as practiced by the Romans, and it was on Roman authority that he was crucified, did not necessarily involve the use of nails and the shedding of blood. Criminals could be tied to crosses and die of asphyxiation when they could no longer bear the weight of their body on their legs. (Indeed, their legs might be broken to ensure this took place.) It was a slow form of punishing death. None of the Gospel stories tell of Jesus being nailed to the cross and John's Gospel has to add the specific, and unusual, comment that

a soldier standing by pierced his side with a spear out of which came "blood and water" (John 19:34). This is because John's Gospel has a specific interest in blood as a medium of salvation from sin. In various letters of the New Testament, especially the Letter to the Hebrews, great stress is placed upon Jesus as the High Priest who offers his own blood in a sacrificial ritual (Heb. 9:12); it also echoes the idea of being made perfect through suffering (Heb. 5:8–9). The overall Christian idea is that Jesus and his sacrificial death form the basis for the New Covenant between God and humanity.

Christ and Self

One aspect of Christ's sacrificial death is reflected in the idea that he was either a representative of or a substitute for believers with the result that his death is related to their ongoing life and, as significant, that their death is no longer just a personal and private event. This is because the language of death, that of Jesus and of the believer, comes to be the means of interpreting one's life and is given fullest formal expression in the language of worship and ethics. Many Christian hymns reflect upon these matters and have ensured that the death of Christ has always remained at the forefront of Christian thought. The piety that sometimes arises in connection with this focus upon Christ's suffering and death has often been profound and is one means of eliciting the responsive love of individuals to God for the love shown to them.

Death into Resurrection

For St. Paul, the combined death and resurrection of Jesus takes place at and as the turning point in history between the Jewish religion focused on a single nation and governed by the divine law—Israel's Torah—and the new international community of believers in Christ inspired by the divine revelation of the gospel. This "good news" was that God forgave the sins of all through this sacrificial death and, in the new unified community, created and led by the Spirit of God, there was a new kind of "body" of Christ—the church—existing in the world. The promises and pre-existing history of Israel had now come to fulfillment in this new community of love through God's action against humanity's sin to demonstrate the divine righteousness and to create a righteous world as expressed in different theories of atonement.

Legal Idioms

Early fathers of the church offered variations on the theme of the life and sacrificial death of Jesus within a legal framework, one that viewed relationships in terms of rights, duties, ownership, and obligations. These are sometimes called legal or juridical theories of the atonement. Origen, writing in the third century, saw Christ's death as a form of ransom paid to the devil who had gained certain rights over fallen humanity. At the close of the eleventh century, Anselm, in his famous book *Why Did God Become Man?*, argued that the death of Jesus was a kind of satisfaction of God's outraged sense of honor caused by human disobedience. Human sin was a kind of debt resulting from the fact that people did not render the honor due to God. Not only ought humanity to return into obedience to God but some satisfaction should also be provided for the outrage perpetrated against the divine. And this was what the voluntary death of Jesus accomplished. His death becomes a satisfaction for the sins of humanity. This view contradicted that earlier theological suggestion that Christ's death was a payment to the devil.

The Exemplary Death

One element of Anselm's thought speaks of the death of Jesus as an example of how ordinary humans ought to live by giving voluntary offerings to God. Abelard, a younger contemporary, developed his exemplary theory further arguing that the suffering death of Jesus should so stir the lives of believers that they would respond anew to God. Something of this exemplarist view also stirred the imagination of early-twentieth-century theologians as when Hastings Rashdall (1858–1924) saw God's love revealed in the life and death of Jesus in ways that evoked a human response to a life of service, as published in *The Idea of Atonement in Christian Theology* (1915).

Drama of Conquest

Another style of interpretation of Christ's death, echoing the earlier ideas that the devil was involved, was prompted by the sixteenth-century German religious reformer Martin Luther and reinforced by the early-twentieth-century Swede Gustav Aulén. Sometimes referred to as the "dramatic theory of atonement," its stress falls on Christ as one who does battle with the devil and emerges



The motive force for hope in most Christian traditions and cultures is, ultimately, grounded in the idea of the resurrection of Jesus and of believers. One of the more common images of Jesus is depicted in this late fifteenth century painting by Lazzaro Bastiani. CORBIS

triumphant, as caught in the Latin title *Christus Victor*, used for the English translation of Aulén's book. This broad tradition expresses the positive accomplishment of Jesus and the sense of confident benefit received by believers through it. In more recent and popular forms this doctrine of the power of Christ over the devil has been used in Pentecostal and Charismatic forms of Christianity in relation to exorcism and gaining power over evil spirits reckoned to be afflicting the sick.

Christian Worship

The death of Jesus did not, however, simply forge the first Christian groups or give opportunity for abstract theology but became central to three ritual practices: baptism, the Eucharist, and funerals. These ensured that the image of death would be kept firmly before Christian consciousness for the next 2,000 years. Baptism is a rite in which water becomes a symbol expressing several meanings,

including (1) the normal function of water to cleanse the body, in this case the cleansing of sin viewed as an impurity or stain to be removed; (2) the biological “waters” associated with birth, in this case symbolizing spiritual birth so that a baptized person can be spoken of as being “born again”; and (3) the image of death, specifically the death of Jesus, for when someone becomes a Christian through baptism he or she is said to “die with Christ.” The death and life of Jesus come to be intimately linked in a ritually symbolic way with the death and life of the believer. In this way the historical death of Jesus has come to be invested with deep theological significance and forms the basis for individual believers to reflect upon the meaning of their own lives. In religious terms not only are they said to have died to their old nature and to have been born again with a new nature on the single occasion of their baptism, but they are also called to “die daily” in a spiritual commitment to live a “new life.”

This emphasis on the transformation from death to life, both in the death of Jesus and in the experience of Christians, is reinforced and developed in a special way in the rite called by a variety of names including the Eucharist, the Mass, the Holy Communion, or the Lord’s Supper. In major Christian traditions such as Greek and Russian Orthodoxy, Catholicism, Lutheranism, and Anglicanism, both baptism and the Lord’s Supper are regarded as sacraments—special ritual activities in which the outward signs of water, bread, and wine reflect spiritual depths and foster the whole life in the process of salvation. The Eucharist enacts an account of the Last Supper, itself probably a traditional Jewish Passover meal that expressed God’s covenant with Israel, held by Jesus with his disciples just before he undergoes the agony of commitment to God’s purposes in the Garden of Gethsemane, where he is finally betrayed, arrested, and executed. The Eucharist tells how it was on that night of betrayal that he took a cup of wine and told his disciples that it was his own blood that is shed for them and that they should repeat the act of drinking it as a way of remembering him. And so too with bread that they should eat in memory of his body given for them. Different traditions have developed these themes, some stressing aspects of remembrance as a mental act and talking about wine and bread as simply wine and bread, some even use nonalcoholic wine or even

water. Others, especially in the Catholic traditions, speak of the Mass as a “transubstantiation” rite in which the bread and wine “become” the body and blood of Christ through the priest’s authority and the proper conducting of the ritual. A major train of thought interprets the Mass as a rite in which the death of Jesus is not simply represented but is also represented.

Modern believers enter into the foundational and epoch-making moments in the life and death of Jesus. The familiarity of these rites possibly tend to cloud the significance of what they express and yet when believers take the communion bread and wine they are engaging with symbols of death and life and bring the death and life of Jesus into intimate association with their own lives and death. Not only that, the rite also mentions the death and eternal life of various ancient saints of the church as well as of the more recently dead. Not only do many Christians pray for the dead but also invoke the saints to pray for the living. In other words, the eucharistic rite activates an entire network in which the living and the dead are caught up together within the Kingdom of God.

Finally, it is in funeral rites that the death of Jesus has come to play a significant part and these rites have become a major feature of the impact of Christian churches upon many societies. Once more, the death of individual believers is associated with the death of Jesus, their grave is symbolically linked to his and, in turn, his resurrection is proclaimed to be the basis for their future life. Christian burial has come to contain two paradoxical elements reflected in the well-known phrases, “earth to earth, ashes to ashes, dust to dust” and “in the sure and certain hope of the resurrection.” These are usually said together, one following immediately after the other, and jointly assert the obvious fact of human decay and the “fact of faith” lodging its hope for the future in the resurrection of Christ.

Hope

The very existence of baptism, the Eucharist, and funerals reflected and stimulated Christian theological explorations of the death of Jesus as a creative source of life, fostering the view that death may not be a futile end but, in some way, beneficial as in the twentieth century’s world wars whose millions of dead have been depicted as not dying in vain but as valiant warriors fighting for the truth.

Many war memorials rehearse the saying accorded to Jesus in St. John's Gospel: "Greater love has no man than this, that he lay down his life for his friend." Such memorials often incorporate or take the form of a cross so that part of the conquest of death comes by aligning the death of soldiers with the death of Christ.

In many contexts of disaster and catastrophe relatives of the dead often seek some explanation of why the loss occurred and express the hope that something good may come out of it or that some lesson may be learned in order that, as the expression holds, "this may never happen again." To speak of disasters in terms of beneficial death is, in some ways, wrong and might appear insensitive to the bereaved and yet this is how some such events are framed.

Resurrection

After Jesus died, the cave-tomb where he had been placed was found to be empty and the body unfound. Disciples say he appeared to them and believed that he had been raised from the dead. The contemporary popular Jewish belief in resurrection came to sharp focus: Resurrection had become personalized in Jesus. The early disciples also reckoned that a spiritual power had transformed them into a strong community, exemplifying the new message of God's love for all, irrespective of social or ethnic background. Identity within the new community of the church involved belief in the triumph over death conferred by this spiritual power coming to believers.

Historical Jesus and Christ of Faith

From the eighteenth century on scholars used historical analysis of biblical texts to interpret Jesus's life, cutting through centuries of developed dogma. Albert Schweitzer's important works, including *The Quest for the Historical Jesus* (1906), argue that Jesus believed the world and history were coming to an end and that he was the Messiah whose own suffering would prompt it and help deliver people from the anguish involved. Rudolph Bultmann wanted to demythologize biblical stories so that the Christ of faith could be clearly heard, calling people to decision and faith. In the 1930s Charles Dodd argued for a "realised eschatology," the idea that a degree of divine fulfillment of the Kingdom of God had already occurred in the ministry of Jesus. In the

1950s Reginald Fuller opted for a belief that fulfillment would only come after Jesus's earthly work was completed. Despite detailed research on biblical descriptions of Jesus's suffering and death, much remains open as to whether he felt abandoned by God or not. Similarly, the theme of the resurrection remains contested as an arena in which ideas of the Jesus of history and the Christ of faith remain open-ended as Edward Sanders has indicated. From a psychological viewpoint, some argue that the resurrection is grounded in grief-induced hallucinations. Whatever the case, the death of Jesus has been the major focus by which millions have reflected upon their own death and sought relief when bereaved of those they love.

See also: CATHOLICISM; CHRISTIAN DEATH RITES, HISTORY OF; LAZARUS; OSIRIS; SACRIFICE; SOCRATES

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DOUGLAS J. DAVIES

JONESTOWN

The People's Temple was a new religious movement started by Jim Jones with the intention of promoting racial equality, but instead ended with over 900 people dead from a mass suicide in Jonestown,

Guyana. Jones started the People's Temple in Indianapolis, Indiana. However, sensing that Indianapolis would never accept his message of racial equality, Jones moved his congregation to Ukiah, California in 1965 and then in the early 1970s to San Francisco. Finally, among growing accusations from former members and highly critical newspaper articles, Jones established in 1977 what he believed to be a utopian, socialistic community in Guyana called Jonestown (Kilduff and Javers, 1978).

Jones and the People's Temple were involved in a number of social welfare programs in both Indianapolis and California, such as "soup kitchens . . . legal aid services . . . [and] childcare centers" (Richardson 1980, p. 250). Additionally, journalists Marshall Kilduff and Ron Javers point out that they were active in politics, particularly in California. Temple members could be expected to write letters of support for a particular issue or to fill up a political rally when needed. Jones served in several appointed civil positions in both Indiana and California.

Jonestown, Guyana

Congressman Leo Ryan was approached by a group called the Concerned Relatives, which consisted of former People's Temple members and the relatives of current members of People's Temple, about their concern for the people in Jonestown. Ryan agreed to make an official visit to Jonestown as a member of the House International Relations Committee. Ryan's attempt to visit Jonestown was met with resistance from Jones. Eventually Ryan, accompanied by both television and print journalists, arrived in Jonestown on November 17, 1978. The visit consisted of a tour of the commune, a meeting with Jones, and some entertainment (Kilduff and Javers 1978; Krause 1978).

Journalist Charles Krause reports that the next morning, Ryan was attacked by a man with a knife, although he was not hurt by the incident. Later that same day, Ryan and his party, which now included defectors from the People's Temple, were attacked by assassins at the Port Kaituma airstrip. Ryan and four others were killed and ten were injured.

As the killing at the airstrip occurred, Jones was leading his congregation through a mass suicide/homicide for which Temple members had been practicing since 1973. Sociologist Ken Levi and religious scholar Catherine Wessinger discuss how and



Similar to other cult leaders, such as David Koresh of the Branch Davidians, Jim Jones, leader of the religious movement People's Temple, was seen by most of his followers as a father figure or, in some cases, the reincarnation of Jesus Christ. ROGER RESSMEYER/CORBIS

why the suicide occurred. The suicide practices were called "White Nights" and consisted of members drinking a liquid that they believed was poisonous as a loyalty test to Jones. However, this day it was not a loyalty test: People lined up to drink the fruit-flavored punch laced with cyanide and tranquilizers or, for the very young, to have the poisonous concoction injected into their mouths. "Nine hundred and nine people died at Jonestown including 294 children under the age of 18" (Wessinger 2000, p. 31). Eighty-five members survived either because they hid, ran into the jungle, or were not in Jonestown that day. Jones himself "died of gunshot wounds" (Wessinger 2000, p. 31).

The question of how many people were murdered versus how many committed suicide is difficult to determine because only seven bodies were

autopsied. Sociologist James Richardson (1980) notes that the decision to not autopsy more bodies was widely criticized in the press. Therefore, other than being certain that the very young children were murdered, it is impossible to determine how many people voluntarily took their own lives.

Reasons for the Violence

Several interrelated factors may have affected the Temple members' decision to stay in Jonestown and to commit mass suicide. First, Jones was a powerful and charismatic leader; he performed faith healings in which he pretended to cure people of cancer and claimed to be the "reincarnation of Jesus Christ" (Johnson 1979, p. 320). Also, Richardson explains that the authority structure in the People's Temple was highly centralized, so Jones had the ultimate authority there. As evidence that many people did see him as a charismatic leader, many of the followers called him "Father or Dad" (Wessinger 2000, p. 34).

Second, Jonestown was isolated—surrounded by thirty miles of jungle—so members were hesitant to leave. Jones made repeated threats that leaving would be difficult because of the lions, tigers, and human enemies in the jungle (Richardson 1980). The psychologist Robert Cialdini argues that isolation creates uncertainty, this uncertainty led Temple members to follow others. Therefore, when Jones was urging people to drink the cyanide-laced punch, Temple members may have looked around to see that others were lining up and compliantly got in line.

Third, coercive methods were used to control the people at Jonestown. The journalists Marshall Kilduff and Ron Javers noted in their book, *The Suicide Cult* (1978), that physical punishments were common at the People's Temple. For example, children may have been shocked using an "electrical cattle prod or heart defibrillator" (Kilduff and Javers 1978, p. 64). Jones frequently had Temple members sign documents in which the member falsely admitted to crimes. Jones would then threaten to use these admissions if the member ever left the cult. Jones built loyalty to him by weakening existing family ties. He would not allow sex between married couples, and children often lived apart from parents in a separate facility at the People's Temple commune.

Fourth, sociologist John Hall argues that Jones believed that he was being persecuted based upon negative news articles, lawsuits filed against him, and the belief that government agencies were conspiring against him. Moreover, Jones created an environment in which people feared persecution if they returned to or stayed in the United States. For the poor, urban African Americans who made up a majority of the group, he convinced them that if they did not come to Jonestown they would be put into concentration camps. For the whites, who often joined because of Jones's message of socialism, he led them to believe that they were being monitored by the Central Intelligence Agency.

Hall further suggests that the purpose of this persecution was to build loyalty to Jones. It may have made the idea of mass suicide more acceptable to many of the Temple members. Congressman Ryan's visit was probably already seen as threatening to many of the cult members. However, in the minutes before the mass suicide/murder, Jones repeatedly made reference to the fact that because his assassins had attacked the congressman that people would come back to destroy Jonestown; therefore, it was better to die in a revolutionary suicide (i.e., dying for a cause) than to have what they had built in Jonestown destroyed.

See also: CULT DEATHS; HEAVEN'S GATE; MASS KILLERS; WACO

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JUDAISM

As a cultural and religious group with a historical connection to contemporary Jewish culture, Judaism, dates to the end of the first century of the C.E. The destruction of the temple in Jerusalem in 70 C.E. was the event that both enabled and forced rabbinic Judaism to take its position as the preeminent contender as the representative of Judaism. The founding text of rabbinic Judaism is actually the third-century Mishnah, not the Torah. The Mishnah is the first compilation or code of Jewish law, which was edited in the early third century. However, it includes material that dates back to the first century and underwent editing and revision several times throughout the second century as the rabbinic academies in Palestine grew.

Some scholars see a smooth and direct link between the religion articulated by Ezra or the Pharisees and the religion that was articulated by the rabbis after the destruction of the Temple in 70 C.E. Most scholars, however, understand rabbinic Judaism as having developed at the same time as early Christianity. A small minority of scholars thinks that rabbinic Judaism developed after early Christianity. The destruction of the Temple in Jerusalem in 70 caused such a break in the practice and consciousness of the Jews of Palestine and the Diaspora that it is all but impossible to directly connect pre-70 and post-70 Judaism. To be sure, the materials necessary for rabbinic Judaism to develop were present before the destruction of the Temple, but in a merely germinal form. Rabbinic Judaism is essentially a different religion than other pre-Temple Judaisms.

The Bible, which embodies a diversity of religious views, says very little about the afterlife. Impurity stemming from contact with the dead is a prominent feature of the Torah, as is capital punishment. The archaeological evidence seems to demonstrate that the Israelites in Biblical times were concerned with the afterlife. It is not until

Daniel, written in third and second centuries B.C.E., that there is seemingly unambiguous reference to the afterlife and the end of days. By the time of Qumran literature—that is, texts discovered around the Dead Sea that date back to the first and second centuries B.C.E. and used by Jewish sectarians—there is a full-blown notion of an afterlife, which is both a reward for the righteous and a means for explaining the ultimate justice of God. Josephus, a Jewish commander in the war against Rome in the first century and who later defected to the Roman side during the war, points to an afterlife and the resurrection of the dead as sources of conflict between the Sadducees and the Pharisees. This description is supported by Matthew.

One of the ways of defining rabbinic Judaism and its descendants is by its textual tradition. Rabbinic Judaism claims the Torah as the cornerstone of the textual tradition. On the other hand, the canonization of Mishnah, the third-century compilation of rabbinic legal thought and ruling, meant the exclusion of much of post-Biblical literature. While Sirach is quoted in the sixth-century Babylonian Talmud, for example, it is not part of the Jewish canon, it is an extra-canonical book from the first century B.C.E. The Mishnah lays out its own apostolic genealogy in the beginning of the tractate, which is known as Chapters of the Fathers: “Moses received the Torah from Sinai and passed it on to Joshua, and Joshua to the Elders, and the Elders to the Prophets, and the Prophets to the Men of the Great Assembly” (Fathers 1:1).

The Men of the Great Assembly is the period that begins with the first exile in the sixth century C.E. and ends with the Pharisaic precursors of the rabbinic movement around the turn of the millennium. Rabbinic tradition numbers even legendary figures such as Mordecai (from the book of Esther) as one of the Men of the Great Assembly.

Mishnah purports to gather traditions from two centuries of rabbinic activity, laying out the boundaries of rabbinic Judaism. Within its sixty-three tractates, divided into six orders, there is legislation pertaining to all areas of life, from Sabbath law to torts to sacrificial law to proper beliefs. This material unfolded and developed at the same time that early Christianity was growing from a Palestinian movement of Jewish followers of Jesus to the official Christianity of the Roman Empire.

If people judge by the quantity of material, Mishnah's central concern with death relates to issues of impurity. One complete order of Mishnah deals with purity issues and determining the minimum dimensions of a part of a corpse that will generate impurity when touched. A majority of the twelve tractates in that order deal with the impurity emanating from the dead. A dead person was considered an ultimate source of impurity, an attitude that arises directly from Torah teachings. It was obviously a central issue in Temple times because no impure person, including priests who had become impure, were allowed into the Temple. The centrality of the concept of impurity in the community is evident in the fact that almost a century and a half after the destruction of the Temple, when impurity no longer had any major significance in daily life, there were still extensive laws on this topic.

One of the so-called lesser tractates, euphemistically titled "Times of Joy," deals with burial and mourning. Another (mourning) deals with dying and suicide. Burying the dead is one of the commandments that supersedes others, and if there is a dead body with no one to bury it, even the high priest (who under normal circumstances is forbidden contact with the dead) must bury the body.

The third area, death as a punishment for sins and crimes, is divided into two types of death: death at the hands of the court and death at the hands of God. Death is also the last step in atonement for certain types of sins. This does not, however, imply anything about the status of a person postmortem.

There is also a passing but interesting reference to the afterlife and resurrection of the dead. "All of Israel have a place in the World to Come. . . . These do not have a place in the World to Come: the one who says there is no resurrection of the dead." The afterlife is presented as a reward for the righteous but is not explored in much detail. Resurrection is presented in both the Gospels and Josephus as an ideological boundary dividing the Pharisees from other sects of Second Temple Judaism.

One type of death that occupied a significant amount of thought and energy among early Christians was martyrdom. There are two types of martyrdom. One is active martyrdom, in which the

martyr willingly goes to his or her death to proclaim a belief in the one God (or in Jesus, for Christian martyrs). The second type of martyrdom is passive martyrdom, in which a believer is given the choice of abrogation of religious obligation or death. This latter, passive martyrdom was a part of rabbinic Judaism from its beginnings. When confronted with the choice of either having to abrogate one of the three core prohibitions (idolatry, murder, or illicit sexual unions) or be killed, the Rabbinic Jew must choose death. Scholars differ about the issue of active martyrdom. Some say that it became a desideratum for rabbinic Judaism hard on the heels of its widespread acceptance in Christianity. Others say that the debate was open until much later and might not have been settled even at the conclusion of the Babylonian Talmud in the seventh century.

These general categories were the boundaries for the discussion of death and dying throughout the rabbinic period and into the Middle Ages. The next layer of the rabbinic textual tradition consists of the Palestinian Talmud (edited in the fifth century) and the Babylonian Talmud (edited in the seventh century). The Talmuds engaged in more explicit discussions of what the world to come might look like and in more extended discussions of the punitive or expiatory efficacy of death. There is also more elaboration of the concept of martyrdom and the introduction of the "time of oppression," when martyrdom might be a more common obligation. On the whole, however, the bulk of the Talmudic discussions of death are concerned with issues of purity and impurity and capital punishment.

Death is seen as a normal part of the cycle of life, even as a necessary part of life. Death is not seen as punishment for original sin or punishment for sin in general; extraordinary death, however, is sometimes seen as punishment for sin. At times, this kind of death is the result of an inexplicable divine decree: "There are those who die without judgment." The dead are judged and rewarded or punished, although there are conflicting reports of what that reward or punishment is. It is also not clear whether the afterlife is corporeal or noncorporeal.

During the eleventh and twelfth centuries the crusades brought in their wake a renewed interest in martyrdom and even in the notion of suicide as

an escape from transgression or forced conversion to Christianity. The biblical story of the binding of Isaac, wherein Abraham attempts to sacrifice his son, as told in Genesis 22, is often cited in justifications of the murder of one's spouse and/or children in the face of a Christian onslaught. Even the greatest of the medieval Talmudists attempted retroactively to find a way to justify these suicides and murders.

The notion that the soul's journey starts before life and continues after death is already found in the Talmud. Its most extensive treatment, however, ensued from the mystical speculations that started in the late rabbinic period and came to fruition with the production of the Zohar, the central text of the Jewish mystical tradition, in thirteenth-century in Spain, and with the advent of the Kabbalistic teaching in the sixteenth century in northern Israel. Whereas the Judaism of the Mishnah, Talmud, and Midrash collections was vague and reticent about the nature of posthumous existence, the mystics were very explicit, discussing the source of souls in the upper realms, the resurrection of the dead to a corporeal existence at the end of time, and the transmigration or reincarnation of souls. The afterlife of the soul is part of a mystical theodicy in which God's justice is worked out over many lifetimes.

At the same time that the mystics were contemplating the journey of the soul and martyrs were lauded in France and Germany, Maimonides, the greatest Jewish philosopher and jurist, was codifying a much different approach to both martyrdom and the afterlife. In Maimonides' formulation, the only acceptable martyrdom was passive martyrdom. While one is obligated to accept death rather than transgression in certain cases, one who falters and transgresses under duress is not culpable. Further, Maimonides' conception of the afterlife is unclear and was contested even during his lifetime. There is support for an Aristotelian reading in which the soul or intellect cleaves to God (the active intellect) and in this way continues its existence after the death of the material body. When challenged on his belief in the afterlife and resurrection, however, Maimonides affirmed a belief in a corporeal resurrection.

The centrality of the communal obligation to the dead, which includes preparation of the body

for burial (*tabarab*) and the burial itself, was already evident in the rabbinic period. According to this law, after passing a certain period of residency, all citizens of a town must contribute toward the burial expenses of the town's destitute. In the early modern period this tradition gained greater visibility and authority. The so-called holy society (*chevra kadisha*), the communal body that is mandated to perform the death and burial rites, became a source of communal responsibility even for matters outside of its immediate purview (i.e., charitable pursuits). The society was supported by a communal tax and had a charter and a complicated acceptance procedure that included periods of probation and study. An actual membership organization called the *chevra kadisha* seems to be an innovation of the early modern period. There are still holy societies that perform the death and burial rites. These include guarding the dead body until it can be brought to the mortuary or cemetery, ritually cleansing the body, clothing the body in special death garments, and bringing the body to burial.

In the modern and contemporary periods the existence of an afterlife and the resurrection and reincarnation of the dead have become points of contention between the different movements within Judaism. On the whole, Reform Judaism does not believe in an afterlife, resurrection, or reincarnation. Orthodox Judaism believes in all three, though there are some factions of Orthodoxy that do not believe in reincarnation. There are varying opinions in Conservative and Reform Judaism that span the gamut.

See also: BUDDHISM; CHINESE BELIEFS; CHRISTIAN DEATH RITES, HISTORY OF; HINDUISM; JESUS; KADDISH

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ARYEH COHEN

K



KADDISH

Kaddish (“holiness”) is an ancient Jewish prayer praising and glorifying God, recited at fixed points of the public prayer of the synagogue, at funeral services, and by mourners of a deceased parent or close relatives.

Kaddish was not composed at one specific time and in its formative stage did not have a fixed text. The earliest form of Kaddish may be traced to the period of the Tannaim, after the destruction of the second temple (70 C.E.), when the initial section, *yehe shemeh rabbah mevarakh le’olam ule-almei almaya* (“may His great name be blessed forever and for all eternity”), was recited after public discourses on Sabbaths and Festivals. This refrain is a paraphrase of the Temple formula *barukh shem kevod malkhuto leolam va’ed* (“Blessed be the name of His glorious kingdom for ever and ever”), which was recited by the congregation upon hearing the High Priest utter God’s name (Mishnah Yoma 3:8). The prayer during that time did not assume the name “kaddish” but was known by its opening words, *Yehe shemeh rabbah* (“may His great name”).

The Kaddish text, *Yitgadal Ve-yitkadasb*, (“Glorified and hallowed”) was formulated and assumed the name “Kaddish” during the period of the post-Talmudic Rabbis—the Saboraim (c. 700 C.E.). The earliest literary reference connecting Kaddish with mourners is in the post-Talmudic tractate *Sofrim* (eighth century). This treatise includes a description of how on the Sabbath the cantor (a synagogue official) bestowed special

honor and mercy to the mourners by approaching them outside the synagogue and reciting in their presence the final Kaddish of the *Musaf* (“additional”) service (Sofrim 19:9).

During the First Crusade (especially in the aftermath of the Franco-German expulsions of the 1090s), Kaddish became a liturgical obligation to be recited by mourners and appended to the conclusion of daily prayer. At first it was recited only by minors (and was called *Kaddish Yatom*, (“the orphans’ Kaddish”) who, according to Jewish law, are not permitted to lead congregational prayers. Gradually Jewish communities adopted Kaddish as a prayer for all adult mourners during the first year of mourning. At a later stage, Kaddish was instituted as a mourner’s prayer for the *Yahrzeit*—the anniversary of a parent’s death (attributed to Rabbi Jacob Molin (1360–1427)).

The significance of Kaddish is honoring the soul of the deceased by the mourner, who sanctifies God’s name in public through the opening lines, *Yitgadal Ve-Yitkadasb Shemeh Rabbah, Be’almah dievrah chire’usei* (“Hallowed be the name of God in the world that he has created according to his will”). By reciting Kaddish, one justifies divine judgment following the Rabbinic maxim, “Bless God for the harsh as well as for the merciful” (Berakhot 9:5).

Late Midrashic legends emphasize the redeeming powers associated with Kaddish. A recurring motif in these tales refers to an orphan having saved a deceased parent from the torments of Hell by reciting Kaddish in his memory; this happens even though no word in Kaddish refers to the

dead. As a mourner's prayer, Kaddish's praise of God in the hour of bereavment and mourning is a sublime expression of faith. Its prayer for the revelation of God's kingdom diverts the individual from personal grief to the hope of all humanity.

With the exception of the final Hebrew clause, *oseh shalom bimromav* ("He who makes peace in the heavens"), Kaddish is in Aramaic, the vernacular spoken particularly by the common people at the time of its crystallization into a formal prayer.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; JUDAISM

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SHMUEL GLICK

KENNEWICK MAN

The dead have power to create controversy in the world of the living. One example involves a 9,500 year-old skeleton, one of the best-preserved early human fossils found in North America, whose discovery triggered a bitter debate over who owns America's past.

Found accidentally in the Columbia River of eastern Washington in July 1996, was a nearly complete skeleton that showed traces of a hard life: a fractured elbow, broken ribs, a possible head injury, and a spear wound in the pelvis. The cause of his death is uncertain, as is the issue of whether he was interred or naturally buried. The man's skull, facial characteristics, and teeth are distinct from those of all modern peoples, including American Indians, but most similar to Polynesians and the Japanese Ainu. These differences, which are also seen in other American skeletons older



This plastic cast is of the 9,500 year-old skull found to be distinct from that of American Indians. Scientists believe that the man was long-limbed, middle-aged, approximately 5 feet 8 inches tall and weighed around 160 pounds. AP/WIDE WORLD PHOTOS

than 9,000 years, raise the possibility that more than one wave of early immigrants peopled America, and that American Indians were not the western hemisphere's first inhabitants.

The skeleton quickly became the center of a political battle pitting conservative Indian tribes and the Native American Identity Movement against the interests of science and the human community at large. Upon announcement of the discovery, leaders of five Pacific Northwest Indian tribes claimed the bones under the Native American Graves Protection and Repatriation Act of 1990 (NAGPRA). The U.S. government, which owned the skeletal remains, agreed to turn them over to the tribes, rebuffing a request by scientists for the opportunity to study this rare find. Eight prominent anthropologists sued to stop reburial, bringing the first test case of the NAGPRA. The case ignited a conflict between religion, the political position of Native American activists, and the public's right to scientific knowledge about the ancient history of its homeland.

On the religious front, the tribes believe that ancestors' remains must be returned to the earth lest

their spirits be offended and wreak havoc among the living. Because the tribes' present-day religion holds that they were created near where the skeleton was found, they insist that Kennewick Man must be their ancestor. To deny their religious claims, they say, is to disrespect and weaken their culture.

However, the religious claim is the less important one from the perspective of the Native American Identity Movement, which has as its goal the assertion of tribal rights to land and resources. In the 1970s this movement selected American Indian skeletons kept in museums as an issue of debate, maintaining that placing their skeletons in museum displays compromised their human rights. Kennewick Man and the few other early skeletons are particularly important because they suggest the chilling possibility that Indian people were not the first to occupy the Americas. If the U.S. government acquiesces to the tribes' claim to these most ancient remains, however, it affirms the movement's claim that Indian people were the first occupants of the American continent and supports the tribes' original right to land and resources. The movement is concerned that proof of an earlier people preceding them will weaken its claims.

For the scientific community, the skeleton is a story about the life and death of an ancient American and a window into the history of the human species. Are the most ancient human fossils and artifacts the property of a few or should they be considered the heritage of all peoples? The answer, scientists feel, has global implications for their quest to understand the history of the human species.

See also: GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; HUMAN REMAINS

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JAMES C. CHATTERS

KEVORKIAN, JACK

The pathologist Jack Kevorkian became the central figure in the physician-assisted death controversy in the United States, a controversy that has had ripple effects throughout the world. Born in 1928, Kevorkian was the son of refugees who escaped the Turkish massacre of Armenians in 1915. Many of the members of his mother's family and all of the members of his father's family were among the victims. The Kevorkians settled in Pontiac, Michigan, where his father worked in an automobile factory and his mother looked after Jack and his sisters Margo and Flora, who would assist him throughout the activism career he launched in his later adult years.

"Intelligent," "resourceful," and "independent" are adjectives often applied to the young Kevorkian by those who knew him. He went his own way and questioned authority long before it became commonplace to do so. An honor student in high school, Kevorkian obtained his medical degree from the University of Michigan in 1952.

Early Career

The specialty with the most appeal to him was pathology, the study of diseases and their effects. He soon devoted himself to studying the physical changes wrought by death. As early as his residency at Detroit Receiving Hospital in 1956, colleagues gave him the nickname "Doctor Death." Kevorkian was especially curious about the status of the eye at death, and arranged to be notified when a patient was on the verge of death. After death, the cornea becomes hazy and the retina segmented and pale as blood circulation ceases. Kevorkian recommended that his fellow physicians examine the eyes whenever there is a need to look for signs of life. His findings were published in medical science literature.

Dying and death were neglected topics of research and education in medicine when the young physician was conducting his studies. He was therefore almost as much an outsider as an insider.



Jack Kevorkian sits with his "suicide machine," a device consisting of tubes, hypodermic needles, saline solution, a muscle relaxant, and a lethal drug. AP/WIDE WORLD PHOTOS

Difficulties in working against the mainstream were also being experienced by other pioneers in their various clinical and academic environments. Kevorkian showed little or no interest in these parallel developments. Years later he still held himself apart from the hospice/palliative care movement, death education and counseling, peer support groups, and the rapidly expanding base of research knowledge. Kevorkian therefore made himself vulnerable to criticism that he had failed to inform himself of significant developments in pain control, social support, and other areas in the field of death and dying.

Meanwhile, he considered marriage but broke off his engagement because he judged that his fiancée did not possess "sufficient self-discipline" (Betzold 1996, p.38). Many years later he expressed regrets for missing out on the satisfactions of family life, but the absence of these obligations and distractions offered more opportunity for his other pursuits. In addition to his primary agenda, Kevorkian learned to play several musical instruments, and created some intense, death-haunted oil paintings.

The Activist

Kevorkian had an activist agenda in mind long before he became a public figure. He proposed that the bodies of executed criminals be used for scientific experiments. The convicts would be anesthetized in order to keep their bodies somewhat alive and therefore available for experiments that could not be conducted on people who were entirely alive. He also transfused blood to living patients from the corpses of people who had experienced a sudden death. Both the death-row proposal and the cadaver donor procedure were ill-received by the medical establishment. Kevorkian's views made him increasingly unpopular and therefore limited his employment opportunities. As his mainstream medical career faded, however, Kevorkian had more time available to advance his mission.

Kevorkian set forth his agenda in his book *Prescription: Medicide* (1991). He took the position that the Hippocratic oath is not and never has been binding on physicians. Kevorkian contended that a new medical specialty, "obituary," should be established to offer "moribund people" a dignified

and easy death and to provide the opportunity for experimental research on their remains. This specialty would be practiced at centers for medically assisted suicide and research, which were to be known as “obituarial.” Kevorkian thought that medically assisted suicide—or what he termed “medicide”—should be made available to all people who wish to end their suffering, whether or not they are terminally ill.

Kevorkian’s Crusade

The first step in applying his program was his construction of a “suicide machine” that he called first the Thanatron, then the Mercitron. The physician prepares the machine, but it is the patient who presses a button to release a deadly drug. A middle-aged woman by the name of Janet Adkins was the first person to make use of Kevorkian’s invention on June 4, 1990. Kevorkian was charged with murder but was then released when the court ruled that Michigan had no law against assisted suicide. His license to practice medicine in Michigan was suspended, however, and later authorities in California did likewise.

During the 1990s Kevorkian was “present” at the deaths of at least 120 people. His participation in these deaths was labeled as “murder” or “homicide” by Michigan authorities who, nevertheless, failed in repeated attempts to convict him. He was charged repeatedly with assisted suicide as well as murder, each time defying and defeating the courts with the help of a high-profile attorney. Kevorkian argued that he had not and would not kill anybody—the patients had made the last move on their own volition.

It was Kevorkian who put himself into a position in which a guilty verdict was almost inescapable. He invited CBS’s *60 Minutes* program to show a videotape he had made of his participation in the death of Thomas Youk. The result was conviction for second-degree murder and delivery of a controlled substance. He received a sentence of ten to twenty-five years in prison, which he began serving in 1999. Despite Kevorkian’s conviction and jailing, the assisted suicide controversy stimulated by his beliefs and actions continues to influence health care, legislation, and the field of bioethics.

See also: BIOETHICS; EUTHANASIA; HIPPOCRATIC OATH;
SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE

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ROBERT KASTENBAUM

KIERKEGAARD, SØREN

Søren Kierkegaard was born on May 5, 1813, in Copenhagen, Denmark, and died there on November 4, 1855. Kierkegaard is recognized to have, in the nineteenth-century, reawakened philosophy to its basic mystery, that the human being exists in the anticipation of death, and that the subjectivity of death anxiety is the source of consciousness and spirituality.

Kierkegaard grew up with the tyranny of his father’s severe and gloomy religious obsessions. His mother and five siblings died in quick succession. The meaning his father gave to his misfortune and grief was that because he had once cursed God, and God was cursing him back. Learning of his beloved father’s curse was a “great earthquake” in Kierkegaard’s life. He described his horror and dread as “the stillness of death spreading over me” (Kierkegaard 1958, p. 39).

Kierkegaard proposed marriage to Regina Olsen, whom he deeply loved, but broke off the relationship, a confounding event that was extremely significant to the rest of his life. His writing was greatly influenced by mourning this sacrifice. During the two years following the end of his betrothal in 1841, he wrote *Either/Or*, *Three Edifying Discourses*, *Fear and Trembling*, and *Repetition*. Kierkegaard’s writings are full of references and innuendoes that indicate how he had internalized this relationship and the breakup as a narrative imbued with powerful affect that is an integral part of his philosophical thinking. He also internalized his relationship with his father this way. While his

journals and some other writings suggest subjective meanings of his life, he said that after his death no one would find in them a clue to his truth. His inwardness was an engagement with himself or with God, both disclosed and hidden in his writings. His public life was marked by a series of scandals, including being savagely mocked in a popular magazine, his broken engagement, and his death bed refusal of either the sacrament or a visit from his brother. The Danish public ridiculed and scorned him.

In his works, Kierkegaard emerges hidden in pseudonyms, irony, paradox, parody, and satire. The scholar Sylviane Agacinski recognized him to be thoroughly ironic. Louis Mackey observed that “his texts exhibit an almost perfect recalcitrance to interpretation” (1986, p. xxiii), and advanced an understanding that Kierkegaard is a philosophical poet. Others have also noted that Kierkegaard’s autobiography and public “lived presence” are part of his indirect communication. Kierkegaard is a master of indirect language. His extremely ironic language and his psycho-philosophico-religious thinking provided the groundwork for post-Hegelian and postmodern philosophy. Kierkegaard’s writing continues to sharpen the blade of the cutting edge of philosophy; and the meaning of his writing and his existence is as unsettled as his writing is startling, provocative, and unsettling. His writing calls into question rather than answer questions. He raises the question of death by calling into question our very existence, which is a radically new question in the history of philosophy; a question that has had a profound impact on Western thinking.

The story of his life, on the one hand, and his philosophical, theological, and psychological writings, on the other, are complexly braided expressions of his particular “existence.” The philosopher appears in the text, but in an ironic and masked way. Subjectivity is realized in anxiety, in dread, and in fear and trembling, which are presentations of death and of God and of nothing. Kierkegaard introduced Western thinking to a new meaning of the term *existence* as a psychological-philosophical-religious term for unique, passionate, temporal subjectivity, deeply associated with dread and anxiety. His writings on existence gave birth to existential philosophy, theology, and psychology. For example, the German psychiatrist and philosopher Karl



Danish philosopher Søren Kierkegaard (1813–1855) suffered many hardships that made him question the meanings of life and death, such as the death of his mother and five siblings. BETTMANN/CORBIS

Jaspers’s psychology is inspired by him; Martin Heidegger’s and Jean-Paul Sartre’s philosophies borrow basic concepts from him; Dietrich Bonhoeffer’s theology is deeply indebted to him.

Kierkegaard’s work explains man’s spiritual flight from mortality and inwardness. He introduces into modernity an awareness of death anxiety as the existential touchstone of religious experience and of philosophical thinking. In *Concluding Unscientific Postscripts* (1846), the unique, subjective individual exists only in the certainty of his death. Death is the temporal being of existence. Through a “silent understanding of anxiety,” which is a philosophical and religious reflection on the subjective certainty of death, Kierkegaard introduces a way of philosophizing that has inspired existentialism and postmodern philosophy. The most astonishing and concealed subjective truth of existence, death, with its infinite responsibility, presents itself in fear and trembling before God’s call.

Kierkegaard has greatly influenced the emergence of death as a central question of philosophy, theology, and psychology.

Kierkegaard's use of the term *faith* often pokes fun at and aims at shattering varieties of shallow faith, objectivity, and universality. As a Christian, he vigorously attacks Christian religion that lacks existential faith. Faith is also the paradox he employs against Hegel's philosophical system; that is, the paradox that the individual is higher than the universal.

In *Fear and Trembling*, the paradox is that in taking the leap of faith one regains what has been infinitely resigned as lost. Who so makes the leap of faith is a hero, "knight of faith." Faith is an absolute obedience to God; that is, a "leap of faith" in which obedience to God overrules human love and ethical norms. The irony of the knight of infinite resignation, as the pseudonymous author Johannes de Silentio (Søren Kierkegaard), or John the Silent, does not lead to the resolution of mortality anxiety, which is achieved by the book's hero, the knight of faith. *Fear and Trembling* centers on an infinitely paradoxical analysis of Abraham, knight of faith, called by God to sacrifice his son. A fool shouts out what de Silentio keeps silent about: "O Abominable man, offscouring of society, what devil possessed thee to want to murder thy son?" The paradox of this pathos is in the terrifying absurdity of Abrahamic faith in God. De Silentio lays out the complex argument of *Fear and Trembling*, yet, as the reader tries to chase down his paradoxes, de Silentio is, in the manner of his name, infinitely resigned to silence.

Kierkegaard is a most extraordinary maker of existential puzzles. The knight of infinite resignation, existentially certain of his death and the loss of the other, no longer believing he will get back what is lost, becomes ironic: He who has not the faith that God gives back what he takes is the knight infinitely resigned. Yet, de Silentio's ironic language gives back and takes away at the same time.

See also: ANXIETY AND FEAR; RAHNER, KARL; TERROR
MANAGEMENT THEORY

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JEFFREY KAUFFMAN

KRONOS

Kronos figures in Greek mythology both as an ogre and as the king whose reign was the Golden Age. The Romans equated him with Saturn. He

was sometimes also mistakenly identified with Chronos, the god of time.

According to the Greek poet Hesiod, in his *Theogony* (c. 750 B.C.E.), Ouranos (“Sky”) mated nightly with Gaia (“Earth”). When their children were born, Ouranos hid them in Gaia’s inward places. Painfully swollen with offspring, she wrought a huge sickle and asked her children, six brothers and six sisters (the Titans), to punish Ouranos. Only her youngest son, Kronos, agreed. Giving him the sickle, she told him where to hide. When Ouranos next lay on Gaia, Kronos grasped him with his left hand, the sickle in his right, and cut off his genitals. From the drops of blood that shed on her, Gaia conceived among others the Giants, and from the severed genitals, which fell into the sea, a white foam arose from which was born the love goddess Aphrodite.

Now followed the rule of Kronos. He married his sister Rhea, who bore him three daughters and three sons: Hestia, Demeter, Hera, Hades, Poseidon, and Zeus (the Olympian gods). But Gaia and Ouranos had foretold that Kronos would be overthrown by a son, so he swallowed his children as each emerged from the womb. About to bear her sixth child, Zeus, Rhea asked her parents how to save him. They sent her to Crete, where she hid him in a cave on Mount Aegaeon. She presented Kronos instead with a stone wrapped in swaddling clothes, which he thrust in his belly. Zeus grew apace and in time forced Kronos to yield up his children. Once reborn, the gods waged war on the Titans, whom they overthrew, and Zeus replaced Kronos as ruler.

The story contains motifs recurrent in European folktales: the son destined to replace his father; the luck of the youngest son; and the monster made to swallow a stone. More importantly, Kronos and the Titans seem related to the archaic “older gods” of Near Eastern tradition, barely personified forces of nature deemed to rule the cosmos before fully anthropomorphic gods took control. In the Babylonian creation epic *Enuma Elish* (composed between 1200 and 1000 B.C.E.), there is war between these older gods and their children, as there is between the Titans and Olympians. The myth of Kronos itself corresponds closely to one from the mid-second millennium B.C.E. preserved in Hittite, which tells how Kumarbi deposed the sky god Anu by biting off his phallus.

Though expressed in terms of father-son rivalry, the Kronos myth is not primarily concerned with the human condition. The stories of Ouranos and Kronos, and Kronos and Zeus, form a single cosmogonical myth or story explaining the universe. It accounts for the separation of the earth and sky, envisaged as originally joined. Once they were separated, primeval creation ended and the gods were born.

Some of the details are vague, partly because Ouranos and Gaia are not fully personified. Where exactly is Kronos when he castrates Ouranos? How does Zeus liberate Kronos’s children? (Writers after Hesiod said that he gave him nectar mixed with emetic herbs to make him vomit.) The myth places Kronos literally between Ouranos (sky, rain) and Gaia (fertile earth), and arms him with the sickle, the reaping tool. In cult, he was connected with agrarianism and honored in the *kronisa*, a harvest festival, during which masters and laborers feasted together—an echo, it was thought, of the mythical Golden Age.

The Golden Age, before Zeus became ruler of the gods and imposed both justice and labor on humankind, was a time of plenty without toil, when people did not suffer old age, and died gently as if falling asleep. This was the reign of Kronos. How the Golden Age ended is unclear; possibly through Kronos’s overthrow by Zeus. An adaptation of this myth spoke of a land called Elysium or the Isles of the Blest. In *Works and Days*, Hesiod says this was at the ends of the earth, and was where divinely favored Greek heroes existed in bliss after their deaths. This happy realm, too, was ruled by Kronos.

The myths gathered around the shadowy figure of Kronos speak of the emergence of the ordered cosmos from primeval chaos but they look back with longing to that interregnum between the unbridled energy of creation (Ouranos) and the rule of order (Zeus), that Golden Age of the world when Kronos was king.

See also: GODS AND GODDESSES OF LIFE AND DEATH; GREEK TRAGEDY

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JENNIFER WESTWOOD

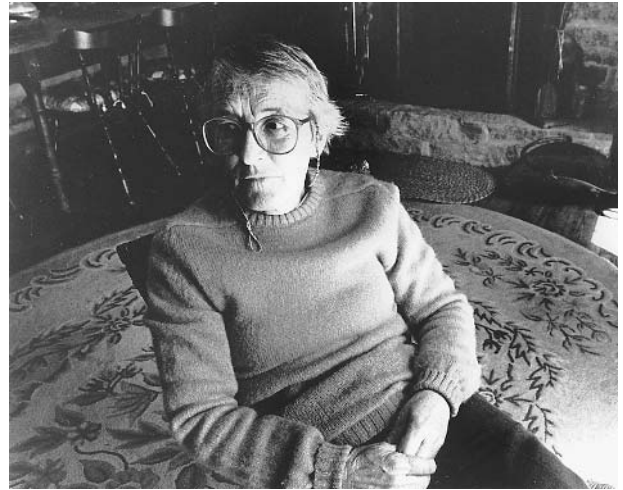
KÜBLER-ROSS, ELISABETH

Elisabeth Kübler-Ross was born on July 8, 1926, the first of three daughters born that day to a middle class family in Zurich, Switzerland. In her autobiography *The Wheel of Life: A Memoir of Living and Dying* (1997), Kübler-Ross commented: "For me, being a triplet was a nightmare. I would not wish it on my worst enemy. I had no identity apart from my sisters. . . . It was a heavy psychological weight to carry around." However, as an adult she concluded that the circumstances of her birth "were what gave me the grit, determination and stamina for all the work that lay ahead" and throughout her autobiography she describes herself as independent, unconventional, opinionated, and stubborn (Kübler-Ross 1997, p. 25).

"The first big decision I made solely by myself" involved defying her strong-willed father (who planned a secretarial career for her) in favor of her dream to become a doctor (p. 21). At school, Kübler-Ross was an excellent student, especially in math and languages, but not in religious studies. As her church, she preferred nature, pets, and animals of all kinds. One key childhood experience was a hospitalization in which an impersonal and uncaring environment isolated and separated her from her family. She often describes later encounters with conventional medical care in a similar way.

In the spring of 1942, the triplets completed their public schooling. Unwilling to become a secretary, Kübler-Ross took jobs as a maid and laboratory assistant. At the end of World War II, she volunteered to work in several areas of war-torn Europe. In Poland, necessity compelled her to practice rudimentary medicine and she was deeply moved by the concentration camp at Maidanek where more than 300,000 people had died.

Back in Switzerland, Kübler-Ross resumed working as a lab assistant and studying for the medical school entrance examination, which she passed in September 1951 with the intention of becoming a country doctor. In 1957 she passed her



An unexpected request to give her first lecture to medical students led psychiatrist Elisabeth Kübler-Ross (1926–) to focus on dying patients to whom she had gravitated because others so often shunned them. AP/WIDE WORLD PHOTOS

medical board examinations and became a physician. In February 1958 she married a fellow medical student from America, Emanuel ("Manny") Ross, and the couple moved to the United States. Becoming pregnant disqualified Kübler-Ross from a residency in pediatrics so she settled for one in psychiatry. There were problems of adapting to a new culture and eventually four miscarriages; as she later wrote, "You may not get what you want, but God always gives you what you need" (p. 111). A son, Kenneth, and a daughter, Barbara, were born in the early 1960s.

A new position brought Kübler-Ross to Billings Hospital of the University of Chicago. There, in 1965, four students from Chicago's Theological Seminary approached her to seek assistance in understanding death as the ultimate crisis in life. She offered to help and search out dying patients for interviews. Many physicians at the hospital were critical of Kübler-Ross for what they viewed as "exploiting" vulnerable patients, and the story of her difficulties in locating suitable interviewees is well known. Nevertheless, by early 1967 Kübler-Ross was leading an unorthodox but popular weekly seminar in which she would interview a patient behind one-way glass with a subsequent discussion with students and medical professionals after the patient had left.

An offer of a book contract from a publisher led to the international best-seller *On Death and*

Dying (1969). This book developed Kübler-Ross's now well-known theory of five stages in dying: denial, anger, bargaining, depression, and acceptance. As a result of this book, together in an interview with a twenty-one-year-old patient published in *Life* magazine on November 21, 1969, Kübler-Ross received numerous requests for interviews and lectures. Still, her hospital was not pleased with her success and she transferred to LaRabida Children's Hospital to work with ill and dying children. Finally, at the age of forty-six, she quit that post to do research on what death is like and to conduct weeklong workshops on life, death, and the transition to afterlife.

Kübler-Ross's research had convinced her that there was an afterlife. She was intrigued by stories of near-death experiences and experienced her first apparition about this time. As a result, she concluded that death does not exist in its traditional definition; rather it occurs in four distinct phases: (1) floating out of one's body like a butterfly leaving its cocoon, assuming an ethereal shape, experiencing a wholeness, and knowing what is going on around oneself; (2) taking on a state of spirit and energy, not being alone, and meeting a guardian angel or guide; (3) entering a tunnel or transitional gate and feeling a light radiating intense warmth, energy, spirit, and overwhelming love; and (4) being in the presence of the Highest Source and undergoing a life review.

At about this time, Kübler-Ross became convinced of the reality of her own spiritual guides and she eventually moved to California in early 1976 to pursue these inquiries. There, she founded a healing center (eventually called Shanti Nilaya, a Sanskrit phrase that she understood to mean "the final home of peace") where she could have a base for her workshops, explore out-of-body experiences, and develop a new lecture entitled "Death and Life after Death." Unfortunately, Kübler-Ross eventually lost confidence in some of her California colleagues and the center's property was sold.

In July 1983 Kübler-Ross purchased and later moved to a 300-acre farm in Head Waters, Virginia. There she built her house and a healing center for workshops. Around this time, the situation of persons with AIDS (acquired immunodeficiency syn-

drome) attracted her attention. However, when in 1985 she announced her intention to adopt AIDS-infected babies, she became, in her words, "the most despised person in the whole Shenandoah Valley" and could not get the necessary zoning approvals to carry out that plan. On October 6, 1994, her house was set on fire and burned to the ground with the complete loss of all her papers and possessions.

In the meantime, she experienced heart fibrillations and an eventual stroke. Again, Kübler-Ross had a low opinion of the medical treatment she received. She refused to give up smoking, coffee, and chocolate, and checked herself out of the hospital. After moving to Scottsdale, Arizona, Kübler-Ross experienced a massive stroke on May 14, 1995, that left her paralyzed on her left side and no longer able to live alone. While writing in January 1997, Kübler-Ross said she was enduring a "miserable" life resulting from pain and the limitations of her paralysis. Although she was "anxious to graduate" she remained opposed to efforts to foreshorten life (p. 280). Instead, she asserted that "our only purpose in life is growth" and that her task in these circumstances was to learn patience even as she was totally dependent on others for care (p. 281).

On Death and Dying and other books by Kübler-Ross have earned her a worldwide reputation. In addition, large numbers of people have been attracted to her many lectures, presentations, and workshops. Many have credited her with helping to draw attention to problems encountered by dying persons and to their needs as living human beings, thus tending to normalize and humanize such experiences. In all of this, she was an early and important contributor to the death awareness movement. The stage theory of dying that she proposed is simple and easy to learn. Its author and many others have since applied this theory to a wide variety of losses, even while some professionals have criticized its limitations. Her views about the afterlife, spiritual guides, out-of-body experiences, and near-death experiences have been consoling to some, but sharply criticized by others from both scientific and theological perspectives.

See also: DYING, PROCESS OF; NEAR-DEATH EXPERIENCES; STAGE THEORY

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LAST WORDS

Last words have long been a subject of fascination for several reasons. The person about to die is sometimes regarded as having special access to the mysteries of death and afterlife, as well as to spirit visitors such as angels or ancestors. There have been many observations of people close to death apparently seeing and talking with a visitor invisible to others. Often, though, the last words in these interactions are not audible or intelligible to others.

The last words of the influential philosopher Georg Hegel (1770–1831) were eagerly awaited because he was regarded as one of the people most likely to have penetrating insights to offer. Hegel proved a disappointment in that regard. Instead of addressing cosmic issues, he complained about the fact that so few people really understood his writings and even fewer understood him as an individual. The expectation that last words will provide insight and enlightenment seems to be more frequently fulfilled in literature, drama, and cinema than in real-life circumstances.

Another common belief is that the dying person will speak the truth about difficult matters either because there is nothing to lose by doing so or because these disclosures will dissolve a burden of stress and guilt. An example is the Ku Klux Klan member who confessed on his deathbed that he had been responsible for church bombings that took place almost forty years prior to his death.

A related expectation is that people on the verge of death will either affirm or alter their guiding beliefs and values. American patriot Nathan

Hale's words, "I regret that I have but one life to give for my country" as he awaited execution by the British for espionage, is a well-known example of affirmation. Reports of atheists or agnostics embracing religious faith in their last hours are examples of exchanging one set of beliefs for another on their deathbed. Many of the conversion reports have been fallacious. Naturalist Charles Darwin, for example, was rumored to have disavowed his theory of evolution in favor of traditional religious faith. This widely disseminated report served the interests of those who opposed the penetration of science into religious belief. It was soon discovered, however, that the "witness" had never seen Darwin on his deathbed or at any time near the end of his life.

Still another belief is that people will die "in character," saying words that do not necessarily have universal significance but that are consistent with their individual personalities. For example, an adult daughter recalls that she tucked her dying father into bed and kissed him on the forehead before leaving the room. While performing these simple actions she was reminded of how her father had so often done the same for her in childhood: "I was embarrassed when I heard myself say, 'Sleep tight,' but he smiled and said, 'Don't let the bedbugs bite!'" Those were the last words anybody heard from him. The daughter's interpretation was that her father was being himself and saying his farewell in a way that affirmed the lifelong bonds of love between them.

A person's last words may also be treasured by family and friends even if there is nothing

remarkable in their substance—these words will be remembered because they were the last. An eighteenth century French socialite’s last words differed from the aged father’s but were consistent with her personality. Madame Martel de Fontaine had long celebrated the pleasures of romantic love. She declared to her bedside companions, “My consolation at this hour: I am sure that somewhere in the world, someone is making love.”

Diversity of Last Words

Diversity of last words is illustrated by the statements given above. Within this diversity, however, there are many examples of people trying to come to terms with their hopes, fears, and doubts at the last moment. Madame Martel de Fontaine celebrated the pleasures of romantic love that would continue to flourish although no longer for her. Today this would be considered a form of symbolic immortality that might serve to moderate the sorrow of separating from one’s life on the earth. Voltaire, one of Madame de Fontaine’s intimate friends, was on his deathbed in 1778 when flames flared up from the nearby oil lamp. Responding with his quick wit, the famed author and dramatist exclaimed, “What—the flames already?” Not a religious person, Voltaire deftly acknowledged the possibility of damnation while at the same time offering himself the saving grace of humor.

Increase Mather and his son Cotton were among the most illustrious people of Colonial New England. The father’s passionate sermons affirmed Christian faith and inspired his congregation through difficult times. He was a pillar of strength and belief. When death was close, however, Mather did not express the same joyful anticipation he had demonstrated in the pulpit. Cotton saw his father suffer in “*Fear and Trembling, lest he be Deceived at the Last*” (Standard 1977, pp. 79–80). He was assailed by doubts: Despite all his good intentions and good works, perhaps he had allowed himself somehow to be deceived by the devil and was therefore on the verge of damnation rather than salvation. Mather’s anxious final words seem to be at odds with his many public statements, but he doubted only his own personal fate, not his basic Christian faith. “Soul searching” is a familiar phrase that is especially apt for people who are keenly aware of their impending death and have issues of faith and doubt, and hope and fear, to resolve.

Most discussions of last words assume a mental state of clarity near the time of death. Dutch Schultz was one of the most vicious gangsters during the years when bootlegging liquor was a highly profitable criminal enterprise—even other professional gangsters considered him to be excessively wild and dangerous. Dying of bullet wounds, Schultz did not relate directly to his impending death but instead relived a variety of scenes in which he acted out bits of his everyday personality. His last words reflected this mental fragmentation: “Shut up, you got a big mouth! Henry, Max, come over here . . . French Canadian bean soup . . . I want to pay. Let them leave me alone.” Schultz might have been struggling for resolution in his final moments, but the stresses and dysfunctions associated with the dying process can prevent the expression of coherent thoughts.

The distinction between coherent and incoherent statements is sometimes blurred, however. A person close to death might speak in a coded or symbolic manner, when meaning remains a matter of conjecture. One woman, for example, spoke of her cruise to Bermuda: “I have the tickets here some place, the tickets.” She had been aware of her impending death, but also had occasionally surprised visitors with her talk of going on a long cruise. Were her last words confused, evasive—or a subtle way of speaking about her departure? An aged resident in a long-term care facility suddenly wanted to tell everybody about the need to dig an eighth grave. He died unexpectedly and only later was it discovered that he had been the only survivor among eight siblings. His seemingly confused statement now seemed to represent a sense of returning to the family circle and completing their stay on the earth.

The Importance of Last Words

The perceived significance of last words depends as much on cultural expectations as it does on individual circumstances. The final moment may be seen as that instant in which life and death both exercise their claims and, therefore, a parting message can have unique value. There is a tradition within Buddhist and Hindu belief systems in which a person approaching death is expected to offer a meaningful farewell statement. This tradition has been especially compelling for Zen masters whose students and friends await the final words of

wisdom. For more than a thousand years it has been customary that Zen masters spontaneously compose and recite a poem with their last breath. These brief poems are seldom pious or sentimental, nor do they promise a heavenly reward. Most often these poems reflect on dying as part of nature's mysterious transformations. It is not unusual for the parting message to be flavored with tart humor and cautions against taking any system of belief too seriously. The idea of acceptance—both of life and death—is frequently paramount. For example, Zen scholar Sushila Blackman tells of a Zen master who was sitting in meditation with his students when he immediately said:

I am at one with this and only this.
 You, my disciples,
 Uphold it firmly.
 Now I can breathe my last.
 And he did.

(Blackman 1997, p. 93)

In Western culture the most fervent attention to last words has occurred within the tradition of deathbed salvation scenes. Here was the final opportunity to repent sins and affirm faith. It was a frightening prospect to die without the opportunity to give confession. By the same token, priests felt they had to make every possible effort to be with the dying person, even if it were a heretic, criminal, or inarticulate wretch. Governmental authorities also took this obligation seriously. In eighteenth century France, for example, physicians were required by law to see that a confessor was summoned when the patient was near death.

Although concern for the fate of the dying person's soul was paramount, there were other reasons for encouraging a dialogue. Perhaps the dying person had wronged somebody years ago and now could express regrets and ask for forgiveness. Similarly, perhaps the dying person could let go of his or her own anger and forgive somebody for a past injustice or disappointment.

Last words have also proved significant outside of religious considerations. Some people have waited until the last moment to reveal where the hidden financial assets can be found. Many others have shared personal memories with family or intimate friends. With his frail breath, an aged and emaciated man sang a favorite song along with his wife, strong enough only to mouth the words. A woman, exhausted after coping with her long

illness, ordered her faithful niece to return to her own family: "They need you, too. Your life is with your own children." She lived another few days but had nothing more to say.

The opportunity for saying "goodbye" in one way or another is not available to all dying people. Making such communications difficult or impossible are circumstances such as social isolation, where the dying person is alone or seen only occasionally and by people who are not inclined to listen. Other situations that can make "goodbye" difficult include the individual's own communicational and/or cognitive deficits; pain that absorbs energy and attention, undermining the opportunity to interact; devices that interfere with communication (e.g., intubation); or an individual's drug-induced stupor or confusion.

These barriers to end-of-life communication are sometimes the result of inadequate management procedures (i.e., over or under medication or hospital staff who are not given enough time to be with their patients). There are no reliable data on the number of people who have a companion at the time of death and, therefore, somebody who might listen to the last words.

It is clear that last words can be of great importance to the person whose life will soon end. Suicide notes, for example, are often the final communication from a despondent and desperate person. Soldiers in Hitler's Sixth Army, abandoned deep in Russia and under punishing attack, knew that they were going to die soon as they wrote their *Last Letters From Stalingrad* (1961). These were messages of consolation to the wives, children, and parents whom they knew they would never see again. Both Confederate and Union soldiers in the U.S. Civil War also thought carefully about what they wrote in letters, as any could be their last.

Interest in last words can have positive and negative implications—positive because it might encourage continued contact with dying people, and negative because of an overemphasis on the final communication rather than sharing in the entire process.

See also: COMMUNICATION WITH THE DYING; GOOD DEATH, THE; IMMORTALITY, SYMBOLIC; IVAN ILYCH; MOMENT OF DEATH; SOCRATES

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ROBERT KASTENBAUM

LAWN GARDEN CEMETERIES

In contrast to the graveyards that immigrants to North America initially created, the picturesque gardens early and mid-nineteenth century Americans fashioned provided a remarkable set of sites where citizens of means could bury their friends and find respite from the rush of daily life in a parklike setting. Yet, these rural cemeteries also quickly proved to be extremely expensive places for the dead and the living. As a consequence, not long after the opening of America's first rural cemetery in 1831, we find the materialization of a rather different kind of gravescape that sought to address the rising expenses of death and reflects an altogether different sensibility. Tracing the development of this new cemeterial environment thus reveals not only the outlines of a new cemeterial form, but also the appearance of a new way of looking at life and death.

Beginnings

Although signs of a new cemeterial sensibility began to appear in the United States as early as the middle of the nineteenth century, the development of a gravescape that fully reflected that sensibility came largely through the efforts of Adolph Strauch, the superintendent of Cincinnati's Spring Grove Cemetery. Just ten years earlier Spring Grove had been created as part of the wave of rural cemeteries that swept across America, but Americans of modest means quickly fostered the need for a less ornate, more frugal place for their loved ones. Originally, the plan to redesign Spring Grove appears to have been directed primarily at removing the ironwork and coping that even rural cemetery owners often described in derogatory terms. But in 1855 Strauch took the plan several steps beyond reformers' expectations.

After removing the copings and ironwork that defined individual plots, Strauch also eliminated burial mounds, hedges, stone fences, numerous trees, tombs, and gravestones, which growing numbers of citizens thought unnecessarily "break up the surface of the ground, cut it into unsymmetrical sections, destroy the effect of slopes and levels, and chop up what should be the broad and noble features of one great picture into a confused and crowded multitude of what seem like petty yards or pens" (Morris 1997, pp. 145–146). By redesigning through negation Strauch had reconceptualized places of the dead, which transformed the cemetery into a landscape "more spacious and parklike. It ceased to be a motley collection of every style, each enclosed in its own well-defined space, and became instead an integrated composition of lawn and clusters of trees" (Jackson 1972, pp. 70–71).

"Esthetic control"—the elimination of diversity in favor of homogeneity—came most distinctly in the form of rigid rules that the owners of Spring Grove Cemetery instituted to prohibit lot owners from altering their lots. Lot owners could still purchase a single monument to be erected in the center of each lot. But because the lots had been arranged symmetrically to make the most efficient use of the land and to simplify maintenance, the cemetery's owners maintained that small, ground-level markers were more than sufficient to say what needed to be said. Spring Grove's owners also encouraged lot owners to plant a single tree instead



As one contemporary proponent of lawn cemeteries has remarked, Adolph Strauch “created what is known as the lawn cemetery; one in which the size and design and placement of the memorials are subject to esthetic control, and where all extraneous ornaments—railings, plantings, cemetery furniture—are forbidden in order to preserve an open and harmonious environment.” PATRICK BENNETT/CORBIS

of erecting a memorial, and disallowed flower-beds and a host of other individualized efforts that had become hallmarks of rural cemeteries.

A New Kind of Death

Strauch’s reconceptualization through redesign was a radical departure from the values of and sentiments expressed by cemeterial designs not only in the United States, but more globally, as advantages. First, it provided visitors with an open vista, unobstructed by fences, memorials, and trees, where signs of death and the dead find no quarter and where, at least ostensibly, an individual’s societal station or place finds little expression. Second, it allowed cemetery superintendents to make the most efficient use of the land in the cemetery, thereby advancing the view that “individual rights must be subordinated to this general plan.” “Civilization,” according to Matthew Brazil, one of the

lawn cemetery’s early proponents, “consists in subordinating the will of the individual to the comfort and well-being of all” (Farrell 1980, p. 118). Third, by eliminating fences, hedges, trees, and other things associated with the rural cemetery, and by requiring markers to be small enough to be level or nearly level with the ground, proponents were able to eliminate nearly all things they associated with church graveyards and rural cemeteries. Together, as Sidney Hare, another early champion of this gravescape, remarked, these “improvements” allowed citizens to eliminate, albeit gradually, “all things that suggest death, sorrow, or pain” (Farrell 1980, p. 120).

Perhaps the strongest advantage to which proponents of this design could point, however, was that their new cemeterial form considerably lowered the cost of burial. When Mount Auburn, America’s first rural cemetery, opened for public

burials, for example a single lot of 300 square feet cost \$60. By the time Adolph Strauch finished redesigning Spring Grove Cemetery in 1855, the price of a lot at Mount Auburn had increased to \$150, and by 1883 lot prices ranged from \$225 for an “unexceptional lot” to \$750 for “choice lots” (Morris 1997, pp. 147–148). Add to this the cost of an elaborate memorial, creating a burial mound, landscaping the lot, an iron or stone enclosure, as well as the cost of the funeral, and the total was well beyond the modest means of most citizens.

By contrast, as late as 1875 the lot prices at Spring Grove ranged only from thirty to fifty cents per square foot—in equivalent terms, from \$90 to \$150 for a lot of 300 square feet. And, having eliminated elaborate memorials, grave mounds, enclosures of any kind, and the various other things that make burial in the rural cemetery extraordinarily expensive, survivors encountered few costs to add to the price of the funeral itself. As one vocal lawn cemetery advocate, F. B. Perkins, proudly told his readers in 1871, “it is a curious illustration of the power of habit over right reason, to see wealthy proprietors sinking a heavy granite coping around a lot, expending perhaps \$2,500 or \$3,000 for the sake of making the place look like a magnified city ‘area,’ and when placing a monument within it at a cost of say \$2,000 more.” A growing number of Americans were moving rapidly to the conclusion that the “mere statement of the contrast shows how incomparably superior in solemnity and impressiveness is the landscape lawn plan” (Morris 1997, p. 148).

Lawn cemeteries did not take the public mind by storm, as did the rural cemetery, but they did increase in number nearly as swiftly as rural cemeteries had; and in the years following the U.S. Civil War they became the most commonly created gravescape—a clear measure of the influence advocates of this gravescape were beginning to have at the national level. Instead of presenting viewers with markers to remind them of their need to prepare for death or with elaborate memorials nestled in sylvan scenes, as earlier gravescapes had sought to do, the modern lawn cemetery presents viewers with “a landscape more spacious and park-like” (Jackson 1972, p. 70) and with memorials that suggest very little in the way of artistic skill, particularity, or death.

Typically, when memorials consonant with this gravescape appear in other gravescapes, the lack

of cemeterial restrictions result in memorials that are overtly expressive of sentiments compatible with the lawn cemetery’s values. True to the mandates of the Strauch’s design, however, cemeterial rules and regulations in lawn cemeteries require markers to be small and, in the vast majority of instances, flush with the ground. The size and position of the markers thus ensure not only that lot owners will be able to erect memorials in an environment that is clearly indicative of their values, but also that anyone who wishes to bury their friends and loved ones in this gravescape will have exceedingly little opportunity to alter or contradict the scene with incompatible sentiments.

In developing this gravescape cemetery, superintendents and owners successfully eliminated not only those things that rural cemetery owners acknowledged were excesses, but also those things lawn cemetery patrons regarded as excessive—especially efforts to particularize the gravescape, individual lots, or markers. Rather than allowing lot owners latitude to “beautify” the cemetery, cemetery owners and superintendents assumed all responsibility for cemeterial aesthetics. As a consequence, those few “works of art” that do appear in lawn cemeteries are selected and situated by others so that the will of the few may be subordinated to the comfort and well being of the many.

See also: CEMETERIES AND CEMETERY REFORM; CEMETERIES, WAR; FUNERAL INDUSTRY

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RICHARD MORRIS

LAZARUS

Lazarus (in Greek, *Lazaros* or *Eleazaros*, meaning "God hath helped") is the name of a person in the New Testament of the Bible who was resurrected in one of Jesus' most spectacular miracles and certainly the most poignant one. According solely to the Gospel of John (John 11–12), when their brother Lazarus fell deathly ill, Mary and Martha of Bethany send for their friend Jesus. Four days later, upon his arrival, Jesus finds that Lazarus has already died. Weeping, the sisters insist that had Jesus been there, their brother would not have died. Jesus goes to the tomb where Lazarus is buried and weeps. Then he asks that the stone of the tomb be removed and cries: "Lazarus, come out!" The dead man comes out and is freed from his burial cloth. Soon thereafter, on the Saturday before Palm Sunday, Lazarus takes part in the banquet that Simon the Leper gives for Jesus in Bethany (John 12:1–11). No other mention of Lazarus is made in the Gospels. According to a tradition in the Orthodox Church, however, Lazarus later became Bishop of Cyprus.

Although enigmatic (experts do not know much of him before or after his resurrection), the figure of Lazarus is of paramount importance in Christianity. This miracle definitely established the "divinity" of Christ (only a God or a son of God could resurrect someone), which later is confirmed by Christ's own resurrection. Lazarus has since become a metaphor not only for resurrection but also for rebirth, recovery (e.g., the Lazarus Data Recovery company), and rehabilitation.

See also: JESUS; NECROMANCY; REINCARNATION

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JEAN-YVES BOUCHER

LESSONS FROM THE DYING

The major lesson for the living to learn from people facing the end of life is how growth can come through loss. Those who open up to these crises have much to teach.

People living with a life-threatening illness can encourage others to recognize their own priorities; to care about how they relate to others; to use time wisely; to say the simple words of apology and thanks and goodbye; to be honest about anger, protest, and negative feelings; and to recognize the releasing and positive elements of these feelings. Relationships may be healed, anger and resentments laid aside, and sources of meaning discovered together with a new sense of self. Those who are dying can teach others to hold on to hope and to cherish relaxation and creativity.

How do people learn these lessons? They will not do so unless they come close to those who are at the end of life. They will not do so unless they open themselves to true communication, not withdrawing behind often inappropriate activity. People learn when they involve themselves in competent and compassionate practice. They also learn by listening to the stories.

Perhaps the best lessons to be learned are from the patient whose last weeks of life in early 1948 proved to be the inspiration for the modern hospice and palliative care movement. David Tasma, a Polish Jew, died at the age of forty of malignant disease. He left a demanding heritage but full of potential for those who were to take up the challenge of his requests. His small legacy gave a start for St. Christopher's Hospice. In few powerful words, "I'll be a window in your home," he gave what became the founding principles of hospice. Reflection on this phrase grew into a commitment to openness, not only to all who would come for care but among those who would welcome them; openness to the outside and those who would come to learn; and, finally, openness to all future challenges.

Tasma challenged future learning and scientific study with his plea, "I only want what is in your mind and in your heart." Hearing David's appeal for comfort led researcher Cicely Saunders's mind and heart to learn about pain. A surgeon challenged her, "Go and read medicine. It is the doctors who desert the dying and there is so much

more to be learned about pain. You'll only be frustrated if you don't do it properly and the doctors won't listen to you."

After medical training, and over the next seven years (1958–1965), Saunders studied hundreds of patients with end-stage malignant disease. Saunders recorded on tape their expressions of "total pain" with physical, emotional, social, and spiritual elements that make up the whole experience of overwhelming sensation. Their descriptions of such suffering and subsequent relief led to a researchable hypotheses: Regular, oral medication with opioids matched to individual need, constantly reviewed and supplemented with the control of other symptoms, would avoid both increasing doses of medication and drug dependence. Patients given space by freedom from the threat or presence of pain showed how fully they could use the chance to live the end of their lives with character and dignity.

This basic method, learning about pain from people in pain, is now being used around the world. There has been worldwide spread of effective and culturally sensitive ways to meet the needs caused by pain. The work has brought comfort and strength to countless numbers of those facing bereavement and the continual challenge of living on after profound loss. This lesson from those with terminal illness enhanced the humanistic aspect of the practice of medicine as well.

In *Experiment Perilous*, the sociologist Renée Fox illustrates the same theme of learning. She described how a group of doctors, researching the early use of steroids in a ward of mostly young men with various life-threatening conditions, came to terms with uncertainty. During the months of her study, Fox observed that in many ways the patients were the leading players. Like the doctors in this new field, they struggled with uncertainties, and their various ways of coping were remarkably similar. Working as a team led to positive outcomes on both sides.

These lessons illuminate living with and after loss. Worldwide, workers in bereavement support resonate to the same theme. They are not merely dealing with a long defeat of living, but are witnesses to a positive achievement of dying.

Another lesson is in the common theme of human dignity enhanced by the assurance of worth. This philosophy is summed up in the

words, "You matter because you are you and you matter to the last moment of your life. We will do all we can not only to help you die peacefully, but to live until you die" (Saunders 1976, pp. 1003–1005). The message of Mother Teresa, the Buddhist hospices of Taiwan, and the palliative care teams of New York are one and the same as this, though their practice and resources are widely different. The end of life can be desperately unfair as health fades, relationships sour or are broken, and parting can be agonizing. Yet if there is honesty about the negative feelings and reactions, there can be a positive outcome.

Paula, a cancer patient still too young to be facing death, suddenly asked a night nurse what she believed was to come. On receiving a simple answer of faith, Paula said, "I can't say I believe now, not like that. Would it be all right if I just said I hoped?" As this was affirmed, she handed over the false eyelashes she had worn day and night, saying, "You can put them away. I won't need them anymore." The spiritual needs of the dying are not merely appropriate rituals of their religion but far wider, as relevant to atheists as to believers. Practical care needs can be met in an atmosphere that helps the dying find sources of meaning, search and question, be listened to with respect and, if asked, be answered with honesty, even when the answer can only be "I don't know."

A few patients maintain denial to the end. They heroically refuse to face defeat. But most of the dying exhibit how honesty is more creative than deception in human dealings with one another. A man having been told the truth of his approaching death said to his doctor, "Was it hard for you to tell me that?" And then, "Thank you, it is hard to be told but it is hard to tell too." It should be hard; the lesson here is that people must care what they do with their words. Words can hurt or heal; they can open or close exchange and development. People should care how the recipients of their words are affected by their delivery, whether the moment or manner was right. Nor must people forget that others need "time off" from difficult words and truths, which is not the same as denial. Discovering new talents, being creative, and celebrating are important elements in life's ending, as well as throughout it.

The important lesson is surely to recognize priorities and give them true space in one's thinking.

As the dying lose so much, the living see how people matter more than “things.” Expressed in many ways, the search for self is a reminder of what will remain. As the English poet D. H. Lawrence wrote:

There is nothing to save, now all is lost,
But a tiny core of stillness in the heart
Like the eye of a violet.

(Lawrence 1959, p. 117)

People need to look at what really matters, what they will look to as they respond to the urge to move fast in the final crises. For many, it is still in the beliefs that have lasted throughout a lifetime. Many, too, have no religious language but turn to symbol or metaphor. They can be helped to find their own way by sensitive pastoral counseling. As one patient, finally managing the essential step of letting go, said to a sensitive nurse, “My hope is that it will lead me into peaceful waters, sailing on a calm sea. I have expended so much anger in the past and have longed to get rid of it. It seems that this tragedy has taken me on that path at last.”

For the professional, the anger that is part of compassion can be a force for change. The movement for hospice and palliative care has spread around the world as a protest against pain and isolation in confidence that every person matters and that there is a better way.

The dying teach professional caregivers that all people need to be accepted. Every person needs to give as well as receive attention, concern, or love. The professional who is prepared to come close will see how ordinary people overcome adversity and make it the means for growth. There is no hierarchy among such achievements. Who is to say who has done best? Is it the young woman who fills a day center with creativity and a feeling of discovery for weeks on end, never showing how much it costs her? Or is it the old reprobate who manages to stop grumbling for his last few days? There is no place for idealizing each other or for denying that ill-led lives may also end badly.

Coming close to those who are at the end of life and opening up to true communication leads to learning and rewards. The dying teach their caregivers to look at their own needs and the priorities of life—and to never forget that time off and recreation are essential to continuing this particularly taxing work. Hope can rise up in the most adverse circumstances. It is not what death does to the deceased that their loved ones remember, but

rather how the dying challenged those living to look at their thoughts about death and respond to life’s challenges.

See also: GOOD DEATH, THE; HOSPICE OPTION; SAUNDERS, CICELY

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CICELY SAUNDERS

LIFE EVENTS

The product of stress and coping research is the concept of a life event which refers to changes in an individual’s life that are likely to have an impact on subsequent behavior. Such major changes can be either negative, such as death of a close family member, or positive, such as marriage. In addition to important life events, there are small life events—“hassles” or “uplifts.” For example a hassle might be having too many things to do; an uplift might be meeting a good friend.

A person’s life events have been measured frequently by using lists of events that the person has to check. Methodological problems (e.g., unwillingness to report very private problems) have prompted the development of clinical interviews.

Models

Life events have been incorporated into theoretical models designed to explain coping. A well-known example is a model of coping formulated by the

stress researcher R. S. Lazarus, which emphasizes the cognitive evaluation of the event. This evaluation includes the personal relevance of the event, its potential to affect well-being (primary appraisal), and the evaluation of the options one can use for coping (secondary appraisal). A means of analyzing coping processes, this evaluation leads to either favorable or unfavorable resolution (or no resolution) and, possibly, to reappraisal, when there is a change in circumstances. The model was applied to a variety of stressors, including bereavement.

Life Events in a Life Span Perspective

Lazarus's approach was also used to develop a life span. Such a model considers life events in their life-stage or sociohistorical context. Death of a spouse, for example, may have a devastating effect at age thirty-five than at eighty-five. The change in the meaning of a life event, according to its position in the life span, has prompted the gerontologist B. L. Neugarten to distinguish between "on time" and "off time" events.

The life span perspective has encouraged a consideration of life events within the general concept of a life story. Individuals create comprehensive life stories. The life story is recreated and revised in an effort to provide life "with a sense of unity and purpose" (McAdams 1992, p. 344). According to the life-span psychologist D. P. McAdams, particular life events—"nuclear episodes"—show either continuity or change over time. In addition to their conceptualization within a life story, life events can be considered in relation to one's identity. Thus, life-span psychologist S. K. Whitbourne describes experienced events as being either assimilated into one's identity or accommodated by changing to fit the event. An individual who uses assimilation frequently might deny the significance of an age-related sign or a life-threatening disorder. An "accommodative" type, on the other hand, might overreact to such signs, perceiving himself or herself as an old person.

Death As a Life Event

Is death a life event? Obviously any biography of a deceased person would include death along with other events. The death of a person can also be a life event in another person's life, as in the case of death of a close relative. It is less clear

whether one's own death is a life event. For example, while one's own death indicates a major change in life, one cannot cope with this change if we consider death to be the disappearance of the subject (of course one can still try to cope with his or her own dying).

The German philosopher Martin Heidegger (1889–1976), in his famous analysis of death in *Being and Time*, originally published in 1927, indicates that death is not an event but rather an existential phenomenon. For the subject, death exists at all times as a possibility, the possibility of the subject's inexistence. While the individual does not have to deal with his or her death as a lived life event, he or she still has to deal with it as a matter of concern for oneself. For Heidegger the relationship to death is founded in the general structure of the human being (*Dasein*) as a being that is concerned about itself. Heidegger calls this basic state of the being care and writes, "With regards to its ontological possibilities, dying is grounded in care" (p. 233). Heidegger saw death as a possibility of being that provides both individuality (no one can die in my place) and wholeness (my life exists as a totality only upon my dying). Therefore, the right attitude toward death is one of anticipation.

Among the major critics of Heidegger's construction of death, French philosopher Jean-Paul Sartre argued powerfully that death, far from giving meaning to life, deprives life of meaning. Therefore, according to Sartre, one cannot "await" his or her death. In fact, because meaning can exist only insofar as there is a future toward which one can project oneself, death deprives such an anticipation of its very meaning.

Such analyses raise the following question: Is there a correct description of "my death"? It is indeed possible to argue that no description is correct and that we are free to construct death as part of the process of creating a life story. In any case, it is likely that the way one constructs death will affect an individual's emotional attitudes toward it and toward life.

Avoiding Death

Negatively constructing death may increase the need to use protective defenses; for example, one simply might want to avoid thinking about the event. Denial as a defense mechanism might be particularly suitable when facing the end of one's

life, either because of illness or because of the actions of other people (e.g., prisoners in concentration camps). In less extreme situations, individuals are likely to use more subtle forms of denial. In *The Denial of Death* (1973), anthropologist Ernest Becker discusses ways to avoid coming to grips with the reality of one's mortality by integrating in a cultural system. Both Becker and terror-management theorists see self-esteem as an important psychological part of the "buffering mechanism." In essence, one who feels good about fulfilling a role in society thinks of herself as valuable and, perhaps, immortal.

Acceptance of Death

People differ in the way they construct death. Those who view death as threatening tend to distance themselves from it. On the other hand, death can be constructed as in a way that reflects acceptance. A distinction can be made between three types of acceptance. Escape acceptance sees death as a better alternative to a very low quality life; neutral acceptance sees death as integral to life; and approach acceptance sees death as the gate to a happy afterlife. The acceptance of death among older people prompted Wong to include a spiritual dimension of meaning (involving death acceptance) in a definition of successful aging.

A congruent notion, the socioemotional selectivity theory, attempts to define perceptual changes that accompany a growing awareness of the finite nature of time, most notably paying increased attention to meaning of things, quality of relationships, positive aspects of existence, and the importance of goals. People develop a sense of appreciation of a finite life as opposed to a sense of entitlement to an infinite one. These ideas are germane to a large literature suggesting that confrontation of death and finitude may promote a sense of urgency and help one to live more fully.

Meaning Reconstruction in Grief

As pointed out by death and grief researcher Robert Neimeyer, "Meaning reconstruction in response to a loss is the central process in grieving." A central task for a theory of bereavement is therefore to specify how loss affects meaning and the restoration of meaning. For example, it is possible to distinguish between two types of meaning: meaning as making sense of the loss, and meaning

as finding some benefits in the aftermath of the loss. The first might relate to the task of rebuilding a threatened worldview while the second focuses on the self.

The potential success of meaning reconstruction is evident in the frequency with which positive emotions follow a great loss. The reconstruction of meaning may bring about a reappraisal of bereavement. To account for such a reconstruction, Folkman revised the original Lazarus-Folkman model by adding meaning-based coping processes that are distinct from the ones that regulate distress and that promote positive emotions.

Conclusion

In the early twenty-first century, while substantial numbers of people die early, death occurs mostly in old age in developed countries. Nevertheless, both one's own death and the death of a person close to him or her, even when expected, can seriously affect his or her system of beliefs and sense of meaning. Acceptance of death requires the active construction of meaning throughout the life span.

See also: ANXIETY AND FEAR; BECKER, ERNEST; PSYCHOLOGY

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ADRIAN TOMER

LIFE EXPECTANCY

Life expectancy refers to the number of years that people in a given country or population can expect to live. Conceptually, life expectancy and longevity are identical; the difference between them lies in measurement issues. Life expectancy is calculated in a very precise manner, using what social scientists call "life table analysis." Longevity

is not associated with any particular statistical technique. Both life expectancy and longevity are distinct from life span, which refers to the number of years that humans could live under ideal conditions. While life expectancy is based on existing data, life span is speculative. Partly because of its speculative nature, there is considerable debate about the possible length of the human life span. Some social scientists argue that Western populations are approaching a biologically fixed maximum, or finite life span, probably in the range of 85 to 100 years. Others believe that the human life span can be extended by many more years, due to advances in molecular medicine or dietary improvements, for example. An intermediate position is taken by other researchers, who suggest that there is no rigid limit to the human life span and as-yet-unforeseen biomedical technological breakthroughs could gradually increase life span.

A considerable amount of research, based on the foundational assumption of a finite human life span, has focussed on the concept of dependency-free life expectancy (also called dependence-free life expectancy, healthy life expectancy, active life expectancy, disability-free life expectancy, and functional life expectancy). These varying terms refer to the number of years that people in a given population can expect to live in reasonably good health, with no or only minor disabling health conditions. Most of the research on dependency-free life expectancy tests, in varying ways, the validity of the compression of morbidity hypothesis, originally formulated by the researcher James F. Fries in 1983. This hypothesis states that, at least among Western populations, proportionately more people are able to postpone the age of onset of chronic disability; hence, the period of time between onset of becoming seriously ill or disabled and dying is shortening or compressing. Research findings on morbidity compression are variously supportive, negative, and mixed.

The Measurement of Life Expectancy

Life expectancy is a summary measure of mortality in a population. Statistics on life expectancy are derived from a mathematical model known as a life table. Life tables create a hypothetical cohort (or group) of 100,000 persons (usually of males and females separately) and subject it to the age-sex-specific mortality rates (the number of deaths per

1,000 or 10,000 or 100,000 persons of a given age and sex) observed in a given population. In doing this, researchers can trace how the 100,000 hypothetical persons (called a synthetic cohort) would shrink in numbers due to deaths as they age. The average age at which these persons are likely to have died is the life expectancy at birth. Life tables also provide data on life expectancy at other ages; the most commonly used statistic other than life expectancy at birth is life expectancy at age sixty-five, that is, the number of remaining years of life that persons aged sixty-five can expect to live.

Life expectancy statistics are very useful as summary measures of mortality, and they have an intuitive appeal that other measures of mortality, such as rates, lack. However, it is important to interpret data on life expectancy correctly. If it reported that life expectancy at birth in a given population is 75 years in 2000, this does not mean that all members of the population can expect to live to the age of 75. Rather, it means that babies born in that population in 2000 would have a life expectancy at birth of 75 years, if they live their lives subject to the age-specific mortality rates of the entire population in 2000. This is not likely; as they age, age-specific mortality rates will almost certainly change in some ways. Also, older people in that population will have lived their life up to the year 2000 under a different set of age-specific mortality rates. Thus, it is important to be aware of the hypothetical nature of life expectancy statistics.

Life tables require accurate data on deaths (by age and sex) and on the population (by age and sex); many countries lack that basic data and their life expectancy statistics are estimates only. However, age-specific mortality tends to be very predictable; thus, if the overall level of mortality in a population is known, it is possible to construct quite reasonable estimates of life expectancy using what are called model life tables.

Life Expectancy at Birth, Circa 2001

Life expectancy at birth for the world's population at the turn of the twenty-first century was 67 years, with females having a four-year advantage (69 years) over males (65 years); see Table 1. As expected, developed countries experience substantially higher life expectancy than less developed countries—75 years and 64 years, respectively.

TABLE 1

| Life expectancy at birth by world region, 2001 | | | |
|--|-------|-------|---------|
| Area | Total | Males | Females |
| World | 67 | 65 | 69 |
| Developed countries | 75 | 72 | 79 |
| Less developed countries | 64 | 63 | 66 |
| Africa | 54 | 52 | 55 |
| Asia | 67 | 65 | 68 |
| Asia (excluding China) | 64 | 63 | 66 |
| Latin America (and Caribbean) | 71 | 68 | 74 |
| Europe | 74 | 70 | 78 |
| North America (U.S. and Canada) | 77 | 74 | 80 |

SOURCE: Population Reference Bureau. *2001 World Population Data Sheet*. Washington, DC: Population Reference Bureau, 2001.

Also, the gender difference in life expectancy that favors females is larger in the developed countries (seven years) than in the less developed parts of the world (three years). Regionally, North America (the United States and Canada) has the highest life expectancy overall, and for males and females separately. It might be expected that Europe would have this distinction and, indeed, there are a number of European countries with life expectancies higher than in North America; for example, the Scandinavian countries and the nations of Western Europe. However, the European average is pulled down by Russia; in 2001, this large country of 144 million people has a male life expectancy at birth of only 59 years and a female life expectancy at birth of 72 years. Male life expectancy in Russia declined over the last decades of the twentieth century, and shows no indication of improvement. A considerable amount of research has focused on the trend of increasing mortality (and concomitant decreasing life expectancy) among Russian men, pointing to a number of contributing factors: increased poverty since the fall of communism, which leads to malnutrition, especially among older people, and increases susceptibility to infectious diseases; unhealthy lifestyle behaviors, including heavy drinking and smoking, sedentary living, and high-fat diets; psychological stress, combined with heavy alcohol consumption, leading to suicide; and a deteriorating health care system.

With the exception of Russia (and Eastern Europe more generally), life expectancy at birth does not vary much within European and North American populations. However, the less developed countries have considerably more range in mortality, as measured by life expectancy at birth. This can be seen in Table 1, which shows a range in life expectancy at birth among females from 55 in Africa to 74 in Latin America. It is clear that Africa lags behind the rest of the world in achieving improvements in life expectancy. However, even within Africa, large differences in life expectancy exist. Life expectancy at birth (both sexes combined) statistics range from the low seventies (in Mauritius (71), Tunisia (72) and Libya (75)) to the low forties (in Swaziland and Zimbabwe (both 40), Niger and Botswana (both 41)) with one country—Rwanda—having an estimated life expectancy at birth of only 39 years.

Life Expectancy at Birth in African Countries: The Role of HIV/AIDS

The HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) epidemic has, thus far, hit hardest in parts of Africa, especially sub-Saharan Africa, which contains approximately 70 percent of the world's population with HIV/AIDS. Many of the African countries with the lowest life expectancies have the highest rates of HIV/AIDS infection. However, this is not always the case; for example, Niger and Rwanda, mentioned above as countries with very low life expectancies, do not have high rates of HIV/AIDS in their populations. Thus, AIDS cannot solely account for low life expectancy in Africa; social and political upheaval, poverty, and the high risk of death due to other infectious (and parasitic) diseases cannot be discounted in the African case. Nevertheless, HIV/AIDS does have a devastating impact on life expectancy in many places in Africa. The United Nations projects that by 2050 the effect of the AIDS epidemic will be to keep life expectancy at birth low in many sub-Saharan African countries, perhaps even lower than that experienced in the latter part of the twentieth century. Figure 1 shows two projected life expectancy at birth statistics for seven sub-Saharan African countries, one based on the assumption that HIV/AIDS continues to claim lives prematurely, and the other based on the optimistic assumption that HIV/AIDS was to disappear immediately. The

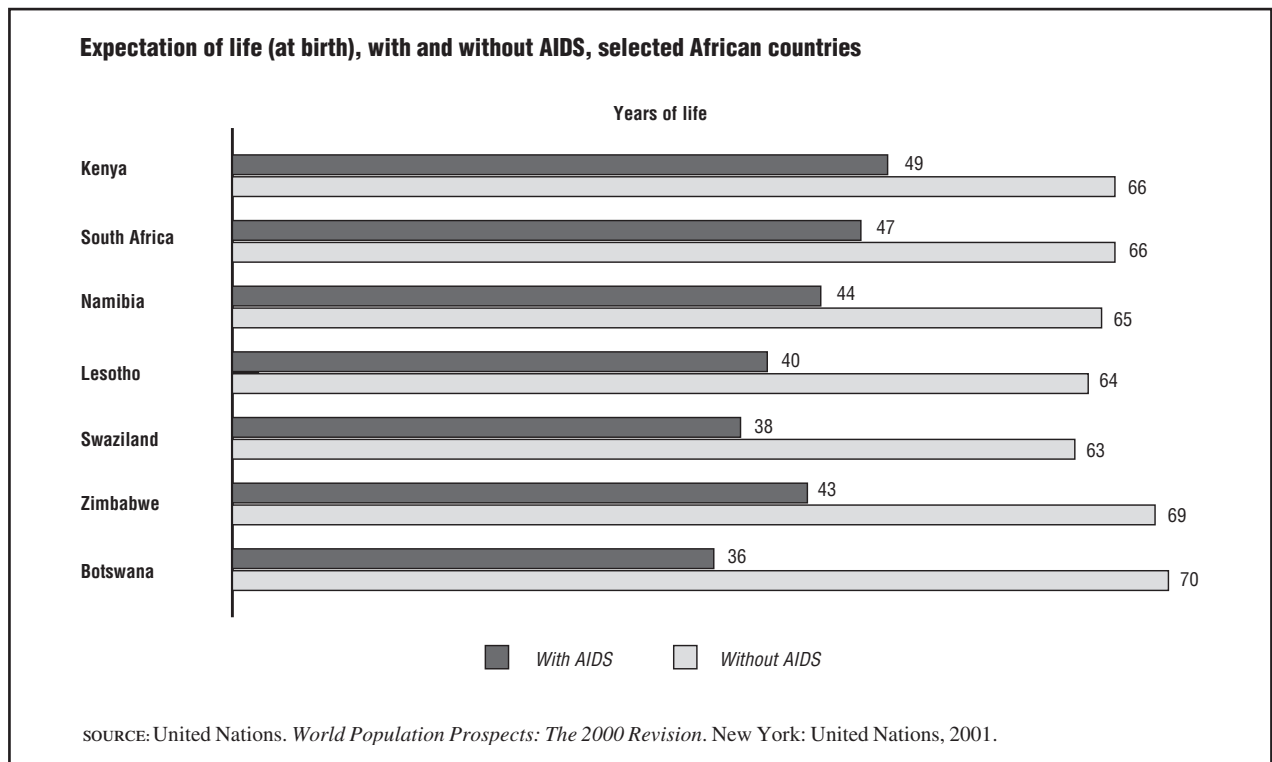
effect of HIV/AIDS is to keep life expectancy in 2050 at levels well under 50; in the absence of the pandemic, life expectancy at birth would improve to the 65 to 70 year range. The projections based on the continuation of HIV/AIDS mark a sad departure for the demographers who make them. Until the 1990s, projections were based on a taken-for-granted assumption that life expectancy would gradually improve. And, for the most part, subsequent mortality trends backed up that assumption.

Trends in Life Expectancy at Birth in Developed Countries

In the developed countries, the fragmentary data that are available suggest that life expectancy at birth was around 35 to 40 years in the mid-1700s, that it rose to about 45 to 50 by the mid-1800s, and that rapid improvements began at the end of the nineteenth century, so that by the middle of the twentieth century it was approximately 66 to 67 years. Since 1950 gains in life expectancy have been smaller, approximately eight more years have been added (see Table 2).

The major factors accounting for increasing life expectancy, especially in the period of rapid improvement, were better nutrition and hygiene practices (both private and public), as well as enhanced knowledge of public health measures. These advances were particularly important in lowering infant mortality; when mortality is not controlled, the risk of death is high among infants and young children (and their mothers), and the major cause of death is infectious diseases (which are better fought off by well-fed infants and children). Being that a large proportion of deaths occurs to infants and young children, their improved longevity plays a key role in increasing life expectancy at birth. The period from the late 1800s to 1950 in the West, then, saw significant improvement in the mortality of infants and children (and their mothers); it was reductions in their mortality that led to the largest increases in life expectancy ever experienced in developed countries. It is noteworthy that medical advances, save for smallpox vaccination, played a relatively small role in reducing infant and childhood mortality and increasing life expectancy.

Since the middle of the twentieth century, gains in life expectancy have been due more to

FIGURE 1

medical factors that have reduced mortality among older persons. These reductions are harder to achieve than decreases in infant mortality; hence, improvements in life expectancy at birth have slowed down. However, reductions in deaths due to cardiovascular disease, cancer (at least for some kinds), and cerebrovascular disease (strokes)—the three major takers-of-life in developed countries—as well as in other types of chronic and degenerative disease have gradually taken place, and life expectancy continues to improve. Nevertheless, looking at the twentieth century as a whole, reductions in mortality among younger persons played the major role in increasing life expectancy at birth; for example, 58 percent of the gain in American life expectancy over the century was due to mortality reductions among persons aged under 20 and a further 17 percent can be accounted for by reductions among the age group 20 to 39.

Trends in Life Expectancy in Less Developed Countries

Very little improvement in life expectancy at birth had occurred in the third world by the middle of the twentieth century. Unlike the developed countries, which had a life expectancy at birth of 67

TABLE 2

Life expectancy at birth by world region, 1950–2000

| Area | Years | | | | | |
|---------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | 1950 –1955 | 1960 –1965 | 1970 –1975 | 1980 –1985 | 1990 –1995 | 1995 –2000 |
| World | 46 | 52 | 58 | 61 | 64 | 66 |
| Developed Countries | 67 | 70 | 71 | 73 | 74 | 74 |
| Less Developed Countries | 41 | 48 | 55 | 59 | 62 | 64 |
| Africa | 38 | 42 | 46 | 49 | 53 | 54 |
| Asia | 41 | 48 | 56 | 60 | 65 | 66 |
| Latin America (and Caribbean) | 51 | 57 | 61 | 65 | 69 | 70 |
| Europe | 66 | 70 | 71 | 72 | 73 | 73 |
| North America (U.S. and Canada) | 69 | 70 | 72 | 75 | 76 | 77 |

SOURCE: Yaukey, David, and Douglas L. Anderton. *Demography: The Study of Human Population*. Prospect Heights, IL: Waveland, 2001.

years at that time, the third world's life expectancy approximated 41 years—a difference of 26 years. However, after the end of World War II, life expectancy in the developing countries began to increase very rapidly. For example, between 1950

and 1970, life expectancy at birth improved by 14 years (see Table 2). Mortality decline was faster than in the West during its period of most rapid decline, and it was much faster than in the West over the second half of the twentieth century. By the end of the century, the 26-year difference had been reduced to 10 years (although Africa lags behind the rest of the developing world).

The rapid improvement in life expectancy at birth in the third world occurred for different reasons than in the West. In the West, mortality declined paralleled socioeconomic development. In contrast, in the developing countries, mortality reductions were, in large part, due to the borrowing of Western death-control technology and public health measures. This in part was the result of the post-cold-war that saw the United States and other Western countries assist nonaligned countries with public health and mortality control in order to win their political allegiance. Whatever the political motives, the result was very successful. As in the West, life expectancy at birth was initially improved by controlling the infectious diseases to which infants and children are particularly susceptible and was accomplished by improvements in diet, sanitation, and public health. In addition, the third world was able to benefit from Western technology, such as pesticides, which played a major role in killing the mosquitoes that cause malaria, a leading cause of death in many countries. This exogenously caused reduction in mortality led to very rapid rates of population growth in most third world countries, creating what became known as the “population bomb.” It also left these poor countries without a basic health (and public health) infrastructure, making them vulnerable to the effects of cutbacks in aid from foreign (Western) governments and foundations. It is in such a context that many third world countries (especially in sub-Saharan Africa but also in Southeast Asia and the Caribbean) are attempting to deal with the HIV/AIDS crisis, as well as a number of infectious diseases that were believed to have been conquered but have resurfaced through mutations.

It is difficult to predict if life expectancy differences at birth between the more and less developed countries will continue to converge. On the one hand, further increases in life expectancy in the West will be slow, resulting from improvements in the treatment and management of chronic diseases among older people. Theoretically, it

would be expected that the third world could, thus, continue to catch up with West. However, new infectious diseases such as HIV/AIDS and the re-emergence of “old” infectious diseases, sometimes in more virulent or antibiotic resistant forms, are attacking many third world countries that lack the resources to cope.

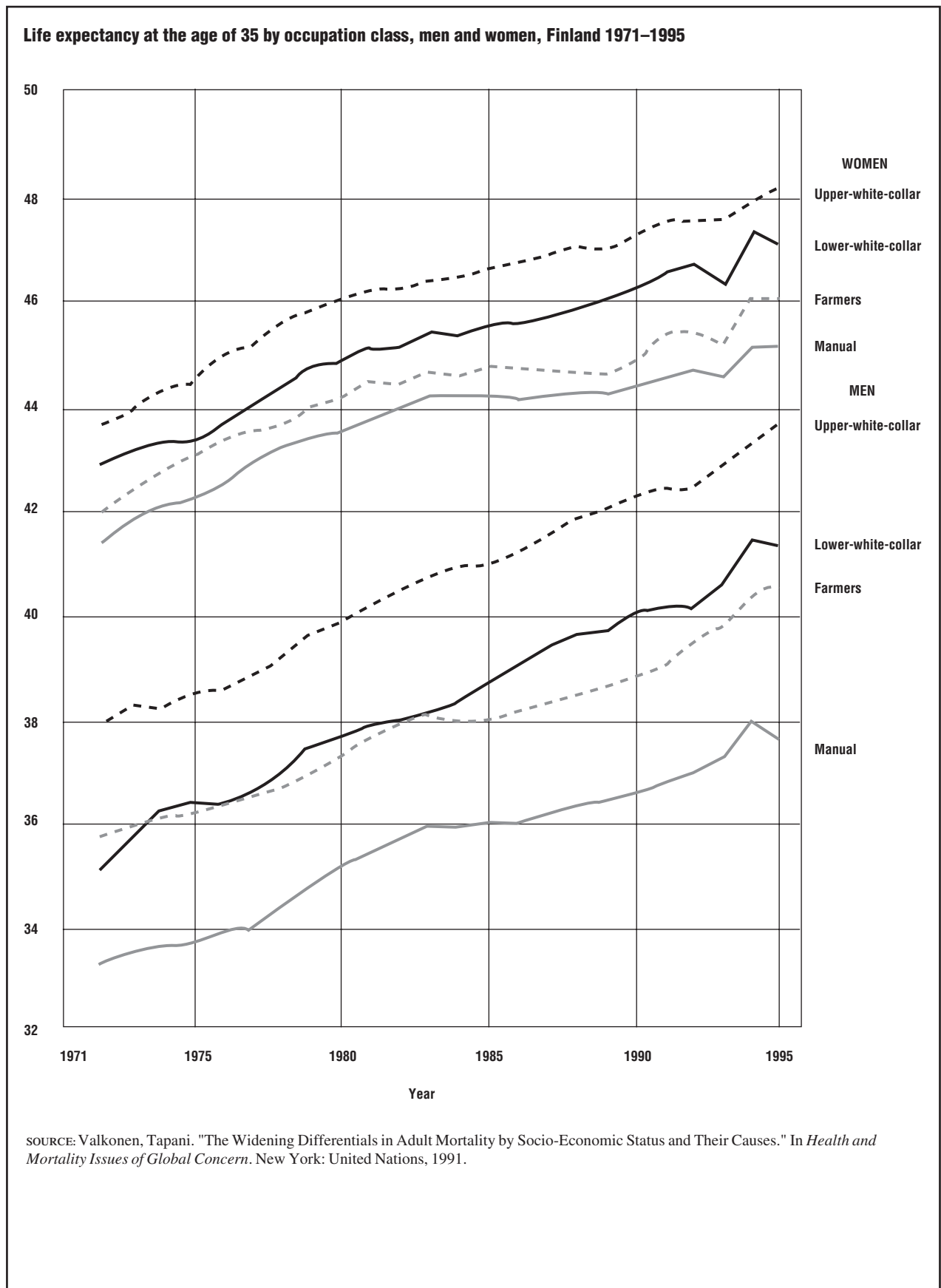
Differentials in Life Expectancy at Birth

Within populations, differences in life expectancy exist; that is, with regard to gender. Females tend to outlive males in all populations, and have lower mortality rates at all ages, starting from infancy. However, the degree to which females outlive males varies; as seen in Table 1, the difference is around three years in the less developed countries and approximately seven years in developed countries.

Another difference in life expectancy lies in social class, as assessed through occupation, income, or education. This research tends to deal with life expectancy among adults, rather than at birth. The earliest work on occupational differences was done in England using 1951 data; in 1969 the researcher Bernard Benjamin, grouping occupations into five classes, found that mortality was 18 percent higher than average in the lowest class, and 2 percent lower than average in the highest class. In the United States in 1973, Evelyn Kitagawa and Philip Hauser, using 1960 data, found that both higher education and higher income were independently associated with longer life expectancy, that is, having both high income and high education was more advantageous than just having one or the other. This was later replicated by researchers in 1993, with the additional finding that the socioeconomic difference was widening over time.

Data on social class differences in life expectancy are difficult to obtain, even in highly developed countries. A 1999 study by Tapani Valkonen contains exceptionally good data on occupational differences in life expectancy in Finland. Figure 2 shows life expectancy at age 35 for four classes of workers, by gender, for the period of 1971 to 1996. While this figure indicates that life expectancy differences by occupation show a female advantage for all occupations and that male longevity differentials are much bigger than female ones, the most important information conveyed for the purposes here is that the occupational gap in

FIGURE 2



life expectancy increased over the period. This finding concurs with that for the United States.

It is not clear why socioeconomic differences in adult life expectancy are growing in Western populations. The major cause of death responsible for the widening differential is cardiovascular disease; persons of higher social classes have experienced much larger declines in death due to cardiovascular disease than persons of lower classes. It is possible that the widening is only temporary, the result of earlier declines in cardiovascular mortality among higher socioeconomic groups. Or, it may be that the widening reflects increasing polarization in health status and living conditions within Western populations. It does not appear that differences in access to health care are responsible, seeing as the trend appears in countries that both have and do not have national medical/health insurance.

Another difference in life expectancy relates to race/ethnicity. For example, in the United States, the expectation of life at birth for whites is six years higher than for African Americans. However, the difference in life expectancy at age sixty-five is less than two years. The narrowing gap with age suggests that mortality associated with younger age groups is an important factor; this inference is reinforced by high rates of homicide among African Americans, especially young males. Ethnic differences in mortality are not unique to the United States. Among countries with reliable data, it is known that the Parsis in India and the Jews in Israel have lower mortality than other ethnic groups; they share, along with whites in the United States, a place of privilege in the socioeconomic order.

See also: AIDS; CAUSES OF DEATH; PUBLIC HEALTH

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ELLEN M. GEE

LIFE SUPPORT SYSTEM

The phrase "life support" refers to the medications and equipment used to keep people alive in medical situations. These people have one or more failing organs or organ systems, and would not be able to survive without assistance. The organs and organ systems that often fail and require life support are breathing (respiratory system); heart and blood pressure (cardiovascular system); kidney (renal system); and intestines (gastrointestinal system). The brain and spinal cord (central nervous system) may also fail, but in this case life support

is directed at keeping the other body systems functioning so that the nervous system has time to return to a state where it can again support the other body functions. The most common types of life support are for the respiratory, cardiovascular, renal, and gastrointestinal systems.

Respiratory System

Oxygen is the basic method for improving the function of lungs. When the lungs do not function properly because they cannot transmit the oxygen across the lung to the blood, or internal temporary (asthma) or permanent (emphysema) changes make the lungs work inefficiently, adding oxygen may often overcome the defect. The problem usually resides in the lungs, but is sometimes in the blood's oxygen carrying capacity, such as in some poisonings.

In the case of severe illnesses or injuries, oxygen alone may not be sufficient. Often the mechanical problem is so severe that, to keep the person alive, a machine must assume the work of breathing. While patients in these situations may temporarily be sustained when a health care professional forces air into their lungs using a bag-valve mask, they will nearly always need a tube placed into their trachea (endotracheal tube) before they are placed on a ventilator. The clear polyvinyl endotracheal tubes can be placed through the mouth in most cases or the nose. Shorter tracheostomy tubes serve the same purpose and are placed surgically, through incisions in the front of the neck. Both can be initially connected to bags that are squeezed to help the patient breathe. Patients are then placed on ventilators.

Ventilators are machines that push oxygenated, humidified, and warmed air into the lungs. These sophisticated machines monitor, among other things, the amount of oxygenated air flowing into the patient with each breath, the pressure needed to deliver that amount of air, and the resistance in the patient's lungs. Patients nearly always need medications to help them tolerate being on a ventilator. These include drugs that induce reversible paralysis, sedatives, and, when necessary, analgesics.

Special ventilators are sometimes used for children, and premature neonates now receive surfactant, which are medications that reduce alveolar surface tension, to help their lungs remain open

while they develop. Adults with life-threatening spasms in their airways receive medications to reverse or prevent them.

When a lung collapses, or when blood or fluid fills a patient's chest outside the lung (pleural space) so that breathing becomes difficult, clinicians place a tube (chest or thoracostomy tube) through the chest wall to drain the fluid or air and to re-expand the lung.

Cardiovascular System

The most common method to support patients with life-threatening abnormalities of the heart or blood vessels (cardiovascular system) is with medications. These include the vasopressors used to raise the blood pressure and antiarrhythmics used to slow, increase, or normalize the heart's rhythm. Other medications used to stabilize the cardiovascular system in life-threatening situations include antihypertensives, used to lower severely high blood pressure when organs are suffering severe damage, such as during a stroke or heart attack, and diuretics to drain excess fluid from the body so that the heart has less work to do.

The heart can be mechanically assisted to function normally. Patients with life-threatening heart rhythms can be cardioverted (shocked with electricity) back into a normal rhythm. Sometimes a temporary cardiac pacemaker must be placed when the heart's electrical system fails. Patients may also be placed on either a partial or complete mechanical system to support the heart. One of several partial systems, the Left Ventricular Assist Device, is passed through a groin artery to temporarily assume some of the heart's work until it can regain its ability to function independently. Patients sometimes go on a heart-lung bypass machine (aside from surgery) in order to maintain their heart while they are treated. Some centers also use artificial hearts, usually to maintain patients until they can receive a permanent heart transplant.

If sufficient fluid collects around the heart, it can decrease the heart's ability to function. In those cases, clinicians must perform pericardiocentesis, drawing fluid off so the heart again functions. If the heart stops, clinicians perform cardiopulmonary massage or open-chest cardiac

massage in an attempt to restore an effective cardiac rhythm.

Renal System

The renal system (kidneys, ureters, and bladder) can fail acutely, causing a threat to life. Many of these patients can only be kept alive through using an artificial kidney system, known as dialysis. In some cases, this may only be used for a short time; for many patients, they spend the rest of their lives—or until they receive a kidney transplant—on this artificial blood-cleansing system. Patients can use either peritoneal dialysis or hemodialysis. Peritoneal dialysis involves instilling into and withdrawing from the abdomen liters of special dialysate (water with a careful mixture of chemicals) each day. Hemodialysis, usually performed three times a week at special centers, uses a shunt, usually in an extremity, to connect the patient to a hemodialysis machine.

Gastrointestinal System

Many patients on life support cannot take in enough calories to sustain themselves, even if they can eat. They receive artificial nutrition and hydration, essentially medically instilled supplements, to keep them alive. These may be given through nasogastric tubes for a limited period of time. Many receive this therapy through central lines (long catheters passing into the larger veins), gastrostomy tubes, or similar surgically placed devices.

Other Types of Life Support

Life support may also include blood and blood product transfusions and many types of drugs. Many patients receive insulin, sometimes as insulin drips, if they are in diabetic crisis. Other patients, especially those with cancers affecting their spinal cord or bone marrow, may receive emergency anticancer drugs or radiation therapy.

Futility and Trials of Therapy

Clinicians may use life support appropriately or inappropriately. The most common appropriate use is to maintain patients long enough so that the individuals' organ systems return to a life-sustaining level of function. In some cases, such as patients with degenerative neurological diseases (i.e., amyotrophic lateral sclerosis, commonly



An intensive-care patient is aided by several of the many life support systems available. PHOTO RESEARCHERS

called Lou Gehrig's Disease) or kidney failure, support for a failing organ may become chronic. In the former case, patients may elect to be placed on ventilators to support their breathing, while in the latter they usually receive dialysis.

Life support is often used inappropriately to maintain patients beyond the point at which it is clear that they have no chance of recovery, sometimes called "futile treatment." Such patients often have failure in multiple organ systems and one or more severe underlying diseases. Futile and medically inappropriate interventions may violate both the ethical and medical precepts generally accepted by patients, families, and physicians. Most of those who receive such futile treatment are elderly, although futile treatment seems to be

more common among the much smaller number of young people dying in hospitals. As shown by Rivera and colleagues, families are responsible for continuing futile treatment in the majority of cases, although it is sometimes accompanied by family dissent over the right course of action. Physicians continue futile treatment in only about one-third of such cases, sometimes because of liability fears. Unreasonable expectations for improvement were the most common underlying factor. Bioethics consultations can often resolve issues of unwanted or non-beneficial medical treatments.

To be on life support the patient must still be alive. However, these systems may be used to maintain the body of an individual who has been declared dead by brain criteria (brain dead) until

critical organs, such as the heart, lungs, liver, kidneys, and pancreas, can be recovered in the operating room. Occasionally these systems are also continued for such a patient until families arrive or until they have come to terms with the death. In these cases, however, they are simply called support rather than life support.

When patients are recovering and as long as they or their surrogate decision makers want medical treatments, continuing life support is appropriate. When it becomes unclear whether the treatment will be of benefit, it is often appropriate for the family (or patient) and the clinician to use a time-limited trial of therapy. This is a decision to use life support for a specific period of time; if there is no improvement at that point, everyone agrees that the support will be stopped.

See also: ADVANCE DIRECTIVES; CRUZAN, NANCY; PERSISTENT VEGETATIVE STATE; QUINLAN, KAREN ANN; RESUSCITATION; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE

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KENNETH V. ISERSON

LINCOLN IN THE NATIONAL MEMORY

At 10:30 P.M. on April 14, 1865, while Major Henry Reed Rathbone, Clara Harris, Mary Todd Lincoln, and Abraham Lincoln watched the third act of *Our American Cousin* from the state box in John Ford's theater, twenty-six-year-old John Wilkes Booth entered the box, aimed his derringer, and discharged a shot that struck the left side of the president's head. Nearly three weeks later, following a series of dramatic funeral pageants stretching from Washington, D.C., to Springfield, Illinois, Lincoln's

body was laid to rest and his place in national memory began in earnest.

An Immediate Context

Some may find it difficult to imagine that Lincoln's contemporaries would not have responded to his death with as much pomp and circumstance and devotion as they could command. Because Lincoln has become such an integral part of the nation's image, and because citizens have witnessed similar tributes during the intervening years, the pageantry and emotionality occasioned by his death, somehow may appear appropriate, inevitable, and, therefore, perhaps rather unremarkable. But this vantage point overlooks an immediate context that makes both contemporaneous responses to his death and his current status as one of the nation's most beloved and legendary presidents entirely remarkable.

In the best of times before his death Lincoln was only a moderately popular president. At other times "Lincoln was the object of far more hatred than love" (Hanchett 1983, p. 7). In the election of 1860 Lincoln received only 39 percent of the popular vote—the second lowest percentage of anyone ever elected to the presidency. Lincoln not only failed to carry a single slave state in this election, he also received only 26,388 of the 2.5 million votes cast in the slave states. Nor did he fare well in the urban North. As the historian David Potter has noted, "Whereas the North as a whole gave him 55 percent of its votes, in seven of the eleven cities with populations of 50,000 or more, he failed to get a majority" (Potter 1976, p. 443). Further, although Lincoln received 180 of the 303 electoral votes, which gave him 27 more than he needed to win the election, his margin of victory very likely was more a result of good strategists and the support of his Secretary of State William Seward, than of Lincoln's popularity. This is particularly telling in light of the fact that the electoral college inflates the margin of victory.

In the election of 1864 Lincoln received 55 percent of the popular vote and 212 of the 233 electoral votes, which seems to imply that his popularity increased significantly during his first term in office. However, several points strongly suggest the opposite. Given the generally accepted belief that changing leaders in the middle of an all-consuming war invites catastrophe, for example,

55 percent of the popular vote and 212 of the electoral votes hardly seem resounding expressions of confidence or popularity. Moreover, the population of the United States increased by more than 4 million between 1860 and 1864; there were several more potential voters in 1864 than there had been in 1860; the states that had seceded did not participate in the election of 1864; and Lincoln actually received nearly 700,00 fewer votes in 1864 than he had received in 1860—all of which adds an interesting dimension to Lincoln's contemporary status.

Even more telling indicators of Lincoln's status in the eyes of many of his contemporaries are the attacks people so frequently and openly made against his character, the constant threats to his life, and the glaring references, even in eulogies, to his flaws. Both North and South "newspapers were filled with suggestions for violence against the president" (Turner 1982, p. 69). In addition, "threatening letters arrived [at the White House] continuously and in large numbers" (Hanchett 1983, p. 23). It is difficult to know whether these constant threats would have been acted out or whether persistent rumors of organized efforts to kidnap or assassinate Lincoln had any firm basis in reality. One assassination effort obviously did come to fruition, and even then criticisms of Lincoln did not cease.

When an individual dies, as Sigmund Freud pointed out, the living typically "suspend criticism of [them], overlook [their] possible misdoings, issue the command: *De mortuis nil nisi bene*, and regard it as justifiable to set forth in the funeral oration and upon the tombstone only that which is most favourable to [their] memory" (Freud 1953, p. 16). Most citizens appear to have abided by that dictum; or, at least, most manifested some degree of restraint subsequent to Lincoln's death. Many others did not.

None of this is to suggest that Lincoln was hugely unpopular, that a majority of citizens disliked him or disapproved of his policies or politics, or that the often frustrated rhetoric of his contemporaries was somehow inaccurate. To be sure, Lincoln's election to the presidency was not especially well received, even in the northern states. Throughout most of his first term in office both he and his policies frequently were objects of ridicule and derision in British and French presses, and southerners

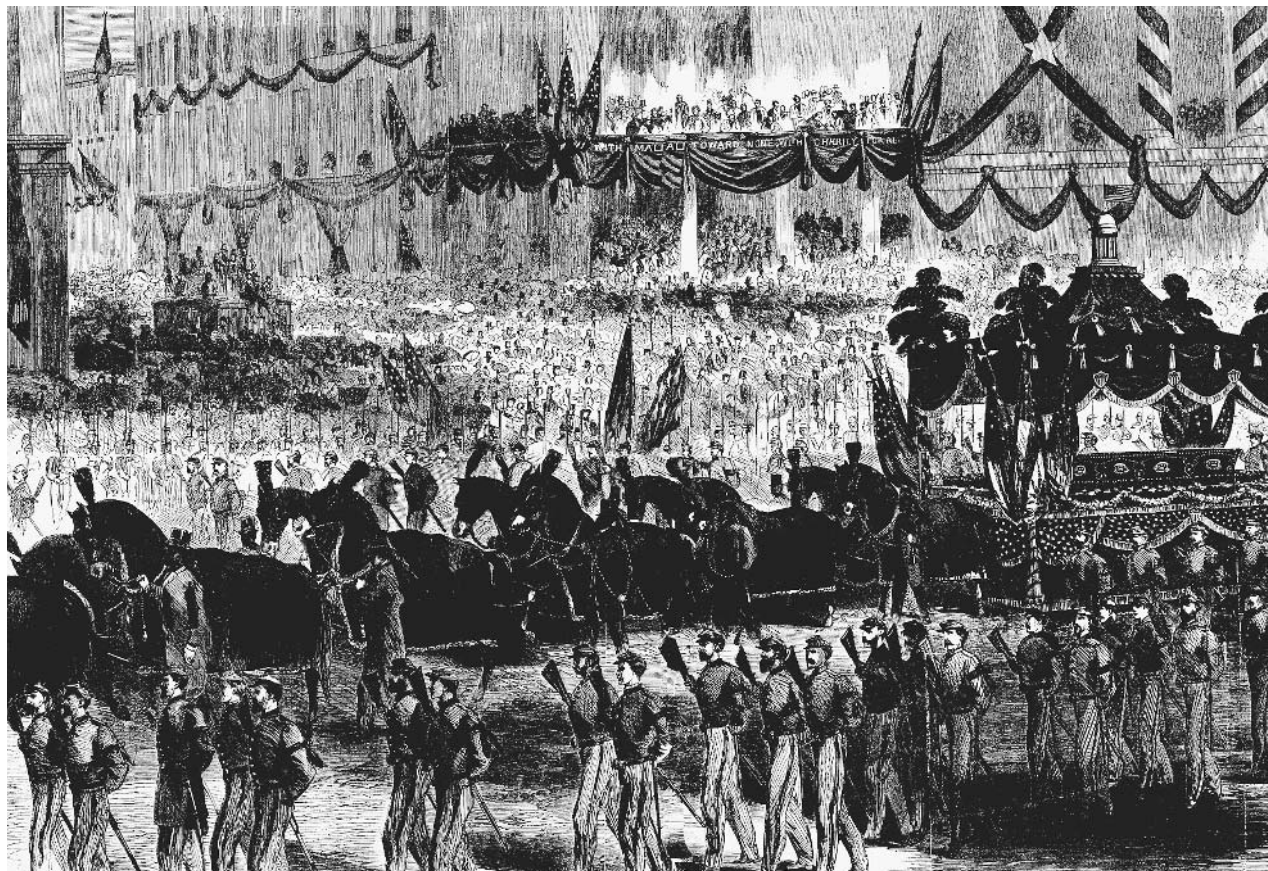
loathed him openly and incessantly. With each step Lincoln seemingly both alienated and attracted supporters. Then, the Union army's capture of Atlanta on September 2, 1864, barely two months before the presidential election, buoyed Northern hopes and virtually assured Lincoln's reelection. Yet, even Lee's surrender to General Grant five months later (April 9, 1865) produced mixed results, with Northerners celebrating "Lincoln's victory" and with Southerners vigorously pursuing a rhetorical campaign against "Lincoln's tyranny" that would continue well into the next century. Threats to his life were constant, violence and subterfuge were ever present, and some people publicly hoped for his death while others had been fearfully anticipating his assassination; therefore, Lincoln's contemporaries were shocked but not entirely surprised when they learned of his death.

Against this backdrop one of the qualities that most impressed and perplexed citizens was the unprecedented character of Lincoln's death. Perhaps because human beings are "fated to puzzle out what it actually means to feel 'right,'" as cultural anthropologist Ernest Becker so aptly put it, Lincoln's contemporaries diligently sought some historical precedent, some point of reference that would place the assassination of an American president in proper perspective (Becker 1975, p. 104). Yet even those who focused on what they thought might be historically or emotionally similar incidents eventually concluded that Lincoln's death and its consequences were simply unprecedented.

The Lincoln Myth and Beyond

The assassination of Abraham Lincoln is a unique case. Despite his status in both past and present day, Lincoln is an individual whose contemporaries continued to criticize and deride him even after his death. Many of those same contemporaries memorialized his death and life as if he had been an intimate member of their family, sparing neither expense nor effort. A partial explanation for this disparity is that the death of a significant individual, even under the least objectionable conditions, necessarily places the living squarely at the center of a nexus of disorganized emotions.

In such an exceptional case, of course, it would be entirely too simplistic to imagine that Lincoln's contemporaries responded to his death as



A drawing of President Lincoln's funeral procession through New York illustrates one of a series of dramatic funeral pageants that lasted three weeks and stretched from Washington, D.C., to Springfield, Illinois. PUBLIC DOMAIN

they did solely out of fear for the status and stability of their social roles—or, for that matter, out of sheer admiration for Lincoln. It would be too simplistic for them to respond out of political considerations necessarily drawn into focus by the fact of and circumstances surrounding his death, or out of guilt that he had been placed in such an impossible position. Responses out of shame that so many had openly and persistently hoped and prayed for his death, or out of remorse that he had been constantly the object of threats and ridicule and derision, would alone be overtly simple. Even responses out of shock for the unprecedented manner of his death, or out of the possibility that his death would provide an opportunity for cultural transformation seem improbable. Much more likely, all of these forces and more were at work within Lincoln's contemporaries, who were bound together in their extraordinary efforts to commemorate his death not by any singular emotion or motive, but by a set of intense discomforts that derived from a number of sources and that

impelled the living to go to extremes to attach their emotions to something concrete.

"While we don't know exactly how the mind works in relation to emotion, how deeply words go when dealing with reality or repressions," Becker wrote, we do know that the death of an intimate occasions rhetoric, the meaningful articulation of symbols, through which "one tries to deny oblivion and to extend oneself beyond death in symbolic ways" (p. 104). In the liminal moments surrounding the death of a significant individual, those symbols finely articulate the ethos and world view that make life and death meaningful and that define how one *ought* to feel and how one can best deal with the way one actually feels.

On the other hand, even given intense discomforts at a variety of levels, it is implausible that the rhetorical and cultural efforts of Lincoln's contemporaries immediately and permanently created the images of Lincoln that now occupy places of honor and reverence in the nation's "collective memory."

Immediate responses to Lincoln's assassination and corresponding opinions of his character varied much too dramatically to have crystallized immediately and permanently into an untarnished hero-image. Indeed, the first and most obvious tribute to the nation's sixteenth president, the Lincoln National Monument in Springfield, Illinois, was dedicated on October 15, 1874. Yet the full weight of the nation's apotheosis of Lincoln did not wholly emerge until Memorial Day of 1922 when the Lincoln Memorial was dedicated in Washington, D.C. Equally important, even if those responses and opinions had been singular, creating a seemingly permanent element of the symbolic code that constitutes collective memory requires time as well as intensity. How, then, did Lincoln come to occupy such a special place in collective memory?

Part of the answer, as Merrill Peterson's *Lincoln in American Memory* (1994) demonstrates, is that a myriad of citizens, working from different assumptions and different motives, have sought to appropriate—and often have successfully appropriated—Lincoln's image over time. And it is through such efforts that Lincoln has continually “belonged to the nation's cultural heritage as well as to its civil history” (Peterson 1994, p. 375). This helps explain why the same three conflicting images that dominated contemporaneous rhetoric about Lincoln later became the three dominant elements of the Lincoln myth—namely, “the rail-splitter,” the man who journeyed “from a log cabin to the White House,” and “the American Christ/Moses” (Warner 1959, pp. 270–289).

Different people memorialize, embrace, and seek to codify through public memory their different images of the memorable not merely because of temporal or spatial or physiological divergences, but because different cultures with different world-views and ethoi require different images of and from their members. That there is a Lincoln myth at all undoubtedly owes much to circumstances; “reality,” however mutable, lives within the possibilities of what is given and of what is conceivable in the midst of what is given. Would the memorial responses to his assassination been different had he not signed the Emancipation Proclamation? What would have been the response if many of his contemporaries had not needed to believe that he publicly and personally identified himself as a religious individual? What if he had not been president during such an enormous civil crisis that

marked an unmistakable moment of cultural transformation? In short, had the circumstances surrounding Lincoln's life and death been substantively other than they were or other than what his contemporaries believed them to be, the memorial responses to his assassination would have been other than they were.

Yet, the struggle to recreate Lincoln reveals a great deal more than the distant sentimentality of nineteenth-century citizens, of some distant past that is only marginally related to the present. Indeed, Lincoln's place in national memory reveals an ongoing ideological conflict through which various groups continuously have sought to lay claim to the nation's hegemony and public memory. And that, fundamentally, is why his image remains so integral to the nation's memory.

See also: ASSASSINATION; BECKER, ERNEST; CELEBRITY DEATHS; CIVIL WAR, U.S.; FREUD, SIGMUND; IMMORTALITY, SYMBOLIC; MARTYRS; ROYALTY, BRITISH; WASHINGTON, GEORGE

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RICHARD MORRIS

LITERATURE FOR ADULTS

As scholars often note, human beings can never accurately report on the experience of death, they can only imagine it. Thus it should come as no surprise that death has played such a significant role in literature, where humans use the imagination to reflect, shape, and understand their world. The scholars Elizabeth Bronfen and Sarah Webster Goodwin explain that “much of what we call culture comes together around the collective response to death” (Bronfen and Goodwin 1993, p. 3), and Garret Stewart insists that “death marks the impossible limit of representation, while at the same time, death is an inevitability of representation” (p. 51). In literature, then, death functions as an inevitable cultural exploration of what it means to be mortal. While some scholars and philosophers would insist that humans strive to deny death, especially in the twentieth century, literature reflects a constant process of trying to understand death and all its implications.

Western literature incorporates a number of conceits that are specifically associated with death. These include conceptions of the afterlife, representations of love and death, death-specific literary forms like the elegy, and staple narrative images like the deathbed scene. But in order to appreciate such conceits, one first needs to understand the way literature has reflected changing cultural responses to death and dying.

“Death in Literature” As Cultural History

Most scholars agree that in classical literature and until the Middle Ages death was represented as a natural and expected part of life. The Greeks tended to avoid details about death in their literature, in part because they simply accepted death as part of the human experience, and in part because they wanted to emphasize life. The Greeks did, however, depict death in war, demonstrating their belief in heroic, noble death, and they did emphasize the delights of the next world, and thus the

afterlife became more of a focus in their literature than death itself. The sociologist Philippe Ariès has termed this era’s dominant philosophy about death the “Tamed Death,” a death that, as in *Le Chanson de Roland*, (twelfth century) was usually forewarned and generally accepted. Closer to the Middle Ages death portrayals increasingly took place in bed and with family and friends nearby—a set of rituals that has remained quite enduring.

The literature of the Middle Ages also began to reflect a profound shift in attitudes and beliefs about death, primarily by associating judgment with death. Christianity’s influence on literature resulted in works showing death as a punishment for one’s sins, and thus one’s death became the crucial event in human experience. Works like *The Pricke of Conscience* (fourteenth century) described the importance and the horrors of death. The literature of this period also focused on the significance of Christ’s death and his wounds, depicted the Danse Macabre, or dance of death, and emphasized bodily decay and images of the skeleton.

This focus on the body carried into the Renaissance where the performance of death, especially on stage, was tremendously emotional. Death was often conceived as it affected the body, and represented in a histrionic fashion, foregrounding time as a natural enemy. Love and death became opposing forces: love the motivation for working against time, and death the inevitable result of time’s progress. Suicide became an ironic affirmation of love and of values that could transcend death. William Shakespeare’s tragedies exemplify these ideas about death, as do carpe diem poems like “The Flea” (1633) and “The Sun Rising” (1633) by John Donne and “To His Coy Mistress” (1681) by Andrew Marvell.

The late eighteenth and early nineteenth centuries saw major shifts in representations of death, due in part to the growing conflict between religion and science. Ariès asserts that the late eighteenth century offered more visions of both beautiful death and eroticized death. On the one hand, popular novels like Hannah Foster’s *The Coquette* (1797) depict the unwed heroine’s death in childbirth as a didactic message extolling the evils of untamed sexuality. On the other hand, literature indulged in an erotics of dying—especially by incorporating emotional deathbed scenes, Little

Eva's from Harriet Beecher Stowe's *Uncle Tom's Cabin*, (1852) being perhaps the most famous. The scholar Michael Wheeler, however, notes that while such scenes might have been erotically charged, they also represented a space of comfort and of quite literal rest, transformed into eternal rest. The late nineteenth century developed the *Victorian Cult of Death*, a term used to signify the period's almost obsessive fascination with the subject.

Ironically, most scholars argue that the twentieth century ushered in a culture that strove to distance and to deny death. The literature both does and does not bear this out. Given that the century was filled with war, the threat of nuclear annihilation, and acts of genocide, the literature often reflects a preoccupation with death. At the same time, the literature reveals a developing lack of faith in religion, in science, and in institutions, all things that have helped people understand death. Wallace Stevens's famous conceit "death is the mother of beauty" from the poem "Sunday Morning," (1915) suggests that death may lead humans to create art and life; but such a notion eventually confronted a world where nuclear war threatened not merely the individual or collective life but all that humanity might create. The scholar Lawrence Langer characterizes death in modern literature as inappropriate, absurd, random, unnecessary—yet very much present. The question became, How does one negotiate a world and culture in which such death exists? Many twentieth-century texts attempted to answer that question, and the efforts continue in the present.

The history of death in literature reveals a culture that has evolved from one that accepted death as a natural part of life, to one that invested it with primary religious significance, to one that almost fetishized death, to one that tried to deny it for its now apparent irrationality. Literature suggests that as death has become increasingly less "natural" and concomitantly less meaningful, people have had to find new ways to negotiate it.

Major Literary Conceits

There are a number of standard conceits that one can identify in literature dealing with death, and not surprisingly many of these reflect the time and values in which the literature was produced. Thus, in a time when Western culture saw death as a punishment for earthly sin, the literature often

focused on the body and its decomposition, and the image of the skeleton became prominent. And when Western culture was in the midst of the Victorian Cult of the Dead, its fascination with death elevated to an almost erotic level, the literature indulged in elaborate deathbed scenes, foregrounding the emotional impact of death for those surrounding the dying individual, at times emphasizing the relation between carnality and death, but also using the bed as a symbol of both beginning and ending—a place of birth and of one's final earthly rest. However, there are a number of other significant conceits.

The afterlife. In literature, the depiction of the afterlife foregrounds death's role and its significance for the individual and the culture. The most common depictions of the afterlife are versions of heaven and hell. Trips to and from the underworld abound, as the classical conception of Hades directly or indirectly recurs in much later works. It is notable, for example, that in James Joyce's *Ulysses* (1922) the "Hades" chapter centers on a funeral, or that in Allen Ginsberg's "A Supermarket in California" (1956) the persona depicts Walt Whitman crossing over into Hades, a presumably better ending than what Whitman would find if he lived in contemporary society. Images of heaven range from a place of peace and glory for figures like John Bunyan's Christian in *Pilgrim's Progress* (1678) to a sedentary and static space in which angels desperately await the return of a departed God in Tony Kushner's *Angels in America* (1992). At the same time, since the nineteenth century literature has often questioned the viability of an afterlife, implying that the natural processes of death and decay may be all that occur. Or, as in some Emily Dickinson poems, the afterlife may mean little more than remaining buried in a tomb, contemplating the life one has just passed, a sensibility that anticipated the later existentialist vision of the afterlife in works like Jean-Paul Sartre's *No Exit* (1944).

Antidotes to death—love, beauty, the imagination. Given the inevitability of human mortality, literature often depicts the effort to challenge death and its apparent omnipotence. Literature has long represented love as a challenge to death, whether in the *carpe diem* poems and romances of the Renaissance, in the Gothic romances of the nineteenth century (where love faced a constant battle with

death), or even in the late nineteenth century where, as the scholar Rudolph Binion notes, the idea that spiritual love remained after death reappeared in literature and culture. At the same time, artists have depicted the imagination and the creation of beauty as a stay against death and the ravages of time. John Keats's "Ode to a Grecian Urn," (1819) for example, symbolizes art's ability to defy death. And even twentieth-century writers like Stevens, William Butler Yeats, and T. S. Eliot, who faced a world of death on a global scale, looked to the imagination, to beauty and to the literary arts, as a way to forge ahead despite a sense of impending apocalypse. Twentieth-century literature increasingly questioned whether any of these "antidotes" to death would suffice, however, especially as culture used its imagination to develop new and more global methods of creating death.

The elegy. The elegy, or song for the dead, is a longstanding poetic form used not only to honor the dead, but to explore human efforts to comprehend death. John Milton's *Lycidas* (1637) is an ideal example. Milton's poem mourns the death of his friend Edward King. At the same time, it explores what it suggests that death can take such a young artist. The poem reflects Milton's own anxiety about being a young poet who had taken time to learn and to experience life. The poem thus signifies Milton's fear that his time may have been wasted because he too could be cut down in his prime before he can create the art that will be his legacy. Thus, again one can see how a literary form not only depicts death or responds to it, but also explores death's significance while conveying the prevailing ideas about death for that culture—in this case, that time is life's enemy.

Crisis of faith. Beginning as early as the late eighteenth century and developing exponentially up to and throughout the twentieth century, literary representations of death began reflecting a crisis of faith, initially of faith in God or religion, but eventually of faith in science, in government, and in society at large. Again, Stevens's "Sunday Morning" serves as a useful example. While the poem asserts that death is the mother of beauty, inspiring one to create, it also suggests that the contemporary culture can only see Christ's death as human—the tomb in Palestine holds his body; there was no resurrection; and there is no paradise. Existentialism would go so far as to suggest that one's death seals off and defines the significance and meaning

of one's life. At the same time, twentieth-century writers like Thomas Pynchon characterize America as a culture headed toward an entropic ending, society and culture winding down in a kind of cultural death. Robert Lowell's "For the Union Dead" (1959) and Randall Jarrell's "The Death of the Ball Turret Gunner" (1945) depict society's callous treatment of the living and of those who have died to protect the living. Death became especially meaningless when governments and other institutions were involved. And, of course, scientific progress more often than not led to death, whether via the automobile in F. Scott Fitzgerald's *The Great Gatsby* (1925) and E. L. Doctorow's *Ragtime* (1974). In both, the development of this new technology directly or indirectly leads to the death of major characters—or via the war machines and diverse weaponry depicted in numerous works of this century.

War. From classical literature to the present, war has been a staple subject. For most of literary history death in war was represented as noble and heroic. Again, however, since the mid-nineteenth century, literature has seriously challenged this idea, often by depicting death in war as senseless and brutal or by suggesting that such belief is culturally necessary; that is, Western cultures can only send its young men to war if it believes that such death carries nobility. Consistently, however, representations of death in war reflect both our human ability to rise, to defend and to prevail as well as the ability to commit inhumane atrocities. Death in war literature remains one of the most compelling ways in which artists use death to speak to readers about their values.

The undead. Whether one considers the ghost of Hamlet's father returning to speak the name of his murderer in Shakespeare's play (1603), or Victor Frankenstein's creature in Mary Shelley's novel (1818), or Bram Stoker's vampire (1897), or Sethe's dead daughter returned to life in Toni Morrison's *Beloved*, (1987) literature reveals a fascination with the dead who have in some way returned to the living. The monstrous undead serve a crucial role in literature's engagement with death. On the one hand, these figures foreground a cultural anxiety about maintaining clear boundaries—living and dead should remain separate, and when humans cross that boundary, they produce something monstrous. But there are often deeper implications. Stoker's *Dracula*, for example, embodies the

Victorian anxiety about the individual's underlying sexuality and desires. Dracula inverts the living: he penetrates his victims to take life rather than to create life. But he also elicits from his victims' desires that must otherwise be suppressed within Victorian culture. Similarly, Victor Frankenstein's monstrous creature serves as a living, breathing testament to what happens if one strives to play God, and it remains an enduring symbol, reminding readers of the ethical implications resulting from unchecked scientific progress. And the ghost who returns to name its murderer or to remind others of its unfair demise foregrounds the way people are haunted by the sins of their past. In other words, the dead often remain alive in people's collective memory. Beloved, arguably the resurrected daughter who Sethe killed to keep from slavery, clearly signifies the way the history of slavery, and its creation of a life worse than death, both must, and cannot help but, be remembered.

Death is everywhere in literature, in large part because it is a force that individually and collectively people must negotiate. In fact, it is so pervasive in literature that any attempt to provide an overview is inevitably incomplete. However, literature clearly reflects humanity's struggle to understand death, to explore the implications of death for the living, and to use death as a way of questioning the value of life, society, and art.

See also: ARIÈS, PHILIPPE; BECKER, ERNEST; DANSE MACABRE; IVAN ILYCH; LITERATURE FOR CHILDREN; SHAKESPEARE, WILLIAM; VAMPIRES

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ANDREW J. SCHOPP

LITERATURE FOR CHILDREN

A historical overview of children's literature, especially fairy tales, reflects society's attitudes toward children and death. Most readers are unaware that every fairy tale has its own history, and many of them originated in the seventeenth century as oral, adult entertainment. Many featured coarse humor and sensational events. As these tales were transcribed and developed specifically for children, they were modified to contain incidents and behavior that reflected the customs of the place and period in which they were told. They contained material intended to provide moral guidance, and in the earliest versions of children's stories death was prominent because of its ubiquity and drama. Over the centuries there has been significant transformation of fairy tales, storybooks, and schoolbooks (basal readers). In the early twentieth century until the 1970s, topics consid-

ered disturbing to children, including death, were toned down and removed. Although late twentieth-century works began to reverse this trend, many children today are insulated from discussions of death in their literature.

The Evolution of Children's Literature

Schoolbooks were developed primarily to educate, teach morality, and assist in children's socialization. Books for children's education preceded the development of children's literature for pleasure. Charles Perrault and Wilhelm and Jacob Grimm wrote tales to caution children about the perils and consequences of inappropriate behavior.

Literature intended specifically for children did not develop until the mid-seventeenth century. Prior to that time children were perceived as miniature adults or as less than human, as typified by Michel de Montaigne, the sixteenth-century French humanist and essayist. In *Off with Their Heads!* (1992), Maria Tatar, a professor of Germanic languages and literature at Harvard University, notes that early children's literature had an unusually cruel and coercive streak. Early books were often written to frighten children into behaving as parents wished. Two approaches predominated: cautionary tales and exemplary tales. In cautionary tales the protagonist was either killed or made perpetually miserable for having disobeyed. Stories of exemplary behavior also had a strange way of ending at the deathbeds of their protagonists.

John Amos Comenius's 1658 Latin schoolbook *A World of Things Obvious to the Senses Drawn in Pictures* was the first picture book for children and the first to recognize that children needed their own literature. In 1744 John Newbery wrote *A Little Pretty Pocket Book* for children. Although other books for children had been published earlier, this book is credited as the start of English children's literature because this book was meant to entertain rather than educate. Newbery is recognized as the first serious publisher of children's literature.

Between the 1920s and the 1970s incidents of dying and death were removed or glossed over in children's reading material. Concurrently, religious material was also removed from children's schoolbooks. Only since the late 1970s and early 1980s has this tendency begun to reverse. Children's books of the twenty-first century frequently deal

with feelings, divorce, sex, and death. Religion is still taboo in schoolbooks—in contrast to colonial America when ministers wrote many of the schoolbooks and the local minister often oversaw the school. The town school was considered an appropriate place for children to be taught not only their letters but also religion.

Basal Readers

Books designed to teach children to read are known as basal readers. They use material from a variety of sources. From the early 1800s until the 1920s, American children were commonly taught to read with basal readers edited by Lyman Cobb, Samuel T. Worcester, Salem Town, William Russell, William D. Swan, and William McGuffey, among others. In *McGuffey's Eclectic Readers*, published continuously from 1879 to 1920, the subject of many of the selections was the death of a mother or child, typically presented as a tragic but inevitable part of life. For example, *McGuffey's Third Eclectic Reader* (1920) contains William Wordsworth's poem "We Are Seven," in which a little girl describes her family as having seven children, even though two are dead. The experience of the death of the older sister is also described. Some of the other short stories and poems in McGuffey's Readers that deal with death as a theme are: "Old Age and Death" by Edmund Waller, "The Death of Little Nell" by Charles Dickens, "Elegy Written in a Country Churchyard" by Thomas Gray, and "He Giveth His Beloved Sleep" by Elizabeth Barrett Browning. Unlike early basal readers, today there are no poems or stories that deal with death nor are there prayers in books used in public schools.

An anonymous selection in *McGuffey's Fourth Eclectic Reader*, entitled "My Mother's Grave," provides an emotional account of a young girl's experience with her dying mother. The story aims to make children polite and obedient to their parents. Through recounting the author's thoughts on revisiting her mother's grave, she remembers being unkind to her dying mother after a trying day at school. She realizes her lapse in manners later that evening and returns to her mother's room for forgiveness and finds her asleep. She vows to waken early to "tell how sorry I was for my conduct," but when she rushes into the room in the morning she finds her mother dead, with a hand so cold "it

made me start" (p. 253). Even thirteen years later the author finds her remorse and pain almost overwhelming. This is not the type of subject matter and emotional content considered appropriate for twenty-first century basal readers. Commonly used basal readers rarely contain references to dying or death. If they do include a chapter from a book that deals with death, such as E. B. White's *Charlotte's Web* (1952), it is not the chapter in which Charlotte dies.

Storybooks

Insight into how dying and death were portrayed in the nineteenth century can be found in the still widely read storybook *Little Women*, written in 1869 by Louisa May Alcott. Alcott described the death of young Beth in a straightforward manner uncommon for her day. Recognizing that her depiction was at odds with the melodramatic scenes current in more romantic literature, Alcott added in the paragraph following Beth's death: "Seldom, except in books, do the dying utter memorable words, see visions, or depart with beatified countenance . . ." (Alcott 1947, p. 464).

Between 1940 and 1970 few children's books contained references to death. Two that have become classics are Margaret Wise Brown's *The Dead Bird* (1965) and *Charlotte's Web*. White's publisher initially refused to publish *Charlotte's Web* unless the ending was modified allowing Charlotte to live, which White refused. Critical reviewers of the era found death not "an appropriate subject for children" (Guth 1976, p. 531).

Separating children from an awareness of dying and death has diminished since the 1970s. Although Robert Fulton and Herman Feifel taught and wrote about dying and death before the 1960s, it was the early work of Elisabeth Kübler-Ross in 1969 that helped make death a subject for discussion and study. During the 1970s and 1980s over 200 fiction books for children contained death as a major theme. Few measured up to the standard set by *Charlotte's Web*, *Little Women*, *The Yearling* (1938), or *The Dead Bird*. During this same period some very well-written nonfiction books about death were published for children of various ages, making it a more acceptable subject. These included *About Dying* by Sara Bonnett Stein (1974), *When People Die* (1977) by Joanne Bern-

stein and Stephen J. Gullo, *Learning to Say Good-bye: When a Parent Dies* by Eda J. LeShan (1976), *The Kids' Book about Death and Dying* and *The Unit at Fayerweather Street School* (1985) both by Eric E. Rofes, and *Living with Death* (1976) by Osborn Segerberg Jr.

Fairy Tales

Fairy tales provide an excellent example of the way society deals with themes considered distressing to children. The insulation of children from death can be traced through progressive versions of typical stories. A generalization can be made about fairy tales that can also apply to all early stories for children: As sexual content diminished, violent content increased. An analysis of successive editions of *Grimms' Fairy Tales* provides insight into the manner in which stories were modified to shield children from exposure to dying and death.

To understand this evolution, it is necessary to understand the milieu in which it took place. In the 1700s children were not perceived as needing protection from portrayals of violence primarily because life was harsh and most children died during infancy or childhood. Violence and death in children's stories of the 1700s take on a different light when viewed in the context of high infant and child mortality and the increasing, universal practice of abandoning unwanted children at the local foundling hospital or on church steps. In the seventeenth and eighteenth centuries, children were routinely required to attend public executions to witness the cost of criminal behavior. The romanticized depiction of an afterlife, superior to the life of this world, served to help children cope with the brutal facts of their lives.

Given these realities, children's literature was motivated by a belief that children needed written material to educate them and prepare them for life. The majority of books published for children through the 1800s can be compared to James Janeway's *A Token for Children: Being an Account of the Conversion, Holy and Exemplary Lives, and Joyful Deaths of Several Young Children* (Parts 1 and 2, 1671–1672). Writers of this era commonly agreed with Janeway's position that they held a sacred duty to salvage the souls of those who were not too young to go to hell. The exemplary stories in *A Token for Children* were also designed to pro-



Like many of Grimm's fairy tales, *Hänsel und Gretel* (1823) provides a vivid description of violence not only toward the characters' antagonist, but children as well. BETTMANN/CORBIS

vide comfort to children facing the tragedy of a sibling's death or confronting their own mortality when visited by some dreaded disease.

Wilhelm and Jacob Grimm's *Cinderella* stressed punishment more than earlier oral versions. In the first version (1697), taken by Perrault from the oral tradition, Cinderella forgave her stepsisters for mistreating her and introduced them at court. The Grimms' first version (1815) has Cinderella's sisters turning pale and being horrified when she becomes a princess, while in the second edition sisters' punishment is to be blinded by pigeons pecking out their eyes.

In the Grimms' *Hänsel and Gretel* (1823), there is a description of how horribly the witch howled when Gretel pushed her into the oven and how ". . . Gretel ran away leaving the witch to burn, just as she had left many poor little children to burn" (Owens 1981, p. 57). The use of violence as punishment is typical in fairy tales, even for minor misdeeds. This tendency is evident in the stories found in *Struwwelpeter*. In these tales,

Little Pauline plays with matches and goes up in flames, and Conrad the Thumbsucker has his thumbs sliced off. Maria Tatar observes that "the weight is given to the punishment (often fully half the text is devoted to its description) and the disproportionate relationship between the childish offense and the penalty for it make the episode disturbing" (Tatar 1992, p. 34).

The removal of sexuality from children's fairy tales paralleled the evolution of housing in Europe. By the seventeenth century, living arrangements had evolved to provide segregation between quarters for working, food preparation, and sleeping. Usually there was a main room used for dining, entertaining, and receiving visitors, but servants and children began to have their own smaller, adjacent rooms. During this same century fairy tales began to transform into works intended primarily for children. The transformation of living spaces parallels the changes that greatly impacted children, including attitudes regarding teaching proper behavior and attitudes toward dying and death.

The obvious changes over time in one fairy tale—*Little Red Riding Hood*—parallel the changes in attitudes toward death, children, and their education. The earliest known oral version from Britain would not be considered suitable children's entertainment in the twenty-first century. In this early version, Little Red Riding Hood is unwittingly led by the wolf to eat her grandmother's flesh, to drink her blood, and to perform a provocative striptease for the disguised wolf before climbing into bed with him. She escapes from the wolf when she goes outside to relieve herself. Because its primary purpose was to entertain adults, the story was not encumbered with the admonitions and advice that later came to distinguish versions intended for children.

The earliest written version of *Little Red Riding Hood* was in French, in 1697, by Charles Perrault. In this version, the grandmother and Little Red Riding Hood are eaten by the wolf and perish. Although Perrault did not have Little Red's mother warning her before leaving for her grandmother's house, he did conclude the story with a moral suitable for the intended children's audience: Do not speak to strangers or you, too, may provide a wolf with his dinner. The death in this story is later moderated in the Grimms' retelling. They introduce an additional character, a hunter or woodcutter, who slices the wolf open and releases the victims alive.

In a popular nineteenth-century retelling of Little Red's tale, the grandmother is eaten by the wolf, but Little Red survives, learning to pay closer attention to her mother's words: "For she saw the dreadful end to which / A disobedient act may lead" (Tatar 1992, p. 39). Another version emphasizes avoiding needless suffering. Here is the depiction of the wolf killing the grandmother: "[The Wolf] jumped up on the bed, and ate her all up. But he did not hurt her so much as you would think, and as she was a very good old woman it was better for her to die than to live in pain; but still it was very dreadful of the wolf to eat her" (1933, p. 20).

In later versions of *Little Red Riding Hood* the hunter arrives in time to shoot the wolf before he eats either Little Red or her grandmother, or the wolf escapes through an open window or becomes Little Red's pet. The moral, or message, of the story also evolves with the transformation of

events. In the traditional, oral version Little Red was not warned by her mother of the dangers of talking to strangers, and cannot be seen as naughty or disobedient. In Perrault's original written version, the mother does not give Little Red any cautions, while in later versions she often gives Little Red many instructions and admonitions. Upon rescuing Little Red from the dire misfortune she brings upon herself, the hunter/woodcutter inevitably lectures her on obedience and on what can happen if she disregards her mother's warnings. The role of death in the changing tale diminishes as the tale evolves. Rather than being the graphic and unmourned event Perrault depicted, it becomes muted and is eventually relegated to the periphery of the readers' attention or disappears entirely.

Fairy tales do not always hold the promise of a happy ending. For example, Hans Christian Andersen's *The Little Mermaid* (1846) has been distorted over time. In the original version the Little Mermaid chooses death for herself rather than murdering the Prince, and thus leave her form as a mermaid. The Little Mermaid would only regain her form as a mermaid if she murdered the prince. She does not do this and so she dies and becomes a daughter of the air. After 300 years of good deeds she then can gain a human soul and enter heaven and join the prince there. The very morning that the Little Mermaid sacrifices herself and spares the Prince, he marries a princess from another land whom he mistakenly believes rescued him. Only in Disney's bowdlerized version does the Little Mermaid manage to displace the "other woman" and marry the Prince, an alteration partly justified by casting the other princess as the evil sea-witch in disguise.

The classic fairy tale *Bluebeard* (1729) also presents a problematic ending. In this tale, one of three sisters marries a wealthy but mysterious man, distinguished primarily by his blue beard. After the wedding she is given access to all of Bluebeard's possessions, but is forbidden to use one small golden key. She inevitably uses the key, and discovers the bloody bodies of Bluebeard's previous wives. Upon discovering his wife's transgression, Bluebeard prepares to add her to his collection. At the last moment, her brothers suddenly appear and save her by hacking Bluebeard to pieces before her eyes. Although the latest wife did not meet the fate of her

predecessors, is it really a happy ending to have her brothers murder her husband? Her disobedience is a necessary part of the story, yet there is no clear resolution of her dilemma. The fast and easy way to conclude a fairy tale is to recite, “and they lived happily ever after,” yet a close look shows that many fairy tales do not have a “perfect” ending.

When fairy tales existed solely as oral tradition, storytellers could personalize their version to suit the time, place, and audience. As stories were printed, they began to reflect more enduringly the nature of the time and place in which they were recorded. Thus it seems odd that parents continue to read to their children—often without the slightest degree of critical reflection—unrevised versions of stories imbued with values of a different time and place. L. Frank Baum, the originator of *The Wonderful Wizard of Oz* (1900), recognized this predicament and recommended that it was time for a new set of “wonder tales”; he suggested that previous fairy tales be classed as “historical” (Tatar 1992, p. 19). Indeed, denoting traditional fairy tales as “historical” would help distinguish the changes that have occurred in the years since they were recorded. It would also encourage parents and teachers to critically examine the material available to children.

Modern Themes

There is a growing perception that children are capable of understanding dying and death as natural processes, and that over time they assimilate a number of such experiences. Since the 1970s adults have begun to recognize the difficulties they experienced as a result of being sheltered from awareness of death and have begun to seek ways to allow children to become aware of the reality of dying and death. Since the mid-1970s hospice programs have enabled several million dying persons to receive care in their homes. As a result, some children have been exposed to meaningful death experiences. Increased awareness of the lethality of AIDS (acquired immunodeficiency syndrome) also makes it important that even the tales told to children reflect current perceptions of dying and death.

Scholars maintain it is important to consider the implications of fairy tales in modern times. Perhaps it is time to begin transforming them to reflect the tremendous changes that have occurred in a world increasingly forced to accept the limits

of medical technology, with death again being acknowledged as a necessary and inevitable counterpart to life.

The terrorist attacks of September 11, 2001, taught children that the world is not a safe place. The *New York Times* best-seller list for September 30 revealed that the new Lemony Snicket book, *The Hostile Hospital*, outsold any of the *Harry Potter* titles that week. Also that week there were four Snicket books and four *Harry Potter* titles in the Top 10. The Lemony Snicket books are an eight-book series dubbed “A Series of Unfortunate Events.” The series tells the story of the Baudelaire orphans, good children to whom bad things happen. In the first book Mr. Poe, a family friend, comes to the beach to tell the children that their parents have died in a fire, and their mansion is destroyed. The narrator cautions that everything to come is rife with misfortune, misery, and despair. Children who are protected by parents from awful truth instinctively know the world is not an absolutely safe place and one way of releasing the tension is to read about someone who is much worse off than they are. Each time the Baudelaire children find a satisfactory situation, something goes wrong. Count Olaf, a distant cousin who takes them in first, is interested only in their money. Kindly Uncle Monty, with whom they next reside, is murdered. Aunt Josephine throws herself out of a window, or at least that is the way it appears. In spite of all the terrible things that happen to the three children, they manage to survive.

See also: CHILDREN; CHILDREN AND ADOLESCENTS'

UNDERSTANDING OF DEATH; CHILDREN AND MEDIA

VIOLENCE; HOSPICE OPTION; LITERATURE FOR ADULTS

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ELIZABETH P. LAMERS

LIVING WILL

A living will is a written document that declares what life-sustaining medical interventions a person wants if she becomes terminally ill with little or no hope of recovery and is unable to communicate her wishes. It was created in response to the increasing ability of medical technology to prolong dying, frequently in a painful and undignified way. Often at the time life supports are needed patients are unable to communicate their wishes. A patient's autonomy and right to privacy may be violated in such circumstances when it is medical personnel or others, and not the patient, who make crucial decisions regarding life supports. Living wills are designed to permit patients to “speak” when they are unable to by providing directions in advance. It is also a way of giving meaning to the doctrine of informed consent, which requires physicians to obtain the consent of their patients before beginning any medical treatment.

The first living will was conceived in 1967 by Luis Kutner, a human-rights lawyer in Chicago and cofounder of Amnesty International, in conjunction with the Euthanasia Society of America (now called Partnership for Caring). The living wills were distributed by the Euthanasia Society, and in addition to their practical use, they served as a way of promoting education and dialogue about end-of-life issues.

The use of living wills was further popularized by the Karen Ann Quinlan case in 1976. Quinlan was twenty-one years old when she was placed on a respirator after she stopped breathing for unexplained reasons and entered a chronic persistent

vegetative state. Her parents were forced to turn to a court to have her respirator removed so she could die naturally, thus bringing attention to the fact that few if any mechanisms existed for making these crucial decisions. The case acted as a catalyst for state legislatures throughout the 1970s and mid-1980s to pass living will laws.

Living wills are narrowly tailored documents that generally apply only when a person has a terminal illness, although some states allow living wills to be used when a person is in an “irreversible coma” or “persistent vegetative state.” Living wills do not apply to all types of medical treatment but are limited to life-sustaining treatment or to maintenance medical care. State living will laws differ in their definitions of what constitutes life-sustaining treatment. Generally it includes artificial technology that postpones death, but not care that eases pain. In over half of the states in the United States nutrition and hydration are not considered life-sustaining treatment (although these types of provisions may conflict with court decisions that have held otherwise). In some states, persons must specifically state in their living will whether or not they want nutrition and hydration withdrawn.

Under most state laws, living wills never expire, although some states require them to be renewed periodically. Living wills can be revoked or changed at any time. Living wills must be signed by witnesses, usually two, who cannot be family members or health care workers. Some states provide mandatory living will forms; other states are more flexible. It is not clear that a living will executed in one state will be effective in another state. Only a handful of states have laws that expressly provide that another state's living will be accepted, although this does not mean that a state without such a law will not honor a living will executed in another state.

Even a properly executed living will poses obstacles to compliance. Many living wills consist of a one- to two-page form that contains standardized and broad language that is too vague to provide enough guidance to physicians. For example, one state's statutory living will form provides, in part, that if the person has “an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician . . . such procedures that will only prolong the dying

process [are to] be withheld or withdrawn.” Such language leaves open to interpretation what is meant by a terminal condition. For some it means imminent death and for others it means an irreversible condition that will ultimately result in death. It also provides only vague guidance as to what procedures shall not be used. A feeding tube may be considered a comfort measure to some and a life support to others.

Even those forms that permit people to insert their own language often suffer from similar deficiencies, with people often using the same broad language to record their wishes. On the other hand, using more specific language can also have its pitfalls. It may make the living will difficult to apply if it does not fit the situation exactly. And even if the directions are clearly understood, when treatment should be stopped may also not be clearly spelled out in the living will. Finally, for many people, it is difficult to predict in advance what one would want in the event of a life-threatening or terminal illness. Not all possible scenarios can be anticipated.

For these and other reasons, many health care providers and advocacy groups suggest that living wills may provide a false sense of security. Physicians may not comply with them for a variety of reasons, including that they are often not available when needed (many people keep their only copy locked away in a security box) or because they do not provide specific enough instructions. To overcome these deficiencies, advocacy groups and legal organizations suggest that in addition to a living will, a person should execute a health care proxy, which appoints a person to make medical decisions when the patient can no longer do so. Several states are now combining health care proxies and living wills into one document. This permits a person who knows the patient, including his values, lifestyle, and religious beliefs, to provide guidance in making a decision that will best reflect the patient’s wishes. It is also suggested that people complete a values history to aid the health care proxy in making decisions. A values history includes a description of the person’s overall attitude toward life and health, dependency, his personal relationships, religious background and beliefs, finances, and other issues that may affect what type of medical intervention he wants at the end of life.

Living wills have served as an important educational tool in educating the public about end-of-life issues. They have been criticized as ineffective, however, because they are often too vague to provide guidance. Increasingly, other forms of advance directives that more clearly set out a patient’s preferences and designate a person to make decisions when the patient cannot are being recommended.

See also: ADVANCE DIRECTIVES; CRUZAN, NANCY; END-OF-LIFE ISSUES; EUTHANASIA; INFORMED CONSENT; LIFE SUPPORT SYSTEM; NATURAL DEATH ACTS; PERSISTENT VEGETATIVE STATE; QUINLAN, KAREN ANN

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VICKI LENS

LOPATA, HELENA Z.

Helena Znaniecka Lopata has published over ten books on the social roles of women, role modification, aging, and social support. Born in 1925 in

Poznan, Poland, she is the daughter of Florian Znaniecki, a well-known sociologist in both Poland and the United States. Lopata's family emigrated to the United States to escape Nazi occupation when she was a teenager. She is Professor Emerita of Sociology at Loyola University of Chicago and a leading expert on widowhood.

Her first book on widows, *Widowhood in an American City* (1973), focused on the metropolitan Chicago area. In *Women as Widows: Support Systems* (1979), she introduced cross-cultural studies. In a collective effort, she coauthored *Widows and Dependent Wives: From Social Problem to Federal Program* (1985) with Henry P. Brehm, and edited *Widows: The Middle East, Asia and the Pacific* and *Widows: North America*, two volumes in 1987. *Current Widowhood: Myths and Realities* (1996) culminates over thirty years of research on this topic. Her work has been supported by funding and research assistance from diverse sources, including the Midwest Council for Social Research on Aging, Social Security Administration, and a Fulbright Fellowship to India.

Her father's theory of social roles as sets of social relations has influenced much of Lopata's work. The methodology of symbolic interactionism was acquired from professors and fellow students such as Herbert Blumer, Howard Becker, Erving Goffman, Rhoda Blumberg, Gladys Lang, Joseph Gusfield, Everett Hughes, Louis Wirth, and Ernest Burgess at the University of Chicago where she received her doctorate degree in sociology in 1954.

Her work has contributed to an understanding of aging and the recognition that marriage is, in many ways, a temporary status or stage that women experience. She focuses on women and widowhood because there are many more of them than widowers, and they remarry less often than men. Her research on widowhood investigates transition and status reconceptualization. She has noted the role of modernization in shaping the various ways in which women experience this role transition (or social development) around the world; in addition, she has also studied different social, ethnic, and class positions in the United States. An important finding of her comparative

and historical approach is the diversity of experience women have in the role of widows.

Lopata looks at widowhood in diverse social systems such as India, where *sati* (the widow's self-immolation on the funeral pyre of her dead husband) was once common, and Israel, where the status of wives who lose their husbands varies by whether he died from "hostile acts" of Palestinians or another cause. Her comparative analysis also covers Korea, Turkey, China, the Philippines, Canada, and Australia. She has concluded that women's loss or gain of status in old age and widowhood depends on their control over societal resources such as money (e.g., Social Security checks) and family support.

Lopata defines herself as a symbolic interactionist concerned with the construction of reality, or the meanings of life. She speaks from personal experience as well. After more than forty years of marriage, Lopata lost her husband, a successful businessman whom she describes as a "Renaissance Man," while writing her latest book on widowhood. In her transition to widowhood, Lopata found the support system she has written about through her work, colleagues, friends, children, and grandchildren.

See also: CONTINUING BONDS; WIDOW-BURNING; WIDOWERS; WIDOWS; WIDOWS IN THIRD WORLD NATIONS

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BARBARA RYAN

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MAHLER, GUSTAV

Gustav Mahler (1860–1911) was a Bohemian-born Austrian symphonic composer whose sprawling sonic canvases were often concerned with death, either as a spur to life or as a tragic and inconsolable end. Mahler grappled with mortality in his personal life as well as in his art.

The desperately comic and the searingly tragic coexist in the composer's ten numbered symphonies and many song cycles. His childhood shows the genesis of this strange pairing. In the building where Gustav lived as a child, the tavern owned by his father was adjacent to a funeral parlor put to frequent use by the Mahler family—eight of his fourteen siblings died before reaching adulthood. Mahler's father was a self-educated, somewhat brutal man, and fights between him and his cultured, delicate wife were common. Piano lessons were a way out of the daily misery for little Gustav, and before long, he was making up distinctive pieces of his own. Mahler's mature output seems an elaboration of that early conflation.

At age fifteen Gustav entered the Vienna Conservatory, where he received a diploma three years later. The early failure of his own music to win recognition sparked a remarkable conducting career that took Mahler to all the great opera houses and concert halls of Europe. Conducting earned him a fortune, but it also meant that composing, his first love, was relegated to the off-season. Throughout much of his life, Mahler composed in isolation in summer cottages.

From the beginning, Mahler declared that his music was not for his own time but for the future. An agnostic, he apparently saw long-term success as a real-world equivalent of immortality. “Mahler was a thoroughgoing child of the nineteenth century, an adherent of Nietzsche, and typically irreligious,” the conductor Otto Klemperer recalled in his memoirs, adding that, in his music, Mahler evinced a “piety . . . not to be found in any church prayer-book.” This appraisal is confirmed by the story of Mahler's conversion to Catholicism in 1897. Although his family was Jewish, Mahler was not observant, and when conversion was required in order to qualify as music director of the Vienna Court Opera—the most prestigious post in Europe—he swiftly acquiesced to baptism and confirmation, though he never again attended mass. Once on the podium, however, Mahler brought a renewed spirituality to many works, including Beethoven's *Fidelio*, which he almost single-handedly rescued from a reputation for tawdriness.

In 1902 Mahler married Alma Schindler, a woman nearly twenty years his junior. They had two daughters, and when Mahler set to work on his *Kindertotenlieder*—a song cycle on the death of children—Alma was outraged. As in a self-fulfilling prophecy, their oldest daughter died in 1907, capping a series of unrelenting tragedies for the composer. In that same year, Mahler was diagnosed with heart disease and dismissed from the Vienna Court Opera following a series of verbal attacks, some of them anti-Semitic. Mahler left for America, where he led the Metropolitan Opera from 1907 to 1910 and directed the New York Philharmonic from 1909 to 1911.

While in Vienna during the summer of 1910, Mahler discovered that Alma was having an affair with the architect Walter Gropius. He sought out Sigmund Freud, who met the composer at a train station in Holland and provided instant analysis, labeling him mother-fixated. Freud later declared his analysis successful, and indeed Mahler claimed in correspondence to have enjoyed an improved relationship with his wife. But it did nothing to stop the deterioration of Mahler's health.

The Mahler biographer Henry-Louis de La Grange has effectively contradicted the popular image of Mahler as congenitally ill. A small man, Mahler was nonetheless physically active, an avid hiker and swimmer throughout most of his life. Nonetheless, he was a man drunk on work, and he grew more inebriated with age. His response to the fatigue and illness was often simply to work more. In 1901, for example, he collapsed after conducting, in the same day, a full-length opera and a symphony concert. He immediately set to work on his Symphony no. 5, which begins with a funeral march.

Mahler's symphonies divide into early, middle, and late periods, respectively comprising the first four symphonies; the fifth, sixth, and seventh symphonies; and the eighth and ninth, plus "Das Lied von der Erde" and the unfinished Tenth Symphony.

Symphony no. 1 in D is subtitled the "Titan," not after the Greek demigods but after a novel of the same name by Jean Paul Richter. The third movement turns "Frère Jacques" into a minor-mode funeral march. Symphony no. 2 moved the symphonic form into entirely new territory. It was longer and required more forces, including a chorus and vocal soloist, and its emotional range was vast. Though subtitled "Resurrection," its texts make no religious claims. Mahler's Symphony no. 3 remains the longest piece in the mainstream symphonic repertory. Its ninety-five minutes open with a massive movement that swiftly swings from moody loneliness to martial pomp, from brawling play to near-mute meditation. An ethereal final adagio is followed by four inner movements of contrasting content, including a quiet, nine-minute solo for mezzo-soprano to a text by Nietzsche extolling the depth of human tragedy. Symphony no. 4, slender by Mahler's standards, concluded Mahler's first period, in which song played an important role.



Gustav Mahler's first composition, written at age six, combined a jolly polka with a solemn funeral dirge. CORBIS

Mahler's next three symphonies were wholly instrumental. Symphony no. 5 is easily read as a backward glance at a man's life. It begins with the most magnificent of orchestral funeral marches, announced by a brilliant trumpet solo, and then slowly moves through movements of anguish and struggle toward the penultimate "Adagietto" (Mahler's most famous excerpt), a wordless love song, and finally to the last movement, filled with the promise of youth. Symphony no. 6, subtitled "Tragic," was formally the composer's most tightly structured, and no. 7, subtitled "Nightsong," is, in its odd last movement, the composer at his most parodistic. In no. 8, "Symphony of a Thousand," Mahler returned to the human voice as symphonic instrument, setting texts from the Catholic liturgy and Goethe.

For symphonists, nine is the number to fear. It took on special status for composers when

Beethoven died after composing only nine symphonies. From Beethoven on, nine had mystical significance. Schubert died after writing nine symphonies, so did Dvorak and Bruckner. Mendelssohn, Schumann, and Brahms did not get near that number before they shuffled off the mortal coil.

Mahler completed his Symphony no. 8 in 1906. In 1907 came his triple calamities: the death of his daughter, his unamicable separation from Vienna Opera, and the diagnosis of heart disease. It was not a good time to compose a symphony whose number cried death. Mahler thought he could skirt the issue by writing an unnumbered symphony that would function as his ninth without carrying the dreaded digit. Thus, Mahler composed “Das Lied von der Erde” (“Song of the Earth”), a massive song cycle for voices and orchestra, that was in every way—except the number—his Ninth Symphony.

Fate read his Symphony no. 9 as the last and would not allow him to finish a tenth. (The one movement he completed is generally performed as a fragment.) In February 1911 Mahler led the New York Philharmonic one last time at Carnegie Hall and then returned to Vienna, where he died three months later of bacterial endocarditis. The twenty-three minutes of the Ninth’s last movement, which have been described as “ephemeral” and “diaphanous,” weep without apology. Somewhere near the middle of this very slow (*Molto adagio*) movement comes a jittery harp figure that mimics the composer’s coronary arrhythmia.

In length, the size of the forces required, and emotional scope, Mahler’s symphonies have rarely been equaled and never surpassed. It is difficult not to see this inflation as the composer’s struggle against mortality. If the world was temporary and afterlife improbable, why not postulate immortality through art? “A symphony should be like the world,” Mahler said to fellow composer Jan Sibelius, “It should embrace everything!”

See also: FOLK MUSIC; MUSIC, CLASSICAL; OPERATIC DEATH

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KENNETH LAFAVE

MALTHUS, THOMAS

Thomas Malthus (1766–1834) was an English clergyman whose theory on population, contained in *An Essay on the Principle of Population* (1798, and later revisions), has had a considerable impact on thinking about the limits of population growth. Malthus believed that unchecked population grows geometrically, a rate that surpasses the ability of the means of subsistence (e.g., food) to support it. To avoid overpopulation, two types of checks on population exist: preventive checks and positive checks. Preventive checks result from human actions that lower the birthrate; for Malthus, this largely meant the postponement of marriage to late ages. Positive checks include anything that operates to increase the death rate (e.g., war, famine, epidemics). While the operation of any of these checks reduces the rate of population growth, Malthus did not think that the preventive checks were powerful enough to prevent the population from growing faster than the means of subsistence. Sooner or later, the more drastic positive checks would come into play. Thus, humans were bound to over-reproduce and, in the end, human numbers would be reduced by increased deaths.

In the two centuries since the *Essay* was first published, the world’s population has increased from less than 1 billion to more than 6 billion. While Malthusian theory is not a dominant theory of population growth in contemporary times, there is a group of neo-Malthusians who are concerned about this rate of population growth. They contend either that family planning and birth control are necessary to decrease fertility in third world countries or that war and other social ills are the result of scarcity and overpopulation. Contemporary

neo-Malthusians include Lester Brown, Paul Ehrlich, and T. Fraser Homer-Dixon. Some leading opponents are Alexander Cockburn and Paul Athanasiou.

See also: DEMOGRAPHICS AND STATISTICS; POPULATION GROWTH; WAR

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ELLEN M. GEE

MARTYRS

The martyr is common to every modern culture, and all societies are proud to acclaim the sacrifices of their spiritual heroes. However martyrdom as a concept is difficult to define, let alone distinguish from simple heroism or idiotic folly, because the awarding of the martyr's crown lies as much in the eyes of the beholder as in the logic of a precise definition. Yet everyone agrees that the martyr exists and that certain acts of sacrifice can legitimately be called martyrdom because martyrdom assigns meaning to death, transforming it into an act of choice and purpose that can be remembered, treasured, and, if necessary, emulated by later generations. The complexities of martyrdom are best studied from three perspectives—historical, sociological, and psychological—because martyrdom is a performance that has evolved and changed over time, requires the interaction of the state and the individual as the martyr attempts to change the power and moral structure of society, and poses questions of motivation that lie outside both history and sociology.

Martyrdom in History

The one common denominator in all martyrdoms (the word stems from the Greek *martur*, meaning “to witness” or “to attest”) is that the martyr, in attesting to his or her faith, dies for a noble cause. But even here the denominator is often discredited by controversy over what constitutes nobility and

blurred by the inclusion of prolonged suffering—torture, imprisonment, and extreme asceticism—that may not end in death.

Originally the cause was invariably religious, or at least articulated in religious terms. An Athenian jury ordered that Socrates (469–399 B.C.E.), the Western world's first recorded martyr, die by poison (the hemlock cup) when he refused to give up his dangerously public insistence that all men and women possessed souls, which knew the difference between good and evil, and were obliged to question historic and religious authority so as to discover the truth for themselves. Jesus of Nazareth suffered (probably in 30 or 33 C.E.) on a Roman cross to display to the classical Judaic world the truth of his message that “the time is fulfilled and the kingdom of God is at hand” (Mark 1:15). Akiva ben Joseph (50?–135 C.E.), one of the “ten martyrs” who founded schools for the study of the Torah in defiance of a Roman decree, was flayed alive with a carding claw, rejoicing that he was “permitted to love God with my life.” Al-Hallaj (858–922 C.E.), the Muslim teacher, mystic, and saint—“the one who is enraptured in God”—was flogged, mutilated, and finally beheaded, accused of usurping “the supreme power of God,” placing himself above the prophet Muhammad, and challenging Islamic Law.

Essential to most definitions of martyrdom are two other characteristics: Martyrs must possess choice; they must elect to die. They cannot be helpless victims of happenstance. And they must feel that death is necessary to their cause, furthering the truth and righteousness of their beliefs. Their sacrifices cannot be simply a private matter between themselves and their deity, let alone a suicide. As the psychoanalyst Erik Erikson said of Mahatma Gandhi, it is easy “to kill and be killed”; what is hard is to “make one's death count for life” (Erikson 1969, p. 197).

Imposing upon the “true” martyr a voluntary death that contributes to the success of the cause severely limits the number of candidates and opens up a minefield of debate. Should the soldier who falls upon a hand grenade in order to save the lives of his comrades be called a martyr? His act is voluntary and his goal is surely noble. Should Martin Luther King Jr., who appears in a multitude of martyrologies, be excluded because he did not consciously elect to die in 1968 at the hands of a

bigoted gunman in order to advance the cause of civil rights in twentieth-century United States? Can the term *martyr* be legitimately applied, as is so often done, to the millions who died in the Nazi holocaust? They suffered unspeakably, but they did not choose their fate. Finally, should Sir Thomas More be acclaimed a proper martyr? In 1535 he chose to be beheaded rather than to publicly sanction Henry VIII's annulment of his marriage to Catherine of Aragon and the ensuing break of the Church of England from Rome, but he did so, not for the sake of papal authority or the unity of the Catholic Church, but for his private relations with God—he “set the world at nought.” He died, as he said at his execution, “the king's good servant but God's first” (Marius 1985, p. 514).

The insistence that true martyrs must deliberately close the door on escape and welcome the chance to display their faith and fortitude, using the occasion to publicize their cause, has created yet another problem. The willingness to die can so easily slide into a death wish that is indistinguishable from suicide. In Judaism, martyrs dying as witnesses to God's existence and as evidence of Israel's worthiness to be Yahweh's chosen people played a crucial function in deflecting divine wrath from the sins of the Jewish nation, but historically Jewish scholars have felt obliged to curb the urge to martyrdom and the fanaticism that so often accompanies it. They limited acceptable martyrdom to the refusal to worship strange gods or commit adultery, incest, and murder, and they warned that voluntary martyrdom is in effect a kind of infanticide since unborn progeny are condemned to oblivion.

In Christianity martyrs play an even more important role. Their courage and blood were the seeds from which the new church sprang. In “On the Glory of Martyrdom,” Saint Cyprian wrote that “so great is the virtue of martyrdom, that by its means even he who has wished to slay you is constrained to believe” (Cyprian 1869, vol. 2, p. 241). Nevertheless, the early church fathers were deeply worried lest the hysteria of mass suicidal martyrdom undermine the psychological impact of the true martyr, and Clement of Alexandria warned that those “in haste to give themselves up . . . banish themselves without being martyred, even though they are punished publicly” (Clement pp. 147, 173).

Likewise, in Islam the primary place of honor is given to the battlefield martyr who dies in a holy war, or Jihad. He is assured forgiveness of sin, a crown of glory, marriage to seventy-two ravishing maidens, and the right to intercede on behalf of seventy family relations. With the delights of paradise so overwhelming, Muslim jurists, however, cautioned that no one is allowed to desire martyrdom; one can only wish for the strength to endure the pain of wounds should they be inflicted upon one's body. Allah could be depended to close the gates of paradise upon those who went into battle simply to glorify themselves or for the spoils of war. As the poet T. S. Eliot has written, the greatest temptation a martyr can face is to “do the right deed for the wrong reason” (Eliot 1935, p. 44).

If over the centuries it has been difficult not to dismiss specific acts of martyrdom as a senseless waste of lives, doing neither the martyr nor the cause any good, it has been even more difficult to decide how to handle the political martyr who is so easily branded a traitor. Early martyrs invariably had hidden political agendas or their opponents attributed to them political motives. Roman officials and the elders of the temple looked upon Jesus's actions—especially his violation of the temple—with the deepest suspicion, and although Jesus died accused of blasphemy against the one and only God, his real crime was that his vision of God's kingdom on earth had no place in the existing Roman-Judaic power structure in Judea. Later Roman emperors and provincial governors regarded early Christian martyrs as political criminals because they refused to sacrifice to the emperor as a semi-divine being, a sign of loyalty to the empire similar to saluting the flag of the United States.

Of all the Christian martyrs before the nineteenth century the martyrdom of Thomas Becket, saint of Canterbury, was the most blatantly political, involving a power struggle between two willful men—Thomas, archbishop of Canterbury and Henry II, king of England—and two institutions: church and state. The archbishop (1118–1170) was assassinated as he stood at the high altar of Canterbury Cathedral by armed men who had taken their sovereign Henry II literally when in a fury he cried out, “What miserable drones and traitors have I nourished and promoted . . . who let their lord be treated with such shameful contempt by a low-born priest” (Grim 1876, p. 429). Henry had cause

to be outraged: The archbishop had excommunicated the king's supporters in the struggle between church and state and had claimed that anyone who violated his rights as archbishop was "damned by Jesus Christ."

The papacy elevated Thomas to sainthood and bestowed the crown of martyrdom upon him with unprecedented speed on the grounds that the cause—the defense of the temporal liberties of the church—was noble, the style of his death was magnificent, and the miracles that had taken place at his grave were proof of divine approval. Although thousands worshiped at his shrine, Becket's prideful and immoderate personality and the political and secular nature of his cause bothered even contemporaries. The bishop of Hereford asked whether the archbishop should in fact be accounted a martyr if "to be a martyr is to die for the faith" (fitzStephen 1876, pt. 3, p. 60). Unfortunately, it was difficult then, as it is today, to disassociate faith from institutional self-interest.

By and large early martyrdom tended to be defensive, although Jesus may be an important exception. Socrates sought to defend an ideal, not to overthrow the laws of Athens. Early Jewish martyrs endeavored to defend themselves and Judea, first from cultural annihilation by Antiochus IV and then from Roman conquest, not to reconstitute society. Second- and third-century Christians maintained only that they should be allowed to worship their God in peace. And Thomas Becket died not to destroy the state but to defend the church. However, as the history of martyrdom reached the nineteenth and twentieth centuries, the martyr became not only increasingly political in behavior but also aggressive in spirit. More and more martyrs turned into belligerent activists against, not passive victims of, society, and therefore increasingly difficult to judge.

John Brown (1800–1859) is the prime nineteenth-century example, melding the demands of a righteous and wrathful Calvinistic God with the cry for social justice on Earth. He cast himself in the role of the Lord's revolutionary instrument to bring about the necessary apocalyptic fury to purge the nation of the sin of slavery. When he was executed for terrorism and treason by the Commonwealth of Virginia for having led an insurrection against slavery, he insisted that he died not solely for "the cause of God" but also for "the cause of humanity"

(Villard 1910, p. 540). But in joining the two, he so mixed martyrdom with political activism that history has been unable to clearly say whether John Brown died a martyr or a terrorist and traitor.

In the twentieth century the death of Dietrich Bonhoeffer generated equal uncertainties. There are those who would call the German pastor a martyr to humanity. Others would argue that, as a would-be assassin of the legal head of state, he violated his Christian beliefs and rightfully paid the price of treason. Bonhoeffer was part of a semi-aristocratic conspiracy to murder Adolf Hitler, having reached the decision that the sixth commandment—"thou shall not kill"—had to be set aside when warring against unspeakable evil. But after Bonhoeffer's execution in April 1945, only days before Hitler took his own life, ministers of Bonhoeffer's own Confessing Church were reluctant to have the names of their "colleagues, who were killed for their faith, lumped together with political martyrs" (Bethge 1970, p. 834).

From the start the presence of political martyrs has bedeviled martyrdom, and in the eighteenth century Pope Benedict XIV established guidelines for determining martyrdom. In regulations that operate to this day, he insisted that the acclaimed martyr had to have died for the faith as laid down by the church, the executioners had to be motivated by "hatred of the faith," and the martyr's motivation had to be purely spiritual and religious. For these reasons the Catholic Church refused to grant archbishop Oscar Romero, "the people's saint of El Salvador," the title of martyr even though he was shot down in 1980 while saying mass in the hospital chapel of the Carmelite sisters. Though the outcry was worldwide, battling against evil and social injustice in the name of the kingdom of God was not sufficient to overcome the concern that the archbishop had been assassinated for his politics, not his faith.

The Sociological Explanation

Martyrs have rarely appeared singly making it tempting to explain their presence in terms of the societies that spawned them. Martyrdom tends to be a group phenomena, drawing strength from a collective identity and representing serious cultural divisions within the state. In contrast to the hero, who is the product of a consensus society where

the quality and worth of the heroic act is undisputed, the martyr is the offspring of a community at war with itself. Such societies are unable to agree whether the martyr's death should be praised as the highest service that can be rendered God or humanity, be dismissed as pointless folly, or be branded as the proper punishment reserved for traitors. Unstable societies experiencing cultural, economic, and political change are particularly likely to generate martyrs as in the case of the classical world during the second and third centuries. Beleaguered communities also spawn men and women who prefer death, often collectively, to surrender or assimilate. Jewish history abounds with this kind of response. Finally, expanding or crusading societies produce those who are eager to give their lives for their religious faith or for their political-social ideology.

Societies such as medieval Europe regarded the martyr as the paramount role model, the stories of their sacrifices being part of the culture and their tombs and relics crucial contact points between heaven and the earth. But so far the martyr has eluded demographic classification by age, class, or sex. In those situations where reliable statistics exist martyrs come from all walks of life. Of the 288 or so English Protestants who were burned at the stake under Catholic queen Mary between 1555 and 1558, only a handful were politically or socially prominent, the vast majority were artisans and agricultural laborers (fifty-one were women), and surprisingly few (7.3%) were clergymen. A generation later, however, of the Catholics executed by Elizabeth I most came from the upper stratum of sixteenth-century society and they were predominantly clerics and males. It would appear that the martyr is far too individualistic to fit into tidy social-scientific categories.

The Psychological Explanation

The principle of reverse optics operates when viewing martyrs: The more distant they are, the more attractive they appear. Close-up martyrs are often found to be harsh, unyielding, and self-absorbed individuals. As the self-proclaimed possessors of the truth, be it social, political, or religious, martyrs find it difficult to live in the world as it is, and more often than not their determination to sacrifice their own lives to a higher purpose is accompanied by an equal willingness to sacrifice



Because of the controversy surrounding Sir Thomas More's execution, the Roman Catholic Church took 400 years to confer full sainthood. ARCHIVE PHOTOS, INC.

other people's lives as well. Martyrs have been the subjects of psychoanalytic study to explain such obsessive behavior, and scholars have suggested that self-interest as well as altruism lies behind their actions. Undeniably religious martyrs, no matter their creed, expect to achieve in martyrdom that uncontroversial act of heroism that makes them memorable in the eyes of both God and man, assuring them a place in heaven and in history books. As Zackary Cawdry proclaimed in *A Preparation for Martyrdom*, a martyr's death is greater than that of other saints "who did not pass through that Red Sea of Blood" (Cawdry 1672, p. 48). "The Christian tradition of martyrdom was absolutely clear: The greater the suffering, the more glorious the reward in heaven. So much so that the early Christian fathers regarded too great an eagerness for martyrdom to be tantamount to the sin of suicide" (Smith 1997, pp. 90–96).

Other authors have argued that martyrs are deeply disturbed men and women devoured by

their obsession. The early Christian and sixteenth-century Marian martyrs in particular have been researched, and hints of paranoia, masochism, and manic depression observed in their response to torture and painful death. Some martyrs are said to be socially ill-adjusted people who seek to draw attention to themselves, their behavior psychologically no different from the exhibitionism of the psychopath who, in a rage against society, shoots down dozens of innocent people in order to be noticed if only in the next day's headlines. Equally disturbing is the role of pride in the martyrs' motivation. It is difficult to find a humble martyr. The possessors of absolute truth are rarely retiring and submissive people; their sense of self is swollen by pride of mission, and they are deeply solicitous of their reputations on earth and in heaven. As Raghavan Iyer has written, "It is at the fire of exceptional and spiritually subtle egotism that many of the saints and mystics . . . have warmed their hands" (Iyer 1978, p. 126). It is that same heat that drives the martyr to acts of sublime heroism and folly.

Impact of Martyrdom

Martyrdom can be a politically and spiritually explosive performance, profoundly dangerous to society. Nothing gives greater credence to the truth of the martyr's message than the spectacle of dying for it. Jesus's death upon the cross seared itself upon the minds and imaginations of later generations who harkened to his words: "Whosoever will come after me, let him deny himself and take up the cross and follow me" (Mark 8:34). The endless storytelling of the suffering and sacrifices of past martyrs can be a potent incentive to action, be it Buddhist, Christian, Jewish, or Muslim.

As a consequence, martyrs are generally viewed by the state as peculiarly dangerous criminals because they commit offenses of the heart, mind, and soul, striking at society's definition of duty, honor, and loyalty. Common criminals—murderers, thieves, and vandals—can be summarily executed and forgotten. Martyrs, however, live on after death. Not only their bodies but also their reputations and the validity of their ideas must be destroyed. Initially the state branded martyrs as perverts and lunatics, and in the eyes of Rome all Christians were sodomites, cannibals, and "enemies of the human race."

In the twentieth century, totalitarian governments have attacked martyrs' individuality and exceptionality, dismissing them as social deviants in need of rehabilitation. They have been denied the chance to stand out from the herd and deprived of the publicity so necessary to their cause. The public Roman arena and the Spanish *auto-da-fé* have been replaced by the high walls of the prison and the mental hygiene clinic, where technicians, armed with electric probes and "truth"-inducing drugs, reshape the strongest personality. As Russian novelist Alexander Solzhenitsyn wrote in 1970, "The incarceration of free-thinking healthy people in madhouses is SPIRITUAL MURDER; it is a variation on the GAS CHAMBER, but is even more cruel: the torture of the people being killed is more malicious and more prolonged" (Rubenstein 1985, p. 137). In their battle to rearrange society more in accord to the truths they hold dear, martyrs must display great strength of body and mind, but in the face of modern technology they may well be an endangered species.

There are all sorts of martyrs. Some seek to test themselves and their faith upon the cross of martyrdom. Some regard themselves as the athletes of truth and God's instruments on earth. Still others pursue paradise and reputation through heroic deaths or nurture stubborn and overly tender consciences that cannot yield or compromise. There are the forgotten or defrocked martyrs such as Thomas Becket, whose bones 358 years after his death were tossed out upon the dunghill, his shrine destroyed, and his reputation in the eyes of the sixteenth-century English state changed from martyr to traitor. Finally, there are the unknown martyrs whose numbers are beyond reckoning. But one and all have possessed the conviction that they could "serve as well by dying as by living" (Gandhi 1958–1984, vol. 54, p. 269).

See also: BROWN, JOHN; HOLOCAUST; IMMORTALITY, SYMBOLIC; ISLAM; JESUS; SACRIFICE; SOCRATES

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MASS KILLERS

When terrorists attacked the World Trade Center in New York City and the Pentagon in Washington, D.C., on September 11, 2001, it was not the most extensive example of mass murder ever committed, but it did have a great impact on the world, launching an extensive "war on terrorism." This incident is just one of thousands of examples of mass murder perpetrated throughout human history.

Mass Murder Defined

Murder is the killing of one person by another person with "malice aforethought"; there may or may not be premeditation. Generally, a person who murders restricts his or her act to one victim. A mass murderer, however, slays three or more victims over a short period of time. The duration is typically hours but can be days. If the act takes place in one location, it is usually continuous. *Murder spree* is a term that criminologists use if the victims are killed at more than one location. Michael Kelleher, in his 1997 book *Flashpoint*, also adds the phrase "mass murder by intention," providing the 1996 example of Larry Shoemake in Jackson, Mississippi, who killed only one victim even though he fired more than a hundred rounds of ammunition and torched a restaurant. Mass killers differ from serial killers in that serial killers murder their victims separately and over a period of time, with a cooling-off period between murders. Serial killers

may slay victims for years until they are caught or turn themselves in to the authorities.

Historical Overview

The site and time of the first mass murder is unknown. The Bible delineates numerous examples of mass murder including Samson's slaying of the Philistines (Judges 16:27–30) and King Herod's order for the murder of all male children who were two years old or less in the region of Bethlehem while trying to kill Jesus (Matt. 2:16). The thanatologist Panos Bardis notes that in ancient Greece it was common to cremate a fallen Greek hero with several enemy soldiers who were still alive. Archaeological excavations have revealed the murder and burial of a royal court with a deceased king. The purpose was to serve their leader in the afterlife. One of the earliest examples of mass murder in the United States took place on August 10, 1810, at Ywahoo Falls, Kentucky, when racist whites murdered over 100 Cherokee women and children. Since the Ywahoo Falls incident the number and examples of mass murders in the United States and other parts of the world have been numerous and varied. Perhaps the most extreme example of late-twentieth-century mass genocide occurred in 1993 when nearly 1 million Rwandans were slaughtered over a period of 100 days by the Presidential Guard, elements of the Rwandan armed forces, and extremist military.

Psychological Profiles of Mass Murderers

One of the difficulties in gathering data on the mass murderer is that he or she often commits suicide. The terrorists involved in the World Trade Center and Pentagon tragedies died when the planes they hijacked hit their objectives. Dylan Klebold and Eric Harris committed suicide after their mass murder at Columbine High School in Littleton, Colorado, on April 20, 1999. Therefore some information about types listed in this entry is limited.

Kelleher outlines seven categories of mass murderers who have somewhat different motivations and profiles. These categories include perverted love, politics and hate, revenge, sexual homicide, execution, psychotic, and unexplained. Ronald and Stephen Holmes, in their book *Mass Murder in the United States* (2000), provide a different typology. Holmes and Holmes use some

types from Park Dietz, including the family annihilator, the disgruntled type, and the set-and-run type. The authors then added the disciple killer, the ideological mass murderer, the disgruntled employee, and the school shooter. Both Holmes' and Kelleher's typologies were created before the attack on the World Trade Center and the rash of suicide bombings; however, the string of early-twenty-first-century events falls under Kelleher's category of politics and hate.

Perverted love. Kelleher's first category is defined by the concept of perverted love, with an example being the family man who kills his entire family out of his own depression or pathology. Perverted love killings may be either of two types: family murder/suicide or a family killing. In the first category, more commonly done by males, the individual commits *suicide by proxy*, a term from the psychiatrist Shervert Fraser used by James Fox and Jack Levin in their book *Overkill* (1994). The families of the offender are seen as part of the self. If there is no happiness in life for the self, then, he reasons, there is no happiness in life for the extended self. He views himself as saving his family from future suffering. The egocentrism of this individual does not allow for his family to have a different opinion on life.

The individual who engages in a family killing without suicide is demonstrated by the example of Ronald Gene Simmons, the father of his daughter's son, who killed fourteen members of his family on Christmas in 1987 when his wife threatened to divorce him. Mass murderer Julio Gonzalez became jealous of his girlfriend in 1990 and torched the Bronx's Happy Land Social Club, killing nearly all ninety-seven persons inside. There have been other instances where a mass murder has been committed to protect a family member or members. During the Allen-Edwards feud in Hillsville, Virginia, on March 13, 1912, feudists entered the courtroom where a family member was being tried, and killed the judge, sheriff, commonwealth attorney, a juror, and an innocent bystander.

Politics and hate. The second type of mass murder involves politics and hate. Adolf Hitler blamed the Jews for Germany's problems, and the result was genocide. The terrorists who attacked the World Trade Center and other suicide bombers perceive the victims as violating one of the terrorists' political or religious goals. From his or her

perspective, the death is viewed as for the greater good because the individual has eliminated a number of people whose views differ from his or hers. Even this minimal expectation may not always be true due to the randomness of the victims. Galvanizing the alienated opposing side into political action and a cycle of revenge is also an obvious and frequently counterproductive consequence of such a terrorist choice for mass murder. According to the September 24, 2001, issue of *Time*, the profile of the suicide bomber before September 11 had been of a young man, aged eighteen to twenty-four, who had been born in poverty and was full of both despair and zealotry, having nothing to lose. But the suicide bombers of September 11 showed a shift in profile. These men were older and had the option of middle-class lives because of their education and technical skills. One of them left behind a wife and children.

According to the April 15, 2002, issue of *Newsweek*, there have been 149 suicide bombing attacks against Israel since 1993, with the perpetrators being most often single (87.2%), from Hamas (47%), residing on the West Bank (59%), between seventeen and twenty-three years of age (67.1%), and possessing some or a full high school education (37.6%).

A differing example of mass murder involving politics and hate includes Timothy McVeigh and Terry Nichols, who bombed the federal building in Oklahoma City on April 19, 1995, because they were angry at the federal government over the 1993 Waco, Texas, raid against the Branch Davidians. They are classified as set-and-run murderers in the Holmes and Holmes typology, for this type of killer sets the killing device in motion, then leaves the location, as McVeigh did before killing 168 people, including twenty children.

Revenge. Revenge killings involve a murderer who gives “payback” to someone who is perceived to have humiliated him or her. The killer’s own personal responsibility is rationalized away and blame is conveniently placed on others. One subtype of this motivation is the Holmes and Holmes type of disgruntled employee, the workplace murderer. David Burke, a fired airline employee, followed his boss onto a plane on December 7, 1987, shot him, and caused the plane to crash, killing forty-three people. Pat Sherrill, fearing that he might be fired from his postal job, killed fourteen

coworkers and wounded six others in the Edmond, Oklahoma, post office on August 20, 1986. Mark Barton, a day trader, became angry after losing a great deal of money and on July 29, 1999, killed his family and entered two brokerage firms, slaying nine and wounding twelve.

Though innocent victims are frequently killed in this type of assault, workplace mass murderers typically plan the assault and are selective in their hunt for particular prime victims. The depersonalization of others is viewed by Kelleher as symbolically eliminating the whole organization or school and is called *murder by proxy* by Fox and Levin. They also point out that murderers in general have an average age of twenty-nine, but workplace mass murderers have an average age of thirty-eight. While a younger man can still see opportunities in the future, the older man sees his salary and/or status disappearing, with no satisfactory substitute in sight. Although many people experience job loss without becoming mass murderers, workplace murderers have frequently experienced chronic or recent social isolation. The only factor in their lives that is meaningful to them is their job or career, and they are incapable of coping with their problems in adaptive ways by changing their behavior. Interestingly, the workplace mass murderer will often have no significant criminal record, and others will perceive him or her to be reasonable or at least harmless. Typically, many years of frustration have occurred before the fatal event.

Fox and Levin’s analysis of workplace killers also showed that 93 percent were male and more than 70 percent were white. Female mass murderers in general are less likely to choose guns or bombs, leaning more toward poison or accidents. Even in suicide, females are less likely to use firearms and more likely to use drugs, indicating that males are more acculturated to lethal mass weapons.

Some individuals, whatever the source of their frustration, lash out at random victims, such as the case of Thomas Hamilton. Upset at losing his volunteer position as a scoutmaster in Dunblane, Scotland, he entered the Dunblane Primary School twenty years later and killed seventeen children on March 13, 1996. James Oliver Huberty, after losing both his job with Babcox and Wilcox and his job as a private security guard, entered a McDonalds restaurant on July 18, 1984, and over a period of one hour and fifteen minutes killed twenty-one

victims and wounded twenty. Holmes and Holmes categorize him as a disgruntled citizen because his victims were complete strangers.

A second subtype of revenge killer identifies his or her problems as coming from a particular “target group” in society. The target group killer may have a vendetta against the persons killed and/or blame the group for personal or societal problems. Marc Lepine, an avid woman hater, slaughtered fifteen “feminists” studying engineering in a Montreal, Canada, school in 1989, then committed suicide.

A third subtype of revenge killing is the school killing. Eric Harris and Dylan Klebold murdered their thirteen victims at Columbine High School on April 20, 1999, in response to societal hatred, a search for fame, and revenge resulting from ridicule by fellow schoolmates. The researchers J. Reid Meloy, Anthony Hempel, and their colleagues analyzed a sample of thirty-four adolescent mass murderers whose median age was seventeen and who had killed alone or in pairs between 1958 and 1999. They divided the sample into five types, as follows: the classroom avenger, the family annihilator, the bifurcated killer (family and classroom), miscellaneous, and the criminal opportunist. The criminal opportunist simply commits a mass murder during the course of another crime and falls into Kelleher’s execution classification.

Meloy and Hempel found that 70 percent of their sample were termed “loners,” 62 percent abused alcohol or drugs; many were preoccupied by violent fantasies; 42 percent had a credible history of violence against a person, animal, or property; and 43 percent were bullied by others. Forty-one percent had a history of at least one sexual-affectual bond with a female. Only 23 percent had a history of psychiatric hospitalization or at least one visit to a mental health professional, and only 6 percent showed evidence of psychosis.

The authors cite the researchers McGee and DeBernardo’s 1999 study of fourteen cases of mass murder, with the murderer profiled again as a “loner or outcast” with no violent history and a middle-class suburban or rural family. According to their study, this type of mass murderer had many violent fantasies, and there was a precipitating event of peer rejection or authority discipline. They showed atypical depression or mixed personality disorders.

The authors point out several differences distinguishing adolescent from adult mass murderers. First, adolescents experience a high rate of bullying, even compared to a baseline of most students, who report being bullied at least once, and a baseline of 14 percent of both boys and girls who say they suffer severe trauma from bullying abuse. When the killer reciprocates that violence with lethal violence, he or she shows identification with the aggressor, now reversing roles and assuming the aggressive posture.

A second difference pointed out by the authors is that one out of four mass killings by adolescents involve killings in pairs. The authors view this as seeking approval from a peer, which is part of adolescent development. In each of the seven pairs in their sample, one perpetrator was dominant.

A third difference among adolescents is discussed by the scholars George Palermo and Lee Ross, who note that there are few suicides of adolescents after their murders. The authors hypothesize that adults have a higher level of moral conscience and recognize in some way the horror of their behavior on a conventional level and the subsequent social and moral consequences. Juveniles feel that because they were wronged it is acceptable to behave at a level of reciprocity, which is a pre-moral level in the psychologist Lawrence Kohlberg’s theory of moral development.

Sexual homicide. A significant number of killings have been perpetrated by a desire to achieve sexual gratification through inflicting pain on the victims (sadism) and/or receiving pain by being kicked, scratched, pinched, or bitten by the victim. Richard Speck was influenced by drugs and alcohol when he killed eight student nurses, raping some of them in the process, on July 13, 1966, in Chicago. Numerous mass murderers such as Peter Manual and “sex beast” Melvin Rees were sadists and derived sexual pleasure from killing their victims and mutilating the corpses. The ultimate pleasure for some masochistic killers is being executed.

Execution. The execution mass murderer kills for greed and personal gain and may engage in either cold-blooded killing for profit or the unplanned execution of witnesses. The St. Valentine’s Day Massacre of 1929 was a result of turf rivalry between Al Capone and “Bugs” Moran concerning the whisky business. William Burke and William Hare, Irish laborers and body snatchers living in

Edinburgh, Scotland, killed approximately eighteen persons in 1829 and delivered their bodies (for dissection purposes) to medical schools, impelled by a desire for money. Jack Gilbert Graham, irritated at his mother when she came to visit him in Denver Colorado, in 1955, decided to murder her for insurance money. He presented her with a bomb wrapped as a Christmas present to take home with her on the plane. It exploded, killing forty-three people on board. Belle Guinness, America's most notorious murderess, killed several people on her Indiana farm in 1908, including her husbands (and potential husbands), adopted daughter, and biological children for monetary reasons.

Psychotic. The psychotic type is a category used to describe a murderer who has a significant mental disorder. Charles Whitman was suffering from a brain tumor when he randomly killed eighteen people at the University of Texas on July 31, 1966. Martin Bryant was suffering from a mental disorder when he went on a rampage on April 28, 1996, in Port Arthur, Tasmania, killing thirty-five people. Howard Unruh, a World War II veteran suffering from posttraumatic stress disorder, became upset with his neighbors in East Camden, New Jersey, and went on a murder spree in September 1949, slaying thirteen individuals. Mental disorder has been an issue in numerous cases in the first two years of the twenty-first century, when a mother has slain her dependent children. Examples include Marilyn Lemak in Naperville, Illinois, who killed three children and Andrea Yates in Houston, Texas, who killed five. Although only a minority of mass murderers are actually severely mentally ill or psychotic, many have other psychological disorders, according to Kelleher. These include clinical depression, as well as antisocial personality disorder, paranoia, alcohol and/or drug abuse, and obsessions of control. Kelleher points out that these types of murderers frequently have a childhood that includes separation, physical or sexual abuse, and family violence.

Unexplained. Those murders that cannot be explained fall into the unexplained group. For example, authorities could never figure out why Thomas Eugene Braun went on his killing spree in 1967. While several hypotheses exist, there is no definitive explanation of why Charlie Lawson, a North Carolina farmer, killed his wife, six children, and himself on Christmas Day, 1929.

Weapons and Media Influences

Influences on mass murder that come not from the individual's personal life but from society include media news or motion pictures about mass killers. Adolescent murderers mentioned *Natural Born Killers* (1994) and *The Basketball Diaries* (1995) as movies that had influenced them, according to Meloy and Hempel. The *copycat effect* is a term that criminologists use to describe society's increased rate of a low-probability event—such as a suicide, skyjacking, or suicide bombing—after such an event is publicized in the media. This phenomenon was clearly operating when James Wilson shot children at a Greenwood, South Carolina, school in September 1988. He had been saving a photo of Laurie Dann, who had appeared on the cover of *People* magazine after committing a similar crime. On May 20, 1988, Dann entered a classroom in Winnetka, Illinois, carrying three pistols, and began shooting children—killing one and wounding five others before killing herself.

Mass murderers have used a variety of weapons. Anton Probst and Lizzie Borden used an axe to slay their victims. Timothy McVeigh, Terry Nichols, Jack Gilbert Graham, and numerous suicide bombers used explosives to perform their acts of murder. Most contemporary mass murderers in the United States employ automatic weapons, particularly hand guns. Males in many parts of the United States feel comfortable with guns as a part of the gun culture; men have been hunting together for both food and recreation since the days of the early republic.

The future for prevention of mass murder is somewhat pessimistic. As long as there is a gun culture or a means for mass destruction, there will be mass murder. As long as the mass media exists, there will be examples for copycat killings. However, the less publicity, glamorization, and reward these actions receive, the less likely it is that individuals will choose such actions in the future.

See also: GENOCIDE; HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; ORGANIZED CRIME; SERIAL KILLERS; TERRORIST ATTACKS ON AMERICA

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MAYA RELIGION

At the time of Spanish contact in the sixteenth century the Maya were not a single, unified political or cultural entity, but rather were composed of competing as well as allied city states and kingdoms,

many of which spoke mutually unintelligible Mayan languages, including Quiche, Tzotzil, and Yucatec. Thus, to avoid overgeneralizations it is important to specify particular Maya cultures when mentioning sixteenth-century accounts. Aside from the sixteenth-century contact period, documents written in Spanish and Mayan languages, there is the rich corpus of texts and imagery pertaining to the Classic Maya (c. 250–900 c.e.), much of which can be read and interpreted for a detailed look at Maya religious practices.

One of the most important sources concerning the contact period is the *Relación de las Cosas de Yucatan*, (Account of the Things of Yucatan) written by the Franciscan Priest Diego de Landa in the 1560s. Landa described in some detail the burial customs of the Yucatec Maya, including a period of fasting and mourning, especially for the husband and wife of the deceased. The corpse was wrapped in a shroud, with maize gruel and a precious bead placed in the mouth. The body was then interred in the house floor, which then was usually abandoned. Landa also noted that people of high rank were often cremated. In this case, the Mayan elite may have been evoking Central Mexican burial practices. Although cremation is generally rare in the Mayan region, it is well documented for the Aztec. According to Landa, the bead placed in the mouth would serve as money in the afterlife. However, it is more likely that the stone signified the life spirit, as in the case of the Aztec, who considered the mortuary bead as the symbolic heart of the deceased. In a description of royal funerary rites in highland Guatemala, the Dominican cleric and chronicler Fray Bartolome de las Casas noted that a precious bead was passed before the mouth of the dying king to capture his expiring breath soul. In ancient Maya art, this breath soul is commonly portrayed as a jade bead or flower floating before the face. Moreover, one of the more common death expressions appearing in Classic Maya texts concerns the expiration of a floral breath soul.

According to Landa, the Yucatec Maya conceived of two afterlife realms, the dark underworld known as *Metnal* and a paradisaical place of plenty, where the souls would be shaded by a tree in the center of the world. The underworld was the foul realm of the skeletal death god *Ab Cimih*, also known as *Cizin*, meaning "flatulent one." The



Mayan Temple I is characterized by multiple steps and located at the religious site of Tikal in Guatemala. Aside from the planting and growth of corn, the dawn rising of the sun was another basic metaphor for resurrection and rebirth in the Maya religion. CORBIS

sixteenth-century *Popol Vuh* (a text concerning the mythology and history) of the Quiche Maya of highland Guatemala gives a very detailed description of the underworld, here known as *Xibalba*, or “place of fright.” The lords of *Xibalba* were malevolent gods of death and disease who, although deceitful and cunning, were eventually defeated by a mythic pair of hero twins.

Many mythic episodes of the sixteenth-century *Popol Vuh*, including *Xibalba* and the hero twins, are present among earlier Classic Maya. Perhaps because of the abundant death imagery on Classic Maya vases, scholars have often assumed that hellish *Xibalba* constituted the only afterlife destination. However, one of the more common classic period themes concerns the hero twins reviving

their father, the maize god. In Classic Maya thought the burial and resurrection of the deceased was compared to the planting of the moribund maize kernel, temporarily buried but destined to re-emerge. One extraordinary carved vessel, commonly referred to as the “Death Vase,” portrays both metaphors of death and resurrection. On one side of the vase three anthropomorphic cacao trees rise out of the skeletal corpse. The central tree is clearly the Maya maize god. The opposite side of the vase portrays the maize god as a supine, bundled corpse. Floating directly above the corpse is a solar disk, quite probably denoting the ascension of the soul into the sky. In Classic Maya art, deceased kings are commonly shown in solar disks or apotheosized as the sun god. Given the identification of the Maya sun god with war and warriors, the Classic Maya may have conceived of a celestial paradise similar to that of the later Aztec, a brilliant, flower-filled realm of heroic kings and warriors.

See also: AZTEC RELIGION; INCAN RELIGION

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KARL A. TAUBE

MEMENTO MORI

The Latin term *memento mori* has long served as a reminder of mortality. Literally meaning, “Remember you will die,” the term has traditionally been linked with striking images and stories of dying. Exceptionally clear examples of this tradition can be seen in New England graveyards, where tombstones from the late seventeenth and eighteenth centuries often contain two phrases: “*Memento mori*” and “*Hora fugit*,” which means, “The hour flees.” These lines explain the accompanying images of hourglasses, skulls, bones, and winged

death’s heads. The gravestones thus ask passersby to remember not only the deceased but their own mortality as well.

The *memento mori* reached extravagant heights in Europe between 1300 and 1600 with four new motifs. First, the Dance of Death featured skeletal figures leading people of every rank—from pope to plowman—into a final dance. The historian Jean Delumeau discovers the dance’s moral in a fourteenth-century manuscript of the Catalan poem, *Dansa de la Mort*: “Toward death we hasten, / Let us sin no more, sin no more” (Delumeau 1990, p. 74). Second, in the Triumph of Death, an armed death figure drives a chariot drawn by oxen. As the French social historian Philippe Ariès comments, this image of “collective” death recalls both the processions honoring a prince’s arrival and royal funeral processions. Third, the era’s most individualized and grittily realistic *memento mori* motif occurs in double-decker tombs. The top carvings portray the deceased lying dressed in full regalia; but the carvings beneath present the deceased as exposed *transi*, or decaying corpses. Finally, in the legend of the Three Living and the Three Dead, three well-dressed men are out hunting, and as they approach a cemetery three dead men attack them. This image accompanies the prayers for dead in a *Book of Hours*, a prayer book from the late fifteenth century. The margins reinforce the image’s point with skulls and scrolls reading “*Memento mori*.”

The prevalence of these motifs has been explained in several ways. Beginning in 1347 the Black Death decimated Europe. Coupled with wars and failing crops, disaster of this scale reshaped society. As Delumeau and Ariès have shown, these empirical forces reacted with a culture of guilt and emerging individualism. Both perspectives found a compelling message in the *memento mori* motifs. As sermons constantly proclaimed, life is short, status and wealth will not last, so prepare to die. Only the prepared will avoid hell and enjoy heavenly life. In all its forms, the *memento mori* thus incited people to learn the *Ars moriendi*, or “art of dying well,” which required one to live righteously in preparation for death. New England tombstones undoubtedly continued this message.

When *memento mori* images appear apart from explanatory sermons and verses, they remain deeply ambiguous. Their focus on the body and its



In Guyot Marchant's 1485 version of the story, *The Three Living and the Three Dead*, the living survive the encounter, pray before a cross, and resolve to change their lives. FREE LIBRARY OF PHILADELPHIA, RARE BOOK DEPARTMENT

decay led historians like Emile Mâle and Alberto Tenenti to contrast these motifs with Christian belief. And as both Delumeau and the art historian Paul Binski note, being reminded of one's mortality can lead in directions that preachers would not approve: Because life is short, one should enjoy its pleasures while they last. These ambiguities also permit the tradition's images of skulls, bones, and decaying flesh to be used and manipulated in popular culture. They can fuel horror films and give an ironic edge to rock bands. Yet the tradition also retains possibilities for more probing, reflective efforts like the "Memento Mori" episode of television's *X-Files*, where Agent Scully confronts her diagnosis of a brain tumor. Remembering one's death can still exert a transforming power.

See also: ARIÈS, PHILIPPE; ARS MORIENDI; BLACK DEATH; DANSE MACABRE; ONTOLOGICAL CONFRONTATION

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DONALD F. DUCLOW

MEMORIALIZATION, SPONTANEOUS

Spontaneous memorialization is a rapid public response to publicized, unexpected, and violent deaths, typically involving the accumulation of individual mementos to create a shrine at the death site. Most spontaneous memorials start within hours of death notification; someone leaves a candle or bouquet of flowers, which is followed quickly by contributions from others. Well-documented spontaneous memorials have appeared near mass death sites like the park overlooking Columbine High School in Littleton, Colorado (the site of fifteen fatal shootings in 1999), the fence surrounding the Alfred P. Murrah Federal Building in Oklahoma City (where a bomb blast killed 168 people in 1995), and the homes of celebrities (e.g., mountains of bouquets were left at the palace of Great Britain's Lady Diana, Princess of Wales, when she died in an auto accident in 1997). Spontaneous memorials also occur in response to less celebrated deaths: the local store owner who died in a robbery, the pedestrian hit by a drunk driver, the child too near the window when a gang member started shooting.

The sociologist C. Allen Haney and colleagues have noted several ways in which spontaneous memorialization is less restrictive than traditional memorial formats, including the following:

- There are no rules of inclusion/exclusion. Anyone (including those who had never met the deceased) can participate, but no one is expected to do so.

- Timing is flexible. Typically one can join the memorial process at any time of day and for however long the memorial is in place. In Oklahoma City, for example, objects were left on the fence for years after the bombing.
- There is no expected ritual behavior. Mourners have been known to weep, pray, curse, gawk, and even videotape at the scene; some express emotions that are taboo at more traditional memorials, especially anger and guilt. Correspondingly, objects left behind do not follow a single theme; traditional death offerings, religious symbols, and idiosyncratic secular objects are common.
- The focus of memorialization varies. While those who knew the deceased mourn the loss of the individual, others grieve over the social pathologies that might have contributed to the death.

Spontaneous memorials also differ from traditional forms of memorialization by appearing where the death occurred (or at a location associated with the deceased) rather than in a site reserved for the dead. Spontaneous memorials thus tend to be impermanent but are an everyday reminder that death can happen to anyone, anywhere, at any time.

Haney and his colleagues postulate that the prevailing death practices in the United States (e.g., the removal of death, dying, and mourning from everyday life), coupled with the spread of the belief that the timing of death can be controlled, contribute to spontaneous memorialization. They suggest that unexpected, violent deaths, especially where the deceased is engaged in mundane, everyday (and presumably safe) behavior, openly violate the assumptions that death can be controlled and that death happens elsewhere. As a consequence, such deaths not only compel the immediate community to mourn but also broaden the community to include those whose lives were shaken by the death because of a perceived connection with the deceased. Members of this broader community, connected by collective mourning, go one by one to the death site to acknowledge their grief and to create a single memorial composed of their diverse, individual offerings. In this practice of honoring their dead, mourners define and reinforce their community connections.

See also: BEREAVEMENT, VICARIOUS; CELEBRITY DEATHS; FUNERAL INDUSTRY; LINCOLN IN THE NATIONAL MEMORY; ROYALTY, BRITISH; SYMPATHY CARDS

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MEMORIAL, VIRTUAL

Virtual memorials, also called web memorials, are web pages or sites specifically dedicated to honoring the dead. Cyberspace tributes to the dead appeared shortly after the creation of computer-based communication. Initially most tributes were responses to death notifications on billboards and in listserv formats. While such tributes continue to appear in most cyberspace community venues, many individuals are utilizing a more permanent and accessible form of acknowledging their dead.

Memorial Types

Web memorials vary by individual involvement, cost, and connection to established ritual. The

most individualized of web memorials are freestanding web pages, which are rapidly increasing in number as the Internet and web page technology become more accessible. Because they are freestanding and there is no single term to describe them, these web pages may be overlooked by search engines, making an estimate of their number difficult. However, even incomplete searches indicate that there are a myriad of memorials for individuals as well as for group tragedies, including airplane crashes, school shootings, and other sudden violent deaths.

More accessible are the growing number of web rings devoted to memorializing the dead. Web rings are individual web pages with a common theme that are linked together so that one can travel from page to page until one comes full circle, returning back to the first web page. Most memorial web rings are run by volunteers who created the web ring in reaction to their own loss. Usually there are no charges and few requirements for linking individual memorial pages to the web ring.

Most memorial web rings are grouped by the relationship of the deceased to the memorial author or by cause of death. Web rings devoted to deceased children are the most common. Generally, there is an opening page that describes the web ring, its mission, and a list of the children memorialized. Clicking on the child's name will take the visitor directly to his or her memorial, or one can view memorials in sequential fashion, using the links at the bottom of each web page to view the next memorial in the ring. Like freestanding memorial web pages, memorials linked to web rings are often elaborate, with pictures (sometimes video) and music. Many memorials have multiple pages devoted to the story of the child's life and death and links to bereavement resources. Most memorial web pages have a guestbook or an e-mail link so visitors can contact the author directly.

Both freestanding web memorials and those linked to web rings are created and maintained by the bereaved. However, Internet services change periodically and volunteer managers vary in their ability to maintain web rings. Consequently, creating and maintaining memorial web pages requires some computer expertise and the willingness to make modifications as they become necessary.

An alternative to creating individual web pages is placing a memorial in a web cemetery, of which

there are several. The oldest web cemeteries are Virtual Memorial Gardens (VMG) (<http://catless.ncl.ac.uk/vmg/>) and Dearly Departed (www.dearlydeparted.net), both free services that began in 1995. VMG is the largest web cemetery, housing thousands of human memorials. Both VMG and Dearly Departed accept e-mail tributes to the dead, which the cemeteries convert into web memorials and arrange alphabetically. Other than requesting the name of the deceased and their birth and death dates, neither service specifies format, content, or length requirements. Consequently, the size of memorials varies, from the simple recording of names and dates to memorials that exceed two single-spaced pages of text. Content also varies, with the majority of memorials emphasizing personal stories about the deceased, while fewer than 10 percent include the accomplishments and affiliations stressed in newspaper obituaries. Another variable is audience; approximately 30 percent of memorials are written as letters to the dead. Once a memorial is posted in either of these web cemeteries, it is maintained by them and considered permanent, much like the graves in traditional cemeteries.

Freestanding web memorials, memorials linked to web rings, and memorials sent by e-mail to the above online cemeteries are free, once one has gained access to the web. Other free web cemeteries include several sites devoted to the memorialization of pets, the largest of which is the Virtual Pet Cemetery (www.mycemetery.com) and sites that include pet memorials along with human memorials, like Virtual Memorial Gardens. All of the free web cemeteries were created and are maintained by either a single individual or a small group of unpaid volunteers, which can affect their services. For example, in 1998 all of the cemeteries previously mentioned requested help from those who utilized their services because of the increasing volume of memorial submissions.

Although there are free services, the majority of web cemeteries charge some fee for the posting and upkeep of memorials. Fees range from ten to fifty dollars for most web cemeteries and generally do not reflect the breadth of services provided by each site. For example, World Wide Cemetery (www.cemetery.org), one of the oldest and best organized sites, has all the amenities of other web cemeteries but charges a one-time fee of ten

dollars. Their memorials have an individual guestbook, can include pictures and links, and are arranged alphabetically on individual web pages.

Most web cemeteries evoke images of traditional cemeteries, with pictures of cemetery gates or gardens on their opening pages. Opening pages often invite visitors to “enter” their cemetery, and once inside, web cemeteries tend to be visually consistent; memorials have similar features and there are simple methods of traveling from one memorial to another (usually through a list of links to memorials or letters of the alphabet). This visual continuity provides a sense of place and to many, a feeling of community; as with traditional cemeteries, other losses and the people who mourn them are nearby.

Most web cemeteries were started in the mid-1990s; since that time, closely related services called “online memorial sites” have appeared on the web. Rather than employing one general format for memorials, most online memorial sites provide a variety of prototype memorials from which the bereaved can choose, making online memorial sites more diverse than web cemeteries. Online memorial sites generally utilize a search engine for locating memorials, so that typing a name on the opening page takes the visitor directly to a particular memorial. This feature provides quick access for the visitor, but limits the experience of the memorial site as a whole that is provided by the listing of names in most web cemeteries. Therefore most online memorial sites are more difficult to browse than web cemeteries where the visitor can stroll from memorial to memorial as easily as in any graveyard.

Online memorial sites and web cemeteries also differ in the cost and length of time memorials are posted. In general, online memorial sites are more costly, with prices reflecting the number of pictures and links included in the memorial, as well as the addition of audio and video clips and e-mail guestbooks. Many online memorial sites also charge according to the length of time the memorial is posted, charging by the month or year. Therefore, unlike the majority of web cemeteries (where permanent memorials are free or provided at a one-time cost), many online memorial sites use the model of the newspaper obituary for their pricing; the more elaborate and longer running tributes are more expensive. In general, costs at

online memorial sites are at least \$100 for posting a memorial for one to three years. Although the initial involvement by the bereaved is similar, online memorial sites may provide less sense of community than web cemeteries because of their potential lack of permanence, increased diversity, and more limited access to other memorials. Examples of online memorial sites are Perpetual Memorials (www.memorials.com) and Virtual Memorials (www.imminentdomain.com).

The popularity of web memorialization has not escaped the funeral industry; many mortuaries are adding the creation and maintenance of web memorials to their list of services. For example, Flintofts Funeral Home and Crematory in Issaquah, Washington, offers a web memorial at no extra charge with all memorial packages, and attached over 400 memorials to their web site from 1999 to June 2001. While their memorials have individualized backgrounds, the general format is the same, with at least one picture of the deceased, information on services and viewings, and a general biography. Unlike other web memorials where the text is written by the bereaved, mortuary-based memorials are written by funeral directors and read more like extended obituaries. Therefore, there is an emphasis on accomplishments, memberships, and survivors, rather than the stories and letters favored by the bereaved. While mortuary-based memorials remove the bereaved from direct involvement in their creation, web technology is utilized to better inform the community and to extend their communication with the bereaved. At the bottom of each memorial are buttons for printing, signing the memorial guestbook, and viewing their list of memorials.

Functions

All web memorials provide a tribute to the dead that can be accessed anytime from almost anywhere. Those lacking an internment site or who live too far away can visit a web memorial when it is most meaningful to them—whether at midnight or midday. Many memorials are visited frequently, and the authors of freestanding or web ring memorials return to maintain them, much like one tends a grave.

Most web memorials provide a way to contact the bereaved, typically through an e-mail guestbook. Guestbooks give anyone the opportunity to offer condolences, potentially expanding the

support network available to the bereaved. Also, guestbooks remain available to visitors and the bereaved long after the normal condolence cycle.

Most web memorials are not limited to a certain size, allowing the bereaved to create more lengthy and personal tributes than in other forms of memorialization. The psychologists Marcia Lattanzi and Mary E. Hale found that after traditional postdeath rituals have ended writing to and about the dead can aid in the expression of emotion, creating a sense of perspective and sharing about the death. Web memorials can be a catalyst for talking with others about the dead as well as a method for sharing with those who never knew the deceased. In addition, creating the web memorial can be a group activity, where sharing strengthens existing relationships.

However, the function of web memorials depends on the type of memorial established. Death educators have argued that the more removed the bereaved are from the ritual process, the less beneficial the rituals will be. From this perspective, mortuary-based memorials may be the least useful, while freestanding memorials or memorials linked to web rings may provide the greatest benefits to the bereaved.

All web memorials except mortuary-based tributes (with their ties to the timing and purchase of traditional services) provide opportunities for publicly memorializing the dead that are not available in other venues. There are no restrictions on who writes a memorial (and for whom); those who have felt disenfranchised in the death system are given the opportunity to engage in this public ritual when they may have been denied access to others. Traditionally disenfranchised groups like parents of miscarried babies, pet owners, and friends of the deceased are frequent authors of web memorials. Web memorials can be created at any time (even years after the death), providing the opportunity to honor continuing bonds with the dead. In addition, the cost of web memorials is not prohibitive—even the most expensive web memorial services are cheaper than most traditional obituaries or grave markers.

Questions and Concerns

The web has created new opportunities for memorializing the dead that appear to enhance the lives of the bereaved. However, because web

memorialization is a late-twentieth-century phenomenon, many issues concerning the future of web memorials remain unresolved. Three of the most troubling issues are:

1. Web memorials could substitute ritual: Web memorialization appears beneficial when used as a supplement to traditional rituals, with time and greater acceptance, web memorials may be considered a substitute instead, perhaps taking the place of rituals that foster direct human contact.
2. Web memorials could remove the bereaved from the process of death: Positive elements of web memorialization include writing, constructing, and maintaining one's own memorial to the dead. As more services remove the bereaved from this process, the abilities to express emotions, share thoughts with others, and continue caretaking activities for the deceased are compromised.
3. Web sites may not be permanent: Web memorials depend on a stable web site and someone to periodically check their functioning. Therefore, the continued existence of web memorials depends on the bereaved themselves, volunteer site managers, and/or for-profit companies. But who will tend the memorials when the companies go out of business and the volunteers become unavailable? Physical graves remain in place after years of neglect, but will web memorials?

As the web has grown and diversified so have web memorials to the dead. Used as a supplement to traditional ritual, such memorials provide extended opportunities to honor the dead and have more meaningful communication about the dead with the living. However, the future course of web memorialization remains to be determined.

See also: BURIAL GROUNDS; CEMETERIES AND CEMETERY REFORM; GRIEF: CHILD'S DEATH, FAMILY; INTERNET; LAWN GARDEN CEMETERIES; VIETNAM VETERANS MEMORIAL

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PAMELA ROBERTS

METAPHORS AND EUPHEMISMS

Twenty-first-century human beings live in a culture in which "dead" is a four-letter word. Because four-letter words have a reputation for being obscene, death is obscene to modern sensibilities; that is, to those in modern death-denying cultures who rarely have firsthand experiences with the dying and the dead. Modernity has afforded people the ability to hide the dying process from public view; and often people see the dead body of a loved one to be so polluting that they pay strangers to dispose of "it" properly. The modern mind can abstract death, further buffering itself from death's horror, through the use of metaphor and euphemism when describing the dead. In daily conversations the deceased tend to pass or fade away, embark on a desired trip to meet their eternal reward or loved ones ("Grandpa is back with Grandma"), or merely fall asleep ("She earned her rest").

Some scholars argue that our circumlocutions should be understood as evidence of death denial, as should such colorful expressions as "buying the farm," "pushing up daisies," or "kicking the bucket." On the other hand, euphemism has a long tradition of use when dealing with the topic of death, and the use of metaphor is often inevitable when trying to explain certain facets of the human condition, particularly death.

Humans are symbolic creatures, perceiving and experiencing their social worlds largely through their symbols, many of which are figurative and metaphoric. Instead of understanding metaphors as embellishments of facts, they are better conceived as ways in which these facts are experienced, filtering and shaping apprehensions of social reality and understandings of things about which they are unfamiliar—like death.

Distinctive metaphors and euphemisms have emerged from the various social institutions directly involved with death. The more powerful the institution, the more likely its metaphors leak into everyday parlance and produce common worldviews. Over the twentieth century, these have included the military, medical, and political orders—the social institutions primarily responsible for death control.

Twentieth-century militarism had a powerful effect on death's metaphoric framings. In George Orwell's futuristic novel *Nineteen Eighty-four* (1949), the Ministry of Truth proclaimed "War is peace." In the twenty-first century war is "pacification." The military sanitizes its lethal activities through benign labels (e.g., the Nazis assigning carloads of concentration camp-bound to *Sonderbehandlung*, meaning "special treatment") or by dehumanizing its enemies (who are "fumigated," "exterminated," or "wasted" like cockroaches and rats). In *Doublespeak* (1989), William Lutz distinguishes euphemism, which covers the unpleasant, from doublespeak, whose purpose is to deceive and mislead. To illustrate the latter, he noted how the U.S. State Department replaced "killing" with "unlawful deprivation of life." Dead enemy soldiers are "decommissioned aggressor quantum." Deaths of innocent civilians are referred to as "collateral damage." When commandos parachuted in the early 1980s American invasion of Grenada, the Pentagon referred to the action as a "predawn vertical insertion."

In *Illness As Metaphor* (1978), Susan Sontag describes the military metaphors applied to disease, the alien invaders that breach bodily defense systems necessitating surgical, chemical, or radiation counterattacks. The frontline in the cultural war against death is the medical establishment. Here death has long been viewed as failure, giving rise to a host of clinically detached euphemisms. Patients "go sour," their respirations cease, or they are simply "no longer with us." Emergency room nurses make references to someone being "DDD" ("definitely done dancing") or "getting bagged."

The euphemisms extend to those most likely to die—those who have lived the longest lives. The most death prone are not "old people" but rather "senior citizens," "Golden Agers," or simply "the mature." They die in "homes"—rest homes, nursing homes, retirement homes—where they are too

often deindividualized and victimized by underpaid staff.

In the political arena, heated battles on the moralities of abortion and euthanasia have produced a new language for death-related matters. In the contest between social movements supporting or opposing legalized abortion and euthanasia has emerged the self-referencing “pro-choice” and “pro-life” labels. For those opposing assisted or accelerated death, “active euthanasia” is a euphemism for murder. For proponents, the practice of keeping the terminally ill alive on hi-tech life supports is “technological torturing” of the dying.

Crisp mortality references often enter into American parlance when referring to non-thanatological matters. People often “die” symbolically, as when failing in their social performances. One certainly does not want to be “dead wrong,” an office “deadwood,” a “deadbeat” father, or within a “dead-end” job. Companies may adopt a “poison pill” defense against a hostile takeover attempt, leaving workers worried about being “axed” or appearing on “Schindler’s List.” The symbolic potency of such death metaphors rise with increases in the centrality of work roles to the identities of men and women. Studies have shown that when a business facility shuts down workers often go through the deathlike stages described by the death expert Elisabeth Kübler-Ross. A late 1980s survey of Richmond, Virginia, entrepreneurs published in the *Wall Street Journal* cited nearly six in ten saying failure was the incident they feared most, with fear of death being but a distant third for both sexes. And when the worker actually does die, he or she dies metaphorically in occupationally unique ways: Deceased soldiers “answer their last roll call,” chefs “lay down their knife and fork,” actors “make a final exit,” and boxers “take the last count.”

Among those whose job it is to deal with the dead, death professionals as scholar Michael Lesy calls them, metaphors arising from their humor produce the death desensitizations required for them to cope with society’s “dirty work.” Among themselves, funeral directors, for instance, refer to embalming as “pickling” or “curing the ham,” cremation as “shake and bake,” and coffins as “tin cans.” When dealing with the public, the “patient” (not the corpse) is “interred” (not buried) within a “casket” (not coffin) beneath a “monument” (not tombstone).

So what do all of these colorful, humorous, consoling, deceptive, demeaning, and frightful framings of death mean? Are they useful? The metaphors and euphemisms that people apply to the dying and the dead shape the way the living now see their connection with the dead. They can sanitize the profound pollution posed by a decaying corpse and assuage the profound moral guilt of collective murder during times of war. They can reaffirm the meaningfulness of the deceased’s life (“He lives with us all”) or degrade their very existence (“The vermin were whacked”).

Perhaps another way to think about the matter is to ask how many words there are that solely capture the single fact that this person or creature is no more. “He died” is the simplest way English speakers can make the point. From there on, everything is an elaboration of a phenomenon of which none of the living has any direct knowledge. The military borrows from the medical when it conducts its surgical operations to remove “the cancer”; the medical from the military in its “wars against enemy diseases.” In sum, metaphors and euphemisms for death are employed as both shields and weapons, to cover the unpleasant or distasteful aspects of mortality, or to apply the power of death to reinforce the significance of certain events among the living.

See also: CHILDREN; COMMUNICATION WITH THE DYING; SHAKESPEARE, WILLIAM; TABOOS AND SOCIAL STIGMA

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MICHAEL C. KEARL

MIND-BODY PROBLEM

What color is a thought? How much does a thought weigh? How tall or short or how fat or skinny is a thought? Precisely where in space and time are thoughts located? What is the temperature of a thought? What is the speed of a thought?

Indeed these are very odd sorts of questions. The oddity itself is revealing: Thoughts do not seem to belong to the class of things that can submit to such questions or provide their answers. Thoughts do not seem to have size, shape, weight, color, velocity, mass, temperature, or location. Sometimes, of course, a thought can be described as "heavy" or "weighty," as in a philosophical discussion that considers such profound thoughts as "Is there a God?" and "Does my life have an objective meaning?" Thoughts can also be described as "dark," as in the statement, "The psychotic mind engages in dark thoughts such as murder and suicide." And people can speak of a "hot" idea, as in the slogan, "Wireless computers are now a hot idea." But these are all metaphorical uses of language. These statements do not literally mean that thoughts can have weight, color, or temperature. In short, the very nature of thought itself raises some serious questions.

Thought, or consciousness itself, does not seem to easily fit into the world of physical nature. In nature, people constantly encounter things with physical characteristics—trees, animals, automobiles, rocks, and other objects, all of which have physical properties such as weight, shape, and color. The human body, too, seems to belong to

this world of nature, for it has size, weight, mass, and color. However, physical characteristics do not seem to be appropriate when discussing mental realities such as thoughts or consciousness in general. Does this mean that the mental world is somehow different from the physical? Does this mean that there are at least two separate realities or substances in the world: minds and bodies? Consequently, what will be the relevance of these questions to issues concerning death?

Dualism

Dualism is the view that there are, indeed, at least two kinds of realities: the physical—characterized by measurable properties such as weight, location, size, and color; and the mental—characterized by nonphysical and immeasurable qualities such as immateriality. Dualism is a very old tradition, having many proponents. Some scholars claim that Plato (428–348 B.C.E.) was the first to make a sharp distinction between the mind and body. For Plato, the relationship between the mind and body is not an ideal one—in fact, the body can be seen as the "prisoner" of the mind or soul, which is the true person. In death, the mind and soul are separated. The body decomposes into its original elements, but the mind or soul cannot decompose because it is not a composed material substance. Therefore, the mind or soul cannot die. In Plato's works one sees the direct result of dualism with regard to the question of death: It provides hope for survival of the person after the death of the body.

However, other scholars argue the tradition of dualism did not begin with Plato. Perhaps the first philosopher to offer this position was Pythagoras (6th century B.C.E.). Pythagoras believed in the transmigration of the soul—the view that the soul is immortal and is bound up with the divine soul, to which it may return when "purified" after its separation from its temporary physical house (the body). Presumably there are any number of transmigrations of the same soul, as taught in the doctrine of reincarnation in religions like Hinduism.

Although Plato is not the "father" of dualism, certainly he provided a far more extended treatment and defense of the doctrine than anyone who came before him. The Platonic dualism had great influence on Christian thinking, though it could not be made perfectly consistent with scriptural views

since Plato shared the Pythagorean belief in transmigration of the soul. The greatest of the early Medieval thinkers was Augustine (354–430) who held,

Man is not a body alone, nor a soul alone, but a being composed of both . . . the soul is not the whole man but the better part of man; the body is not the whole but the inferior part of man . . . and when both are joined they received the name of man. (*Dods 1872, p. 24*)

We can say that Christianity, for the most part, adopted a form of Platonic dualism as its official view, which went more or less unchallenged until Aquinas (1225–1274) who followed Aristotle's line of thinking on the mind-body relationship. Aristotle (384–322 B.C.E.) disagreed with Plato, his mentor and teacher, and provided a closer relationship between the mind and the body, claiming that the soul is the "form" of the body.

In modern philosophy it is René Descartes (1596–1650) who is most associated with dualism. Descartes's philosophy radically separates the mental and the physical, by claiming that they are, indeed, two very different kinds of substances. In his *Meditations*, he writes:

There is a great difference between the mind and the body, inasmuch as the body is by its very nature always divisible, while the mind is utterly indivisible. For when I consider the mind, or myself in so far as I am a thinking thing, I am unable to distinguish any parts within myself. . . . By contrast, there is no corporeal or extended thing that I cannot think of which in my thought I cannot easily divide into parts; and this very fact makes me understand that it is divisible. This one argument would be enough to show me that the mind is completely different from the body, even if I did not already know as much from other considerations (*Cottingham 1966, p. 9*)

But Cartesian dualism suffered from the beginning under the criticism of the "interaction problem." Namely, if mind and body are radically distinct substances, how is it that the mind and body can interact at all, as they obviously do?

Dualism has been under severe attack in the twentieth century, especially since Gilbert Ryle's

book *The Concept of Mind* (1949). Some support for dualism, however, can be found in works such as Arthur Koestler's *The Ghost in the Machine* (1967); Karl Popper and Sir John Eccles's *The Self and Its Brain* (1977); and Zeno Vendler's *Res Cogitans* (1972) and *The Matter of Minds* (1984).

Monism

Those who deny that mind and body are two different and distinct realities, are called monists. Monism holds that there is only one ultimate reality, and that mind and body are essentially reducible to it. The oldest tradition within this view is known as materialism, which states that the ultimate reality is physical matter, and all that is or ever was arises out of and is ultimately reducible to matter. Perhaps the first real materialism is the view of atomism as proposed by Leucippus (c. fifth century B.C.E.) and Democritus (c. 460–360 B.C.E.). According to this view, all things are composed of indivisible particles of matter (atomoi). The human soul, too, is composed of "soul-atoms" which may be different from others in being smooth and spherical, but they are atoms nonetheless. Epicurus (342–270 B.C.E.) later adopted the Democritean materialism to argue that death is nothing to be feared since it is simply the dissolution of the soul into its original atoms. The Roman philosopher-poet Lucretius (c. 95–55 B.C.E.) also developed materialism as an attempt to rid human beings from religious fears by arguing against any nonphysical soul, and therefore proposing the mortality of all human beings.

The most important materialist in the modern period is the English philosopher Thomas Hobbes (1588–1679), who was greatly impressed by the progress during his day within science and mathematics. Galileo and Johannes Kepler, in particular, had shown the importance of using mathematics with careful observation of moving bodies in space. True knowledge, Hobbes felt, seeks to observe and understand true reality, which for him, is made up simply of "bodies in motion." For Hobbes, all reality and substance is corporeal or material. He firmly believed that someday science would be able to offer a full account of all reality based on a materialistic model, without recourse to a transcendent, incorporeal God. Nearly two centuries after Hobbes's death, Charles Darwin's *Origin of Species* (1859) and Thomas Henry Huxley's

Man's Place in Nature (1863) provided scientific support for just such a materialistic explanation for the origins and development of life, without resort to any outside immaterial agency or deity.

In contemporary times, science has made some progress in showing that life itself may be understandable in terms of biological and biochemical terms. Much of the focus in the twenty-first century has centered on the question whether the mind can be completely reduced to materialistic and mechanistic functions. Many philosophers, beginning with the analytic thinkers, began to hold to a materialist or "physicalist" position. A variety of more or less materialistic views have emerged. One of the most popular theories to emerge since the 1950s is the "mind-brain identity theory," developed by Herbert Feigl, U. T. Place and J. J. C. Smart, which holds that "mental states are quite literally identical with brain states" (Borst 1970, p. 13). Other forms of materialism contend that mental states are reducible to "statements about behavior" and are therefore referred to as "behaviorism" (p. 15).

Perhaps the most famous philosophical behaviorist is Gilbert Ryle. His book, *The Concept of Mind* (1949), has had a major impact for many in discrediting dualism. Ryle refers to the concept of dualism as "Descartes' Myth" and as "the dogma of the Ghost in the Machine." The myth of dualism, he contends, is the result of a type of mistaken thinking which he calls a "category mistake." The example Ryle uses illustrates it best. Imagine someone on a campus visit of a university. He receives a full tour of the university, visiting the classroom buildings, the library, and the dormitories. At the end of the tour, the visitor then asks, "But where is the university?" He has mistakenly assumed that the university is some separate entity existing apart from all of its constituents. He has mentally placed "university" in the same category as "classroom buildings," "library," and "dormitories." But the university is not some separately existing entity alongside of the buildings that make it up; rather it stands for the entire collection. So, too, Ryle contends, the "mind" should not be thought of as some separate entity in the same category as "body" (or brain).

Partly because of Ryle's arguments, many philosophers have ceased to talk about "the mind" as a separate category. The focus since the 1970s has been on mental activity or consciousness in

general. Perhaps the most audacious work comes in Daniel Dennett's *Consciousness Explained* (1991), which provides more attacks on dualism, but attempts to explain consciousness in terms of brain events has not avoided its critics either. Dennett himself agrees the task is difficult: "Scientists and philosophers may have achieved a consensus of sorts in favor of materialism, [but] getting rid of the old dualistic visions is harder than contemporary materialists have thought" (Dennett 1991, p. 37). Thinkers who have provided serious obstacles to any simple materialism include Jerry Fodor's *A Theory of Content and Other Essays* (1990), Roger Penrose's *The Emperor's New Mind* (1989), and John Searle's *Intentionality: An Essay in the Philosophy of Mind* (1983).

Relation to Death

The mind-body issue has crucial impact on questions concerning death. In the end, the materialist's position is that a person is identical with his or her body; or that the "mind" is identical with the brain and its functioning. When the body/brain dies, therefore, there is no continuation of the person; there is no hope for an afterlife. The dualist position does not identify the person with his or her body/brain. Therefore dualism leaves open the door for belief in an afterlife. For most, this is primarily a religious question that cannot be resolved by philosophy or science.

The mind-body issue has bearing on how one defines death. Does death occur only when the body expires? When exactly does this happen? The Harvard Brain Death criterion defines death as including a flat electroencephalogram (EEG). The materialist position would seem supportive of such a view. If death is the end of the person, and if the person is to be identified with something like brain functioning, then it would follow that one should define death as an event tied to something like a flat EEG.

But is there something like a mental death as well, which is totally separate from physical death? Consider such medical cases as Karen Ann Quinlan and Nancy Cruzan, where the brain is still functioning, but where the forebrain—the most human part of the brain—is destroyed. Both cases were famous U.S. euthanasia cases and each had their forebrains destroyed through illness. Cruzan's case (request for euthanasia by family) went to the U.S.

Supreme Court (1989). Some scientists, along with the Quinlan and Cruzan families, argued that the patients in those cases (referring to the person as identified with some qualitative, human, mental life) were already dead; that is, Quinlan and Cruzan, as the persons the families knew before their accidents, were already gone. Keeping their bodies alive was, they argued, a grotesque injustice.

According to death researchers like R. S. Morison, the human being does not die as a unit. According to this view, life in any organism has no real sharp beginning and end points. Defining death is all the more difficult with a complex organism such as a human being. The dualist would seem supportive of this recognition that mental death (or the death of the person) may occur before and apart from physical death, because it does not identify the person with brain functioning. The mind-body debate, therefore, has relevance for a number of issues concerning death, such as religious concerns about an afterlife and moral issues such as euthanasia.

See also: AFRICAN RELIGIONS; BUDDHISM; CHINESE BELIEFS; CHRISTIAN DEATH RITES, HISTORY OF; IMMORTALITY; ISLAM; JUDAISM; NEAR-DEATH EXPERIENCES; PHILOSOPHY, WESTERN

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WILLIAM COONEY

MISCARRIAGE

Miscarriage, or in medical terminology spontaneous abortion, is the termination of a pregnancy from natural causes before the time the fetus can survive for even a few minutes outside the uterus. (Induced abortion is the term used for those expulsions of an embryo or fetus that are artificially induced by mechanical means or drugs.) Miscarriage generally occurs before the twentieth week of pregnancy. A fetus born dead from natural causes after twenty weeks is called stillborn. Perhaps 50 to 78 percent of all fertilized eggs spontaneously abort. Only about 10 to 15 percent of the time are women aware that they have miscarried. Spontaneous abortions often seem to be functional in that they naturally eliminate many fetuses that may have birth defects.

Before miscarrying, a woman usually has spotting or more obvious bleeding and discharge from the vagina. The uterus contracts, causing pelvic cramps. Bleeding, discharge, and cramps become more severe if the miscarriage continues, and part or all of the contents of the uterus may be expelled. One miscarriage does not mean that later pregnancies will spontaneously abort, however, and about 70 to 90 percent who have miscarried eventually become pregnant again. Only about 1 percent of women suffer three or more miscarriages, perhaps because of anatomical, hormonal, genetic, or immunological factors.

About 85 percent of miscarriages happen in the first twelve weeks of pregnancy; the remaining 15 percent occur between thirteen and twenty weeks. The most likely reason is an abnormality in fetal development, usually as a result of extra chromosomes (about 60% of miscarriages). Occupational exposure to some chemicals may increase the chances of having a miscarriage. Other possible causes include chronic infections, unrecognized diabetes in the mother, and defects in the uterus. About one-third of the time there is no known cause for the miscarriage. Many studies have indicated that emotional disturbances in the mother's life are not usually linked with miscarriage. Miscarriage does, however, cause emotional disturbance in the lives of many women. Women tend to blame themselves: "I exercised too hard"; "Stress at work caused this"; "I fell down and hurt the baby." However, stress or physical trauma rarely results in a miscarriage, and health care professionals advise women not to blame themselves.

American society tends to define the loss of the fetus as "just a miscarriage," but most women who experience a miscarriage see the loss as a death—the death of a life or the death of a dream. Research indicates that losing a baby due to miscarriage can be a devastating experience for family members. Some women consider suicide after a miscarriage. Some couples' relationships are thrown into turmoil as a result of the loss. Some surviving siblings will feel guilt that they somehow caused the death, and will grieve in silence. However, researchers have found that families who support each other through these difficult times are likely to end up feeling stronger and more deeply committed to each other.

See also: ABORTION

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JOHN DEFRAIN

MISSING IN ACTION

It is a value of possibly all known cultures that the remains of their fallen warriors be retrieved so that they can be buried with all the honor due those who sacrificed their lives for the group. It is also one of the greatest indignities for an enemy to deny such ritualization. Today there are teams of American civilian and military personnel scouring the jungles, mountains, and waters of Southeast Asia for the remains of military servicemen who were listed as missing in action (MIA) from the Vietnam War. In addition, forensic teams are pursuing leads in recovering and returning remains of MIA servicemen from both the Korean War and World War II. These search teams are a direct result of the efforts of the Vietnam-era wives who, unlike the wives of previous wars, banded together to improve the living conditions in which the American POWs were living in. After the return in 1973 of the American POWs in Operation Homecoming, the group's focus shifted to the return of all U.S. prisoners, the fullest possible accounting for those still missing, and repatriation of all recoverable remains.

Military Missing Personnel

The United States' Department of Defense (DOD) lists a military serviceman as MIA if "he or she was not at their duty location due to apparent involuntary reasons as a result of hostile action and his/her location is not known" (Department of Defense 1996, p. 5). In addition, three criteria guide the accounting process for missing personnel by the Defense Prisoner of War/Missing Personnel Office:

(1) the return of a live American; (2) the return of identifiable remains; and (3) provision of convincing evidence why the first two criteria are not possible. Since the 1950s the DOD has listed thousands of military personnel as missing in action. There are more than 2,600 American servicemen listed as MIA from the Vietnam War; approximately 8,900 from the Korean War; and an additional 80,000 from World War II. If one considers only the immediate family members missing servicemen, the number of people affected by the MIA tragedy is in the hundreds of thousands.

In past wars, when military personnel were listed as MIA, their status was reviewed after one year according to the Military's Missing Persons Act. A tribunal of fellow military personnel familiar with the war situation was convened. Evidence was presented as to whether the serviceman should continue to be carried as MIA or changed to the status of killed in action/body not returned (KIA/BNR). Most MIA statuses in the Vietnam War were not changed, as had been done in prior wars, because of reliable U.S. intelligence reports indicating hundreds of MIA servicemen possibly being alive and held in captivity. By the 1980s the U.S. government changed all but one MIA to a presumptive finding of death (PFOD), despite the official position that "we cannot rule out the possibility that American POWs or MIAs were left behind at the end of the [Vietnam] war" (The National League of Families, October 1997). The goal of the United States continues to be the return of any live Americans, the repatriation of all recoverable remains, and the fullest possible accounting for those still missing.

Known Death versus Unknown Death

Normally, when one thinks of grief it is in the context of the loss of a loved one through a "known" death. A known death is when a person dies and there is a body that gives physical testimony to that individual's death. For the bereaved, the grieving cycle can begin as the body confirms, against deepest wishes, that the deceased no longer lives in the physical world (Attig 1991). Therefore, when one thinks of a loss it is usually equated with a documented death and a physical body to mourn over.

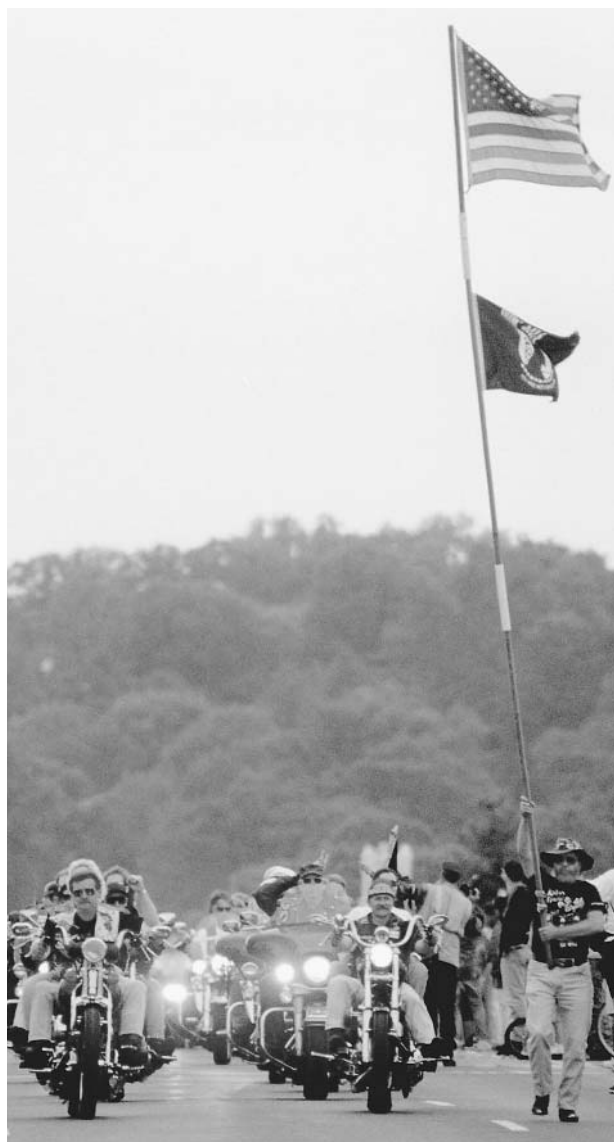
The missing in action status is unique in that the loss is not final. There is no certainty of death,

no "physical body" to identify or mourn over, and no official documentation of the person's death. The MIA situation is similar to individuals who are lost through natural or human disasters (i.e., floods, tornadoes, shipwrecks, or airplane crashes) and whose bodies are never recovered. The difference between the two losses lies in the cognitive realization that death is certain even though there is no body to identify.

Grief and the MIA Loss

When the bereaved learn of the death of a loved one they begin a process of grief and, after a culturally accepted period of time, achieve grief resolution. When the military authorities first notify the MIA families that their loved one is "missing in action" the initial shock is typically followed by the hope for rescue or the known status of prisoner of war (POW). When this hope is not immediately realized, the family members begin exhibiting the first symptoms of the grief cycle, such as shock, numbness, and disbelief (Freud 1917, 1957; Bowlby 1961; Parkes 1970). Thus, the MIA wartime casualty is a paradox. On the one hand grieving is triggered by the MIA loss, which causes the family members to try and make sense of the loss, break their emotional and internal attachments to the deceased, and reintegrate the deceased within one's self, thereby reaching closure. On the other hand, MIA family members have largely been unable to bring grief to closure due to the lack of evidence to support the death and the persistent belief (hope) that the missing serviceman may still be alive. Further complicating the picture is the fear that by letting go and reaching grief closure, the MIA family members are abandoning the missing serviceman. This fear can give rise to feelings of guilt and betrayal. The result is that, for many MIA family members, the grieving process is interrupted and drawn out indefinitely. In the absence of any credible evidence the MIA family members remain in bereavement limbo, "figuratively 'stuck in time' and unable to go forward" (Hunter 1988, p. 312).

The clinical psychologist Pauline Boss argues that MIA families face another type of challenge. She describes the concept of boundary ambiguity in which the family does not know with certainty "who is in" and "who is out" of the family system. Boss posits that as long as there is ambivalence about the role of the husband/father and when the



Motorcyclists, during the eleventh Annual Memorial Weekend Rolling Thunder Rally, ride in protest of the U.S. military's unwillingness to acknowledge prisoners of war and failed attempts to find those missing in action. AP/WIDE WORLD PHOTOS

psychological husband/father presence is maintained, “the family system, systemic communication, feedback, and subsequent adjustment [to the ambiguous loss] over time are curtailed” (Boss 1977, p. 141). This ambivalence can lead to family members feeling helpless and more prone to depression and anxiety, leaving them poorly equipped to achieve closure to their grief work.

When the Vietnam War officially ended in 1975, some of the wives of the missing were able

to accept the fact that their loved ones were probably never coming home—they were dead. Some of the wives eventually remarried and moved on with their lives. But have these wives or their children forgotten the husbands/fathers that they waited so many years for? More important, have these family members been able to fully accept their loss and attain a state of grief closure? Edna Hunter-King suggests that this is not so. The following is an excerpt from a 1983 interview of a wife who had “closed the book and got on with living” by remarrying:

I've come to realize that his remains have not been returned so there is no finality to it. Also, all the news in the papers recently [about the possibility of American POWs still being held in Southeast Asia after the war ended] has upset me. I didn't know I was still vulnerable. . . . What if he were still there? I can't even think about it! . . . Looking at this thing 10 years later, I feel less removed now than I did, say, seven years after Homecoming. (*Hunter 1988, p. 323*)

For many MIA families the uncertainty and ambiguity of the wartime loss have transformed the journey of grief from one with a clear endpoint and closure into one of extended, indefinite grief (Hunter 1998). Many MIA family members exhibit patterns of grief, including avoidance, denial, guilt, intrusive thoughts, and preoccupation with the loss. However, because these symptoms are prolonged, they are often misinterpreted as dysfunctional and in many cases can lead to an assessment of frozen, impacted or unresolved grief—all “maladaptive” forms of grief. The MIA trauma highlights the misunderstanding that an ambiguous loss can engender. The ambiguous nature of the MIA loss challenges grief therapists and researchers alike to devise new models of therapies, which may help the MIA families find meaning in the loss, learn to live with the uncertainty, and move forward with their grief.

Several family members have offered the following suggestions to help others move forward in their grief. Family members, relatives, and friends can perform a small burial service wherein personal items associated with the missing serviceman are placed in a box and buried. Others have suggested that, when possible, visiting the physical location of the loss can bring a sense of “realness” and even

“finality” to the ambiguous wartime loss. Finally, dedicating a small area in a room and placing pictures, letters, medals, and memorabilia belonging to the serviceman can give meaning to the loss by creating a physical memorial to the missing serviceman, thereby making the loss more tangible.

For most MIA family members, however, the ambiguous MIA loss will be forever troubling and in many cases grief resolution will remain elusive due to the lack of finality regarding the fate of their missing loved one. As the grief experts S. Zisook and S. R. Shuchter wrote in 1986, “There is no prescription for how to grieve properly . . . and no research-validated guideposts for what is normal versus deviant mourning. . . . We are just beginning to realize the full range of what may be considered ‘normal’ grieving” (Zisook and Shuchter 1986, p. 288).

See also: CEMETERIES, MILITARY; CONTINUING BONDS; GRIEF: OVERVIEW, FAMILY; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; WAR

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MICHAEL S. CLARK

MOMENT OF DEATH

Is there a moment of death? Millions of death certificates provide abundant evidence—or do they? Many world religions also envision an awesome moment in which the soul departs from the body to continue its existence in another form. Furthermore, the moment of death is the signal for an abrupt change in society’s way of dealing with the individual: Medical attention gives way to mortuary services and rites of passage; the death is announced through formal and informal channels;

personal records are reclassified; the deceased person's assets are redistributed (or become the subject of conflict and litigation); and there is additional tension in situations such as organ donation and cryonic suspension. In each of these scenarios there is often a sense of urgency to move on to the next step whether this be the removal of organs to save another person's life or the preparation for cryostasis. The moment of death, then, has both symbolic resonations and practical consequences. Nevertheless, despite the definitions, assumptions, and beliefs that surround it, the moment of death can be quite an elusive concept.

Is There a Final Moment of Life?

The most common assumption in Western society is that life gives way to death in a "razor-thin" moment. This image has been reinforced by numerous movie and television scenes in which a sick or injured person suddenly falls silent and lies still, the struggle is then over. These depictions are also consistent with the inclination to see much of reality in dichotomous terms. One either wins or loses; one's conclusions are either right or wrong; a person is either good or bad, a friend or an enemy, and dead or alive. This way of thinking has the advantage of reducing complexity and ambiguity, but the disadvantages of oversimplification and premature judgment. By contrast, Eastern religions and scientific thought are more likely to emphasize process and flow. Buddhists and Hindus, for example, regard perpetual change as a basic feature of the universe. Within this worldview, living and dying can be regarded as a tidal play of forces that occur throughout life.

Death certificates seem to support the assumption that there is a clear and definitive moment of death when time of death is recorded. Often, though, this information is based on estimates rather than direct observation. A resident of a long-term care facility or a hospital patient may have been seen alive at Time A and then discovered dead at Time B. Precisely when the death occurred between A and B is unknown, but a time is recorded to complete the certificate. It is not unusual for the death certificate to be signed by a physician who was not there at the specified time. There can also be a strategic basis for selecting the moment of death. For example, a patient who dies in the operating room may not be pronounced dead until moved to a postsurgery unit.

No reliable information is available on the number of deaths that are actually witnessed, whether at home, in the community, or in medical care settings. Patients enrolled in hospice programs seem to have a better chance for companionship at the time of death, but even then this does not always happen. The collective experience of caregivers and researchers suggests that many people pass from life to death without another person at their side. Nobody knows if they experienced a definitive moment of death.

It can be difficult to identify a moment of death when the person has not been able to respond and communicate effectively for some time. This situation may arise after a stroke, drug reaction, or catastrophic failure of the cardiovascular or some other system. A nurse could detect the cessation of vital functions if the patient is on life support, and this might be considered the moment of death. Not all unresponsive patients are under this kind of intensive observation, however, and nurses may have conflicting duties to perform even when they are trying to monitor vital signs.

The moment of death has become a more problematic concept with the changing definitions of death and the technological advances that can keep basic physiological systems going even if there is no discernible mental functioning. The person may seem to have perished some time ago, and the moment of death may become a matter of professional, family, and legal decision making. Even a slight possibility of recovery, though, can create the lingering question of whether or not the moment of death has actually occurred.

How one decides to define the moment of death also depends on one's willingness to consider rigor mortis and other physiological processes that continue for some time afterward. The person is dead, but organic processes still have their sequences to complete.

The Mystery of the Moment

The moment of death is not as clear and firm a fact as many people have often supposed. It has been defined and assessed in many ways throughout history, and there may be other changes yet to come. For personal, religious, and bureaucratic purposes it is often useful to assume that a specific, identifiable moment separates life from death. Biomedical

research and experience offers only mixed support for this belief. The body becomes cooler after death, for example, but people have survived at even lower temperatures. A sudden “flat-line” shift in electrical brain activity is considered evidence for death, yet the readings may be continued for another twenty-four hours just to be sure.

Nevertheless, there have also been many observations to verify an obvious moment of death for some people. Companions have seen a person change in an instant, as though a subtle wave had passed through them (or a subtle something had passed from them). Everything seems to be as it was a moment before—except that a vital quality is missing and a shell of the person left behind. The sense of moment has occasionally been intensified by the feeling that an energy has been shared from the dying person to the companion. Known as the “death flash,” this phenomenon has not been successfully studied but has experiential validity for those who feel that they have been part of a mysterious transfer.

The moment of death is unlikely to be the same for the dying person and the other people who may be in attendance. The dying person might have a final experience before the signs become visible to others. Similarly, a person might be considered by others to have passed into death but actually retain some form of mental life, possibly even continuous awareness of the situation. Still again, death might occur so suddenly that the afflicted person has no time to register any experience. Battlefield deaths have provided many examples. Some soldiers killed in the battle of Gettysburg, for example, remained frozen in their active positions, such as scaling a wall. For these victims there may not have been a moment of death, but their last moments remained as though fixed forever in time for those who later entered the killing ground.

Depending on the perspective one takes, then, the moment of death can be seen to be a religious image, a bureaucratic convenience, or a socio-medical complexity.

See also: COMMUNICATION WITH THE DYING; CRYONIC SUSPENSION; GOOD DEATH, THE; LAST WORDS; LIFE SUPPORT SYSTEMS; ORGAN DONATION AND TRANSPLANTATION; SYMPTOMS AND SYMPTOM MANAGEMENT

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ROBERT KASTENBAUM

MORTALITY, CHILDBIRTH

Until the late twentieth century, and then only in developed countries, the mortality risks associated with childbearing were substantial. Although there are risks to infants, the following entry focuses on the mortality risks faced by mothers. Maternal mortality is measured by the maternal mortality ratio, which is the number of deaths related to pregnancy per 100,000 live births.

Getting an accurate measure of the maternal mortality ratio in many parts of the world is difficult primarily because one needs reliability in both the number of pregnant women and in the number of live births. A pregnant woman may die, perhaps due to an illegal abortion, but her death is not counted as pregnancy related either because her pregnant status is not ascertained or that information is withheld due to religious/moral convictions. In addition, maternal deaths extend to forty-two days past delivery or past pregnancy termination; if a woman is not receiving any medical care in the immediate postpartum period, her death may not be attributed to childbearing. The number of live births is not available in the countries that do not have a birth registration system. Even among countries that do, there may be systematic differences between countries in the designation of a birth as “live.” Thus statistics on maternal mortality for all but the most developed countries are best-guess estimates only.

Global Variation in Maternal Mortality

At the turn of the twenty-first century, there were substantial differences in maternal mortality. According to Women's International Network News figures, the number of maternal deaths worldwide per 100,000 live births is 430, with a sharp division between developing countries, where the maternal mortality ratio is estimated to be 480, and developed countries, where the ratio is 27. These ratios can be translated into women's lifetime risk of dying from pregnancy/pregnancy-related reasons: 1 chance in 48 in the third world contrasted with 1 in 1,800 in developed countries. The highest maternal mortality levels are found in eastern and western Africa; Mozambique's maternal mortality ratio is among the highest in the world at 1,500. The lowest levels occur in northern Europe.

Causes of Maternal Mortality around the World

Maternal mortality is the result of any number of complications that beset pregnant women worldwide. The most common direct causes of maternal death are severe bleeding (25%), infection (15%), unsafe abortion (13%), eclampsia (pregnancy-induced hypertension, often accompanied by seizures, 12%), and obstructed labor (8%). Fundamental to the reduction of maternal mortality is the identification of the wider social, economic, health, and political factors that are associated with it, an area that is the subject of considerable debate among policymakers. Some argue that maternal mortality is an unusual public health problem in that it is primarily affected by institutionally based medical interventions. This viewpoint is unusual in that most causes of death have responded more to public health initiatives (e.g., clean drinking water, sanitation) than to medical interventions. According to this view, the way to reduce maternal mortality is through the provision of emergency obstetrical care. In contrast, others argue that the key factor in maternal mortality is the disadvantaged status of women, a position that reframes maternal death as a social justice issue. Maternal mortality is viewed as the accumulation of a number of risks that girls and women face (e.g., malnutrition, female genital mutilation, premature marriage and pregnancy, lack of family planning mechanisms for child spacing) that reflect the relative lack of status and worth accorded to them in certain countries.

Both medical and social factors play important roles in maternal mortality. There is clear evidence that medical interventions are important in reducing maternal mortality, as long as those interventions are performed by trained personnel. Especially important is competent emergency obstetrical care. Research done in rural Gambia shows that prenatal care is far less effective than emergency care in reducing the rate of death related to childbirth. This fact may be because many of the life-threatening complications that accompany pregnancy and delivery cannot be predicted for individual women. Also important is the provision of family planning services, which operate to lower the number of births and thus reduce the risk of maternal death. Evidence on the importance of social factors in maternal mortality is less well documented. Overall maternal mortality is much lower in societies in which women have higher educational levels and higher social status. However, there is no direct one-to-one relationship between improvements in women's social conditions and reductions in maternal mortality. Nevertheless, access to legal abortion is important in reducing deaths because legal abortions are more likely to be performed in a clean environment by trained medical personnel. It is estimated that about one-half of abortions lead to maternal death in Indonesia where abortion is illegal; this translates to the deaths of nearly 1 million women per year. In certain third world countries, the provision of safe and legal abortion is bound up with cultural views about gender roles, and is intimately related to women's position in society.

Maternal Mortality in the United States

Figure 1 shows the trend in the maternal mortality ratio in the United States over the course of the twentieth century. Maternal mortality ratios were over 600 (somewhat higher than in the contemporary developed world) until the early 1930s, when decline commenced. (The high rates around 1920 are likely due to the global influenza epidemic.) Compared to general American mortality decline, this is a late starting date; reductions did not occur despite an increasing proportion of deliveries in hospitals, the introduction of prenatal care, and the increased use of antiseptics in labor and delivery. Two reasons have been given for the lack of reduction in maternal mortality during the first third of the

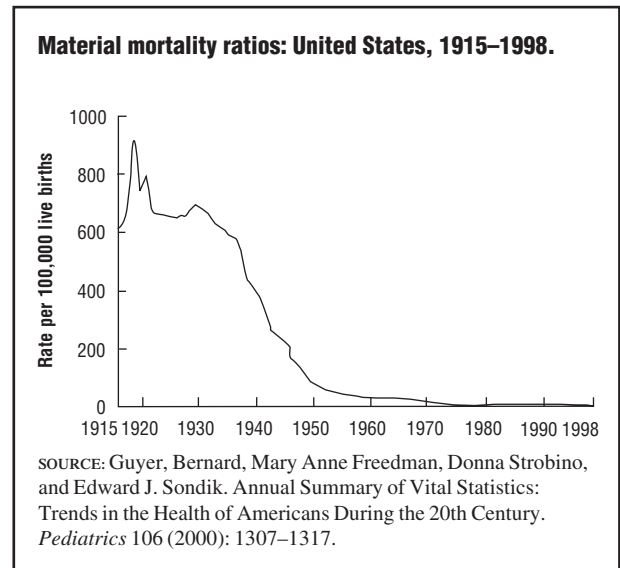
twentieth century: Women either received no care or care in which the attendant did not recognize the severity of complications; and women received improperly performed medical interventions. It is likely that the second reason was more of a factor because unnecessary or improperly performed interventions and a lack of careful antiseptic procedures were common during that time period.

The huge decline from the mid-1930s to the mid-1950s (from 582 to 40) has been attributed to a number of factors: the shift in responsibility for maternity care to obstetricians; the introduction of new antibiotics, the establishment of blood banks (along with blood typing and transfusion procedures); the introduction of safer types of anesthesia; and safer use of forceps. A good portion of the decline from the mid-1950s is due to declining infections related to septic abortion, resulting from the liberalization of abortion laws starting in the early 1960s and the legalization of abortion in 1970.

Although the timing of the decline in maternal mortality was late in the United States relative to general declines in mortality, the same can be observed for England and Wales. With improved living conditions (e.g., nutrition, sanitation), the nineteenth century saw reductions in infant mortality and in deaths due to infection, with little benefit from medical advances. However, reduction in maternal mortality had to wait upon the development of medical interventions and procedures, and their proper use. While later declines were dependent upon social and political change (i.e., acceptance of abortion), the early and very large decline in maternal mortality was the product of medical advance. The dependence of safe childbirth on medicine is at odds with a trend commencing in the late twentieth century in Western societies to return to an idealized demedicalized childbirthing past. The evidence is compelling that medicine is key to safe childbirth.

The contemporary maternal mortality ratio in the United States is 7.7, a level that has remained unchanged since the early 1980s despite reductions in general and infant mortality and despite a national goal to reduce maternal mortality to no more than 3.3 by 2000. Part of the reason for the failure to meet this goal is the existence of a persistent and large racial difference in maternal mortality. African-American women—who bear 16 percent of U.S. babies—have a maternity mortality

FIGURE 1



ratio (19.6) that is nearly four times higher than white women (5.3). The reasons for the racial disparity are not clear. Some of the factors that are likely involved include racial differences in susceptibility to high blood pressure, a leading cause of maternal death; general health; and receipt of high-quality prenatal care. However, generalizations are difficult, especially given state differences. For example, the maternity mortality ratio for African Americans varies from a low of 8.7 in Massachusetts to a high of 25.7 in Washington, D.C.

The rate of decline in maternal deaths had stalled, and persistent racial differences—showing a substantial African-American disadvantage—remain. Yet, almost no research, either by biomedical or by social scientists, is addressing these issues. As a result, the safe motherhood goal of maternal mortality less than 3.3 has not been achieved in America.

See also: CAUSES OF DEATH; GENDER AND DEATH; MORTALITY, INFANT

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ELLEN M. GEE

MORTALITY, INFANT

Infant mortality refers to deaths of children under the age of one year. It is measured by the infant mortality rate, which is the total number of deaths to children under the age of one year for every 1,000 live births. The infant mortality rate is often broken down into two components relating to timing of death: neonatal and postneonatal. The neonatal mortality rate refers to the number of deaths to babies within 28 days after birth (per 1,000 live births). Sometimes a special type of neonatal mortality is assessed. The perinatal mortality rate measures the number of late fetal deaths (at or after 28 weeks gestation) and deaths within the first 7 days after birth per 1,000 live births. The postneonatal mortality rate involves the number of deaths to babies from 28 days to the end of the first year per 1,000 live births. The distinction between neonatal (and perinatal) and postneonatal mortality is important because the

risk of death is higher close to the delivery date, and the causes of death near the time of birth/delivery are quite different from those later in infancy. Therefore, effective interventions to reduce infant mortality need to take into account the distribution of ages at death of infants.

Many developing countries lack the resources to keep track of infant deaths; therefore data for these areas are estimates only. Another methodological problem in measuring infant mortality is ascertaining the number of live births. Sometimes this problem is one of undercounts of births (i.e., births are not registered and thus not counted); sometimes the difficulty lies in inconsistently differentiating stillbirths and live births, especially across countries because this distinction is not as clear-cut as one might imagine.

Infant Mortality in International Perspective

Table 1 provides infant mortality rates for the world, for developed and developing countries, and by continent, with some selected countries that highlight the range of levels. At 57, the world's infant mortality rate has never been lower; however, differences across the world are substantial. Africa's rate (88) is ten times higher than the average rate (8) for the developed countries. Within Africa the highest levels of infant mortality in the world are experienced, with rates as high as 157 in Sierra Leone. On average the rate for Asia (56) is somewhat lower than for Africa, but some Asian countries such as Afghanistan have rates (150) as high as anywhere in the world. On the other hand, Hong Kong's rate (3.2) is very low, illustrating that the most variation in infant mortality level occurs in Asia. Both Europe and North America (the United States and Canada) have low levels of infant mortality, with average rates well under 10. However, European variation is not inconsequential; rates in at least some parts of Eastern Europe are nearly 10 times higher than in northern European countries such as Iceland and Sweden.

Overall, income and education, both at the societal and individual levels, are closely associated with infant mortality. While the relationship between infant mortality and level of socioeconomic development is not perfect, the infant mortality rate is commonly used more than any other measure as a general indicator of socioeconomic well-being and of general medical and public health

TABLE 1**Infant mortality rates by region
(and selected countries), 2001**

| Area | Rate |
|--------------------------------------|------|
| World | 57 |
| Developed Countries | 8 |
| Less Developed Countries | 63 |
| Africa | 88 |
| Sierra Leone | 157 |
| Western Sahara | 150 |
| Liberia | 139 |
| Asia | 56 |
| Afghanistan | 150 |
| East Timor | 143 |
| Hong Kong | 3.2 |
| Europe | 9 |
| Iceland | 2.6 |
| Sweden | 3.5 |
| Albania | 22 |
| Romania | 20.5 |
| Latin America (and the Caribbean) | 35 |
| North America (U.S. and Canada) | 7 |

SOURCE: Population Reference Bureau. *2001 World Population Data Sheet*. Washington, DC: Population Reference Bureau, 2001.

conditions in a country. Richer countries can provide the basic ingredients for infant survival: clean water, sanitary surroundings, adequate food and shelter, and access to health care services. A large portion of infant mortality is due to infectious and communicable diseases, which sanitary practices and an adequate diet do much to prevent.

At the individual level mothers (and fathers) with higher income and education are more likely to possess knowledge of sanitary behaviors and the money for adequate food, as well as to take their babies to a health service if needed. Especially important in the latter regard is oral rehydration therapy, which is effective in saving babies from dying from the dehydration that accompanies diarrhea.

Causes of Infant Deaths

Postneonatal mortality is most often caused by infectious diseases, such as pneumonia, tetanus, and malaria. An important factor in reducing postneonatal mortality is adequate nutrition, particularly breast milk, which provides babies with both the nourishment and the antibodies to fight infectious diseases. Of course adequate breast milk depends upon adequately nourished mothers.

Also important is the proper use of breast milk substitutes—mixing formula with unclean water and/or diluting formula for cost-savings reasons, both known to occur in developing countries, have negative affects on the health of infants. The promotion by multinational corporations of breast milk substitutes to women in poorer countries has been one of the travesties of our times; it is estimated that 1.5 million deaths a year could be prevented by breast-feeding.

The issue of HIV-infected mothers' breast-feeding has become controversial. A number of countries have instituted policies that recommend that mothers with HIV (human immunodeficiency virus) not breast-feed, based on some evidence of mother-to-child transmission of HIV through breast-feeding. In contrast are policies that promote breast-feeding in areas with high HIV prevalence. Because breast-feeding protects against the infectious diseases that take the lives of millions of infants every year, there is policy debate about the best course of action. Researchers do not know if the protection against infectious diseases afforded by breast-feeding outweighs the risks of HIV transmission to children, so it is not possible to make a definitive conclusion about the risks and benefits of breast-feeding by mothers with HIV. However, a 2000 study by the World Health Organization (WHO) Collaborative Study Team on the Role of Breastfeeding on the Prevention of Infant Mortality determined that the breast-fed babies of mothers with HIV had six times the protection against diarrheal deaths in the first few months of life than babies not breast-fed. In the second half-year of life, protection against both diarrheal and acute respiratory infections was about double that for non-breast-fed babies. Protection declined with age of child, and was greatest for the children of the least educated women. It appears the benefits may outweigh the risks for limited (in time) breast-feeding and for poorer women, who are unable to afford safe substitute milk substitutes. However, another issue to consider is that breast-feeding may negatively affect the health of mothers with HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome).

Another cause of infant mortality is violence. Research conducted in two areas in India show that wife beating, closely linked with patriarchal social structures, leads to both pregnancy loss and

infant mortality. Other violence, such as infanticide, the deliberate killing of infants, is extremely difficult to document, but it seems likely that some portion of the “missing girls” in India and China were the victims of infanticide. When infanticide is practiced, it is most likely a response to difficult economic circumstances (and coercive population policy, in the case of China) in conjunction with male-child preference.

Violence against babies is not limited to developing countries. Violence to infants in the form of head trauma, including shaken baby syndrome (SBS), has been studied in America. In 2000 the researchers Suzanne Starling and James Holden found that in both a western and southern U.S. sample men are more likely (70 percent) to be perpetrators of violence, with biological fathers (not necessarily married to the mother or living with the child) the most likely to cause fatal (and nonfatal) head trauma to infants, followed by boyfriends. The victims were more likely to be boys, with an average age of six months.

Excluding violence, neonatal mortality (in contrast to postneonatal mortality) is less likely to be the direct result of social, economic, and environmental conditions. Major causes of neonatal mortality include low birthweight, preterm (premature) birth, congenital malformations, and sudden infant death syndrome (SIDS). In developed countries most infant mortality is concentrated in the early neonatal period, with the aforementioned causes of death predominant.

Infant Mortality in the United States

Over the course of the twentieth century, each developed country has a somewhat unique trend in the timing and tempo of infant mortality decline, an examination of the American case provides a general sense of the Western pattern. In the early part of the twentieth century, the infant mortality rate was in excess of 100—much higher than in the developing countries (on average) of the twenty-first century. In other words, more than 10 percent of children born died in the first year of life. In the earlier stage of decline, postneonatal mortality was reduced. Over the period from 1915 to around the end of World War II, postneonatal mortality experienced a steady and dramatic decline to a level of approximately 10 (Wegman 2001). At the same time, deaths of babies from 28 days to one year of

age decreased as a proportion of total infant deaths (i.e., all death under the age of one). This decline was due to improvements in nutrition and in public health, such as clean drinking water, sewage disposal, and personal hygiene. Deaths due to diarrhea and infectious diseases such as pneumonia, diphtheria, and typhoid fever were reduced dramatically. In the post–World War II era, vaccines and other medical interventions such as antibiotics played a role in further declines.

Neonatal mortality declined more slowly and later than postneonatal mortality. It was not until around 1975 that the neonatal rate reached 10—lagging behind neonatal mortality by a generation. Neonatal mortality decline is much less dependent on nutrition and public health measures; rather, it requires more sophisticated medical interventions, especially to keep low birthweight babies alive. In the twenty-first century, approximately two-thirds of all infant deaths occur in the neonatal period, with the leading causes of death associated with low birthweight, congenital malformations, and SIDS.

The latest data available reveal that the United States' rate for infant mortality is not as low as one might expect. According to the Population Reference Bureau, its rate of 7 is surpassed by several European countries (Denmark, Iceland, Finland, Germany, Netherlands, Switzerland, and the Czech Republic all have rates under 5), several Asian countries (Singapore, Hong Kong and Japan all have rates under 4), Canada (5.5), Australia (5.3), and New Zealand (5.5) (Wegman 2001). Countries in the 7 to 8 range in infant mortality, along with the United States, include Cyprus, Malaysia, and Cuba—all considerably less developed than the United States. The United States' comparatively poor ranking in infant mortality has led to concern at the national level, especially relating to racial inequalities. The figures for African Americans show a consistent disadvantage in infant mortality, a disadvantage that is increasing, especially with regard to neonatal mortality.

An important factor influencing the relationship between race and infant mortality is birthweight. At the end of the twentieth century, 13 percent of (non-Hispanic) African-American babies were born in the low birthweight category (under 2,500 grams or approximately 5 pounds), compared with approximately 6.5 percent of (non-Hispanic) Caucasian babies and Hispanic infants.

The reasons why African-American women are so much more likely to give birth to high-risk, low birthweight infants remain unclear, although differences in prenatal care may be implicated, as may the absence of a national health care system and inadequate social welfare. Another factor to note is that the infant mortality of whites is lowered by the contribution of immigrants who have lower infant mortality than the native born.

In the decade of the 1990s, Caucasian women (and American Indian and Asian/Pacific Islander women) experienced some increase in low birthweight babies. This statistic has been attributed in part to an increase in multiple births (e.g., twins, triplets), which are more likely to be low birthweight newborns. Increases in multiple births are associated with fertility drugs and reproductive technologies such as in vitro fertilization and, to some degree, later age at childbearing. This increase in low birthweight infants does not bode well for future declines in neonatal mortality.

The Future

In developing countries considerable progress against infant mortality, especially postneonatal mortality, can be accomplished through the implementation of basic public health measures that will reduce infant deaths due to diarrhea and infectious disease. However, the HIV/AIDS epidemic places some countries, especially sub-Saharan Africa and parts of Southeast Asia, in a difficult position since HIV/AIDS kills infants directly and, through lowering immune functioning, indirectly. In developed countries, the major immediate challenge is to reduce the proportion of low birthweight infants. While improved prenatal care will advance that goal, restructuring (i.e., dismantling) of welfare states presents a possible barrier, as does the continuing popularity of technologies to increase fertility. Another unknown factor in all countries is the future role of re-emerging old and emerging new viruses and pathogenic bacteria; these microbes could significantly increase postneonatal mortality.

See also: CAUSES OF DEATH; GENDER AND DEATH; INFANTICIDE

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ELLEN M. GEE

MOURNING

The term *mourning* is probably the single most inconsistently used term in thanatology. Traditionally it has been used to refer to the cultural and/or public display of grief through one's behaviors. This usage focuses on mourning as a vehicle for social communication. In this regard, mourning can pertain at various times to specific rituals, particular outward signs (e.g., black clothes or an armband), the identification of who is to be recognized as bereaved, and a specified time period during which signs of grief can be shown. However, the term has been assigned other meanings that contribute to its being used interchangeably with the terms "grief" and "bereavement" to denote personal and subjective responses to loss. As yet there is no total consensus on the use of the term; however, in this essay mourning is discussed as a distinct phenomenon that is stimulated by the experience of loss (i.e., bereavement). While it encompasses "acute grief," it includes and implies substantially more than that experience.

Conceptual Development

Theories of mourning have changed significantly over time. Initially psychoanalytic conceptualizations held sway. There was particularly strong, early input from Sigmund Freud, whose oft-quoted 1917 paper "Mourning and Melancholia" tends to be cited by scholars erroneously as the first work on the topic. (Among others, there was Karl Abraham's 1911 paper on the treatment of manic depression and allied conditions, which partially prompted Freud's classic paper.) Later substantial psychoanalytic refinement was provided by Erich Lindemann, whose 1944 paper "Symptomatology and Management of Acute Grief" shared with Freud's particular prominence as a basis for later observers's comparisons, agreements, and disagreements. Coming originally out of the psychoanalytic school, John Bowlby, the chief architect of

attachment theory, then incorporated the philosophical tenets of that theory into the theory of mourning a number of publications during the 1960s through 1980s. Bowlby dispensed with abstract and unverifiable psychoanalytic concepts and incorporated principles from ethology, control theory, and cognitive psychology. Early-twenty-first-century thanatologists hold views that are strongly influenced, at least in large part, by attachment theory. This makes it the predominant, although not exclusive, perspective from which mourning is currently explained. While Bowlby's protégé, Colin Murray Parkes, has continued to expand understanding of mourning in numerous ways along attachment dimensions, he also has promoted the concept of psychosocial transitions that has been well incorporated into contemporary mourning theory.

Concepts from three theoretically and clinically related domains are being incorporated into the thinking about mourning. Each has generated a number of important implications about mourning, selected examples of which are noted herein.

From the generic psychological arena of *stress, coping, and adaptation theory* comes the notions that mourning involves more than merely reacting to loss, but active attempts to contend with it; that the individual's cognitive appraisal of the loss, its implications, and one's coping attempts is a critical factor determining response and accounting for its idiosyncrasy; and that successful outcome of mourning appears to require both problem- and emotion-focused coping.

Out of the realm of *traumatic stress and victimization theories* are being adopted into scientific understanding of mourning the ideas that assumptive world revision is necessary after major loss; that acute grief is a form of traumatic stress reaction; and that posttraumatic growth is possible as a positive consequence of loss.

From the province of *cognitive theory*, particularly *constructivism*, stems the belief that much of the painfulness of bereavement comes from disruption of the mourner's personal construct system caused by the death; the expectation that personal meaning reconstruction is at the heart of mourning; and the realization that there is traditionally an insufficient appreciation of cognitive processes in bereavement due to relative overfocus upon affective processing and failure to comprehend the two

main sets of cognitive processes (i.e., the mourner's learning about the reality and implications of the loved one's death, and the mourner's transforming to incorporate the changes necessitated by the death).

Eight specific bereavement-related notions are also becoming assimilated into contemporary understanding of mourning:

1. Mourning does not necessarily proceed in invariant sequences; staged-based models of mourning are inaccurate in implying that all mourners undergo the same processes in the same order.
2. Continued connections to the deceased are not necessarily pathological and, if appropriate, can be therapeutic.
3. People do not necessarily "get over" major loss, but learn to live with it, with struggles to do so persisting far longer than previously thought.
4. Routinely suggesting professional intervention for all mourners can be harmful; it tends only to be regularly needed by bereaved persons who are at high risk.
5. There is no one way to respond to loss; Western mental health has been biased in favor of emotional expressiveness and this has been harmful to people with other styles.
6. Mourning and meaning making occur not only on an intrapersonal individual level, but also on an interpersonal familial/social level.
7. Mourning can become complicated; this need not automatically suggest pathology on the mourner's part, but may be due to other factors (e.g., circumstances of the death, the role of the deceased, and availability of support, among others).
8. Mourning is culturally relative.

Taken together, these associated concepts and specific bereavement-related notions have significantly broadened and deepened the comprehension of mourning, and enhanced appreciation of the complex challenges and experiences that it brings to mourners.

Mourning and Grief: Definitions and Distinctions

To comprehend mourning, it is necessary first to understand its distinctions from and relationship to grief. There is much to be gained by distinguishing between acute grief reactions to loss and the psychosocial labors of mourning undertaken over time to live with that loss. To assert that they are the same disregards two very different sets of experiences and demands, and seriously compromises bereavement intervention and research efforts. This discussion is predicated upon Therese A. Rando's 1993 model of mourning, which was developed specifically in relation to Western society. Consistent with the action-oriented nature of mourning, a process rather than content focus is maintained in this discussion.

Grief refers to the process of experiencing the psychological, behavioral, social, and physical reactions to the perception of loss. A grief response expresses one or a combination of four things: (1) the mourner's feelings about the loss and the deprivation it causes (e.g., sorrow, depression, guilt); (2) the mourner's protest at the loss and wish to undo it and have it not be true (e.g., anger, searching, preoccupation with the deceased); (3) the effects caused by the assault on the mourner as a result of the loss (e.g., traumatic stress, disorganization, physical symptoms); and (4) the mourner's personal actions stimulated by any of the previous three (e.g., crying, social withdrawal, increased use of medication or psychoactive substances).

However, the ultimate goal in contending with any major loss is for the individual experiencing it to be able to recognize that the loved one truly is gone and to make the necessary internal (psychological) and external (behavioral and social) changes to incorporate that loss into his or her ongoing life. Grief in itself cannot accomplish what is required to reach this goal. As solely a complex set of passive reactions to the loss, it fails to take the individual far enough.

Accommodation suggests an adaptation to make room for a particular circumstance. Clinical experience suggests that it is to be preferred over the term *resolution*, which insinuates a once-and-for-all closure that typically is not achieved—or even desirable—after the death of a dearly loved one. The bereaved must make a series of readjustments to cope with, compensate for, and adapt to

the absence of what has been lost physically and/or psychosocially. Failure to make the proper adaptations and re-orientations necessitated by the loss leaves the survivor related inappropriately to the lost person and the now-defunct old world.

For these reasons, grief is a necessary, but not sufficient, condition to come to successful accommodation of a loss. Grief is to mourning like infancy is to childhood: It is the beginning, but not the entire course, of events. However, it is pivotal because without the experiences and learning provided by acute grief—where the mourner confronts and is taught the reality of the loss and the need for the mourner to change is made clear—the rest of mourning cannot take place.

Mourning, then, encompasses much more than grief, which starts it off. It refers as well to the consequent conscious and unconscious processes and courses of action that promote three operations, each with its own particular focus, that enable the individual ultimately to accommodate the loss. The first operation promoted by mourning is the undoing of the psychosocial ties that had bound the mourner to the loved one when that person was alive, with the eventual facilitation of new ties appropriate to that person's now being physically dead. The focus is internal, upon the mourner's readjustment vis-à-vis the deceased. In the second operation, mourning processes help the mourner to adapt to the loss. The focus again is internal, upon the self and the making of revisions in one's assumptive world and one's identity insofar as the loss invalidates certain of one's assumptive world elements and aspects of one's previous identity. The third operation promoted by mourning helps the mourner learn how to live healthily in the new world without the deceased. Here, the focus is external, upon the physical and social world as the mourner attempts to move adaptively into it without the loved one through the adoption of new ways of being in that world and reinvestment in it.

Uncomplicated reactions of acute grief may last many months and in some cases even longer. In contrast, because of its myriad aspects and demands, uncomplicated mourning can last a number of years, long after acute grief is spent. In fact, it lasts forever for many people, as there often is revisiting and reworking of major loss over time. This does not necessarily mean that the individual

is in acute grief all that time (that would be considered pathological), nor that the reality of the loss and its implications were not fully comprehended earlier on. It merely speaks to the ongoing nature of living with major loss.

The distinction between grief and mourning is crucial not only to the maintenance of appropriate expectations for mourners, but also for helping them cope. Many individuals assist the bereaved with the beginning processes of acute grief by enabling their reactions to the loss, but do not assist sufficiently, if at all, with the important latter processes of readjustment. Consequently, mourners are frequently left alone to reshape themselves and their world after the loss of a loved one, and suffer additionally as a result.

Requirements for Healthy Mourning

For healthy mourning to take place, a number of actions must be undertaken. These vary depending upon the model utilized, yet there is remarkable overlap. According to Rando, there are six specific "R" processes that must be completed successfully by the individual in order for the three reorientations—in relation to the deceased, self, and external world—of healthy mourning to occur.

1. Recognize the loss. Recognizing the loss involves acknowledging the reality of the death and understanding what caused it.
2. React to the separation. This process involves experiencing the pain; and feeling, identifying, accepting, and giving some form of expression to all the psychological reactions to the loss. It also involves identifying and mourning the secondary losses that are brought about by the death.
3. Recollect and reexperience the deceased and the relationship. Healthy mourning involves reviewing and remembering realistically, with reviving and reexperiencing being the associated feelings.
4. Relinquish the old attachments to the deceased and the old assumptive world.
5. Readjust to move adaptively into the new world without forgetting the old. This process, involves revising the assumptive world, developing a new relationship with the de-

ceased, adopting new ways of being in the world, and forming a new identity.

6. Reinvest. The emotional energy once invested in the relationship with the deceased eventually must be reinvested into other people, objects, pursuits, and so forth in order that emotional gratification can be received by the mourner.

Each person undertakes these processes (or not) in his or her own fashion and to his or her own depth. This is because each individual's mourning is determined by a constellation of thirty-seven sets of factors that renders the mourner's response as unique as his or her fingerprint. To be able to understand any mourner adequately, one must know the factors circumscribing the particular loss of that individual at that precise point in time. A response that is perfectly appropriate for one person in one set of circumstances may be pathological for another person in those circumstances or for the same person under different circumstances. These factors cluster under three main areas: (1) psychological factors, which are subdivided into characteristics pertaining to the nature and meaning of the specific loss, the mourner, and the death; (2) social factors; and (3) physiological factors.

Duration and Course of Mourning

There is no general time frame for the length of mourning, it is dependent upon the unique constellation of factors associated with the mourner's particular bereavement. It is important to differentiate between the duration of acute grief and of mourning. The former may be very time limited; whereas the latter, technically, can go on forever in some ways. Contrary to the myth that mourning declines linearly over time, its course often fluctuates significantly. Fluctuations occur over both the short (e.g., hourly basis) and long (e.g., a period of months or more) terms. Different types of losses are associated with diverse patterns of fluctuations (e.g., sudden death, parental loss of a child).

Even long after a death has occurred and acute grief has subsided, a wide variety of circumstances can produce within the mourner subsequent temporary upsurges of grief (STUG) reactions. These are brief periods of acute grief for the loss of a loved one that are catalyzed by a precipitant that

underscores the absence of the deceased or resurrects memories of the death, the loved one, or feelings about the loss. Although such reactions previously have been inappropriately construed as being pathological, they typically are a normal part of uncomplicated mourning. This is not to say that they cannot be a manifestation of some problem, only that they are not necessarily so. There are fourteen types of STUG precipitants. These are classified under the three categories of cyclic precipitants (i.e., experiences that occur repeatedly over time), linear precipitants (i.e., experiences that are one-time occurrences), and stimulus-cued precipitants (i.e., those that involve stimuli unrelated to time).

Mourning in a Changing Sociocultural Milieu

Any person's mourning is powerfully influenced by the sociocultural context within which it occurs. This affects all manner of factors circumscribing an individual's mourning—from the type of loss that transpires to the reactions exhibited; from the meaning of that loss to the characteristics of the mourner and the types of support received or not.

Twentieth-century sociocultural and technological trends in Western society have significantly increased the prevalence of complicated mourning by causing a rise in virtually all of the seven high-risk factors predisposing to complicated mourning. The trends that have contributed most substantially to this include, among others, urbanization, technicalization, secularization, deritualization, increased social mobility, social reorganization, multiculturalism, escalating violence, wide economic disparity, medical advances, and contemporary political realities.

On the other hand, improved, and improving, bereavement research is providing more accurate information, pointing the way to primary prevention on personal and social levels and to a spectrum of interventions for bereaved persons at all degrees of risk. Socially, bereavement is more accurately understood and more visible as a legitimate topic for discussion than ever before; nevertheless, there remains significant room—and need—for improvement in these areas.

See also: GRIEF; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; THANATOLOGY

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THERESE A. RANDO

MUMMIFICATION

The word *mummy* comes from a procedure often used by families in the Middle East to prepare a corpse for burial. During this procedure, the body is washed and then wrapped in strips of linen. To secure and protect this wrapping, a coating of Bitumen tar—also known as mum—may be applied. The effectiveness of this substance has been demonstrated in its preservation of extinct animals for long periods of time, as exemplified by the La Brea Tar Pits of Los Angeles. "Ice mummy" has also become a familiar term as both human and animal corpses have been discovered in a state of remarkable preservation.

It is this apparent resistance to decay that has made the mummy such a compelling object, whether achieved by technical knowledge and skill or by circumstance and whether intended or unintended (as were the ice mummies). There has long been a widespread aversion to the sight and smell of a decaying body, as well as the fear that one can be contaminated by contact with the dead. A corpse that appears intact, and even lifelike, deflects these anxieties. The mummified corpse also stimulates curiosity: What secret knowledge might be discovered, what elusive mysteries brought to

light? And—for those not afraid to ask—can the mummy walk again?

Mummies have been most closely associated with Egypt ever since ancient tombs were opened in a continuing series of archeological discoveries (preceded by centuries of grave looting and destruction). There is good reason for this emphasis. The numbers alone are striking: Researchers estimate that about 70 million people were mummified in Egypt in addition to a large number of animals. The spectacular nature of the royal chambers and the remarkable condition of some of the mummies have well deserved their attention. Moreover, scholars have provided invaluable information about the ancient world through their studies of mummies, their surroundings, and their artifacts. The story of mummies, though, neither begins nor ends with the Egyptians. Attention is given to mummies in other times and places after visiting the ancient dynasties that flourished by the banks of the Nile.

The Egyptian Way of Life and Death

Egypt's large and largely arid land has been populated for at least a half million years. Drought, disease, and other hardships required a determined communal effort for survival as well as ingenuity in problem solving and a viable belief system. Death was an insistent part of everyday experience (the average life expectancy has been estimated as not much more than twenty years). Nothing was more predictable than the rising of the sun, the flooding of the Nile, and the transformation from life to death. About 7,000 years ago the Egyptians started to create a civilization that was a marvel in its own time and a source of inspiration to the present day. Astronomy, mathematics, engineering, and the healing, cosmetic, and textile arts were all brought to a new level. With every advance in their civilization the Egyptians brought additional skill, finesse, and grandeur to their dealings with death, their ancient nemesis.

The art of mummification underwent its own lengthy period of development. A small and hard-pressed population functioning on the edge of survival could only dig resting places for their dead in the dry desert sands. The historian Bob Brier noted, "Because these graves were shallow, on occasion the sand would blow away to reveal the shocking sight of a dead body that had retained its

flesh and hair—a still-recognizable individual” (Brier 1996, p. 19). The lack of moisture in the parched sands was responsible for the preservation of the general shape and features of the deceased. Extremely dry and extremely cold conditions both inhibit the bacterial activity that usually consumes flesh and organs.

Belief in some form of afterlife was widespread in the ancient world. The Egyptians’ encounters with sand-dried corpses might have influenced their particular beliefs and practices regarding the afterlife. Although mummification is the most striking feature of the Egyptian way of death, it draws its meaning from a more encompassing view of the world. Both beliefs and practices continued to evolve over the long span of Egyptian history. The Predynastic period dates from approximately 5,000 years before the Common Era. The Egyptian nation came into existence about 2,000 years later during what is known as the Archaic period. Egyptian history has been divided into many other phases, but it is the Old Kingdom (starting about 2660 B.C.E.) and the New Kingdom (about 1500 B.C.E.) that are of most interest to the discussion of mummification. Pyramids were built and bodies mummified in the Old Kingdom, but the sands of time (along with many acts of vandalism and looting) have left only scattered and often enigmatic traces of the civilization. Also, mummification techniques were not as effective in the earliest years. Nevertheless, some elements of the most ancient beliefs and customs have survived within writings, illustrations, and wall paintings from the New Kingdom.

Remarkable survivors from the past are five sets of documents that reveal much about the ways in which Egyptians conceived of death and the afterlife. Most renown of these documents is a work whose title was originally translated as *Book of the Dead*, but which has had its more accurate title restored, *Book of Going Forth by Day*. The other documents are *The Pyramid Texts*, *The Coffin Texts*, *The Books of Breathing*, and *The New Kingdom Books of the Netherworld*. Earliest of these is *The Pyramid Texts* that were found in the tombs of Old Kingdom kings and queens (though not the whole remains of the royal personages themselves). *The Pyramid Texts* consists of 227 magical spells to help the deceased Pharaoh ruler to pass through the various checkpoints in the postmortem journey. It was not for the common person, nor was it an explicit statement of religious principles.

One idea embodied in *The Pyramid Texts* has especially impressed later historians and theologians: The dead will be judged. In fact, all the dead will be judged, even the mighty Pharaoh who judged others. The history of religion scholar S. G. F. Brandon credits the ancient Egyptians with introducing and elaborating the belief that how a person has lived will have a profound effect on the afterlife. Christian concepts of faith, good works, salvation, and damnation were yet to come, but the Egyptians had made the basic link between the quality of life and afterlife. These early texts, though, are guides not to a higher level of morality but to strategies for negotiating the perilous passage to the netherworld. The flourishing New Kingdom society provided elaborate funerals for its most illustrious people. These rituals offered channels for expressions of grief and mourning and affirmed the power of the family line—but also launched the departing soul on its journey with all the right moves. Specialists in funerals, tomb construction and decoration, and mummification were valued members of society, as were the priests with their incantations and gestures.

Inspiring and justifying all these practices were two myths that each contributed to a view of the afterlife. Osiris was revered as the person who showed the Egyptians how to create their great civilization, but his murdered corpse was hewn into many pieces. Through heroic efforts, his wife (or sister-wife) Isis put him back together again. This myth has been interpreted as a fertility and renewal symbol: Life passes into death, but from death life emerges anew. Egyptologists have noted that the Osiris myth emphasizes the importance of an intact corpse, and that their funerary art often depicted this mythological figure. The other myth centers around Atum-Re, a local god who was closely associated with the life-giving force of the sun. The pharaohs were the incarnated sons of Atum-Re and would rejoin him in the skies at the end of their days on the earth.

The corpse was regarded as more than a lifeless body. It included several spiritual forces or entities. The *ka* was a spirit-twin that accompanied the person throughout life and, surviving death, preserved individual identity. It remained within a *ka* statue created in the likeness of the living person. In turn, the *ka* needed to be fed and looked after by mortuary attendants. The *ba*, often represented as a soul-bird, lingered in the vicinity of the

corpse as a faithful companion. If all went well with the funeral ritual and mummification, the deceased would achieve the status of an *akh* (translated by Brandon as “glorified being”). The rules for achieving a glorified afterlife were not quite the same for royalty and commoners: Other affluent members of society benefited from quality mummification and other funerary amenities, while the general population had to make do with much simpler arrangements and with less expert mummification procedures.

The Making and Unmaking of Mummies

Transforming a royal corpse into a mummy in the New Kingdom period involved the following actions, many or all of which would be accompanied by prayers and magic spells:

1. Remove the internal organs by incision and pull the brain through the nostrils on an iron hook.
2. Replace the heart with the carved replica of a scarab (the dung-beetle, symbolizing the recycling transactions between life and death).
3. Rinse the body cavity with palm wine.
4. Reshape face and body as necessary to repair damages caused by the final illness.
5. Place aromatic substances within the body, sew it up, cover with “divine salts” and allow seventy days for drying and other preparations.
6. Wash the body, wrap in undercoated linen sheets, draw facial features in ink to recreate the appearance of the living person.
7. Place in a tapered coffin and the coffin into a sarcophagus (stone vessel).
8. Add objects that could be useful to the deceased in the next life.
9. Seal the tomb.

The results were sometimes magnificent. Even so, the preserved body itself was but a shell in artistic disguise. Lacking internal parts, there was no way the mummy could walk again, and the Egyptians did not have this expectation. The mummy was part of a spirit communication system, not a dead person waiting to be resuscitated.

Mummies could also be unmade. Some attempts at mummification failed. Looters destroyed

many presumably successful mummies in ancient times. Royal remains were often removed from their original lodgings for safekeeping, but some nevertheless became casualties. The slaughter of the mummies began in earnest as tombs were discovered and their contents plundered by outsiders. Mummies were powdered into medicines that were sure to cure what ailed the medieval person, or so the alchemists promised. Bits of mummy remains also had commercial value as relics. Wholesale destruction of mummies occurred during the heyday of European colonialism and the Industrial Revolution. Showing no regard for religious belief or history, exploiters consigned thousands of mummies into the flames as fuel for the railroads, or held mummy unwrapping parties that destroyed the remains. Even a museum official casually tossed away a preserved arm from the Old Kingdom, in all likelihood the most ancient mummy part ever discovered. Fortunately, some of the most illustrious tombs were not unearthed until a more responsible attitude had developed in the late nineteenth and twentieth centuries.

Mummies As Frozen Time

Mummies are far from an Egyptian exclusive. As with the pharaohs, however, every mummy, wherever found, has the potential for revealing something about the ways in which people have lived and died. The ancient people of Chile, for example, developed complex mummification techniques at least 2,000 years before the Egyptians. These mummies were notable for having no tooth decay, a finding that is thought to be related to their diet as foragers. Researchers were also able to determine that there were clear divisions of labor in the society, gender-related and otherwise. Laborers, for example, had more skeletal distortion than did priests.

Discoveries in the towering and icy peaks of the Andes have added substantially to scientists’ knowledge of past societies. Ceremonial sites have been excavated on mountain peaks from central Chile to southern Peru. Here chilling discoveries were made: the mummies of Inca children—by the hundreds—who were sacrificed to the mountain gods and their supreme deity, the sun. There is one obvious similarity to the Egyptians: the belief in a sun god. The differences, though, are profound. These were children put to death in order



Wealthy and valued members of Egyptian society, such as this priestess, benefited from a quality mummification.

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to placate the gods and therefore receive rain, bountiful crops, and protection from disasters.

These human sacrifices occurred in relatively modern times, only 500 years ago. In September 1995, anthropologist Johan Reinhard discovered 18,000 feet high atop Mount Ampato a fourteen-year-old girl whose body was accompanied by gold and silver dolls. The remarkable state of preservation was attributed to the freezing temperatures and high altitude. The life of the “Ice Maiden,” as she has been called, was almost surely offered to the gods. The relationship, if any, between the Inca practices and those of Chileans almost 8,000 years ago remains to be determined.

Archeologists and anthropologists could add that ice is also sufficient for preservation. Notable discoveries of ice mummies have been made in other places. For example, at about the same time that Incan priests were sacrificing children on mountaintops, the Inuit were burying six women and two children in a small settlement on the west coast of Greenland. As the anthropologist Hart Peder Hensen and his colleagues reported in *The Greenland Mummies* (1991), the deceased were provided with warm clothing and useful items for their journey to the land of the dead. The cold terrain and the dry air had preserved their bodies until they were discovered in the twentieth century. The relatively intact bodies and their undisturbed burial hut have enriched sociologists’ understanding of Inuit history and culture (for example, people living in the rigors of the extreme north were up-to-date in European fashions and also dressed their children as miniatures of adults). It is clear that the same form of mummification—in this case, freezing—can occur within situations as different as ritual murder and loving farewell.

Researchers are still studying and learning from the highly publicized Ice Man (also known as Otzi), whose mummified body was discovered in a glacier in the Otztaler Alps on the Austrian-Italian border in 1991. Remarkably well preserved, Otzi was a Neolithic hunter more than 5,000 years ago. The exceptional condition of the permafrost-protected corpse, his clothing, and his tools has provided scientists with invaluable information about the Neolithic way of life, although not necessarily about their way of death, since the Ice Man died while apparently on a hunting expedition. Konrad Spindler’s *The Man in the Ice* (1994) is a major contribution for readers who want to explore mummies and mummification beyond the Egyptian Valley of the Kings.

The Mummies of Urumchi tells still another story. The earliest of these mummies are contemporaneous with the most renowned Egyptian examples from the New Kingdom period, but even better preserved. The people are Caucasian, tall, blond, and apparently blue-eyed. They are dressed in brightly colored woolen clothing and high-peaked hats. The surprise is their place of death: the desert wilderness of China’s Uyghur Autonomous Region. Controversy immediately engulfed this discovery: Was it possible that 4,000 years ago

the people of China included Caucasians who were sporting the most advanced textiles? Does world history have to be rewritten to accommodate this find? Anthropologist Elizabeth Wayland Barber makes a strong case for the proposition that many great people migrated across Europe and Asia during the Bronze Age, bringing a variety of skills with them. Furthermore, what has long been a desert may once have been fertile land.

Every now and then mummies return from various times and places. Peat bogs in Denmark, England, Germany, Ireland, and the Netherlands have reluctantly yielded their cache of bodies—some deposited there as long as 6,000 years ago. The cool, damp soil, perhaps with the help of a tanning action, seems responsible for the preservation. The deaths themselves often seem to have been caused by murder, perhaps ritualistic.

Attempts to protect a corpse from deterioration have also been motivated by the reluctance to let go of a beloved or powerful person. For example, the body of Suzanne Curchod was preserved in alcohol by her loving husband, a minister under France's Louis XVI, to honor her wishes to remain near him. As early as the eighteenth century suggestions were made to vitrify the more notable dead, transforming them into a kind of stone-glass. As the French sociologist Philippe Ariès observes, both the actual and the proposed acts of preservation were in accord with the spirit of the times. Even the halls of academia have surrendered to the impulse. When death claimed Jeremy Bentham, a trenchant social philosopher whose writings have remained influential over the years, his colleagues at University of London had him mummified and placed in a closet. Legend has it that he has been invited as honored guest to attend occasional faculty meetings.

An ironic attempt at mummification occurred following the death of Vladimir Lenin, the founder of the Soviet Union, in 1924. The Bolshevik party, seeking complete domination, tried to replace religion with its own version of science. Before long, though, the secret police virtually kidnapped physicians and required them to mummify the fallen leader. This endeavor proved to be a tragicomedy as described by the biochemist Ilya Zbarsky in *Lenin's Embalmers* (1997). The political imperative that Lenin's body appear intact and robust was at

odds with its condition when physicians were summoned to the task, and they had no effective procedures at hand. Trial-and-error ingenuity was required to create the desired but misleading impression that a high quality of mummification had been achieved. Despite all of the medical advances made since the New Kingdom, there had also been a loss of knowledge specific to mummification. Lenin's embalmers did what they could to make a sacred icon of his body while party officials twisted in anxiety. The desire to preserve the remains of a powerful person had persisted from the sun god worshippers of ancient times to a modern society whose leaders were determined to get along without any gods at all.

In the twenty-first century mummies continue to hold interest to researchers for what they can reveal of history, illness, and past ways of life. They are also subjects of ethical and legal disputes as part of the general concern about the proper treatment of human remains. Perhaps more attention could be given to the simple fact that so much loving and often creative attention has been given by the living to those who have passed on.

See also: CRYONIC SUSPENSION; EGYPTIAN BOOK OF THE DEAD; HUMAN REMAINS; IMMORTALITY; KENNEWICK MAN; OSIRIS; PYRAMIDS; SACRIFICE; TOMBS

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ROBERT KASTENBAUM

MUSEUMS OF DEATH

In Western Europe there are a variety of museums, and in several countries the scenery is enriched by special museums that are dedicated exclusively to the topics of death, dying, funerals, and remembrance. Because these entities are largely considered social taboos, the existence of such institutions appears to be anachronistic. Therefore, one is forced to question their origin and goals, as well as their social and political acceptance.

The fact that the museums are relatively new or still in their founding or building phases seems to indicate a changing attitude toward death and dying. Questions about dying with dignity, modern forms of funeral services, or an adequate way of mourning and remembrance are more insistent in the twenty-first century than they were in the 1980s. Regardless of a societal change in attitude, these museums are neither called museums of death or dying nor do they otherwise bear the

terms *dying* or *death* in their names. Instead, they bear more culturally accepting translations, calling themselves, for example, Museum of Piety (Budapest, Hungary), Funeral Museum (Vienna, Austria) or Museum for Sepulchral Culture (Kassel, Germany). Despite their often misleading names, none of these museums makes any effort to hide its subject; notably, death and dying.

These museums primarily foster a culture-historical approach related to the public interest in history, culture, and the arts. Therefore, collections and exhibitions focus strongly on the impressive examples of funeral and cemetery culture, pictorial documents of these events, and curiosities. In comparison to other specialized museums, like museums of bread, glass, or chinaware, the funeral museums have above all a responsibility for their visitors, who always react very sensitive to the subject of death and dying.

The Vienna Funeral Museum best exemplifies a museum of funeral culture. Founded in 1967 as a branch of the Vienna Municipal Funeral Department, the museum is a business museum whose goal is to present the history of the company in objects, pictures, and written documents. Accordingly, the collection comprises many of the company's products and equipment such as coffins, urns, funeral vehicles, shrouds, and more. However, the Vienna Funeral Museum also documents the entire funeral culture in Austria, with an emphasis on Vienna. Of particular emphasis is the history of the funeral in Vienna. At the beginning of the twentieth century numerous competing private funeral homes were replaced by a municipal funeral company. The main reason behind this move was a social concern: The desire for evermore luxurious funerals—as exemplified by the proverbial *Schoene Leich* (“beautiful corpse”) in Vienna—had driven the citizens to excessive expenditures that were even pushed further by the commercial interests of the funeral directors.

The Vienna Funeral Museum became the model for a similarly organized museum in Budapest whose Hungarian name, *Kegyyleti Muzeum*, may be best translated as Museum of Piety. Opened in 1991–1992, this museum is associated with Vienna and Austria due to the long-lasting common history within the Habsburg monarchy. In addition, the Museum of Piety strives to consider

the regional and confessional differences of Hungary. Both the Vienna and the Budapest museums are branches of their respective Municipal Funeral Departments and receive no public funding.

Unlike the Vienna Funeral Museum, the *Museum fuer Sepulchralkultur*, (Museum of Sepulchral Culture) in Kassel must meet public and political acceptance. Although it is supported by the *Arbeitsgemeinschaft Friedhof und Denkmal* (Association for Cemetery and Memorial), it was built entirely with public funding. The costs of running the museum are mostly paid by the federal and state government, the municipality, and churches.

In accordance with the statute of its governing body, the mission of the Museum of Sepulchral Culture is to promote public understanding of the culture of funerals, cemeteries, and mourning. In addition to its permanent exhibition, which presents objects of funeral culture within Germany, Austria, and Switzerland on a total area of 1,400 square meters, the museum features special exhibitions that focus on various aspects of the cultural history of funerals, current developments and trends, and artistic confrontations with death, dying, and mourning. An affiliated library consists of a large stock of monographs, catalogues, and offprints, as well as an extensive collection of original source material. The museum is home to various archives, such as a collection of graphic art consisting of 15,000 pieces, which serve as a resource for research and scientific studies throughout Europe.

The two cemetery museums in Riehen near Basel, Switzerland, and in Hamburg, Germany, owe their existence to the personal commitment of single individuals. The collection *Friedhof Hoernli* (Hoernli Cemetery) was compiled in a tireless effort by an employee of the cemetery and has been on display since 1994. It was the goal of the collector to preserve old and vanishing items used in everyday funeral and cemetery activities; its purpose is to document the history of less-recognized professions dealing with death. The museum is supported by a private association, receives some funds from the cemetery administration, and otherwise relies on donations from sponsors.

The situation was similar in Hamburg. Individuals with a strong interest in preserving the world's largest cemetery formed the *Förderkreis Ohlsdorfer*

Friedhof (Society for the Promotion of the Ohlsdorf Cemetery), and opened the *Museum Friedhof Ohlsdorf* (Museum of the Ohlsdorf Cemetery). The museum is dedicated to raising public interest for the Friedhof Ohlsdorf cemetery, and for promoting historical and contemporary funeral culture. The collection in the museum, on display since 1996, focuses mainly on the history of Hamburg's cemetery culture. Since the Ohlsdorfer Friedhof was opened in 1877 as the first American-style park cemetery in Germany, it is of significant importance to the European cemetery culture.

The National Funeral Museum in London, which was initiated by an undertaker from London's West End, has a status all its own. It was the growing public desire to reintroduce the old horse-drawn hearses that provided the impetus to start the museum. The result is an impressive collection comprised of both historical hearses and one of the oldest motorized funeral vehicles. The collections have been complemented by historical funeral equipment, old drawings and prints, shrouds, mourning dresses, and mourning jewelry. In addition, an extensive library was founded. Since the museum is entirely a private institution, the funeral company covers all expenses. Training and seminars are other sources of income.

The Netherlands' *Uitvaartmuseum*, known as the Museum of Exit, is still in its initial phase. Supported by a private association, it has a complete collection that has attracted considerable attention. The museum is an important impetus for a renewal of the funeral culture in the Netherlands, where in a liberal and open-minded atmosphere new funeral rites have developed. The Netherlands have become famous for a remarkable variety of funeral-related artistic forms.

Finally, the *Museu de Carrosses Funebres* (Museum for Hearses) in Barcelona, Spain, which specializes in the collection of historical funeral vehicles.

Increasing public awareness and presenting the goals of the museums is part of the mission of the European Federation of Funeral Museums (EFFM). Founded in Vienna in 1998, the association unites museums that specialize in the culture of funerals, cemeteries, and mourning, and whose common intention is to disseminate historical and contemporary values in this field.

See also: CEMETERIES, MILITARY; CEMETERIES, WAR

REINER SÖRRIES

MUSIC, CLASSICAL

Western classical music has commemorated death in ritual and pondered it in concert works. A deeper relationship to death exists in the very syntax of Western harmony.

Origins of Classical Music

Western art music has its origins in the system of tonality developed in the Medieval Church. That system, which grew out of the church modes, consists of two or more tones sounding at once in a pattern of tension and release (“dissonance” and “consonance”). This was unique among the musical forms of the globe until the twentieth century when Western tonality, through popular music, essentially preempted other local musical forms.

This dominating pattern of tension and release means that Western tonality, unlike all other known musical systems, mimics a natural cycle of birth/growth/decay/death/new birth. The simplest chord progression initiates a home key (birth), develops relationships to other keys by venturing from the home key (growth), reaches a knot of dissonance requiring relief (decay), and finally resolves to the home key again (death, with an implied rebirth). In other cultures, ritual and art music sought to transcend the natural process through hypnotic repetition or intricate, non-tonal patterning. Western classical music embraced it, and accompanied the rise of material science.

Death Motifs

Death is built into the syntax of Western music. When portrayed as the subject of a composition, mortality has certain specific musical characteristics; the mood is somber, the tonality almost always minor, and the tempo slow. Yet the most famous recurring death motif in classical music, the Dies Irae, which dates to the Dark Ages, is more sinister than somber. Its text, “Day of wrath, day of doom,” conjures the Christian last judgment in its most horrible aspect. The first eight notes are distinctive, with or without the sung text, and they fit

into the format of many common chords and progressions. Composers, therefore, have employed the Dies Irae often, both in sung works (the text forms part of the Requiem Mass which has been set to music by countless composers) and in purely instrumental contexts. The Russian post-Romantic Sergei Rachmaninov employed it almost obsessively, not only in appropriate works such as his tone poem, *Isle of the Dead*, but in such unlikely places as the playful pages of the *Rhapsody on a Theme of Paganini*.

The Requiem Mass is probably the largest and most dramatic classical musical form borrowed from ritual. Composers who set its Latin text for use in concert rather than liturgy have included Palestrina, Vittoria, Mozart, Cherubini, Berlioz, Faure, Bruckner, Verdi, and Stravinsky. Brahms, vigilantly Protestant, composed a German Requiem to biblical rather than Catholic liturgical texts. The Passion, a liturgical text relating the death of Jesus Christ, has also been used by composers as concert works. Two extraordinary Passions by Johann Sebastian Bach (one *According to St. John*, another *According to St. Matthew*) belong at the pinnacle of the repertoire.

Another smaller and more universal ritual that became an instrumental form was the funeral march. Mozart’s Masonic Funeral Music, the second movement of Beethoven’s Symphony no. 3 (“Eroica”), and the penultimate movement of Chopin’s B-flat minor Piano Sonata, are excellent examples. The latter has become boilerplate, often simply referred to as “The Funeral March.” Mahler used funeral marches throughout his oeuvre, perhaps most spectacularly (and unexpectedly) in the opening movement of his Symphony no. 5.

Death Myths of the Great Composers

Death holds a prominent place in the mythos of great composers. Existential defiance was a favored theme for composers dying in the nineteenth century. Beethoven died at age fifty-six, reputedly shaking his fist at a clap of thunder as at God. Schumann went insane and walked into the Rhine to drown himself; the attempt failed. Recent, controversial scholarship seems to support the idea that Tchaikovsky, long thought to have died from accidentally contracted cholera, committed suicide on the discovery of his homosexuality. The truth of his death has yet to be established beyond doubt.

The number of composers who died young is greater even than that of great poets. In addition, their modes of death were diverse and often disturbingly colorful or mysterious. The most famous case is that of Mozart. The theories of Mozart's death, numerous and ever-growing, have become a part of the composer's identity. The most notorious is that Mozart was murdered by his rival Antonio Salieri, which was the subject of a play by Alexander Pushkin and an operatic setting by Nikolai Rimsky-Korsakov nearly a century before it became the subject of Peter Shaffer's play (later made into a popular film) *Amadeus*.

Mozart was thirty-five when he died in 1791. Franz Schubert was thirty-one years old when he died in 1828; syphilis was the probable cause. Chopin and Mendelssohn both died before their fortieth birthdays. The dubious prize for the youngest death of a composer with any still-active repertoire goes to the eighteenth-century Belgian Guillaume Lekeu, who succumbed at age twenty-five to an intestinal infection brought about by tainted ice. Charles-Valentin Alkan, a nineteenth-century French composer of exorbitantly difficult piano music, was also a Talmudic scholar who died when his bookshelves collapsed and the heavy volumes of his library crushed him. The Second Viennese school of Arnold Schoenberg and his students were obsessed with number. When Schoenberg's great student Alban Berg suffered an insect bite that infected him, Berg calculated his chances based on a personal numerology, and died on the day he predicted.

In 1937 the musicologist Alfred Einstein put forth the theory that great composers die with a "swan song," a final masterpiece before death. He

supported this idea with numerous examples, including Bach, whose masterful *Art of the Fugue* was left unfinished at death, and Mozart, who left behind the trunk of a Requiem, begun shortly before he died. The theory hardly applies universally, however, and it is ironic to note that the single terminal work actually titled "Swan Song," was a compilation of Schubert songs slapped together posthumously by a publisher looking to trade on the sensation of it.

Though George Frideric Handel, Franz Josef Haydn, Franz Liszt, and Giuseppe Verdi all lived and worked past seventy, composers who enjoyed their full share of three-score-and-ten are rare before 1900. Twentieth-century composers who lived and thrived into their eighties include Igor Stravinsky, Aaron Copland, Leos Janacek, Ralph Vaughan Williams, and Elliott Carter.

See also: DANCE; FOLK MUSIC; MAHLER, GUSTAV;
OPERATIC DEATH

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KENNETH LAFAVE

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NATIVE AMERICAN RELIGION

Because they lived so close to nature, all Native American peoples from the Stone Age to the modern era knew that death from hunger, disease, or enemies was never far away. The various death customs and beliefs, which first evolved during the invasions of Asians from Siberia to Alaska across a land bridge during the last Ice Age at least 12,000 years ago, gave them the means to cope with that experience. Individual tribes maintained their own death customs and adapted them to their regional environments into which they migrated, although such rituals and beliefs could pass from one group to the other through trade and intermarriage. Most Native American tribes believed that the souls of the dead passed into a spirit world and became part of the spiritual forces that influenced every aspect of their lives. Many tribes believed in two souls: one that died when the body died and one that might wander on and eventually die.

Burial customs varied widely from tribe to tribe. Indians disposed of their dead in a variety of ways. Arctic tribes, for example, simply left their dead on the frozen ground for wild animals to devour. The ancient mound-building Hopewell societies of the Upper Midwest, by contrast, placed the dead in lavishly furnished tombs. Southeastern tribes practiced secondary bone burial. They dug up their corpses, cleansed the bones, and then reburied them. The Northeast Iroquois, before they formed the Five Nations Confederation in the seventeenth century, saved skeletons of the deceased

for a final mass burial that included furs and ornaments for the dead spirits' use in the afterlife. Northwest coastal tribes put their dead in mortuary cabins or canoes fastened to poles. Further south, California tribes practiced cremation. In western mountain areas tribes often deposited their dead in caves or fissures in the rocks. Nomadic tribes in the Great Plains region either buried their dead, if the ground was soft, or left them on tree platforms or on scaffolds. Central and South Atlantic tribes embalmed and mummified their dead. But during outbreaks of smallpox or other diseases leading to the sudden deaths of many tribe members, survivors hurriedly cast the corpses into a mass grave or threw them into a river.

Rites among Native Americans tended to focus on aiding the deceased in their afterlife. Some tribes left food and possessions of the dead person in or near the gravesite. Other groups, such as the Nez Perce of the Northwest, sacrificed wives, slaves, and a favorite horse of a dead warrior. Among many tribes, mourners, especially widows, cut their hair. Some Native Americans discarded personal ornaments or blacked their faces to honor the dead. Others gashed their arms and legs to express their grief. California tribes engaged in wailing, staged long funeral ceremonies, and held an anniversary mourning ritual after one or two years. Southwest Hopi wailed on the day of the death, and cried a year later.

Some Southwestern tribes, especially the Apache and Navajo, feared the ghosts of the deceased who were believed to resent the living. The nomadic Apache buried corpses swiftly and burned

the deceased's house and possessions. The mourning family purified itself ritually and moved to a new place to escape their dead family member's ghost. The Navajo also buried their dead quickly with little ceremony. Navajos exposed to a corpse had to undergo a long and costly ritual purification treatment.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE;
GHOST DANCE

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KENNETH D. NORDIN

NATURAL DEATH ACTS

Natural Death Acts (also known as Death with Dignity Acts and Living Will Acts) are laws that determine in what situations, and how, people can refuse life-sustaining medical interventions. The purpose of these laws is to permit patients to choose a "natural" death, unencumbered by medical technology. The laws are a response to the great strides made by medical science over the last half of the twentieth century in prolonging the life of the chronically and severely ill. Concerns arose that medical technology that could forestall death, such as respirators and feeding tubes, increased the agony of dying. It also spawned concerns that an individual's right to autonomy and self-determination could be infringed by such invasive technology.

Origins in the United States

The first law in the United States that clarified the right of persons to refuse life-sustaining medical technology was passed in California in 1976. It permitted patients whose condition was terminal and death imminent to stop or refuse medical treatment. Throughout the late 1970s and 1980s other states began passing similar laws. At the start of the twenty-first century, every state had laws protecting the rights of dying patients.

There are several legal principles underlying these laws. The common law recognizes the right of each individual to control his own person without interference from others. This right extends to the medical arena, requiring doctors to obtain the consent of their patients before treating them. As stated by U.S. Supreme Court Justice Benjamin Cardozo, "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable" (*Schloendorff v. Society of New York Hospital*, 1914). This consent must be informed, requiring doctors to disclose the nature of what they are doing and the risks and benefits. The principle of informed consent to medical procedures governs all medical care, including life-sustaining treatment, and includes the right to refuse such treatment.

The U.S. Constitution also protects the right of dying patients to refuse medical care. This right was first established in the case of *In re Quinlan*, decided by the New Jersey Supreme Court in 1976. It involved a twenty-one-year-old woman who had been placed on a respirator after she stopped breathing for unexplained reasons and then entered a chronic persistent vegetative state. The court granted her parents' request for removal of the respirator, finding that it infringed upon her right to privacy as protected under the Constitution. Fourteen years later, the U.S. Supreme Court, in the case of *Cruzan v. Director, Missouri Department of Health*, also involving a young woman in a coma, found that the Fourteenth Amendment to the Constitution, which provides that a person may not be deprived of her liberty without due process of law, includes a liberty interest in refusing heroic medical measures.

Advance Directives

These legal principles are embodied in Natural Death Acts, which outline the procedures for exercising the right of dying patients to refuse life supports. Because many dying patients are incompetent at the time the crucial decision to withdraw or refuse life supports must be made, these laws provide mechanisms for patients to exercise their rights in advance. The primary mechanism is the advance directive, which is a statement, usually in writing, that declares what kind of lifesaving medical treatment a patient wants after he has become

incompetent or unable to communicate to medical personnel. One form of an advance directive, the living will, provides specific instructions on whether or not a person wants to accept life-sustaining medical interventions. Another form of advance directive is a health care proxy (or power of attorney), which appoints another person to make the decision and which may also include instructions on life supports. The laws also set forth what is required to prove the wishes of the patient when he has failed to complete an advance directive. Many Natural Death Acts also provide for the appointment of a surrogate decision maker.

While each state has its own Natural Death Act, there is also a federal law, the Patient Self-Determination Act (PSDA), which is designed to encourage patients to exercise their rights by completing advance directives. The PSDA requires hospitals, health maintenance organizations, and others that receive federal funds to tell patients of their rights under the applicable state law to make end-of-life medical decisions. The PSDA also requires that advance directives be maintained in patients' charts.

Despite these laws, the vast majority of people—between 80 and 90 percent—never execute advance directives. Nevertheless, largely through the passage of such laws, and the publicity generated by various right-to-die cases, a consensus has emerged over the years that patients have a right to refuse life-sustaining medical intervention. In one poll, 84 percent of Americans said they would not want life supports if they had no chance of recovery. How far that right should extend, however, is still a matter of controversy.

Right-to-Die Opposition

Initial opposition to the “right to die” was based on a state’s interest in protecting the sanctity of life, preventing suicide, and protecting innocent third parties (i.e., a patient’s children). These interests, however, become less significant in cases where a patient is terminally ill or severely incapacitated with no hope of improving. The ethical integrity of the medical profession, whose primary mission is to enhance life, is also cited as a reason for opposing the right to die. Nevertheless, virtually every professional organization, including the American Medical Association, recognizes that patient autonomy and good medicine may require

the withdrawal of life supports. Natural Death Acts also typically include a “conscientious objection” exception that permits physicians with religious or moral objections to refuse to honor a request to withhold or withdraw life supports so long as alternative accommodations, such as transfer to another hospital, are made.

Natural Death Acts also do not distinguish between withholding and discontinuing life supports. Thus, for example, removing a ventilator from a patient is considered the same as never starting it. One reason for this is that it encourages heroic measures be taken in times of uncertainty, with the understanding that they can be discontinued at a later point if found to be of little benefit or a burden to the patient.

There is some disagreement over whether nutrition and hydration should be treated the same as other forms of mechanical life support, such as respirators. This is primarily because of the emotional and symbolic significance of food and water. To some, withholding water and food, even if it must be supplied though such mechanical means as inserting a gastrostomy tube in a patient’s stomach, is causing death by starvation or thirst. Courts, however, do not distinguish between the two, viewing artificial nutrition and hydration as medical interventions as invasive as other forms of life-sustaining technology. Many Natural Death Acts, however, do treat the provision of nutrition and hydration differently. Some prohibit their withdrawal (although a court will likely ignore this prohibition). Others require people completing a living will to explicitly state whether artificial hydration and nutrition is to be included as a form of life support.

Assisted Suicide

Whether the right to die includes the right to ask others, such as a physician, for assistance in dying, is an intensely debated issue. Such assistance usually means the prescription of drugs, self-administered by the patient, which will hasten death. Physicians do engage in the practice, but until the late twentieth century remained silent about it. In 1991 the physician Timothy Quill brought the issue to the public’s attention by publishing an article in the *New England Journal of Medicine* describing how he provided a prescription of barbiturates to a patient with instructions on

how to use them to hasten the patient's death. A subsequent study, published in the *New England Journal of Medicine* in 1996, found that 20 percent of the physicians surveyed had knowingly and intentionally prescribed medication to hasten a patient's death. Other times, physicians will prescribe medication to ease pain, knowing that it will hasten death.

There appears to be some support for physician-assisted suicide among the general public. The same 1996 *New England Journal of Medicine* study found that 66 percent of the public supported its legalization. Supporters of the right contended that there was no difference, in hastening death, between the removal of life supports and the self-administering of a prescribed drug. They contended that writing a prescription required a less active role for the physician than physically removing equipment and caused less agony and pain.

Opponents believed that permitting assisted suicide violated the sanctity of life, and would open the door to more active forms of euthanasia, such as a physician administering a lethal injection or even ending a patient's life without his or her consent. They were also concerned that elderly and dependent people, who might perceive themselves as a burden to family and society, would feel an obligation to die sooner rather than later if physician-assisted suicide were made legal. They also argued that it would change the role of the medical profession from protectors of life to agents of death. As of 2001, the American Medical Association (AMA) opposed physician-assisted suicide, because "the physician's role is to affirm life, not to hasten its demise." Instead, the AMA recommended that physicians focus on making the dying more comfortable through the provision of palliative care which seeks to provide comfort, not a cure, including the full use of pain medication (even if it hastened death).

The law has been hesitant to recognize a right to assisted suicide. In 2001 every state, except Oregon, had laws prohibiting assisted suicide, making it illegal for anyone, including physicians, to assist in another's death. In 1997 the U.S. Supreme Court, in the case of *Vacco v. Quill*, refused to overturn such laws on the grounds that they violated a person's constitutional right to privacy. The Court distinguished between the right to refuse life-

sustaining medical interventions and requesting that affirmative acts be taken, such as prescribing a lethal dose of drugs, to hasten death. The Court explained the distinction by noting that "when a patient refuses life sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."

The Court left it to individual states to decide whether to legalize physician-assisted suicide. The only state to do so was Oregon, which passed the Death with Dignity Act in 1994, permitting physicians to prescribe medication that enhanced death, generally barbiturates, to patients under certain circumstances. It applied only to terminally ill persons with less than six months to live. Two physicians had to agree on the prognosis. A referendum to appeal the act was rejected by 60 percent of Oregon voters, thus demonstrating that there was considerable public support for physician-assisted suicide. As of 2001, only a handful of people had requested assisted suicide since the law went into effect. The law has also been upheld by the federal courts.

The Exceptional Case of the Netherlands

Most other countries recognize the right to refuse life-sustaining treatment but do not recognize the right to physician-assisted suicide. The one exception is the Netherlands, which permits not only assisted suicide but also other more active forms of euthanasia, including permitting a physician to actually administer the cause of death, such as a lethal injection. This right was first recognized by the Dutch Supreme Court, who excused from criminal culpability physicians who assist in the suicide of a dying patient when ethics and the good practice of medicine required it. It has since been codified into law, which requires that the patients are competent, have voluntarily and repeatedly over time requested assistance in dying, and are enduring unacceptable suffering, and where a second physician agrees assisted suicide is appropriate. A commission to study the effects of this initially judicial-made law, the Rammelink Committee, found that 2,300 deaths resulted from euthanasia in 1990. It is not known whether any of these deaths were involuntary, a concern of people who oppose assisted suicide. Some contend that the rates of euthanasia in the Netherlands are no different than those in other countries, just more visible.

The Societal Consensus

By the early twenty-first century, the existence of Natural Death Acts in every U.S. state reflected a societal consensus that people should be able to control the manner and timing of their own death in the face of medical technology able to prolong life. There were limits, however, to this right. Physician-assisted suicide and more active types of euthanasia had not, with some exceptions, been recognized under the law.

See also: ADVANCE DIRECTIVES; CRUZAN, NANCY; EUTHANASIA; INFORMED CONSENT; LIVING WILL; QUINLAN, KAREN ANN; RIGHT-TO-DIE MOVEMENT; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE

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VICKI LENS

NEAR-DEATH EXPERIENCES

Near-death experiences (NDEs) have been reported for much of human history. There is evidence in early Greek and Roman literature, in medieval Western religious literature, ancient literature of Buddhism, and the oral history and folklore of aboriginal societies in Australia, North and South America, and Oceania. The parapsychological literature has discussed NDEs since the nineteenth century, however the popular discussion of these experiences only dates from the early 1970s with the publication of Raymond Moody's best-selling *Life After Life* (1975). Moody coined the term *near-death experience* but later regretted its overidentification with physical death and changed the term for these experiences to *paranormal deaths*.

In *Life After Life* Moody discussed fifty individual cases of people who, when unconscious and apparently near death and then resuscitated, reported conscious social and psychological experiences. Some people reported sensations of traveling in a dark tunnel. Others reported meetings with bright beings of light or deceased relatives and friends.

Since this early book of casual observations from an author who had been an academic

philosopher retrained as a medical practitioner first appeared, other more research-based books have been published. Among these are the behavioral and clinical studies of the psychologist Kenneth Ring (*Life At Death* 1980), the cardiologist Michael Sabom (*Recollections of Death* 1982), and the psychotherapist Margot Grey (*Return from Death* 1985). These were soon followed by other studies from parapsychology, religious studies, sociology, philosophy medicine, and particularly psychiatry.

Among the many studies that have been published since Moody's work include several that have been conducted with children. Childhood NDEs are similar to those reported by adults with some minor differences in phenomenology. Life review, for example, is present for those with a long enough life to recall. Children seem to more often see animals in their NDEs than do adults, suggesting that perhaps animals are one of the few "dead beings" a child might expect to see in such a state. The incidence of NDEs is extremely difficult to assess and depends much on the definition one uses as much as the methodology one employs. In clinical settings, frequently employing cardiac patients, the incidence has been reported in the vicinity of between 9 percent and 18 percent.

Estimates of incidences within the general population have been attempted with surveys. Researchers estimate that approximately 5 percent of the United States population has experienced an NDE, which has led researchers in the U.S. to suggest that some 10 million Americans have had an NDE and in Germany over 3 million people have experienced NDEs.

Some twenty years after the initial observations and theories studies have uncovered and discussed negative NDEs—experiences near death that are less than pleasant for the person in this near-death state. In these accounts, people visit dark places, encounter cruel or taunting beings, and experience feelings of sadness or anxiety. As of 2001 there have been few psychological or social correlates to predict NDEs, either of the positive or negative variety. Gender, age, class, and religious affiliation do not appear to play any role in predicting these experiences. There are some circumstantial correlates, such as surgical or suicide patients who appear not to experience life review compared to those whose injuries or illnesses are of sudden

onset. But most of these predictive correlates appear to predict one or more NDE features (e.g. lights, life-reviewed, tunnel sensations, etc.) rather than actual incidence.

The professional and popular profile of NDEs has exploded since the 1970s. It is not immoderate to claim the NDE has become an important and central subject of study and entertainment since the late twentieth century. Moody's book has sold some 12 million copies to date. Film and video consistently employ NDE imagery in their scenes of death—from *Flatliners* (1990) to *What Dreams May Come* (1998). Several autobiographical NDE accounts have made the *New York Times* best-seller list.

The International Association for Near-Death Studies was established in the early 1980s in the United States, with chapters in the United Kingdom, Europe, Canada, and Australia. The association has an academic peer-review journal—*Journal of Near-Death Studies*—edited from the Department of Psychiatry at the University of Virginia Medical School. Articles about the NDE have appeared in prestigious medical journals including *Lancet*, *British Medical Journal*, *Journal of Nervous and Mental Disease*, and the *American Journal of Psychiatry*, among many others.

Theories

Understandably, near-death studies have drawn major theoretical debate from several quarters, in particular New Age and skeptical writers. Church leaders and writers are divided. Some side with materialist medical theories, while others argue that such experiences are the work of darker forces. Others allow that such experiences may be revelations into some larger human and perhaps divine dimension.

New Age writers, influenced by modern spiritualism and Eastern religions, have found the afterlife imagery rich in suggestion and confirmation about the eschatological theories of these influences. Skeptics, wary of religious resurgence and supernatural explanations, have tended to scrutinize the case details and research methodologies more carefully. They have tended to favor neuroscientific theories of explanation, particularly those with behavioral and psychobiological models of consciousness.

Among the chief psycho-neuro-biological theories of NDE have been theories of sensory deprivation and cerebral anoxia. Both events have been traced to abnormal temporal lobe seizure activity or the release of ketamines or other hormonal and chemical reactions in the brain. There have been theories about the role of drugs—both medical and illicit—but these took less prominence as more NDEs were reported in situations where these drugs were not implicated. The central problem with biological theories of NDEs is that most of these assume the experience to be closely associated with unconscious states. Increasingly this appears to be less the case.

There has been less effort in surveying the cross-cultural evidence around these experiences, yet it is here where the diversity of NDEs becomes increasingly apparent. What examination there has been in this area seems to indicate that the stereotypical profile of NDEs as an unconscious experience enjoys significant variation. Experiencers (people who experience NDEs) from hunter-gatherer societies, for example, tend not to report tunnel sensation or life review—an important observation that could undermine the credibility of attempts to create particular neurophysiological theories based up on these two details.

However, taking the stereotypical NDE profile of sensations of euphoria, out-of-body experience, tunnel sensation, life review, and meetings with beings of light or deceased people has also opened up another model of near-death experiences as experiences *not* near death and *not* unconscious. Here, similar phenomenology has been reported in connection with shamanic initiation rites, castaway experiences, experiences of trapped miners, mountaineering accidents, and bereavement experiences.

Further complicating the question of causation is the finding that near-deathlike experiences may be induced in therapeutic settings through use of eye-movement desensitization and reprocessing (EMDR) techniques in psychotherapy. During grief therapy using EMDR techniques, patients may experience reunion with deceased relatives and friends, tunnel sensation, experiences of light and peace, and the observation of supernatural vistas. Near-death experiences are no longer phenomena simply associated with unconscious experiences of cardiac arrest and resultant resuscitation.

The examination of these kinds of conscious experiences has led to the recognition of two important points. First, NDE phenomenology is not always associated with real, physical experiences of death but merely the expectation of dying and loss. Second, NDE phenomenology is associated with conscious as well as unconscious experience. These observations immediately call into question theories of NDE that rely on unconscious cases and that employ cerebral anoxia (oxygen deprivation of the brain) as their primary mechanism of causation. Any physiological theories of NDE must take into account that the phenomenology spans conscious and unconscious experiences and enjoys significant cultural variation.

Notwithstanding these qualifications, it is important to note that physiological theories have no more power in undermining supernatural explanations than New Age theories have of establishing them. The issue of whether consciousness is merely a function of physical processes or is mediated by them is not settled by biological debate, least of all one with obvious materialist assumptions.

The issue of the nature of consciousness and death, specifically the fate of consciousness beyond death, is a philosophical question. It is not settled by empirical claims if only because all scientific conclusions are subject to revision. And because they are ipso facto empiricist models of explanation, such models are biased against theories of experience not subject to these types of tests and proofs.

The nature of death or of consciousness is also not settled by logical argument if only because there are always better arguments to be made, and will need to be made, by the changeable requirements of a diverse and evolving professional and academic culture. The arguments about human survival are made in the service of persuasion and are rarely definitive except to those with faith—in religious or scientific, materialist ideas. Evidence and argument must have a context to be persuasive within. They are most effective among a community of believers. This remains true of twenty-first-century skeptics and religious adherents.

Even away from the ideological posturing of the more extreme opinions from religion and science, NDEs are not readily explained by current neurophysiology. Some researchers have argued that drugs may be implicated, but often they are



Some people who have had near-death experiences (NDEs) reported an experience of life review or the sight of supernatural vistas such as cities or blissful rural scenes of beauty. In these early accounts nearly every NDE was reported to have feelings of great peace and happiness, even euphoria. GEORGE D. LEPP/CORBIS

not. Other researchers have argued that tunnel sensation is due to the side effects of oxygen deprivation to the brain, but NDEs occur to people who are fully conscious as well.

Personality changes linked to disturbances to temporal lobe, such as religiosity, philosophical pursuits, widening affect and so on, have been associated with obsessiveness, humorlessness, anger, and sadness—qualities not normally associated with NDEs. There have been claims that NDEs have occurred when patients were connected with electroencephalograph (EEG) machines, but these claims were subsequently proven false. There are now documented cases, but the reliability and validity issues behind measurement of brain activity are far from certain and so such cases are intriguing at best and irrelevant at worse.

What scientists are able to say is that the research to date has provided fruitful indicators of the type of brain/consciousness models that are

needed to further explore and understand the physiological basis of these experiences. Advances in this scientific area will undoubtedly supply researchers with a basic benchmark for understanding the broad biological context of NDEs but they do not solve, and probably will never solve, the diverse incidents and experiences that are regularly reported near death. In this context, the best answer researchers will ever have when it comes to the question of whether or not NDEs represent evidence of human survival of death is that perhaps they might, but rarely conclusively.

Implications of Near-Death Experiences

Aside from the professional debates about the causes of NDEs there lies a major discussion about their consequences. Those whose NDEs are clinically derived from close physical encounters with death often report changed values and lifestyles. Those whose NDEs are derived from initiation rites, castaway experiences, or mining accidents

also report life changes. These changes to values or lifestyles are associated with both positive and negative NDEs, although such changes may be dissimilar from each other. For people whose NDE is a positive experience, many report a lessening or disappearance of any personal fear of death. These people also report a greater “love of humanity,” often expressed as a desire to change career or work aspirations so as to work for the good of others.

There is a greater expressed desire to be more tolerant or patient of human foibles and a greater appreciation for the interconnectedness of all living things. Those who encounter near-death experiences report an increase in their interest in spirituality but often expressly distinguish this from a church-going religiosity. Many other people have reported an increased interest in education or higher learning. This is often associated with a simple post-NDE desire for learning, but also for retraining into some kind of helping profession to meet their newly found ambition to “help others.” People who have experienced a negative NDE will often, understandably, report a greater fear of death, and are more likely than those with positive experiences to return to church attendance.

There has been some suggestion that those who experience near-death experiences encounter a new type of consciousness. NDEs create human beings that have higher spiritual values and such people are important to an evolution of improved social and political values within humanity. But it is not at all clear that the research on post-NDE changes in individuals reflects genuine changes or simply new attitudes and hopes in these people. People often report stigma and rejection of their new attitudes and values, while many others are even skeptical of the actual NDE itself. Many near-death participants have reported being withdrawn or depressed about such responses and more than one book has recorded that the diverse reactions of people and their networks have led to job loss and marital breakdown.

It appears that experiences of light and love near death no more makes a better person than any other experience of crisis. Experiences that are testing and challenging to one’s personal values and character can transform one for the better or may destroy that person. But it is not the experi-

ence that holds the key, but one’s capacity to learn and be changed by that experience. In this way, NDEs occupy similar psychiatric and social space as bereavement, job loss, poverty, personal failure, and social rejection. They may be sufficient but not guaranteed grounds for personal growth and change.

As mentioned previously, the NDE is not confined to people near death or loss. It may also take “passengers.” In his book *The Last Laugh* (1999), Moody calls these experiences “empathic,” “conjoint,” or “mutual” NDEs. People caring for dying people may report some actual NDE phenomenology—experiences of light, out-of-body experiences, meeting supernatural or deceased beings, and enjoying sensations of peace and joy. These are part of a discreet subset of near-death phenomenology such as shared near-death visions, shared near-death experiences, and shared illness experiences. They have been reported in early-nineteenth-century parapsychology literature and in late-twentieth-century near-death studies and literature.

The social and psychological pattern for their appearance seems to be a personal journey that takes the dying or ill person through similar stages of social isolation and reintegration. The number of reported cases of shared NDE are small and their documentation inconsistent in thoroughness. Yet, such cases continue to strengthen the importance of the social and psychological nature and complexity of NDEs. There can be no doubt that biological factors play a role but it may yet turn out to be a diverse mediating one, subject to equally complex social factors. Just as the physiology of smiling is no key to the secret of happiness, the physiology of NDEs may not unlock the secret of the fate of the soul nor even of its whereabouts.

The problem of NDEs appears to tread similar territory to other problems of social and psychological marginalization. In that space, NDEs are areas of contested social meanings between modern-day “experts” of one persuasion or another, and individuals trying to make sense of experiences for which science and religion have poorly prepared them. Without a settled, agreed-upon set of meanings, the status of NDEs, their passengers, and their public relationships with the outside world will always be ambiguous and problematic.

See also: COMMUNICATION WITH THE DEAD;
COMMUNICATION WITH THE DYING; IMMORTALITY;
MOMENT OF DEATH; REINCARNATION

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ALLAN KELLEHEAR

NECROMANCY

Necromancy (derived from the Greek *nekros*, meaning "dead," and *manteia*, meaning "divination") is the evocation of the dead to obtain omens about future events or secret facts. It is based upon the belief that the deceased, free of physical limits, holds the power to obtain information that is not accessible to the living.

Necromancy is a practice that originated in ancient Persia, Greece, and Rome, but was most popular during the Middle Ages, and is rare today. The most common form of necromancy is to summon the spirit of the corpse by sacrifices and incantations but there is also the less common practice of attempting to raise the corpse to life. The rituals demand meticulous execution and exacting preparations involving the choice of a proper place, for example a cemetery or the ruins of an ancient monastery; the choice of the right time, usually between the hours of midnight and one in the morning; use of specific incantations; and accessories, such as bells. One of the most important elements is the use of a magic circle which protects the necromancer and his or her assistant from being harmed by provoking the dead.

There are many examples of necromancy throughout history, but the best-known necromancer was the witch of Endor, who, according to the Bible, summoned the spirit of Samuel to answer Saul's questions. Often considered a sinister

practice, necromancy was condemned by the Catholic Church and was outlawed by the Witchcraft Act of 1604 in Elizabethan England.

See also: COMMUNICATION WITH THE DEAD; DEAD GHETTO

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ISABELLE MARCOUX

NECROPHILIA

The term *necrophilia* is mostly used as a psychiatric expression for a pathological sexual attraction to corpses. It is a very rare and poorly understood phenomenon. In his seminal 1894 work, *Psychopathia Sexualis*, Richard von Krafft-Ebing, one of the first psychiatric writers, called it a horrible manifestation of sadism. Abraham A. Brill, who published the first comprehensive examination of the subject in 1941, characterized necrophiles as many other authors had—mentally deficient, psychotic, and incapable of obtaining a consenting partner. Necrophilia has been associated with cannibalism and vampirism as all are considered perversions.

In 1978 Neville Lancaster reported in the *British Journal of Psychiatry* the case of a twenty-three-year-old student of music at a teacher's training college in England. He was convicted of the murder of a young woman, and sentenced to imprisonment for life. The defendant admitted that he had broken into a mortuary on two occasions prior to the murder and had sexual intercourse with female corpses. The prosecution saw him as a necrophile who desired a dead body and therefore decided to kill the victim. The student was tested with an IQ of 153, and no evidence of psychiatric illness was found. The defendant had a normal romantic relationship with a music teacher. The three necrophilic incidents occurred after the student was drinking extensively and taking other chemical agents, so the previous incidents of sexual in-

tercourse with corpses completely disquieted him the following morning. Necrophilia seemed to upset him as much as the murder itself.

This report demonstrates how difficult it is to draw any generalizations from a single case history. In 1989 Jonathan Rosman and Phillip Resnick reviewed 122 cases manifesting necrophilic acts or fantasies. They distinguish genuine necrophilia from pseudonecrophilia and classify true necrophilia into three types: necrophilic homicide (murder to obtain a corpse for sexual purposes); "regular" necrophilia (the use of already dead bodies for sexual pleasure); and necrophilic fantasy (fantasizing about sexual activity with a corpse, without carrying out any necrophilic acts). The pseudonecrophile has a transient attraction to a corpse, but a corpse is not the object of his sexual fantasies. According to Rosman and Resnick, neither psychosis, mental retardation, nor sadism appears to be inherent in necrophilia. The most common motive for necrophilia is possession of an unresisting and unrejecting partner. Necrophiles often choose occupations that put them in contact with corpses.

Based on single case histories, many researchers offer psychoanalytic explanations for necrophilia. Rosman and Resnick developed an empirical model to get a deeper understanding of how psychodynamic events could lead to necrophilia: "(1) The necrophile develops poor self-esteem, perhaps due in part to a significant loss; (a) He (usually male) is very fearful of rejection by women and he desires a sexual object who is incapable of rejecting him; and/or (b) He is fearful of the dead, and transforms his fear of the dead—by means of reaction formation—into a desire for the dead; (2) He develops an exciting fantasy of sex with a corpse, sometimes after exposure to a corpse" (Rosman and Resnick 1989, p. 161). Because no therapist has treated a sufficient number of necrophiles, research literature on effective treatments does not exist.

See also: GRIEF; NECROMANCY; VAMPIRES

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RANDOLPH OCHSMANN

NEONATAL INTENSIVE CARE UNIT

Neonatology is a specialty within pediatric medicine that provides care for sick and/or premature infants. It is an area of medicine that is very young in comparison to other areas of medicine. This is also true for the newborn babies that begin their lives in the neonatal intensive care unit (NICU). Infants less than one month old are often referred to as "neonates." These neonates can be born as early as twenty-four weeks gestation (five months of pregnancy) and spend several months in the NICU. The NICU is a highly technical specialized unit in a hospital that provides medical/nursing care and technological support to sick and/or high-risk premature infants. Premature infants (infants born before thirty-seven weeks gestation) are the largest group of infants who require this high-tech environment to survive. Most preterm infants stay in the NICU until their due date. Thus, if a child was born six weeks early, parents can expect that their child will be in the NICU for six weeks. The NICU often becomes a second home for many families, where parents spend many hours each day with their infants. For the most part, these tiny infants must learn to breathe and grow before they can go home.

Other infants who require this specialized medical/nursing care are either born sick with some kind of disease or have a congenital defect or syndrome. These infants require specialized care until they can be easily cared for by their families at home. This medical/nursing care may be supportive, palliative, or surgical in nature and is determined by the individualized needs of the child.

The NICU did not exist until the early 1960s and the specialty of neonatology did not begin until the 1970s. These special units were established soon after the death of President John F.

Kennedy's newborn son, who died of respiratory distress and immature lungs. He was born at thirty-four weeks gestation. His death brought increased awareness in the United States to the numbers of preterm infants who were dying because of immature lung development shortly after their births. Knowledge and expert care of these infants increased, and by the early 1990s more than 90 percent of these premature infants were surviving, including those infants born as early as twenty-four weeks gestation. There are more than 1,500 NICUs in the United States. Most are regional centers that provide training and consultation to a network of newborn nurseries in several communities. Regionalized care brings perinatologists (specialists who treat high-risk pregnant mothers) and neonatologists together to provide the best possible support and care to this special dyad. This is necessary because even though the NICU team can support the infant, most often the best place for the child is in the womb of his or her mother until forty weeks gestation, the normal length of a pregnancy.

The ability to better support these vulnerable infants and families has changed primarily because of a substantial increase in knowledge and understanding of the physiologic, psychosocial, and neurobehavioral capabilities of high-risk infants. In addition to this enormous growth in knowledge, there have been many advancements in technology, such as the development of surfactants and the refinement of mechanical ventilation, that have greatly influenced the ability of medical personnel to physiologically support infants in the NICU. Research findings have contributed many facets and dimensions to providing care that further enhance the long-term outcomes for high-risk infants and their families. For example, although there is still some mystery to the underlying pathophysiology of retinopathy of prematurity (retinal damage related to immature developing retina of preterm infants, once believed to be related to too much oxygen therapy), refined management of the progression of the disease often minimizes long-term problems for these infants. The delivery of expert medical/nursing care requires the artful use of technology and the integration of developmentally supportive and family-centered concepts into routine medical practices.

There are many different kinds of technology in the NICU, including different types of infant

ventilators, monitors, and supportive devices, such as infusion pumps, oxygen hoods, and incubators. Although this equipment has become more responsive to the needs of the infants, there is still much the scientific and medical communities can learn about the use of technology to support neonates. The benefits of these machines are often coupled with iatrogenic hazards that may lead to long-term complications and increased numbers of chronic patients in the NICU. Although this equipment is intended to support infants in the NICU, many times all it does is increase the time infants spend in the NICU with little improvement in long-term outcomes. Technology must be used prudently with outcomes and cost-benefit as part of the decision-making process. Even with the technological advances and neurobehaviorally based interventions that are available to the premature infant, nothing can substitute for the normal environment of the womb.

More than any other phenomenon, technological developments seem to have become the most transforming force in the advancement of neonatal care. It was the development of the first infant ventilator that many medical professionals believe actually “birthed” the NICU. Prior to that time, incubators kept infants warm but only the strongest survived in the small isolated special care nurseries. The equipment in the twenty-first-century NICU has evolved significantly since the 1980s and 1990s. Previously, equipment used in the NICU was developed as scaled-down versions of technology used to support adults. These adult designed machines, however, did not meet the very different and unique physiologic needs of the infant. Providing care in the highly technical environment of the NICU is challenging. Technologic interventions allow for greater medical support and management of sicker and smaller preterm infants. And, although these infants are indisputably more vulnerable and dependent on the care of others, they are continually developing and maturing into amazingly independent and resilient human beings.

The professionals who work in the NICU are highly trained in the care of preterm babies. There are neonatologists, neonatal nurse practitioners, staff nurses, respiratory therapists, developmental specialists, occupational therapists, and physical therapists. This team of professionals works together with the family to provide a holistic approach to the management of the child’s needs.



Newborns can be treated for jaundice with phototherapy in NICUs, one of the many technologies available in intensive care units. AMERICAN ACADEMY OF PEDIATRICS

Sometimes pediatric specialists are used as a resource when, for example, an infant requires cardiac surgery for a congenital defect. The neonatal team requests a specialized consultant, who is then invited to examine the child and his or her medical records and provide focused input with regard to the continued management of the child. Sometimes management requires surgery. Because the infants are so small and so susceptible to infection, this surgery is often performed within the confines of the NICU rather than the institution’s operating room. The decision regarding the operation’s location is based on how well the NICU is equipped to handle the type of surgery required and the comfort of the surgeon with the NICU environment.

Neonatal intensive care has become a leader in the provision of family-centered care, which recognizes the unique and individual needs of each infant and family. Family-centered care is a philosophy of care in which the pivotal role of the family is acknowledged and respected in the lives of children. Within this philosophy, families are supported in their natural caregiving and decision-making roles, and medical professionals respect their unique strengths as people and families. Family-centered care recognizes and promotes normative patterns of living at home and in the community. Parents and professionals are seen as equals in a partnership committed to the child and the development of optimal quality in the delivery of all levels of health care. Family-centered care also helps the family achieve the best possible environment for promoting the growth and development of

individual members of the family. Family-centered care strengthens the family unit through advocacy, empowerment, and enabling the family to nurture and support their child's development.

Family centered caregiving interventions include individualizing care to include providing clustering of caregiving tasks. "Clustering" caregiving increases rest periods for the infant, providing medical and supportive interventions based on the individualized behavioral cues of the infant, supporting the infant's long-term development by acknowledging the infant's post-conceptual age when choosing interventions, paces procedures, and integrates the family into the interdisciplinary caregiving team. Particular interventions might include providing developmentally supportive positioning, skin-to-skin (kangaroo) holding, music therapy, infant massage, and/or cuddler programs. However, individualized interventions unique to the needs of each child are the key to success with a particular infant and family. Although some infants die in the NICU, the number is relatively low compared to the number who are cared for and discharged home as relatively "normal" with their families.

See also: INFANT MORTALITY; LIFE EXPECTANCY

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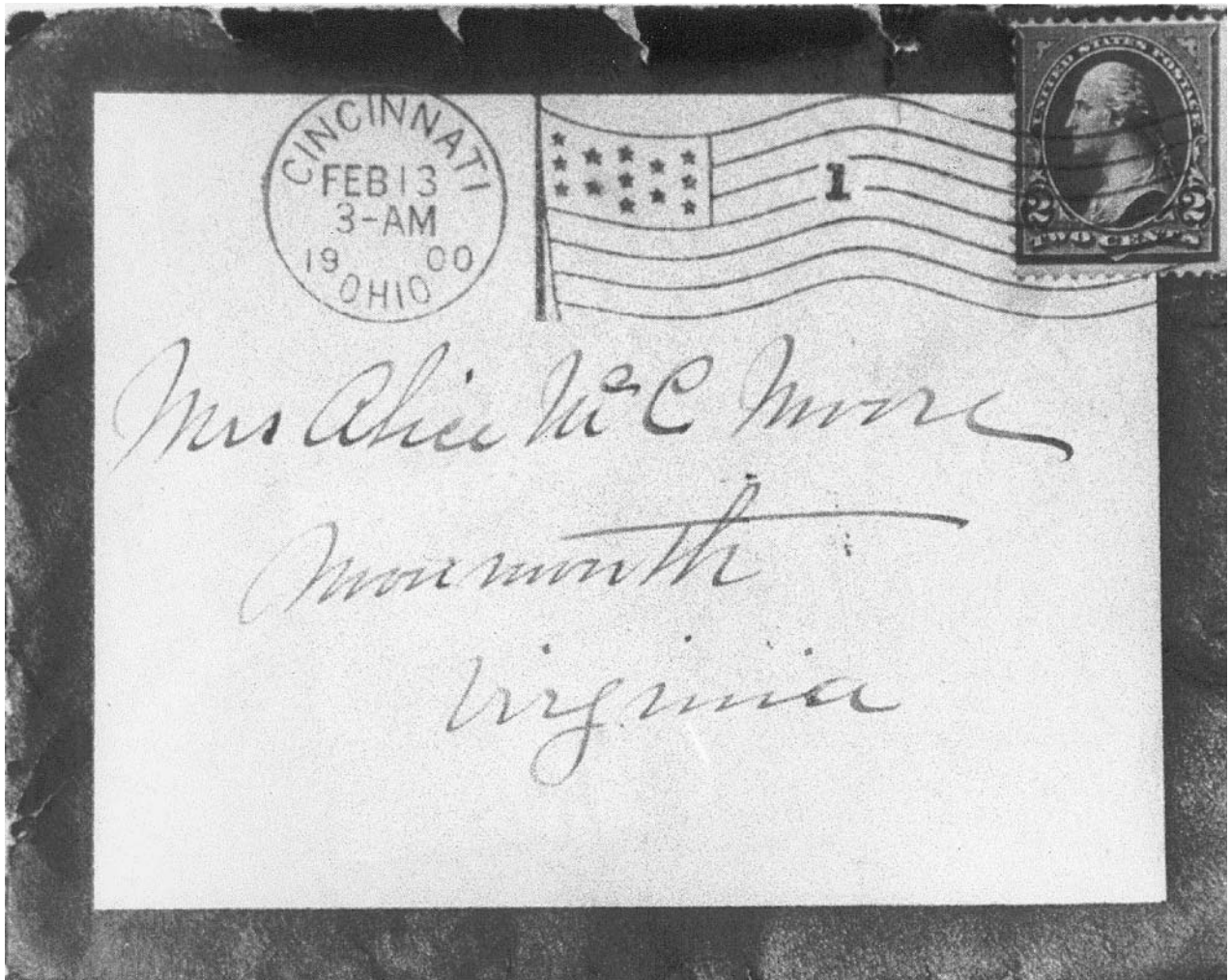
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JACQUELINE M. McGRATH

NOTIFICATIONS OF DEATH

One of the most important messages communicated in human societies has always been the notification that one of their members has died. The news spreads outward—like ripples in a pond—from family members to friends, to employers, and to fraternal orders and other organizations to which the deceased belonged. Various bureaucracies, too, must be informed, such as Social Security, insurance agencies, and voters' registration, as the deceased is no longer entitled to the benefits of the living. A death notice announces a void in the social fabric and the survivors' entry into the bereavement role. Who delivers the death notification, and to whom it is delivered, reveals much about the nature of individuals' ties to the broader society.

The order and nature by which notifications are made reveal a prioritizing of the importance of the social bonds between the deceased and his or her kinship groups, friends, work and civic associates, and the wider public. If the wrong approach is employed when informing someone of a death,



Until the early twentieth century an individual did not attend a funeral without an invitation. One way of providing an invitation was a letter edged in black, generally enclosed in a black-edged envelope. The invitation served the dual purpose of notifying the receiver of the death and inviting him or her to the deceased's funeral. JAMES CRISSMAN

as when a distant cousin is informed before a sibling of the deceased, people may feel slighted and ill feelings can result. Therefore, a “ranking” process usually exists with regard to whom the contact person(s) should be and the order in which survivors should be notified of a death. Each family unit usually has its own plan of contact order for those who should be a part of the notification process.

Traditional Methods of Delivering Death Notifications

When societies were rural, small, and members lived near one another, it was feasible to walk from residence to residence and personally spread the

news that someone had died. When horses were available, riding, rather than walking, was an option.

The custom of ringing a bell to announce a death originated in Europe and became a cultural trait. In Tudor England, it was called a “Passing Bell” or “Soul Bell” (Montell 1975, p. 68). Tolling the bell was used in different ways depending on the community. The bell might simply be sounded several times and people would understand its meaning. It could be rung several times, there would be a pause, and it would be tolled again each hour for several hours. In some societies, the number of times the bell was rung reflected the age of the person. The famous English poet, John Donne, obsessed with his own death and lying in

bed suffering from a serious illness, wrote “For Whom the Bell Tolls” while listening to the tolling of a distant funeral bell. The custom of ringing the bell was brought to early America and utilized in areas such as Central Appalachia for many years.

In the small American towns of the nineteenth and twentieth centuries, where no newspapers, telephones, or other means of fast conveyance were extant, it was common to place a funeral notice in the window of a business establishment. People who lived in the community, or were visiting, would go to the window of the business to see who had died and then respond accordingly. In some areas of Europe and America it was also a custom to place a black badge or flower wreath on the door of a residence or business to denote a death.

When telephones were introduced, for people who could afford them, tolling bells and other forms of notification were no longer necessary. Messages could be sent to people who lived a long distance from where the death occurred. With the phone, the message which had been public, now became privatized. The advent of the telephone brought a new form of death anxiety. When the knowledge of an impending death exists, there is a degree of anxiousness every time the telephone rings. There is the certainty that “this call is the one” and there is an element of hesitancy to answer the phone. If it is not answered, the bad news will not be received, and the death can be denied for a while longer.

Twentieth-Century Death Notifications

From the early 1900s to the present, many radio stations have a daily broadcast, usually in the morning, to inform the listening public of those who have died, with a biographical summary similar to an obituary and notice of the time and place of the funeral. These programs are usually supported by local funeral establishments.

While one might consider the obituary that appears in newspapers to be a modern contrivance, it actually dates to at least the Middle Ages. The obituary is a published announcement of a death. It includes a brief biography of the deceased and information concerning the funeral, but the quantity and type of data included vary from one obituary to another. Symbolically reaffirmed is the community’s social hierarchy. Occasionally the

person’s standing in the social hierarchy is denoted, and in rare instances there may be a photograph of the deceased.

Sudden Death Notification

In the hospital setting, it is generally the duty of the physician to notify the next of kin that a death has taken place, but there are instances in which the task has been assigned to a nurse, clergy person, or social worker. In the case of accidental death, vehicular or nonvehicular, it often is a police officer, accompanied when possible by a chaplain, who delivers the news. When death occurs, the victim’s name is withheld from the public pending notification of the family as family members who have proprietary rights to being first informed.

To soften the impact of a death notice, the police and military have developed their own system of informing survivors of the demise of a loved one. While procedures vary from department to department, generally when a police officer is killed the chief of police and the officer’s immediate supervisor go to the residence of the deceased to deliver the news. If a chaplain is available, he or she will take part in the notification process. When a death occurs in the military, a chaplain or high-ranking officer will go to the home of the survivors. During a war, when there are not enough personnel to deliver the news directly, a registered letter is sent to the home. The Louvin Brothers’ 1991 song “Robe of White” best describes the process:

“I’m sorry,” said the postman, “I must ask
you to sign
This little book that I have brought along.
You see this letter’s registered.” He slowly
bowed his head.
And then she knew that there was something
wrong.
The address on the corner of this envelope
of blue
Told her that her darling son was dead.
Where Jimmy’s name and number had always
been before,
His captain’s name was written there instead.

When there is a lingering illness prior to a death, survivors have a chance to adjust to the demise of their loved one. Some thanatologists even refer to a process of “anticipatory grief” where the person actually ends the grieving process (and

sometimes abandons the dying person) prior to the death. However, when there is a sudden death, whether it is the result of an accident, suicide, murder, fatal heart attack or stroke, disaster, or war wound, sudden death notification can have a traumatic impact on the recipient of the news. Grief may be more intense than in instances where there is time to prepare for a death.

There is always a right way and a wrong way to notify someone of a sudden death. Neither the military nor the police should send a lone novice to notify the family or next of kin; however, it may be a good idea to have an inexperienced person accompany someone who is experienced to learn the correct process of notification). The notifier should be someone who is experienced in interpersonal relations (e.g., a clergy person) or someone who has either received a notification of death at some point or has been a notifying agent at least once. A death notice should not be sent directly through the mail, it should be hand delivered. The deliverer should not walk up to the door, hand the letter to the survivor, and leave. It is best to deliver it to a friend of the family and have them carry it by hand to the survivors.

When a sudden death notice is delivered, the message should be short and to the point. The bearer should simply say that they have bad news and then tell the survivor(s) that their loved one is dead. According to the sociologists Michael Leming and George Dickinson, "Because the recipient of the news will probably be in shock and will disbelieve immediately after receiving the news, then is the time to add the simplest of details"—the person is dead, place of death, brief description of how they died, and where the deceased is located (Leming 2002, p. 477). No matter how well the deliverer of bad news may do his or her job, the survivor will in most cases accept the news with great difficulty.

See also: DEATH SYSTEM; GENDER DISCRIMINATION AFTER DEATH; GRIEF: FAMILY; SYMPATHY CARDS

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NUCLEAR DESTRUCTION

The Nazi death camps and the mushroom cloud of nuclear explosion are the two most potent images of the mass killings of the twentieth century. As World War II ended and the cold war began, the fear of nuclear annihilation hung like a cloud over the otherwise complacent consumerism of the Eisenhower era. The new technologies of mass death exacted incalculable costs, draining the treasuries of the United States and the Soviet Union and engendering widespread apocalyptic fatalism, distrust of government, and environmental degradation.

The advent of nuclear weapons fundamentally altered both the nature of war and the relationship of the military with the rest of society. A 1995 study by John Pike, the director of the space policy project at the Federation of American Scientists, revealed that the cost of nuclear weapons has constituted about one-fourth to one-third of the entire American military budget since 1945. President Eisenhower, in his farewell speech on the threats posed by the "military-industrial complex," warned of the potential of new technology to dominate the social order in unforeseen ways. The "social system which researches, chooses it, produces it, polices it, justifies it, and maintains it in being," observed British social historian E. P. Thompson, orients its "entire economic, scientific, political, and ideological support-system to that weapons system" (Wieseltier 1983, p. 10).

Throughout the cold war, U.S. intelligence reports exaggerated the numbers and pace of development of the Soviet Union's production of bombs and long-range nuclear forces, thus spurring further escalations of the arms race and the expansion of the military-industrial complex. In the 1950s there was the bomber gap, in the 1960s it was the missile gap, in the 1970s the civilian defense gap, and in the 1980s the military spending gap. The Soviet Union and the members of the NATO alliance developed tens of thousands of increasingly sophisticated nuclear weapons and delivery systems (e.g., cannons, bombers, land- and submarine-based intercontinental ballistic missiles) and various means of protecting them (e.g., hardened underground silos, mobile launchers, antiballistic missiles). With the possible exception of the hydrogen bomb, every advance in nuclear weaponry—from the neutron bomb and X-ray warheads to the soldier-carried Davy Crockett fission bomb—was the product of American ingenuity and determination.

A Brief History of Cold War Nuclear Developments

During World War II, while German research resources were largely invested in developing the V-1 and V-2 guided missiles, similar investments were being made by the United States and selected allies in producing the ultimate bomb through the highly secret Manhattan Project. The first nuclear device was detonated before dawn on July 16, 1945, at the Alamogordo Test Range in south central New Mexico. Within two months, atomic bombs were dropped on the Japanese cities of Hiroshima and Nagasaki. The U.S. government claimed that these bombings were necessary to shorten the war and avoid the anticipated heavy casualties of a land invasion of Japan, but later revisionist historians have disputed that motivation, claiming rather that the blasts were intended as an advertisement of American power over the Soviet Union.

The United States continued to develop the new weaponry despite the fact the war had concluded. Whether this was the reason why the Soviet Union embarked on its own weapon program, or if it would have done so if the U.S. had ceased production, remains a matter of debate. The Soviets deeply feared that the United States, having demonstrated its willingness to use the weapon on civilian populations, might not hesitate to do so

again during the cold war. Two weeks after Hiroshima's destruction, Stalin ordered a crash program to develop an atomic bomb using Gulag prisoners to mine uranium and construct weapons facilities, putting the needs of his people behind those of the bomb. The race for nuclear supremacy had begun.

The 1940s saw the dawn of the cold war: the Soviet blockade of Berlin, Mao's victory over the Nationalists in China, discoveries and accusations of espionage, and, in September 1949, evidence that the Russians had tested their own bomb. Major General Curtis LeMay, head of the newly formed Strategic Air Command, was ordered to prepare his Air Force unit for possible atomic attack. His first war plan, based on a concept called "killing a nation," involved attacking seventy Soviet cities with 133 atomic bombs.

Fears of imminent nuclear war swept the globe. President Truman believed that if the Russians had the bomb, they would use it. The physicist Edward Teller pushed for a thermonuclear weapon whose virtually unlimited power would dwarf the atomic bombs produced under the Manhattan Project. The "Super," as it would be called, was the hydrogen bomb. In January 1950 Truman approved its development. Five months later, North Korea, with Stalin's support, attacked South Korea. Later that year, when in retreat, the North Koreans were reinforced by another Russian ally, Communist China. The cold war was in full swing, and the climate of fear and suspicion fueled McCarthyism. In 1952 the first hydrogen bomb was detonated, releasing a force some 800 times greater than the weapon that had destroyed Hiroshima. The bomb, initially sixty-two tons, was later made smaller and lighter, allowing its placement on missiles.

It was then that President Eisenhower's Secretary of Defense, John Foster Dulles, presented the impression that the United States would instigate nuclear war if there were any communist encroachments upon the "free world." Peace was maintained through the deterrent of fear: "Mutually Assured Destruction" (MAD) became the principle nuclear strategy for the rest of the twentieth century, making it inconceivable that politicians would risk the destruction of the planet by actually deploying the weapons they were so busily and alarmingly developing and stockpiling. To ensure

retribution following a first strike, stockpiles continued growing to the point where human populations could be killed many times over.

Nuclear anxieties intensified with the development of strategic intercontinental rockets capable of delivering a nuclear warhead anywhere in the world within minutes. Because atomic war would basically be a one-punch affair, the alacrity and thoroughness of the first strike became the preoccupation of strategic planners. The race between the United States and Russia to refine German rocket technology intensified during the 1950s. When Russia launched the first satellite, *Sputnik*, in 1957, Americans panicked at the thought of Soviet hardware overhead and its ability to drop weapons from orbit. To recoup lost face and bolster national confidence, the United States entered the space race with its own orbital missions and even considered a plan to detonate a Hiroshima-size nuclear bomb on the moon that would be visible to the naked eye. In 1961 the Soviets placed the first man, Yuri Gagarin, into orbit as the nuclear-arms race combined with the space race as the key instruments of cold war rivalry between the Soviet Union and the United States.

But the critical event of the 1960s was the 1962 discovery that Russians had deployed forty-eight offensive ballistic missiles in Cuba. In a showdown of nuclear brinkmanship, both the Soviet Union and the United States went on highest alert in their preparations for war. For thirteen days the cold war almost went hot. As the Russian nuclear missiles were nearing operational status the Kennedy administration weighed such options as mounting an air strike, staging an invasion, or conducting a naval blockade. After the latter was selected, a Russian fleet steamed west to break it; a U.S. spy plane was shot down over Cuban territory killing the pilot. Eventually, though, diplomacy and level heads prevailed. The missiles were removed in exchange for a U.S. pledge not to invade the communist country and to remove its obsolete Jupiter missiles from Turkey. The nations' closeness to the unthinkable contributed to their agreeing on the 1963 Nuclear Test Ban Treaty.

There was one final peaking of fears and expenditures before the collapse of the Soviet Union: the entry of another communist superpower on the nuclear game board. China, which had detonated its first atomic bomb in 1964, claimed thirteen

years later to have successfully tested guided missiles with nuclear warheads. Reports surfaced of nuclear shelters being constructed in Manchuria. The 1970s concluded with six members in the nuclear club and with memories associated with the seventy-fifth anniversary of the beginning of World War I and how an unpredictable chain of events could set into motion unwanted global conflict.

In 1982 President Reagan unilaterally discontinued negotiations for a comprehensive test ban of nuclear weapons, echoing the military's claims of a "testing gap" with the Soviet Union. In fact, as of the beginning of 1985, the United States had over the previous four decades (since 1945) conducted some 200 more nuclear tests than had the Soviets. The President proposed the Strategic Defense Initiative, popularly known as "Star Wars," to protect the nation from missile attack by using exotic technologies that were still on the drawing board. Pure scientific research in physics, lasers, metallurgy, artificial intelligence, and dozens of other areas became largely focused on direct military uses. By the mid-1980s, 70 percent of American programs in research and development and testing and evaluation were defense-related, and nearly 40 percent of all U.S. engineers and scientists were involved in military projects.

Compounding public anxieties was a 1982 forecast by U.S. intelligence agencies that thirty-one countries would be capable of producing nuclear weapons by 2000. From the scientific community came highly publicized scenarios of a postwar "nuclear winter," possibly similar to conditions that led to the extinction of dinosaurs following the impact of an asteroid. Groups such as Physicians for Social Responsibility warned that such a conflict would lead to the return to the Dark Ages. Books like Jonathan Schell's *The Fate of the Earth* (1982) and media images such as ABC television's special *The Day After* (1983) produced a degree of public unease not seen since the 1962 Cuban Missile Crisis.

The collapse of the Soviet Union and the end of the cold war in the late 1980s did not conclude American research and development—nor fears of a nuclear holocaust. In Russia, equipment malfunctions have accidentally switched Russian nuclear missiles to a "combat ready" status, and deteriorating security systems have increased the

likelihood of weapons-grade materials falling into the hands of rogue states and terrorists. In the United States, major military contractors sought long-term sources of revenue to compensate for their post-cold war losses, and Republicans continued pushing for a defensive missile shield. In the mid-1990s the Department of Energy approved expenditures of hundreds of millions of dollars for superlasers and supercomputers to simulate weapons tests. A sub-critical nuclear weapons test, called Rebound, was conducted in 1997 at the Nevada Test Site. At the beginning of President George W. Bush's term, the 2001 Defense Authorization Bill was passed requiring that the Energy and Defense Departments study a new generation of precision, low-yield earth penetrating nuclear weapons to "threaten hard and deeply buried targets."

The Proliferation

Through espionage, huge national investments, and a black market of willing Western suppliers of needed technologies and raw materials, the American nuclear monopoly was broken with the successful detonations by the Soviet Union (1949), the United Kingdom (1952), France (1960), China (1964), India (1974), and Pakistan (1998).

Although the Western allies made the Soviet Union the scapegoat for the proliferation of nuclear weapons, it has been the export of Western technology and fuel that has given other countries the capability of building their own bombs. Although publicly dedicated to controlling the proliferation of "the bomb," in the fifty years following the Trinity detonation the United States shipped nearly a ton of plutonium to thirty-nine countries, including Argentina, India, Iran, Iraq, Israel, Japan, New Zealand, Pakistan, South Africa, Sweden, Turkey, Uruguay, and Venezuela.

The countries suspected of having (or having had) nuclear weapons programs include Iraq, Romania, North Korea, Taiwan, Brazil, Argentina, and South Africa. There is little doubt that the sixth member of the nuclear club is Israel, which was supplied a reactor complex and bomb-making assistance by the French as payment for its participation in the 1956 Suez Crisis. Despite its concerns over nuclear proliferation, the United States looked the other way as the Israeli nuclear program progressed, owing to the country's strategic position amid the oil-producing countries of the Middle

East. When a Libyan airliner strayed over the highly secretive Negev Nuclear Research Center in 1973, Israeli jets shot it down, killing all 104 passengers.

Living with the Bomb

In *By the Bomb's Early Light* (1985) Paul Boyer asks how a society lives with the knowledge of its capacity for self-destruction. However such thinking was in vogue with the approach of the West's second millennium, with the media saturated with doomsday forecasts of overpopulation, mass extinctions, global warming, and deadly pollutants. By the end of the 1990s, half of Americans believed that some manmade disaster would destroy civilization.

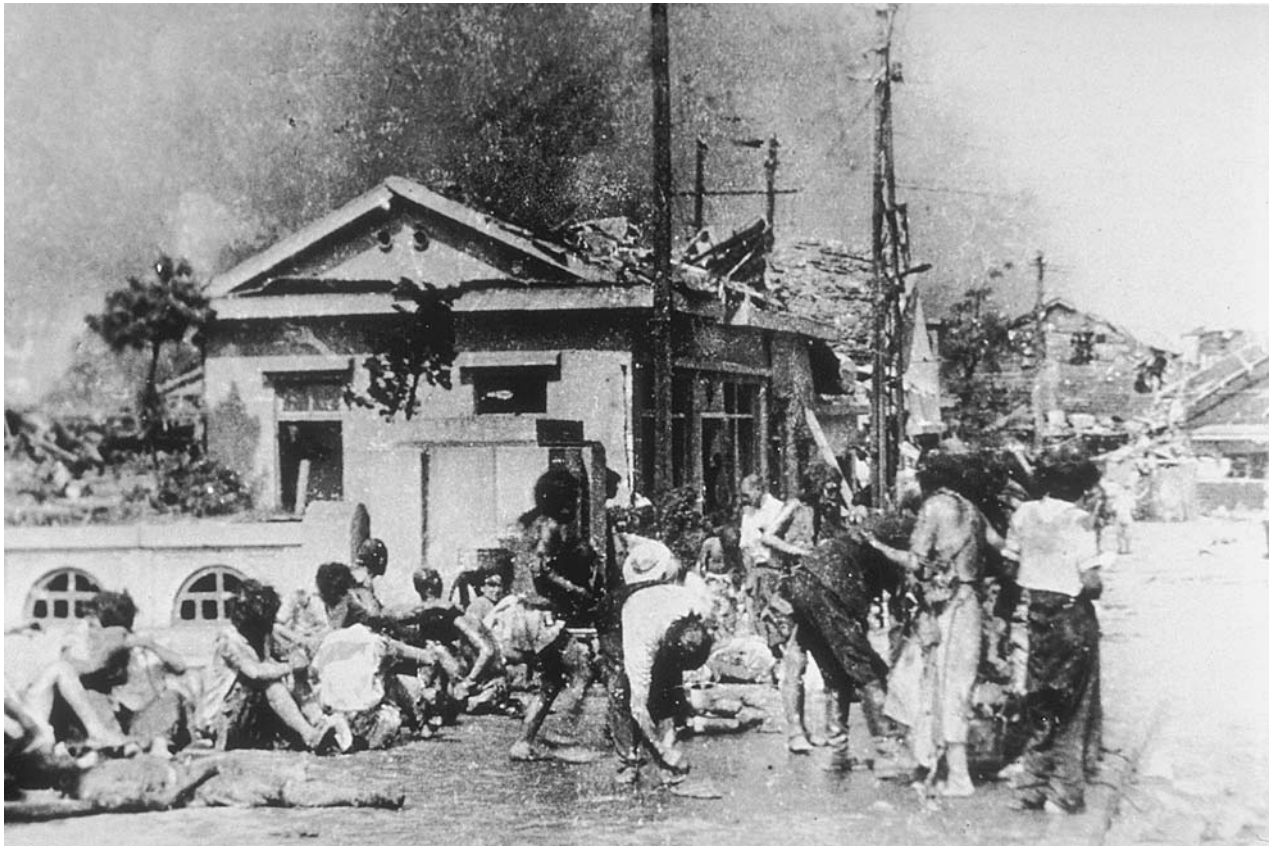
The real possibility of nuclear war threatens the very meaning of all personal and social endeavors, and all opportunities for transcendence. In 1984, to dramatize the equivalency of nuclear war with collective suicide, undergraduates at Brown University voted on urging the school's health service to stockpile "suicide pills" in case of a nuclear exchange.

Such existential doubts were not mollified by the government's nuclear propaganda, which tended to depict nuclear war as a survivable natural event. Americans were told that "A Clean Building Seldom Burns" in the 1951 Civil Defense pamphlet "Atomic Blast Creates Fire," and that those who fled the cities by car would survive in the 1955 pamphlet "Your Car and CD [civil defense]: 4 Wheels to Survival."

Not even the young were distracted from thinking about the unthinkable. Civil defense drills became standard exercises at the nation's schools during the 1950s, including the "duck and cover" exercises in which students were instructed to "duck" under their desks or tables and "cover" their heads for protection from a thermonuclear blast. In the early 1980s, a new curriculum unit on nuclear war was developed for junior high school students around the country. Psychologists wrote about the implications of youngsters expecting never to reach adulthood because of nuclear war.

The Impacts of the Nuclear Arms Race on Culture and Society

In the words of Toronto sociologist Sheldon Ungar, "Splitting the atom dramatically heightened the sense of human dominion; it practically elevated us



The 1945 atomic bomb in the Japanese city of Hiroshima, one of the only times that nuclear weapons were used in warfare, instantly killed 100,000 people and injured thousands more, with the majority of its victims being civilians. GETTY IMAGES

into the empyrean. The control over nature's ultimate power was also taken as a sign of grace, an indication of America's moral superiority and redemptive capacity" (1992, p. 5). But this seeming benefaction turned into a nightmare, destroying Western faith in moral progress and providential history.

Scholars and essayists have speculated liberally on the psychological and cultural effects of growing up with the possibility of being vaporized in a nuclear war. For instance, did it contribute to permissive parenting strategies by older generations seeking to give some consolation to their children? Or the cultural hedonism and dissolution of mores evidenced when these children came of age? It certainly did contribute to the generational conflicts of the 1960s, as some baby boomers laid blame for the precarious times on older generations.

It is in the arts that collective emotions and outlooks are captured and explored, and fears of the atomic unknown surfaced quickly. As nuclear

weapons tests resumed in Nevada in 1951, anxieties over radioactive fallout were expressed cinematically in a sci-fi genre of movies featuring massive mutant creatures. These were to be followed by end-of-the-world books (e.g., *Alas, Babylon* in 1959), films (e.g., *On the Beach* in 1959, *Fail-Safe* in 1964, *Dr. Strangelove* in 1964), television series *Planet of the Apes*, and music (e.g., Bob Dylan's "Hard Rain" and Barry McGuire's "Eve of Destruction").

The bomb also opened the door to UFOs. In the same state where the first nuclear bomb exploded two years earlier, near Roswell, New Mexico, an alien space ship supposedly crashed to Earth, although later reports have debunked that story despite the stubborn beliefs in an alien visitation by various UFO aficionados. Were they contemporary manifestations of angels, messengers carrying warnings of humanity's impending doom? Or did our acquisition of the ultimate death tool make our neighbors in the cosmos nervous? The latter idea was the theme of the 1951 movie *The Day the Earth Stood*

Still, where the alien Klaatu issued an authoritarian ultimatum to earthlings to cease their violence or their planet will be destroyed.

Harnessing the Atom for Peaceful Purposes

The logic of the death-for-life tradeoff runs deep throughout all cultural systems. It is a price we see exacted in the natural order, in the relationship between predator and prey, and in the economic order in the life-giving energies conferred by fuels derived from the fossils of long-dead animals. Over 80 percent of American energy comes from coal, oil, and gas, whose burning, in turn, produces such environment-killing by-products as acid rain.

This logic extends to attempts to harness nuclear energy for peacetime uses. In theory, such energy can be virtually limitless in supply. In the words of the science writer David Dietz, “Instead of filling the gasoline tank of your automobile two or three times a week, you will travel for a year on a pellet of atomic energy the size of a vitamin pill. . . . The day is gone when nations will fight for oil . . .” (Ford 1982, pp. 30–31). But it is a Faustian bargain because the by-products, most notably plutonium, are the most lethal substances known to man. Thousands of accidents occur annually in America’s commercial nuclear plants. Collective memory remains vivid of the meltdown at the Chernobyl nuclear plant in the former Soviet Union in 1986 and the 1979 accident at Three Mile Island in Pennsylvania.

The Ecological Legacy

A comprehensive 1989 study by Greenpeace and the Institute for Policy Studies estimated that at least fifty nuclear warheads and 9 nuclear reactors lie on ocean floors because of accidents involving American and Soviet rockets, bombers, and ships. Radiation leaks south of Japan from an American hydrogen bomb accidentally dropped from an aircraft carrier in 1965. In the 1990s equipment malfunctions led to Russian missiles accidentally being switched to “combat mode,” according to a 1998 CIA report.

The cold war rush to build nuclear weapons in the 1940s and 1950s led to severe contamination of the land and air. In one 1945 incident at the 560-square-mile Hanford nuclear reservation in

Washington State, over a ton of radioactive material of roughly 350,000 to 400,000 curies (one curie being the amount of radiation emitted in a second by 1,400 pounds of enriched uranium) was released into the air. There, the deadly by-products of four decades of plutonium production leaked into the area’s aquifer and into the West’s greatest river, the Columbia. Fish near the 310-square-mile Savannah River site, where 35 percent of the weapons-grade plutonium was produced, are too radioactive to eat. Federal Energy Department officials revealed in 1990 that 28 kilograms of plutonium, enough to make seven nuclear bombs, had escaped into the air ducts at the Rocky Flats weapons plant near Denver.

Such environmental costs of the cold war in the United States are dwarfed by those of the former Soviet Union. In the early years of their bomb program at Chelyabinsk, radioactive wastes were dumped into the Techa River. When traces showed up 1,000 miles away in the Arctic Ocean, wastes were then pumped into Karachay Lake until the accumulation was 120 million curies—radiation so great that one standing on the lake’s shore would receive a lethal dose in an hour.

The Corruption of Public Ethics

Perhaps even more devastating than the environmental damage wrought by the nuclear arms race was its undermining of public faith in government. Public ethics were warped in numerous ways. Secrecy for matters of national security was deemed paramount during the cold war, leaving Americans unaware of the doings of their government. The secrecy momentum expanded beyond matters of nuclear technologies and strategies when President Truman issued the first executive order authorizing the classification of nonmilitary information as well.

Some instances of severe radioactivity risk were kept secret from the public by federal officials. Thousands of workers—from uranium miners to employees of over 200 private companies doing weapons work—were knowingly exposed to dangerous levels of radiation. Though many of these firms were found by various federal agencies to be in violation of worker safety standards set by the Atomic Energy Commission, there were no contract cancellations or penalties assessed that might impede the pace of weapons production. After three decades of denials and fifty-seven years

after the Manhattan Project began processing radioactive materials, the Federal government finally conceded in 2000 that nuclear weapons workers had been exposed to radiation and chemicals that produced cancer in 600,000 of them and early death for thousands of others.

The dangers extended well beyond atomic energy workers; ordinary citizens were exposed to water and soil contaminated toxic and radioactive waste. From 1951 to 1962, fallout from the Atomic Energy Commission's open-air nuclear blasts in the Nevada desert subjected thousands to cancer-causing radiation in farm communities in Utah and Arizona. According to a 1991 study by the International Physicians for the Prevention of Nuclear War, government officials expected this to occur but nevertheless chose this site over a safer alternative on the Outer Banks of North Carolina, where prevailing winds would have carried the fallout eastward over the ocean. The study predicted that 430,000 people will die of cancer over the remainder of the twentieth-century because of their exposures, and millions more will be at risk in the centuries to come.

According to a 1995 report of the Advisory Committee on Human Radiation Experiments, between 1944 and 1974 more than 16,000 Americans were unwitting guinea pigs in 435 documented radiation experiments. Trusting patients were injected with plutonium just to see what would happen. Oregon prisoners were subjected to testicular irradiation experiments at doses 100 times greater than the annual allowable level for nuclear workers. Boys at a Massachusetts school for the retarded were fed doses of radioactive materials in their breakfast cereal. And dying patients, many of whom were African Americans and whose consent forms were forged by scientists, were given whole-body radiation exposures.

Conclusion

Nuclear anxieties have migrated from all-out war among superpowers to fears of nuclear accidents and atomic attacks by rogue nations. According to Valentin Tikhonov, working conditions and living standards for nuclear and missile experts have declined sharply in post-Communist Russia. With two-thirds of these employees earning less than fifty dollars per month, there is an alarming temptation to sell expertise to aspiring nuclear nations.

During its war with Iran, Iraq in 1987 tested several one ton radiological weapons designed to shower radioactive materials on target populations to induce radiation sickness and slow painful deaths. And during May of 1998, two bitter adversaries, India and Pakistan, detonated eleven nuclear devices over a three-week period.

Some believe that with the advent of nuclear weapons, peace will be forever safeguarded, since their massive use would likely wipe out the human race and perhaps all life on Earth. Critics of this outlook have pointed out that there has never been a weapon developed that has not been utilized, and that the planet Earth is burdened with a store of some 25,000 to 44,000 nuclear weapons.

See also: APOCALYPSE; DISASTERS; EXTINCTION; GENOCIDE; HOLOCAUST; WAR

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MICHAEL C. KEARL

NURSING EDUCATION

Nurses spend more time with patients who are facing the end of life (EOL) than any other member of the health care team. In hospice, nurses have been recognized as the cornerstone of palliative care, and it is increasingly apparent that nurses play an equally important role in palliative care across all settings. Studies have documented that nurses and

other members of the health care team are inadequately prepared to care for patients with pain at the EOL. Inadequate care of the dying continues to be a problem in the twenty-first century. Many reasons have been cited for this failure, including inadequacies in the basic and continuing education of health care providers.

Challenges to EOL Care

Numerous studies during the 1980s and 1990s have documented that nurses lack knowledge about pain control, one key aspect of EOL care. Pain management has been described as a situation in which physicians continue to underprescribe, nurses inadequately assess and undermedicate patients, and patients take only a portion of the analgesics prescribed or underreport their pain. Generally, physicians and nurses have an inaccurate knowledge base about common pharmacologic agents used in pain control and have exaggerated fears about the likelihood of addiction. The fear of addiction continues to be a major obstacle to adequate treatment of pain at the EOL.

However, pain management is only one aspect of EOL care. Other EOL needs include management of other physical and psychological symptoms, communication with patients and families, preparation of the staff and family care at the time of death, and many other aspects of care of the dying. Attention to EOL issues, such as a report by the Institute of Medicine on EOL care and action by the U.S. Supreme Court on the right to die, have prompted a focus beyond pain management to include other dimensions of EOL care.

Improving EOL Care

Two milestones, a key EOL care project supported by the Robert Wood Johnson Foundation conducted between 1997 and 2000 and its resultant recommendations and the 1997 Institute of Medicine report on EOL care, have addressed these deficiencies, resulting in increased awareness of EOL issues and spurring changes to EOL care and nursing education.

The Robert Wood Johnson Foundation Project. The Robert Wood Johnson Foundation funded study was conducted by the City of Hope investigators. The overall purpose of this project was to strengthen nursing education to improve EOL care by accomplishing three goals: (1) to improve the

content regarding EOL care included in major textbooks used in nursing education; (2) to insure the adequacy of content in EOL care as tested by the national nursing examination, the NCLEX; and (3) to support the key nursing organizations in their efforts to promote improved nursing education and practice in EOL care.

The primary activity for the first goal, improving the content regarding EOL care in nursing textbooks, was a review of fifty major textbooks used in nursing education. These fifty texts were selected from a list of over 700 textbooks used in schools of nursing, and then were stratified by topic areas. The areas selected and number of books included were AIDS/HIV (1), assessment/diagnosis (3), communication (2), community/home health (4), critical care (4), emergency (2), ethics/legal issues (5), fundamentals (3), gerontology (3), medical-surgical (5), oncology (2), patient education (2), pediatrics (3), pharmacology (4), psychiatric (3), and nursing review (4).

A detailed framework for analyzing the content of the textbooks was developed by the City of Hope investigators. This framework was based on a review of current literature and expert opinion about optimum EOL care. Nine critical content areas were selected: palliative care defined; quality of life (physical, psychological, social, and spiritual well being); pain; other symptom assessment/management; communication with dying patients and their family members; role/needs of caregivers in EOL care; death; issues of policy, ethics, and law; and bereavement.

The fifty texts encompassed a total of 45,683 pages. Each text was reviewed using the framework. The reviewer scanned the complete index, table of contents, and all text pages for possible content. The reviewers were very inclusive and liberal in their approach, and when any EOL content was identified, those pages were copied. The copied pages then were analyzed for content using a "cut-and-paste" approach in which the content was placed on the analysis grid within the appropriate framework section. Key findings of the study were:

- Of the 45,683 pages of text reviewed, 902 pages were related to EOL content, representing only 2 percent of the total content.
- Of 1,750 chapters included in the texts, 24 were related to EOL, representing 1.4 percent of all chapters.

- The nine EOL topic areas reviewed were included infrequently in the texts' tables of contents or indexes. At least one chapter was devoted to an EOL-related topic in 30 percent of the texts.
- The EOL topics with the poorest focus in the texts were quality-of-life issues at EOL and role/needs of family caregivers. The areas of strongest content were pain and policy/ethics issues.
- Overall, 74 percent of the content in the framework was found to be absent from the texts, 15 percent was present, and 11 percent was present and commendable.

Recommendations from this analysis were presented to a conference of publishers and the City of Hope investigators continue follow up with the editors of these texts and other books in order to improve EOL content in future editions. Major progress has been made to date and the textbook editors and authors have been very responsive.

The second goal of the project, ensuring the adequacy of content in EOL Care, as tested by the NCLEX exam, was also successfully implemented. City of Hope investigators worked with the staff of the National Council of State Boards of Nursing to increase the emphasis of EOL care within the exam to increase its priority for nursing education, and thus the knowledge of practicing nurses. Goal three, supporting key organizations in their efforts to promote nursing education and practice in EOL care, was also achieved. Many nursing organizations have been mobilized to address the deficiencies in EOL care.

In addition to studying nursing education, City of Hope nurse researchers also surveyed over 2,300 practicing nurses to determine their perspectives on EOL care. Respondents were asked to rate these dilemmas based on their occurrence as "not common," "somewhat common," or "very common." The most frequently occurring dilemmas were use of advance directives and preserving patient choice/self-determination, which 37 percent and 23 percent, respectively, cited as very common. Interestingly, 93 percent of respondents cited requests for assisted suicide and requests for euthanasia as not common dilemmas, and 6 percent cited these requests as somewhat common. More than one-third of all nurses reported seven of the nine dilemmas, excluding those of assisted suicide

and euthanasia, as somewhat common or very common. Acknowledging the diversity in responses to these dilemmas is important. For example, although 37 percent of respondents reported use of advance directives as very common dilemmas, 31 percent of the respondents reported this area as not common.

Respondents were also asked to rate how much of a barrier each factor was to providing good EOL care in their settings. The items were rated as “not a barrier,” “somewhat of a barrier,” or “a severe barrier.” Respondents most frequently cited “influence of managed care on end-of-life care” (25%) as a severe barrier followed closely by “lack of continuity of care across settings” (23%). The barriers that were reported as common and the diversity of these barriers illustrate the complexity of effective EOL care. The respondents identified not only system barriers (e.g., continuity of care, influence of managed care) but also cited patients’ (70%) and family members’ (73%) avoidance of death as somewhat of a barrier. Other prominent barriers were health care providers’ lack of knowledge and personal discomfort with death.

Institute of Medicine report. The Institute of Medicine report on improving EOL care concluded with seven recommendations, two of which spoke directly to the need for improved professional knowledge:

- Physicians, nurses, social workers, and other health care professionals must commit themselves to improving care for dying patients and using existing knowledge effectively to prevent and relieve pain and other symptoms.
- Educators and other health care professionals should initiate changes in undergraduate, graduate, and continuing education to ensure that practitioners have relevant attitudes, knowledge, and skills to provide good care for dying patients.

End-of-Life Nursing Consortium

The studies of the 1990s lead to the End-of-Life Nursing Education Consortium (ELNEC) project—a comprehensive, national education program to improve EOL care by nurses. Primary project goals include developing a core of expert nursing educators and coordinating national nursing education

efforts in EOL care. This project points to the future of nursing education in the twenty-first century.

This three-and-a-half-year ELNEC project began in February 2000, and is a partnership of the American Association of Colleges of Nursing (AACN) and the City of Hope Cancer Center (COH). A primary goal of the project is to bring together leading nursing groups and perspectives to form a collaborative approach to improve EOL education and care. The ELNEC curriculum has been developed through the work of highly qualified subject matter experts serving as consultants, with extensive input from the advisory board and reviewers. Courses are designed to prepare educators to be instructional resources for their schools and organizations, and serve as a vital force in the dissemination of this important content.

ELNEC includes a total of eight courses, five of which are offered for baccalaureate and associate degree faculty who can then facilitate integration of EOL nursing care in basic nursing curricula. Two courses are planned for school-based, specialty organization, and independent nursing continuing education providers in order to influence practice of nurses in their target groups. The final course will be for state board of nursing representatives to strengthen their commitment to encourage end-of-life education and practice initiatives in their states. In addition, five regional ELNEC courses will be offered.

See also: COMMUNICATION WITH DYING; DEATH EDUCATION; PAIN AND PAIN MANAGEMENT; SYMPTOMS AND SYMPTOM MANAGEMENT

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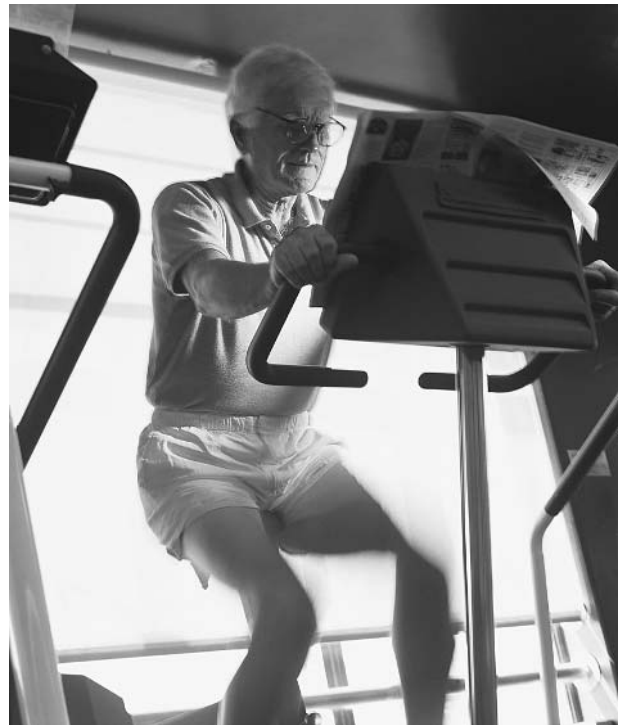
BETTY R. FERRELL

NUTRITION AND EXERCISE

Since the mid-1990s health practitioners, researchers, and scientists have learned that regular exercise and nutritional balance can significantly reduce degenerative diseases associated with aging and extend the human life span. The mechanism by which this occurs involves numerous physiological and biochemical mechanisms. For instance, researchers know that exercise improves neurological function by improving the transmission of nerve impulses in nerves and brain pathways. When this occurs, the human body experiences improved mood, faster reflexes, and better endocrine control.

Diabetes and Heart Attack Prevention

When engaged in a regular routine of exercise and a balanced diet, the human body experiences a reduction in many diseases that are associated with shortening of life, such as diabetes, hypertension, atherosclerosis, heart attack, and stroke. Cardiovascular disease is the number one killer in the industrialized world. In the United States alone, every year there are approximately 1 million deaths due to heart attacks. Hundreds of thousands more are left cardiac cripples, unable to work or enjoy life to the fullest. In addition, there are 16 million people diagnosed with diabetes every year and the numbers keep rising. Even more frightening is the fact that the disease is occurring at a



Regular exercise and the consumption of nutrient-dense vegetables help reduce the incidence of cardiovascular disease, diabetes, certain cancers, and brain aging. RAOUL MINSART/CORBIS

younger age. Previously, non-insulin-dependent, or Type II, diabetes mellitus was considered a disease of middle age. Now it is being diagnosed in children as young as ten years of age. The incidence of this disease increased 40 percent from 1990 to 2000, with a 70 percent increase in thirty-year-olds during this same decade. Given these statistics, the benefits of regular exercise and good nutrition should be seriously considered by those who live in the Western world.

In addition, heart failure and diabetes are linked because diabetes accelerates atherosclerosis and can increase the risk of heart attacks and strokes by as much as sixfold. Diabetes is also associated with damage to numerous organs and tissues, including the kidneys, eyes, and nervous system. Diabetes is recognized as the leading cause of blindness and kidney failure in the United States.

These two conditions can be drastically reduced by a combination of regular exercise and balanced nutrition. For example, it has been recognized that there is a strong link between childhood Type II diabetes and obesity, with 90 percent of such children being obese. Conversely, while other

factors play a role, lack of exercise and poor nutritional choices play a major role in both diseases. By flooding the body with a high intake of fats and simple sugars, cells become resistant to insulin function. That is, the pancreas is able to manufacture enough insulin but it is unable to transfer the glucose into the cell. If the process continues, the pancreas will eventually exhaust itself and be unable to produce more insulin. When this occurs, the diabetic person becomes insulin dependent, and is characterized as having Type I diabetes mellitus.

Medical professionals recognize that exercise improves glucose entry into the muscles and that many Type II diabetics can be managed or, in some cases, cured through a regular program of exercise and nutritional changes. Nutritional changes are particularly important and many failures are caused by the diabetic's failure to adhere to these dietary changes.

Numerous diseases are related to the production of free radicals by cells. Free radicals are destructive chemicals, mostly produced during metabolism that oxidize fats, DNA, and proteins within cells and tissues. For example, oxidation of fats within the walls of blood vessels is thought to result in the formation of atherosclerotic plaques that clog the arteries. Likewise, when diabetes develops the number of free radicals formed increases significantly, and when complications develop the rate increases dramatically. These free radicals begin to damage cells and tissues, resulting in the numerous complications associated with the disease.

Exercise not only reduces the incidence of the diseases responsible for many of these free radicals, but it induces the tissues and cells to produce more antioxidant enzymes. A diet high in fruits and vegetables, especially the more nutrient-dense vegetables, significantly reduces the incidence of cardiovascular disease and diabetes and reduces the severity of these disorders by providing the body with very powerful and versatile antioxidants.

Brain Aging and Cancer Prevention

Most people are aware of the vitamin-based antioxidants, such as vitamins A, C, and E, and the carotenoids (i.e., beta-carotene and lycopene), but of equal or greater importance are the plant-based flavonoids. Researchers have identified over 5,000 flavonoids, which have been shown to be powerful and versatile antioxidants against numerous

types of free radicals—including many that are not neutralized by vitamins A, C, and E.

A multitude of studies have shown that a diet high in nutrient-dense vegetables and fruits can significantly lower the incidence of many cancers, hypertension, diabetes, and atherosclerosis, and delay nervous system aging. In one study, in which various fruits and vegetables were tested, it was found that blueberries, strawberries, and spinach were the most powerful in slowing brain aging, as measured by careful studies of brain chemistry and function. Regular exercise has also been shown to slow brain aging changes. When combined with good nutrition, an even greater effect can be expected.

Regular exercise and good nutrition have been shown to reduce the incidence of certain cancers as well. This is especially true for colon cancer and breast cancer. The explanation may lie in the improved immune function, increasing the number of antioxidant enzymes, and metabolic efficiency induced by exercise. Numerous nutritional components, such as vitamins, minerals, and flavonoids, have also been shown to significantly inhibit cancer formation, growth, and spread. Studies have shown that nutrients do this by a multitude of methods involving cell biochemistry and enhanced immunity.

Avoiding Overexercising

While exercise is critical to good health, too much exercise can be harmful, and even bring on many of the diseases human beings are attempting to prevent. This is because extreme exercise, by significantly increasing metabolism, also dramatically increases free radical production. As the human body ages, it produces more free radicals and accumulates more free radical damage in cells. Studies have shown that after age seventy DNA accumulates free radical damage ten times faster than at a younger age. Extreme exercise would be especially hazardous for the elderly. Moderate exercise has been shown to provide the same amount of health benefits as more vigorous exercise programs.

For ultimate benefits, doctors generally recommend that individuals exercise at a moderate level at least three times a week, avoid simple sugars, eat complex carbohydrates low on the glycemic index, maintain a fat intake slightly below 30 percent of caloric intake, and include a small amount of lean meats in their diets.

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RUSSELL L. BLAYLOCK

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OFFICE OF THE DEAD

See CHRISTIAN DEATH RITES, HISTORY OF.

OMENS

Humans have always desired to break free from the “custody of time,” to shed the anxiety engendered by uncertainty over the time of one’s own death. The creation of death omens in nearly all cultures has, perhaps, arisen from a deep-seated yearning to quell this gnawing doubt. Such omens might take several various forms: the prediction of approaching death may be connected with specific dreams (whitewashing, tooth extraction, the fence falling, drowning in muddy water, and so on) or to the strange behavior or sudden appearance of certain animals (e.g., hens crowing or a visit from an owl, which are called “death-birds” in many cultures). Some death omens not only predict the fact of approaching death but also disclose its location and precise circumstances.

The following function analysis intends to examine the syncretic death omens of European peasants (the above mentioned examples are also taken from the experience of this cultural segment), in which both Christian and non-Christian elements may be found.

The Structure of Omen Beliefs

In traditional European peasant societies—the main focus of the ensuing remarks—death omens have

functioned as a kind of code recognizing mechanism and as a guide to action. The most important task of code recognition is for the individual to connect and store the knowledge concerning the interdependence of the signifier, the signified, and the traditional meaning of the symbol as cultural code. This interdependence is necessary for the observer, for instance, to be able to associate the hooting of the owl landing upon the granary (as signifier) with death (as signified) and to draw a conclusion from the association that is considered conventional by the given culture.

Action strategies fall into three categories: The first category is group of communication rules that define the way in which the news of the omen may spread. It is a generally accepted rule that nobody should talk about bad dreams before sunrise and that news of bad omens should not be given to a dying person, especially someone in great pain, so that the victim should not fear that the relatives are looking forward to his or her death. Such omens are discussed among the neighbors or distant relatives. Nevertheless, if the critically ill person’s condition is worsening—and the relatives seem to reject the possibility of the approaching exit—the neighbors may send for the priest to prevent the dying person from leaving this life without receiving the last rites.

Additionally, action strategies contain a preventive-evasive behavior model. Following such a model, the observer of the omen may try to prevent the impending death by means of various sacred magical rites. Prayers to saints, in particular to Saint Job, are said to cast off the realization of

death-prophesying dreams. These should be offered immediately after awakening, before sunrise, or facing the rising sun. Praying in a group, crossing, practicing charity, asking the priest to say a mass—or a combination of the foregoing—are also frequently applied preventive measures.

If nobody is seriously ill or elderly in the neighborhood and the observer cannot therefore infer who the target of the omen is, he will decide to wait and will warn his family members to be exceedingly cautious. If the bad dream or other omen is not followed by a death until the end of the consensually established “incubation” period (generally three days, three weeks, or three months), the omen will cease to have any significance in the future.

Should the preventive-evasive acts prove ineffective, or if they seem worthless because of the advanced state of illness, an awaiting-preparing behavior model will be activated. If it can be inferred who is about to die in this case, the omen urges the observer to start realizing the possibility of an impending death and to measure its consequences.

On the other hand, the omen might warn the observer to prepare for the ritual group activity following the onset of death (e.g., vigil, funeral feast, burial) and to provide for the spiritual needs of the dying person (such as receiving the last rites). Consequently, the main purpose of the systems of behavior and beliefs connected with the portents is to ensure that neither the observer nor his immediate environment (nor indeed the dying person) is left entirely unprepared for the challenges of the approaching crisis.

The omens of death contain code recognizing techniques and sophisticated action strategies that are developed and inherited through direct communication. The latter constituent involves communicative rules as well as preventive-evasive and awaiting-preparatory behavioral instructions intended to prevent the realization of the ill omen and prepare all the affected members of the community for the approaching loss.

The Role of Death

Omens in the Death Rituals

There are three partially overlapping, organically social and psychological functions of death omens.

First, the conditioned sphere of activity in life periods when the observation of omens is not followed by death (within the culturally regulated “incubation period”); second, the realization-rationalization-preparation occurring in the crisis period preceding death; and, finally, the reorganizational function during the period of mourning.

Unfulfilled Omens

If approaching death cannot be anticipated by any other means than the observed omen, the observers will pay special attention to the surroundings, lamenting whomever the ill omen could refer to. When they cannot attribute the omen to a definite person, they forget it. In this way “there are always a few individuals in the community who are in a ‘state of being warned.’” (Kunt 1980, p. 326) Although a number of omens remain unfulfilled, the individuals are never discouraged and do not consider this fact a failure of the omens’ functioning mechanism. These omens are forgotten, and the next omen is received in the usual way.

In the state of “being warned,” the observer individual recalls all the basic beliefs and behavior instructions of peasant attitudes toward death (the above mentioned action strategies; the belief in resurrection or heaven as “healing theories”) that help to prevent the occurrence of death or conduce to survive the event with the smallest possible shock. In this way a background of worries triggering the observation of the omen or activated by the observation is brought to the “surface” in a culturally regulated frame and may be kept partially under cultural control.

In order to avoid a possible disturbance caused by the unfulfilled omen and to prevent the emergence of doubts about the reality and validity of omen beliefs, the peasant community has a number of plausible and unquestionable explanations at hand that help to interpret the situation in a “reassuring way.” It is generally agreed that the absence of death is attributed to the devout intervention of transcendent powers (St. Job or Jesus). Occasionally it is explained by the success of danger-averting magic activities (i.e., killing the crowing hen.) The generally accepted interpretation is that the clearing of the danger is not due to “mal-functioning” of the omen but to the favorable influence and mercy of transcendent powers.

It is precisely for this reason that if the omen is not followed by a death within the conventionally accepted “incubation” period, the “preshock” state results in a new equilibrium, relegitimizing the faith in the basic Christian regulating principles of the peasant world-and-death concept, and the particular omen is forgotten. (Naturally, the omen may well be related to deaths occurring years after its appearance.)

In that case the omen’s conditioning function becomes significant, which serves to strengthen fundamental principles, beliefs of peasant death concept (belief in life after death and resurrection, adhering to the prescriptions of Christian ethics, and so on). This is precisely why all unfulfilled omens are “really a symbolically expressed ‘Memento mori’ ” (Kunt 1980, p. 327).

Omens Appearing Immediately Prior to Death

In traditional accounts, members of peasant communities are far more likely to observe omens portending death (especially in the form of negative dreams) if they have been tending a seriously ill or dying relative. In this period, anticipation of death may be more manifest in the dream-work, which makes possible the activation of the realization function. In the European peasant communities predictions based upon dreams have always been considered an accepted, legitimate method of gaining knowledge of reality. The world of dreams is outside the observer; it is interpreted as an authentic and objective system of prophecy. Thus, dreams as widely accepted form of knowledge, are particularly suitable for transforming negative foreboding into a realization of the inevitability of the impending death; they foretell and realize the fact of death of the ill relative in the form of a confirming feedback.

Traditional explanations about omens that appear immediately before death may contain estimates of the expected length of the expected interval before the onset of death. It is a common belief, for example, that the strange behavior of animals only briefly precedes the onset of death—twenty-four hours at the most. The last phase of dying is marked by the death-bed visions (Kastenbaum 2000; Parkes 1998; Rososenblatt, Walsh, and Jackson 1976; Zaleski 1987) in which the deceased relatives of the ill person appear and he or

she talks to them aloud, tussles with them. (The arrival of deceased relatives is signaled by such events as the door of the dying person’s room opening by itself or by the mirror falling from the wall.) The family standing around the deathbed interprets this phenomenon of visitation by the dead as if the deceased are waiting for the dying person, calling him or her to them, and that after the person’s departure from this life it is they who will lead the way to the other world.

The significance of the rationalizing function exemplified above is that through the approximate time coordinates built upon traditional experience, death omens play a significant part in distinguishing the stages of the dying process. In this sphere of activity at least two advantageous effects are worth mentioning.

The first is that these time coordinates mark the events leading up to death as a gradual process and are thus able to alleviate the elemental feeling of anxiety connected with the unpredictability of the exact time of the death. Second, these temporal reference points may help the relatives to carry out their duties properly because their observation has an activating function; they urge and warn the observers to fulfill their tasks accompanying the final stages of death (i.e., calling for the priest to perform the last rites). In this way the omens immediately preceding death have a preparatory role as well: They inform the immediate environment of the dying person of the approaching death, and they prompt the family to start accustoming themselves to the situation and to concentrate their spiritual energy.

The survival of portents appearing immediately prior to death is primarily due to the fact that they were able to provide approximate points of reference and time coordinates in cases where official Christian guidance regarding the crisis period left people without counsel (or the guidance provided tended to be generalizing and impersonal). In other words, these omens essentially filled the “blank areas” of Christian interpretations of the death process.

Retrospective Interpretation: The Reorganizational Function

Often, in peasant death culture, after the last respects are paid to the next of kin, close neighbors convene to discuss and evaluate the events in the

crisis period leading to the death. These discussions cover the portents of death, the process of dying, the number of people attending the funeral, their behavior, and so on.

Several studies have made it clear that in such discussions a number of events and episodes were identified as omens that had not been deemed as such earlier—occasionally because they trusted in the sick person making an unexpected recovery, so they tried to ignore any signs to the contrary.

This process, defined as retrospective meaning attribution, may contribute significantly to the success of the grief-work process, the fast and successful modification of the survivor's "assumptive world to incorporate loss, thereby achieving a new sense of normalcy and purpose" (Gilbert 1995, p. 310).

Its foremost support in the grief work is in the way in which the closest relatives build into their memory of the dying process motifs retrospectively identified as omens, thereby partly modifying their original impressions. The retrospectively incorporated omens are interpreted in the final, modified narrative about death as indicator elements (which help the survivors to cut the process of dying into discrete segments), thus helping to alleviate the relative's own painful vulnerability to death.

Through retrospective meaning attribution the close relatives partly rewrite their memories of the dying process, unconsciously adapting it to the prerequisites of successful grief work by comprehending the process of departure in a manner more rational and foreseeable than reality—thus facilitating the coping with loss.

However, if the dying person was not cared for properly (e.g., could not receive the last rite because the family misinterpreted the situation), the evaluation of omens may also bring about remorse—and that could lead to a breakdown in grief work and the appearance of pathological reactions.

Conclusion

While all omens preceding death are considered to be elements of rites of separation (Gennep 1960; Littlewood 1993), retrospective meaning attribution incorporates rites that help to humanize and rationalize the preserved impressions of dying and death; it also fosters the development of a new relationship between the surviving kin and the departed individual by transforming their relationship

into "an inner representation based on memory, meaning and emotional connection" (Romanoff and Terenzio 1998, p. 701). It may also facilitate the mourners' early reintegration into the wider community, into the traditional order of peasant life, and help to strengthen their faith in its essential principles and values.

See also: GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; GRIEF: ANTICIPATORY, THEORIES; NEAR-DEATH EXPERIENCES; MEMENTO MORI

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PETER BERTA

ONTOLOGICAL CONFRONTATION

Human beings have a degree of awareness of personal existence not found among other species. This awareness, the province of ordinary people as much as philosophers and theologians, encompasses the finitude of life, the personal existence of others, the possibility of other worlds, and the questions of when people came into the world, why they are on Earth, and what happens when they die. Asking these questions is motivated not merely by curiosity but also by the anguish inspired by the prospect of one's own death or that of a loved one.

The most powerful ontological confrontation occurs when facing the inevitability of one's own death, whether as an immediate reality or as an imagined, distant eventuality. How does one confront his or her own real death? In the highly developed countries, more people die a long and slow death (e.g., from cancer or from AIDS). People experience ever longer waits for life-saving surgery. Although little is known about how individuals cope with impending death, there does seem to be a common avoidance of ontological questions, even on the deathbed.

What about the anticipation of death? How does one confront the finite nature of life? These questions arise persistently in philosophy and literature. For example, psychotherapist Jeffrey Kauffman presented the philosophical perspective by editing the book *Awareness of Mortality* (1995). He stated that awareness of mortality is the alpha and omega of thanatology (where it starts from and where it is heading). But what are the consequences of this confrontation for the individual? There is various anecdotal evidence but little in the way of systematic research. This question has, however, come under experimental scrutiny, and

there are only a few areas of thanatology where results of experimental studies provide new insights. In everyday life, the idea of death may enter the mind many times a day even for individuals unconcerned with death. This kind of ontological confrontation can also take place in a laboratory, where researchers have discovered that the confrontation with death leads to cognitive reactions and to various emotional responses that can have positive or negative effects.

Consequences of Confrontation with Death

Existential philosophers and psychotherapists focus on the positive consequences of ontological confrontation. For example, Irvin Yalom emphasizes that the idea of death is a powerful agent of change. Facing one's own death is the highest challenge to the individual, potentially imparting greater intensity to life and even leading to a radical personal transformation. A literary example of this process is Leo Tolstoy's classical story "The Death of Ivan Ilych." Faced with imminent death, Ilych taps previously dormant resources of empathy for his family and friends, and his former fear of death is replaced by a fulfilling sense of well being. Working with cancer patients in a therapeutic group setting, Yalom has shown that cancer can heal psychoneurosis. It is astonishing that tragedies such as life-threatening illnesses or losses of significant others can be followed by an increase of personal maturity.

In his book *Is There an Answer to Death*, Peter Koestenbaum also wants to show the positive consequences of ontological confrontation by demonstrating that there are times when dealing with existential questions can bring a greater meaning to life. He argues that the anticipation of death reveals who one really is. Intellectually, death helps to define human nature and brings people into contact with their deepest feelings, needs, and opportunities.

According to Koestenbaum, anticipation of death can have the following ten consequences:

1. By accepting the fact of being condemned to death, the individual can start living and thereby then neutralize fear.
2. By recognizing death, the individual is on the way to becoming decisive.
3. By remembering death, the individual concentrates on essentials.

4. By being aware of death, the individual achieves integrity.
5. Through knowing about death, the individual finds meaning in life.
6. By recognizing death, the individual will become honest.
7. Through the realization of death, the individual will gain strength.
8. By accepting death, the individual is motivated to take charge of his or her own life.
9. Through the thought of death, the individual is willing to assume a total plan for life.
10. By being aware of death, the individual escapes the stranglehold of failure.

From an existential and phenomenological perspective, meditation on personal death is a precondition for achieving meaning and freedom of fear in everyday life. Adrian Tomer has shown, however, that other philosophical approaches contend that reflection on death does not necessarily confer meaning on life and that it is even questionable whether facing death is the best way to deal with the problem of death. The psychologist Patrick C. Thauberger and his colleagues used the construct labeled “avoidance of ontological confrontation” as the basis of an empirical study whose results challenge the notion that awareness is the answer to the problem of death. Individuals classified as “existential confronters” did report significantly more use of stimulants and soft drugs. Being that ontological confrontation is also negatively related to self-reported health and quality of life, it seems that one must pay a price when trying to face death. Confronters were no better off than “avoiders of the confrontation with death,” who required a few agents (e.g., tranquilizers) of their own to deal with reality. Overall, the results suggest a rather complex network of relationships among avoidance/-confrontation strategies, various kinds of social behavior, and health-related variables.

There is also empirical evidence that ontological confrontation leads to changes of beliefs. Investigating the notion that belief in afterlife serves the function of helping the individual to deal with fear of death, Michael Osarchuk and Sherman Tatz selected subjects scoring high and low on a belief-in-afterlife scale and exposed them to stimuli designed to arouse fear of death, to the threat of being shocked, or to a nonthreatening task. Comparing

the scores on an alternate belief-in-afterlife scale, only the high believers exposed to death threat intensified their belief that there is a life after death. Data obtained by Randolph Ochsman, however, does not support this notion because strengthening belief-in-afterlife was not accompanied by lower scores of anxiety. With highly religious subjects, confrontation with death did not intensify this belief. The low religionists, however, showed even less of an inclination to believe in an afterlife and intensified their hedonistic preferences.

The consequences of ontological confrontation can be discerned empirically. In one experimental study, Christian subjects either considered or not considered the question of their own death, and were then asked to rate target persons on an interpersonal attraction scale. Ontological confrontation caused them on the one hand to rate a target person significantly more favorable who was presented as a fellow Christian, that is an ingroup member. On the other hand, thinking of their own death led to much less favorable ratings of target persons who were presented as Jews, that is outgroup members. The same pattern was found in a second study when subjects rated target persons who either held very similar or very dissimilar attitudes. Thus it seems that mortality salience leads to more negative evaluations of outgroup members and those who criticize one’s culture. It provokes harsher punishment for moral transgressors and increased aggression against those who challenge one’s beliefs. Another study has shown that for individuals for whom driving ability is a barometer of self-esteem, mortality salience leads to increased risk-taking while driving and while driving in a simulator task.

Implications

Results of experimental studies cannot be applied directly to everyday life, of course. Most likely, there are psychological factors that will weaken the effects of mortality salience. But it cannot be ruled out that other interactive forces will lead to an increase of negative consequences, for example, and even stronger favoritism of ingroup members and discrimination of outgroup members. Nonetheless, reported results do raise some serious questions.

For example, it seems necessary to discuss the situation of individuals who care for the terminally

ill. Basic fears of death caused by the salience of mortality are prominent among caregivers. While attending to the dying, professional and nonprofessional helpers sometimes fend off their fears, but this defensive repression is less successful when confrontation with death is very frequent. Does mortality salience contribute to emotional exhaustion and depersonalization “burnout”? Knowing that ontological confrontation will lead to greater anxiety among individuals with low self-esteem, one should reconsider demands of institutional caregivers who are expected to subordinate their own psychological well-being to that of the patient. Professional helpers themselves should be more sensitive to their own “terror management” to improve interaction with the terminally ill and persons who suffer severe loss. Discrepancies between the altruistic motivations of caregivers and their actual behavior might well be linked to low self-esteem and the necessity of defensive reactions. Considering the potentially negative consequences of ontological confrontation, death-education programs should receive much more attention.

Research also indicates that mortality salience may lead to hostile reactions toward “outsiders,” members of other cultures who might present a threat to the individuals’ self-esteem, especially in homogeneous cultures that do not prize diversity. Under such conditions, hostility toward foreigners might increase proportionately with the anxiety arising from confronting death. It might not be accidental that far-right groups often stage meetings at cemeteries to honor so-called heroes, and publicly wear death symbols (e.g., skulls and crossbones). The individual’s fundamentally defensive need to protect himself from anxiety must therefore be incorporated into programs developed to fight intolerance, racism, and xenophobia.

There is evidence that mortality salience has an effect on intentionally risky behavior such as unsafe sex, extreme sports, which is a growing problem in advanced industrial societies. Among adolescents and young adults, car accidents are one of the most common causes of death. Appeals to fear evidently do not work when the self-esteem of a person is linked to driving or other kinds of risky behaviors. On the contrary, people may be motivated to take even greater risks after confronting death.

Robert Kastenbaum has discussed the negative consequences of ontological confrontation in the context of possible links between terror management and some major social problems, such as murder, suicide, alcohol, and drugs. What happens when there is no management of terror? What happens when there is neither individual self-esteem nor a cultural belief system to defend against death anxiety? There is ample reason to doubt that contemporary industrialized cultures are fostering a meaningful conception of reality that instills self-esteem and hence respect for the humanity of others inside and outside the culture.

See also: AIDS; ANXIETY AND FEAR; BECKER, ERNEST; BONSEN, F. Z.; CANCER; KIERKEGAARD, SØREN; MEMENTO MORI; NEAR-DEATH EXPERIENCES; PSYCHOLOGY; TERROR MANAGEMENT THEORY

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RANDOLPH OCHSMANN

OPERATIC DEATH

Opera began in the last decades of the sixteenth century in Florence, Italy, when a group of music and drama enthusiasts called the Camerata decided that ancient Greek drama must have been sung throughout. While there is evidence that music played a role in the theater of ancient Greece, this surmise of the Camerata involved a leap of the imagination: What if the words were declaimed as song? From this idea sprang opera. The form has

gone through so many changes according to era, national, and individual temperament that it challenges common sense to draw it all under one umbrella. Yet the constant of sung drama has remained.

As the earliest operas were modeled after a certain conception of Greek drama, the tragic ones among them naturally reflected an idea of death in line with their model. The first operas took plots from mythology, including Claudio Monteverdi's *Orfeo* (1607), the oldest opera still produced with any regularity. The story is the familiar one that begins when the happy marriage of Orpheus to Euridice is terminated by Euridice's death. The gods then give Orpheus permission to travel into the underworld to retrieve his wife, such is his love for her. Their single prohibition: "Do not look at her until you reach the sunlight." Of course, he cannot resist a glance backward and the entire enterprise is ruined. The story links love and death; in a very broad sense, the ensuing history of tragic opera has been an elaboration on that theme.

Love and Death

Peter Conrad's *A Song of Love and Death: The Meaning of Opera* (1987) addresses this confluence of Eros and Thanatos. Conrad espouses the theory that desire and annihilation in opera directly parallel their respective personifications in Greek mythology: Apollo (god of the sun and reason, and therefore of individual desire) and Dionysus (god of wine and therefore of the obliteration of individual consciousness). He uses the theory of the nineteenth-century German philosopher Friedrich Nietzsche in support of his idea that the history of opera forms a kind of dialectic in which desire fulfilled is desire destroyed (Conrad 1987).

In the beginning, however, opera was less a quest to bind love and death than to portray them as mutually exclusive opposites. Death in the earliest operas is accompanied neither by the quest for Apollonian individuation nor a need for self-forgetting, though both emotional states play roles in later operas. Instead, many characters in early operas die simply for lack of love, frequently accompanied by the most wretched self-pity. In Henry Purcell's *Dido and Aeneas* (1689), the first English opera to find a permanent place in the repertoire, the climax of the score occurs when Dido, deserted by the Trojan Aeneas so that he

may go found the city of Rome and father Western civilization, cries in music her famous Lament. “Death must come when he is gone,” she sings, weeping herself to death, though in “reality” she dies atop a funeral pyre. This mood of pulling one’s own tragic death around the shoulders like a blanket would be revived briefly in the nineteenth century and given to the same character, when Berlioz’s Dido in *Les Troyens* sings in French: “Je vais mourir / Dans ma douleur immense submergée,” which is interpreted as, “I wish to die, In my immense anguish submerged.”

In the early eighteenth century opera became highly formalized. *Opera seria* (tragic opera) and *opera buffa* (comic opera) both took on rigid formulas in which certain sorts of characters recurred and a handful of librettos (texts) were recycled among composers such as Gluck and Handel, less as inspiration to tell stories in music than as excuses to display technique. This was the age of the castrato, the castrated male singer whose unnaturally high, pure sound was relished by knowledgeable opera goers. Opera seria was chorus-less, representing a disappearance of society from the stage. Without the presence of society, and without the threat of sex (the castrato was, after all, harmless) opera took on a strange coolness. Sexual love was replaced by fanciful sentiment, tragedy was muted by its isolation.

Wolfgang Amadeus Mozart is a singular case with regard to the subject of opera, just as he was exceptional in most other regards. In a short span of time, he virtually founded modern opera, fulfilling and then abandoning the old opera seria, reinvigorating the German form known as Singspiel and, with librettist Lorenzo da Ponte, inventing a new form in which full-blooded characters experienced life in ways that conformed neither to tragic nor comic preconceptions.

Although as a Freemason he espoused belief in death as “man’s best friend,” and while one of his last completed pieces was a work for use in Masonic funeral ceremonies, Mozart seemed to shy away from death in certain key operatic and even religious scores. In his setting of the Latin Mass in C Minor (1781), Mozart waxed operatic, with solos and choruses worthy of the stage. Left unfinished, its omissions are telling. The twenty-five-year-old composer did not merely take the Latin text as far

as he could, one movement after another, but instead stopped cold at the point in the credo in which Jesus is made man—the extraordinarily beautiful Et Incarnatus Est. The remainder of the credo deals with Jesus’s crucifixion, death, and resurrection, yet Mozart skipped over this to the following movement, the *Sanctus-Benedictus*, and never returned to finish it. This deliberate avoidance of portions of text dealing with death is all the more peculiar, as the score was composed as a memorial for his mother.

Mozart loved opera from early in life and composed for the theater until his death at age thirty-five. He composed his first opera seria, *Mitridate*, at age fourteen and his last, *Idomeneo*, at age twenty-three. In both, fathers wrong their sons, to whom it is left to redeem the fathers’ actions. King Mitridate distrusts both sons and envies the love one of them enjoys with the beautiful Aspasia. Only in death does he see the truth and ask his sons’ forgiveness. The unlucky title character in *Idomeneo* pledges his son, Idamante, in sacrifice, but this is avoided and the son, at close, is morally triumphant.

As soon as he was done with opera seria, Mozart was, for all intents and purposes, done with death onstage. In his triptych of operas made in collaboration with Lorenzo Da Ponte—*The Marriage of Figaro*, *Don Giovanni*, and *Così fan tutte*—life takes center stage and is flooded with light. Forgiveness among quarreling and conspiring lovers is the theme of both *The Marriage of Figaro* and *Così fan tutte*. Death figures only in *Don Giovanni*, when the famous lover (Don Juan of legend) kills the father of one of his conquests in a duel, and is later himself dragged to hell by the dead father’s shadow. Even so, Giovanni’s killing of the Commendatore is an act of self-defense, not premeditated murder, and when Giovanni is pulled to hell, the punishment seems inappropriate. In some versions of the opera an ensemble of Giovanni’s friends and enemies sing about life after his death and the distinct feeling is one of loss. An aspect of life has been condemned by moral agent (the Commendatore) and snuffed out.

In *The Magic Flute*, Mozart’s penultimate opera and one steeped in Masonic ritual and symbolism, the characters do not die, though at the end several of them are vanquished from the holy realm of

the supremely wise Sarastro. Flute is a psychological study, and just as the early degrees of Freemasonry are initiations into one's own inner states, the various characters in the opera may be seen as parts of one ideal character. The hero Tamino is that character's questing self, while the sidekick Papageno calls himself the "doppelganger," or Tamino's superficial double. Tamino contains within himself the archetype of the Mother, personified as the Queen of the Night, and an anima figure with a name much like his, Pamina. The evil Monostatos is his shadow, and the great Sarastro the Wise Man he would become. The dark archetypes are vanquished, but death as such does not appear in *The Magic Flute*.

The title says all in Mozart's final opera, *La Clemenza da Tito*. The clemency of the Emperor Titus is the subject and the end of an opera that commemorates forgiveness, reason, and free will, completely contradicting the operatic tradition of revenge, emotional chaos, and fate. But all of that made a quick comeback.

Bel canto ("beautiful singing") opera was the most popular in early-nineteenth-century Italy. Vincenzo Bellini and Gaetano Donizetti were among its greatest practitioners. Donizetti was unusual in his ability to compose very effectively in both comic and tragic modes. His *Daughter of the Regiment* (1840) is so light that it could fly away, while *Lucia di Lammermoor* (1835) probably deserves the prize for the bloodiest opera written before the twentieth century.

In *Lucia*, love and death make a huge return. The Scottish lass Lucy, of the castle Lammermoor, is in love with Edgar of Ravenswood and he with her. But her brother Henry has other plans and forces Lucy to marry a man named Bucklaw for money and advantage. On her wedding night, Lucy goes insane and stabs Bucklaw to death, then sings a very long and very effective insanity scene, accompanied by flute and usually draped in a bloody nightdress, then collapses, dead of sheer sorrow. Not to leave anyone innocent alive, Donizetti has Edgar stab himself to death at Lucy's grave.

Thus did the *bel canto* tradition revive the marriage of Eros and Thanatos. Society was back, too, in the form of large choruses that sang commentary on the action while distancing themselves from the horror. Death does not happen to crowds; it comes only to individuals.

Giuseppe Verdi summed up the traditions that had gone before and created, over a period of several decades, a body of work that forms the very center of most opera houses, at least in the United States. He was much stronger a tragedian than he was a comedian, and the sense of doom forecast in a typical Verdi opera is palpable from the start. Love and death now started to merge. Verdi's *Aida* (1872) offers perhaps the clearest single example of the purity of their union. The Egyptian Radames loves the enslaved Aida and proclaims it in the aria "Celeste Aida," translated as "Heavenly Aida." The beauty of the music and the extra-earthly location of Radames' praise immediately signal death at the end of the tunnel. And indeed, at the end, Radames and Aida, the victims of political wrangling and the circumstances of birth, are together in a tomb, awaiting their suffocation together song singing, "O terra, addio!" or "O earth, farewell!"

Dying for love is permitted, even praiseworthy, but murder for revenge will get its karmic due. In Verdi's *Rigoletto* (1851), the hapless title character, a hunchbacked jester, believes the dying human in a sack he is about to throw into the river is the Duke of Mantua, whose murder he has plotted. Instead it is his own daughter, Gilda, who dies in the duke's place.

The Verdi opera that most crucially mixes love and death with greatest intensity is also the composer's most unusual opera, *La Traviata* (1853). Alone among his works, *La Traviata* takes place in the composer's own time; every other Verdi opera happens among ancient nobility or in biblical times. Based on the play *The Lady of the Camellias* by the French novelist and playwright Alexandre Dumas, *La Traviata* finds the courtesan Violetta in love with dashing, callow, young Alfredo Germont. When the elder Germont, Alfredo's doleful father, wishes to forbid the relationship, he addresses not his son, but Violetta. His admonition to her takes the form of a warning that his son's future will be irredeemably tarnished by association with such a woman as she. Violetta gives up Alfredo, and dies of tuberculosis.

In *La Traviata* the themes of love and death come together. Old Germont, the voice of the crowd, society, and its morals, severs the sexual from the personal and thus condemns Violetta to

death, for without love she cannot live. The tuberculosis is either a punishment for her sexual liaison, a symbol of her airless life without Alfredo, or both.

The advent of Richard Wagner's music dramas ushered in an entirely reformed view of death. While the death of the individual was the cornerstone of tragedy for the Italians, it took on a transcendent meaning for Wagner. In a Wagner music drama (a term he preferred to the Italian "opera"), individual death is nearly always a meaningful sacrifice to a greater whole. Death is no longer punishment, it is a kind of reward in the form of escape from desire. In Wagner's *Tristan und Isolde*, the title characters find true love only in death; in fact, the musical climax is a passage called the "Liebestod," or "Love-Death." Their ends as individuals return them to a transcendent unity. Desire and death are one.

The opera-obsessed German philosopher Friedrich Nietzsche, whose views Peter Conrad draws upon, saw clearly that Wagner's innovation advanced the transcendental over the real. Yet Nietzsche's view of the role of opera as musical tragedy changed markedly over the course of his short professional life. In his first major, published essay, *The Birth of Tragedy out of the Spirit of Music* (1872), he announced himself as a Wagnerian. German music has "Dionysian root" he wrote, starting in Bach and culminating in Wagner. The Dionysian death-ecstasy in German music contradicted the Apollonian habit of placing importance on individual ego, replacing it with the superiority of Dionysian sacrifice of the individual.

Late in life Nietzsche contradicted himself. In an essay titled *The Case of Wagner* (1888), he condemned Wagner's embrace of death and praised Georges Bizet's *Carmen* (1875) for its sunniness and embrace of life. *Carmen*, of course, ends with the death of its heroine, and she even sees it coming. She has rejected her former lover for a new one and the former will stab her to death outside the bullring. She has seen this in the cards—literally. But her death is not a sacrifice, it is an affirmation of the values by which she has chosen to live. Nietzsche at the last saw in this a greater, larger thing than Wagner's "love-death."

For most of the nineteenth century the Italian and German models existed side by side. Giuseppe Verdi continued, and brought to a climax, operatic death as the portrayal of individual

tragedy. In Verdi, death is punishment, from god or at least from some faceless universal fate. In Wagner's four-part *Ring of the Nibelung* (completed 1876), death is the supreme reward, coming only to great heroes such as Siegfried, and to his female counterpart Brunnhilde, who rides her horse Grane onto Siegfried's funeral pyre.

In both Wagner and Verdi, the action was nearly always removed from contemporary realities. All Wagner is myth-ridden and Verdi preferred to distance his characters from immediate relevance by placing them in the past or upon a throne. Toward the end of the nineteenth century a school of Italian composers brought about a revolution that turned this upside down.

It was called *verismo*, literally "realism," and it transposed the traditional subjects of betrayal, revenge, and murder among nobility to those of betrayal, revenge, and murder among everyday people. The first verismo opera to enter the repertoire was a one-act, unusual in the operatic realm. *Cavalleria Rusticana* marked the debut of twenty-eight-year-old composer Pietro Mascagni. Terse, intense, and violent, *Cavalleria* was shocking in its time, as much for its directness of expression as for what it expressed. Here were revenge and murder stripped bare of any noble pretence or mythological garment. The story is a simple one involving a Sicilian soldier, his burning lust for a married woman, and the inevitable outcome.

The composer Ruggero Leoncavallo tried to duplicate the success of *Cavalleria* in *I Pagliacci* (1892), cast in two short acts and a prologue, but short enough to be produced in tandem with another brief opera. (Today, in fact, it is usually teamed with *Cavalleria*.) In *I Pagliacci* there is the added element of layered reality: A player (*un pagliaccio*) acts out in character the very feelings of jealousy and revenge he is feeling as a private individual. Again, jealousy leads to murder, but what "on stage" has been merely a distraction becomes, in real life, shocking tragedy. The famous final line sums up this irony: "La commedia e finita!" ("The comedy has ended!")

With Giacomo Puccini, the greatest name of the verismo school, all sacrifices are love offerings, and they are made exclusively by women. Between 1896 and 1904, Puccini composed three of the most enduring tragic operas in Italian: *La Boheme*, *Tosca*, and *Madama Butterfly*. In *La Boheme* Mimi dies of



In Puccini's *Madama Butterfly*, a Japanese woman commits *hara-kiri* when her American husband returns home to Nagasaki with an American bride. This is one of Puccini's three tragic operas where each ends with the dramatic passing of its central heroine. BETTMANN/CORBIS

tuberculosis—Violetta's disease—while the title characters of the others snuff themselves in contrasting emotional modes. In *Tosca* the eponymous heroine attempts to foil fate and fails when her lover, Cavalradossi, is shot to death by a Napoleonic firing squad. Tosca had thought the muskets to be loaded with blanks; in horror, she flings herself from the parapet of the castle of Saint Angelo-Rome. And in *Madama Butterfly*, a Japanese wife commits *hara-kiri* when her American husband returns to Nagasaki with an American wife after not taking the Japanese ceremony seriously.

In Puccini's *Girl of the Golden West* and *La Rondine*, nobody dies. They are his least produced works. In *Suor Angelica* of his *Trittico*—a set of three one-act operas—Puccini presents what is perhaps the most poignant death of any in his works. The title character, who has taken vows as expiation for having had a child out of wedlock,

finds out that her child has died, and so ends her own life.

Death figures oddly in the sole comedy of *Trittico*, the enduringly charming *Gianni Schicchi*. In this opera after Dante, the title character feigns to be the voice of a dying man (who is, in fact, already dead) in order to will himself the man's fortune. This is not selfishness, but a distorted nobility, the opera implies, as Schicchi does this in order to produce a proper dowry for his love-stricken daughter. In *Turandot*, left incomplete at Puccini's death in 1924, the gentle Liu sacrifices herself for her master Calaf so that he can claim as his own the moon goddess Turandot. This role of woman as sacrificial object was uniquely nineteenth century and predominantly Mediterranean.

There is nothing in opera before *bel canto*, nor after Puccini, to match the regularity with which women die in Romantic Italian operas. (German operas offer up gender-neutral sacrifices.) They do not languish, like Dido, but either give themselves willingly or are punished for sin—theirs or another's. This almost certainly reflected the role of women in Catholic countries of the time, at once relegating them to secondary status and elevating them to a kind of deity. When Gilda dies willingly for the worthless Duke in *Rigoletto*, it confers on her a sainthood no male character in Italian opera comes remotely near achieving.

Russian opera of the nineteenth century had a distinct political bent. The death of the czar in Mussorgsky's *Boris Godonov* is also the temporary death of the state. The title character, who has seized power through an innocent's murder, is toppled by a pretender; his personal tragedy is merely symbolic of the national tragedy his fraud has initiated. In Tchaikovsky's *Eugene Onegin*, the death of one of the characters in a duel is rendered nearly meaningless by his killer's lack of regard for Tatiana, the woman they have fought over. Russian society at large—has the final say, rejecting the killer's eventual advances and propping up the stability of her conventional marriage.

The twentieth century saw an explosion of opera, which took on myriad forms and generated many subgenres. Richard Strauss announced in *Salome* (1905) and *Elektra* (1908) a new and heightened dissonance, all the better to accompany the beheading of John the Baptist in the former and the bloodbath of the latter. But he soon dropped

this innovative language for operas that cradled gentle melodies set to more optimistic stories, such as *Der Rosenkavalier*. The ceaseless anxiety produced by the unrelieved dissonances of *Elektra* is a cue for future work that Strauss himself never took up. The musical language hangs on to dissonance as to some painful reminder of life; to achieve cadence, to dissolve into consonance, would mean death.

The Czech composer Leos Janacek bloomed late, composing a first opera of any significance (*Jenufa*) at age fifty, and his greatest operas after age sixty-five. This imbued his works with the glow of wise emotional distance. Forgiveness and understanding, not revenge and murder, are the dominant themes. In *Jenufa*, the title character is repeatedly wronged by those around her. Her fiancé's jealous brother disfigures her, her fiancé leaves her, and her stepmother drowns her illegitimate baby. Through it all, Jenufa finds opportunity to grow emotionally. In *The Cunning Little Vixen*, the story is set among animals. The title creature escapes a gamekeeper to found a family, only to see her path lead to death. Yet, it is a death absorbed into a cycle of life. Nature has taught humankind a lesson. *The Makrapulos Affair* concerns an opera singer as old as her art. In the course of the opera, 337-year-old Emilia Marty (one of many names she has had over the centuries) must learn how to die.

Death seems to be the least of worries for the characters in Alban Berg's two operas, *Wozzeck* (1921) and *Lulu* (left unfinished at the composer's death in 1935). The titular character in *Wozzeck* is a simple-minded soldier and fool of nature. He makes extra money by shaving his captain and by offering his body as a guinea pig for a doctor bent on proving arcane theories, the funds from which he gives to his common-law wife, Marie, and their child. But when he finds that Marie has bedded the handsome Drum Major of his battalion, he slits her throat under a blood-red moon and then, in remorse and confusion, drowns himself. In *Lulu*, the title character is cut to pieces by Jack the Ripper. Sex and death meet here in the most hideous fashion. Notably, the only "pure" character in the opera is the Countess Geschwitz, a lesbian. All male advances made to Lulu, with their potential for procreation and the regeneration of life—and therefore death—are treated essentially as acts of

violence. Only the Countess, whose sexual relation with Lulu cannot continue the wheel of life/death, is pure. Here Wagnerian "transcendence" is given modern meaning.

In English, composer Benjamin Britten's operas, death usually involves the sacrifice of an innocent for the supposed good of the greater whole. In *Peter Grimes* (1945), a misfit suffers under the watchful eyes of a judgmental society. In *Billy Budd*, after Herman Melville's novella, the title character is made a scapegoat and in *Death in Venice*, after Thomas Mann's work, life itself is viewed as sacrifice.

In the French composer Francis Poulenc's *Dialogues of the Carmelites* (1958), death is the very subject. A young woman fears death and, seeing the tumult of life around her and the threat of the 1789 French Revolution, escapes to a convent. At length, it becomes clear that the other nuns have taken vows in order to embrace death, not avoid it. The final scene, one of the most chilling in the repertoire, calls for the sisters to chant a *Salve Regina* (Hail Queen of Heaven) as they exit the stage, one by one, to be guillotined. Periodically, the guillotine falls. The chilling effect is a constant diminuendo, until at last only one voice is heard singing, and that, too, is terminated.

No other theatrical form treats death in the heated and often terrifying way opera treats it. Opera's stepchild, the musical play, may involve death but it is infrequently given emotional coloring. The deaths in four of Rodgers and Hammerstein's musicals—*Oklahoma!*, *Carousel*, *South Pacific*, and *The King and I*—are nearly incidental to the stories. Only in the 1990s, with Stephen Sondheim's *Passion* and Adam Guettel's *Floyd Collins*, did American musical theater come to treat death with a sobriety approaching that of opera.

Tragic drama without music can convey horror, pity, fear, and sorrow, but music adds a dimension of unsettling personal involvement. Aristotle's famous dictum to the effect that drama is a purgation of the emotions does not really fit opera. One might leave *Aeschylus* feeling grateful that one is not among the characters, yet likely to leave Strauss's *Elektra* feeling very much like one or more of the characters. In the end, opera has become a form vastly distanced from the ancient Greek drama it was originally designed to emulate.

See also: FOLK MUSIC; GREEK TRAGEDY; MAHLER, GUSTAV; ORPHEUS; SHAKESPEARE, WILLIAM

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KENNETH LAFAVE

ORGAN DONATION AND TRANSPLANTATION

Since the eighteenth century researchers have been experimenting with organ transplantation on animals and humans. However, the modern era of organ transplantation really began in the 1950s. In its early years, these were truly perilous procedures, fraught with danger, very likely not to be successful in particular instances, and rightly characterized as involving “the courage to fail”—a seminal work of the same name was written by Renée Fox and Judith Swazey in 1974.

Over time a combination of advances in knowledge, technology, pharmacology, and practice made it possible to transplant specific organs

successfully from one human to another. In North America some milestones in this work include the first successful transplants of a kidney (Boston in 1954); pancreas/kidney (Minneapolis in 1966); liver (Denver in 1967); pancreas (Minneapolis in 1968); heart (Stanford in 1968); heart/lung (Stanford in 1981); single lung (Toronto in 1983); double lung (Toronto in 1986); living-related liver (Chicago in 1989); and living-related lung (Stanford in 1990). Transplants of kidneys, livers, hearts, pancreases, lungs, and heart-lungs are an accepted part of twenty-first-century medical treatment.

Twentieth-century specific achievements rested on two important developments. The first was tissue typing, or the ability to classify and compare human tissues. This led to the realization that a graft or transplant will have the greatest likelihood of success when it is most closely matched to the biological characteristics of the recipient. For example, a transplant is most likely to succeed when it takes place between identical twins who share a high degree of genetic material.

The second important breakthrough, which has been termed “the most notable development in this area” by the United Network for Organ Sharing, was the scientist Jean Borel’s discovery of an immunosuppressant drug called cyclosporine in the mid-1970s. This drug was approved for commercial use in November 1983. Effective immunosuppression prevents the recipient’s immune system from attacking and rejecting the transplanted organ as a foreign body. There are side effects to using this drug and clinicians must balance the threat of rejection against the dangers of rendering the transplant recipient susceptible to infection and other life-threatening assaults. When properly managed, however, immunosuppression has saved hundreds of thousands of lives and greatly enhanced quality in living.

The Need for Donations and Available Transplants

The growing need for transplantable human organs arises mainly from nonfunctioning or poorly functioning organs in potential recipients. With improved screening practices and diagnostic techniques, individuals who might benefit from transplantation have been identified earlier and more effectively. At the same time, transplant centers

have advanced their technical abilities to transplant major organs.

Recognizing these developments, in 1984 the U.S. Congress enacted the National Organ Transplant Act (NOTA), which established the national Organ Procurement and Transplantation Network to facilitate the procurement and distribution of scarce organs in a fair and equitable way. The United Network for Organ Sharing (UNOS) administers this network under contract to the government's Division of Transplantation in the Department of Health and Human Services. NOTA also created the Scientific Registry of Transplant Recipients, a system to measure the success of transplantation by tracing recipients from time of transplant to failure of organ (graft) or patient death, which is administered under contract by the University Renal Research and Education Association at the University of Michigan.

The need for organ transplantation can be seen in data from the National Transplant Waiting List (see Table 1). The top line of this table identifies the major bodily organs that can currently be transplanted: individual kidneys, livers, and hearts; entire lungs, pancreas, and intestines, or portions thereof; and joint transplants of a kidney/pancreas or heart/lung. Clearly, the greatest numbers of transplant candidates are waiting for kidneys and livers. Table 1 also offers a snapshot, as of May 31, 2001, of the estimated number of patients (76,555) registered on the waiting list by gender, age, and race or ethnicity. Among registrants on the waiting list, the ratio of males to females is nearly 60/40, the largest numbers by age are 18 to 49 years old (followed closely by those 50 to 64 years of age), and the largest numbers by race or ethnicity are Caucasian Americans and African Americans.

Table 1 discloses two distinguishing features about African-American candidates on the waiting list. First, they are disproportionately in need of kidney transplants. More than 90 percent of African-American registrants are waiting for a kidney transplant by contrast with 70 to 77 percent of individuals from other minority groups who need such a transplant. This appears to result from elevated rates of high blood pressure, diabetes, and sickle cell anemia in the African-American community, all of which can have a deleterious effect on

kidney functioning. Second, African Americans who make up about 12 percent of the overall U.S. population, are present in unusually high numbers on this list—more than 24 percent of all those registered with a U.S. transplant center.

Developments in Organ Donation and Transplantation

Table 2 reports end-of-year data for numbers of patient registrations on the transplant waiting list from 1988 through 2000, as well as the number of transplants accomplished and the numbers of donors from whom organs were recovered in each of those years. These data and Figure 1 show that during the last twelve years of the twentieth century in the United States the number of patient registrations on the transplant waiting list increased by over 360 percent, while numbers of transplants and donors increased only about 81 percent and 96 percent, respectively. In other words, during this time period the United States witnessed a gradual or incremental increase in the availability of transplantable organs, while there was a huge growth in the need for such organs.

Consequently, the single largest obstacle to organ transplantation in the twenty-first century is the scarcity of transplantable organs. In fact, there would be no transplantation of organs if the concept of donation did not exist. For that reason, it is helpful to consider some facts about organ donation and to take note of some efforts that have been made to increase the pool of organs available for transplantation.

Organ Donation and Consent to Donation

Organ donation is only possible when: (1) the organ in question is not uniquely vital to the donor's health; or (2) the donor is already dead when the organ is retrieved from his or her body. Living donors can offer replaceable materials (such as blood or blood products), one of a pair of twinned organs (such as kidneys), or a portion of certain organs (such as a liver, lung, or pancreas). Nonliving donors—individuals who have died prior to donation and the subsequent recovery of their organs (sometimes called "cadaveric donors")—can donate all of these and other transplantable organs provided that conditions preceded, at the time of, and immediately following their

TABLE 1

Number of individuals (patients or registrations) on the National Transplant Waiting List as of May 31, 2001, by organ, gender, race, and age ^a

| Number Percentage | Kidney | Liver | Pancreas | Kidney - Pancreas | Intestine | Heart | Heart-Lung | Lung | Total |
|------------------------------|----------------|----------------|-------------|-------------------|-------------|---------------|-------------|---------------|----------------|
| Total:^b | 49,203 | 17,733 | 1,133 | 2,502 | 165 | 4,250 | 217 | 3,673 | 76,555 |
| By Gender: | | | | | | | | | |
| Females | 22,056 42.5 | 7,661 42.4 | 518 45.1 | 1,147 44.4 | 72 42.6 | 952 22.3 | 125 57.3 | 2,161 58.1 | 34,692 42.3 |
| Males | 29,860 57.5 | 10,399 57.6 | 630 54.9 | 1,439 55.6 | 97 57.4 | 3,309 77.7 | 93 42.7 | 1,556 41.9 | 47,383 57.7 |
| By Age: | | | | | | | | | |
| 0-5 | 90 0.2 | 547 3.0 | 7 0.6 | 2 0.1 | 99 58.6 | 127 3.0 | 16 7.3 | 22 0.6 | 910 1.1 |
| 6-10 | 121 0.2 | 207 1.1 | 1 0.1 | 0 0.0 | 16 9.5 | 39 0.9 | 3 1.4 | 44 1.2 | 431 0.5 |
| 11-17 | 426 0.8 | 361 2.0 | 7 0.6 | 0 0.0 | 15 8.9 | 86 2.0 | 19 8.7 | 138 3.7 | 1,052 1.3 |
| 18-49 | 25,644 49.4 | 6,807 37.7 | 970 84.5 | 2,158 83.4 | 29 17.2 | 1,227 28.8 | 146 67.0 | 1,731 46.6 | 38,712 47.2 |
| 50-64 | 19,824 38.2 | 8,435 46.7 | 161 14.0 | 420 16.2 | 10 5.9 | 2,268 53.2 | 33 15.1 | 1,686 45.4 | 32,837 40.0 |
| 65+ | 5,811 11.2 | 1,703 9.4 | 2 0.2 | 6 0.2 | 0 0.0 | 514 12.1 | 1 0.5 | 96 2.6 | 8,133 9.9 |
| By Race or Ethnicity: | | | | | | | | | |
| Caucasian Americans | 22,555 43.4 | 13,412 74.3 | 980 85.4 | 1,977 76.5 | 104 61.5 | 3,325 78.0 | 171 78.4 | 3,111 83.7 | 45,635 55.6 |
| African Americans | 18,169 35.0 | 1,311 7.3 | 108 9.4 | 380 14.7 | 42 24.9 | 563 13.2 | 23 10.6 | 382 10.3 | 20,078 24.5 |
| Hispanic Americans | 7,144 13.8 | 2,244 12.4 | 46 4.0 | 171 6.6 | 17 10.1 | 288 6.8 | 18 8.3 | 160 4.3 | 10,088 12.3 |
| Asian Americans | 2,895 5.6 | 702 3.9 | 7 0.6 | 36 1.4 | 4 2.4 | 49 1.1 | 3 1.4 | 33 0.9 | 3,729 4.5 |
| Others | 1,152 2.2 | 391 2.2 | 7 0.6 | 22 0.9 | 2 1.2 | 36 0.8 | 3 1.4 | 31 0.8 | 1,645 2.0 |

^aSome patients are multiply listed at different transplant centers for the same organ or at the same transplant center for multiple organs (e.g., kidney and heart). The data in this report are not adjusted for multiple listings at different centers. However, the data are adjusted for multiple listings at the *same* center; thus, a patient is counted only once per center. The degree of multiple listing of the same patient at different centers has been difficult to determine accurately, but is estimated to involve less than five percent of all patients and appears to have declined over time.

^bThe numbers in this line represent current estimates of *patients* listed on the waiting list. Note that the overall total in this line (= 76,555) is less than the sum of the organs (= 78,876) because some patients are listed for multiple organs. Such patients are counted separately under each organ for which they are waiting, but only once in the overall total. All other figures in the remainder of this table reflect numbers of *registrations* (whose total = 82,075) rather than numbers of patients.

SOURCE: Adapted from United Network for Organ Sharing, 2001. Available from www.unos.org.

death do not damage the organs or otherwise render them unsuitable for transplantation.

For nonliving donors, this usually means that organs must be recovered shortly after the death of an otherwise healthy donor and before they have begun to deteriorate (the time frame depends on the particular organ in question). In most instances, the donor will have died of external trauma to the head (e.g., as associated with an accident, homicide, or suicide) or a cerebrovascular incident (e.g., resulting from cranial hemorrhage or stroke), and will have been pronounced dead (“brain dead”). Often, some bodily functions in a potential organ

donor will be artificially sustained by external intervention for a limited period of time in order to preserve the quality of transplantable organs while decisions are made about donation and a search for appropriate recipients is undertaken. This does not mean that an already-dead donor is “being kept alive”; only some biological functions are being supported externally, not the life of the person.

As reported in Table 2, the ratio of nonliving to living donors has declined over time from 69/31 percent to approximately 52/48 percent. That appears to reflect the increasing willingness of living donors, whether or not they are related by blood or

TABLE 2

Number of patient registrations on the National Transplant Waiting List, number of U.S. transplants, and number of U.S. organ donors, end of year 1988–1994

| | Year | | | | | | |
|--|--------|--------|--------|--------|--------|--------|--------|
| | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 |
| Number of Patient Registrations on the National Transplant Waiting List | 16,026 | 19,095 | 20,481 | 23,198 | 27,563 | 31,355 | 35,271 |
| Number of Transplants | | | | | | | |
| Non-living donors | 10,803 | 11,225 | 12,879 | 13,327 | 13,559 | 14,735 | 15,206 |
| Living | 1,823 | 1,918 | 2,123 | 2,423 | 2,572 | 2,899 | 3,086 |
| Total: | 12,626 | 13,143 | 15,002 | 15,750 | 16,131 | 17,634 | 18,292 |
| Number of Donors | | | | | | | |
| Non-living | 4,080 | 4,012 | 4,509 | 4,526 | 4,520 | 4,861 | 5,100 |
| Living | 1,827 | 1,918 | 2,124 | 2,425 | 2,572 | 2,906 | 3,102 |
| Total: | 5,907 | 5,930 | 6,633 | 6,951 | 7,092 | 7,767 | 8,202 |

Number of patient registrations on the National Transplant Waiting List, number of U.S. transplants, and number of U.S. organ donors, end of year 1995–2000

| | Year | | | | | | Total |
|--|--------|--------|--------|--------|--------|--------|---------|
| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | |
| Number of Patient Registrations on the National Transplant Waiting List | 41,179 | 46,925 | 53,123 | 60,299 | 67,079 | 73,951 | 515,545 |
| Number of Transplants | | | | | | | |
| Non-living donors | 15,902 | 15,965 | 16,253 | 16,943 | 16,946 | 17,255 | 190,998 |
| Living donors | 3,438 | 3,735 | 4,009 | 4,473 | 4,768 | 5,653 | 42,920 |
| Total: | 19,340 | 19,700 | 20,262 | 21,416 | 21,714 | 22,908 | 233,918 |
| Number of Donors | | | | | | | |
| Non-living | 5,359 | 5,416 | 5,477 | 5,799 | 5,822 | 5,984 | 65,465 |
| Living | 3,458 | 3,756 | 4,021 | 4,496 | 4,748 | 5,600 | 42,053 |
| Total | 8,817 | 9,172 | 9,498 | 10,295 | 10,570 | 11,584 | 108,418 |

SOURCE: Adapted from United Network for Organ Sharing, 2001. Available from www.unos.org.

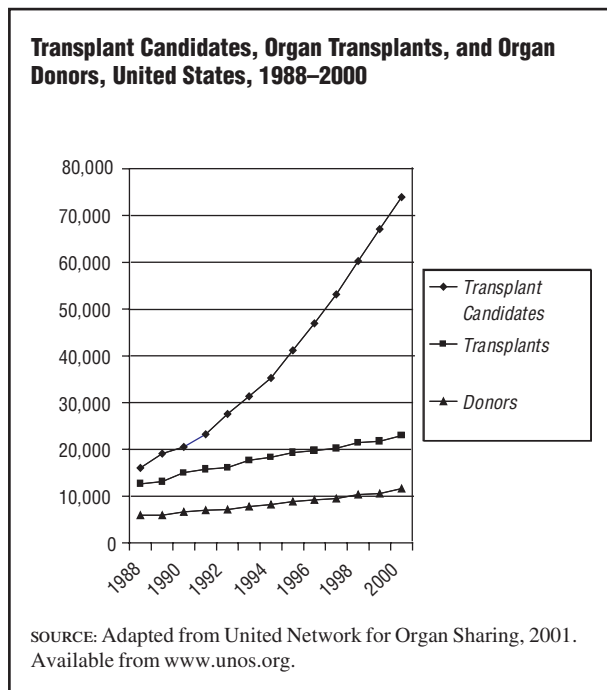
marriage to a potential recipient, to offer a part of their bodies for transplantation. At the same time, although the ratio of organs that are actually transplanted from nonliving donors to those from living donors has declined from 86/14 percent to 75/25 percent, transplantation remains much less frequent from living donors than from nonliving donors.

One reason for the infrequency of donation is that living persons can only donate one of a pair of organs or a portion of an organ to a single recipient, while a nonliving donor can donate six to eight major organs, along with ocular components and numerous other tissues that can affect the lives of fifty or more recipients. Still, living donation offers advantages in that the donor's medical history

is known, an extensive evaluation can be done beforehand, the organ is removed under elective circumstances, and the donated organ is out of the body only a very short period of time.

Consent for donation is obtained from potential living donors after a suitable screening and evaluation process to determine that they understand the procedure that will be undertaken, are consenting freely, are a good tissue match to the potential recipient, are likely to be able to withstand the surgical donation process, and can be expected to cope effectively with the aftermath of the experience however that may work out. In the case of a potential donor who has died, health care professionals who are not part of the transplant

FIGURE 1



team will determine death and communicate that diagnosis to next of kin. Wherever possible, an effort will be made to disassociate this declaration of death from issues associated with organ donation.

Donation of major organs in the United States does not follow a policy of “presumed consent,” although such policies are practiced elsewhere around the world. In the United States, the Uniform Anatomical Gift Act (1968, with amendments in 1987) regulates who may make or receive an anatomical gift, under what conditions, and for what purposes. Permission to donate from nonliving donors must be obtained from an appropriate source. Furthermore, under a government regulation called the Medicare and Medicaid “Conditions of Participation” that went into effect in 1998, hospitals must: (1) report all patients whose deaths are imminent or who have died in their institution to their local or regional Organ Procurement Organization (OPO); (2) ensure the right of next of kin to choose donation; and (3) arrange for trained personnel (members of the OPO staff or hospital personnel whom they have trained for this purpose) to offer the opportunity to donate.

It is difficult to approach grieving family members shortly after the (often sudden and traumatic) death of a loved one to discuss organ donation. However, many believe it would be even worse to

fail to make this option available to family members at a time when they have been victimized by death and when so little else is within their control, or to have them realize later that they could have found some measure of solace in a dark time if someone had only mentioned the possibility of making a “gift of life.” Done properly, offering the opportunity of donation can provide a way of continuing the legacy of an individual’s life, assisting family members in their bereavement, and helping others through transplantation.

Efforts to Increase Organ Donation

Efforts to increase organ donation have taken many forms. Among them, public education projects have sought to emphasize a number of relevant facts, including “brain-dead” individuals cannot return to life; donor families incur no costs to donate; human tissues and organs cannot legally be bought and sold in the United States; and organ donation usually has no substantive effect on desired funeral practices, other than the possibility of a brief delay. In addition, transplantation is encouraged and supported by nearly all religious communities in the United States; members of minority groups are most likely to find a close tissue match with other members of similar groups and gene pools; a large and growing number of individuals on the transplant waiting list are in desperate need of a transplanted organ; an average of fifteen persons on the waiting list (5,597 in 2000) die each day in the United States because a transplantable organ does not become available for them. These public education efforts are summarized by the slogan, “Don’t take your organs to heaven . . . heaven knows we need them here!”

Similar efforts involve urging potential donors to sign, date, and have witnessed an organ donor card. Such cards can be obtained from the federal government’s Division of Transplantation and local, regional, or national organizations, such as the Coalition on Donation, the United Network for Organ Sharing, or the National Kidney Foundation. Many states have a donor card on the reverse side of their driver’s licenses and/or encourage applicants for new or renewed driver’s licenses to indicate willingness to donate by registering in a computer database.

However, individuals who wish to donate should discuss this matter with their next of kin.

Regardless of any written or oral expression of wishes that an individual might make, next of kin are likely to be key decision makers in this matter. Lack of discussion among family members about their wishes is the single most significant barrier to organ donation. Thus, public education campaigns have urged potential donors to “Share your life. Share your decision.”

Xenotransplantation and Non-Heart Beating Donors

Two other efforts to enlarge the pool of potential organ donors involve xenotransplantation and what are called “non-heart beating donors.” Xenotransplantation is transplantation across species, that is, from animals to humans. At present, xenotransplantation has been successful in cases like heart valves from pigs, but that success has been limited to certain tissues. Non-heart beating donors are individuals in permanent vegetative states who are not yet dead but for whom competent decision makers (their next of kin or those authorized to act for them as substitute decision makers) might decide: (1) to withdraw life-sustaining interventions; and (2) to authorize donation. In such circumstances, the interventions are withdrawn and a brief interval is allowed during which the individual is observed to determine whether or not he or she resumes spontaneous functioning. If the individual is pronounced dead, interventions are resumed as needed to permit recovery of donated organs. From 1993 to 2000 in the United States, organs were recovered from a total of 581 non-heart beating donors.

Issues and Controversies

At present, attempts to meet the need for transplantable organs and tissues depend primarily on human donors, generating numerous social, personal, professional, ethical, and legal issues.

One set of issues concerns the types of physical, psychosocial, and spiritual care that are appropriate or mandatory for living and nonliving donors, donor family members, and transplant candidates and recipients both before and after donation and transplantation. When a loved one has died and he or she is approached about donating his or her organs, donor family members have been especially concerned that: (1) the need for information and care should be addressed at a time

when they are first learning about the death and about the implications of donation; (2) determination of death should be made without regard to donation and their loved one should be cared for with respect and dignity; and (3) their subsequent needs for follow-up bereavement care after the donation decision should be met in appropriate ways. To that end, the National Donor Family Council published in 1994 a “Bill of Rights for Donor Families.” Similarly, concerns about specific needs of transplant recipients for ongoing, seamless, and high quality medical, psychosocial, and spiritual care led the transAction Council of the National Kidney Foundation to develop and publish in 2001 a “Transplant Recipients’ Bill of Rights and Responsibilities.” Further, all of these parties are concerned about implications of donation as a “gift of life” and what may follow from that decision (e.g., are there implied obligations and/or bonds?).

Another set of issues involves efforts to increase the availability of transplantable organs. Campaigns to increase public awareness about organ donation and the need for transplantation have not substantially increased the number of available organs. Here, the key issue has to do with consent for donation. In cases involving non-living donors, some have proposed that formal indications of an individual’s desire to donate made prior to death (e.g., through a signed donor card or consent for inclusion in a state donor registry) should become legally definitive, sufficient in themselves, and not subject to being overruled by next of kin.

For non-heart beating donors, issues of consent relate to the fact that decisions to withdraw life support and then (after death has been determined) to recover organs are made by next of kin or substitute decision makers acting on the authority of an advance medical directive. There are potential issues about whether the individual is really dead before being returned to interventions designed to preserve the quality of the organs to be transplanted. If so, on what basis is that determined? How long does one have to wait after withdrawing life support before pronouncing death? Why are pain medications sometimes administered to such patients, if they are in fact dead? In addition, there are issues regarding whether decisions to authorize withdrawal of life support and donation are properly made by a substitute decision

maker who may be the individual's beneficiary or have some other personal interest in the outcome.

In the case of living donors, consent to donate may become problematic if psychosocial pressures or familial influences impose coercion on the potential donor. This would be especially true in cases of child donors. And in all cases of living donors there can be questions as to whether it is appropriate, even with their consent, to impose the risks of major surgery and all that entails on healthy individuals who derive no direct physical benefit from that procedure. An issue for professionals who work with living donors concerns the injunction to "do no harm" because organs do not regenerate and the donor will be permanently impaired.

Further, while the buying and selling of human organs is not legal in the United States, some have suggested that funding of some type should be made available, either directly or indirectly, to donor families to facilitate decisions to donate. For example, funds might be paid directly to funeral homes to alleviate some financial burdens on families who agree to donate organs from a loved one. Surveys of family members who have agreed to donate do not report them as favoring such proposals. However, views of family members who declined to donate are not well-known.

The first issue that faces potential transplant candidates involves gaining access to the national transplant waiting list. This issue has particular relevance for those who are economically disadvantaged or who are members of minority groups. When such individuals receive their health care services from impersonal institutions or systems in which they do not have full confidence, they may not be adequately informed about how they might benefit from transplantation or not sufficiently empowered to bring up their interest in that possibility. By contrast, individuals with sufficient time, energy, and other resources may be able to gain access to the waiting list more easily and may be able to do so at more than one transplant center. Further, in order to be accepted by a transplant center, one must demonstrate ability to pay for this expensive procedure. There are not any hospitals that can afford to offer many free organ transplants. People who cannot show that they have adequate resources available to them—in the form of funding from Medicare, state assistance, private

insurance, or money that they themselves raise—may not be accepted as transplant candidates.

Once on the transplant waiting list, discrimination is less likely because organs are allocated to those at the top of the list as determined by criteria that strive to ensure equity in terms of antigen matching, how sick the person is, and how long he or she has been on the list. However, when insufficient numbers of transplantable organs are available (as in the United States), issues still exist concerning whether these scarce resources should be allocated: (a) locally or regionally before being made available nationally or (b) to the sickest individuals first on the waiting list (regardless of geography). It has been argued that local or regional allocation would encourage individuals to donate in support of their local communities. The counterargument is that allocation without regard to geography would direct organs in the first place to individuals on the waiting list who are the sickest and most in need of a transplant. Proponents speaking on behalf of the primacy of local and regional allocation reply that those who are sickest have a lower likelihood of long-term success as transplant recipients. From another perspective, in light of the typical pool of patients that each serves, it has been suggested that giving primacy to local or regional organ allocation tends to favor smaller transplant centers over larger, national transplant centers that tend to enroll sicker patients on their waiting lists.

Further, funding is an ever-present issue in this field for the recovery of transplantable organs and tissues, for transplantation itself, and for the long-term support of transplant recipients. To the issue of funding, one can add issues involved in the "commodification" of transplantable organs and especially human tissues that, once processed, have a long shelf life and seem to many to lose their connection to their original source in a human body. Has this led to excess profit making by some tissue banks and processors? Does it all imply an unwillingness to realize that in the end death is part of the human condition?

Tissue Donation and Transplantation

In addition to organs, it is also possible to transplant human tissues such as skin grafts for burn and accident victims; heart valves and aortic patch grafts to sustain heart functioning; saphenous and

femoral veins, which are used in cardiac bypass surgery; eye and ocular components to restore or improve sight; and bone and connective tissue grafts, which make possible periodontal and trauma reconstructions, as well as spinal fusions. Because blood and fat cells are removed during the processing of donated tissues, there is usually no issue of rejection after transplantation and many tissues can be sterilized, frozen, and kept in storage often for many years. Upwards of 400,000 tissue transplants are accomplished each year in the United States.

Conversations about retrieval of transplantable tissues may be part of the overall discussion of organ donation or they may occur independently—often in the form of a telephone conversation rather than a face-to-face interaction. In the former instance a procurement coordinator from an OPO might be the principal professional in the discussion; in the latter instance a staff member from a specialized eye or tissue bank might assume that role.

See also: BIOETHICS; DEFINITIONS OF DEATH; INFORMED CONSENT

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ORGANIZED CRIME

In the pantheon of the American violent antihero, the gangster has occupied an enduring price of place second only to the cowboy; both have enjoyed the distinction of inspiring an entire genre of popular music. Whether the cinematic iconography is that of the loyal family operative—*The Godfather* (1972)—or the brutal sadist—*The Untouchables* (1987)—the adventure, violence, and bloodshed of the American gangster continues to grip the imagination of the world.

In reality, organized crime is mainly another business—the bursts of machine-gun fire and “rubouts” that dominate the movie version of gangland are really only the occasional means to a higher (or lower) end—money. Like rogue nation-states securing their national interests, organized criminal syndicates aggressively defend their profits and business “turf” by any means necessary.

In distinction to other forms of criminality, organized crime is a conspiratorial activity involving the collaboration of numerous people over a prolonged period. Unlike other criminal groupings, syndicates have maintained enough organizational strength to allow continued operation in the face of the loss of one or more members. Criminal syndicates rely on rules and regulations to maintain

discipline and control within their ranks. Breaking the rules typically results in verbal or physical punishment, including death.

Organized crime groups are motivated by money rather than ideology—a characteristic that distinguishes them from organized terrorism. Although there are occasional links between terrorist groups and organized criminals (e.g., the Russian Mafia is often accused of supplying Russian nationalists with weapons), organized criminals generally avoid connections with terrorists and are much more restrained and functional in their use of violence.

Like other plunderers, from the state level to the back alleys, organized criminals are willing to use violence and murder to accomplish their goals. Although reliable statistics on mob murder and violence are unavailable, the level of bloodshed seems proportional to the vigor of the market for mob-supplied goods. Expanding markets and profits associated often intensify competition between existing groups and spawn new ones; violence tends to flare when several groups are jockeying for the same market niche. Violence also plays an important internal role among criminal groups who use it as a deterrent to insubordination. Violence can also be the price of failure. Mexican organizations, for example, kidnap, torture, and execute members whose drug shipments are confiscated by U.S. border agents.

Gangsters themselves are the most likely victims of organized-crime-related violence; however, bystanders sometimes get caught in the middle. The DeMeo crew of the Gambino family murdered well over a hundred people; while most of them were criminals, several were simply in the wrong place at the wrong time.

Criminal syndicates tend to specialize in the provision of illicit goods and services. Organized crime is not limited to any one kind of activity, illegal or otherwise, but syndicates tend to focus on gambling, drug trafficking, loan sharking, prostitution, and extortion. To accomplish their goals, participants function in hierarchical networks, with each member assigned a particular task. The structure of organized crime insulates the leadership from direct criminal involvement. The subordinates are willing employees with specialized skills, such as computer hacking or contract murders.

Organized criminals often make use of government corruption to accomplish their organizational goals. Bribery and extortion are necessary tools for the survival of their enterprise. For example, a recent federal investigation in Arizona resulted in the arrest of ten federal officers, two deputy sheriffs, three local police officers, and one local judge. In another investigation, federal agents discovered that four Immigration and Naturalization Service inspectors were paid over \$800,000 to pass more than twenty tons of cocaine into the United States.

Traditional Organized Crime

The origins of organized crime in the United States date back to at least the early 1800s, when criminal gangs victimized the residents of New York, Boston, and other cities. By the middle of the nineteenth century, at least some of these gangs had emerged in a sufficiently structured and prominent form to warrant public recognition of “organized crime.”

One of the first criminal groups with a tightly organized and acknowledged leadership was New York’s Forty Thieves Gang, which thrived from 1820 to about 1860 (another gang by the same name operated between 1930 and 1940). Throughout the early and mid-nineteenth century, many sons of poor Irish immigrants formed gangs and participated in criminal activities, including theft, burglary, and extortion. The Forty Thieves and groups like them were also heavily involved in local politics. In fact, New York’s infamous Tammany Hall politicians used the brawling Irish gangs as tools of political power, selectively procuring their services for such unlovely reasons of state as breaking up picket lines, intimidating voters, and stuffing ballot boxes. In return for their help, the gangs received protection from the police, access to political power, and jobs for their relatives.

Other immigrant groups were associated with organized crime in the nineteenth and early twentieth centuries—among them Jewish, Polish, Chinese, and Italian—leading many criminologists to suspect that immigration may have facilitated the growth of organized criminal activity in the United States. One scholar has argued that because early immigrants were wedged into poverty-stricken ghettos with few legitimate opportunities for conventional success, they were more likely to turn to crime to escape poverty. “The aspiring ethnic,

blocked from legitimate access to wealth and power, is permitted to produce and provide those illicit goods and services that society publicly condemns but privately demands” (Ianni 1975, p. 89). In short, organized crime provided the immigrant and his family a means to escape the penury and indignity of the ghetto. The same processes may still be at work in the twenty-first century with more recent immigrants to U.S. cities.

Like many other immigrants groups, the Irish-American population found increasingly legitimate avenues for success outside the ghetto. With fewer members of their own ethnic group willing to support or even tolerate their criminal ventures, Irish syndicates found it difficult to maintain control over the criminal rackets. For the most part, the Irish were slowly, sometimes violently, replaced by other criminal groups.

However, while Irish and other ethnic groups have come and gone on the American organized crime scene, none have rivaled the impact or resilience of the Italian-American syndicates. Between 1820 and 1930 almost 5 million Italians immigrated to the United States—more than 2 million between 1900 and 1920. Like the Irish before them, Italian immigrants found themselves isolated in ghetto areas with few legitimate opportunities to realize the American dream, so that some of their number sought to escape poverty by supplying the illicit goods and services demanded by the local populace.

Some argue that the Italian experience was even more conducive to the formation of criminal syndicates. Because many Italian immigrants did not speak English, they were even more isolated and had even fewer opportunities for positive influence outside their ethnic enclaves. Moreover, the organizational antecedents of organized crime, including secret societies such as the Italian Mafia and the Camorra already permeated southern Italian culture. Thus, Italian immigrants brought with them knowledge of the ways of secret societies and the spirit of the Mafia that they used to construct a uniquely American organization that emerged later, with the advent of Prohibition.

In 1919 the passage of the Volstead Act made it illegal to produce, distribute, or sell alcoholic beverages. Prohibition (1920–1933) provided the context for the rapid development of a new illegal enterprise and the necessity for a more complex

division of labor between and within the criminal groups responsible for bringing in and distributing illegal alcohol. In essence, the large profits that could be made by satisfying the public demand for alcohol motivated small-time, local Italian gangs to expand beyond the ghetto.

While it is easy to focus on the violence associated with gang wars during Prohibition, the breadth of the market induced many Italian gangs to work more extensively with other criminal groups than they ever had before. At times, however, cooperation failed and resulted in bloody conflicts. For example, in Chicago a four-year feud between rival Irish and Italian forces culminated on February 14, 1929, when members of the Capone mob, disguised as police officers, systematically executed seven members of the Moran gang in the aptly named “St. Valentine’s Day Massacre.” Interestingly, collaboration with non-Italians increased profits, and most syndicate leaders recognized that gang wars were bad for business. Working with non-Italian groups also demonstrated the utility of other models of organization that departed radically from the family patronage model of the traditional Italian Mafia that many of the young American-born Italians rejected.

The violence reached its peak in the Castellammarese War of 1930–1931, when the Old World faction headed by Salvatore Maranzano was nearly exterminated by younger, Americanized factions under the direction of Giuseppe Masseria. By the end of the war, Maranzano was dead along with many of his compatriots, clearing the way for the Americanized gangsters to assume new levels of leadership in Italian-American crime syndicates. In the shadow of Prohibition, newer, younger leaders replaced their fractious elders with an organization that was on the whole more cooperative, stable, and profitable. Some criminologists contend that by the end of Prohibition, U.S. organized crime had developed a national, rigidly hierarchical framework under almost exclusive control of the Italian Mafia. Others cite evidence that indicates the criminal syndicates maintained a fluid, decentralized, ethnically diverse structure that has promoted their interests in an environment hostile to their very existence. As of the twenty-first century, the Mafia (also known as *La Cosa Nostra*) remains the most powerful organized-crime group in the United States, but most criminologists deem it a declining force.

Nontraditional Organized Crime

The contemporary war on drugs, like Prohibition in an earlier generation, has drawn the attention of organized crime, generating expanded opportunities for cooperation and competition among the various criminal groups seeking entry into this illegal market. While the Mafia may be the best-established criminal group involved in the American drug trade, many of the nontraditional groups vying for a share of the action are better organized, both nationally and internationally, and more violent. Specialization in drug trafficking is one of the hallmarks of the emerging criminal syndicates that experts refer to as nontraditional organized crime; they can also be found operating in other criminal rackets like gambling and prostitution. Although various Asian gangs, primarily of Chinese origin, have been active in the United States since the 1850s, they are also labeled nontraditional organized crime.

The Chinese Triads are among the most feared and interesting criminal syndicates that operate in the United States. Overseas the Triads are heavily engaged in illegal gambling, prostitution, and extortion; inside the United States they generate millions of dollars trafficking in opium products such as heroin. Like many criminal syndicates, Triads are principally involved in the importation and wholesale distribution of narcotics; however, because of their close ties with American Tongs and Chinese-American youth gangs, Triads have ready access to street-level markets. Youth gangs are also instrumental in protecting the Triad/Tong narcotics turf from infiltration by competitors (i.e., rival African-American groups) through intimidation and violence.

Mexico is also home to a number of powerful organized crime groups. Mexican cartels, also considered nontraditional organized crime, vividly illustrate the brutality of drug trafficking. For many years the Juarez Cartel has controlled the El Paso, Texas, gateway for drug traffic. Authorities believe that the Juarez Cartel is responsible for more than 300 drug-related disappearances in Mexico, more than 120 drug-related homicides, and 73 disappearances in El Paso. In a separate incident in 1998, a U.S. border patrol agent confronted and was murdered by narcotics smugglers along the Arizona-Mexico border. Events such as these along the U.S. border with Mexico are part of a larger

pattern in which organized criminals attempt to maximize its profits by protecting shipments and territory through the use of deadly force.

Another nontraditional organized-crime group making headway in the United States is the Russian Mafia. With the collapse of the Soviet Union, the Russian Mafia, or *vorovskoi mir*, emerged as an important criminal organization in both Russia and America, supplying coveted but illegal goods and services in both markets. In addition, the Russian Mafia is intimately tied to the political and economic structure of Russia, much more so than most organized crime groups. Russian businesses, for example, often have little choice but to turn to criminal syndicates for investment capital. While many Russian gangs are local or national, more and more are establishing international links, including links to the United States, where they are involved in multiple rackets, including drug trafficking and securities fraud.

Organized Crime and the Media

The mass media both reflect and shape public perceptions of organized crime. Films such as *Goodfellas* (1990), television shows like *The Sopranos* (1999), and books like Mario Puzo's *The Godfather* (1969) all portray Italian-Americans as the primary perpetrators of organized crime. Furthermore, stories of organized crime in the news often focus on only the most superficial and sensational crimes. This coverage leaves the public with the view that this type of criminal behavior, while somewhat romantic, is excessively violent. In all likelihood, members of crime syndicates go out of their way to avoid exposure to such violence. Thus the media has fueled society's appetites for stories about mobsters while at the same time obscuring the reality of organized crime groups by providing stereotypical images of their members, their modes of organization, and their activities. Suffused with the romance of death and daring in the popular imagination, the bulk of organized-crime activities carry all the panache of a corporate board meeting or an accountant's balance sheet.

See also: FIREARMS; HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; HOMICIDE, EPIDEMIOLOGY OF

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ORPHEUS

Orpheus, according to Greek myth, is one of the few who descended into Hell and lived to tell about it. The son of Oeagrus (King of Thrace) and the muse Calliope, he is famous for his musical and poetic gifts inherited from Apollo and the Muses. His lyre and his odes were so charming that upon hearing them, wild animals became quiet, and trees and rocks started to move.

Orpheus fell in love with the nymph Eurydice and married her, but she died suddenly from a snake bite. In despair, Orpheus followed Euridyce into Hades (Hell) to bring her back. His music and lyrics enchanted Hades' protectors, even the triple-headed dog, Cerberus, and the gods of Hades were persuaded to bring back to life his dead wife. One condition of Eurydice's return was that he could not look back at her until he reached the threshold of Hades. Orpheus looked back to see whether Eurydice was following him and lost her forever.

Orpheus's death is subject to many interpretations, but the most common is that the Thracian women, jealous of his love and fidelity toward his deceased wife and hurt by his indifference, tore his body to pieces and threw his head and lyre into the river Hebre. His remains finally reached Lesbos Island, the cradle of lyric poetry. Orpheus is also

considered an initiate, a prophet who retained secrets from the afterlife, having brought back revelations from his descent into Hell.

The Orpheus myth has inspired many forms of artistic representation, among them the vanished Polygnote fresco (fifth century B.C.E.), which presented Orpheus during his descent into Hell, that has now disappeared; *Orfeo*, a musical drama by Monteverdi (1607); *Orph'ee aux Enfers*, a spectacular opera by Offenbach (1858) and *Le testament d'Orph'ee*, a film by Jean Cocteau (1959).

See also: CHARON AND THE RIVER STYX; OPERATIC DEATH

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OSIRIS

In Ancient Egyptian mythology, Osiris was the god of the beyond whose death and resurrection brought a guarantee of an afterlife to mortals. He was a kindly Pharaoh, teaching agriculture, music, arts, and religion to his people. Jealous of his successful reign, his brother Seth killed him with the help of many accomplices and took control of Egypt. However, Seth's reign was foreshortened by Isis's great love for her husband and brother Osiris, whom she brought back from the dead. A skillful magician, she gave Osiris breath by flapping her wings above him while she transformed into a bird. Osiris and Isis then conceived Horus, their beloved son. Seth, seething in anger, killed Osiris once again, this time by cutting his body to pieces and throwing them into the Nile River. Isis, with the help of Anubis, the god with the jackal head, reconstituted Osiris's body with bandages and embalming rites, thus creating the first mummy. During this act, the god Thoth recited an incantation. Finally, Horus avenged his father Osiris in a bloody

duel with Seth in which Horus lost his eye, which was then given as a food offering to Osiris.

Each of the ceremonies which were followed after Osiris' death, became the actual rituals that the Egyptians performed to ensure access to the eternal life after death. Egyptians performed mummification of the body to preserve it eternally, recited incantations to facilitate access to the hereafter and provide gifts to help them on their voyage. The deceased's soul proceeds to Hell and must appear before Osiris's Court, which weighs the soul's good and bad actions; the heart must be light as a feather to obtain salvation. Otherwise, the consequence is torment and destruction.

In pictorial representations, Osiris is portrayed wearing the white clothes used in mummification;

he typically holds the king's scepter and the judge's whip, symbols of supreme authority.

See also: CANNIBALISM; GODS AND GODDESSES OF LIFE AND DEATH; JESUS; SACRIFICE

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PAIN AND PAIN MANAGEMENT

In June 2001 a California jury awarded \$1.5 million to the family of a terminally ill eighty-five-year-old man, finding the doctor liable for elder abuse and reckless negligence because he had failed to order appropriate pain medication. This court judgment brought the issue of pain control for the terminally ill into sharper focus. The thought of dying in pain can contribute to the desire for suicide or assisted suicide. Since the 1990s a movement has emerged to improve pain management and thereby reduce the anxiety of both patients and caregivers.

What Is Pain?

Pain has been characterized in a variety of ways. There are physical definitions such as an unpleasant sensation; a warning that something is wrong; or the body's response to a thermal, chemical, or mechanical injury. There are also definitions that attempt to provide a meaning or explanation. For example, pain is a punishment; it lets the body know it is alive; it is a teacher helping to modify future behavior; or it is "all in one's head."

Two definitions have become particularly influential among health care providers, educators, and researchers. The International Association for the Study of Pain (IASP) proposes that pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Margo McCaffery suggested as early as 1968 the widely accepted definition, "Pain is whatever the

experiencing person says it is, existing whenever the experiencing person say it does" (McCaffery and Beebe 1989, p. 7). Both definitions point to the fact that pain is much more than tissue damage that triggers a response from the nervous system. The management of pain therefore involves more than treating the tissue injury. The individual's cultural background, present circumstances, and state of mind all require assessment and attention. It has become clear that cultural learning leads to differences in the way that people express pain. Furthermore, it is also becoming increasingly accepted among the medical community that, in contrast to previous medical beliefs, children feel pain even when they are too young to express it effectively. Elderly people may also have different, less obvious, ways of expressing pain, especially if affected by Alzheimer's disease. Health care providers are therefore improving their expertise in recognizing signs of pain across a broad span of patients.

How Does Pain Work?

Research about pain is still limited, but is going forward on many fronts. A major focus is the search for a molecular description of how a pain stimulus is signaled to the brain and how the brain signals its response. Until that process has been firmly identified, caregivers and researchers can utilize the following overview of pain pathways.

Cell damage occurs. Proteins trigger specific channels that set off the pain signal. As chemicals are released the area becomes inflamed and swollen. Identification of the specific pain channels may lead to the development of highly selective

local anesthetics with reduced side effects for the rest of the body.

When the tissue damage threshold is reached, nerve fibers in the area carry a message to the spinal column. There are three types of nerve fibers, each of which has a distinctive role in producing pain sensations. Small, myelinated fibers known as *A delta* carry localized and sharp thermal and mechanical impulses to the neospinothalamic tract. The small, unmyelinated *C fibers* carry aching, throbbing, burning, dull, unlocalized messages to the paleospinothalamic tract and on to the brain stem and thalamus. *A beta fibers*, which are large and myelinated, serve to inhibit impulses from the A delta and C fibers, thereby modulating the number and intensity of impulses sent up the spinal tracts.

The physiologist Patrick Wall, one of the world's foremost authorities on pain, describes what happens in the dorsal horn of the spinal cord, "If the input message comes only from the large A beta fibers as a result of touch, the cell fires briefly and then is turned off. If, however, the input volley comes from tissue damage detection fibers, A delta and C, the cell fires more vigorously and exaggerates the output. During all this time, the brain is sending down control messages to amplify, diminish, or ignore the signal" (Wall 2000, p. 40). An example of this occurs when hitting one's shin on a sharp object. The immediate response is to reach down and rub the area. The rubbing message is carried by the A beta fibers closing the gate to messages from the A delta and C fibers.

Once in the spinal cord the messages cross to the opposite side of the spinal column. Next they travel upward through the spinothalamic tract, conveying information about the nature and location of the stimulus to the thalamus, cerebral cortex, and spinoreticular tract. This process activates autonomic and limbic (motivational-affective) responses in the brain stem and thalamus. Messages descend the spinal cord as a result of these responses.

It is in the brain stem and the cerebral cortex that the pain messages are analyzed. Here the body meets the mind. While little research is available, there are theories and some pieces of the puzzle to suggest what is happening.

Endorphins. Endorphins are important pieces of the puzzle. Scientists know something of the

body's defenses against pain. Some neuropeptides, such as Substance P, appear to be pain specific transmitters. Other peptides, such as the endorphins and enkephalins, provide profound analgesic (pain-relieving) effects. Morphine and other opioid medications were in use long before the opioid receptor sites in neural tissue were discovered in the 1970s. The word *endorphin* was coined as a contraction to the terms *endogenous* (meaning "a natural property of the body") and *morphine*. Methods to turn on secretion of the endorphins have been studied. Massaging or moving a painful part may owe some of its effectiveness to stimulating endorphin production. The "runner's high," a good feeling as a result of exercise, has also been attributed to endorphin release.

Placebo response. Less well explained is the "placebo effect." This occurs when a treatment produces an effect primarily because of its intent rather than its specific therapeutic physical or chemical properties (e.g., taking a pill that actually contains no medicine). People sometimes report that they feel better even though they have had only the expectation and appearance of a treatment. The double-blind research technique that pits a new drug against an inactive substance has been developed to offset the placebo effect. The placebo would be expected to produce no effects. In actuality, however, placebo users frequently report positive effects. An important aspect of the placebo effect seems to be that the person trusts the person administering the treatment and believes that the treatment will be effective. The placebo effect can be a useful supplement to therapeutic treatment but its effectiveness differs markedly from person to person and is not entirely reliable.

Both the presence of endorphins and the well-documented placebo response point to the power of the mind-body connection in pain management.

Treatment of Pain in the Terminally Ill Person

Pain is the most common symptom experienced by hospice patients. The World Health Organization has estimated that more than two-thirds of patients in the advanced stages of cancer experience pain. Other studies confirm this estimate. Unrelieved pain leads to fatigue, nausea, and loss of appetite.

Daily activities and sleep patterns are disrupted. The patient may experience depression and anxiety that damage relationships because loved ones do not know what to say or do.

Careful assessment of the patient's pain is the starting point for achieving adequate control. Patient and family understanding of the purpose and goals of assessment enhance communication with the health care provider. Patient communication starts with awareness of the location, quality, and intensity of the pain. "Stabbing," "throbbing," "burning," or "cramping" help identify the quality of the pain. Choosing words carefully can help the health care provider understand the pain and monitor changes in the quality over time.

The intensity of pain is often monitored through the use of a pain scale, typically asking the patient to choose a number from one (no pain) to ten (worst pain). The Waley/Baker Faces Rating scale, depicting five faces (from smiling to frowning with tears) assists children and some adults to indicate pain intensity. Health care providers also ask about the factors that precipitate or aggravate the pain. Patients are asked to identify any ways they may have discovered to control the pain and how they carry on with their activities of daily living.

Understanding the meaning of pain can be elusive for both the patient and his or her family and the health care provider. The patient's background, beliefs, and values can affect how the pain is interpreted and consequently the expectations for pain control. For example, some children have been raised to bear scrapes and injuries without tears and sobs, and some have learned to keep their vulnerabilities to themselves when in the company of strangers. Still others have been taught that suffering is a test of spiritual strength, therefore it is a moral weakness to admit to pain. People with such backgrounds may inhibit their expressions of pain even during a terminal illness. It is then up to the caregivers to detect signs of suffering and provide relief without challenging the patient's intention to appear in control of herself.

Thorough assessment of the many factors of pain is essential when selecting appropriate treatment. The patient and health care provider form an active collaboration. Confidence that the health care provider understands the patient and that the pain will be managed is a crucial first step to



A terminally ill cancer patient who advocated for euthanasia in a 1999 Australian television commercial, said that she takes twenty pills a day in addition to three doses of morphine but is still in pain. Control of pain is a major concern at end-of-life treatment because terminally ill patients tend to have suicidal thoughts or make suicide attempts. AFP/CORBIS

achieving control. The partnership with the health care provider is even more important when the patient is facing the end of life. Pain, with no prospect of relief, leads to profound hopelessness in many patients.

Techniques to Control Pain

Often patients and family assume that new and increasing pain must be expected. In actuality, a search for cause should be conducted at the earliest possible time. Identifying potential causes of pain can lead to effective prevention and control. The same approach should also be used with regard to other symptoms, such as constipation, pressure ulcers, and respiratory difficulties. These symptoms can often be prevented with attentive care.

Regular comfort measures deserve constant attention. As energy for activities of daily living and self-care wanes near the end of life, it is not uncommon for the patient to omit regular movement, mouth care, and basic physical cleanliness. Assistance with passive exercises, bathing, tooth brushing, and hair care may not seem like pain control, but in actuality these details can play a big part in maintaining comfort. A warm shower, if possible, provides dermal stimulation, relaxation of muscles,

and a decrease in anxiety because it is such a routine part of life.

Use of Noninvasive Pain Control Measures

The first methods of pain control probably included stimulation of the skin with heat, cold, massage, and vibration, all of which have the ability to relieve pain without causing injury, at a low cost, and with little experience. Other types of stimulation of the skin include massage with menthol-based lotions, transcutaneous electrical nerve stimulation (an electrical current administered through skin patches), and acupressure (gentle pressure applied to acupuncture points).

Rubbing a bumped shin or applying a cool cloth to a forehead works to relieve discomfort. A parent's kiss to make everything "all better" helps a child through a painful experience. It reminds the individual that the presence of a loved one has a role in relieving pain.

Assisting the patient to focus attention on stimuli other than pain is another effective noninvasive pain control measure. Because the pain stimulus does not go away, but instead becomes "more bearable," this strategy has the advantage of being under the patient's control. It is also inexpensive. Many patients use the distraction strategy without realizing it by watching television, reading, doing crossword puzzles, listening to music, or attending to the company of friends and relatives. Meditation and guided visual imagery are also in this group of therapies. A disadvantage is that the existence of the pain may be doubted by others if the patient can be distracted. Distraction requires concentration and may drain the energy resources of the patient, perhaps leading to increased fatigue and irritability. The method is particularly effective for brief painful episodes.

Freedom from skeletal muscle tension and anxiety produces the relaxation response, characterized by specific physiological responses (decreased oxygen consumption, decreased respiratory rate, decreased heart rate, decreased muscle tension, normal blood pressure, and increased alpha brain waves) and a lowering of the subjective sense of distress. Conscious attempts can be made to interrupt the cycle of pain that leads to anxiety and muscle tension with increased pain as a result. The relaxation response requires active patient involvement. Many patients need specific

instruction to invoke the relaxation response effectively. Some techniques include deep breathing exercises, jaw relaxation, review of peaceful past experiences, and a meditative or progressive relaxation script or tape.

Use of medication. While the noninvasive therapies are useful for mild pain, they should be considered supplements to the effective management of moderate to severe pain. Moderate to severe pain are often treated with medication and invasive pain control measures.

The World Health Organization developed the "analgesic ladder" to illustrate a systematic plan for the use of pain medication. Mild pain is treated with medications such as aspirin, acetaminophen, and non-steroidal anti-inflammatory drugs (NSAIDs). Maximum recommended doses of these drugs restrict amounts in order to prevent toxicity and damage to the liver and kidneys. As pain increases, opioids such as oxycodone may be used. Severe pain requires morphine or other long-acting opioids. The dose is matched to the pain level. Although there are side effects to these drugs, the amount of drug is not limited. If pain level increases, the route by which the medication is given may change from the slower acting oral route to a faster route, whether transdermal, transmucosal, or intravenous. It is important to avoid routes that actually cause pain, such as intramuscular injection.

For continuous pain, medical practitioners often maintain that continuous pain medication should be available. This requires drugs that are long acting and given on a continuous schedule. The goal is to keep pain in check, rather than waiting until it is out of control before administering more medication.

Side effects of the drugs should be anticipated and prevented. The most common and preventable side effect of the opioids is constipation. Prevention includes adequate fluid and fiber intake and the possible use of stool softeners and laxatives.

It is important to remember that withstanding pain uses energy. When pain is first adequately relieved with medication, the patient may sleep for an extended period of time. This sleeping does not indicate that too much medication is being taken, it means that the person's body is recuperating and regaining energy. This sleepiness can lead family and caregivers to fear that the disease is progressing or that too much medication is being given. If

the person arouses easily, then it is an indication that he or she is not taking too much medication.

Invasive Pain Relief Strategies

Some approaches to pain relief are called invasive because tissue damage may be caused by the procedure itself. The procedure may involve stimulation of nerves, the spinal cord, or areas of the brain. Blocking the nerves with medication or by actually cutting the nerve may reduce pain. These approaches may be useful if the patient is not able to withstand extensive surgical procedures. Acupuncture is considered an invasive approach to pain because the needles enter the skin. It is unknown whether acupuncture analgesia is superior to placebo analgesia or other types of hyperstimulation procedures.

Self-Management Concept

The fear of unrelieved pain raises anxiety for terminally ill patients and their families. Many caregivers remember instances when they felt helpless in the face of pain. Giving the patient information about pain leads to better pain control and lowered anxiety. The confidence that pain will remain in control and the continued presence of the health care provider can go a long way to assure that pain will not be an issue at the end of life.

The patient plays a significant role in providing information about the pain and in selecting and using diverse pain control methods. The patient is the best judge of the adequacy of control. Caregivers may hear statements such as the following that express personal preference:

- “It is okay if I only have pain when I move.”
- “I want to continue to be up and walking, so I will need more medication.”
- “A warm shower, meditation, and pain medication at bedtime helps me get a good night’s sleep.”
- “I just want to have no pain. I don’t care if all I do is sleep.”

The adequacy of pain control can be judged by the patient’s feeling of comfort and ability to participate in activities of daily living. The goal of complete freedom from pain may not be achievable.

Fear of addiction is often an issue with pain control, especially when opioids are used. Psychological dependence is a pattern of compulsive drug

use characterized by a continued craving for an opioid and the need to use the opioid for effects other than pain relief. Addiction resulting from medical treatment regimen is extremely rare. On the other hand, the need to increase doses over time is not uncommon because of tolerance for the drug or changes in the disease process. Other drugs may be added to the regime. Medical practitioners cite the importance of not abruptly stopping the medications.

Health care providers themselves may be a barrier. It is important to seek out providers who believe the pain is real, who are willing to provide diverse approaches to the pain, and who plan for continued contact. Concerns about providing sufficient medication to relieve pain without precipitating the death of a terminally ill person should be discussed openly. If large doses of opioids are required, the physician may be hesitant to order them and nurses may be reluctant to administer the needed dose because the actions might be considered performing euthanasia or assisting suicide. The line between relieving pain and hastening death may not be clear. Patients can help with the ethical issues by making their wishes clear and by seeking the assistance of a like-minded counselor or medical professional in explaining their preferences.

Pain Management: The Future

Research concerning the physiologic mechanisms of pain continues in the early twenty-first century. These research efforts will most likely reveal new, more specific pain control measures. In the meantime, the controversy between governmental control of opioids to prevent abuse and the need for opioid use for pain relief continues. Professional care providers need education and organizational support that establishes standards and accountability for pain management. A recent initiative to require that pain be assessed as often as the patient’s temperature, heart rate, respiratory rate, and blood pressure are taken provides a starting place for standards and accountability. Dissemination of information about pain-relieving drugs and other interventions remains crucial to quick, effective responses to pain. Access to analgesic medication and pain is crucial. Paying for the cost of health care should not become a barrier to pain management. Professionals must continue to advocate for patients in pain as American society struggles to afford health care for the entire population.

The public should be appropriately educated about pain and pain relief if it is to advocate for the use of pain medications. Fears that medication will cause addiction and the inability to experience and control life decisions prevents use of some effective pain measures. Patients' fear of stigma if they offer complaints of pain can keep providers from understanding patients' extent of pain and thus appropriately treating it.

Researchers and leading edge practitioners agree that people in pain can be empowered by knowing what to expect from health professionals in relation to pain management. Assessment of the pain and its causes is the first step. Professionals should seek a clear understanding of the meaning of the pain to the patient and family. Multiple approaches to the pain can be recommended. Concerns about addiction and other effects of the controls measure can be addressed through patient education and referral to pain specialists. The knowledge, skills, and tools exist to meet the goal that no one should die in pain.

See also: CHILDREN, CARING FOR WHEN LIFE-THREATENED OR DYING; SYMPTOMS AND SYMPTOM MANAGEMENT

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BEATRICE KASTENBAUM

PALLIATIVE CARE

See HOSPICE OPTION.

PARAMEDICS

See EMERGENCY MEDICAL TECHNICIANS.

PERSISTENT VEGETATIVE STATE

Individuals in persistent and permanent vegetative states (both called PVS) are not dead, although philosophers still debate whether they are "people." Their brains still function at a very rudimentary level; they have sleep-wake cycles; and they normally can breathe without assistance. According to the American Academy of Neurology, about 10,000 to 25,000 PVS individuals exist in the United States at any one time. Approximately 50 percent of them have been in this state less than six months and 70 percent for less than a year.

People go into PVS after their brains suffer a lack of oxygen, a lack of sugar, or a similar event. Normally, the onset of a coma is the first stage. If they neither die nor awaken, they lapse into a "vegetative state." Usually, only young trauma victims awaken from this state; older or oxygen-deprived individuals, which is the more common situation, usually do not. After one month health practitioners call the condition a "persistent vegetative state." If their brain damage is the result of a non-traumatic event, adults and children rarely emerge from a persistent vegetative state after being in it for three months. If the damage results from trauma, children rarely recover after being in the state for one year; adults rarely emerge after six months in that state. At some indeterminate time later, the patient's condition transforms into an irreversible "permanent vegetative state."

Physicians with training and experience in PVS make the diagnosis on clinical grounds established by the American Academy of Neurology, which include:

- no awareness of themselves or their environment—an inability to interact with others;
- no reproducible, purposeful, or voluntary responses to visual, auditory, tactile, or noxious stimuli; and
- no ability to speak or to understand language; sleep-wake cycles with intermittent wakefulness without awareness; sufficiently preserved lower brain and brain stem functions to permit survival with medical and nursing care; bowel and bladder incontinence; variably preserved cranial nerve (pupillary, oculocephalic, corneal, vestibulo-ocular, gag) and spinal reflexes.

No diagnostic study can make the diagnosis with certainty. Except in the case of infants with anencephaly, reliable criteria do not exist for making a diagnosis of PVS in infants less than three months of age.

The American Academy of Neurology states that of the adults in a persistent vegetative state for three months after brain trauma, 35 percent will die within a year after the injury. Another 30 percent will go into a permanent vegetative state, 19 percent will recover with severe disabilities, and 16 percent will recover with a moderate or minimal disability. If they remain in a persistent vegetative state for six months, 32 percent will die, 52 percent will go on to a permanent vegetative state, 12 percent will recover with severe disabilities, and 4 percent will recover with moderate or minimal disability. Nontraumatic brain damage markedly decreases the chance of any recovery. After such patients have been in PVS three months, only 6 percent will recover with severe disabilities and 1 percent will recover with a moderate or minimal disability. After six months, no adults who remain in that state recover.

Children have a better chance of recovering from brain trauma than adults. Virtually all children in a persistent vegetative state from causes other than trauma go on to a permanent vegetative state rather than to death. Unlike adults, about 3 percent of these children recover, but always with severe disabilities.

Medical experts differ in opinion as to exactly how those in PVS should be classified. These individuals cannot interact with or experience their environment, feel pain, or communicate in any

way—their thinking, feeling brain is gone. Their condition will not improve, but they can live with medical and nursing support for many decades.

See also: CRUZAN, NANCY; DO NOT RESUSCITATE; END-OF-LIFE ISSUES; LIFE SUPPORT SYSTEM; QUINLAN, KAREN ANN; RESUSCITATION

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KENNETH V. ISERSON

PERSONIFICATIONS OF DEATH

Visitors to the Church of St. Nicholas in Tallinn, Estonia, will recall the representation of death as a bony, dark figure with a skull, as depicted in Bernt Notke's famous canvas, *Danse Macabre* (c. 1460). Many others are acquainted with the image of death as the reaper in Ingmar Bergman's dramatic film *The Seventh Seal* (1957).

Through the ages people have tried to personify death by giving it a humanlike form. Personification is used in this context as the mental transformation of inner thoughts and feelings into autonomous figures. The term *personify* is defined as giving inanimate objects or abstract ideas human characteristics. Formed in this way, death personifications can be considered culture-bound channels to transfer invisible phenomena into external patterns.

Death Personifications in History

In the ancient world, life and death were perceived as two forces of the Great Mother, the oneness of everything. Life was associated with the Good

Mother, and death with the Evil Mother. According to the psychologist Erich Neumann, death is the hungry earth, devouring its own children.

In classical Greek tradition, the unity of life and death is split into opposites. Life is personified as feminine, and death as masculine. Death is named Thanatos, the twin brother of Hypnos, the god of sleep. His mission is to accompany the departed to Hades, the underworld, where the aged boatman Charon ferries them across the Sinister River, which separates the underworld from the world above. In Greek mythology, death is considered inevitable, but not purely evil. Illustrations on Greek vases depict Thanatos and Hypnos as two young men. In European art, literature, and iconography, Thanatos is often portrayed as an earnest, winged youngster holding an extinguished flare.

In Judeo-Christian religion, death is considered exceedingly evil. It is not personified as a human-like figure; rather it is described by its actions. The Old Testament says that humans are cast down in the kingdom of death, which resembles Hades, where the wicked are punished. The Christian concept of death associates death with sin. Sin is regarded as opposition to the will of God, requiring repentance and God's forgiveness. Only in apocalyptic writings is death personified as a human figure, a pale horseman who kills people using violence.

Death Dance

During the plagues (the Black Death) and wars of the fourteenth and fifteenth centuries, personifications of violent death were popular. Throughout this time there was a belief that the skeletonized dead rose from their graves and tempted the living of all ages and ranks to join them in a dance to the death. The "dance of death," or dance macabre, was an allegorical theme in art, literature, and music. It was first embodied in murals, then in woodcuts. The Parisian painter Guyot Marchaut published a portrayal of the death dance in woodcuts and verse (1486), which was circulated throughout Europe. Best known are the fifty-one drawings of the German painter Hans Holbein the Younger (1497–1543), where death is personified as a skeleton, and each individual dances through life embracing his own death.

Death Personifications in Art

This theme of personifying death as a skeleton or a reaper has continued into the twenty-first century. In Sweden the dramatist August Strindberg's play *The Dance of Death* (1901) is filled with macabre medieval symbolism. Bergman's film *The Seventh Seal* personifies death as a man with a hood obscuring his face. In "La Mort et le Bûcheron" (Death and the woodcutter) the French landscape painter Jean François Millet depicts death as the grim reaper. Alfred Kubin paints death as a skeleton in "Blätter mit dem Tod." The Austrian painter Gustav Klimt personifies death in the flamboyantly dressed skeleton in his "Tod und Leben" (Death and life, 1916). Musical renderings of the personification of death include *Totentanz* (1864) by the Hungarian composer Franz Liszt, *Danse Macabre* (1874) by the French composer Camille Saint-Saëns, and *La danse des morts* (1940) by the French composer Arthur Honneger.

Personification of Death in Children and Adults

In 1948 the researcher Maria Nagy observed that Hungarian children had a tendency to personify death as "the reaper" or "the skeleton," a figure that appeared in order to carry people off. Later research in the United States could not confirm Nagy's findings. American children showed no signs of personifying death. In Canada more than thirty years later, Richard Lonetto showed that children tended to personify death as exemplified through their drawings. In Sweden, Maare E. Tamm and Anna Granqvist observed that less than 10 percent of children and adolescents personified death. The personifications of younger children were ideographic, a "death man," while those of older children were formed from cultural symbols. All children personified death as masculine.

Personification of death in adults is studied in the United States by Robert Kastenbaum and Carol Herman. In 1997 they found that females most often select "kind and gentle" imagery, as "the gentle comforter" or "the gay deceiver," while males are more likely to see death as a "cold, remote" person. Grim and terrifying personifications of death were infrequent. In Sweden, Maare E. Tamm found that a majority of the adults studied personified death as an old man, the reaper figure being the most apparent personification.



Similar to Gustave Doré's nineteenth-century engraving *Death on a Pale Horse*, death is most commonly personified as a skeleton or reaper by children and adults.

BETTMANN/CORBIS

Conclusion

Death has been personified through the ages; in the ancient world as a feminine figure, and from classical Greek civilization to the present as a masculine figure. When the plague raged throughout Europe, death acquired a violent, frightening, and macabre image. The image of the "grim reaper" is preserved in art and literature, and in people's minds, to the present day. It is hard to say how death will be portrayed in future decades, when new technology like the Internet and virtual reality introduces new ways of thinking in philosophy, theology, and the human mind. Certainly people will continue to personify death in some way because there is a universal tendency among humankind to understand the world as a humanlike entity, and personification of an image—in this case death—makes its qualities more palpable and less terrifying.

See also: ARS MORIENDI; BLACK DEATH; BLACK STORK; DANSE MACABRE; VAMPIRES

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MAARE E. TAMM

PHILOSOPHY, WESTERN

"The hour of departure has arrived, and we go our own ways—I to die, and you to live. Which is better God only knows" (Edman 1930, p. 88). These dramatic lines, spoken by Socrates at the end of Plato's *Apology*, are among the most memorable in the history of Western philosophy. Their implication that death is a blessed relief from the suffering that is life has proved a watershed in Western philosophical attitudes toward life and death, with some subsequent thinkers echoing their otherworldly metaphysics and others, like Nietzsche, countering with a passionate affirmation of life against death. Because a philosophical verdict on death entails a judgment on life as well, no issue is more central to the metaphysical controversies that have marked the history of Western philosophy nearly from the beginning.

Ancient Period

The first philosophers in ancient Greece (c. 600 B.C.E.) were cosmologists chiefly concerned with the origin and nature of the universe, so the meaning of death to humans was not a prominent issue in their work. The first of these thinkers was Thales, who described the universe as “full of gods,” a view that seems to imply that the universe is alive and that there is no such thing as dead, inert matter. Anaximander, who was Thales’s student, seems to have been the first to suggest an evolutionary mechanism for life and for the human species. About death he says, “Things perish into those things out of which they have their being, as is due . . .” (Guthrie 1971, p. 76), seeming to imply that death and change are natural parts of the cycle of life. For Anaximenes, life occurs through the breathing in of air, seen as a divine element and the nature of soul itself. He offers the first purely naturalistic explanation of death. It occurs, he explains, when the creature is no longer able to respire and the outside air can no longer enter in to counteract compression.

Heraclitus spoke of death more often than his contemporaries. For him death is a basic feature of the universe, for he believed in the periodic consumption of the universe by fire. In his cosmology, the whole world and each creature in it are in a constant state of flux, and each element lives by the death of the other. The processes of life and death are a necessary feature of the world; he argues that without them the cosmos would disintegrate. Heraclitus was among the first to suggest that not all souls perish at death; virtuous souls, he believed, may rejoin the divine spark itself. Pythagoras, the philosopher and mathematician, elaborated a doctrine of reincarnation or transmigration of the soul; in his view, life and death involve a process and a progress through many series of physical forms (human and animal) with the goal of achieving a spiritual purity leading to an ultimate reunion with the state of divine origin.

The survival of the spirit or mind after the death of the body is supported in other pre-Socratic thinkers such as Empedocles and perhaps Anaxagoras. But this view met a stiff challenge in the materialist metaphysics of the atomists Leucippus and Democritus. The atomistic theory suggests that all things in the universe are composed of indivisible particles of matter (*atomoi*); at death the

atoms simply disperse, and there is no survival of the individual. Atomism is the last great theory offered by the philosophers before Socrates, and the theme is picked up again by Epicurus, with important consequences for human dealings with death.

With Socrates, the gadfly-philosopher of the ancient Greek agora, the topic of death achieves more focus. The *Apology*, recounts Socrates’ (469–399 B.C.E.) unjust condemnation to death by a court in Athens. Before leaving the court, Socrates requests to speak to his friends on the subject of his impending execution. He reasons that death is not an evil; in fact, he argues, “There is much reason to hope for a good result. . . . Death is one of two things. Either it is annihilation, and the dead have no consciousness of anything, or, as we are told, it is really a change—a migration of the soul from this place to another” (Hamilton and Cairns 1961, p. 25). If death is a state of nothingness, he argues, it will be like an eternal sleep and therefore will be a gain and nothing to fear. If death is migration of the soul into another world, a spiritual world of true judges, then there is also nothing to fear because no evil can await a good and just person. So, Socrates concludes, the good person can be of good cheer about death, and know for “certain—that nothing can harm a good man either in life or after death” (p. 41).

Plato (428–348 B.C.E.) took a more definite stand than his mentor Socrates (though because Plato made Socrates the major character in *Dialogues*, it is sometimes hard to distinguish between the two). Plato believed that death is most definitely not an eternal sleep but rather the moment at which the soul (that is, the true person) is finally released from the body (its earthly prison). In the *Phaedo*, there is no either/or argument. Rather, Plato attempts to prove the immortality of the soul, offering reasons why the real philosopher, who is “always pursuing death and dying,” should never fear the end. In the *Phaedo* no less than four arguments or proofs are offered; all of them, however, depend on two main Platonic premises: a dualistic view of the relation between the body and soul, and the conviction that the core of true being is the soul, which survives the death of the body. Perhaps the most widely discussed argument is the last offered by Plato: The soul is incapable of death because death is, after all, decomposition (wherein the dying subject is dissolved), but the

soul, being simple and uncompounded, cannot decompose.

Aristotle (384–322 B.C.E.), Plato's greatest student, did not share a similar conviction about the immortality of the soul. In *De Anima* (On the Soul) he denies the Platonic dualism of soul and body, arguing instead for a far closer relationship: the soul, he says, is the "form" of the body. The comparison he makes is that between the pupil and the power of sight: "As the pupil *plus* the power of sight constitutes the eye, so the soul *plus* the body constitutes the animal. From this it indubitably follows that the soul is inseparable from its body, or at any rate that certain parts of it are (if it has parts) . . ." (McKeon 1941, p. 556). As the son of a physician, Aristotle was much more closely attuned to the material world than Plato; he viewed the human being as a preeminently biological creature, a member of the animal kingdom. Aristotle was the first of the philosophers to carry out detailed study and writings on animals in *De Partibus Animalium* (On the Parts of Animals), a topic he pursued in such biological writings as *De Generatione et Corruptione* (On Generation and Corruption), where he studies "coming-to-be and passing-away" as changes uniformly found in all of nature, and *Historia Animalium* (The History of Animals).

While it is clear that Aristotle denies the Platonic dualism and the consequent views on immortality—indeed, he seems to suggest that a desire for immortality is a wish for the impossible—it is not certain that he believes that death is the final end of the soul entirely. The highest part of the soul, the purely intellectual part, is akin to the divine, he argues, and may survive death. Aristotle does not elaborate on this possibility, but it is clear that this cannot be a belief in the survival of the whole person (such as in Plato's view), since for him the person is a union of body and soul together, and at death that union no longer exists.

Classical philosophy after Aristotle concerned itself with practical issues of living, especially the quest for happiness and peace of mind. Epicurus (341–271 B.C.E.), who was introduced to the writings of Democritus in his early teens, propounded an atomistic metaphysics and the attendant skepticism toward an afterlife. For epicureanism, the goal of each human being is tranquility (*ataraxia*) of soul. This tranquility can be achieved only after certain fears are conquered—chiefly, the fear of

the gods and of death. Atomism solves both fears at once, he argues, while at death the subject ceases to exist and therefore is touched neither by the gods or the experience of death itself.

As Athens gave way to Rome as the cultural epicenter of the ancient world, the philosophy of stoicism grew in prominence and influence. Among its most eloquent expositors was the Roman emperor Marcus Aurelius (121–180), whose *Meditations* is an especially rich source of reflection on the meaning of life in the face of death. Stoicism emphasizes acceptance of that which is outside of human control, in particular, the workings of nature, seen as a divine and governing force. Aurelius viewed death as either a cessation of sensation or as an ascent to the divine—and hence nothing to fear in either case.

Medieval Period

The Middle Ages saw a gradual convergence of philosophical and theological concerns. The great thinkers of this age were theologians first and philosophers second. Augustine (354–430) held firm to the Christian notions of the human predicament. The human being is in a state of misery because of a diseased condition brought on by original sin, for which the chief punishment is death. In Augustine's view, God created human beings to live according to his commandments. In the *City of God*, Augustine argues that should the human being live righteously,

He should pass into the company of angels, and obtain, without the intervention of death, a blessed and endless immortality; but if he offended the Lord his God by a proud and disobedient use of his free will, he should become subject to death, and live as the beasts do, the slave of appetite, and doomed to eternal punishment after death. (*Dods 1872, XII, p. 21*)

But there is a way out of this misery. Augustine, accepting the Platonic dualism, believed that the soul was the true person and can exist apart from the body. The soul, therefore, can escape the misery endemic to earthly life, but only with God's help and grace.

For many medieval thinkers, Plato's thinking provided the necessary philosophical groundwork for belief in an afterlife. For the most part,

the medieval theologian/philosophers welded Platonism to Christianity so firmly that criticism of the synthesis was nearly tantamount to heresy. This dogmatism was reflected clearly in Bonaventure (1221–1274), a Franciscan and Augustinian thinker who rejected the influx of Aristotelian ideas in his time because they seemed to deny the immortality of the soul.

There was the occasional crack in the Platonic/Christian foundation of medieval philosophy. The Islamic theologian/philosophers Avicenna (980–1037) and Averroes (1126–1198) appear to have interpreted Aristotle in such a way to raise doubts about individual immortality. According to this perspective, if anything of the soul survives, it is not the individual person but some divine spark that rejoins its supra-individual source.

It took the towering intellect of Thomas Aquinas (1225–1274) to come to terms with the powerful Aristotelian system and the consequences for Christianity of its clear-cut denial of the mind-body dualism. For Aristotle, the soul is not trapped in a body but is naturally allied with it. Although this conception makes it harder to disentangle a distinctly immortal soul from the mortal body at death, Aquinas elicits from it support for the Christian notion of an afterlife—that is, a bodily resurrection. Since the soul is united with a particular body, at death this natural unity will be restored through a physical resurrection that reunites body with soul. Christ's own resurrection was, after all, a bodily resurrection.

Modern Period

The Frenchman René Descartes (1596–1650), the father of modern philosophy, provides support for belief in an afterlife. In *Discourse on Method* he writes,

Next to the error of those who deny God . . . there is none which is more effectual in leading feeble minds from the straight path of virtue than to imagine that . . . after this life we have nothing to fear or to hope for, any more than the flies or the ants. (Haldane and Ross 1931, p. 276)

Further, the original subtitle to Descartes's major work, the *Meditations*, was "In which the existence of God and the Immortality of the Soul are demonstrated." Descartes provides an argument for the

immortality of the soul by suggesting a radical difference between the two substances, mind and body, such that mind is in no way dependent on the body for its existence.

Arguments like Descartes's were rejected by those who did not share his radical dualism. The Englishman Thomas Hobbes (1588–1679), for instance, held that belief in an afterlife is a result of religious superstition driven chiefly by the fear of death. David Hume (1711–1776), in "Of the Immortality of the Soul," argues that the case for mortality was strong and asked, "What reason is there to imagine that an immense alteration, such as made on the soul by the dissolution of the body, and all its organs of thought and sensation, can be effected without the dissolution of the soul?" (Hume 1993, p. 406).

An entirely different approach was taken by Immanuel Kant (1724–1804), who provided what has come to be known as the "moral argument" for the immortality of the soul. Kant acknowledged that humankind cannot demonstrate, as a matter of certainty, things like the existence of God and the immortality of the soul. However, in *Critique of Practical Reason*, he writes, "It is morally necessary to assume the existence of God" and that morality requires humankind to pursue a state of complete virtue (*summum bonum*), which is "only possible on the supposition of the immortality of the soul" (Abbot 1927, pp. 218–219).

Among the other major moderns who grappled with human mortality, the French thinker Blaise Pascal (1623–1662) argued in *Pensées* that the human being is unique in having the knowledge of death. In *Ethics*, the Dutchman Baruch Spinoza (1632–1677) wrote that "a free man thinks of nothing less than death, and his wisdom is a meditation not of death but of life" (Elwes 1919, p.113). Some interpret these lines as simply a recommendation to avoid consideration of death because it arouses wasteful fears. On this interpretation, Spinoza's advice is similar to that of the French essayist Michel de Montaigne (1533–1592), who, in *Essays* wrote that humans should adopt the attitude of the simple, nonphilosophical person and not "have death constantly before our eyes" because "nature teaches [him] not to think of death except when he actually dies" (Zeitlin 1936, p. 208). Others see in Spinoza one who became a

free and wise man only after much thought about death and much grappling with his fears about it, so that what he really meant was that a wise and free man will become so only after confronting and conquering death.

Contemporary Period

Reflections on death and dying in the nineteenth and twentieth centuries extended and reshaped the themes discussed in the modern period. The existentialists, in particular, follow the lead of the German Arthur Schopenhauer (1788–1860), who called death the “muse of philosophy.” Schopenhauer, in *The World As Will and Idea*, states “all religious and philosophical systems are principally directed toward comforting us concerning death, and are thus primarily antidotes to the terrifying certainty of death” (Haldane and Kemp 1948, p. 378).

Existentialist thinkers, beginning with Søren Kierkegaard (1813–1855) and Friedrich Nietzsche (1844–1900), were directly concerned with contemplating the deeper meanings of death. Kierkegaard, the father of religious existentialism, begins by contemplating the meaning of existence itself, rather than engaging in philosophical abstractions; he wrote that it was easier to indulge in abstract thought than it was to exist. For him, existence requires passion and truth—and not just any truth, but a truth for which he can live and die. The most important existential truths for Kierkegaard were not those available to objective reason, but those which require subjectivity (or passionate inwardness), courage, commitment, and faith. For Nietzsche, the father of atheistic existentialism, truth required courage. The courageous individual, however, will have the courage to face the inevitable fact for Nietzsche that “God is dead.” For Nietzsche, this means that there is no cosmic order, purpose, or meaning in the universe or in human life. What is required is to create one’s own order, purpose, and meaning by facing and then slaying death. In *Thus Spake Zarathustra*, he says that what is required is courage which “is the best slayer—courage which attacks: which slays even death itself” (Kaufmann 1954, p. 269).

The twentieth-century existentialists continued the exploration into death as a necessary theme for anyone seeking “authenticity,” as Martin Heidegger (1889–1976) put it. In his view, it was all too easy

to fall back into an artificial, inauthentic life by ignoring the reality of death and by failing to recognize that the human being is, after all, a “being towards death” (Heidegger 1962, p. 296). Heidegger argues that authenticity comes only in the recognition of human temporality and finitude. For the French thinker Albert Camus (1913–1960), the reality of death must not only be accepted, but it also provides evidence of the “absurd,” the lack of any real correspondence between the desires of humankind and the cold, dark universe. The French existentialist Jean-Paul Sartre (1905–1980) followed Nietzsche in rejecting God or any attempt to ground meaning objectively in the universe itself. For Sartre, meaning was found in human freedom, but death was not an obstacle to an individual’s freedom. As he states in *Being and Nothingness*, “Death is not an obstacle to my projects; it is only a destiny of these projects elsewhere. And this is not because death does not limit my freedom but because freedom never encounters this limit” (Barnes 1956, p. 547). In a sort of atheistic existentialist version of Epicurus, death is seen as that which a meaningful life never encounters. As Sartre explains, meaning requires subjectivity (as in Kierkegaard), and “I myself escape death in my very project. Since death is always beyond my subjectivity, there is no place for it in my subjectivity” (p. 548).

The analytic philosophers, being drawn to issues of language and logic, perceived the whole topic of death as being outside the proper study of philosophy since, in their view, it is hopelessly bound up with religion and metaphysics. The English philosopher A. J. Ayer (1910–1989), in *Language, Truth, and Logic*, is typical in demanding empirical evidence for belief in an afterlife because “all the available evidence goes to show that it is false” (Ayer 1946, p. 117). Bertrand Russell (1872–1970) went further in *Why I Am Not a Christian*, declaring:

Man is the product of causes which had no prevision of the end they were achieving; that his origin, his growth, his hopes and fears, his loves and beliefs, are but the outcome of accidental collocations of atoms; that no fire, no heroism, no intensity of thought and feeling, can preserve an individual life beyond the grave; that all the labors of the ages, all the devotion, all the

inspiration, all the noonday brightness of human genius, are destined to extinction in the vast death of the solar system, and that the whole temple of man's achievement must inevitably be buried beneath the debris of a universe in ruins. (*Russell 1957, p. 107*)

The French religious existentialist Gabriel Marcel (1889–1973) countered this point of view. In *Homo Viator* he states, “If death is the ultimate reality, value is annihilated in mere scandal, reality is pierced to the heart” (Crauford 1951, p. 152). Marcel discusses death from several unique perspectives. He speaks of the “death of man” as following upon the heels of Nietzsche’s “death of God.” Marcel does not refer to the death of the human species itself because of some catastrophe such as a nuclear war. Rather, he refers to a radical change stemming from what he calls “techniques of degradation,” wherein the human person is degraded, dehumanized, and treated as a thing or an object rather than as a person. Under this system of depersonalization, the person is already “dead.” However, Marcel finds the possibility for hope. In *Being and Having*, he says that death can be “considered as the springboard of an absolute hope” (Farrer 1949, p. 93). How can death provide hope? An essential part of one’s personhood, he argues, lies in one’s relationship with others, for humans are intersubjective beings. And while other thinkers have focused on what death and dying means to the individual, Marcel explores what death may mean as an avenue for fuller relationships with others—in particular, those that we love. For Marcel, loving transcends the world of things—and nothing that can happen to the world of things (including death) can affect the person.

In the last few decades of the twentieth century, certain postmodern thinkers have revisited the “death of man” theme. The French thinker Michel Foucault (1926–1984), for instance, speaks of the “death of man,” and his countryman Jacques Derrida (1930–) refers to the “ends of man.” Foucault, following Heidegger, also examines death in terms of an “analytic of finitude” (Shuster 1997).

See also: BUDDHISM; CHINESE BELIEFS; HEIDEGGER, MARTIN; HINDUISM; ISLAM; KIERKEGAARD, SØREN; MIND-BODY PROBLEM; PLATO; PLOTINUS; SARTRE, JEAN-PAUL; SCHOPENHAUER, ARTHUR; SOCRATES; ZOROASTRIANISM

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WILLIAM COONEY

PHOENIX, THE

In ancient Greek and Egyptian mythology, the phoenix is a mythical bird associated with the Egyptian sun god Ra and the Greek god Phoibos Apollo. The bird symbolizes resurrection and immortality and has retained its symbolic connotation of life arising anew from the ashes of death. The Romans compared the phoenix with the Eternal City, and even put it on a coin as a symbol of the undying Roman empire. The phoenix as a symbol of resurrection might have appealed to early Christians as well.

According to the Egyptians, the phoenix was as large as an eagle or as a peacock, with brilliant plumage and a melodious cry. According to the Greeks, the bird lived in Arabia. Each morning at dawn the phoenix would bathe in the water and

sing so beautifully that the sun god would stop to listen. Both the Egyptian and the Greek traditions mention that only one phoenix could exist at any time and that it had a long life (from 500 to 1,461 years). Upon sensing its approaching death, the phoenix would build a nest of aromatic wood, set it on fire, and allow itself to be consumed by the flames. From the ashes in the pyre a new phoenix would spring to life that would then embalm the ashes of its father in an egg of myrrh and fly with them to Heliopolis ("the city of the Sun") in Egypt. There it would deposit the egg on the altar of the sun god.

See also: OSIRIS; REINCARNATION

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JEAN-YVES BOUCHER

PLATO

The poet Ralph Waldo Emerson once remarked, "Plato is philosophy and philosophy is Plato" (Emerson 1996, p. 21). No less adulation came from the philosopher Alfred North Whitehead, who claimed that Western philosophy was a "series of footnotes to Plato," (Whitehead 1929, p. 63). These kinds of acclamations give one a sense of the major importance of the thinker originally named Aristocles, who came to be called Plato because of his robust figure. Born into one of the most distinguished families in Athens, Plato (428–348 B.C.E.) seemed destined for a career in politics. This changed mainly because of the influence of his great mentor Socrates (470–399 B.C.E.), who was falsely accused of impiety and corrupting the youth and executed by the state. Becoming

distrustful of politics, Plato decided to carry on the philosophical traditions of his mentor. He founded the Academy, considered the first university in Western civilization, and wrote the *Dialogues*, which continue the eternal questions raised by Socrates.

Plato was especially interested in his mentor's pursuit of real, eternal truths (Justice, Beauty, Goodness), which Plato believed had an existence beyond the mere physical world of flux and change. Accordingly, Plato developed a dualism: There is the physical and changing world (to which the body belongs), and the permanent and immaterial world (to which the mind or soul belongs). The body is then seen as the prisoner and temporary residence of the soul, which has existed before its imprisonment and which will exist again after its release from the body at death. In this way, says Plato, the true philosopher is "always pursuing death and dying" (Emerson 1996, p. 21).

The *Dialogues* offer a variety of arguments for the immortality of the soul. In the *Republic*, Plato argues that the soul cannot be destroyed by any inherent evil or by anything external to it. In his *Phaedrus* he reasons that the soul is its own "self-moving principle" and is therefore uncreated, eternal, and indestructible. And in the *Phaedo* a series of arguments are offered based on the cyclical nature of life and death; knowledge the soul could only have gained in a pre-existence; the incorporeal or spiritual nature of the soul; and the view that the soul is the essence and principle of life itself.

The argument regarding the nature of the soul is perhaps the one that gets discussed by scholars most often. If the soul is incorporeal, it is simple or uncomposed (not made up of parts). But death is the decay and corruption of a thing into its elementary parts (decomposition). The soul, therefore, cannot die since an uncomposed entity cannot be decomposed. The logic of this argument is compelling; however, it depends entirely on its key premise: that the soul is spiritual, not corporeal. This is a major point of contention for many, including Plato's greatest student—Aristotle (384–322 B.C.E.). Though he firmly believed in the immortality of the soul, Plato never considered his arguments to be conclusive proofs and recognized the need for further discussion and consideration, saying that one can only "arrive at the truth of the matter, in so far as it is possible for the

human mind to attain it" (Hamilton and Cairns 1961, p. 107).

See also: PHILOSOPHY, WESTERN; PLOTINUS; SOCRATES

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PLOTINUS

Plotinus (c. 204–270) was the leading exponent of Neoplatonic thinking, which blended Plato's philosophy with religious mysticism. Born in Egypt, he grew up in Alexandria (located on the central coast of Egypt, just west of the Nile Delta) and was educated in the classics. His own teachings quickly gained notoriety, especially in Rome. He did not begin to write until late in life, and his lectures were edited by his student, Porphyry, for the *Enneads*.

Plotinus was attracted to the Platonic metaphysics of transcendence; that is, the location of reality outside of this physical, sensory world, in a suprarational, spiritual world of the "Good." Plotinus used religious/mystical phrases to refer to this reality, such as "the One," "All-Transcending," "Author at once of Being," "The First," and the "Indefinable." His religious views have typically been described as pantheistic, which holds that the divine principle is present in and throughout the entire universe, although a dualistic representation (where the divine and the created universe are seen as separate) could also be supported, given the subtleties of Neoplatonic thought.

Plotinus saw life in the universe as a double movement—first as an emanation from the source (as light emanates from the sun), and then a return back to the divine. The human soul lives in exile on this earth, and desires the return home. One

can achieve “home” in this life through a mystical union with God. Porphyry relates that his master had achieved a mystic state quite often in his life, and that this experience could not be given a completely rational account. One can also reach home through reincarnation (another Platonic influence)—where one can achieve higher forms of life until eventually passing out of the cycle of birth and death. This “emancipation of souls” is accomplished only by a “purification” whereby the soul avoids attachments to the body, in particular, lusts and sensual desires and impulses.

Neoplatonism was one of the chief ways in which the Platonic philosophy was introduced to Medieval thinkers like Augustine, and therefore had major impact on the Christian world.

See also: PHILOSOPHY, WESTERN; PLATO

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POLYNESIAN RELIGIONS

In treating all subjects, including death, Polynesian religions are based on experience rather than faith. Prominent among those experiences are encounters with many different types of gods and spirits. These include human beings who have died and assumed one of several possible forms. For instance, miscarried or aborted fetuses can be transmuted into vicious demons. Neglected souls can become wandering, homeless, pathetic ghosts. Revered relatives can be transformed into family gods. The diversity of such experience stimulates a wide variety of beliefs and practices.

Polynesians believe in life after death. Indeed, the wall between the living and the dead is more permeable than in modern Western culture. When a person is about to die, one of his or her souls can—unbeknownst to him or her—warn the immediate family. Shortly after dying, a person can

visit relatives and friends. The family of the deceased prays for the soul's successful journey to the land of the dead. The dead can linger, however, around the living to whom they were especially attached. Elderly couples continue to converse long after one of them has died. The surviving lover can be pulled toward the new home of the beloved. According to the Polynesian belief system, the world of the living is in continual communion with that of the dead.

Family and friends must, therefore, establish methods for both detachment and attachment. The clothes and belongings of the deceased can be destroyed. At the wake of the deceased, the New Zealand *māori* “trample” through the house to reclaim it for the living. In formal oratory, they call upon the ancestors for their blessing but dismiss them before the body of their speech. Throughout Polynesia, the troublesome presence of a dead person reveals the existence of unfinished business that must be resolved before the soul can depart in peace.

The positive relation to the ancestors and the recently dead is, however, one of the strengths of Polynesian culture. Genealogy provides identity as well as individuals upon whom one can call for help. An elder who has been revered as a leader in life does not lose his or her love of family after death. If the family feels the need for his or her continuing care, they can strengthen the soul's presence with offerings and prayer. Hawaiian families conduct ceremonies to transform the deceased into the body of the animal to whom the family is related. A fisherman of the shark family is guarded by his embodied relative. Children of the owl family can be led out of danger by the bird who appears to help them. Similarly, family and even friends can use body parts of the dead to create servant spirits, which lack the full personality of a family god but are obedient servants for limited tasks.

Polynesian spiritual practices are possible because souls are physical. At death, a soul exits the body from a tear duct and begins a tentative, instinctive journey into the uplands for a time and then proceeds along the path of the spirits to the place on each island where the souls jump off into the land of the dead. If a soul expert feels the person should not have died, he or she can find the soul, “snatch” it between cupped hands, reinsert it



Ancient Polynesian temple platforms, marae, are still considered to be holy places by many Polynesians although indigenous religious practice has largely ceased. Ritual dances and sacrifices are sometimes re-enacted for tourists and guests of the islands. JACK FIELDS/CORBIS

under the big toe, and massage it up the body until the person revives. On the other hand, an enemy can capture the soul and destroy it, annihilating the deceased. Polynesians believe in life after death, but not necessarily immortality.

As in all aspects of Polynesian religion, human beings are seen as powerful and capable. They are not terrified and overpowered by phenomena of the dead. Inborn talent, trained sensitivity, and education enable them to handle gods and spirits as naturally as they do the winds and the waves. Indeed, Polynesian Christians, living in the same world as their ancestors, often supplement their new religion with such traditional beliefs and practices. The combinations they create are compelling and broadening. The Polynesian's understanding of family as a spiritual power, of deceased family members as continuing sources of love and care, of the closeness and communion of the living and the dead, and of the human being's capacity to

manage death as well as life are a genuine contribution to the world.

See also: AFRICAN RELIGIONS; AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; HOW DEATH CAME INTO THE WORLD

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JOHN P. CHARLOT

POPULATION GROWTH

Population growth refers to change in the size of a population—which can be either positive or negative—over time, depending on the balance of births and deaths. If there are many deaths, the world's population will grow very slowly or can even decline. Population growth is measured in both absolute and relative terms. Absolute growth is the difference in numbers between a population over time; for example, in 1950 the world's population was 4 billion, and in 2000 it was 6 billion, a growth of 2 billion. Relative growth is usually expressed as a rate or a percentage; for example, in 2000 the rate of global population growth was 1.4 percent (or 14 per 1,000). For every 1,000 people in the world, 14 more are being added per year.

For the world as a whole, population grows to the extent that the number or rate of births exceeds the number or rate of deaths. The difference between these numbers (or rates) is termed “natural increase” (or “natural decrease” if deaths exceed births). For example, in 2000 there were 22 births per 1,000 population (the number of births per 1,000 population is termed the “crude birth rate”) and 9 deaths per 1,000 population (the “crude death rate”). This difference accounts for the 2000 population growth rate of 14 per 1,000, which is also the rate of natural increase. In absolute numbers, this means that approximately 78 million people—or about the population of the Philippines—are added to the world each year. For countries, regions, states, and so on, population growth results from a combination of natural increase and migration flows. The rate of natural increase is equivalent to the rate of population growth only for the world as a whole and for any smaller geographical units that experience no migration.

Populations can grow at an exponential rate, just as compound interest accumulates in a bank account. One way to assess the growth potential of a population is to calculate its doubling time—the number of years it will take for a population to double in size, assuming the current rate of population growth remains unchanged. This is done by applying the “rule of seventy”; that is, seventy divided by the current population growth rate (in percent per year). The 1.4 percent global population growth rate in 2000 translates into a doubling

time (if the growth rate remains constant) of fifty-one years.

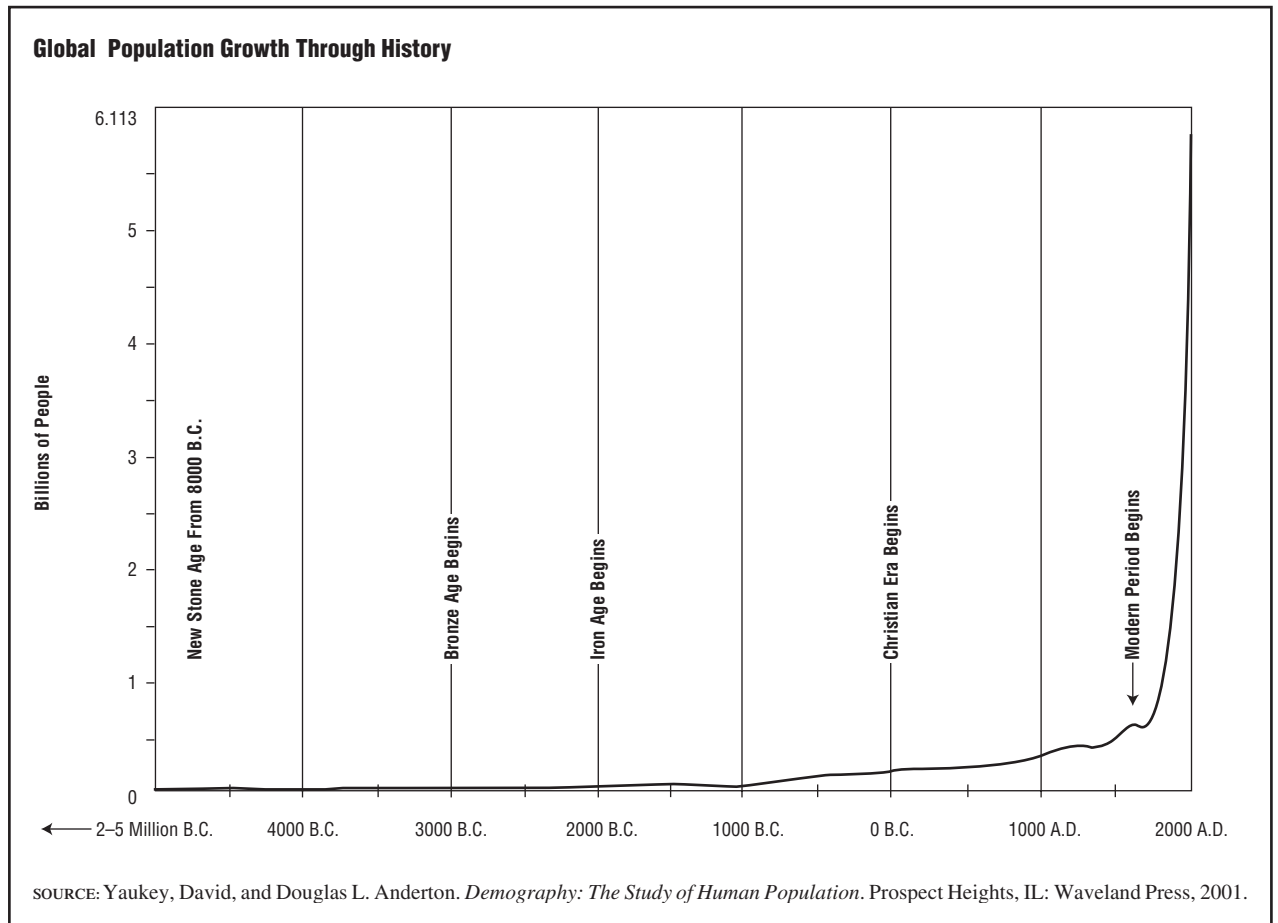
History of Global Population Growth

As can be seen in Figure 1, the world's population grew very slowly until about 1750. There was a long period of stationary growth (no growth) until 1000 B.C.E., when the world's population was approximately 300 million; this was followed by a period of slow growth from 1000 B.C.E. to approximately 1750, at which time global population was an estimated 800 million. Until this time, the world's population was kept in check by high death rates, which were due to the combined effects of plagues, famines, unsanitary living conditions, and general poverty. After 1750, the world's population grew substantially; by 1950 it had tripled to around 2.5 billion. In this 200-year period, the doubling time was 122 years. Growth from 1950 to 1985 was even more dramatic; by 1985, the human population was 5 billion. World population had doubled in thirty-five years. By 2000 global population was 6 billion and is projected to be 9 billion in 2050.

Population growth did not become exponential until around 1750. Before that, high mortality counterbalanced the high fertility needed by agrarian parents. Death rates were high and life expectancy was low; life expectancy at birth was in the range of twenty to forty years (most likely around thirty years) until the middle of the eighteenth century. This high mortality was a function of several factors, including poor nutrition, which led directly to deaths through starvation and indirectly through increasing susceptibility to disease; epidemics; and, quite possibly, infanticide and geronticide, especially during times of food shortage.

Starting in the middle of the eighteenth century, the mortality rate began to decline in the West, the first place in the world where the natural balance between births and deaths was altered by humans. This decline in deaths occurred not because of major medical breakthroughs (e.g., penicillin was first used only in the 1940s) but rather because of improvements in food availability, housing, water cleanliness, personal hygiene, and public sanitation. Later, in the twentieth century, medical advances, particularly vaccinations against infectious diseases, accelerated mortality decline.

FIGURE 1

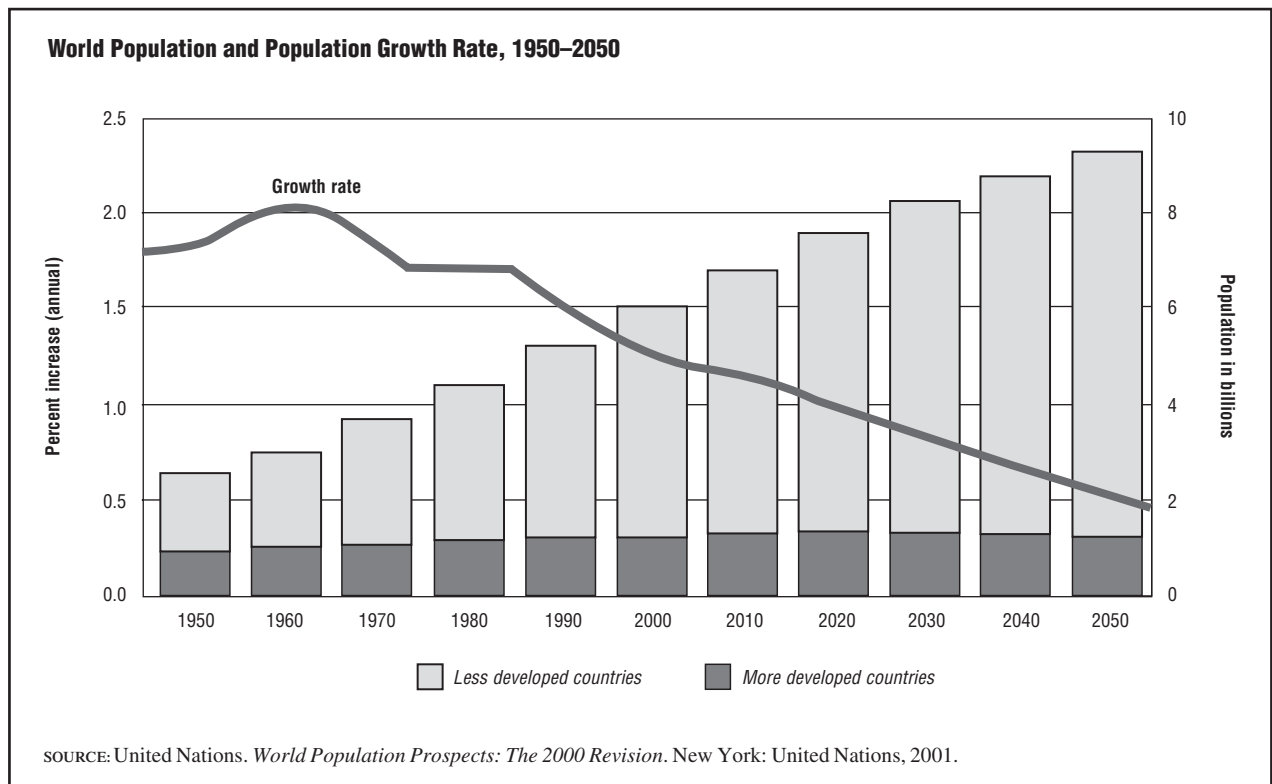


Western mortality decline was relatively slow, paralleling socioeconomic development, and it occurred in a global context in which European population “surplus” (arising from gaps between lowering mortality and more slowly lowering fertility) was able to migrate to new areas (e.g., the United States, Canada, and Australia) that were very sparsely populated by Aboriginal peoples (whose numbers were reduced even more by contagious diseases brought by Europeans).

Mortality decline in less developed countries followed a different path. First, mortality decreases did not begin until around 1950, much later than in the West. Second, in many less developed countries, substantial mortality reductions occurred in a short period of time. A classic example is Ceylon (now Sri Lanka), where the death rate was halved in less than a decade, starting in the early 1950s. (In the West, a comparable reduction typically took around one century.) In these less developed countries, mortality decreases were not matched by

fertility decreases, where they produce population growth rates much greater than those experienced in the West. So the demographic transition that took two centuries to unfold in the West occurred (or is occurring) within the span of a single life. Third, mortality decline did not parallel economic development. Rather, the impetus behind third world mortality reductions originated, for the most part, in factors external to the society. For example, the speedy mortality decline in Ceylon was due to the importation of American technology (pesticides and the airplanes for spraying them) that killed the mosquitoes that were responsible for malaria, the leading cause of death. During the cold war, it was not uncommon for the United States to provide nonaligned countries with such assistance in the hopes of wooing them away from the Soviet Union and a communist development model.

As a result, the world witnessed unprecedented rapid population growth between 1950 and 1985, owing, in large part, to third world increases.

FIGURE 2

Further, the phenomenal increase in human numbers over the past 250 years is largely the consequence of mortality declines—not fertility increases. The first deaths to be reduced were those due to infectious diseases, the victims of which were most often children. The old killers of the past were to be replaced by chronic and degenerative diseases; the primary victims shifted from the young to the old.

Population Growth 1950–2050

The rate of global population growth has declined significantly from its 1970s highs (see Figure 2). Current estimates anticipate a continued decline to about 0.5 percent in 2050. This corresponds to a doubling time of 140 years, a rate that has fostered concern about how the world will cope with 18 billion people in 2190.

It is in the less developed countries that the continued growth in population will occur in the twenty-first century. Even though mortality is much higher in less developed countries (e.g., life expectancy at birth in 2000 was 75 years in the more developed countries and 62 to 64 years in the less developed countries), fertility remains even higher,

thus accounting for relatively high growth in the third world. However, projections are not guarantees. Population may grow more slowly if, optimistically, fertility declines more quickly than experts expect (e.g., between just 1965 and 1987 the average number of children born to Thai women dropped from 6.3 to 2.2) or, pessimistically, if mortality increases, especially in light of the persistence of HIV/AIDS pandemic and other communicable diseases.

Theories of Population Growth

While theories about population growth first appeared in ancient Greece, the English clergyman and economist Thomas Malthus (1766–1834) is considered to be the pioneering theorist of the modern age. Malthus formulated a “principle of population” that held that unchecked population grows more quickly than the means of subsistence (food and resources) to sustain it. Population will be controlled either by preventive checks (lowering the number of births, particularly by postponement of marriage age) or by positive checks (increasing deaths as a result of famines, plagues, natural disasters, war). Given a morally based preference for

preventive checks, later followers of Malthus (neo-Malthusians) have supported family planning and contraception even though Malthus himself felt that contraception was unacceptable. Other neo-Malthusians have focused upon the claimed negative effects of rapid population growth: war, violence, and environmental degradation.

Karl Marx's views on population were directly opposed to those of Malthus. Marx disagreed with the Malthusian idea of a universal principle of population that applied to all societies. For Marx, population growth depended upon the economic base of society. Thus, capitalist society is characterized by its own population principle, which Marx termed the "law of relative population surplus." He argued that capitalism creates overpopulation (i.e., a surplus of people relative to jobs), leading to increased unemployment, cheap labor, and poverty. Also, capitalism requires unemployment in order to ensure a docile, low-paid class of laborers. Marx envisioned that overpopulation would not occur in postcapitalist, communist society.

In the middle of the twentieth century, demographic transition theory became the dominant theory of population growth. Based on observed trends in Western European societies, it argues that populations go through three stages in their transition to a modern pattern. Stage One (pretransition) is characterized by low or no growth, and high fertility is counterbalanced by high mortality. In Stage Two (the stage of transition), mortality rates begin to decline, and the population grows at a rapid pace. By the end of this stage, fertility has begun to decline as well. However, because mortality decline had a head start, the death rate remains lower than the birth rate, and the population continues to experience a high rate of growth. In Stage Three (posttransition), the movement to low fertility and mortality rates is complete, producing once again a no-growth situation. The theory of demographic transition explains these three stages in terms of economic development, namely industrialization and urbanization. Since about 1980, demographic transition theory has been criticized on a number of grounds, including its assumption that the demographic experience of non-Western societies will inevitably follow that of the West; its failure to consider cultural variables; and its hypothesized relationship between population growth and economic development. Indeed, all three theories above contain assumptions about population

growth and economic development; however, there is mounting evidence that this relationship is complex and varies from context to context. As the twenty-first century begins, the attempt to erect a general theory of population growth has been abandoned, signaling for some an alarming trend in population studies.

See also: CAUSES OF DEATH; DEMOGRAPHICS AND STATISTICS; LIFE EXPECTANCY; MALTHUS, THOMAS; SOCIAL FUNCTIONS OF DEATH; TECHNOLOGY AND DEATH

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ELLEN M. GEE

PROTESTANTISM

Protestantism is the collective term applied to Christian denominations originating in groups that separated from the Roman Catholic Church in Europe's sixteenth-century Reformation. Reformers challenged the Church's manipulation of concerns about death and destiny to achieve temporal power and raise revenue. Church responses to the reformers' challenge, and the social and political alliances shaped by the debate, led to the major reform movements becoming churches independent of Rome.

At this time society was preoccupied with death. The Roman Catholic Church occupied a central role mediating between the living and the dead, who were in purgatory—a place of purification for souls readying themselves to enter heaven. The period of suffering in purgatory could be reduced by masses and prayers endowed by family and friends. It was also possible to obtain a special gift of pardon, or indulgence, and by the late Middle Ages indulgences had become commodities sold by the Church.

The reformers asserted that God saved souls by a free, unmerited gift of grace, not through church practices or decrees. They rejected purgatory, prayers for the dead, and the invocation of the saints, adopting an agnostic stance concerning such matters that were not directly attested to by Scripture. Their insistence that the living could no longer work on behalf of the dead brought significant changes to beliefs and practices concerning death, dying, and disposal.

On their death beds Protestants no longer made provision for the repose of their souls through endowing masses, purchasing indulgences, or providing alms for the poor so as to be remembered by them in their prayers. Rather, they sought to testify to the faith they held and in which they now died. A good death was calm, peaceful, and assured; although later in Puritan New England, especially belief in predestination required necessary doubt of salvation, assurance being replaced by anxious repentance.

While Catholic funerals eulogized the deceased and interceded for them in their entry into eternal life, Protestants preached to the living, avoiding any suggestion of intercessions on behalf

of the dead. The performative ritual of Catholicism was abandoned: Protestants simply remembered the deceased and sought to learn from their example. Both Catholicism and Protestantism continued to evangelize by heightening the fear of death, fostering contempt for the world and emphasizing suffering as a route to salvation.

The social reorganization that accompanied industrialization changed European burial practices. Garden cemeteries replaced churchyards, separating places of worship from the place of burial. Undertakers appeared to prepare and transfer bodies and, in due course, to coordinate the religious services involved. Further, as medicine became dominant later in the nineteenth century, death was regarded increasingly as a medical challenge, not a spiritual transition. This secularization of dying and disposal initially affected Protestants more than Catholics, as the latter retained their ritual requirements.

The first half of the twentieth century saw the end of any distinctive idea of a Protestant death, and an increasing silence (except in some fundamentalist circles) about the afterlife issues that had dominated earlier religious discourse. By the 1970s these remaining distinctions eroded. Purgatory effectively disappeared from Catholic discourse. Cremation, since World War II a more usual mode of disposal among Protestants, became common among Catholics as well. In the twenty-first century both Catholicism and Protestantism focus upon the living rather than the dead, and both struggle to address the renewed interest in connection with the dead which is emerging in Western societies.

See also: CATHOLICISM; CHRISTIAN DEATH RITES, HISTORY OF

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BRUCE RUMBOLD

PSYCHOLOGY

For much of its 125-year history, psychology, the study of human behavior, could not find a place for death and dying among the topics that it considered worthy of scientific attention. Although psychology was derived from philosophy, a system that gives death a central role in shaping human thought and conduct, early on there was a schism between those who wanted to study behavior from an experimental, physiological perspective and those who wanted to keep a broader, person-based focus. In Europe during the late 1800s, experimental psychology was advanced by such pioneers as Wilhelm Wundt, Francis Galton, and Alfred Binet, and in the United States by E. L. Thorndike, G. Stanley Hall, James McKeen Cattell, and John Dewey. A more encompassing, holistic approach was advanced in Europe by Sigmund Freud and in America by William James.

With late-nineteenth-century science dominated by Charles Darwin's theory of evolution, it was perhaps inevitable that the fledgling science of psychology steered itself toward the experimental, psychophysiological side of investigation and away from philosophy. Although there were voices in the field hinting at the importance of death for understanding human behavior, psychology as a whole paid little attention.

Logical positivism, a method of inquiry that rejects transcendental metaphysics and requires as proof verifiable consequences in experience, held center stage in psychology until the events of World War II fundamentally changed the way psychologists considered their task. Many of the early experimental theories of behavior emphasized evolutionary (genetic) determinism. However, nothing in the psychologist's laboratory manual could predict or explain the wholesale human destruction of two world wars in fewer than thirty

years. Science the savior turned out to be the specter of death in the guise of Nazi Germany and the atomic bomb.

In the wake of World War II, psychology turned its attention to social and organizational behavior, as well as to explanations of racism and violence in the development of malignant personality patterns. It was again willing to consider philosophical approaches to behavior that emphasized the whole person. Logical positivism was eclipsed by existential and humanistic philosophies that grappled with the nature of humanity and the meaning of behavior.

In this context, psychology's first organized approach to death was a symposium titled "The Concept of Death and Its Relation to Behavior," chaired by clinical psychologist Herman Feifel and presented at the 1956 annual meeting of the American Psychological Association in Chicago. The symposium served as the basis for the 1959 book *The Meaning of Death*, edited by Feifel, which is widely recognized as the single most important influence in galvanizing what has since become the multidisciplinary field of thanatology (the study of death, dying, and bereavement).

During the two decades that followed publication of Feifel's book, psychologists began to fully participate in the thanatological community by making important contributions to theory, research, education, and service delivery. Empirical and clinical advances were made in understanding how people construct their ideas and attitudes about death, how ideas about death change from childhood through old age, the nature and meaning of death anxiety, the biological basis of attachment and grieving, and why people commit suicide. Psychologists such as Daniel Leviton and Robert Kastenbaum helped spearhead the death education movement, and the latter built one of the first university centers devoted to the study of death at Wayne State University in Detroit, Michigan. Two of the premier research journals devoted to this topic area were created by psychologists: *Omega: The Journal of Death and Dying* edited by Robert Kastenbaum, and *Death Education*, now called *Death Studies*, edited by Hannelore Wass.

The last two decades of the twentieth century saw a maturing of the field of thanatology, the role played by psychologists in shaping the future of

death studies, and the treatment of dying and bereaved persons. During this time psychologists were at the forefront in research on death attitudes and death anxiety; coping with life-threatening illnesses such as cancer, heart disease, and AIDS; grief and bereavement; and the study of suicide. Psychologists helped build and staff hospices for terminally ill patients. Many colleges and universities hired psychologists who made death studies a major focus of their work as part of an expansion of research and coursework in thanatology for students in developmental, clinical, counseling, and school psychology programs.

Empirical and Clinical Findings

From its inception, thanatology has been a multidisciplinary field encompassing anthropology, education, medicine, nursing, philosophy, psychiatry, religion, social work, sociology, the arts, and the humanities. In contrast to this ecumenical trend, research on death attitudes and death anxiety has been conducted mostly by psychologists. Perhaps this is why the literature has shown a strong focus on methodological issues rather than broader sociocultural and applied concerns. By 1995 there were more than 1,000 published studies in this field that addressed diverse subjects, including children, adolescents, adults, the elderly, and the mentally ill. Almost all of these studies involved descriptive, atheoretical, single-assessment designs and used self-report questionnaires. In spite of the limitations inherent in these studies, four themes have emerged from their findings:

1. Most people think about death to some extent and report some fear of death, but only a small subset exhibit a strong preoccupation with death or fear of death.
2. Women consistently report more fear of death than men, but the difference is typically minor to moderate.
3. Fear of death does not increase with age among most people.
4. When considering their own death, people are more concerned with potential pain, helplessness, dependency, and the well-being of loved ones than with their own demise.

Studies have also demonstrated that fear of death is not a unidimensional variable. Various subcomponents are evident in fear of a painful or

unpleasant afterlife, fear of the unknown, and fear of a loss of dignity or individuality. In addition, some research has shown that fear of death may take different forms on the conscious and unconscious levels. For example, low levels of self-reported death anxiety may be an outright aversion and avoidance at an unconscious level.

Death possesses many meanings for people and is an important psychological element for all persons, not just the elderly, dying persons, and those facing potential death in their daily activities (e.g., military and police). People think about death and experience the deaths of others throughout life. Adult conceptions of death can be quite complex and involve multiple abstractions, among them the concepts of futurity, inevitability, temporal uncertainty, universality, personal inclusion, and permanence. As humans develop from early childhood into adulthood, their ability to think abstractly also increases. Research has confirmed that among children and adolescents, comprehension of death is related to general levels of cognitive development and personal experiences with death-related phenomena.

The pioneering work of the Hungarian psychologist Maria Nagy identified three stages of development in children's ideas about death. In children from three to five years old she found great curiosity about death and a widespread view of death as a separation where the dead are not as alive as the rest of us but can come back to normal living status. From ages five to nine children begin to understand that death is final but they persist in believing that one might avoid it. Death also becomes personified at this age. From age nine into adulthood there is recognition of death as personal, universal, final, and inevitable.

Research on the death attitudes of children and adolescents demonstrate that they must not be shielded from knowledge of death and should be included in discussions about death at appropriate times. Even the youngest children are aware of separation and its threat to their well being. Young people are inquisitive about death. Adults who exclude children from death-related conversations and experiences do them a disservice by removing them from important sources of information and thus reinforcing anxiety and fear. Adults who wish to participate in educating their children about death must be aware of their own attitudes and

values, be prepared to share their feelings and experiences, and serve as models for a healthy appreciation of the importance of death.

Treatment of the Dying and Bereaved

Medical advances have extended the human life span, yet created a growing population of persons (particularly the elderly) who die with chronic diseases. Too often the focus of professionals has been on the physical disease rather than the experiences of the victims. Both clinical and research findings underscore that dying is not just a biological process but also a psychological one. There is an essential need for open and honest communication between the dying person, health-care providers, family, and friends.

The attitudes and fears of caregivers strongly influence the way in which they view and treat the dying and bereaved. Most dying persons and their families want to be apprised of the processes of death, communicate about death and its consequences, and be included in decision-making as it applies to treatment and end-of-life issues. Unless health-care providers can become aware of their own feelings and attitudes, receive education about dying and grief, and become comfortable with the knowledge of death as a multifaceted process that has many derivatives and outcomes, their patients will often be ill-served or even harmed.

The psychiatrist Elisabeth Kübler-Ross conceived a five-stage model of dying and grief that has helped to increase death awareness in the general public and has spawned numerous research investigations. She proposed that as individuals respond to awareness of impending death (their own or that of a loved one), they move through stages of denial, anger, bargaining, depression, and acceptance.

Empirical and clinical investigations inform us that grief unfolds in many different ways and demonstrates not weakness but rather a necessary and deep human need most of us have in reacting to the loss of our own life and that of a loved one. Hard data do not support the existence of stages or schedules through which all persons move as they experience and respond to death. For example, studies of Kübler-Ross's model have shown a simultaneity, omission, or reversal of stages in some individuals.

Because of a lack of precise clinical criteria, healthy and unhealthy grief can be difficult to distinguish. Hence practitioners must be cautious in encouraging survivors to abandon grief prematurely or to wallow in it. They must be alert to signs of personal denial, avoidance, or antipathy among the dying and bereaved so that meaningful interventions can be considered early enough to have the greatest positive impact.

Current and Future Directions

Among the areas of current interest and importance to psychologists are the development of comprehensive theories of dying and bereavement; studies of death and dying among children; theory-based, experimental, longitudinal, and cross-cultural investigations of how death attitudes are related to diverse human behaviors; and development of empirically-validated models and methods for treating the dying and bereaved.

Although thanatology is still waiting for a compelling, realistic framework for understanding death, progress is being made by psychologists in conceptualizing dying and bereavement. People in the field have moved away from viewing grief as a series of predictable stages to seeing it from a task-based perspective. Charles Corr identified four dimensions of tasks: physical, psychological, social, and spiritual. Kenneth Doka suggested a five-phase model of life-threatening illness: prediagnostic, acute, chronic, terminal, and recovery. Clinical psychologist Therese Rando advanced the concept of anticipatory grief to include not only one's reactions to an impending death but also all of the losses experienced throughout one's life. Robert Neimeyer, clinical psychologist, and colleagues have developed their view of bereavement as a task of meaning reconstruction. Robert Kastenbaum has argued for a life-span-developmental approach to death and dying that incorporates a biopsychosocial perspective, stressing an awareness of what anthropologists call *etic* and *emic* frames of reference; that is, viewing death from the outside (as observer) and inside (from the point of view of the dying person). He has drawn attention to deathbed scenes as a way of developing a more complete understanding of dying at what is arguably the single most critical point in the process. The social psychologists Tom Pyszczynski, Jeff Greenberg, and Sheldon Solomon applied terror

management theory to the fear of death. They argued that a wide variety of behaviors, many of them seemingly unrelated to death, guard against conscious and unconscious fear of personal death.

Since 1956 psychology has moved from its original ostrich approach to death to a recognition of death studies as among the most important in the field. The bounty of books and hundreds of research articles published each year portend a continued flourishing of thanatology in the twenty-first century.

See also: ANTHROPOLOGICAL PERSPECTIVE; ANXIETY AND FEAR; DEATH EDUCATION; DYING, PROCESS OF; FEIFEL, HERMAN; KÜBLER-ROSS, ELISABETH; SOCIOLOGY; STAGE THEORY; TERROR MANAGEMENT THEORY

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STEPHEN STRACK
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PSYCHOPOMPS

See DEATHBED VISIONS AND ESCORTS.

PUBLIC HEALTH

Public health services can prevent premature death from epidemics such as the plague, cholera, and many other infectious and environmentally determined diseases; and enhance the quality of life. Public health is among the most important institutions of organized societies, almost entirely responsible for the immense improvements in life expectancy everywhere in the world in the past 150 years. Its aims are to promote, protect, and preserve good health, and to sustain people when disabilities render them incapable of fending for themselves. Public health is practiced by a team of specialists trained in medicine, nursing, sanitary engineering, environmental, social, and behavioral sciences, health education, administration, and a variety of other fields. In many nations, including the United States, public health is organized hierarchically at national, regional, and local levels.

Public health services are distinguished from other aspects of the health care system because they are financed by taxation, with no fees paid by the users of these services. This phenomenon can lead to funding crises and staff layoffs when there is political pressure to cut taxes. People and their political representatives often take their health for

granted when no epidemics threaten them, so they are not motivated to maintain public health services, staff, and infrastructure at a high level of efficiency and effectiveness, even though ensuring public health is an essential component of the health care system. No nation remains healthy if public health services break down, as they did in Russia after the collapse of the Soviet Union. In this case, infant mortality rates rose, life expectancy fell, and epidemics of diphtheria, typhoid, and other lethal infections occurred. Public health services are as vital to national security as efficient armed forces and the police and fire services. The people of the United States recognized this fact when cases of anthrax occurred in 2001, caused by the introduction of anthrax spores into letters sent through the U.S. Postal Service.

Deadly Epidemics

Since the origins of agriculture and permanent settlements 10,000 years ago, human progress has been punctuated by deadly epidemics. Often arising seemingly out of nowhere, they cut a swath through the population, arousing fear among victims and survivors alike. They were perceived as due to the wrath of a vengeful god, retribution for sinful conduct, or manifestations of evil spirits. Before their causes were understood, survivors full of grief and rage sometimes blamed witches, or those perennial scapegoats, the Jews, extracting vengeance by burning them at the stake or conducting pogroms. Epidemics of plague, smallpox, typhus, cholera, malaria, influenza, and measles have contributed to the fall of civilizations and the defeats of campaigning armies, and they have long fascinated historians as well as epidemiologists. Biblical stories of epidemics indicate the people of those times encountered smallpox and bubonic plague. The historian Thucydides described the plague that decimated the Athenian forces at the end of the first year of the Peloponnesian War (426 B.C.E.), but despite his meticulous description (based partly on having had it himself) the cause remains uncertain. It may have been influenza complicated by bacterial infection. The vitality of the late Roman Empire (200–400 C.E.) was sapped by two diseases better described as endemic than epidemic—malaria, spread by mosquitoes in the Pontine marshes nearby, and lead poisoning, caused by drinking from cups made of tin-lead alloys.

The greatest of all epidemics was the Black Death, which entered Europe at Genoa on ships trading from Asia Minor in 1347, and spread over the next two to three years until it had laid waste to the entire continent. The Black Death killed at least one-third of the population. Sometimes whole villages were wiped out and, in cities such as Paris, organized life and everyday commerce came to a halt. Plague had struck before, for instance at the time of Justinian (543 C.E.), and continued to cause occasional epidemics such as the one in London in 1665 described in Samuel Pepys's diary. However, society had not seen anything on the scale of the pandemic of 1347–1349. The plague bacillus primarily infects rodents and is transmitted by the rats' fleas. Human epidemics occur when ecological conditions bring rats, their fleas, and people together at close quarters in dirty, verminous conditions.

Typhus, caused by a microorganism called *Rickettsia*, a small bacterium, is spread by the body louse. Epidemics of typhus occur when large numbers of people are confined in close quarters in dirty, verminous clothing (e.g., war refugees and campaigning armies). An impending epidemic that would have had a serious strategic impact was stopped in Naples in 1944 by liberal use of the insecticide DDT. In his classic work *Rats, Lice and History* (1935), the microbiologist Hans Zinsser vividly describes how the outcome of wars has often been decided by which side was more successful in withstanding the deaths from typhus among its fighting forces. The European conquest of the Americas and colonization of the rest of the world was materially assisted by the impact of measles, smallpox, and tuberculosis on the people who had been there before them. Europeans had some inherent resistance to those diseases after many centuries of exposure had weeded out those most susceptible. The Allied campaigns in the Pacific during World War II were facilitated by the fact that American, Australian, Indian, and British forces had effective anti-malarial agents and their Japanese adversaries did not. This fact may have played a larger part in the victory than the atom bombs dropped on Hiroshima and Nagasaki.

In the eighteenth and nineteenth centuries an arrogant assumption by medical men that they could lay their healing hands upon women in childbirth—even when those hands were laden with dangerous bacteria—led to a tragic epidemic

of fatal childbed fever. The epidemic ended only when the studies of Ignaz Semmelweiss in Vienna and Budapest and Oliver Wendell Holmes in Boston in the 1840s were translated into hand washing in antiseptic lotion. The use of antiseptics in labor wards and operating rooms, as practiced and advocated by the surgeon Joseph Lister, followed hand washing more than twenty years later.

In the late twentieth and early twenty-first centuries, the HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) pandemic had a catastrophic impact on sub-Saharan Africa, comparable to the Black Death in medieval Europe except for the different course of the disease. The plague killed in a few days and HIV/AIDS takes a few years, but the ultimate death rate is higher, approaching 100 percent, whereas at its worst the Black Death killed between 70 percent and 80 percent of its victims. By the end of the twentieth century, HIV/AIDS afflicted more than 40 million people and killed 30 million people.

With the insights of modern evolutionary biology and medical sciences, researchers know that epidemics and many other widely prevalent diseases originated from and are perpetuated by a combination of ecological conditions. Malaria, yellow fever, other vector-borne diseases, and many parasitic infections probably first occurred in humans as a result of evolutionary developments in the causative agents and their vectors. Smallpox, influenza, measles, plague, and several other epidemic diseases probably first afflicted humans by “jumping species” from their origins as diseases of animals that were domesticated by Palaeolithic humans.

In the second half of the twentieth century, most people in the rich industrial nations were able to live long and healthy lives, but as many as 30 to 40 percent of middle-aged men were dying before their potential life span of lung cancer or coronary heart disease, two modern epidemic diseases often attributable to tobacco addiction. Undeterred by the massive evidence that their product is the most powerful addictive substance known, and lethal if used as the manufacturers intended, the tobacco manufacturers embarked upon aggressive and successful campaigns to market cigarettes to girls and women who had previously not often smoked. The result is that lung cancer death rates among women began to rise sharply in the final two decades of the twentieth century, and can

be confidently predicted to keep rising so long as women continue to fall victim to tobacco addiction. Similar aggressive and unprincipled tobacco marketing campaigns are being conducted throughout the developing nations in the early twenty-first century. The World Health Organization estimates that the annual number of deaths from tobacco-related diseases could reach 8 to 10 million worldwide by 2025 as a result. This would make tobacco addiction a lethal epidemic disease comparable to if not greater in magnitude than HIV/AIDS.

Historical Origins of Public Health

Contemporary public health services began in the middle of the nineteenth century in response to the squalid conditions that existed in the rapidly growing cities and towns of the industrial revolution. These cities and towns were dangerous places. In the early nineteenth century, a newborn had about one chance in four or five of dying before his or her first birthday, and only about half survived long enough to grow up and have children of their own. They died of diarrheal diseases, including cholera, or of respiratory infections, such as bronchitis, measles, croup, pneumonia, and tuberculosis. Life expectancy in the new industrial towns was only about thirty-five years. This appalling situation challenged the emerging medical sciences and the social reformers to act. Aided by an expanding knowledge and understanding of the times, their efforts led to reduction of infant mortality rates and rising life expectancy. By 1900 infant mortality rates in the industrial nations had fallen to about 100 per 1,000 live births, and life expectancy had risen to about 45 to 50 years. By 1950 infant mortality rates were down to about 40 per 1,000 live births and life expectancy was at or above seventy to eighty years in most of the industrial nations. By 1999 infant mortality rates were below 10 per 1,000, and life expectancy approached 80 years, even in the United States, which has traditionally lagged behind many other wealthy industrial nations.

Social, medical, and public health reform originated largely in England, but took place almost simultaneously throughout much of Western Europe and the United States. A combination of several essential factors made possible these reforms, collectively known as the sanitary revolution. The same

essential factors must exist before almost any public health problem can be resolved. These include an awareness that the problem exists; an understanding of what is causing it; the capability to control the cause or causes; belief that the problem is important enough to tackle; and political will.

An awareness that the problem exists. In the middle to late nineteenth century, awareness was facilitated by rising literacy, the availability of newspapers, and the development of vital statistics that provided documentary evidence of the magnitude of the problem of deaths from diarrheal diseases and respiratory infections in infancy, childhood, and early adult life. Since the mid-twentieth century, television has played an increasingly important role in drawing attention to new public health problems, such as those associated with toxic pollution of the environment.

An understanding of what is causing it. John Snow, the English physician who investigated the cholera epidemics in London in the 1840s and 1850s, provided evidence that the disease was spread by polluted drinking water. The cholera vibrio, the causative organism, was not discovered until about thirty years later, but recognition that polluted water was spreading cholera enabled some preventive action—provision of clean water supplies—to begin.

Capability to control the cause or causes. Oliver Wendell Holmes and Ignaz Semmelweis demonstrated that washing hands in a disinfectant could prevent most cases of childbed fever. Both men were vilified by their colleagues who regarded it as an insulting slur on their character to imply that their dirty hands caused the disease. Joseph Lister was successful because his carbolic spray implied that the cause was not necessarily the unhygienic habits of the doctors but rather bacteria in the air in operating rooms and lying-in wards in hospitals. By then, many varieties of dangerous bacteria had been discovered and linked to the diseases that they caused.

Belief that the problem is important enough to tackle. Historically, a mounting emotion of public outrage about what is perceived to be an intolerable burden upon the people is the catalyst for change. The phrase “filth diseases” evokes the distaste for unhygienic conditions that contributed to the burden of premature deaths in nineteenth-century industrial Britain. Geoffrey Vickers, a

British social policy specialist, referred to this rising public outrage as “redefining the unacceptable”—a phrase that captures the essential factor in setting a new goal for public health.

Political will. A public health problem will persist unless there is determination to correct the conditions that cause it. This usually means disturbing the status quo and encroaching upon the livelihood of individuals and often powerful interest groups—slum landlords, nineteenth-century water supply companies, twentieth-century tobacco manufacturers, and twenty-first-century industry, energy, and transport sectors resisting action to control global climate change. Moreover, it costs money to make the necessary changes, which usually results in additional taxes and extended political debate.

Methods of Public Health

Health can be preserved, protected, and promoted in several ways, including ensuring the environment is safe, enhancing immunity, and living a healthy lifestyle.

Ensuring the environment is safe. A safe environment includes drinking water that is free from dangerous pathogenic organisms and toxic substances. This requires purification of public water supplies, a sanitation service with efficient sewage disposal, and safeguards against contamination of water and food supplies by pathogens and toxic chemicals. In modern urban industrial societies clean air is another part of the natural environment that must be protected: clean indoor air, free from tobacco smoke, as well as urban air free from smog. Efforts to clean both outdoor and indoor air are often initially resisted by various interest groups.

Enhancing immunity. Immunity is enhanced by vaccination or immunization against infectious diseases in infancy and childhood. Vaccination against smallpox began after Edward Jenner, a physician in Gloucestershire, England, experimented on his patients with cowpox lymph in the late eighteenth century. His results, published in *An Inquiry into the Variolae Vaccinae* (1798) were perhaps the single most important public health advance of the second millennium. Smallpox had long been one of the great epidemic scourges. It killed 40 percent or more of all who were infected

by the virus, and disfigured, sometimes blinded, many more. Within one hundred years it had been brought under control in most parts of the world and in 1980, after a determined global eradication campaign, the World Health Organization proclaimed the worldwide eradication of smallpox. Vaccines and sera containing immunizing agents have been developed against many other dangerous and often lethal infectious agents. See Table 1 for a list of the most important, all of which (except polio) caused innumerable premature deaths. Vaccines to prevent smallpox and rabies, two deadly virus diseases, were developed long before the agent was discovered, which had to await the invention of the electron microscope. Discovery of the bacterial agents responsible for many other dangerous infections occurred rapidly in the late nineteenth century, following the development of high-quality microscopes and the techniques of bacterial culture.

Living a healthy lifestyle. Living a healthy lifestyle means abiding by the maxim of the ancient Greeks, “Nothing to excess.” It includes avoiding harmful addictive substances, especially tobacco, and adhering to a balanced diet and regular exercise program. Living a healthy lifestyle can be encouraged by health education campaigns. Adhering to a balanced diet—comprised of the right mix of protein, fats, and carbohydrates, with vitamins and essential trace elements—is necessary to achieve good health and prevent premature death. Famine conditions have killed populations of people in the past, partly from starvation itself but also because malnutrition makes people, especially children, vulnerable to deadly infections such as measles, and reduces resistance to tuberculosis.

Other methods of public health include carefully nurturing the next generation; ensuring that children are well-borne and do not have inherent genetic defects or malformations that result from exposure to toxic substances; and prudent use of diagnostic and therapeutic medical services (i.e., avoiding multiple and often needless exposures to diagnostic X rays, coronary artery surgery for elderly people at the upper extremity of the life span, and cosmetic breast implants), which can be harmful if improperly applied.

See also: AIDS; BLACK DEATH; CAUSES OF DEATH; DEATH SYSTEM; LIFE EXPECTANCY; TECHNOLOGY AND DEATH

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JOHN M. LAST

PURGATORY

From the third century onward, Christian theologians developed a theory of psychic postdeath purification on the basis of the words of St. Paul: “Fire shall try every person’s work.” He continues by saying that those who have built their lives upon shoddy foundations “shall be saved, yet saved through fire” (1 Cor. 3:11–15). Paul’s was a doctrine of postdeath purification that was shared with late Judaism and early rabbinic thought. From the beginning of their organized existence, therefore, both the synagogue and the early Christian church prayed extensively for their dead, and many of the most ancient prayers to this effect are still found in the liturgies of the Greek and Latin churches.

Several early theologians reflected on the obscurities of the primitive Christian teaching on the state of the soul after death and deduced that between the death of the individual and the final judgment at the end of time there would be an intermediate state. During this state the souls of the dead inhabited a place where, according to their deeds, they were either happy or wretched. Those souls who required purification of their past lives would experience the purifying fire (in Latin *purgatorium*) more drastically than those who were more advanced in holiness before their death. The Greek theologians generally regarded the posthumous purification by fire in the “spiritual” or symbolic sense of psychic transfiguration into a higher condition. Clement and Origen of Alexandria had

envisaged that the soul of the departed would be made to learn all the things it had refused to learn on the earth through the strenuous ministrations of correcting angels until it had been purified enough to ascend closer to God. The fourth-century teacher Gregory of Nyssa expressed the idea more generically: “We must either be purified in the present life by prayer and the love of wisdom (*philosophias*) or, after our departure from this world, in the furnace of the purifying fire.” And Gregory of Nazianzus, his contemporary, writes in his poetry of the “fearful river of fire” that will purify the sinner after death.

The idea of purgatorium as a place of after-death purification distinct from the finality of the place of the elect and the damned (heaven or hell) that would be determined by God only on Judgment Day was put forward as a learned opinion by leading Western theologians, particularly Jerome, Augustine, and Gregory the Great. These thinkers seemed to wish more than the Easterners to bring some systematic order into the diffuse doctrine of the afterlife and judgment. It was Pope Gregory in the seventh century who elevated the opinion of the earlier thinkers into a more or less formulated doctrine: “Purgatorial fire will cleanse every elect soul before they come into the Last Judgement.” So began the divergent thought that developed over the course of centuries between the Byzantines and Latins.

The Eastern Christian world retained a simpler doctrine of the afterlife that maintained that the souls of the elect, even those who were not particularly holy, would be retained in “a place of light, a place of refreshment, a place from which all sorrow and sighing have been banished.” This view reflected the statement in Revelation 14:13 that “those who die in the Lord rest from their labors.” In short, the state of afterlife as it was envisaged in the Eastern church was generally a happy and restful condition in which the departed souls of the faithful were not divorced from God, but waited on Judgment Day with hopeful anticipation, as the time when they would be admitted to a transfigured and paradisaical condition in proximity to God.

The Latin church, on the other hand, developed its doctrine of purgatory with a more marked stress on that state of painful purification that would attend the souls of all those who had not reached a state of purity before their death.



Aptly titled The Burden of Pride (1868), French printmaker Gustave Doré recreated a scene from Dante's Purgatory. Quite possibly the greatest medieval work on the topic, Purgatory was the second book in his Divine Comedy. CHRIS HELLIER/CORBIS

In the tradition of both churches, the state of the souls after death called out to the living to assist them in prayers, both public and private, so that God would show them mercy. In the tenth century, under the influence of Odilo of Cluny, the Feast of All Souls (November 2) was established in the Western calendar as a time when the living prayed for the release from sufferings of all departed Christians. The popularity of this feast helped to fix the idea of purgatory in the religious imagination of Latin Christians. After the twelfth century, Western theology further rationalized the state and purpose of purgatory in arguing that it was a cleansing by fire of the lesser sins and faults committed by Christians (venial sins), and the payment of the debt of “temporal punishment,” which medieval theologians taught was still owed by those who had committed grave offenses (mortal sins) even though the penalty of such sins (condemnation to an eternity in hell) had been remitted by God before death. The later rationalization for purgatory, therefore, stood in close relation to the

highly developed Western church's penitential theory, as the latter had devolved from feudal ideas of penal debt and remission. The theological tendency is best seen in the work of the scholastic theologian Anselm, who reflects on the nature of eternal penalties incurred by mortals who offend against the prescripts of the deity, in his influential study of the atonement *Cur Deus Homo* (On Why God was Made Man), published in 1098.

Purgatory, as it developed in the West through the later Middle Ages, became more and more of a dismal idea, linked to the understanding of redemption as a penal substitutionary sacrifice, and increasingly distanced from the early Christian notion that the redemption represented God's glorious victory given as a gift to liberate the world. The medieval obsession with the state of the souls after death led to a flourishing of legends and popular narratives of the sufferings of the souls in purgatory. They were, in a sense, the prelude to the greatest medieval work of graphic imagination relating to the subject, Dante's *Purgatory*, the second book of the *Divine Comedy*. Mystics such as Catherine of Genoa also made it a central theme of their visionary teachings, further fixing the idea in the Western mind. In the medieval Latin church the desire to assist the departed souls in their time of sorrow led to a thriving demand for masses and intercessions for the dead, and for "indulgences," which were held to lessen the time of suffering that the souls in purgatory would be required to undergo. This led soon enough to the concept of purgatory being one of the early points of contention in the great religious crisis known subsequently as the Reformation.

Protestant theologians rejected the doctrine of purgatory as one of their first public departures from medieval theological speculation, and the English church censured the "Romish doctrine of Purgatory" outright in its Article 22. The Orthodox churches had much earlier censured the whole idea when ecumenical union was being contemplated in the thirteenth and fifteenth centuries. On each occasion, the Latin Church defended its position in conciliar statements (the Council of Lyons in 1274 and the Council of Florence in 1439). The rejection of the idea by the Reformation teachers led to its defense once again in the sixteenth-century Council of Trent, which led to renewed focus on the idea of purgatory as a distinguishing mark of the authority of the Roman Catholic

Church in the domain of defining dogmas not clearly distinguished in the scriptural accounts.

As an idea it lives on in Dante's writings, and in dramatic poems such as John Henry Newman's nineteenth-century "Dream of Gerontius." As a religious factor it is still very much alive in Western Catholicism in the celebration of various Feasts of the Dead, and in the liturgical commemorations of the departed on November 2. Modern Roman Catholic theology, after Trent, has clearly moved away from emphasizing the purifying pains of purgatorial fire and instead highlights the need for the living to commemorate the dead who have preceded them.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; HEAVEN; HELL

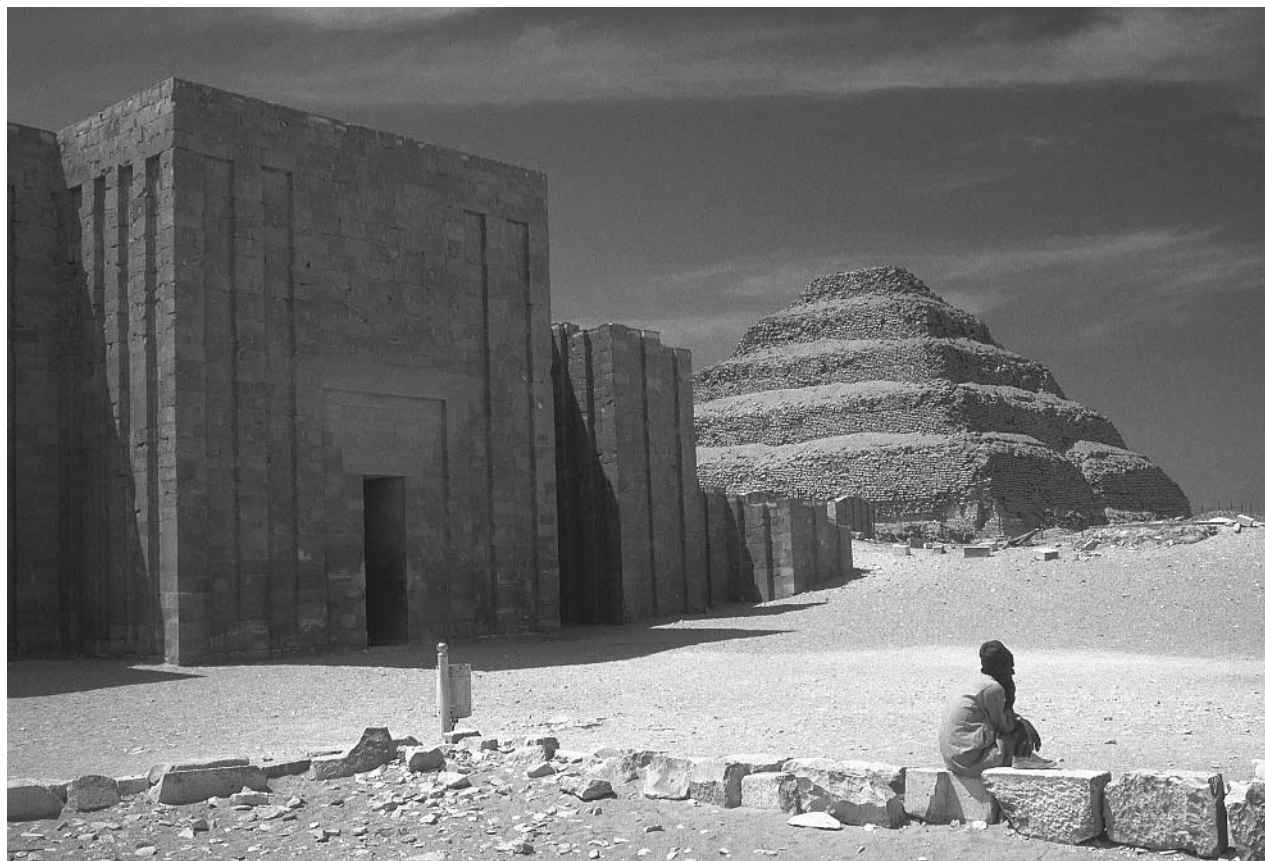
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J. A. MCGUCKIN

PYRAMIDS

Historians have said that most of what humans know about ancient cultures is based on funerary artifacts. Certainly no other example of mortuary culture stands out in modern consciousness than the Egyptian pyramids. The first large-scale stone construction in Egypt was the funerary complex of the Third Dynasty king, Netjerikhet Djoser at Saqqara, demonstrating already at this point in history the strong connection between the pyramid and the royal afterlife. This monument was designed by the king's famous vizier and overseer of



The first pyramid of Egypt, designed by Imhotep in the Third Dynasty, was made for the pharaoh Zoser. The stepped pyramid at the center of the funeral complex, reaches a height of 200 feet, with Zoser's original burial chamber 90 feet below ground. RICHARD T. NOWITZ/CORBIS

works: Imhotep. At its center stood a step-pyramid rising in seven stages to approximately 240 feet in height. Pyramid building reached its climax during the Fourth Dynasty. The first king of the dynasty, Snofru, constructed the first true pyramid, but it was his son Khufu (Kheops) who built the first and largest of all the pyramids at Giza. Over 2.3 million blocks of stone averaging around 2.5 tons apiece were used to erect this enormous structure, which attained a height of about 481 feet and whose square base was 756 feet at each side.

These enormous constructions must have placed a considerable strain on the nation's resources, so it is not surprising that after the Fourth Dynasty both pyramids and royal mortuary complexes and their pyramids dramatically decreased in scale and their construction was shoddier. After some rather small monuments at the beginning of the Eighteenth Dynasty, pyramids ceased to be used for royal burials. Nevertheless, the Egyptians

continued to consider pyramids as the most preferable tomb form so that small versions were occasionally incorporated into the superstructure of private tombs during the New Kingdom and Ramesside periods.

The fact that such an inconceivable amount of energy would be expended on these massive funerary structures has given rise to many fantastical alternative explanations as to their origin and purpose. Even though texts explain little specifically about the meaning of the pyramids and say virtually nothing about how they were built, the preponderance of evidence clearly shows that they were intended as the kings' funerary monuments. A combination of archaeological evidence from the sites along with some sparse textual material clearly demonstrates a connection between these monuments and the royal mortuary cult. However, there was a strong association with worship of the sun god Re, the chief religious belief during the

Old Kingdom. The pyramids' shape reminds some of a staircase, but a similarity with a sunburst seems a more probable intent.

Normally the pyramid was the largest part of a vast, tripartite temple enclosure whose purpose was to maintain the king's cult, theoretically in perpetuity. The design details changed constantly, but retained essentially the same pattern. The main access to the pyramid complex was at the valley temple at the edge of the cultivation in the Nile valley, usually affording access to a canal. The valley temple was connected to the high desert plateau by a covered causeway. Finally, the pyramid precinct itself was surrounded by an enclosure wall behind which were subsidiary temples and satellite pyramids intended for the king's soul or family members.

The very fact that the pyramids were intended for the king meant that they had a much broader connection with religion. In Egyptian religious and

political ideology, the king—who was both the earthly incarnation of the god Horus and the son of the sun god Ra—was always the nexus between humanity and the realm of the gods. Therefore the pyramids were not merely royal tombs but national endeavors that could help all Egyptians in terms of the gods and the afterlife, reminiscent of the spirit that one can sense behind the great European cathedrals. Interestingly, they did provide at least symbolic immortality to their occupants.

See also: EGYPTIAN BOOK OF THE DEAD; IMMORTALITY; MUMMIFICATION; TOMBS

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OGDEN GOELET JR.

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QIN SHIH HUANG'S TOMB

Until 1974, thousands of statues remained to be unearthed on the archaeological site at Shaanxi province, where Qin Shih Huang (c. 221–210 B.C.E.), the first unifier of China, was buried. For more than 2,200 years, these statues had been buried together with the Emperor in a massive city surrounded by two walls some twenty meters high (about 65 feet), and punctuated with gates on the northern, southern, western, and eastern sides and square towers at each corner. The excavation near Qin Shih Huang's tomb also uncovered four pits containing a total of nearly 8,000 figures. The soldiers are organized according to the military conventions of the time. In December 1987 the mausoleum was included in the World Heritage List by United Nations Educational, Scientific, and Cultural Organization.

Qin Shih Huang (259–210 B.C.E.) was king of Qin, the largest warrior state in ancient China. One of the most powerful and innovative monarchs in Chinese history, he decreed the building of the Great Wall. He also created many extravagant palaces. Wishing to retain his riches in the afterlife, upon taking the throne he began to build a magnificent underground palace in which he was to be buried. The tomb took some 700,000 workers thirty-eight years to complete. The details of the tomb's scale and contents were recorded in the *Shiji*, an ancient historical record. Relics excavated from the mausoleum are rich in contents and great in quantity. The king was buried with a symbolic force of life-sized terracotta soldiers, chariots, and



Emperor Qin Shih Huang, who was only thirteen years old when he became king of Qin, ordered an underground palace to be built as his burial place. PUBLIC DOMAIN

horses assembled to protect him in the next world. Other sculptured animals include oxen, dogs, sheep, and pigs. Also, a clay soldier lies beside two iron cooking pots, two large ceramic soup bowls, and some smaller bowls. The figures are all impressively lifelike in their degree of detail.

The arrangement of a tomb was not only an important life event but also a religious rite. Qin

Shih Huang believed that some people could escape from death, either by living for a very long time or by being reborn in a new form. Therefore, he sent people to find drugs that would grant him longevity. He also prepared replicas of worldly goods to help him in his new life. People believed that if the spirit of the deceased were happy, it would intercede in the spirit world on behalf of its descendants and they would do well.

See also: CHINESE BELIEFS; DEATH SYSTEM; IMMORTALITY; TOMBS

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MUI HING JUNE MAK

QUINLAN, KAREN ANN

On April 15, 1975, Karen Ann Quinlan, seventeen years old, presumably ingested barbiturates and alcohol at a party. She became comatose and experienced two periods of apnea (absence of breathing) of about fifteen minutes each, which resulted in irreversible brain damage. She was placed on a respirator and was fed nutrition and fluids by a gastrostomy tube. Her parents were told that she was in a persistent vegetative state from which there was no hope of recovery. Her physician, Robert Morse, considered the ventilator medically appropriate. He claimed that allowing a person in a persistent vegetative state to die was in violation of the professional standard of the time. Quinlan was still in a vegetative state five months later. The electroencephalogram (EEG) showed no signs of brain function, and she did not respond to verbal, visual, or even painful stimuli.

The Quinlan family priest told the parents that they had no moral obligation to continue extraordinary means (the respirator) to support their daughter's life, but that artificial feeding and fluids were "ordinary means" and should be maintained. Quinlan's father said he did not want to kill his daughter but merely wanted the respirator removed so that she had the option of dying a natural death. The Quinlans petitioned the New Jersey Superior Court for permission to remove the respirator. On November 10, 1975, that court denied the parents' request based on its contention that people have a constitutional right to life but do not have a parallel constitutional right to death. The lower court decision was appealed to the New Jersey Supreme Court, which in 1976 decided that "refusal of life-saving treatment" fell under the constitutional "right to privacy." They ruled that Quinlan could be removed from the respirator. However, hospital staff had already weaned her from the respirator, so the court decision was moot. She lived for ten years with the aid of artificial nutrition and hydration. She finally died in December 1985 of pneumonia. Since the Quinlan decision, a number of other states have permitted families to withdraw life support from comatose or terminally ill patients.

The Quinlan case is significant for several reasons. The definition of death, once linked to brain damage and the cessation of heart and lung functioning, had to be modified to accommodate technological advances in life support systems. Patients who formerly would have died can now be maintained indefinitely on life support. Further, considerations to maintain or withdraw life support raised moral and legal issues involved in the nationwide debate on abortion rights, patient's rights, and as well as organ and tissue retrieval for the burgeoning field of organ transplantation. The Quinlan case provided a focus for energetic and productive discussion of the complex and interrelated moral, ethical, and legal issues related to the definitions of life and death, the right to die, and the freedom of choice. The Quinlan case therefore stimulated intensive and productive national debate, discussion, and research on the related subjects of physician-assisted suicide, the quality of life, and the quality of dying.

See also: ADVANCE DIRECTIVES; CRUZAN, NANCY; DO NOT RESUSCITATE; LIVING WILL; NATURAL DEATH ACTS

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WILLIAM M. LAMERS JR.

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RAHNER, KARL

The Jesuit priest Karl Rahner is widely regarded to have been one of the leading Catholic theologians of the twentieth century. Rahner's early writings on death were published at a time when academic theology gave little serious consideration to the topic. Less sophisticated believers generally assumed that they knew what death was, and quickly moved on to mythological conjectures about the afterlife. Rahner sought to illuminate death's religious and theological significance. These initial publications and later writings are typical of his pioneering investigations, which creatively appropriate diverse theological and philosophical sources (e.g., Ignatian spirituality, Thomas Aquinas, Catholic neoscholasticism, Kant, Hegel, and Heidegger). Notwithstanding their uncompromising rigor, most of his articles had a broadly pastoral concern to explore ways of recovering the meaning of Catholic doctrine in an intellectually plausible and contemporary idiom.

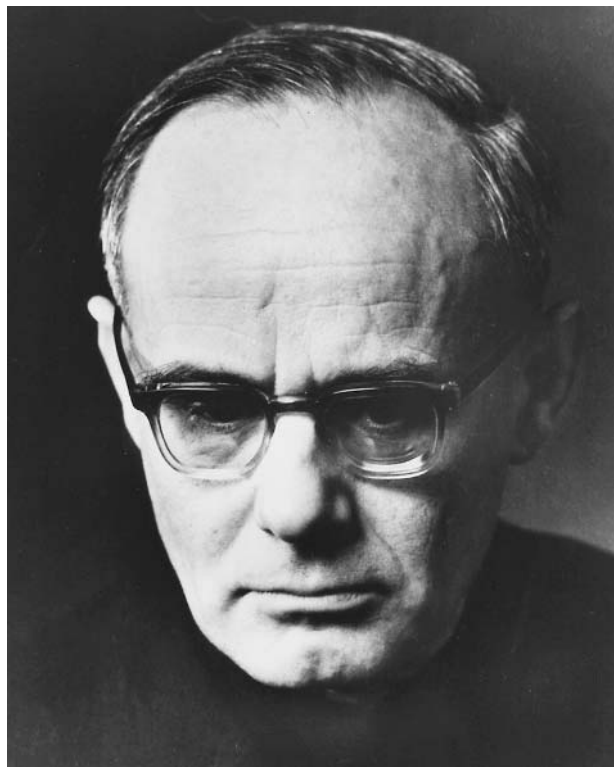
The density of Rahner's work is rooted in the subject matter itself. God, Rahner insisted, is not—and cannot—be an object for thought the way the things of our world are. But a person can know God by attending to the movement of knowing itself toward its objects, which reveals that human thinking always reaches beyond its immediate objects toward a further horizon. The movement of knowing, and the ultimate “goal” toward which it reaches, can be grasped only indirectly (or “transcendentally”) as one's thinking turns back on itself reflexively. Rahner identified the elusive and final

“term” of this dynamism of knowing with God, and argued that the same kind of movement toward God as “unobjectifiable” horizon is entailed in freedom and love.

By conceiving God, who always exceeds human reach, as the horizon of the movement of knowing, freedom, and love, Rahner emphasized that God is a mystery—a reality who is known and loved, but only reflexively and indirectly, as the ever-receding horizon of the human spirit. God remains a mystery in this sense even in self-communication to humanity through Jesus and the Holy Spirit. With this participation of God in an earthly history of human interconnectedness, something of God is anticipated—known reflexively and indirectly—at least implicitly whenever we know, choose, or love a specific being, particularly a neighbor in need. Conversely, God is implicitly rejected in every refusal of truth, freedom, and love.

Because it is often the good of a neighbor or the world, rather than God or Jesus which is directly affirmed or refused, it is quite possible that the one deciding will be unconscious or even deny that the act is a response to God. In either case, however, one turns toward or away from God and Jesus in turning one's mind and heart freely toward or away from the realities of the world.

Death is a universal and definitive manifestation of this free acceptance or rejection of God's self-communication (“grace”). In that sense, death is the culmination and fulfillment of a person's freedom, the final and definitive establishment of personal identity. It is not simply a transition to a new or continued temporal life. If there were no



Karl Rahner's wide-ranging concerns encompassed questions about the nature of God, Christ, and the relation of the Christian belief to modern understandings of the world. BETTMANN/CORBIS

such culmination, no ability to make a permanent and final commitment of self, then freedom would be an illusion. Genuine self-determination would be denied because every choice could be reversed. If everything is reversible, no act or succession of acts could definitively express an individual's identity. The Christian conviction that this life is the arena in which human fate is worked out, requires the freedom for such definitive acceptance or rejection of God's self-communication. But any anthropology that takes seriously the human capacity for free self-determination would also be required to see death as a kind of culmination and definitive expression of personal identity. Hence death is not something that happens only to the physical body. Death involves and affects the person as a whole. It involves consciousness, freedom, and love. It is not endured passively.

Hence, death as a personal and spiritual phenomenon is not identical with the cessation of biological processes. For example, illness or medication can limit personal freedom well before the onset of clinically defined death. Moreover, insofar

as all the engagements of one's life anticipate death, Rahner maintained that every moment of life participates in death. Hence he disputed the notion of death as a final decision if this is understood to be an occurrence only at the last moment.

The Christian tradition has emphasized the definitive and perduring character of personal existence by affirming the soul's survival after death. Rahner warned that this way of conceiving of death can be misleading if one imagines that the separation of soul and body, entails a denial of their intrinsic unity. The contemporary appreciation of the bodily constitution of human reality was anticipated by the scholastic doctrine of the soul as the "form" of the body and thus intrinsically, not merely accidentally, related to it. Personal identity is shaped by one's embodied and historical engagement with the material world. So the culmination of freedom in death must entail some sort of connection with that embodiment. Rahner's notion of God as mystery, beyond objectification in space and time, provides a framework for affirming a definitive unity with God that does not imagine the unity as a place or as a continuation of temporal existence. In the early essays, Rahner addressed the problem of conceiving the connection to embodiment, particularly in the "intermediate state" before the resurrection of the dead on judgment day, with the hypothesis that death initiates a deeper and more comprehensive "pancosmic" relationship to the material universe. In later essays, he recognized that it was not necessary to postulate an intermediate state with notions such as purgatory if one adopts Gisbert Greshake's conception of "resurrection in death," through which bodily reality is interiorized and transformed into an abiding perfection of the person's unity with God and with a transformed creation.

The Christian doctrine of death as the consequence and punishment of sin underscores its ambiguous duality and obscurity. If the integrity of human life were not wounded by sinfulness, perhaps death would be experienced as a peaceful culmination of each person's acceptance of God's self-communication in historical existence. But death can be a manifestation of a definitive "no" to truth and love, and so to God, the fullness of truth and love. Ironically, this results in a loss of self as well because it is unity with God's self-communication that makes definitive human fulfillment possible. In the "no," death becomes a

manifestation of futile self-absorption and emptiness, and as such punishment of sin. Moreover, everyone experiences death as the manifestation of that possibility. As a consequence of sin, people experience death as a threat, loss, and limit, which impacts every moment of life. Because of this duality and ambiguity, even a “yes” to God involves surrender. Just as God’s self-communication to humanity entailed fleshing out the divine in the humanity of Jesus, including surrender in death on the cross, so death-to-self is paradoxically intrinsic to each person’s confrontation with biological death.

See also: HEIDEGGER, MARTIN; KIERKEGAARD, SØREN;
PHILOSOPHY, WESTERN

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ROBERT MASSON

REINCARNATION

The concept of reincarnation, that of an individual dying and then being reborn into another body, has existed in various religions for at least 3,000 years. The belief most likely arose independently in different areas, and this was followed by periods in which the concept spread to other regions. It has now spread to the point that there are probably more people alive who believe in reincarnation than do not. Even in cultures such as the United States and Western Europe that do not have a predominant belief in reincarnation, 20 to 30 percent

of the population holds the belief. While the general concept is present in a number of religions and people groups, there are also significant differences between the various belief systems.

Hinduism

In Hinduism, it is believed that an enduring soul survives after death, spends a variable amount of time in another realm, and then becomes associated with a new body. Rebirth into the opposite sex or, under certain circumstances, into a nonhuman animal form is considered possible. Hinduism includes the concept of *karma*, the idea that the conditions into which one is born are determined by one’s conduct in various previous lives. Life on Earth is considered undesirable, and an individual may engage in religious practices in each life until eventually earning release from the cycle of rebirth, losing individuality, and achieving union with the infinite spirit (*nirvana*).

Buddhism

Buddhism shares some concepts with Hinduism but also has some significant differences. In particular, Theravada Buddhism, found in the southern parts of Asia, emphasizes in the doctrine of *anat-ta*, or no soul, which states there is no enduring entity that persists from one life to the next. At the death of one personality, a new one comes into being, much as the flame of a dying candle can serve to light the flame of another. When an individual dies, a new personality is born, generally first into a nonterrestrial plane of existence followed later by a new terrestrial personality. As in Hinduism, karma determines the circumstances of subsequent lives, so there is continuity between personalities but not persistence of identity. For this reason, Theravada Buddhists prefer the term *rebirth* to *reincarnation*.

In Buddhism, the law of karma is viewed as naturalistic, akin to the laws of physics. Thus, circumstances of rebirths are not seen as rewards or punishments handed out by a controlling God but are simply the natural results of various good deeds and misdeeds. The cycle of rebirths has involved innumerable lives over many eons, including ones in both sexes, in nonhuman animals, and in other realms. It inevitably involves suffering and continues until all cravings are lost and nirvana is achieved.

Shiite Muslims

A number of groups of Shiite Muslims in western Asia, such as the Druses of Lebanon and Syria and the Alevi in Turkey, have a belief in reincarnation that does not include the concept of karma. Instead, they believe that God assigns souls to a series of lives in different circumstances that are generally disconnected from one another until the ultimate Judgment Day, when God sends them to heaven or hell based on the moral quality of their actions during all the various lives. The Druses also believe that rebirth occurs immediately after death with no discarnate existence possible. While the Alevi believe that rebirth in nonhuman animals can occur, the Druses do not, and, in fact, they believe that they can only be reborn as other Druses. Neither group believes that they can be reborn as members of the opposite sex.

Judaism and Christianity

While reincarnation is not a belief in mainstream Judaism and Christianity, it has been part of the belief system of some of their groups. In Judaism, the Kabbalah, the body of teaching based on an esoteric interpretation of Hebrew scriptures, includes reincarnation, and Hasidic Jews include it in their belief system. In Christianity, some groups of early Christians, particularly the Gnostic Christians, believed in reincarnation, and some Christians in southern Europe believed in it until the Council of Constantinople in 553 C.E. Some Christians find support for reincarnation in the passage in the New Testament Book of Matthew in which Jesus seems to say that John the Baptist is the prophet Elijah returned.

Ancient Greece

The Greek philosophers wrote extensively about the concept of reincarnation, beginning with the legendary Orpheus and with Pythagoras. After Socrates, Plato, whose ideas about reincarnation became particularly influential, taught that one's soul is immortal, preexists before birth, and is reborn many times. Each soul chooses its next life, guided by its experiences in the previous lives. Aristotle initially accepted the ideas of his teacher Plato, but later largely rejected the concepts of reincarnation and immortality, becoming the father of materialism in Western thought.

West Africa

The concept of reincarnation is common among the various peoples of West Africa. In general, unlike Hindus and Buddhists, they believe that rebirth is desirable and that life on Earth is preferable to that of the discarnate, limbo state. They believe that individuals are generally reborn into the same family and that their souls may split into several rebirths simultaneously. Some groups believe in the possibility of rebirth into nonhuman animals while others do not. Many have the concept of "repeater children," in which one soul will harass a family by repeatedly dying as an infant or young child only to be reborn into the family again.

Native Americans and Inuit

The Inuit and many other Native American tribes, particularly those in the most northern and northwestern parts of North America, also believe in reincarnation. The details of the beliefs have varied greatly across different groups. Many do not necessarily expect all individuals to be reborn, but they instead focus on those who have had premature deaths, such as deceased children being reborn into the same family or dead warriors being reborn with birthmarks corresponding to their wounds. Some have believed in human to nonhuman rebirth and in cross-sex reincarnation. Many of them also believe that an individual may be reborn simultaneously as several different people.

Evidence for Reincarnation

In the twentieth century, researchers began exploring possible evidence for reincarnation. In 1961 Ian Stevenson, then the chairman of the Department of Psychiatry at the University of Virginia, began investigating cases of young children who claimed to remember previous lives. In a typical case, a child at the age of two or three would begin to speak spontaneously about another life. Some children described the life of a stranger while others talked about a deceased individual known to the child's family. In the cases involving a stranger, the child would often persist with the claims until the family eventually made efforts to locate the family of the previous personality; that is, the person whose life the child was describing. In many cases, their efforts were successful, and the child would then meet the family. At these meetings, the child would often be said to identify

members of the previous family as well as items belonging to the deceased individual.

Stevenson discovered that such cases were fairly easy to find in many parts of the world, particularly in Asia, and he eventually relinquished his position as departmental chairman to pursue the research full time. Since that time, he and other researchers have collected over 2,500 cases of children claiming to remember previous lives. As of 2002, such cases were still being collected regularly. While they each have individual variations, they generally share certain characteristics.

Location of cases. Cases are most easily found in cultures with a belief in reincarnation, and the most common areas for cases include India, Sri Lanka, Turkey, Lebanon, Thailand, Myanmar, West Africa, and among the tribal groups of northwest North America. Cases have been found, however, wherever they have been sought, and they include well over 100 nontribal American ones.

Types of lives described. The children who spontaneously report past lives generally describe a life as someone in their own culture. Even the exceptions usually show some geographical connection, such as Burmese children who describe the lives of Japanese soldiers killed in Burma during World War II, and cases of children describing lives in far-away countries are very rare.

In addition, the lives described are almost always ordinary ones, as the children describe typical family life and routine occupations. Claims to have been a famous person or royalty are essentially nonexistent in the spontaneous child cases. The children also tend to describe recent lives; the average interval between the death of the previous personality and the birth of the child is around fifteen months.

One exceptional part of the lives described is the percentage of violent deaths reported. Stevenson found that approximately 60 percent of the children who talk about the mode of death of the previous personality describe a violent one. Compared to cases with a nonviolent mode of death, the cases that involve violence have a shorter interval on average between the death of the previous personality and the birth of the subject.

Age and manner of speaking. The children studied almost always start talking about the previous lives between the ages of two and five years. Some

with unusual verbal skills may make statements earlier, and some make gestures earlier that are not understood until they develop the verbal skills to make statements that connect the gestures to a previous life. They almost always stop talking about the previous life between the ages of five and eight, which is generally the age when children branch out from the family and begin school, and also the age when children tend to lose early childhood memories.

Many of the children show extreme seriousness or great emotion when they talk about the previous life. They may cry as they talk about missing their previous family or show great anger in describing their killer. The children in the stronger cases, such as ones with more verified statements about the previous life, tend to show more emotion in describing the previous life than those in the weaker cases. Some children may talk about the previous life with great emotion one minute and then go off to play the next, and some parents say that their child has to be in the "right" state of mind to discuss the previous life. In U.S. cases, this is often during relaxed times such as during a car ride or after a bath. Other children, however, appear to have access to the memories at all times.

Themes of the past life statements. The children in the studies who talk about previous lives do not tend to make statements indicating great wisdom. Instead, they generally talk about events from the end of the previous life; almost three-quarters of the subjects describe the mode of death of the previous personality. They are also much more likely to talk about people from the end of that life than about people from earlier in it. Thus, a child who describes the life of an adult tends to talk about a spouse or children rather than parents.

Few subjects talk about any time between lives. Of those that do, some describe staying near their homes or the site of their deaths, and they may describe seeing their funerals or other events that occurred after their deaths. Others report going to a discarnate realm, at times describing meetings with other beings such as sages or guides.

Birthmarks and birth defects. In about 35 percent of the cases, the child bears a birthmark or birth defect that matches a wound of the previous personality, usually the fatal wound. The birthmarks tend to be unusual ones, often being puckered scarlike areas, and some of them are said to have

oozed or bled for some time after the child was born. The birth defects are often ones that are extremely rare. In the late 1990s Stevenson published a series of over 200 such cases in which he documented the correspondence of the marks to wounds on the previous personality, using post-mortem reports whenever possible. Examples include cases in which children had birthmarks that matched the bullet entrance and exit wounds on the previous personality and others with multiple marks matching the wounds from the shotgun blasts that killed the previous individuals.

Behaviors related to the previous life. Many of the children in these studies show behaviors that suggest a connection to the previous individual. They often show emotions toward the various members of the previous family that are appropriate: demurring to a husband, being bossy to a younger sibling (who is now, in fact, much older than the subject), and so forth.

Many of the children show phobias related to the mode of death; 50 percent of those describing a violent death show a phobia of the instrument of that death. At times, the phobia will be present long before the child talks about the previous life; for example, a baby may show an intense fear of water, and that child later reports a memory of having drowned in the previous life.

Some children show likes and dislikes that match those of the previous personality. For example, Burmese children who describe lives as Japanese soldiers may complain about the spicy Burmese food while requesting raw fish to eat.

Many of the children show connections to the previous life in their play. For example, some act out the occupation of the previous personality. At times, this can reach compulsive proportions so that, for instance, the child misses school because of the insistence on continuing with this play. Others repetitively act out the death that they describe in what appears to be posttraumatic play. Many of the children who report previous lives as members of the opposite sex show behaviors appropriate to that sex. They may dress, play, and think of themselves as members of the opposite sex, and this behavior can be of such severity to warrant a diagnosis of gender identity disorder. Most of the children, however, show a normal course of development that is indistinguishable from their peers.

Methods and Interpretations

In the vast majority of cases, the investigators do not get to a case until after the subject's family and the previous personality's family have met, often not until years after. This leads to the need to interview as many firsthand witnesses as possible. These include, of course, the subject, but he or she may not still be reporting memories of the previous life by the time of the interview. The child's parents are always important witnesses, since the young child has often told more to them than to others. In addition, other family members and family friends can be important witnesses. After they have been interviewed and the information recorded, the previous personality's family is interviewed. Those family members can confirm both the details of the previous personality's life that are relevant as well as any recognitions or information that the child demonstrated when the two families met. In all instances, firsthand knowledge rather than hearsay is sought. Interviews are conducted with the use of an interpreter in countries where one is needed.

Repeat interviews are often conducted, both to obtain additional details that were missed during the first ones and to determine whether the reports remain consistent. In addition, other evidence is gathered when relevant. For example, postmortem reports may be obtained, both to confirm the details that the child gave about the death as well as to confirm, when applicable, that the child's birthmarks do match wounds on the deceased. In the cases in which the previous personality was unknown to the subject's family, investigators also attempt to learn whether the child or the family may have had a connection to the previous personality or possible access to information about that life that is not immediately apparent.

There are also times when the researchers find a case in which the previous personality has not yet been identified. The information from the subject and his or her family is recorded, and it is then used in an effort to identify the deceased individual whose life the child is describing.

There are several possible ways in which these cases could arise through normal means. One is fraud, but this is quite unlikely for the vast majority of cases, given the number of witnesses often involved, the amount of effort that would be necessary to perpetrate such a fraud, and the lack of motive to do so.

Another possibility is that the children have learned about the deceased person through normal means but then forgotten where they acquired the information. This would not explain the birthmarks that match the wounds of the deceased. Also arguing against this interpretation are the lack of opportunity in many cases for the child to have heard anything at all about the previous personality, the mention by some children of information known to only a select few intimates of the previous personality, the child's strong sense of identification with the previous personality, and other behavioral features that the children often show. In addition, the stronger cases, such as ones with more verified statements about the previous life, tend to involve greater distance between the homes of the child and the previous personality than the weaker ones.

A third possibility is that after the families of the subject and the previous personality have met, the family members credit the subject with having had more knowledge of the prior life than he or she actually had. According to this interpretation, the evidence for a connection with a previous life is not valid due to faulty memory on the part of the participants. While this possibility would not explain the birthmark cases or the ones in which a written record was made of the child's statements before the previous personality was identified, it could explain many others. Two studies, however, argue against this hypothesis. In 2000 Stevenson and Jürgen Keil conducted a study in which Keil reinvestigated cases twenty years after Stevenson's initial investigation. They found that the cases had not become stronger in the participants' minds over the years, and, in fact, some had become somewhat weaker as witnesses recalled less specific details of what the child had said. In the other study, Schouten and Stevenson in 1998 compared cases from India and Sri Lanka in which written records had been made before the two families met with other thoroughly investigated cases without such written records. The two groups had the same percentage of correct statements, and the overall number of statements was actually lower in the cases without a written record made beforehand.

In addition to normal means, a possible way to explain the cases would be that the children gain knowledge of the previous personality through extrasensory perception. This seems unlikely because most of these children show no other extrasensory

ability and because the cases involve multiple features—birthmarks, identification with the previous personality, longing for the previous family, phobias, repetitive play—other than the knowledge of the previous life.

Another possible explanation is reincarnation. These cases, taken at face value, suggest that memories, emotions, a sense of identification, and even physical features can carry over from one life to the next. This does not necessarily mean that these characteristics carry over for other individuals who do not remember previous lives, or that other individuals have even had previous lives. The cases do, however, provide evidence that should be considered in any evaluation of the concept of reincarnation.

See also: AFRICAN RELIGIONS; AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; BUDDHISM; HINDUISM; ISLAM; PHOENIX, THE; PLATO

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JIM B. TUCKER

REPLACEMENT CHILDREN

When a family suffers the death of a child, the reverberations can extend beyond the immediate period of bereavement. When a child is born into a family that has suffered such a loss, there is concern that the new child might be compromised in his or her development. Such a baby is often described as a "replacement child," a substitute or replacement for the child who died. This baby is thought to be at risk for later psychological difficulties because of an inability to form an identity separate from the dead child. It is thought that parents who are unable to fully and completely mourn the death of their child may compromise a subsequent child's mental health by imbuing that child with the qualities and characteristics of the dead sibling and by continuing to mourn the earlier death.

Parental Bereavement

The death of a child is among the most profound losses that an individual can suffer, and the resulting grief can be especially intense and prolonged. This is in part due to the uniqueness of the parent-child relationship. From the moment of conception, the parents fantasize about the child-to-be, investing in him or her their hopes and dreams for the future. Parents see themselves in their children,

and when the child dies, it is as if a part of the parent dies, too. Parents also feel acutely the loss of the parenting role when their children die. The social role of parent, which can begin at conception, is an important organizer of time, activity, and identity. The loss of the parental role often challenges the parent's sense of meaning or purpose in life. The death of a child also changes the nature and composition of the family constellation and alters the family story.

Parents cope with the death of a child in multiple ways. Often, particularly when the death occurs during or shortly after birth, parents express the desire to have another child. They feel a strong need to fulfill the expectations created by the previous pregnancy and assume the parenting role. When the child that dies is older, parents may feel the need to fulfill the expectations, hopes, and dreams engendered by the dead child.

The Replacement Child As a Clinical Phenomenon

There has been much concern in mental health literature about families inadvertently creating replacement children. This phenomenon was first described in a 1964 paper by Albert and Barbara Cain, who reported on six families receiving psychiatric treatment following the death of a child or adolescent and the birth of a subsequent child who later developed psychiatric problems. This clinically important paper led to the prominence of the term *replacement child* in the mental health field. The parents in the Cain and Cain study were characterized by intense idealization and investment in the dead child, maternal personality dysfunction that predated the child's birth, and a history of losses in the mother's own childhood. The parents were restrictive and overprotective, and the children were fearful, anxious, morbidly preoccupied with death, and lacking in self-esteem. The authors of this study warned that parents should not have another child until they have had the opportunity to completely mourn the death of their child.

Although Cain and Cain note that the replacement of a child who dies at birth or in infancy is less likely to be complicated by confused identifications and comparisons with siblings, other clinicians suggest there may be some risk when a child

dies at or near birth as well. In this case, the parents' experience with their baby is very limited. They have few memories to mourn and instead must mourn the wishes and expectations that they held for the child. The baby remains an abstraction even after the death.

The replacement-child concept has influenced contemporary obstetric and neonatal caregiving practice. When a child dies during the perinatal period (at or near birth), parents are encouraged to have contact with the dead baby, including holding and naming him or her, taking pictures, and making memories. It is suggested that parents who have these experiences are better able to grieve the loss, can separate the real baby from the fantasy image they hold, and thus may be better able to parent a subsequent child. Medical personnel have often counseled parents who have experienced perinatal loss to wait before attempting subsequent pregnancies in order to grieve fully for the dead child.

Research into Parents' Opinions

There is a considerable body of psychiatric case studies on the pathology of the replacement child. Studies that solicit parents' opinions suggest that giving birth after the death of a child may be helpful to the parents and help families grow through loss. One researcher found that recently bereaved parents experienced their loss as a void or hole in the family. For some parents, the decision to have another child provides a reason to begin living again. Although parents indicate that they could not replace the dead child, many want another child of the same sex as soon as possible and often give the subsequent child a name that resembles that of the dead child.

It is important to directly assess the psychological functioning of children born subsequent to parental bereavement. Parental attitudes toward the decision to have other children, parental beliefs about practices, and parents' interpretation of the family structure directly and indirectly affect child mental health. Parental interpretations of the family constellation and stories about family life determine family practices and, through these practices, child development. Family stories give meaning to the past and direction to the future, shaping subsequent development.

What Family Practices Say about Subsequent Children

By listening to and analyzing the stories of parents who have lost children at or near birth and who have gone on to have subsequent children, it is apparent that many parents do not replace the dead child with a child born later. Some parents continue to represent their family as including their deceased child and maintain an imagined relationship with the dead child that is separate and apart from their relationship with their living children. Other parents continue for years to feel the death of their child as a hole or void in the family constellation. Other parents may, in fact, fill in the gap in the family with a newborn "replacement child." Many parents continue to remember and pay homage to their dead child long past the initial mourning period. None of these arrangements or representations of family are necessarily pathological.

Theoretical Constructions of Grief and the Replacement Child: Stage Models

Concerns about the risk of having a replacement child are derived from a stage model of grieving. This way of understanding grief suggests that there is a typical pathway through grief and a "good" and "bad" way to grieve. The "good" way consists of moving from a period of shock or denial, through an intensely painful period during which the deceased is acutely missed and the bereaved may feel guilty and angry as well as sad, followed by a period of grief resolution characterized by changed or diminished attachment to the deceased, loosened emotional bonds, reinvestment in the social world, and return to preloss levels of functioning. A "bad" way would include denial of the loss or premature focus on moving forward. Cain and Cain note that the replacement children in their study represent a "pseudoresolution" of mourning because there is a denial of loss and a retention of intense emotional ties to the dead child.

Meaning Reconstruction

Some psychologists suggest that the grieving is a means of reconstructing meaning in the face of a world that has irrevocably changed. Making meaning is, of course, highly personal, and the meanings a grieving individual creates are unique. Hence there is no universal path through grief, and

no practice (i.e., replacing a child) can be prescribed or be considered detrimental on its face. Rather, the place the child holds in the family story and the meanings the parents ascribe to the dead child and the surviving and subsequent children require individual assessment. Further, contemporary models of grief note the commonality and normalcy of maintaining continuing bonds to the deceased. Thus, a continued relationship with the dead child, considered pathological in the Cain and Cain study, is increasingly noted as common practice and one that does not necessarily interfere with the growth and development of surviving children.

Conclusion

While the replacement-child construct may have clinical utility, especially in cases where parents may have preexisting dysfunction and/or a significant history of losses, it seems clear that clinical axioms like “replacement child” do not do justice to the complexity of parental interpretations of the child and the family constellation. When parents are asked to describe how they coped with the loss of a child, and when families who have experienced the birth of a child subsequent to a loss describe their experiences, it becomes clear that there are many paths through this grief that do not result in the anticipated pathology. As caregivers for families who have experienced the death of a child, one must seek to understand the meaning of the dead child and subsequent children, and what those children represent to their families. Without listening closely to the stories that parents tell, mental health practitioners are in danger of assuming psychological risk when there may be none.

See also: CHILDREN; GRIEF: CHILD’S DEATH, FAMILY; GRIEF COUNSELING AND THERAPY; MORTALITY, INFANT

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RESUSCITATION

The term *resuscitation*, as used by medical personnel, means both trying to revive those who have gone into cardiac arrest (cardiopulmonary resuscitation or CPR) and any intense intervention that will prevent imminent death. Such interventions usually include helping people get oxygen and breathe, restoring the amount of fluid and blood in their system, keeping their hearts beating effectively, and halting any process that is interfering with their ability to survive. Some of these processes merge almost seamlessly with the process of “life support.”

The simplest resuscitation procedure to assist oxygenation and breathing is to position the head and body so that the airway (e.g., nose, mouth, pharynx, and trachea) remains open. In some cases, clinicians may insert an oral or nasal airway device to help keep it open while patients continue breathing on their own. If the clinician believes that they may stop breathing, do not have control of their airway, may aspirate stomach contents, or have stopped breathing (apnea), he or she will usually put a tube into the trachea. These endotracheal tubes, made of clear polyvinyl, protect the

airway or are used to attach patients to a mechanical ventilator (sometimes referred to as a respirator). In some cases, clinicians cannot pass the tube orally or nasally into the trachea because of damage to the area, swelling, or a person's unusual anatomy. In those cases, the clinician uses an emergency surgical technique, a cricothyrotomy, to pass the tube into the trachea through a hole made in the neck just below the thyroid cartilage (Adam's apple). An alternative surgical technique, more difficult to perform in emergencies, is the tracheotomy, in which physicians insert a smaller "trach" tube low in the neck.

Once the clinician places a tube in the trachea, patients may simply have humidified oxygen administered through the tube if they are still breathing adequately on their own. More commonly, they will first be "bagged" by hand, using a bag-valve mask, and then attached to a mechanical ventilator. These ventilators force oxygenated air into the lungs in the amount and at a pressure appropriate for each patient.

Sometimes, most frequently after trauma, one or both lungs collapse and may accumulate blood around them in the "pleural space." This often causes patients to have difficulty breathing. In some cases, it may decrease the oxygen getting into their systems and diminish the ability of their hearts to pump blood. In such cases, the clinician must immediately place a tube (chest tube or thoracostomy tube) into the pleural space through the chest wall. He or she then connects it to suction and removes the air and blood.

IVs, Fluids, Blood

Another common resuscitation measure is to administer fluids into a patient's veins. This helps improve the blood flow and thus the amount of oxygen and nutrients available to the body's tissues, thereby facilitating the cells' ability to discard waste products. Used for patients who are dehydrated, bleeding, or who simply cannot take adequate amounts of fluid orally, this procedure often includes inserting intravenous catheters with large internal diameters (large-bore IVs), into the arm, foot, neck, shoulder area, or groin. Through these IVs, medical personnel may administer large amounts of fluids, such as Normal Saline, Ringers Lactate Solution, plasma, or blood.

During resuscitations, medical personnel may place a large monitor/infusion catheter, such as Swan-Ganz or triple-lumen catheter, to assess a patient's state of hydration, heart functioning, and the amount of fluid in the lungs. Personnel may also place a catheter into the bladder to assess how the patient is producing urine, which is a simpler measure of how well the kidneys are functioning and an indirect measure of a patient's fluid status.

Heart

Clinicians often must concentrate on correcting cardiac (heart) abnormalities while resuscitating a patient. The most obvious and dramatic measure is cardiopulmonary resuscitation (CPR), in which clinicians pump on the sternum to generate circulation of blood. Resuscitation, however, may include many other activities before the clinician resorts to this procedure.

One of the most common resuscitative measures is to administer antiarrhythmic drugs to stop abnormal heart rhythms, such as overly rapid or slow heartbeats. In either case, the heart is not pumping effectively and so is not supplying enough blood to the brain and the rest of the body. The drugs may also be used when the heart is producing beats from an abnormal site, such as from the ventricle. This can either be an ineffective rhythm (not producing good blood flow) or a forewarning of cardiac arrest and so must be corrected. If the antiarrhythmic drugs prove ineffective, the patient may require an electrical shock to restore the heart to a normal rhythm. This can either be synchronized with the heartbeat (often at a relatively low voltage), called "cardioversion," or at higher energies and unsynchronized, called "defibrillation." Defibrillation is generally used to resuscitate patients in cardiac arrest.

Other measures to improve heart activity during resuscitations include inserting a temporary pacemaker, administering thrombolytics (clot busters), performing angiography, and doing pericardiocentesis. Temporary pacemakers, often placed through the same large IV sites as are used for fluid resuscitation, are inserted when the heart is beating too slowly to be effective, or to override an abnormally fast and life-threatening heart rate that they cannot stop any other way. Clinicians use thrombolytics, one of a class of medications, to help open coronary arteries during or immediately

after a heart attack. If these drugs prove unhelpful (or sometimes even if they are working), physicians may take patients to the cardiac catheterization laboratory for coronary angiography. This procedure visualizes and opens coronary (heart) vessels and is particularly useful in patients in cardiogenic shock. In some patients, a sudden accumulation of blood or fluid around the heart (pericardial tamponade, often due to trauma) causes their heart to pump ineffectively. In those cases, physicians may need to put a needle into the sac around the heart to withdraw enough fluid, usually less than 50 cc, so that the heart can again pump normally. After this procedure, called pericardiocentesis, cardiac surgeons generally must take patients to the operating room for a definitive procedure.

Treating Underlying Problems

An essential step in resuscitations is for clinicians to definitively remedy underlying problems. Among other things, this may include stopping bleeding, halting or preventing infection, controlling blood pressure, and treating poisoning.

While external bleeding can be easily controlled with direct pressure, surgeons often need to operate on patients to halt bleeding in the chest, abdomen, or head. They may perform laparotomies (abdominal operations), thoracotomies (chest operations), and craniotomies (entering the skull) if bleeding does not stop spontaneously. Patients with continuing bleeding, such as from a torn artery, will die without such surgery. When necessary, neurosurgeons also perform craniotomies to relieve pressure on the brain from blood that has accumulated within the skull. In some cases, rather than operating, radiologists control bleeding with small pledgets of material that they put into the vessels through arterial catheters. In an even simpler procedure, orthopedic surgeons may slow or stop bleeding by stabilizing fractured bones (particularly the pelvis and femur). Physicians administer a variety of medications and clotting factors to reverse the process in patients bleeding due to hemophilia, liver failure, disseminated intravascular coagulation (DIC), platelet dysfunction, or other abnormalities related to the blood-clotting system. Unlike mechanical interventions, treatment for bleeding disorders may last for days until patients improve.

Infections still cause many deaths, and not all infections can be treated effectively. Yet, when

possible, clinicians treat or try to prevent infections in patients undergoing resuscitations. For example, patients with perforated intestines may need broad-spectrum antibiotics administered both before and after surgery. Those with open fractures need similar antibiotic coverage, both to prevent and to treat infections. These patients, if they are not already immunized, also must receive immunizations against tetanus.

Patients undergoing resuscitation often have an altered blood pressure. Blood pressure is a measure of the effectiveness of cardiac activity (the pump), the distention and porosity of the blood vessels (the pipes), and the amount of blood in the circulatory system (fluid). The brain (control station) regulates these elements, directly or indirectly. When illness or injury alters any of these factors, blood pressure moves out of the safe and healthy range. Low blood pressure (hypotension) usually accompanies serious illness. Clinicians must frequently administer intravenous vasopressors to such patients to help elevate their blood pressure and to assure that adequate blood is flowing to their vital organs. In some cases, blood pressure is too high, a development that can be accompanied by or lead to strokes, heart attacks, dissecting aortas, and other life-threatening events. Physicians must use antihypertensive drugs to help resuscitate such patients.

Resuscitations often occur in patients who have taken overdoses of dangerous medications or illicit drugs, or who have come into contact with a dangerous poison. Treatment for such events includes using medications to reverse a drug's effect, when possible. There are few specific antagonists for common drugs, with the exceptions being narcotics, benzodiazepines (i.e., Valium) and Tylenol. Other antidotes also exist for some exotic poisons, such as cyanide, snake and insect toxins, heavy metals, and industrial chemicals similar to those used as warfare agents. Treatment for most drug overdoses, however, employs measures to support the affected systems, especially breathing, the heart and blood pressure, and the kidneys. Treatment often includes using charcoal to bind any of the medication still in the gut or washing off any toxin that is on the skin. Occasionally, clinicians must use renal dialysis or other supportive measures. Patients may also have severe reactions to a normal medication dose, an event termed "anaphylaxis," including a closed airway, impaired breathing,

and falling blood pressure. Resuscitation involves supporting each of these systems.

Other resuscitations involve patients with severely abnormal temperatures (usually from environmental exposure or medications), acid-base and electrolyte abnormalities (sodium, potassium), and protracted seizures. These may occur alone, or in combination with other problems that also require resuscitative efforts and aggressive, organ-specific support while the clinician attempts to treat the problem's underlying cause.

Calling for Help, Viewing Resuscitations, and Stopping Resuscitative Efforts

In many U.S. jurisdictions, ambulance personnel must attempt resuscitation when patients are not clearly dead. Many people have received unwanted resuscitation attempts after their loved ones simply tried to notify authorities that the person had died. Most states have statutes or protocols whereby individuals can prevent unwanted resuscitation through an out-of-hospital Do Not Resuscitate (DNR) order or an advance directive that is recognized by ambulance personnel. Often referred to as "orange forms" because of their common color, prehospital advance directives allow medics to not begin resuscitative measures in cases of cardiac arrest. They are usually used for homebound, hospice, and nursing home patients.

The paramedic profession was formed primarily to implement new cardiac resuscitation methods and to "raise" the clinically dead from cardiac arrest. Yet, for patients on whom medics perform out-of-hospital CPR, only about 1 to 7 per every 100, on average, are discharged from hospitals alive. In those who have a cardiac arrest after trauma and are brought to a hospital, only about 5 per 200 survive, with only about 3 per 200 being able to function, meaning that many patients are pronounced dead on the scene, either after failed resuscitative efforts or where CPR was not begun because it would have been futile. As paramedic Mike Meoli wrote, "No matter how quickly we are summoned or how well we perform, the usual outcome of a CPR call is the same: death" (1993). While the phrase "dead on arrival" once meant that no resuscitation was attempted, the media now often use it for many patients who actually died in the emergency department, sometimes after a resuscitation attempt.

Family members who arrive during resuscitations should be allowed in the resuscitation area, if they wish. Senior staff (nurse, social worker, chaplain) should quickly brief them on what they will see and then accompany them throughout the procedure. When survivors witness resuscitative efforts, the resuscitations often run more smoothly (and more quietly), and the survivors have fewer problems accepting both the death and the notion that significant efforts were made to save their loved one. Studies show that they do not disrupt the resuscitative efforts. Subsequently, they also have lower levels of anxiety, depression, posttraumatic avoidance behavior, and grief. If the family is present when it is clear that resuscitative efforts have been unsuccessful, this should be explained to the family before supportive measures are discontinued, to provide them with a chance to "say goodbye" before death is pronounced.

Patients are dead when a physician declares them dead. Because errors are occasionally made, care must be taken to assure that patients declared dead are, in fact, dead. Such precautions also prevent implementing unnecessary resuscitative efforts. These errors can be avoided by checking vital signs and observing isoelectric cardiac activity in at least three ECG readouts (leads). This can be omitted when anatomical injuries (i.e., decapitation) are incompatible with life.

Prehospital personnel (EMTs, paramedics) should not begin or should halt resuscitative efforts if it would jeopardize their safety, if they cannot physically continue, or if there is a valid prehospital advance directive specifying not to resuscitate. This also applies when any of the following are present: rigor mortis, livor mortis, evidence of decomposition, bodies burned beyond recognition, or injuries clearly incompatible with life. Hospital personnel should not begin or should stop resuscitative efforts when the patient has declined them, in situations in which inadequate resources exist to treat all patients (e.g., disasters), or when appropriate resuscitative efforts have not been effective. Following resuscitation, physicians have two responsibilities: pronouncing the person dead and notifying the survivors.

See also: ADVANCE DIRECTIVES; DO NOT RESUSCITATE; END-OF-LIFE ISSUES; LIFE SUPPORT SYSTEM; NECROMANCY; PERSISTENT VEGETATIVE STATE

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KENNETH V. ISERSON

REVOLUTIONARIES AND “DEATH FOR THE CAUSE!”

Willingness to die for a religious or political cause has long been recognized as a key measure of an activist’s commitment. To supporters of the activist’s cause, such sacrifice amounts to martyrdom, whereas critics are more likely to view it as a triumph of irrational extremism.

Literature on the subject of dying for a cause divides between analyses of two frequently overlapping categories: religious and political causes. While there are striking parallels between self-sacrifice for religious and political purposes, particularly in their intended impact on observers, there are also significant differences pertaining to belief in an afterlife.

Religious Self-Sacrifice

Dying for a religious cause is predictably linked with religious persecution, with self-sacrifice justified as a means to the salvation of others. Persecution may take several forms, including an established religious system attempting to suppress a new, emerging faith that poses a threat; the consequence of political activities that threaten those practicing a particular faith; or an intragroup battle to prevent an established faith from changing its beliefs too radically. The functions of self-sacrifice under such situations include generating negative publicity which may prevent further threats to the faith, establishing the viability of the faith as one for which people are prepared to lose their lives, or exonerating prophecies that foretold the demise of a true believer.

Heresy trials. In medieval Europe, particularly the period of 1200–1500 C.E., the Roman Catholic Church often undertook investigations of heresy accusations. Individuals charged with subscribing to and disseminating heretical beliefs could escape severe punishment by confessing ignorance of proper views, assisting the inquisition that had condemned them by identifying other heretics, and accepting nonlethal sanctions. Refusing to confess or to assist the inquisition led to the heretic’s death, either during interrogation or at a public execution. Self-sacrifice in this setting was the act of an individual who refused to implicate others or to accept the established faith’s legitimacy.

It is difficult to measure the effect such deaths had on rallying supporters. Inquisitorial hearings were protracted and thorough, and appear to have been effective at ending specific heresies, such as the Cathars (persecuted and wiped out during the twelfth and thirteenth centuries), but their frequency suggests that heresy (or belief that heresy was a problem) was widespread. Awareness of the severe sanctions meted out to heretics may have made many people reluctant to listen to them, but such sanctions may also have made those risking heresy charges appear more appealing for their willingness to undertake the risk of persecution and certain death.

Religious expectation of self-sacrifice. Several religious traditions include an expectation that devoted followers will willingly risk their lives in defense of the faith. Proclamations of this sort often accompany a call to battle in which true believers are expected to take the lives of nonbelievers at

great risk to themselves. Given widespread reluctance to undertake such risks, other assurances are often added, such as absolution of sins, certainty of salvation, and eternal life in paradise.

The religious beliefs of the early Normans, which did not emphasize an afterlife, carried similar expectations. A glorious life was to be ended with an equally glorious death, preferably in a battle where chances of survival were nonexistent.

Death of charismatic leaders. As sociologists have long believed, one test of a new belief system constructed around the life and works of a charismatic leader involves his or her death. Can the belief system make the transition to a new period in its existence when it is denied its most attractive spokesperson? Chances of success are enhanced if the charismatic leader foretold his or her death or consciously pursued it, presenting followers with the explicit challenge of responding appropriately. The death of such a figure also creates a role model for others to follow. Lacking the leader's bearing and vision, followers nonetheless can revere their leader's life and extol the virtues of self-sacrifice to new generations of believers. That new generation, then, is socialized to appreciate, accept, and adopt the value of self-sacrifice in defense of the faith.

This does not mean that all followers of a faith with a long tradition of self-sacrifice are themselves destined to commit such acts, but rather that any religious tradition that recognizes and celebrates self-destruction spawns future generations of martyrs.

Political Self-Sacrifice and Marxism

Revolutionary Marxists view revolution as a necessary and natural component of history. Violent upheaval is thought to be essential to moving society from one stage of development to the next, ending with the arrival of communism. It is the clash between antagonistic classes that propels history onward, with ascending classes violently displacing obsolete ruling classes whose political and economic structures obstruct the rise of more progressive systems. The key to this analysis is the creation of class consciousness, whereby members of exploited classes realize not only their existence as a class with a common condition but also their historic mission of bringing about inevitable change. Because ruling classes cannot imagine themselves

as being obsolete and justify their continued control with the belief that those that they dominate are incapable of self-rule, they do not relinquish power voluntarily. This means that violent revolution is the only way to remove them and advance the course of history.

Marxists also recognize the variability of conditions under which a revolution can be expected to succeed. Many unsuccessful, premature uprisings misread the strength of ruling classes or the loyalty of armies and police. Quite often, the cost of a failed revolution is execution for its principal supporters, such as occurred after the many European revolutions of 1848. In Paris, for example, 3,000 insurgents were killed and another 4,000 deported while the 1871 Paris Commune was suppressed at the cost of 20,000. Given these contingencies and the likelihood of violent opposition, revolutionaries must be prepared to die for their political activities and may very well be killed during a failed uprising.

One key motivation for this willingness to die for the cause is a deep-rooted belief in the cause's inevitability. Sooner or later, substantial change will be needed. An activist who chooses to hasten that day may succeed and become a hero of the revolution or else fail and eventually become recognized as a martyr. While ruling classes portray those whom they dominate as unintelligent, leftist revolutionaries believe they have extensively studied and fully understand human history. While ruling classes often employ religious ideology to justify their domination, revolutionaries believe that their scientific analysis of economic development reveals a more substantial truth: that their success is ultimately both progressive and inevitable. Because they usually reject organized religions for their role in supporting oppressive political systems, revolutionaries typically dismiss the idea of an afterlife. Any form of immortality they can hope for, then, can be achieved only by a posthumous reverence among the living.

Some revolutionaries undertake great risks and court self-destruction because the political system that they attack is seen as responsible for having killed members of their family or community. For such individuals, there is no reason to continue living, beyond exacting revenge. Vladimir Ilyich Ulyanov (Lenin), for example, became a dedicated political activist and revolutionary after his brother



Police attempt to control a crowd of University of Wisconsin students protesting Dow Chemical's Napalm in 1967. The first requirement for a social movement is the potential for strain, characterized by genuine conflict or contradiction within a society. AP/WIDE WORLD PHOTOS

was executed for having participated in a failed attempt to assassinate the czar.

Stages in Social Movements

According to the sociologist Neil Smelser, successful political movements proceed in several stages. Smelser's ideas, while most commonly applied to social movements such as the American civil rights movement, can also aid in an understanding of revolutionary uprisings, especially in identifying potential junctures of self-destruction.

The first requirement is the potential for strain, some genuine conflict or contradiction within a society, for the possibility of angry demands for change to develop. Sociologists believe that most simple societies and all complex societies possess significant potential for strain. This strain must be sufficiently strong or durable to generate a reaction. For example, a society engaged in war initially may find its people united behind it. If the conflict is short and victory complete, that unity will remain strong. However, if combat persists and there are significant losses, demands for radical change are certain to appear.

A third stage is characterized by the formation of a generalized belief. Individuals seeking to thwart change may characterize the strain as inevitable, normal, not severe, or soon to end. Others may claim a variety of causes for the strain, none requiring dramatic change. Still others may recognize a need for significant change but claim that reform rather than radical overhaul of the current society or political or economic system would be sufficient. Finally, some may diagnose the problem as fundamental to the system and requiring radical, even violent, change to eliminate it. It is at this point that some supporters of extreme solutions may use the occasion of their own destruction to draw attention to their analysis of the situation.

Intellectuals are important for providing generalized beliefs that transcend the often splintered and localized beliefs of oppressed groups. If those beliefs include a justification for violence to bring significant change, then death may appear very early in a movement's development. Quite common, for example, is a distinction between violence used to bring needed change and violence used to prevent such change from occurring. The writings of political theorist Herbert Marcuse, for example, were popular with elements of America's New Left in the 1960s. Marcuse's distinction between what he called "red terror" and "white terror" was intended to evoke comparisons with the Bolshevik-Menshevik clash during the revolution and the ensuing counter-revolution in Russia during World War I. For Marcuse, violence was justifiable if its objective was to bring an end to all violence, to end a system that routinely relied upon violence to keep itself in place. This liberating (red) violence was regrettable but largely reactive, brought on by oppressive (white) violence that was used to keep privileged groups in place. If this perspective had dominated the American antiwar movement, protests against the country's involvement in Vietnam would have been far more violent.

Social movements enter a new phase with the appearance of precipitating incidents. A string of events can persuade large numbers of individuals that the strain is not going away and that many of the attempts to explain the strain are incorrect. People can quickly cluster around a given belief system. In the context of an evolving revolution, precipitating incidents are often violent and reveal how much force an oppressive system is prepared to employ to keep itself in power. For that reason,

self-destruction is sometimes seen as a necessary step to show potential followers of the revolution both the bravery of revolutionaries and the callous attitude toward life of those they are challenging. One motive behind terrorist attacks is to provoke a brutal reprisal that might be viewed as disproportionate to the initial assault. Intended as a deterrent that will show the high price to be paid for the use of violence by revolutionaries, under some circumstances such reprisals can have the opposite effect of generating widespread sympathy for rebels. The persistent conflicts between Palestinians and the Israeli government, for example, have created this sort of assault-and-retaliation sequence.

Mobilization of opposition is essential for movements to progress to their next level of development. Unless opponents are able to mobilize, there may not be any significant social change. Just as important, control of key resources is necessary, such as mass media, systems of transportation, and power grids. Mobilization of opposition also means the generation of crowds and new opportunities for violence, as explained by two popular theories of crowd behavior: convergence and emergent norm.

Because people with similar backgrounds and beliefs are likely to gather together, any decision to employ violence may spread to others in the group. This would occur not because of Gustave LeBon's once-popular belief that a crowd's excitement can produce a kind of "group mind," but rather because of the similarity of the crowd's constituents, many of whom may be persuaded that violence is necessary or even essential.

While everyday life has predictable continuity, individuals joining large, unregulated, expressive crowds are unsure of what sort of behavior is expected of them. They search for information about their situation and thus are responsive to rumor. If a rumor becomes widespread, it may be seen by several crowd members to justify aggressive action, such as a violent confrontation with police. Others witnessing the aggression come to believe that anger and hostility are expected, conform to the newly emergent norms of behavior, and so place themselves at more risk than they might otherwise have. Emergent norm theory does not claim that any specific norms are certain to develop in crowds but rather that most people are unsure of just what constitutes appropriate behavior because of their lack of familiarity with the setting.

If agents of social control, such as the police, army, and judicial system, are unable to restrain mobilized groups, then dramatic social change is inevitable. In the example of revolutionary movements, this stage can entail full-scale physical assault on the agents of social control and thus the clear risk of self-destruction. Less dramatically, it can involve political prisoners either working to create uprisings, escapes, or widely publicized starvation campaigns, such as that effectively employed by Irish Republican Army member Bobbie Sands.

Conclusion

Despite the aforementioned differences, religious and political martyrs share certitude in their causes' ultimate truths. For this reason, they must be distinguished from self-destructive, isolated bands of individuals lacking a larger agenda, such as those involved in the Columbine High School attack in April 1999.

See also: ASSASSINATION; CULT DEATHS; DEATH SYSTEM; MARTYRS; SOCIAL FUNCTIONS OF DEATH

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JONATHAN F. LEWIS

RIGHT-TO-DIE MOVEMENT

In 1976 the New Jersey Supreme Court handed down its decision in the case of Karen Ann Quinlan, and in 1989 the U.S. Supreme Court ruled in

the case of Nancy Beth Cruzan. The issue in both cases concerned whether the parents of these two women, who were both in a persistent vegetative state (PVS), could withdraw life-sustaining treatment when their daughters' preferences were unknown. Quinlan's treatment was a ventilator; and Cruzan's a feeding tube. The courts ultimately ruled the life-sustaining treatment could be withdrawn, although each court required a different process for doing so. It is these two court decisions that are considered America's landmark right-to-die cases.

In 1976 Quinlan, who was twenty-one, suffered a respiratory arrest that resulted in a PVS. After it became evident that she would never recover, her parents decided to take her off the ventilator; however, the hospital and medical staff refused their request. Her parents asked the courts to grant them the power to authorize the ventilator's withdrawal. Almost a year later the New Jersey Supreme Court held that the state's interest in protecting Quinlan's life was outweighed by her right of privacy, given her poor prognosis and the invasion of her body that would be necessary to keep her alive.

In 1983 twenty-five-year-old Cruzan was found lying in a ditch after a car accident. This too resulted in a PVS, but without the need of a ventilator. As with the Quinlans, Cruzan's parents came to accept the fact that she would never recover. With this realization they asked her health care providers to withdraw her feeding tube; their request was also refused. The legal odyssey that ensued ended at the U.S. Supreme Court. The Supreme Court upheld the Missouri Supreme Court, which required "clear and convincing" evidence that Cruzan would forgo artificial nutrition and hydration given her current state before her parents could remove the feeding tube.

After the Supreme Court's decision was handed down several of Cruzan's friends came forward with recollections of statements she had made regarding patients who were in similar circumstances to hers. They said Cruzan had stated she would never want to live like that. These friends gave her parents the "clear and convincing" evidence they needed to have the feeding tube withdrawn.

Out of the Quinlan and Cruzan cases, particularly the latter, came the Federal Patient Self-Determination Act (PSDA). The PSDA went into

effect on December 1, 1991, and requires all hospitals, nursing homes, hospices, and health maintenance organizations (HMOs) to provide patients with information on advance directives. The PSDA also requires these organizations to provide educational programs to their staff and community on advance directives.

An advance directive is a legal document that allows adults to state their preferences for end-of-life treatment. There are typically two kinds of advance directives: The first is a living will, which allows adults to state what treatments they would or would not want at the end-of-life such as cardiopulmonary resuscitation, a ventilator, or antibiotics. The second kind is a Durable Power of Attorney for Healthcare, which allows an adult to appoint someone, such as a friend or family member, to make health care decisions for him or her should he or she lose decision-making ability. It is through an advance directive that patients can meet the "clear and convincing" evidence standard as required by some states, such as Missouri. However, advance directives are of little help to end-of-life patients who are not dependent on life-sustaining treatment. As a result, it was just a matter of time until the public demanded the next logical step after the right to refuse treatment—the right to end their lives with their physician's help.

In fact it took less than five years from the passage of the PSDA for the federal courts to hear arguments that patients ought to have the right to end their lives with the assistance of their physicians by way of an intentional overdose; in short, they wanted to legalize physician-assisted suicide. Pushing the courts was a newly passed voter-approved referendum that allowed just that.

The Oregon Death with Dignity Act was passed in 1994 by popular referendum with a 2 percent margin. The act allows adult residents of Oregon who are capable of making health care decisions and are terminally ill to request from their physician a prescription for a lethal dose of a medication. Immediately after its passage an injunction preventing its implementation was imposed. After three years of legal battles all hurdles were finally cleared, or so the general public believed. Oregon's legislators placed on the November 1997 ballot a measure calling for the repeal of the act. The measure was voted down by a 20 percent margin.

Following the second passage of the act another injunction was issued, pending court appeals. On March 6, 1996, the 9th Circuit Court of Appeals in *Compassion in Dying v. Washington* held that preventing a competent adult from seeking physician assistance in committing suicide interfered with an individual's liberty interest and, therefore, violates an individual's substantive due process rights. Less than a month later in a similar case, the 2nd Circuit Court of Appeals in *Quill v. Vacco* held that the New York statute criminalizing assisted suicide violated the equal protection clause of the Fourteenth Amendment. The court reasoned that the state has no rational or legitimate interest in preventing a mentally competent terminally ill patient in the final stage of his or her illness from taking a lethal dose of a physician-prescribed medication. Ultimately, the U.S. Supreme Court overturned both decisions; the Washington case became known as *Washington v. Glucksberg*.

On June 27, 1997, the Supreme Court ruled that a state's ban on suicide is rationally related to a legitimate government interest and therefore there is no constitutional right to physician-assisted suicide; however, states are free to decide for themselves whether to allow physician-assisted suicide. Currently, Oregon is the only state that allows physician-assisted suicide, as voter referendums that sought to legalize it have failed in Washington (1991), California (1992), Michigan (1998), and Maine (2000).

The Oregon Death with Dignity Act took effect on October 27, 1997. To date, ninety Oregon patients have died after the intentional overdose of medication that was prescribed by their physician for that exact purpose: 15 patients in 1998, 27 in 1999, 27 in 2000, and 21 in 2001.

See also: CRUZAN, NANCY; DEFINITIONS OF DEATH; DO NOT RESUSCITATE; EUTHANASIA; QUINLAN, KAREN ANN; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE

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MATT WEINBERG

RIGOR MORTIS AND OTHER POSTMORTEM CHANGES

Once the heart stops beating, blood collects in the most dependent parts of the body (livor mortis), the body stiffens (rigor mortis), and the body begins to cool (algor mortis).

The blood begins to settle in the parts of the body that are the closest to the ground, usually the buttocks and back when a corpse is supine. The skin, normally pink-colored because of the oxygen-laden blood in the capillaries, becomes pale as the blood drains into the larger veins. Within minutes to hours after death, the skin is discolored by livor mortis, or what embalmers call "postmortem stain," the purple-red discoloration from blood accumulating in the lowermost (dependent) blood vessels. Immediately after death, the blood is "unfixed" and will move to other body parts if the body's position is changed. After a few hours, the pooled blood becomes "fixed" and will not move. Pressing on an area of discoloration can determine this; if it blanches (turns white) easily, then the blood remains unfixed. Livor mortis is usually most pronounced eight to twelve hours after death. The skin, no longer under muscular control, succumbs to gravity, forming new shapes and accentuating prominent bones still further. The body then begins to cool.

At the moment of death, the muscles relax completely—a condition called "primary flaccidity." The muscles then stiffen, perhaps due to coagulation of muscle proteins or a shift in the muscle's energy containers (ATP-ADP), into a condition known as rigor mortis. All of the body's muscles are affected. Rigor mortis begins within two to six hours of death, starting with the eyelids, neck, and jaw. This

sequence may be due to the difference in lactic acid levels among different muscles, which corresponds to the difference in glycogen levels and to the different types of muscle fibers. Over the next four to six hours, rigor mortis spreads to the other muscles, including those in the internal organs such as the heart. The onset of rigor mortis is more rapid if the environment is cold and if the decedent had performed hard physical work just before death. Its onset also varies with the individual's age, sex, physical condition, and muscular build.

After being in this rigid condition for twenty-four to eighty-four hours, the muscles relax and secondary laxity (flaccidity) develops, usually in the same order as it began (see Table 1). The length of time rigor mortis lasts depends on multiple factors, particularly the ambient temperature. The degree of rigor mortis can be determined by checking both the finger joints and the larger joints and ranking their degree of stiffness on a one- to three- or four-point scale. Many infant and child corpses will not exhibit perceptible rigor mortis. This decreased perceptible stiffness may be due to their smaller muscle mass.

During this period, the body gradually cools in a process called algor mortis. The best way to accurately assess a corpse's temperature is with a core (tympanic membrane, liver, or rectal) thermometer. Rectal insertion may be difficult and cause postmortem injury.

A few adult corpses may not undergo perceptible rigor mortis. Folklore in Britain, the Philippines, and elsewhere ascribed fearsome supernatural powers to these "limber corpses."

In the early nineteenth century, the American and British poor often prepared their own dead for burial in a process called "laying-out," "streaking," or rendering the "last offices." Women normally washed the corpse, plugged its orifices, closed its eyes and mouth, straightened its limbs, and dressed or shrouded it. It was ritually important to close the eyes quickly, being that they are the first to rigidify in rigor mortis, and it was thought that a corpse with open eyes posed a threat to its kin. As has long been the case in many cultures, they used coins to keep the corpse's eyes closed. The practice of using coins endures, representing a feeling that money, so important in life, may also be important in death.

TABLE 1

Approximate times for algor and rigor mortis in temperate regions

| Body temperature | Body stiffness | Time since death |
|------------------|----------------|--------------------------------|
| warm | not stiff | dead not more than three hours |
| warm | stiff | dead 3 to 8 hours |
| cold | stiff | dead 8 to 36 hours |
| cold | not stiff | dead more than 36 hours |

SOURCE: Stærkeby, M. "What Happens after Death?" In the University of Oslo Forensic Entomology [web site]. Available from http://folk.uio.no/mostarke/forens_ent/afterdeath.shtml.

In the embalming process, embalmers first position the body. They then relieve rigor mortis by flexing, bending, and massaging the arms and legs. They then move the limbs to a suitable position, usually with legs extended and arms at the sides or hanging over the sides of the table, so that blood can drain into and expand the vessels for better embalming. They need to position the body before injecting embalming fluid, for no matter what stage of rigor mortis a body is in, once embalming fluid is injected, the muscles begin to firm up, or "set." (Without embalming, they would become flaccid over a period of hours.) After embalming, the muscles harden gradually over the next eight to twelve hours. Once they are set, embalmers cannot alter the body's position.

Putrefaction

In the absence of embalming or relatively rapid cremation, the body putrefies. The first sign of putrefaction is a greenish skin discoloration appearing on the right lower abdomen about the second or third day after death. This coloration then spreads over the abdomen, chest, and upper thighs and is usually accompanied by a putrid odor. Sulphur-containing intestinal gas and a breakdown product of red blood cells produce both the color and smell. The ancient Greeks and the Etruscans paid homage to this well-recognized stage of decomposition by coloring a prominent god aquamarine, considered the color of rotting flesh.

Bacteria normally residing in the body, especially the colon, play an important part in digestion of food during life. They also contribute mightily to

decomposition after death—the process of putrefaction. The smell, rather than the sight, is the most distinctive thing about a putrefying body.

Under normal conditions, the intestinal bacteria in a corpse produce large amounts of foul-smelling gas that flows into the blood vessels and tissues. It is this gas that bloats the body, turns the skin from green to purple to black, makes the tongue and eyes protrude, and often pushes the intestines out through the vagina and rectum. The gas also causes large amounts of foul-smelling bloodstained fluid to exude from the nose, mouth, and other body orifices. Two of the chemicals produced during putrefaction are aptly named putrescine (1,4-diaminobutane) and cadaverine (1,5-pentanediamine). If a person dies from an overwhelming bacterial infection, marked changes from putrefaction can occur within as few as nine to twelve hours after death.

By seven days after death, most of the body is discolored and giant blood-tinged blisters begin to appear. The skin loosens and any pressure causes the top layer to come off in large sheets (skin slip). As the internal organs and the fatty tissues decay, they produce large quantities of foul-smelling gas. By the second week after death, the abdomen, scrotum, breasts, and tongue swell; the eyes bulge out. A bloody fluid seeps out of the mouth and nose. After three to four weeks, the hair, nails, and teeth loosen and the grossly swollen internal organs begin to rupture and eventually liquefy. The internal organs decompose at different rates, with the resistant uterus and prostate often intact after twelve months, giving pathologists one way to determine an unidentified corpse's sex.

Aside from the action of microbes, the breakdown of cells (autolysis) helps destroy the body unless the corpse is kept at or below 32 degrees Fahrenheit. Cells die (necrosis) through the progressive destruction of their various parts. First, the cellular fluid (cytoplasm) and the energy-releasing mechanism (mitochondria) swell. Various products, including calcium, begin to coalesce in the mitochondria as other mechanisms within the cell dissolve. Next, loss of energy causes the cell to lose its connections with neighboring cells (tissue destruction) and to further lose control over the fluid within its outer barrier, much like an over-filled water balloon. The cell controller (nucleus) fails, and the packs of destructive acids (enzymes)

within the cell break loose. These enzymes complete the work of destroying the cell.

The sociologist Ruth Richardson summed up decomposition aptly: "The physicality of a human corpse is undeniable. It is a carcass, with a predisposition to decay, to become noisome, obnoxious to the senses, and harrowing to the emotions. Disposal of such perishable remains is imperative" (1987, p. 15).

See also: AUTOPSY; BURIED ALIVE; CRYONIC SUSPENSION; DEFINITIONS OF DEATH

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KENNETH V. ISERSON

rites of passage

Rites of passage are special rituals societies employ to assist their members at key times of biographical change. These life transitions follow a recognizable pattern of behavior in many cultures; for example, babies are given a name and social identity, youths enter adulthood or marry, others retire, gain particular qualifications such as degrees or enter particular professions, or pass from the world of the living to the world of the dead. Changes of status can be related to changes in identity because the term *identity* embraces social and psychological aspects of life. The term *status* tends to refer to sociological values without reference to the personal feelings and self-evaluation of individuals. In this entry, the term *status* emphasizes the social

dimension and identity of the psychological aspects of an individual's life.

The idea of status passage rituals was first introduced by the anthropologist Arnold van Gennep, who saw regeneration as the law of life and described rites of passage as a threefold process with phases of separation, segregation, and integration. For there to be a new self the old self must ritually die. Candidates for some rite would be separated from the status to be left behind, leaving familiar companions, surroundings and home, perhaps encountering actual or symbolic aggression in being wrenched away or carried off. Second, they enter a "between" period devoid of distinguishing marks of status and expressions of their old identity, such as names or clothing. In the case of passage to adulthood, adolescents may together undergo a degree of discipline and share a mutual sense of hardship, bonding them together. Their curtailed freedom begins a reorientation toward their future status and life obligations. This may involve learning the traditions of their society or the skills of some particular profession or trade. Only after this period of learning and endurance is complete do they undergo the third phase of reincorporation into society. However, they do so with their new status and identity, perhaps involving a new name or title, forms of dress or style of language and, almost certainly, new patterns of behavior with appropriate duties and responsibilities.

Van Gennep likened society to a house with people moving over thresholds from room to room. The Latin word for threshold is *limen*, hence his three phases of rites of passage as preliminal, liminal, and postliminal. He also argued that, depending upon the final goal of a ritual, the preliminal, liminal, or postliminal phase would be stressed over and above the others. Rites of passage sometimes involve more than one type of status change. In a marriage, for example, it is not only the bride and groom that pass from being single or divorced to being married but their parents also become parents-in-law. Parents, siblings, and friends may all enter new relationships.

Van Gennep's scheme was constructed to describe patterns of life in those traditional societies often described as primitive or tribal societies. In such communities of relatively few people and

high levels of face-to-face contact, many would acknowledge the change of status and identity of an individual during rites of initiation into manhood, womanhood, or motherhood. However, caution is required when the idea of rites of passage is applied to events in contemporary and large-scale societies where little such recognition exists.

Such understandings of ritual permit insight into the significance of funerary ritual, a rite of passage observed in a great majority of human societies. Numerous changes of identity are associated with funeral rites, affecting the statuses of the dead, surviving relatives, and members of the broader community.

Death separates the deceased from their statuses of living parent, spouse, or coworker. The period of preparing the dead for burial or cremation moves them into a transitional phase when they are neither what they have been nor yet what they will become. Such moments of transition often involve uncertainty and potential danger. The ritual impurity of the corpse derives from its inability to respond to others, yet is still "present" in their everyday routines. Accordingly, people pay their respects to the dead, marking their former identity with them, express sorrow for the bereaved and, by so doing, reaffirm their continuing relationship with them. Stories recounting the achievement or character of the dead and supernatural powers may be invoked to forgive any evil the deceased may have perpetrated and to guide them into the afterlife. Gifts and goods may be provided to assist the individual to depart from this world to the next.

Just as initiates in their liminal period may be taught mysteries of their culture so the dead may be given their own form of education in the form of guidance provided in sacred texts, chants and prayers assist their journey, as in texts like the Egyptian *Book of the Dead* and the Tibetan *Book of the Dead*. Very often there are special priests or ritual experts to attend to this task. Sometimes additional rites are performed to assist the departed, often referred to as soul or life forces, to settle in their new world. A major goal of death rites is to ensure that the individual who has died leaves the realm of the living for the realm of the afterlife. Liminal periods of change include uncertainty and are often regarded as potentially dangerous, with the case of death providing powerful examples as



During the Indian Navjote ceremony, the ritual rite of passage where the person is accepted into the Parsi community, a priest ties a sacred thread around the child's waist as he or she chants the Abuna-Vairya (ancient prayers). LINDSAY HEBBERD/CORBIS

key social members depart and others have to take their place.

Just as living persons become ancestors or souls in heaven so the living undergo changes in relation to them. Robert Hertz argues that funeral rites involve a kind of parallel process in which the decay of the dead reflects the path of grief in the bereaved. Bereavement involves both the social change of status of people—from, say, being a wife to being a widow, from being a child to being an orphan, or from being a subordinate adult to becoming the head of the family. It also involves psychological changes of identity associated with such shifts. Human beings become dependent upon each other and, in a sense, each identity is made up of elements of other people's influence. People become "part of" each other, and thus when one dies a portion of one's self perishes as well. Some theories of grief discuss this in terms of attachment and interpret bereavement as the loss that follows when attachments are removed.

The fear of ghosts or spirits, for example, can be related to both the dimensions of status and identity. In terms of status, ghosts and spirits can be seen as the dead who have not been successfully moved from their place in this world to that of the next. They are those who are caught in the between realm of an unintended liminal state, potentially dangerous liminal entities, or phenomena as they symbolize radical change that challenges the social life set up against such change. Sometimes further rites exist to try to get such spiritual forces finally to leave the world of the living and get on with their future destiny. At its most extreme, rites of exorcism serve to banish the dead or other supernatural entities and prevent them from influencing the living. In terms of identity, this time the identity of the living, ghosts and spirits and perhaps we should also include vivid dreams of the dead, all reflect the individual experience of a bereaved person who is still, psychologically speaking, caught up with the identity of the deceased

person. Physical death has also been widely employed as an idiom to describe the leaving of an old status and the entry into a new one.

Two other anthropologists, Victor Turner and Maurice Bloch, have developed van Gennep's scheme. Turner explored liminality as a period in which human beings found great strength in the mutual support of others in the same situation. He coined the word *communitas* to describe this feeling of shared unity among those who, for example, were initiated together. The same might also apply to groups of people in the army or at college together, groups of people at carnivals or in pilgrimages, and those who are bereaved. Together they share the succor of their common humanity as they come together in adversity. For a moment they forget their different statuses and the symbols that divide them to enter into the shared emotional experiences associated with grief. To be with others at such a time is to acknowledge what it means to be human and to be mortal. In these types of situations, people sometimes speak of finding a strength they did not know they possessed, or they speak of the support they felt from others over a period of bereavement.

Maurice Bloch extensively modified van Gennep's scheme, criticizing its stress on the social status aspects of life and its ignoring of more psychological aspects. Bloch added the emphasis upon the psychological realm of experience as basic to human beings. This existentialist-like stress provides a welcomed realization that the anthropology of ritual is, ultimately, about people with feelings. Bloch stressed that while a threefold ritual scheme of preliminal, liminal, and postliminal phases may suffice to describe changes in social status, it does not do justice to the changes individuals experience. It is not that an individual is simply removed from social life, taught new things, and given a new status on re-entry to ordinary social life. Far from it, that individual changes not least because of the experiences of bereavement and grief.

Bloch makes a significant contribution to rites of passage in his theory of rebounding conquest, or rebounding violence. He describes the ordinary facts of life in terms of people being born, maturing, and then dying. Most human cultures, however, are unhappy with this simple progression. Through ritual forms they take living people and in

a symbolic sense cause them to "die" and be "reborn" as new kinds of individuals, shedding old, used-up selves so new ones can take their place. Not only are they given a new status but they will also have experienced inner changes to their sense of identity. Many rituals of initiation in religions as well as in some secret societies use the natural idioms of birth and death but reverse them to speak of death and rebirth. It is as though the ordinariness of human nature is "killed" and a new and higher nature is bestowed. In some religious traditions this scheme of rebounding conquest can be applied to death rites when physical death is said to be the basis for a new and spiritual life either in future transmigration of the soul or in some form of resurrection.

See also: GENNEP, ARNOLD VAN; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; HERTZ, ROBERT

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DOUGLAS J. DAVIES

ROYALTY, BRITISH

The large-scale public reactions that followed the death of Diana, Princess of Wales, on August 31, 1997, and that of Queen Elizabeth the Queen Mother on March 30, 2002, illustrate the long-standing tendency of prominent British royal deaths to stir an emotional response from millions who had never personally been acquainted with the deceased. Royal deaths have also evoked important forms of ritual and symbolic commemoration that are significant both in the context of the evolution of British civil religion and national identity, and in shaping and representing wider social and cultural responses to death. Despite occasion-

al subversive undertones, the expression of such collective grief usually provided a potent legitimation of the institution of the monarchy and the existing social and political order.

Historical Survey

The deaths of Tudor monarchs such as Henry VIII in 1547 and Elizabeth I in 1603 were followed by elaborate ceremonies, combining religious and secular elements, and apparently reflecting genuine depth of public feeling. During the reign of James I from 1603 these rituals were developed further into a “theatre of death” through which the new Stuart dynasty sought to assert its prestige, but in so doing it began to outrun popular sentiment. At this period royal funeral ceremonies—like those of all members of the elite—were controlled by precise regulations from heralds designed to ensure that they reflected, sustained, and stabilized a social and political order that had been disrupted by the death.

A seeming low point in the fortunes of the monarchy came in January 1649 when, following its victory over King Charles I in the English Civil War, Parliament sentenced him to death “by the severing of his head from his body.” When, however, the king was publicly executed on the balcony of Whitehall Palace, one observer recorded that the fall of the axe was greeted with “such a groan by the thousands then present as I never heard before” (Bland 1986, p. 54). Charles, who conducted himself at the last moments with great dignity, claimed that he died a martyr, and subsequent religious veneration for his memory and the restoration of the monarchy in 1660 indicated that his enemies had indeed overreached themselves by committing regicide.

From the seventeenth century until the early nineteenth century royal funerals—in common with those of the nobility—took place at night. This custom was intended to lessen the burden of precise heraldic regulation, which was already beginning to seem anachronistic. It had the effect of giving enhanced drama to the occasions, lit by torchlight, but reduced the scope for public participation. In the meantime, few royal deaths inspired strong public emotions. Notable exceptions were the untimely demise of Mary II in 1694, a victim of smallpox at the age of thirty-two, and the death in childbirth in 1817 of Princess Charlotte, then the

only legitimate grandchild of George III and second in line to the throne. In 1821 the funeral procession of George IV’s estranged wife Queen Caroline was accompanied by demonstrations against the king and the government, who were held responsible for shabby treatment of the deceased. In general, however, the late Stuart and Hanoverian royal family inspired dutiful observance rather than intense feeling in an era that in its overall response to death tended to emphasize ritual rather than emotion.

There was a gradual change in attitudes during the long reign of Queen Victoria (1837–1901). The funeral of the queen’s husband, Prince Albert, in 1861 was a private one, but it was accompanied by strong expressions of collective public grief, and in the decades that followed his widow appeared to make continued mourning a way of life. In this period the royal family came to be seen increasingly as paradigmatic of the joys and sorrows of ordinary families, and hence there was a growing tendency for the public to view its bereavements in a quasi-personal way. This phenomenon was strikingly illustrated by sentiment following the early death of the queen’s grandson, Prince Albert Victor, in 1892, and on Victoria’s own demise in 1901. Meanwhile precedents for a more grandiose form of public mourning were set by two major non-royal funerals, those of Lord Nelson in 1806 and the Duke of Wellington in 1852. These trends combined to produce extensive popular engagement with large-scale funerals for Queen Victoria and, in 1910, Edward VII.

During the period since World War I there have only been two deaths of reigning monarchs, George V in 1936 and George VI in 1952. Both gave rise to strong and extensive public emotion, which was focused by repetition of essentially the same forms of ritual used in 1910. Until the end of the twentieth century, responses to the deaths of other members of the royal family were relatively low-key. In 1997, however, the tragic and untimely nature of Princess Diana’s death following the very high profile nature of her life ensured that feelings would run high. The Queen Mother’s death at the age of 101 in 2002 was, by contrast, hardly unexpected, but it evoked a widespread mood of sadness at her passing and of celebration of her life. Her funeral followed a broadly similar pattern to that of her husband George VI. Even

here, though, there were innovations that reflected the social changes of the intervening half century, including the presence of the Princess Royal among the male mourners following the coffin, and the conveyance of the body to its final resting place at Windsor by road rather than railway.

Organizing and Performing Rituals

Overall responsibility for the funerals of sovereigns rests with the Earl Marshal, an office of state held on a hereditary basis by the dukes of Norfolk, who are assisted by the heralds of the College of Arms. The funerals of other members of the royal family are organized by Lord Chamberlain's office, which is part of the permanent royal secretariat. Numerous other agencies are involved in more complex and large-scale rituals. These have included the Office of Works (for temporary additions to buildings), the church, the armed services, the police, and the railways.

Until the beginning of the nineteenth century royal funerals were usually held in London with interments in Westminster Abbey. George III, however, moved the royal burial place to St. George's Chapel in Windsor Castle, thus focusing ceremonially on what was then a relatively small country town, several hours journey from the capital in pre-railway days. Scope for public participation was therefore limited. Only following the death of Queen Victoria was there a decisive move back to a more public and large-scale ceremonial. Her funeral, which included a spectacular naval review and a military procession through central London, represented a return to a "theatre of death" on a scale not seen since the early seventeenth century. The trend was confirmed upon the death of her son Edward VII when a further ritual of a public lying-in-state in Westminster Hall was added and proved enormously popular.

Major royal funerals, especially those of sovereigns, were made up of a series of ceremonies extending over several days, public and private, religious and secular, and presenting different aspects of the deceased. For example, Edward VII's body initially lay privately in his bedroom at Buckingham Palace, before being moved ceremonially to the Throne Room, and then in a street procession to Westminster Hall. After the three days of the public lying-in-state, there was a further street procession to Paddington Station, a train journey to

Windsor, a procession from the station to the Castle, and a culminating religious service in St. George's Chapel.

The apparent seamlessness of such events conceals a reality of extensive improvisation and last-minute decision making. Royal funerals—unlike coronations, jubilees, and weddings—need to be arranged in a timescale measured in days rather than months. Although Queen Victoria was eighty-one at the time of her death, no developed plans for her funeral were in place and the ten days between her death and funeral were marked, according to one participant, by the most "extraordinary hurly burly of confusion" (Wolffe 2000, p. 235). Although some discreet advance planning can be made, the exact circumstances of a death are unforeseeable and, in particular, the unexpected death of a relatively young person, as in the case of Princess Diana, is likely to catch the authorities almost wholly unprepared.

During the nineteenth and early twentieth centuries the days of royal funerals were increasingly marked by parallel processions and church services in provincial towns and cities. By this means many people remote from London or Windsor were able to achieve a sense of participation in a national ritual. Solidarity in grief was expressed by the wearing of mourning clothes and emblems such as black armbands. In this period instructions for the general wearing of mourning for periods of several weeks drew general compliance, giving a somber atmosphere to the streets. From the mid-twentieth century onward, the advent of radio and, eventually, television intensified this sense of involvement while shifting it from the communal public religiosity of streets and places of worship to the individualistic and domestic environment of people's homes. Film and television have increased consciousness of royal funerals as mass spectacles, as manifested in the unprecedented size of the worldwide television audience that watched Princess Diana's funeral.

Functions and Effects

As in the aftermath of death in private life, responses to royal deaths have been shaped by contingent circumstances and emotions, which were often fluid and fast moving. Explicit social, cultural, and political agendas were seldom articulated. Nevertheless, a number of strong implicit functions



Princess Diana's funeral, with novel elements such as the Elton John song "Goodbye England's Rose/Candle in the Wind," showed the way in which long-standing tradition is continually being reshaped by the British community—just as Diana reshaped the traditions of royalty while alive. CORBIS

and more or less intentional consequences can be identified.

First, there was the need to reaffirm the social and political hierarchy that had been disrupted by the death. This function was especially strong in the early modern era of close heraldic regulation, but persisted in the nineteenth and twentieth centuries, with processions and other rituals being designed to display order and stability. At the same time, from the early twentieth century onward, public lyings-in-state, and large crowds—whether present in person or participating at a distance through radio and television—constituted a democratic element. Conversely, however, on some occasions responses to royal deaths have had a subversive dimension. Public reactions to the deaths of Princess Charlotte in 1817 and Queen Caroline in 1821 were colored by hostility to the Tory government of the day and to the Prince Regent, who succeeded to the throne as George IV in 1820.

Such a tendency to question rather than sustain the existing order recurred in the hostility expressed toward the surviving royal family following Princess Diana's death.

Second, the aftermath of royal deaths has provided an opportunity for affirming or reshaping the image of the deceased. In life Prince Albert was liable to be seen as a meddling foreigner exercising an inappropriate influence over the government, but in death he became a symbol of ideal English manhood. Queen Victoria was celebrated as an ideal of motherhood, but the reality of her relationships with her children and grandchildren was much more ambivalent. Princess Diana, perceived in life as sometimes wayward and manipulative, became a quasi-saint in death.

Third, collective mourning for royalty has been a focus for common identity within the multinational United Kingdom state and, in the past, the diverse and scattered territories of the British Empire.

Royalty are perceived to transcend social and political divisions to a degree that has only been matched by exceptional non-royal figures (i.e., Sir Winston Churchill, who died in 1965). The psychological constraints imposed by a sense of decency in the face of death made open dissent very rare, even in countries such as India and Ireland where British rule was otherwise strongly contested.

Fourth, royal deaths have served as a communal representation of private fears and griefs. Thus Princess Charlotte was identified with the numerous early-nineteenth-century young women who died in childbirth, just as Princess Diana's car crash painfully reminded the public of this characteristic form of death for late-twentieth-century young women. Prince Albert's early death was a focus for the personal bereavements of other widows and young children, while in responding to the deaths of Queen Victoria and subsequent monarchs, members of the public showed themselves to be recalling or anticipating losses of their own parents and grandparents.

Finally, royal deaths have marked the passage of time. Many people recall their own exact circumstances when they heard of the death of Princess Diana, or among an older generation, George VI. Monarchs who reigned for a long period, such as George III (1760–1820), seemed to symbolize a whole era, and their passing therefore stirred a sense of discontinuity and new beginnings. This phenomenon was especially pronounced in the case of Queen Victoria, whose death coincided closely with the beginning of the twentieth century, and has recurred in relation to Queen Elizabeth the Queen Mother, whose long life spanned the whole of that same century.

Conclusion

Overall, responses to British royal deaths can be set within a broadly Durkheimian theoretical perspective. In other words they serve as a ritual expression of social solidarities and a means for regenerating and sustaining the fabric of national life. They are also a significant component of a British form of civil religion, being an occasion for the affirmation both in rituals and in speeches and sermons of the perceived fundamental spiritual values focused upon the institution of the monarchy. For example, at the lying-in-state of Edward VII, the Archbishop of Canterbury spoke of a renewing of

a sense of national mission. Upon the death of George VI the February 15, 1952, edition of the *Times* affirmed that "the sentiments evoked by the death and accession of monarchs have a quality that it is no impiety to call religious." By the time of Princess Diana's death the explicitly Christian content of such religiosity had become significantly more attenuated, but the sense of a spiritual dimension to national grief remained.

The British experience invites comparison with other countries that have remained monarchies in the contemporary era. The deaths of King Olaf V of Norway in 1991 and of King Baudouin of Belgium in 1993 were followed by widespread public grief, which gave occasion for significant reaffirmations of national unity and identity. Further afield the elaborate rituals that follow the deaths of Thai monarchs constitute politically significant affirmations of continuity and royal prestige, while the assassination of King Birendra of Nepal in 2001 evoked intense and emotionally charged reactions. Monarchs, in contrast to most presidents and prime ministers, normally hold office for life, and accordingly become for their generation seemingly permanent carriers and symbols of national identity. Their deaths, inevitable as they are in the course of nature, are therefore particularly psychologically disorienting for their people. Study of the ways in which nations react to this disruption of the fabric of seeming normality both adds to understanding of attitudes to death itself, and illuminates wider historical and social processes.

See also: CELEBRITY DEATHS; DURKHEIM, ÉMILE; LINCOLN IN THE NATIONAL MEMORY; QIN SHIH HUANG'S TOMB; TOMBS

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SACRIFICE

Prayer is a form of communication with a deity or other spiritual being. Words addressed to a deity usually offer praise or seek guidance, blessing, forgiveness, fertility, victory, or protection. Like prayer, sacrifice is a form of communication with a deity for similar purposes. The word itself means “to make holy.” As distinct from prayer, sacrificial offerings include objects of value and symbolic significance that are given to the gods to earn their favor. The gifts can take many forms, becoming sacred themselves through ritual consecration. The gods might be offered the most desirable foods or provided with the finest vessels, carvings, tools, and weapons. Historians, however, have often regarded blood sacrifice as the most powerful way to appease the gods. It was not unusual for societies to engage in both animal and human sacrifice, although the historical trend has been toward a sharp reduction in the latter.

Participants in blood sacrifice rituals experience a sense of awe, danger, or exaltation because they are daring to approach the gods who create, sustain, and destroy life. The buildup of tension prior to the blood sacrifice gives way to a festive sense of triumph and relief. Morale is strengthened by the ritual killing because the group has itself performed the godlike act of destruction and is now capable of renewing its own existence. The underlying philosophical assumption is that life must pass through death.

According to ancient rites of sacrifice, the sacrificial animal or human should be of high value.

The gods would be offended by a sickly or inferior offering. In Old Testament tradition, Abel was obeying what was already an ancient tradition when he sacrificed the firstborn of his herds to God. Bulls were sacred to Egyptians more than 5,000 years ago, being associated with Taurus, a god with both animal and human features. For the Egyptians, then, the sacrifice of a bull was the gift of a demigod to the gods. In the years immediately preceding the emergence of Christianity some mystery cults switched from bull to human sacrifices, using the same ceremonies in which the victim was first honored as a god, then put to bloody death. Osiris, the legendary Egyptian ruler who, murdered, became the god of fertility, cast a long shadow over these proceedings. Biblical scholars have often commented that the death of Jesus had been prefigured by other events in which a person was raised to the status of a god and then sacrificed for the good of the people. The significance of blood as a link between Jesus and his followers is consistent with that tradition.

Sacrifice and Society

Human sacrifice is sometimes regarded as a bizarre practice carried out by a few scattered societies who either were uncivilized or exceptionally cruel and violent. However, there is persuasive evidence that the sacrificial impulse has been common throughout history and has played an important role in society.

The origins of blood sacrifice are lost in the mist of prehistory. Nevertheless, inferences can be drawn from archaeological research and from

the practices and beliefs of people whose rituals continued into the historical period. The same societies usually performed other types of sacrifices as well, but these examples demonstrate the widespread use of ritual murder as an approved component of social policy.

Foundation and passage sacrifices. There is abundant archaeological evidence that many societies practiced both animal and human sacrifice to persuade the gods to protect their buildings and ensure safe passage through dangerous areas where their own gods might lack jurisdiction. Burials suggestive of sacrifice have been found in the sites of ancient bridges and buildings throughout Asia, Europe, and North Africa. It was widely believed that territories were under the control of local gods who might be angered by intrusions. Blood sacrifice at border crossings (often marked by rivers) and within buildings were thought to be prudent offerings. Sacrificial victims were also interred beneath city gates.

Children were often selected as the sacrificial offerings. Excavation of the Bridge Gate in Bremen, Germany, and several ancient fortresses in Wales are among the many examples of this practice. According to the Book of Kings, when Joshua destroyed Jericho he prophesized that the man who rebuilds Jericho “shall lay the foundation stones thereof upon the body of his first born and in his youngest son shall he set up the gates thereof.” In rebuilding the city, Hiel later sacrificed his oldest and youngest sons in precisely this manner. The historian Nigel Davies observes that biblical accounts of foundation sacrifices have been supported by archaeological investigations:

In the sanctuary in Gezer were found two burnt skeletons of six-year-old children and the skulls of two adolescents that had been sawn in two. At Meggido a girl of fifteen had been killed and buried in the foundations of a large structure. Excavations show that the practice of interring children under new buildings was widespread and some were evidently buried alive. (Davies 1981, p. 61)

Foundation sacrifices dedicated to fertility (as, for example, in storage buildings) often involved infant and child victims. Captives, slaves, and criminals have also been selected as sacrificial victims on many occasions. That foundation sacrifices be-

long only to the remote past could be an erroneous assumption. In early twentieth-century Borneo an eyewitness testified that a criminal was buried alive in every posthole for a new building so that he might become a guardian spirit.

Attempts to Explain Blood Sacrifice

No one attempt to explain blood sacrifice seems adequate for the variety of forms and purposes associated with this practice in many societies over many years. Nevertheless, it is useful to consider the following accounts as informed attempts to explain the relationship between blood sacrifice and society.

Male bonding and collective killing. Hunters learned to cooperate with each other to improve their chances of success. This common purpose led to a sense of brotherhood, what is often called “male bonding” in the twenty-first century. Their mutual allegiances and rituals set them apart from others as they swore their oaths on blood and became the specialists in killing. Some theorists suggest that the basic forms of society were derived from the distribution of roles within the hunting group and their codes of loyalty. The structure of society in general has been modeled on male-bonded groups who relied on blood sacrifices to achieve their own survival and success—or so upholds this theory that seems to seriously underestimate the contribution of women to the shaping of society.

Sacrifice reduces violence. It may seem peculiar to suggest that sacrifice reduces violence, but some anthropologists and historians have drawn this inference. Aggressive tensions within a society can lead toward violence against fellow members. Ritual sacrifices provide a relatively safe framework to keep violence within bounds while at the same time offering emotional release through killing substitute victims. This theory suggests that, at least in some circumstances, ritual killing of a designated victim can restrain the larger group from tearing itself apart.

Sacrificial companions to the next life. Many societies have considered their leaders as representative of their people both in this life and the next. It was important, then, to make sure that the ruler of the land (be it a king or otherwise) was accompanied to the afterlife with a retinue of loyal attendants. Rulers often had their concubines and servants (as well as household animals) entombed

with them. Even distinguished ministers might be among the companions who were either entombed or immolated in order to serve their ruler after death. Examples include major archaeological finds in Egypt and China where the bodies of numerous attendants were discovered in chambers adjoining the royal coffin. There is evidence that elaborate ceremonies were conducted to honor the chosen companions prior to their deaths. It appears that the sacrificial victims often were given libations that provided a drug-induced insensitivity prior to their deaths.

The practice of burying the living with the dead encountered increasing criticism through the centuries. Eventually many societies shifted to symbolic sacrifices; for example, the later Egyptian practice of placing figurines (*Shabti*) in the royal tombs. China, Japan, the Greek states, and other ancient civilizations also moved toward symbolic rather than actual sacrifice of companions upon the death of their rulers. Furthermore, with the development of Christianity and Islam, a life after death appeared more likely to be within reach of individuals other than royalty, therefore making voluntary sacrifice a less attractive proposition.

Sacrifice keeps the world going. The most sweeping theory is based on an interpretation of history that pictures the human condition as fearful and perilous, beset with threats to survival from starvation, attack, and events such as earthquakes, volcanic eruptions, and floods that were taken to be the work of angry gods. Possessing limited knowledge and technology, societies tried to find a way of negotiating with rival, demanding, and frequently unpredictable gods if the world and their own lives were to continue. Sacrifice soon became a significant form of exchange with the gods, a sort of currency in an age before the establishment of a monetary system. In modern parlance, sacrifice was a way of doing business.

Human sacrifice was considered so crucial a measure that it persisted for some time even in societies that had become more complex and sophisticated. For example, the practice of sacrificing the eldest son was a salient feature of Mediterranean cults 5,000 years ago and still a powerful theme in Judaism and early Christianity. Sacrifice would be tamed slowly as societies developed more effective ways to manage their needs and cope with their environments. The gradual and still



Among the ruins of Montsegur in southern France, a memorial stands in the Field of the Burned to commemorate the sacrifice of over 200 Cathar heretics in 1244.

FORTEAN PICTURE LIBRARY

incomplete abolition of slavery throughout the world also reduced the supply of potential victims. And, again, the slow and still incomplete movement toward according full human rights to females eventually spared many the death of a sacrificial victim.

Controversies and Unsettled Questions

Many questions and differences of opinion continue to exist around the issue of human sacrifice. This situation is not surprising, considering the limits and ambiguity of some of the evidence and the strong emotions aroused by the subject.

Death does not always signify sacrifice. Bodies dating from the first and second centuries B.C.E. have been recovered from bogs in England, Denmark, Wales, and other Northern European

sites. These have often been considered sacrificial victims because the bodies showed many signs of having been subjected to ritualistic treatment. More sophisticated examination of the remains, however, indicates that at least some of the bodies had been accorded high honors, not put to death by sacrifice or punishment. It is probable that other errors have been made in identifying sacrifice victims, although enough clear and substantial data are available to demonstrate that sacrifice has been a common practice throughout much of the world.

Why child sacrifice? One of the most dramatic episodes in Judeo-Christian Scripture begins with God's command that Abraham sacrifice Isaac, his son. Abraham sorrowfully prepares to obey, but God intervenes and provides a ram as a sacrificial substitute. The meaning of this episode has been the subject of intense discussion through the centuries, although it is most often interpreted as a celebration of faith on Abraham's part and mercy on the part of God. Another human sacrifice reported in the Bible has remained more difficult to interpret in a favorable light and, therefore, has received less attention. Jephthah pledged he would sacrifice the first living creature that he saw when returning home if God would grant him victory in an upcoming battle. The victorious Jephthah was greeted by his daughter upon returning home. True to his pledge, Jephthah made a burnt offering of his daughter (who is not given a name in the biblical account). Why would God intervene for Isaac but not for Jephthah's daughter? Was Jephthah pious or callous in carrying through with the execution? These questions continue to haunt scholars and ethicists.

How many people were sacrificed by the Incas and Aztecs? This question can now be answered with confidence. Yes, the Incas of Peru and the Aztec of Mexico put a great many people to ritualistic death. This proposition was doubted for some years, in part because this kind of mass slaughter was difficult to imagine. Evidence has become increasingly clear, however, that human sacrifice was a core feature of the Inca and Aztec cultures.

Remains of Inca sacrifices have been dated from as long ago as 5000 B.C.E., sometimes on the towering peaks of the Andes, sometimes in the coastal desert. Archaeological investigations have found evidence of human sacrifice into the sixteenth century, and this practice is thought to have

continued for some time afterward. Tenochtitlan (predecessor to Mexico City) is known to have been the active site of human sacrifices long before Spanish forces arrived to witness these events first-hand: There were already huge collections of skulls on display.

Twenty-first-century historians tend to agree that human sacrifice was both a unifying event and an intense demonstration of religious beliefs for these powerful empires. The Aztecs believed that the "vital energies" of one person could be transferred to another person through drinking the blood and eating the flesh. The gods also craved flesh and blood, so human sacrifice benefited both Aztecs and their ever-hungry deities. Sacrifice was an integral part of their worldview in which the threat of death was ever present, a threat that had to be countered by extreme and relentless measures that would magically transform death into life. Discoveries since the mid-twentieth century confirm that many women were sacrificed in special rituals intended to renew the fertility cycle.

Peruvian sacrifices were also concerned with encouraging the gods to bless their fertility. For reasons that are not entirely clear, the priests appear to have sacrificed an extraordinary number of children. Also somewhat obscure are the reasons for their practice of decapitating their victims. Having left no written records, the Incas and other Peruvian cultures have also taken with them their secrets and mysteries.

Do human sacrifices still exist? A few scattered reports of ritualistic murders believed to be sacrificial appear in print occasionally, usually in American and European newspapers. The reports are brief and inconclusive; for example, one October 1999 *Irish Times* article read, "Police in the eastern Indian state of Bihar yesterday dug up the remains of two teenage girls allegedly killed by their father in a ritual human sacrifice this week." It is probable that at least some such killings are the work of deranged individuals rather than religious celebrants. It is also possible, however, that credible evidence of contemporary human sacrifice may come to light.

A controversial theory suggests that patriotism, war, and adherence to the flag are incitements to a disguised form of sacrifice. Generally, the homicide rate decreases when a nation is involved in a

popular war. Although there are other ways to interpret this fact, it is a challenging thought that patriotism might be regarded as “a civil religion of blood sacrifice, which periodically kills its children to keep the group together” (Marvin and Ingle 1999, p. 315).

See also: AZTEC RELIGION; CANNIBALISM; CHILDREN, MURDER OF; GODS AND GODDESSES OF LIFE AND DEATH; HUNTING; INCAN RELIGION; OSIRIS

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ROBERT KASTENBAUM

SAFETY REGULATIONS

Safety regulations are defined as mandatory requirements that aim to prevent or reduce injury. They include laws and regulations, such as prohibiting the sale of fireworks, and mandatory standards, such as specifying that children's nightwear be fire resistant. Table 1 presents examples of safety regulations that fall into a number of categories.

Environments for Safety Regulations

A common factor in whether regulation is used is the seriousness of the outcome being addressed in terms of human health. For this reason regulation is more common in transportation and the workplace, where the potential for fatal injury is perceived to be relatively great, and less common in the home and in sports environments, where the potential for fatal injury is perceived to be less. Regulations are often introduced in situations where the actions of one person can injure other persons who do not have the ability or opportunity to decide whether to accept the risks associated with those actions. The most common examples relate to regulations protecting the safety of children and of workers.

Even where a person's actions are likely to cause injury only to herself, regulation may be introduced if the costs of injury to that person are largely borne by the public. Perhaps the most contentious among this class of regulations in the United States are mandatory motorcycle helmet and

safety belt laws. The overall effectiveness of safety regulations depends on whether the requirement being mandated is capable of preventing or reducing the target injury and on whether the process of regulation is effective. Some of the factors that influence the effectiveness of the process of regulation include: (1) whether the regulation requires active or passive compliance; (2) the effectiveness of enforcement; (3) public awareness of the regulation; and (4) public support for the regulation.

Regulations can require active compliance by the person being protected, for example putting on a safety belt, or they can provide passive protection, for example the temperature of hot water systems being preset before leaving the factory. Compliance with passive protection is generally much greater and there is less need for enforcement activity at the level of the individual when this approach to regulation is adopted.

To be effective the process of regulation requires sufficient public knowledge about the regulation and adequate enforcement. Promotion of voluntary compliance to achieve a level of community support before regulating has been an effective paradigm in countries such as Australia with respect to issues such as the mandatory use of safety belts and bicycle helmets. Once there is a high degree of public acceptance, there is less need for widespread enforcement and greater potential to focus enforcement on the nonconforming minority.

The most productive role of enforcement is to increase compliance, rather than detect noncompliance. Public education about the regulation that stresses the likelihood of detection has been found to increase compliance with drunk driving and speeding laws. There is little evidence that very large penalties produce significantly greater compliance by individuals than sizable, but not extreme, penalties. For companies, penalties are generally larger to minimize noncompliance based on commercial reasons. Selective enforcement of regulations can lead to ineffectiveness of the regulations for the group that is not being enforced and concerns about victimization from those groups being enforced. The police generally enforce traffic safety regulations. In the workplace, the enforcement role is sometimes undertaken by labor unions or by government workplace safety bodies.

TABLE 1

| Aim of safety regulations | |
|--|--|
| Aim of regulation | Examples |
| Limit access to dangerous products or activities | Graduated driver licensing Machine operator licensing Restrictions on the sale of alcohol to minors Child-resistant closures on pharmaceuticals or cleaning products Firearm regulations |
| Limit levels of harmful substances | Lead in paints Speed limits Power restrictions on motorcycles Temperature of hot water systems Manual handling limits |
| Require the use or installation of particular protective devices | Safety belts Motorcycle helmets Protective gear in workplaces Smoke detectors Electrical safety switches |
| Prescribe protective performance | Motor vehicle safety standards Standards for personal protective equipment Fire-resistant nightwear Isolation pool fencing Safety glass |
| Require information to be provided to consumers about likely hazards | Labeling of poisons and pharmaceuticals Alcohol content labeling on beverage containers |

SOURCE: Courtesy of Haworth, 2001.

In other arenas, community groups or local government enforce.

Regulations can be prescriptive or performance based. In relation to a product, prescriptive regulations prescribe how the product must be constructed but performance-based regulations require that the product meet certain performance criteria (e.g., acceleration values on a crash test dummy). Manufacturers have argued that prescriptive regulation has the potential to impede the development of innovative solutions and possibly safer products.

Effects of Safety Regulations

Improving safety by regulation is a relatively slow process. It can take many years to have regulations passed by the government. In addition, most regulation is not retrospective and only applies to products manufactured or activities commenced after the implementation of the regulation (or even some years after implementation). For example, a regulation that requires electrical safety switches

to be fitted to new homes constructed after a certain date will take many years to permeate a significant proportion of homes.

The levels of safety performance required by legislation may be very low. An alternative approach that is becoming more common in transport safety is to combine regulation with encouraging consumer pressure to drive the market to produce something safer than is required by regulation. For example, the Snell Memorial Foundation tests motorcycle helmets to what is generally considered a more rigorous standard than that required by the U.S. Department of Transportation standard. Many manufacturers submit their helmets for Snell testing because they perceive that certification to this standard provides a market advantage. In such instances, the role of regulation may become that of providing a minimum standard to prevent unacceptably poor performance, rather than encouraging good safety performance.

However, regulation may sometimes result in counterproductive behavior. Those who resist the regulation may attempt to circumvent it. One example of this problem is the phenomenon of “toy” motorcycle helmets that provide little or no head protection. Some objectors to compulsory helmet wearing legislation wear these helmets to avoid detection by police.

Sometimes there are objections to safety regulations on the grounds that they subjugate individual rights to the public good, particularly in the United States. Mandatory-helmet-wearing legislation has been extremely contentious on these grounds. Helmet use reduces motorcyclist fatalities, injuries, and treatment costs and universal helmet laws increase helmet use substantially. The requirement is capable of preventing or reducing the target injury and the process of regulation is effective; however, the price for these benefits is that individual actions are restricted. Through a helmet use law, society requires each motorcyclist to take an action that appears to affect only him- or herself, but a motorcyclist’s injury or fatality affects many others, directly and indirectly. Family, friends, and coworkers must adapt to the personal consequences of an injury or fatality. Society as a whole bears many of the direct and indirect costs, and these issues must be weighed against individual freedom of action.

See also: CAUSES OF DEATH; INJURY MORTALITY; TRIANGLE SHIRTWAIST COMPANY FIRE

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NARELLE L. HAWORTH

SAINTS, PRESERVED

The lives and deaths of saints have long occupied a distinctive place in Christian belief. Other religious traditions have also revered certain individuals as embodying their most admired virtues and having a special relationship with God. Christian saints, however, became such powerful figures that church authorities have had to balance carefully between supporting and moderating their influence. This influence includes the veneration of objects said to have been used by or associated with a saint and, even more precious, their physical remains.

Martyrs, Hermits, and Town Saints

Christianity was but one of many religious sects that were active within the extended reach of the Roman Empire as disciples started to disseminate the teachings of Jesus. The zeal of the early Christian converts brought them into conflict with their Roman overlords, who feared any destabilizing movements. Some Christians were executed by the authorities, others were slaughtered. The persecutions continued into the fourth century before abating. Those who died for their beliefs became the first martyrs, and the first martyrs became the first saints. Sanctification occurred by acclaim of their fellow believers; it would be another millennium before the pope and the church acquired authority over this process.

An early example of spontaneous sanctification was Polycarp of Smyrna (second century). He was admired as a person who had sacrificed himself in emulation of Jesus and therefore strengthened the faith. Polycarp's bones were buried in a secret and safe place. This action could be regarded simply as a sign of respect, but eventually veneration of physical remains of saintly persons would become a widespread and intense phenomenon. Martyrs predominated among the earliest saints. There is no comprehensive record of all the men and women who were martyred in the early Christian centuries, and many of the names have been lost. Another type soon emerged: the desert hermits, most notably Anthony (fourth century), who chose an ascetic and isolated life in the desert wilderness to overcome the temptations of the spirit and the flesh. Having accomplished this daunting task, he laid down guidelines for other Christians and became the inspiration for monasticism.

As time went on the number of saints increased greatly. Local and regional saints appeared in profusion throughout the Western domains of Christianity. Most of these saints were people who had impressed their community but were not known beyond their limited area. High church officials had little influence over the creation of town saints or the cult practices that formed around them.

Solace for the People, Challenge for the Papacy

Christianity struggled with dissension and numerous practical problems through the first millennium. The organizational effectiveness of the Roman Catholic Church gradually improved, however, and popes were in position to exercise a greater degree of control. One of the issues that needed serious attention was the status and function of saints. Many of the faithful relied heavily on both local and universally acclaimed saints. Images, statues, and shrines represented and honored the saints. People overwhelmed by anxiety and suffering turned to their favorite saints for help. The saints of choice were compassionate. They listened to the fears and sorrows. They certainly had more power than the people, whose sense of hopelessness and despair led them to beg for intercession.

Church leaders knew that the venerated saints represented an accessible point of comfort for the great mass of believers who, illiterate and poorly

educated, had only limited understanding of the more subtle and abstract ideas that comprised Christian theology. The saints were mercy and salvation brought near. At the same time, though, there were also problems that could not be ignored. The numerous saint cults often seemed more pagan than Christian. Purists were dismayed by what appeared to be the worship of images that drew attention away from the true meaning of Christianity. There was also concern that the status of saint had been seriously debased by the uncritical and unrestrained enthusiasm of people who had been carried away by their emotional needs.

One other phenomenon required special attention: the ever-growing fascination with the bones and other remains of saints. Many of the people acclaimed as saints since the fourth century had been credited with miracles either while alive or dead. It was widely believed that their physical remains could also be invoked to produce miracles, usually of healing the desperate and incurable. Aside from the medical and religious questions involved there were also the economic and power issues. Churches were competing with each other for relics and remains (including even body parts claimed to have belonged to Jesus). The church that had no illustrious saint remains was in a difficult position in attracting parishioners and donations. Saint remains were offered for sale to the highest bidder, and many a church official suspected their authenticity, yet hesitated to challenge or withdraw from the bidding.

The church worked hard to sort things out, starting in the eleventh century, and continuing into modern times. Many local saints were dropped from the lists. Guidelines and procedures were established to rule out weak and spurious claims for new candidates. It was a hard blow when very popular saints such as Christopher were eliminated on the grounds that no such person had actually existed (although Christopher has continued to thrive despite this directive). The investigative techniques developed by the church helped to lay the foundation for present-day detective work and intelligence analysis. This dedication to ensuring that only the deserving are venerated was accompanied by a reaffirmation of the power of saints. Any lingering doubts were put to rest by the Council of Trent (1563), which made belief in the efficacy of saintly intervention a core article of Catholic faith.

The church did little, though, to subdue the fixation on saintly remains or to dry up the commerce of same. It is unlikely that any such campaign would have been very successful because there was a widespread horror of the decomposing body during the Middle Ages (to the extent that the illustrious dead would often be boiled until the flesh separated from the bones, with the former then tossed and the latter buried). It was therefore a most welcome miracle when a corpse did not decay, when divine intervention had spared a person the indignity of decomposition. Some of the most beloved saints were those whose bodies had “the odor of sanctity” rather than the rank smell of decomposition when unearthed after a lengthy period of burial. The Virgin Mary escaped decomposition through her ascension to heaven and therefore also avoided corruption of the flesh. Medieval destinations for pilgrimage invariably featured saint relics and remains.

Germaine Cousin is a relatively recent example of an incorruptible. Born in rural France in 1579, she was described as an unattractive and mentally unstable person who attracted little attention when she died at the age of twenty-two. Her corpse happened to be disinterred forty years later and was reported to be perfectly preserved, even unto the garland of carnations and rye that had been placed on her hair. This preservation (like many others) could not be attributed to embalming. In due time she had become St. Germaine, provided with an altar by which her remains could perform their work of healing and protecting those who sought her intercession.

Preserved remains of saints can still be seen. Lawrence Cunningham expresses a not uncommon discomfort with viewing “the incorruptible bodies encased in glass coffins or the statues of Santa Lucia with eyeballs on a plate held in her hand or the large reliquaries with shriveled arms and tibias” (Cunningham 1980, p. 1). Anneli Rufus vividly describes several preserved saints in their contemporary settings.

A Perspective on Preserved Saints

History suggests that saints of the Roman Catholic Church achieved their distinctively influential status first as exemplars of faith and courage and then as intermediaries through which troubled people could convey their fears and hopes to God. The prospect

of salvation and immediate triumph over death became attenuated as the centuries went by and people continued to suffer and die. Saints became increasingly valued as available resources to help with pressing concerns; female saints provided an alternative to the male-dominated church hierarchy.

Two themes had been widespread in world societies long before Christianity: fear of the dead and belief in sympathetic magic. These themes were often combined in cults of the dead where rituals attempted to keep the peace between the living and the dead while drawing upon the special powers of the latter. The emerging saint cults exhibited some of these features, but with a significant twist: The sacred remains of the saints were not to be feared; they were, rather, tokens of hope. The remains also functioned as objects for the working of sympathetic magic. Whatever had been close to a person—or, in this case, part of the person—could be used to make good things happen.

People who otherwise felt powerless to understand and control their fate could take inspiration from those who had become saints by virtue of their virtue, and could participate in a sense of mystic communion with those whose bodies had been preserved from the corruption of the flesh. Even the staunchest faith can sometimes use another glimmer of hope.

See also: CATHOLICISM; CHRISTIAN DEATH RITES, HISTORY OF; JESUS; MARTYRS; VIRGIN MARY, THE

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SAMARITANS

See BEFRIENDING.

SARTRE, JEAN-PAUL

Traditional European Christian philosophy, particularly in the eighteenth century, was filled with images of and sermons on the fear of the judgment that would come upon the time of death. Characterized by Plato as the need to free the soul from the “hateful” company of the body, death was seen as the entrance into another world. By contrast, the efforts of nineteenth- and twentieth-century existentialists were to humanize and individualize death as the last stage of life rather than the entrance into that which is beyond life. This shift historically helped to make death conceptually a part of life, and therefore could be understood as a human phenomenon rather than speculation as to the nature of a spiritual life.

If death is the last stage of life, then one philosophical question is, What is the nature of the experience? It is to this question that the phenomenological analysis of Jean-Paul Sartre contributed significant insight. It can be said that when a child dies, the child becomes frozen in time. Always a child, the potential of that child is never realized

and the experience of the life of that child ends. Sartre explains in his analysis of time that the past is fixed in the experiential history of the person. Whatever the person did, or even did not do, is simply the way it is. If a person was a coward when he or she died, then the image of that person as a coward is how the individual is remembered.

In his book *Being and Nothingness* (1956) Sartre established his early phenomenological method, exploring the nature of the human experience. Since Socrates, Western philosophers have suggested that essence or those basic aspects that make up the person are divinely preordained or predesigned prior to birth. Sartre, on the other hand, understood that the person must first exist before that which makes up the person can be identified, as human beings are not objective objects but rather subjective in their dynamic ability to change. Thus for Sartre, existence precedes essence. If analysis starts with the first human experience and ends with the last, then one's past is the past that was experienced by the individual, the present is the current reality, and the future reflects his or her potential. For Sartre, at the point of death the person does not have a past, as he or she is now dead and cannot continue to write in the log of the present. Rather, a person then becomes his or her past. Like the child who has died, in death the person is frozen in the minds of those persons who remember him or her.

Sartre used the concept of a wall to explain the transition from life to death. This concept is best understood by persons in a hospice who find that their comrades in death often understand them better than their families or those who do not understand their own finite nature. As he often did, Sartre offered his existentialist philosophy in a more academic volume and then explained it in his plays and novels. In his story *The Wall* (1964) Sartre writes about Pablo, a Spanish loyalist in his cell with two other republicans waiting execution by Generalissimo Franco's soldiers. He reflects as follows: “For twenty-four hours I have lived at Tom's side, I had heard him, I had talked to him, and I knew that we had nothing in common. And now we resemble each other like twins, only because we shall die together” (Stern 1967, p. 174). Persons faced with their own finitude often see the meaning of both their experiences and their lives from a larger perspective.



Jean-Paul Sartre and lifetime companion Simone de Beauvoir, whose ashes are buried side-by-side, share the same gravestone in the Montparnasse Cemetery in Paris, France. ROBERT HOLMES/CORBIS

Sartre would say that as he has not experienced death, he does not know what it is, but he can see that it must have some reality as others seem to experience its presence. An atheist, he believed that there is no divine being and therefore no heaven or an afterlife. Rather, there are only those aspects of the conscious choices made by the individual that live on in the lives of those the person has touched. Sartre's understanding of life is that it reflects the experience of one's existence. When the person is dead, he or she is only memories held by those who are in some way a part of the life of the individual. These contributions to the humanizing of the dying experience and the philosophical understanding of the role of death offer benchmarks in the history of the philosophy of death.

See also: FRANKL, VIKTOR; FREUD, SIGMUND;
IMMORTALITY; PHILOSOPHY, WESTERN; PLATO

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JAMES W. ELLOR

SAUNDERS, CICELY

The name of Cicely Saunders is synonymous with one of the major social innovations of the twentieth century: the modern hospice movement. Saunders was born in England on June 22, 1918, the first of three children of Gordon and Chrissie Saunders. She enjoyed the material comforts of a successful middle-class family, and at the age of fourteen was sent to Roedean, one of the country's exclusive boarding schools for girls. In 1938 she went to Oxford University to read politics, philosophy, and economics, but interrupted her studies two years later to become a student nurse at the Nightingale Training School of London's St. Thomas's Hospital. When a back injury forced her to leave nursing, she returned to Oxford and qualified in 1944 with a diploma in public and social administration. She then commenced training as a hospital almoner, or medical social worker.

In a large London hospital Saunders became involved in the care of a patient who was ill and dying far away from his own home. His name was David Tasma, and he had come to London as a refugee from Poland's Warsaw ghetto. In the short time that they knew each other, he proved an inspiration to Saunders, and their professional relationship turned into a deep friendship. One day he said to her, "I want only what is in your mind and in your heart." This combination of emotion and intellect proved to be a guiding theme in her subsequent work. The two discussed an idea that it might be possible to create more homelike places where people could end their lives. When Tasma died, on February 25, 1948, he left Saunders with a

gift of £500 and the following encouragement: “Let me be a window in your home.”

Saunders determined immediately to learn more about the care of the terminally ill. First she worked as a volunteer in St. Luke’s, a home for the dying in Bayswater, London. Then she made the momentous decision to study medicine, starting in 1952 and qualifying at the age of thirty-eight. She began to see her work with dying people as a form of religious calling or vocation.

In 1958 she took up a position as Research Fellow at St. Mary’s School of Medicine, conducting work at St. Joseph’s Hospice in Hackney, in the East End of London. Here she laid down the basic principles of modern hospice care. She developed a systematic approach to pain control in terminally ill patients; she gave attention to their social, emotional, and spiritual needs; and she began teaching what she knew to other people. Her concept of “total pain” provided a revolutionary way of conceptualizing the complexity of patients’ suffering. In response to medicine’s despairing rejection of the dying patient—“There is nothing more we can do”—she offered a positive, imaginative alternative that sought to ensure pain relief, maintain dignity, and enhance the remaining period of available life, however short.

Soon Saunders made plans to build her own modern hospice. To signify that it would care for people on their last journey in life, it was given the name St. Christopher’s, referring to the patron saint of travelers. She gathered a group of supporters who helped to work out the plan in detail, and she traveled to the United States and other countries to promote and refine her ideas. There were huge barriers to be overcome, including the low priority assigned to the care of the dying in the British National Health Service, a lack of research, no specialized education in the field, and social indifference to matters of care at the end of life. Yet, after eight years of fund-raising, planning, and promoting the idea, Saunders saw St. Christopher’s Hospice open to its first patients in 1967. As she often remarked afterwards, “It took me nineteen years to build the home round the window.” Along the way she had marshaled help from major charitable donors, from senior figures in the establishment, and from a growing body of clinicians and lay people committed to the development of this work.



Cicely Saunders’s approaches to pain relief and tending to the emotional and spiritual needs of terminally ill patients helped shape the modern hospice movement. ST. CHRISTOPHER’S HOSPICE

For the next eighteen years Saunders was the medical director of the hospice she had created. She quickly expanded its services to include home care; she promoted research into pain control and into the efficacy of the program; and she developed a center for specialist education. During this time she authored some eighty-five publications, some of which appeared in several languages. Constant media attention made the hospice well known throughout the world. Her work was acclaimed internationally, and she received many prizes and honors from numerous countries, including the Lambeth Doctorate of Medicine (1977); the Gold Medal in Therapeutics of the Worshipful Society of Apothecaries, London (1979); the Templeton Prize for outstanding contributions in the field of religion (1981); and entry into the

Order of Merit, the highest honor within the British system (1989). St. Christopher's received thousands of visitors each year and became a beacon of inspiration for others who came to study, develop clinical skills, and conduct research.

In 1985 Saunders retired from full-time work at the hospice but remained active in her writing, teaching, and support for developments in hospice and palliative care. Both her private and professional life continued to be matters of public interest. She became the subject of a biography and of television documentaries and press interviews. In 1980 she married the Polish artist Marian Bohusz-Sysko, whom she had first met in 1963. She continued to travel and give lectures and presentations, especially after her husband died in 1995; her work remained a source of inspiration to those endeavoring to develop palliative care around the world. Her eightieth birthday was celebrated in 1998 with a conference in her honor at the Royal College of Physicians, London. In 2000 she retired from the position of chairman at St. Christopher's Hospice to take on the role of president/founder and to assist in the development of a new palliative care institute that will bear her name.

See also: HOSPICE AROUND THE WORLD; HOSPICE IN HISTORICAL PERSPECTIVE; HOSPICE OPTION; PAIN AND PAIN MANAGEMENT

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DAVID CLARK

SCHOPENHAUER, ARTHUR

Arthur Schopenhauer (1788–1860) was one of the few notable thinkers of his time to regard the relationship between life and death as the central problem of philosophy. He was also among the

first Western intellectuals to draw insights from Buddhist and Hindu worldviews.

The German philosopher was born into a prosperous family that had many social and cultural connections. Contemporaries described Schopenhauer as a scintillating conversationalist with discerning taste in the arts. However, he was also seen as a gloomy person whose company was difficult to bear. Even as a youth, Schopenhauer was strongly affected by the imperfections of life—one must endure suffering, loss, disappointment, and frustration until the hammer blow of death ends all. Life seemed like an all but unbearable burden. Why go on living, then? The answer was clear to him: People put up with the miseries of life because they are terrified of death. Schopenhauer's need to resolve the dilemma of a miserable life and a terrifying death would contribute much to his elaboration of a philosophical system that has continued to influence world thought. His writings often challenge the reader's stamina: Schopenhauer himself cautioned his readers that they must resign themselves to reading all three volumes of *The World As Will and Representation* (1818) twice—and then perhaps once again for good measure.

The Thing-in-Itself

Following Eastern religious perspectives, Schopenhauer rejected the assumption that the world presents itself directly to the human mind. He believed it is more accurate to say that people construct representations of the world and then respond to these ideas or images as though they were objective reality. Even such powerful ideas as life and death are framed within the conventions of language and societal custom. Not denying that there is a core of reality within representations of life and death, he argued that people often respond more to the representations than the reality.

The philosopher's quest to understand the world through words, logic, and reason had been missing the point, according to Schopenhauer. Words are usually limited to the superficial appearance of reality. Seldom do people recognize the thing-in-itself, the inner nature of both the universe and human nature. The essence of life is to be sought in a driving force, an incessant impulse

that is far more powerful than reason. He called this force “The Will.” The will might be regarded as the thing-in-itself in action. Life is the most significant example. The essence of life is the fierce impulse to continue, to survive. The will operates for the species as well as for the individual. The blind will of nature does not hesitate to sacrifice many individuals in order to keep the species going.

Death As the Answer to Life

Humans face a unique situation—they are driven by the will to live, like all other creatures, but are also aware of the certainty of death. In Schopenhauer’s view, all religions have been motivated by the desire to find some way of coping with this dilemma. His own conclusion is, “Only small and limited minds fear death” (Schopenhauer 1957, vol. 1, p. 27). Humans have death as their destiny, their completion. Individuality ceases with death, but the essence of being is indestructible and remains part of the cosmic process.

Schopenhauer invites the reader to take a larger view of the universe instead of the usual concern for individual life. From this cosmic vantage point, life and death are reciprocals, not opposites. He notes that Eastern thought has long represented the same god as having both creative and destructive powers. Siva, for example, displays the lingam, a symbol of generation, although she is adorned with a necklace of skulls. Greeks and Romans celebrated “the full ardour of life” at their funerals to make a similar point (Schopenhauer 1957, vol. 1, p. 355). It would be wise then, according to Schopenhauer, for people to look “away from the death of the mourned individual [with] knowledge that the whole of nature is the phenomenon and also the fulfillment of the will to live” (p. 355).

The answer to death proposed by Schopenhauer has not been widely accepted, in part because many people continue to focus on individual fate rather than cosmic process. Among his many influences, however, was the life versus death instinct of Sigmund Freud, and continuing discussions about the value of death education and the ethics of rational suicide.

See also: BUDDHISM; HINDUISM; PHILOSOPHY, WESTERN; PLATO; THANATOLOGY

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ROBERT KASTENBAUM

SÉANCE

See COMMUNICATION WITH THE DEAD.

SERIAL KILLERS

Descending into minds that people view as belonging to despicable monsters is a requirement for individuals who search for or attempt to understand serial killers. The serial murderer Jeffrey Dahmer would go to bars in Milwaukee, Wisconsin, and pick up young men, sometimes telling them he was a photographer and luring them back to his apartment with an offer of money to be his model. He would then drug their drinks to subdue them so that they would be easier to strangle. However, those factors did not tell investigators the emotional core of his killing, they were simply the modus operandi (MO) of the crime. MO includes victim type, how the criminal approached or overcame his victim, tools used, and the time and place that the crime occurred.

More revealing is what has been called a killer’s “signature,” which has been defined by John Douglas as “a personal detail that is unique to the individual, *why* he does it: the thing that fulfills him emotionally” (Douglas 1997, p. 26). John Douglas, the first full-time profiler at the behavioral science division of the Federal Bureau of Investigation Academy in Quantico, Virginia, thinks the killer’s signature is a better guide to behavior than his MO. While the MO may change as the killer comes up with a better technique, the emotional reason he commits the crime does not change. In Dahmer’s case his murder signature

showed the sadistic sexual satisfaction and control of living with his victims' bodies. In his case, some of these behaviors included engaging in sex with the bodies, cutting up the victims and cannibalizing body parts such as the heart, pulling muscles from the bone and wearing them on his own shoulders, painting the skulls to put over his bed, and storing one victim's head in the refrigerator.

Characteristics of Serial Murder

What is serial murder? The British author John Brody first used the term in 1966, and the National Institute of Justice defined serial murder in 1988 as "a series of 2 or more murders, committed as separate events, usually, but not always, by one offender acting alone" (Newton 2000, p. 205). Another perspective is that of Steve Egger, who uses six characteristics in his definition of serial murder: (1) There are a minimum of two murders; (2) the killer and victim are unrelated; (3) the murders have no direct connection to each other and occur at different times; (4) the murders usually occur at different locations; (5) victims may have characteristics in common with earlier or later victims; and (6) the murders are not committed for material gain but for gratification based on fantasies.

Several of these characteristics are debatable. The material gain motive is more common with the female than the male style of serial murder, thus Egger's definition could be seen more as serial signature murder. Also, individuals such as Edmund Kemper, who killed his grandparents and mother, and Henry Lee Lucas, whose mother was his first victim, are generally classified as serial killers. The criminologist Eric Hickey states that most researchers define serial killers as having three to four victims, but also includes in his database of serial killers some individuals who "killed only two victims but were suspect in other slayings or in which evidence indicated their intent to kill others" (Hickey 1997, p.27). The problem with using a definition based strictly on three victims omits the two-time signature killer who has obsessive qualities and would be expected to continue to kill.

Serial murder differs from mass murder in that mass murder involves killings of four or more victims in the same general area and occurs as one

event in a short period of time. The mass murderer "appears to give little thought or concern to his or her inevitable capture or death" and may give him- or herself up or commit suicide if not killed by police (*ibid.*, p. 7).

Characteristics of the Serial Killer

According to Hickey's 1997 database of approximately 399 serial killers, the average age of the murderer at the time of the first killing was 27.5 years, and they typically were white males. Criminologists James A. Fox and Jack Levin (2001) found that males made up more than 90 percent of the sample. Seventy-three percent of male offenders were white, 22 percent were African-American, and the remainder were of different ethnic groups. Fox and Levin report that the researcher Grover Godwin's 1999 database of 107 serial killers revealed an average age of thirty. Ninety-five percent were males, 5 percent were females, and 16 percent were African-American. Godwin also found that only 4 percent of his sample graduated with a bachelor's degree, while most were employed in blue-collar jobs. Victims were 67 percent female, with children, prostitutes, and the elderly as other preferred victim categories, although 20 percent of Godwin's sample were males who had additionally been raped by their attackers.

In 1992 the researchers Robert Ressler, a veteran of the FBI who served as founder of the FBI's Violent Criminal Apprehension Unit; Ann Burgess and John Douglas interviewed thirty-six convicted, imprisoned, sexual murderers who had a total of 118 murder and attempted murder victims among them. The interviews with the sexual murderers showed very active, violent, sexualized fantasies, which focused on killing until the first murder occurred and perfecting the killing after the first murder had occurred. The researchers were surprised by the lack of positive childhood fantasies remembered by the offenders. They noted progression in seven of the offenders from conscious awareness of a fantasy to actually acting out the fantasy within only a year. They saw clear behavioral progressions as well. Numerous authors have cited the childhood predictive behavior for serial killers of torturing animals. Many serial killers had been arrested, or had been in mental hospitals, for less serious behaviors before the serial killing began.

Organized vs. Disorganized. There are several typologies of serial killers. Ressler, Burgess, and Douglas viewed them either as “organized” or “disorganized” based on crime scene information. The organized killer plans the murder, chooses a stranger as a victim, then engages in limited conversation with the relatively personalized victim. The crime scene is not sloppy, but controlled, as is the victim, who suffers aggressive acts before death. The weapon is not present, nor is the victim’s body. The crime scene for a disorganized murderer, on the other hand, is a spontaneous offense with either the victim or the area, or both, known to the perpetrator. There is very little conversation with a depersonalized victim, who suffers sudden violence. A few personal qualities of the organized criminal are good intelligence, high birth order status, some social competence, and the use of alcohol with the crime. The disorganized killer has average intelligence, is socially immature, has lower birth order status, uses alcohol minimally, and is more likely to be psychotic than an organized killer.

Some killers have qualities of both types, such as Jack the Ripper, who operated in 1888 in Whitechapel, the east end of London. This area of poverty and misery saw the savage assaults of Jack the Ripper on a series of prostitutes. Because his true identity was never officially revealed, John Douglas profiled the killer a century later, and the biographer Phillip Sudgen believes Douglas would have labeled him “disorganized.” Yet Sudgen points out that this murderer also had some organized qualities such as the ability to hold a conversation with potential victims and his typical removal of weapons and clues.

Male vs. Female. Hickey reviewed differences between male and female serial killers. Results show female serial killers are more likely to kill husbands, relatives, or people in hospitals or nursing homes where they work; murder in one specific place; poison the victims; and report money to be a motive. Males are more likely to kill strangers, be geographically mobile, torture or mutilate more often when killing, and report a sexual motive. Most females thus meet the definition of the National Institute of Justice as serial murderers but do not meet Egger’s definition with its additional parameters of the killer and victim being unrelated and a murder not committed for material gain but for fantasy gratification.

The Psychological Phases of Serial Killers

In 1988 the psychologist Joel Norris described the psychological phases that serial killers experience. Norris worked on the defense teams of several convicted killers from Georgia and completed 500 interviews with such individuals, during which he identified the following phases.

The killer begins with an *aura phase*, in which there is a withdrawal from reality and a heightening of the senses. This phase may last anywhere from several moments to several months and can begin as a prolonged fantasy, which may have been active for a short time or for years. The killer may attempt to medicate himself with alcohol or drugs.

The *trolling phase* consists of the behavior patterns that a particular killer uses to identify and stalk his victim. Norris described how Ted Bundy strapped his arm in a sling and asked for help with books, packages, or even the hull of a sailboat to lure the victim into his car. Some victims escaped and said he never seemed out of control until the moment he actually attacked them.

The *wooing phase* is that time period when most killers win the confidence of victims before luring them into a trap. The *capture phase* may include the locking of a door or a blow that renders the victim helpless. The killer savors this moment. Norris described the *murder phase* as the ritual reenactment of the disastrous experiences of the killer’s childhood, but this time he reverses the roles.

The next phase Norris described is the *totem phase*. After the kill, murderers sink into a depression, so many develop a ritual to preserve their “success.” This is why some killers keep news clippings, photographs, and parts of the victims’ bodies, or eat parts of the victims, wear their skin, or show parts of victims’ bodies to later victims. The trophy is meant to give the murderer the same feelings of power he experienced at the time of the kill.

The last phase is the *depression phase*. A victim, now killed, no longer represents what the killer thought he or she represented, and the memory of the individual that tortured the murderer in the past is still there. Ressler compares the murder to a television serial with no satisfactory ending because the serial killer experiences the tension of a fantasy incompletely fulfilled. In each subsequent murder, he attempts to make the scene of the crime equal to the fantasy. Norris notes that there

is an absence of the killer's sense of self and, during this phase, the killer may confess to the police before the fantasies start once more. However, because victims are not seen as people, recollections of murders may be vague or viewed as the killer having watched someone else. They may have a memory for tiny details about the murder, which is dissociated from the event as a whole.

Psychological, Social, and Biological Factors in the Serial Murder

Psychological factors in the development of serial murder have sometimes included obvious abuse or emotional isolation in childhood. An example of the obviously abusive stands out in Henry Lee Lucas's prostitute mother hitting him for years with broom handles, dressing him as a girl for school, and forcing him to watch her having sex with men who would then be violent toward him. In such cases, the child appears to identify with the aggressor and replay a childhood victimization, this time as the aggressor. But not all cases show obvious massive family dysfunction. Many cases, however, according to Ressler and his fellow researchers Ann Burgess and John Douglas, do show loss of a parent or parental rejection. Robert Keppel and William Birnes describe the formation of the diphasic personality, in which a person's life develops two phases. One phase is the fantasy life where the child has complete control, while the other phase is the shell that walks through the real world and has little energy or effort committed to it. The child is emotionally isolated with his fantasies.

From a social construction point of view, Hickey describes a trauma-control model of the serial killer. While head injury or brain pathology may be predisposing factors, the eventual offender responds to traumatization in the formative years in the negative way of having low self-esteem and increasingly violent fantasies. Traumatic experiences and feelings from the past may be dissociated from conscious feelings, and the adult offender may aid an altered state of consciousness by facilitators such as alcohol, pornography, or drugs. Finally he commits murder as a way of regaining control and may initially feel reinforced before the low self-esteem sets in again.

Biological causes of crime were hypothesized by Hans Eysenck, who believed that criminality resulted from a nervous system distinct from that of

most people, and that extroverts were more likely to be involved in antisocial behavior. J. A. Gray proposed a behavioral inhibition system as the neural system underlying anxiety. This system teaches most people not to make an antisocial response because of anxiety and is called passive avoidance learning. The researcher Don Fowles continued this concept with the idea that criminal personalities have deficient behavioral inhibition systems, therefore will proceed to make the antisocial response. The second half of Gray's model is the behavioral activation system, which causes reward-seeking behavior and active avoidance of punishment, such as running away. Fowles believes this system is normal in the criminal personality. Gray's theory also says there is a nonspecific arousal system receiving excitatory inputs from both systems.

Similar ideas may be viewed directly from the brain. In a 1997 article in the *Journal of Psychoactive Drugs*, the researcher Daniel Amen reported findings with Single Photon Emission Computerized Tomography (SPECT) brain imaging, which measures metabolic activity and cerebral blood flow patterns to examine differences in the aggressive brain. He examined forty aggressive adolescents and adults from a psychiatric population that physically attacked someone or destroyed property within six months of evaluation, and compared them to an age-, sex-, and diagnosis-matched control group of forty psychiatric patients who had never had reported problems with aggression. No person was included in the study who had a history of a substance abuse problem in the last year or a history of head injury involving loss of consciousness.

Amen found aggressive individuals show significant differences from nonviolent individuals. First, there is decreased activity in the prefrontal cortex; decreased functioning would result in less impulse control, less ability to focus attention, and poor judgment of highly charged situations. He found increased activity in the left side only of the basal ganglia and limbic system. Among multiple complex functions, he noticed that overactivity in the basal ganglia is associated with anxiety, and overactivity in that part of the limbic system is associated with negative mood and a higher chance of violent behavior. He found increased activity in the temporal lobes, which, among other functions, have been connected to temper outburst and rapid mood shifts, especially noted for the left temporal

lobe. He found increased activity in the anteromedial portions of the frontal lobes (anterior cingulate area), which, among other functions, results in obsessive inability to stop thinking about negative events or ideas. In his 1997 publication, Amen discusses how correct medication can improve some of these abnormalities and, along with therapy, improve problem behavior. He has also found that the use of alcohol results in overall decreased brain activity, and chronic alcoholism is associated with reduced metabolism, especially in the frontal and temporal regions of the brain. These are the same regions involved in violent behavior. Interestingly, Ressler and colleagues specifically listed alcohol use during the murder as one of the characteristics of the organized serial killer.

Violence has also been connected to a variety of serotonin abnormalities as well as reduced glucose metabolism shown by positron emission tomography. In 1997 the scholar Adrian Raine and colleagues examined glucose metabolism in forty-one murderers pleading not guilty by reason of insanity, compared to an equal number of age- and sex-matched control subjects. The murderers showed reduced glucose metabolism in the prefrontal cortex, superior parietal gyrus, left angular gyrus, and corpus callosum. The left hemispheres of their brains had lower activity than the right in the amygdala, thalamus, and medial temporal lobe.

Research has identified certain brain dysfunctions, parental loss or rejection, and the development of the diphasic personality and the trauma control model as potential factors in the development of the serial killer. In the future, identifying the diphasic, emotionally isolated child and helping him or her to connect with people could potentially occur in the school. Perhaps brain scans as well as school-based behavioral evaluations could indicate those people who might benefit from psychotherapy, social skills interventions, medication, or some combination of the above to prevent or control their aggressiveness. A society with the skills and the willingness to finance such a possibility would have to make careful decisions about the freedoms of the people it labeled as well as the rights of the public. Yet deinstitutionalization of the mentally ill, as flawed as it is, took hundreds of thousands of people out of hospitals and gave them a less restrictive life. Perhaps a similar, but well-managed, outcome could be the future of a safe public and of the murderers society must lock away.

See also: AIDS; HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; MASS KILLERS

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SANDRA BURKHALTER CHMELIR

SEVEN DEADLY SINS

Pride, Envy, Avarice, Wrath, Lust, Gluttony, and Sloth are the seven deadly sins that popes, saints, preachers, artists, writers, dramatists, and musicians have urged Christian believers to avoid at all costs. Life can be placed at risk by indulging in these sins; for example, those whose arrogant pride invites disaster, the gluttons who eat their way to the grave, or the violently wrathful who are executed according to the laws of the land. Far more significant, though, are the consequences of sin for the fate of the soul. The corruption of the soul through sinful thoughts and actions literally dis-graces the perpetrator during his or her sojourn on the earth. Having fallen out of grace with God during life, the person is in peril of damnation after death. The sins are “deadly,” then, primarily in their effect on the soul as divine judgment offers salvation or hurls it to damnation.

Historical Perspective

What became crystallized as the seven deadly sins does not appear as such in the Bible, although the Old and the New Testaments identify attitudes and behaviors that violate the principles of a righteous life. Theologians compiled lists of the most serious sins as they attempted to instruct monks, priests, and laities on the requirements for a virtuous Christian life. The earliest influential list identified eight sins that were obstacles to perfection. John Cassian, a fifth-century monk and spiritual leader, specified several sins that later became part of the standard list: pride, gluttony, covetousness (envy), anger (wrath), and ennui (sloth). Two other items on his list—impurity and vanity—are related to lust and pride, and “dejection” was folded into sloth, although not until the seventeenth century.

The standard list of seven deadly sins was established by Pope Gregory the Great in the sixth century. He maintained that pride breeds all the other sins, and is therefore the most serious offense. St. Thomas Aquinas, author of the landmark thirteenth-century *Summa Theologica*, reaffirmed that pride (or “vainglory”) is rebellion against the authority of God. Aquinas reasoned that some sinful acts are venial rather than deadly: They arise from the temptations of everyday life and have the effect of weakening the bonds of trust and fellowship among people. Lust, for example, threatens the crucial relationship between parents and children. Such actions become elevated to deadly sins when they arise from the spiritual failing of pride and therefore threaten the soul's acceptance into the kingdom of God.

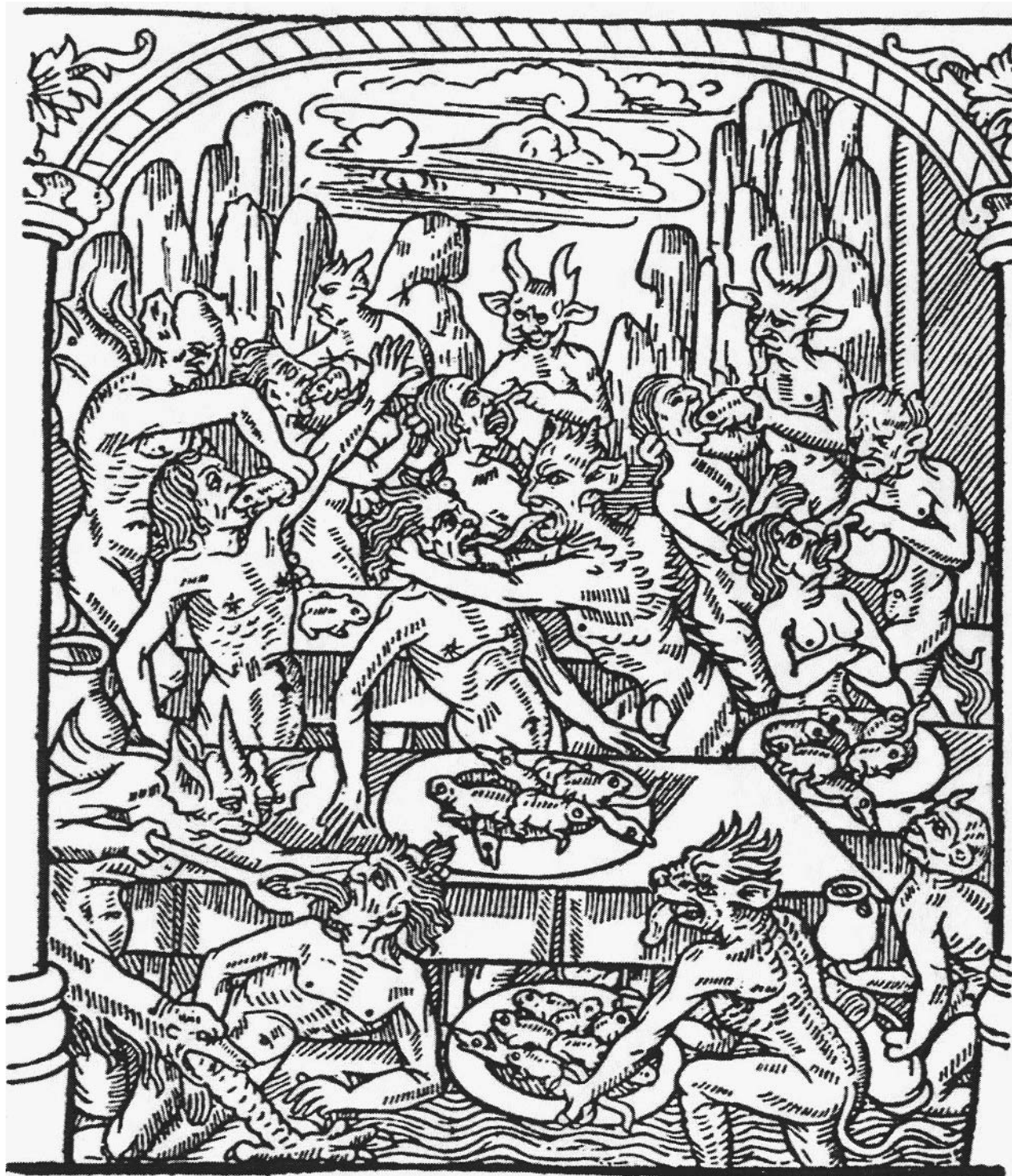
Many ideas and images became associated with each of the deadly sins over the centuries. The particular associations varied, but specific punishments often were considered to await the perpetrator. In all instances the sinner is assumed to be alive in some form after death in order to experience the agony and despair.

- Pride=Broken on the wheel
- Envy=Encased in freezing water
- Avarice (Greed)=Boiled in oil
- Wrath (Anger)=Torn apart, limb from limb
- Lust=Roasted by fire and brimstone
- Gluttony=Forced to eat rats, snakes, spiders, and toads
- Sloth (Apathy)=Thrown into snake pits

Set against the deadly sins were the heavenly virtues, also seven in number. The first three of these virtues have remained the most widely mentioned: faith, hope, and charity. The others are fortitude, justice, temperance, and prudence. Attempts have been made to match these virtues against the sins, but it is difficult to discern a one-on-one correlation.

Influence of the Seven Deadly Sins

The medieval world was conceived largely in religious terms, and lives were to be governed by rules derived from divine authority. Morality and



Indulgence in pleasures of the flesh paved the road to damnation. Gluttons, for example, were forced to gobble down toads, rats, and snakes, as revealed by this fifteenth-century French illustration. DOVER PUBLICATIONS, INC.

order in human affairs required constant and vigorous attention, then as now. The seven deadly sins and their punishments offered a striking set of cautions, while other teachings, such as the seven

heavenly virtues, limned the positive path. Creative artists in all the media contributed much to the message, some of their work becoming enduring masterpieces of Western culture.

Geoffrey Chaucer's fourteenth-century *Canterbury Tales*, Dante Alighieri's fourteenth-century *Divine Comedy*, Edmund Spenser's sixteenth-century *The Fairie Queen*, and Christopher Marlowe's sixteenth-century *Tragical History of Doctor Faustus* all feature depictions of the seven deadly sins that remained influential long after their periods of creation. When Hieronymus Bosch introduced his unique and startling visual representation of the seven deadly sins in the fifteenth century, it was with a revisionist twist. The sins were converted from theological abstractions to the follies of everyday people in their everyday lives—with a bracing addition of dark humor.

As the medieval mindset gave way to the modern there was more attention given to naturalistic explanations for events (i.e., disease, famine, and earthquake) and to human actions. The concept of sin would come under increasing pressure from rival explanations, many with psychological and sociological orientations. Nevertheless, the seven deadly sins have continued to appeal to the artistic imagination and to engage the attention of people who, in times very different from Pope Gregory's, are still attempting to negotiate their way between temptation and virtue. Examples of contemporary or near-contemporary contributions include *The Seven Deadly Sins* (1933), set as a musical theater piece by the twentieth-century composer Kurt Weill (best known for *The Threepenny Opera* (1933)), and the motion picture *Seven* (1995), starring Brad Pitt, Morgan Freeman, and Kevin Spacey. The survival of this concept has also included numerous examples of accommodation to technology and consumerism.

See also: CATHOLICISM; CHRISTIAN DEATH RITES, HISTORY OF; HELL; PURGATORY

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ROBERT KASTENBAUM

SEX AND DEATH, CONNECTION OF

Sex and death have a number of connections other than having been taboo topics in polite company and controversial subjects in school curriculums. As is the case with many taboos, both can lead to fetishes and eroticisms, and their mere mention holds shock value for young adults.

Few question that life's greatest drives are to reproduce and to avoid death. The Austrian psychoanalyst Sigmund Freud and the French social theorist Michel Foucault argued that the two are fused, that the death instinct pervades sexual activity—a connection easily seen by a Frenchman whose language frames orgasms as *petit mort*, or "mini-deaths." With the AIDS epidemic their view has become particularly poignant. A 1992 study from Amsterdam, for instance, found that about one in six U.S. soldiers surveyed said that sex without condoms was worth the risk of getting the AIDS virus. A year later a story released by Planned Parenthood counselor offices in San Antonio, Texas, explained how teenage girls were demonstrating their toughness by having unprotected sex with an HIV-infected gang member. It seems that, for some, sexual desire is intensified in the presence of taboos and boundaries, even deadly ones.

The Scientific Perspective: Death As the Cost of Reproduction

Early lessons about the connection between reproduction and death often come from exceptional stories from the animal kingdom. Pacific salmon, for instance, return after three or four years in the

ocean to battle hundreds of miles upstream—against gill nets, predators, and dams—to the tributaries where their lives began, to spawn and to die. Their remains fertilize the streams, providing food for the tiny microorganisms on which their offspring will feed. In addition, one cannot forget the story of how the female praying mantis bites off the head of her partner while mating. Or how in several marsupial mice species, the immune systems of the mice collapse after their first mating, leading to death shortly thereafter.

It has been observed that death is the price multicellular creatures must pay in order to reproduce. The biologist William Clark observed, “Obligatory death—as a result of senescence (natural aging)—may not have come into existence for more than a billion years after life first appeared. This form of programmed cell death seems to have arisen at about the same time cells began experimenting with sex in connection with reproduction” (Clark 1996, p. xi). Perhaps one legacy of this original immortality is the telomerase, the so-called immortality enzyme, found within the cells of testes and ovaries. Absent from normal cells that age and die, telomerase is what allows cancerous cells to reproduce without limits.

In the case of the life span of mammals, the period in which they have the greatest resistance to harmful environmental factors is when they have the greatest reproductive capacity. Evolution has little interest in the survival of those who have produced viable offspring and are in the post-reproductive period of life, hence the extreme rarity of senescent (old) animals in the natural order.

Humanity is not immune from this law of death as the cost of sex. This toll for reproduction has particularly been borne by women. Unlike at the start of the twenty-first century, when women held a seven-year life-expectancy advantage over males in developed nations, historically, because of their high maternal death rates, women were the shorter-lived sex. Maternal death rates remain high in poor nations of the world, where women are up to 200 times more likely than women in the richest countries to die as a result of complications of pregnancy, abortion, or childbirth—the causes of one-quarter of all deaths of those of childbearing age. In the United States, the Centers for Disease Control and Prevention reported in 2001 that black women were four times more likely than

non-Hispanic white women to die of pregnancy-related problems.

Even the sex act itself can prove lethal. Cardiovascular specialists have long warned how extramarital sex was dangerous for heart patients, as it increased their blood pressure and pulse rate more than when having sex with a familiar partner. Such activity killed a former American vice president, Nelson Rockefeller, who died of a heart attack during an extramarital tryst in 1979. In 1998, having sex shortly after having given birth proved fatal for two British women, who died of air embolisms.

Attempts to enhance one’s sexual experiences can be deadly as well. In 1998 the Food and Drug Administration reported the deaths of several men taking the highly popular Viagra impotence pill. Each year, attempts at sexual self-gratification accidentally kill between 500 and 1,000 individuals, predominantly men, because of autoerotic asphyxia. To heighten their sexual orgasm during masturbation, these individuals cut off the supply of oxygen and blood to their head, often by tying a belt or rope around their neck. Consciousness may be lost, and the individual dies by strangulation.

Relationships between Sex and Longevity

The need for species to change over time underlies evolution’s mechanisms for triggering death with sex. In addition, there are genetic clocks determining the time frame for species to produce and raise the next generation to the point where it can successfully pass on its genetic code. Thus the later in life a species reproduces, the longer its life expectancy. Fruit flies with special “longevity genes” have been created, allowing them to live twice as long as their normal counterparts. By breeding them at increasingly advanced ages, Carla Sgrò and Linda Partridge also found that fruit flies that produced eggs at a young age died earlier than those that reproduced when they were older. When the younger-reproducing flies were sterilized with X rays, they began living as long as their older counterparts.

How this phenomenon might apply to humans raises interesting questions. Will the trend toward postponing parenting ultimately lead to the delaying of senescence and death? And, given the trend of affluent older males beginning second families with their young “trophy wives,” will an even greater longevity advantage develop in the upper classes?

Nevertheless, postponement of parenting indefinitely can also lead to premature death. In 1986 Evelyn Talbott found that women over the age of fifty who had been married but had never had children might face an increased risk of dying suddenly of heart disease. Several studies in the early 1990s found that men who had vasectomies increased their risk of testicular cancer and prostate cancer, the latter by 56 to 66 percent at all ages.

Another 1994 study of 1,800 Seattle women by Janet R. Daling and her colleagues for the National Cancer Institute found that abortion increased women's risk of breast cancer by 50 percent. In the same year, a study directed by Mats Lambe found that having a child increased a woman's risk of breast cancer in her younger years but protected her against cancer in later life. For example, a thirty-five-year-old woman who gave birth at age twenty-five had an 8 percent higher risk of breast cancer than did a childless woman the same age; at age fifty-nine, however, the former's risk was 29 percent lower than the latter's.

On the other hand, eliminating one's ability to reproduce has also been found to reduce the likelihood of death. A 1999 study by physician Edward M. Messing and his associates showed that castration increased the survival chances of men with spreading prostate cancer. And Canadian researchers in 2001 reported that women with a high probability of developing ovarian cancer could reduce their cancer risk by up to 72 percent with tubal ligations.

Special Case of AIDS

During the late twentieth century it was the AIDS epidemic that most universally symbolized the lethal aspects of sexuality, particularly acts outside of monogamous relationships. While the popular conception in the United States initially saw the sex-death connection largely confined to specific high-risk groups, particularly homosexual populations, throughout most of the world the epidemic spread through heterosexual unions.

At the start of the twenty-first century, the highest rates of HIV infection were in sub-Saharan African countries, occurring within the most sexually active segment of the population, those fifteen to forty-nine years of age. Here the cultural sex order made for an epidemiological nightmare,

where individuals were more likely than their European counterparts to have numerous sex partners. Once again women were disproportionately the victims, more likely being the one infected than infecting—owing to greater male promiscuity and female subservience—and being the sex to most quickly develop full-blown AIDS infection and dying of its effects. Projections, made in 2000, were that men would outnumber women by eleven to nine. Without AIDS, life expectancy in 2010 was projected to be 70 years in Zimbabwe, 68 in South Africa, and 60 in Zambia. With AIDS, life expectancy was expected to fall below 35 years in Zimbabwe, to 48 in South Africa, and to 30 in Zambia.

The HIV deaths resulting from sexual relations extend from individuals to entire social orders. The epidemic has killed family structures—producing a huge generation of orphans—and severely diminished chances for economic development. In 1999 at Eskom, South Africa's electric utility, 11 percent of the workers were infected with HIV, as were an estimated 40 percent of the Ugandan military and one-third of that country's teachers. In South Africa, Zimbabwe, and Kenya, some of Africa's most industrialized countries, gross domestic product was predicted to be 20 percent lower by 2005 than it otherwise would have been without the epidemic.

When the Sex Drive becomes Deadly

Evolution has endowed human males with a high sex drive coupled with considerable aggressiveness—especially regarding matters of breeding rights. In Pakistan, husbands are often acquitted for the “honor killing” of their spouses, whose “crime” may range from a simple flirtation to an affair.

Violent sexual assaults on the weak and unempowered occur throughout the world. In Juárez, Mexico, during the late 1990s, at least seventy women had been raped and murdered by sexual predators, their bodies dumped in the Chihuahua Desert. In the United States, the rape, maiming, and murder of children are frequent news items, leading to most states passing sexual predator legislation and demands that the public be informed of where these individuals reside when released.

Violence between sexual intimates is unfortunately common. Domestic violence is the leading cause of injury to women in the United States, resulting in more injuries than muggings, rape by strangers, and car accidents combined. In about

one-third of killings of women, the killer is either her spouse or boyfriend. And of females murdered by strangers, prostitutes comprise a disproportionate number of victims.

Rough sex has produced its share of fatalities as well. One highly publicized death occurred in the mid-1980s in New York City's Central Park, where an eighteen-year-old woman was found strangled. Robert Chambers, a nineteen-year-old from an affluent family, confessed to having accidentally killed her while engaging in "kinky sex." This turned out not to be the case, but the defense has been used several times since for deaths resulting from sadomasochistic sexual activities.

Psychiatrists have long seen the underlying sexual motivations behind serial killers, typically featuring elements of sadism and necrophilia. Tim Cahill's psychobiography of John Wayne Gacy—who between 1972 and 1978 raped, tortured, and then murdered thirty-three young men in the Chicago area—detailed Gacy's feelings of inferiority and unworthiness in his father's eyes, guilt about his homosexual tendencies, and feelings of inadequacy in male-female relationships.

Connections between Sexual and Death Moralities in the American Mind

Moral codes often contain messages of restraint regarding matters of sex and harm of others—the antithesis of social chaos with its orgies of sex and violence. It is worth noting the internal consistencies of these issues in individuals' minds, for how they coalesce affects outlooks toward a host of political and religious matters.

Consider, for instance, attitudes toward the moralities of abortion, euthanasia, and the right of the terminally ill to commit suicide, and how they correlate with the perceived moralities of premarital sex and homosexual relations. According to the National Opinion Research Center's "General Social Surveys," (Davis and Smith 1998), between 1977 and 1998 the proportion of American adults supporting all three death matters increased from 26 to 38 percent, while the percent disapproving of all three declined from 33 to 26 percent. During the mid-1990s, 70 percent of those who endorsed all three death issues believed it was "not wrong at all if a man and woman have sex relations before marriage," compared to only 15 percent of those who opposed these three death issues. Similarly,

64 percent of those who endorsed all three death issues believed that "sexual relations between two adults of the same sex" was "not wrong at all," compared to 12 percent of those opposed to all three death issues.

Death-Sex Connections in the Arts

In a 1992 book, Camille Paglia claimed that it was in the West that sex, violence, and aggression are major motivations for artistic creativity and human relationships. There is little doubt that these are qualities of audience appeal. Hollywood has long known of the attractions to the erotic and the violent, which is why 60 percent of R-rated movies and nearly half of X-rated movies contain violence. The long-term success of the James Bond movie series derives from its fusion of sex and death.

According to Geoffrey Gorer, such seductions derive from cultural pruderies to matters of sex and death. William May observed that as sex becomes pornographic when divorced from its natural human emotions of love and affection, so death becomes pornographic when divorced from its natural emotion, which is grief. Perhaps the pornographic connotation is why designer Christian Dior chose in the 1990s to label one of its perfumes "Poison."

See also: AIDS; ANXIETY AND FEAR; DEATH INSTINCT; SERIAL KILLERS; SEVEN DEADLY SINS; THRILL-SEEKING

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MICHAEL C. KEARL

SEXTON, ANNE

A number of creatively eminent individuals have taken their own lives, including John Steinbeck, Ernest Hemingway, Sylvia Plath, and many other writers. The large number of such cases suggests

that there may be a functional relationship between creativity and psychological health. This relationship seems to vary across domains, with the rate of suicide especially high in certain groups of artists, suggesting that there may be something unique to those domains that either draws suicide-prone persons into the domain or has an impact on the individual such that suicide is considered and often attempted.

The American Pulitzer Prize-winning poet Anne Sexton took her own life in 1974 via carbon monoxide poisoning before reaching the age of fifty. Her life and work are especially interesting because her poetry was clearly tied to her own psychiatric treatment. She began writing with only moderate formal education (a high school diploma), but after being published she was given honorary degrees from several universities, including Tufts, Radcliffe, and Harvard. While she is probably best known for *Live or Die* (1966), which was awarded the Pulitzer Prize, Sexton also received acclaim for *The Awful Rowing towards God* (1975), *The Death Notebooks* (1974), *The Book of Folly* (1972), *Mercy Street* (1969), *Love Poems* (1969), *All My Pretty Ones* (1962), *To Bedlam and Partway Back* (1960), *Transformations* (1971), and several volumes of selected and collected poems.

Sexton was born in Massachusetts on November 9, 1928, to Mary Gray Staples and Ralph Churchill Harvey, who were known to drink regularly and sometimes heavily. They were somewhat prominent and quite socially active. Scholars suggest that they may have valued their social engagements over their family responsibilities. There is some evidence that Sexton's mother was jealous about her very early writing. Sexton did not have obvious creative aspirations, but instead seemed to think more about a family of her own. At one point her mother accused her of plagiarism and had that particular writing examined. It was deemed to be original, but many scholars suggest this incident affected Sexton's relationship with her mother. When Sexton reported feelings of guilt about her childhood, she focused on the relationship she had with her grandmother. She admitted to feeling responsible for the failure of this relationship.

Sexton had two older sisters. Biographers have noted that Sexton and her sisters were not especially close to one another, and her position as the youngest child in the family has been underscored.

Research on family structure, including birth order, often suggests that an individual's expectations and worldview are associated with ordinal positioning within the family; interestingly, it is frequently the middle-born child who grows up to be the creative rebel. Sexton was socially active as a teenager, but also showed signs of a preoccupation with death. She was active in extracurricular activities, including athletic teams and cheerleading.

Sexton's aunt on her father's side attempted suicide in early childhood, lived several decades in an apparently stable marriage, and eventually committed suicide just before she turned seventy. The family believes that if her aunt's suicide had any sort of influence on Sexton, it was probably informational (e.g., the aunt modeling suicide) rather than genetic.

Sexton eloped with Alfred Mueler Sexton II when she was twenty years old, maintaining the view that she would become a traditional housewife. She apparently got along no better with her mother-in-law than she did her own mother. There were instances of various kinds of misbehavior, ranging from cigarette smoking to angry outbursts in the home of her in-laws. There were also instances of depression, especially after the birth of her two children: Linda in 1953 and Joyce in 1955. Sexton's first attempted suicide was not long after the birth of her second child. Although Sexton had planned to be a housewife and mother, she had difficulties coping with life, especially when her husband was away on business, falling into bouts of depression during the times he was gone.

Sexton was a bit of a rebel and nonconformist, or at least had difficulty with certain social norms. There is, for example, some indication that she was promiscuous, and she eloped with Alfred after knowing him for a very brief period of time—and while engaged to a different man. Scholars note that this type of behavior was not unusual given Sexton's creative temperament.

Other researchers suggest that the social and historical milieu of Boston in the 1950s was a factor in Sexton's troubled life. Sexton's expectation of being a housewife could easily have reflected social norms and pressures rather than a true inclination and intrinsic interest. Perhaps Sexton had a creative drive that she could not reconcile with the pressures placed on her to move in a more conventional direction. Depression could have easily

resulted from the incompatibility between her creative temperament and social expectations.

Sexton was apparently addicted to sleeping pills and perhaps also to alcohol, further evidencing serious psychiatric disorders. At one point she had an affair with one of her therapists, further supporting the idea that she was not bound by most social norms.

Another explanation for Sexton's suicide involves the domain of poetry. Poets often invest a great deal of themselves into their work. Even if the poetry is eventually critically acclaimed, the writing of poetry can be quite stressful because on one hand the individual exposes a great deal of herself, and on the other hand the individual is working alone in an area where feedback is often quite delayed. The delayed gratification may have been particularly difficult for Sexton because she manifested many strong social needs.

Biographers place great emphasis on Sexton's psychiatric treatment, which was significant as evidenced by the content of her poetry. And, it is possible, given her nonconformism, that Sexton suffered from a borderline personality disorder. There are reports of her schizophrenic language, for instance, as well as her tendency to enter some sort of trance at the end of her psychiatric treatment sessions. She apparently did not want to end the sessions, perhaps because of emotional and social needs.

Sexton's increased reputation as a poet seemed to cause a new kind of marital difficulty. There were reports that her husband did not appreciate her work, and additional suggestions that her schedule, required by her publishing and the promotion of her work, caused friction at home.

See also: SUICIDE INFLUENCES AND FACTORS: GENDER

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MARK A. RUNCO

SHAKESPEARE, WILLIAM

For Shakespeare and his contemporaries, death—which modern society has sanitized and rendered largely invisible—was a brutally conspicuous presence. Early modern London, whose gates were decorated with the boiled heads of traitors and criminals, was a place in which public executions formed a regular staple of entertainment, where the corpses of condemned persons were available for public dissection, and where the fragility of life was repeatedly brought home by devastating epidemics of plague that swept away tens of thousands of citizens at a stroke. Magnificent pageantry might adorn the funeral processions of royalty and nobles; but every church in the kingdom contained a charnel house whose stench of putrefaction acted as a constant reminder of the grim facts of mortality. Under these circumstances it is hardly surprising that the drama of the period should be much possessed by death and preoccupied by the struggle to tame its apocalyptic menace.

“Death,” Hamlet declares in the most famous of all his soliloquies, “is a *consummation* / Devoutly to be wished” (Hamlet, 3.1.62). He seeks to persuade himself that dying is no mere ending, but marks the fulfilment and perfection of mortal life. Behind his words lie centuries of consolatory writing, from the classical philosophy of the Stoics, for whom the encounter with death was the ultimate proving ground of wisdom and virtuous living, to the Christian *ars moriendi*, with its merciful translation to a better state. The prospect of mortality is seldom so reassuring for Shakespeare’s characters, however; more typical than the calm resolve of Hamlet’s final moments is the panorama of decay in the graveyard, with its parade of identically grinning skulls and the parables of levelling indifference they excite in the Prince’s imagination: “Why may not imagination trace the noble dust of Alexander, till ’a find it stopping a bung-hole?” (5.1.202–3).

In *Measure for Measure* it is the gross material realities of death, as much as its metaphysical uncertainties, that inspire Claudio’s terror as he awaits execution:

Aye, but to die, and go we know not where;
To lie in cold obstruction and to rot;
This sensible warm motion to become
A kneaded clod. . . .

To be imprisoned in the viewless winds
And blown with restless violence round about
The pendant world; or to be worse than worst
Of those that lawless and incertain thought
Imagine howling —’tis too horrible!

(*Measure for Measure*, 3.1.117–27)

This is what it means to be, like Cordelia in Lear’s despairing phrase, “dead as earth” (*King Lear*, 5.6.262). Claudio’s apparent imperviousness to the salvific promises of religion, and his existential vertigo at the prospect of annihilation, give his speech a distinctly modern feel; but underlying his horror, as it underlies the sardonic humor of Hamlet and the gravediggers, is a historically specific anxiety about the social menace of death, its arbitrary cancellation of the entire system of differences on which the profoundly hierarchical order of Renaissance society depended; for the dead in Claudio’s vision are consigned to an utterly chaotic condition, as “lawless and incertain” as the restless imaginings it inspires.

Such anxieties are traceable everywhere in early modern culture. They are especially apparent in iconic representations of universal mortality, like the Dance of Death, whose grinning cadavers sweep off representatives of every rank to their common end; or the Triumph of Death, in which the corpses of monarch and peasant, merchant and pauper lie promiscuously heaped together beneath the chariot wheels of King Death. But they also motivated the lavish pomp of heraldic obsequies and the increasingly worldly extravagance of the memorials crowding the aisles of parish churches and cathedrals. “Never,” marveled Francis Bacon, “was the like number of beautiful and costly tombs and monuments erected in sundry churches in honourable memory of the dead” (Bacon 1861, p. 158).

If this fantastic elaboration of funeral art can be explained as a defiant reaction to the leveling assaults of death—especially in the recurrent epidemics of plague whose cartloads of corpses were stripped of all individual dignity—it also offered a secular answer to a crisis in the management of mourning created by the Protestant denial of Purgatory. The consequent abolition of the vast medieval industry of intercession deprived the living of any power to assist the dead. Haunted like Hamlet by the Ghost’s importunate “Remember me!” (*Hamlet*, 1.5.91), the bereaved had now to

rely on the ambiguous consolations of memory and art—hence Hamlet’s distress at the scant mourning rituals allowed his father, or Laertes’ rage at Ophelia’s “maimed rites,” and his bitter resentment of the “obscure funeral” and “hugger mugger” burial of Polonius, “No trophy, sword, or hatchment o’er his bones” (5.1.219; 4.5.84, 214–215); hence, too, Hamlet’s dying insistence on the need for Horatio to remain behind, as a kind of “living monument” to “tell my story” (5.1.297; 5.2.349). The ending of *Hamlet*, with its self-conscious wordplay on “stage” and “audience” (5.2.378, 387, 396), itself constitutes an elaborate demonstration of the power of dramatic story and theatrical art to overcome the power of death.

The rivalry of art and death is, of course, a recurrent theme in the literature of the period—never more powerfully treated than in Shakespeare’s Sonnets. At the heart of the sequence is a group of powerful lyrics in which the poet, performing his superb variations on a well-known trope from the Roman poet Horace (“*exegi monumentum aere perennius*,” *Carmina*, 3.30), sets the monumental claims of poetry against the ravages of Death and his thieving ally, Time. Death is a leveling “churl” (Sonnet 32) or “wretch” (Sonnet 74) who renders his victims “base” (Sonnet 74) by consigning them to anonymous “dust” (Sonnet 32) and the degrading ministrations of “vilest worms” (Sonnet 71); while his “mortal rage” (Sonnet 64) reduces even the loftiest memorials to “unswept stone besmear’d with sluttish time” (Sonnet 55). Yet Shakespeare insists that his own “powerful rhyme,” by its capacity to outlast death, can confer the immortality to which “the gilded monuments / Of princes” vainly aspire (Sonnet 55). It is this that enables the poet, despite his humble status, to assert a kind of parity with the beloved patron to whom his lyrics are addressed. The poet’s mortal remains, consigned to the indifference of a common grave, may be “too base” to be remembered by his aristocratic “friend”; yet he can claim both immortality and a kind of equality by virtue of the “gentle verse” that memorializes his beloved’s fame (Sonnets 74, 81).

The Sonnets create a kind of stage on which “the eyes of all posterity” can witness the spectacle of the patron’s fame: “Gainst death and all-oblivious enmity / Shall you pace forth” (55); and the touch of swagger in “pace” recalls the postures of heroic self-assertion with which so many

protagonists of Renaissance tragedy confront their deaths. So Macbeth, defying the chaotic “wrack” of the apocalyptic storm that he himself has invoked, prepares to die “with harness on [his] back” (*Macbeth*, 5.5.50–51); or Othello reasserts his martial Venetian identity by transforming his suicide into a re-enacted triumph over the Turkish enemy; or Coriolanus calls on the Volscian mob to “cut me to pieces” with an insolent reminder of his conquest of Corioles (“Alone I did it. ‘Boy!’” (*Coriolanus*, 5.6.115).

But even in the bleak world of *King Lear*, where the force of undifferentiation is so overwhelmingly felt as to allow no room for such egotistic self-assertion (“Why should a dog, a horse, a rat, have life, / And thou no breath at all?” 5.3.307–308), theatrical convention nevertheless contrives to impose a consolatory show of order upon the final panorama of desolation: The concluding stage direction, “Exeunt with a dead march,” is a reminder of the extent to which Renaissance tragedy with its “industrious scenes and acts of death” (*King John*, 2.1.376) self-consciously mimicked the arts of funeral. The dressing of the tragic stage in black hangings, like those that adorned both churches and great houses in time of funeral; the use of black costumes; the display of hearses, tombs, and monuments as stage properties; and the convention of ending the play with a funeral procession—all these served as reminders that tragedy was conceived above all as the drama of death. But because the obsequies of the great, organized with lavish attention to the prerogatives of rank by the College of Heraldry, were imagined (like coronations and royal progresses) as a species of “triumph,” the incorporation of funeral pomp in tragedy also symbolized the power of art to challenge the universal monarchy of death.

The tragic catastrophe enacted the human confrontation with death’s arbitrary cancellation of meaning; and through its displays of agony, despair, and ferocious self-assertion, early modern audiences were encouraged to rehearse vicariously their own encounter with death. Thus tragedy served, in a fashion that was inseparable alike from its didactic pretensions and its entertaining practice, both as an instrument for probing the painful mystery of ending and as a vehicle of resistance to the leveling assaults of death; for even as it paraded the emblems of undifferentiation, tragedy offered to contain the fear of mortality by staging



In the popular film adaptation of William Shakespeare's *Romeo and Juliet* (1968), directed by Franco Zeffirelli, Juliet kills herself with Romeo's dagger when she discovers that he killed himself after he thought she drank the fatal poison. CORBIS (BELLEVUE)

fantasies of ending in which the moment of dying was transformed by the arts of performance into a supreme demonstration of distinction. That is why Cleopatra carefully stages her death in a royal monument. Claiming her suicide as that which “shackles accidents and bolts up change” (*Antony and Cleopatra*, 5.2.6) through her double metamorphosis into spiritualized “fire and air” and eternizing “marble” (*Antony and Cleopatra*, 5.2.240, 289), the queen’s language makes an exceptionally powerful connection between the bravura of her own performance and the dramatist’s triumphant art.

Almost every tragedy of the period ends in a funeral procession of some kind, and this conventional expectation allowed playwrights to create

striking theatrical effects by displacing the pageantry of death into other parts of the dramatic structure. Thus the national discord, which is the subject of *Henry VI*, is signaled as much by the disconcertingly abrupt obsequies of Henry V that open its action, as by the unpromising royal betrothal (a parody of comic ending) with which it concludes; while in *Titus Andronicus* the process of political and social disintegration is measured by the gap between the pompous interment of Titus’s sons in the first act and the grotesque mock funeral of Tamora’s sons, their heads encased in pastry “coffins,” in Act 5.

Even more striking disruptions of convention could be achieved by transposing episodes of

death and funeral into comedy—like the sober-faced travesty of burial rites which the repentant Claudio must perform at Hero's family monument in *Much Ado About Nothing*, or the mock deaths on which the plots of late romances like *Pericles*, *Cymbeline*, and *The Winter's Tale* depend. While the menace of death is always restrained by the expectation of a happy ending, such details are sufficient to remind the audience that the domains of folly and mortality are never quite as far apart as the symmetrically opposed masks of tragedy and comedy might at first suggest.

At one level, indeed, comedy—as the critic Marjorie Garber and others have shown—is deeply preoccupied with mortality, its action involving a symbolic expulsion of death from the stage world. But this comic victory is a fragile one, always vulnerable to some crack in the veneer of comic artifice. The concluding nuptials of *Love's Labours Lost* (a play that begins with a meditation on “brazen tombs” and the “disgrace of death”) are suddenly arrested by the entrance of Marcade, like a black-clad summoner from the Dance of Death; Falstaff's parade of comic immortality never recovers from the moment when his mistress, Doll, “speaks like a death's head” (*Henry the Fourth, Part 2*, 2.4.31); and even *A Midsummer Night's Dream* follows the ludicrous mock deaths of Pyramus and Thisbe with the sinister frisson of Puck's chanting—“[Now] the screech-owl, screeching loud / Puts the wretch that lies in woe / In remembrance of a shroud” (5.1.376–378)—before Oberon and Titania reappear to summon the fairy dance of exorcism and blessing in which the play ends.

The latest of all Shakespeare's comic performances, the tragicomic *Two Noble Kinsmen*, written with John Fletcher, seems to concede the ultimate impotence of the comic triumph over death, ending as it does with a melancholy prospect of wedding overhung by funeral: “Journey's end in lovers meeting,” Feste the clown had sung in *Twelfth Night* (2.3.43); but the lovers' reunion that resolves the accidents of plot in this final play only fulfills the prophecy of the mourning Queens in the “funeral solemnity” that concluded Act I: “This world's a city full of straying streets, / And death's the market-place where each one meets” (2.1.15–16).

See also: GREEK TRAGEDY; OPERATIC DEATH; THEATER AND DRAMA

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MICHAEL NEILL

SHAMANISM

Shamanism is the world's oldest and most enduring religious, medical, and psychotherapeutic tradition. For tens of thousands of years and across the world, shamans have functioned as tribal general practitioners and have offered a means for understanding and dealing with death and the dead.

Shamanism is a family of traditions whose practitioners focus on voluntarily entering altered states of consciousness in which they experience themselves or their spirit(s) traveling to other realms at will and interacting with other entities from whom

they gain knowledge and power in order to serve their community. Shamans often undergo a rigorous training program that may involve apprenticeship, solitude, asceticism, and spirit guides. When trained, they function as tribal physicians, counselors, priests, and spiritual practitioners.

Shamans' relationships to death and dying are multifaceted and involve both their training and their healing work. Shamans may sometimes be chosen because they unexpectedly cheat death by recovering from severe illness. During their training they may undergo one or more powerful death-rebirth experiences in which they experience themselves dying and being reborn, often finding themselves healed and strengthened by the process. In contemporary terms this can be understood as an early example of a profound, archetypal process that has been valued and sought in multiple cultures and religious traditions for its spiritually transformative potential. During training, the shaman is also expected to develop the capacity to see and relate to "spirits," some of whom are thought to be ancestors and ancient shamans, and some of whom may become helping guardian spirits that guide and empower the shaman.

Once shamans are trained, several of their practices relate to the dead. The spiritual entities that shamans interact with may be the spirits of the living or the dead. Sick individuals may lose their spirit—the term *dispirited* is still used—and face suffering and death unless the shaman can recover it. Spirits of the dead may be lost, troublesome, or malevolent, and the shaman must intervene by guiding, healing, or vanquishing them. Others might be troubled by spirits, but the shamans alone are masters of them and their realms.

Techniques such as fasting, solitude, drumming, dancing, and using psychedelics may be employed to induce altered states of consciousness in which spirit vision is enhanced for diagnostic and therapeutic purposes. These techniques may especially be preludes to, and inducers of, the shamanic journey: a controlled out-of-body experience to other realms where shamans may meet, mediate with, learn from, and heal spirit entities.

The tradition of shamanism has much to teach contemporary researchers and healers. It demonstrates an ancient form of medicine, spirituality, and thanatology; the power of disciplines such as

solitude, asceticism, and spiritual practice; the responsible use of psychedelics; the potentials of altered states of consciousness and controlled out-of-body experiences; and the use of all these for dealing with death and serving one's community.

See also: COMMUNICATION WITH THE DEAD; GHOSTS

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ROGER N. WALSH

SHINTO

The term *Shinto*, which is translated as "the way of the gods," was not coined until the nineteenth century. Because Shinto, unlike Buddhism, has never been an organized religion or tradition and has no official doctrines or creed, its ideas concerning death can vary widely from one individual to the next. This entry makes references to *kami*, or native Japanese deities, as representative of the Shinto tradition and focuses on these deities as core to Shinto thought.

No moral notion of sin exists in Shinto. Death is not the "wages of sin," that is, the outcome of evil-doing. Rather, because purity is valued above all else, evil is defined as that which is "pollution." The primary pollutions are sickness, blood, and death. When *kami* are offended because of exposure to pollution, they can create disasters such as plagues and famines. Consequently, Shinto shrines usually do not conduct funerals. This tradition is evidenced in the familiar adage, "Shinto for weddings, Buddhism for funerals."

Nevertheless, historically, Shinto ideas have dealt with death. Practitioners believe that the spirits of the dead go to the mountains, above the sky, below the earth, or beyond the horizon. *Kami* and other supernatural beings also dwell in these places. Living beings from this world may visit those from the other worlds in border lands, which include cliffs, caves, and coastlines. The Japanese welcome



Asakusa's Sensoji Temple, said to be the oldest in Tokyo, was dedicated to the Goddess of Mercy, Kannon. Statues of the gods of wind and thunder are on either side of the Kaminarimon Gate. SUSAN D. ROCK

these souls back to their homes in August at the Obon festival. Usually, however, after thirty-three years deceased ancestors are no longer considered. There is no concept of an eternal soul in Shinto.

Two of Japan's oldest texts, the *Kojiki* (Record of ancient matters, 712) and the *Nihongi* (Chronicles of Japan, 720), tell the story of Izanami and Izanagi, the two kami who created Japan. After Izanami dies giving birth to the kami of fire, she goes to a place called the Land of Darkness (known as *Yomi no Kuni*). Her husband misses her so badly that he follows her, only to be shocked by Izanami's advanced state of decay. He flees the Land of Darkness, stopping at a river to cleanse himself on his way back to the land of the living. This early story emphasizes the Shinto understanding of death as pollution.

Occasionally deceased people have become kami, when the deceased were thought to be angry with the living or because of the circumstances surrounding their deaths. The most famous example of such a kami is Sugawara Michizane (845–903), who was exiled to Kyushu, a southern

island of Japan, in 901 because he was viewed as a political threat by the scheming regent. Shortly after Michizane's death a number of disasters struck Japan, which were thought to be caused by his angry spirit. To pacify him, he was recognized as a kami and enshrined in Kitano Tenmangu Shrine in Kyoto in the middle of the tenth century.

In Japan's Meiji period (1868–1912), a time of extreme nationalism, leaders adapted Shinto ideas to fit their political agenda. Tokyo's Yasukuni Shrine, established in 1869, enshrines the spirits of all the Japanese war dead since that time. Nevertheless, most deceased persons in Japan are not regarded as kami, and most Japanese turn to Buddhism for answers to problems concerning death.

See also: BUDDHISM; CONFUCIUS; TAOISM

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SARAH J. HORTON

SIKHISM

“We are destined to die, as death is an essential part of the life-cycle.” These words of Guru Tegh Bahadur (reigned 1664–1675 C.E.), the ninth of the ten Indian Gurus who founded Sikhism, typify the approach to death of Sikhs. Death for this religion’s 20 million members is an essential path in the journey of life and not to be feared. Death is followed by rebirth through transmigration—literally, metempsychosis, the passage of the soul of a human being or animal after death into a new body of the same or a different species, an understanding common to Sikhism, Buddhism, Jainism, and Hinduism—unless, through faith and divine favor, the deceased individual is endowed with the knowledge of God (*Brahm Gyani*) and released from the cycle of life, death, and rebirth (the laws of karma). Nevertheless, according to Guru Nanak (1469–1539 C.E.), the first Guru and founder of the line of Gurus, or inspired teachers, “rare are such men in the world whom after testing God has gathered unto his treasury.”

At the deathbed of a Sikh, the relatives and friends console themselves and the departing soul by reading the religious hymns of the Sikh Gurus (*Gurbani*), especially *Sukhmani*, the Psalm of Peace, written by the fifth Guru, Arjan (reigned 1581–1606). When death occurs, no loud lamentations are allowed. Instead, the Sikhs chant *Wahiguru Wahiguru* (“Hail to the Guru,” or “Wonderful Lord”). All dead bodies, whether those of children or of adults, are cremated, usually within twenty-four hours in the Indian subcontinent, but this may occur several days later in other countries where the body can be more easily preserved. Where cremation is not possible, it is permissible to throw the dead body into a sea or river.

The dead body is washed and dressed in new clothes (in the case of a male, complete with the five symbols of the Khalsa, the body of initiated Sikhs instituted in 1699 C.E.) before it is taken out on a bier to the cremation ground. The procession starts after a prayer, with the participants singing

suitable hymns from the Sikh scriptures (*Guru Granth Sabib*) on the way. At the cremation ground, the body is placed on the pyre, the *Ardas* is recited, and the nearest relative (usually the eldest son) lights the pyre. When the fire is fully ablaze, *Sobila* is read and prayers are offered for the benefit of the dead. People then come away and leave the relatives of the deceased at their door, where they are thanked before departing.

The bereaved family, for the comfort of their own souls as well as for the peace of the departed, start a reading of the holy *Guru Granth Sabib* either at their own house or at a neighboring temple (*gurdwara*). Friends and relations take part. After a week or so they again come together when the reading is finished. The usual prayer is offered and the holy food or sacrament (*karah prasad*) is distributed. The charred bones of the dead, together with the ashes, are taken from the cremation ground three or four days later and, where this is permitted, thrown into the nearest canal or river (this is not allowed in the West, and therefore relatives often take the ashes to Punjab, India, to be disposed of there). It is forbidden to erect monuments over the remains of the dead, although a suitable monument in the person’s honor at another place is permissible.

See also: CREMATION; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; HINDUISM

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SIN EATER

For those who believed in an afterlife, death included the fear of punishment for misdeeds committed and unforgiven. For centuries, believers confessed their sins and sought forgiveness on

their deathbeds. The souls of these who had not been forgiven were believed to wander where they had lived, bringing distress and ill fortune to their survivors. Over time, humankind developed various means to ease the passage of souls to a peaceful life in the hereafter. One method, whose origins can be traced to Egyptian and Greek civilizations, was embodied in the “sin eater,” a person who was believed to possess the ability to symbolically ingest the sins of the deceased through eating and drinking over the recently deceased corpse. The sin eater, a secular person performing a quasi-spiritual role, was paid for this important service.

The central theme of this custom is the persistent, universal need to placate the souls of the deceased, to help the soul on its way and to be rid of it, lest it return and cause distress among the living. Eating in the presence of the corpse is customary in a number of cultures, as is token payment of a coin to those who assist in passage to the afterlife, such as the Greek mythological character Charon.

See also: GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE

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WILLIAM M. LAMERS JR.

SOCIAL FUNCTIONS OF DEATH

When one reflects on the social upheavals and personal tragedies inflicted by deadly epidemics, terrorist attacks, droughts, and floods, it takes a change in thinking to reflect upon death's social functions. Further, one must consider from whose perspective death is perceived to be “functional.” The bubonic plague, for instance, meant the death of roughly 25 million Europeans, but it also was the death knell for feudalism and, according to the historian William McNeill, laid the groundwork for

capitalism. The death of a military tyrant may well be functional for his oppressed peoples, but dysfunctional for his nation's allies. Here we consider the positive effects for self and society as well as the ways societies attempt to harness death's power and minimize its disruptiveness.

Sociological Functions Served

As the old maxim goes, for there to be life there must be death. This holds true not only for biological systems but social systems as well. Just as programmed aging and death are evolution's requirements for species to gradually change over time, so social stability and change require the death of older generations so younger ones can take their turns on center stage.

Death checks population growth and avoids the Malthusian nightmare of overcrowding. As wildlife biologists know, once a species reproduces itself beyond the carrying capacity of its habitat, natural checks and balances come into play. Any species that breeds excessively will eventually experience a “die-back” or “population crash.” The human species is not immune to this natural law, which is why the birth in 1999 of the planet's 6 billionth member received the mixed reception that it did: Human numbers had doubled since 1960 and tripled since 1927. Over the past 2,000 years the doubling time of the human population has accelerated roughly fortyfold, from sixteen centuries to forty years.

Paul Ehrlich, a Stanford professor of population studies and biological sciences, in *The Population Bomb* (1968), predicted that the population of the third world would double in the following quarter century and, unless a “birth rate solution” was made, one of three “death rate solution” scenarios would occur. These scenarios featured limited nuclear war, famine, social chaos, and deadly pollution. Humanity made it to the new millennium, of course, without the mass death Ehrlich had predicted. By the mid-1990s, fertility rates declined by at least one-half in seventeen countries. However, his grim prophecy may have only been postponed. Overfishing, overgrazing, and overcutting have become commonplace, as have shortages of fresh water suitable for human use.

Death constantly replenishes the vitality of the gene and meme (the cultural equivalent of DNA) pools, allowing for innovation and change. In his

Structure of Scientific Revolutions (1962), Thomas Kuhn describes how new scientific paradigms do not succeed by virtue of their truth but rather come to be accepted when proponents of old ones die off. Similarly, social progress in matters of gender and racial equality in the United States occurs when older generations die with their prejudices and beliefs. For instance, between 1972 and 1998, the percentage of white Americans who answered “yes” to the question, “Do you think there should be laws against marriages between blacks and whites?” decreased by two-thirds, from 39 percent to 13 percent. Approximately 40 percent of this decrease can be statistically explained by the deaths of older generations over the time frame.

In hierarchical organizations, death allows the upward mobility of younger generations, thereby securing their loyalty to the social order. Death of older generations allows younger ones to have their turn on life’s central stages. Relatedly, death dilutes concentrations of power and wealth; consider, for instance, the Rockefeller family. Time has fragmented the wealth accumulated by John D. Rockefeller Sr. (1839–1937), whose Standard Oil at its peak controlled 90 percent of the American oil industry. In 1976 there were eighty-four descendants of John Sr.’s only son, John Jr.; a quarter century later they numbered in the hundreds.

Somewhat more abstractly, there is the power of death to bring people together, producing new social solidarities. Death commands human attention and its associated rituals, like human sacrifices and martyrdom, harness death’s power to increase social solidarities and promote change. An example of how death can lead to new solidarities coalescing in the cause of greater social justice can be seen in the Triangle Shirtwaist Company fire. Before this disaster garment workers, largely fearful immigrant women, were unorganized. The broader public was generally indifferent or ignorant of the child labor being exploited, and was often opposed to unions. On one Saturday afternoon fire broke out in New York City’s Triangle Shirtwaist Company, wherein 500 workers were crammed. Doors were locked to keep the young immigrant children within and labor organizers out. In the end 146 died, and were seen on the sidewalk in piles where they landed after nine-story jumps. The dead became martyrs for the International Ladies’ Garment Workers’ Union, which called for a day of mourning. With union pressure against

unsafe working conditions, the New York State governor appointed the Factory Investigation Commission. Its hearings led to the passage of factory safety regulations.

Social groups often harness the power released by the deaths of their members to amplify the solidarities among the living. Consider, for instance, the November 1999 bonfire accident that killed eleven Texas A&M students and one alumnus. At 10:00 P.M. on the first Tuesday of the following month, the university community gathered in silence to observe Silver Taps, a century-old ritual for remembering fellow students who had died the month before. In this ceremony, silence is broken by three volleys of seven rifles followed by trumpeters playing taps. On April 21 the students’ memories were reaffirmed on Texas Aggie Memorial Day. Honoring a tradition that has been in place since 1883, all around the world alumni of Texas A&M gather annually for a roll call (the Muster) of those who had died during the previous year.

Social-Psychological Functions

At a more social-psychological level, death poses the ultimate of “deadlines” and thereby forces prioritization and the setting of personal and collective goals. As is the case of all endings, death forces reflection and summary. Rarely does one give words to life’s core meanings and goals, nor reflect on how life would have differed had not one existed, except within funerary observances. In addition, there is death’s power to enhance appreciation of life. When ruminating on the leukemia death of his eighteen-year-old daughter, the baseball Hall of Famer Rod Carew shared the lessons he learned, such as appreciating what you have and the importance of giving one’s child extra attention.

Several ingenious experiments have supported the social scientist Ernest Becker’s Pulitzer Prize-winning thesis of how personal death anxieties intensify individuals’ allegiance to moral codes. For example, in 1989 psychologist Abram Rosenblatt of the University of Arizona and his colleagues organized an experiment where eleven municipal judges were told to write about their own deaths, including what they thought would happen physically and what emotions were evoked when they thought about it. A control group of eleven other judges was spared the activity. When asked to set bond for a prostitute on the

basis of a case brief, those who had thought about their deaths set an average bond of \$455, while the average in the control group was \$50. From this and other experiments researchers found that when awareness of death is increased, in-group solidarity is intensified, out-groups become more despised, and prejudice and religious extremism are increased.

How societies dampen death's disruptiveness. Despite its occasional social functions, death—even the “good,” anticipated deaths of those who have lived full, complete lives—is invariably disruptive. To minimize the inevitable schism in the social fabric, a number of social shock absorbers have evolved to manage the problem of immortal social systems being populated by mortal members.

The most apparent of the social mechanisms for coping with death is the funerary ritual. Funerals evolved not only to dispose of the dead and to assist the surviving, but to harness death's power and direct it toward the reaffirmation of social solidarities. Consider the 1990 funeral of the business tycoon Malcolm Forbes, which attracted an assemblage of varied individuals, including such notables as Richard Nixon, Lee Iacocca, Barbara Walters, David Rockefeller, Ann Landers, and Mrs. Douglas MacArthur, as well as Hell's Angels motorcyclists.

Death's disruptiveness can be dampened by minimizing the social status of those most likely to die. For most of human history, for instance, children comprised the largest segment of societies' mortalities. Whereas in the twenty-first century a child cannot leave an American hospital until he or she is named, at least as late as the eighteenth century American children were often not called by name until they were about six years of age or older. The main reason that children “did not count” was their considerable likelihood of death; most couples could expect to lose two or three children before they reached the age of ten. In Puritan New England, parents often would send their children away to the home of relatives or friends. Ostensibly this was a method of discipline (Protestantism assisted the distancing by viewing children as sinful and corrupt) but in actuality this act served to prevent parents' emotional closeness to their children and thereby minimize their inevitable emotional pain if the children died. With social evolution, the old replaced the young as the cultural death lepers as they became those most

likely to die. The Puritan custom of sending children away has been replaced by the American practice of sending the elderly to nursing homes to be cared for by others.

Social systems can also hide the dying and grieving processes, further minimizing the disruptions of dying and death. In contemporary American society, a reportedly “death-denying” culture, specialists are paid to impersonally manage the deaths of family members within institutional settings (where roughly seven out of ten now die) and then pay others to dispose of their physical remains.

The deaths of powerful leaders, particularly those of “founding fathers” and of charismatic individuals, pose severe crises of continuity for political, religious, and corporate systems alike. The power vacuum (and associated threats of disorder) becomes particularly acute when their deaths come suddenly and unexpectedly. Even rumors of their impending end of life can trigger power struggles from within and incite challenges from without. To address such crises of succession, social systems have devised explicit rules for the changing of the guard. In the United States, for instance, between 1841 and 1975 more than one-third of all the country's presidents have either died in office, quit, or become disabled, and seven vice presidents have either died or resigned. In response to this social phenomenon, the 1947 Presidential Succession Law specifies an order of presidential succession (comprised of sixteen role incumbents, beginning with the Speaker of the House, president pro tempore of the Senate, and secretary of state) should both the president and vice president die or be incapacitated simultaneously. In addition to the transference of power, social groups, particularly families, attempt to avoid conflict over the disposition of the deceased's possessions through rules of inheritance.

The changing nature of social roles has contributed to society's ability to dampen death's disruptive effects. Historically, there has been the shift from particularistic to universalistic roles, meaning that individuals are rarely known as entire selves but rather as role occupants. This creates an analytical distinction between individual and role, unlike the earlier situation where the two were so thoroughly fused that the death of the individual meant the death of the role. Instead, twenty-first-century

roles can rarely be held indefinitely by their incumbents, but rather must be ritually surrendered. Roles have become more important than their interchangeable occupants. Within the bureaucratic structure of contemporary societies, such ritual surrenderings are part of the institutionalized rules of succession. In the case of the elderly and the institutionalization of retirement, older individuals are disengaged from many of their social roles to minimize the disruptions caused by their deaths. Further, given the accelerating pace of social change, many of these roles themselves have become obsolete before their occupants have grown old.

Finally, there are the successes of modern societies' war against premature death. By minimizing death risks—through environmental cleanups, warnings of the health dangers of cigarettes, gun control, improvements in sanitation, use of antibiotics to control infectious diseases, political control over the purity of food, and building safer vehicles—death is largely confined to the old. Rarely needed are the historical cultural consolations for the sudden, premature deaths, as death often comes to those who have completed their life projects and who, when suffering from the degenerative diseases of advanced age, often view death as preferable to a continued existence. And for the survivors of elderly victims of Huntington's chorea or Alzheimer's disease, their deaths may actually be viewed as a blessing.

See also: CAPITAL PUNISHMENT; DEATH SYSTEM; MALTHUS, THOMAS; POPULATION GROWTH; TECHNOLOGY AND DEATH; TRIANGLE SHIRTWAIST COMPANY FIRE

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MICHAEL C. KEARL

SOCRATES

Socrates is a name often relied upon when historians want to invoke a notable person from antiquity. There is good reason for the fame and durability of this name. In both his life and his death Socrates (469–399 B.C.E.) provided a model for wisdom and courage.

Socrates spent his life in Athens, the city of his birth (470 B.C.E.). Athens already had produced thinkers and artists of the highest order as well as an experiment in (limited) democracy that has continued to inspire and influence seekers of equality, freedom, and creativity through the centuries. The bust of Socrates in the Museo delle Terme in Rome displays the hearty features of a broad-faced, pug-nosed, thick-lipped, and generously bearded man. His friend Alcibiades teased Socrates by likening his face to that of a wild, sensuous satyr. Socrates not only accepted this comparison but added that he had better do more dancing to reduce his paunch. Humor came naturally to Socrates and, in fact, played a significant role in his philosophical method.

Specific information about Socrates' life is sparse. It is believed that he was the son of a sculptor and a midwife. He followed his father's footsteps, working as both a stonemason and a sculptor. He also claimed to be following his mother's line of work, "by helping others to deliver themselves of their conceptions" (Durant 1968,

p. 36). Socrates usually kept himself in good physical condition and earned a reputation as a soldier of exceptional stamina, as well as skill and courage. His marriage to Xanthippe produced a family but also her justified complaint that he spent more time gadding about and annoying people than with his wife and children. He enjoyed companionship, cared little about material possessions, and was considered the very model of a well-balanced person: moral, but too earthy to be revered as a saint.

The Athens of Socrates' time enjoyed exceptional intellectual vitality. Almost every facet of life was open for discussion. Here philosophical issues were fresh, live, and compelling—the same issues that would later become weighed down by centuries of further speculation and commentary. The political establishment, however, did not necessarily cherish this free exchange of ideas. Some of these ideas could be dangerous to the institutions that kept the establishment in power.

Socrates became the most adept and, therefore, the most fascinating and most dangerous asker of questions. The “Socratic method” is one of his enduring contributions to philosophical inquiry. He believed that everyone with a competent mind already knows the basic truths of life deep inside of one's being, even if unaware of possessing this knowledge. Socrates would educe knowledge through conversations guided by an unfolding series of questions. True education was educating—drawing something out of, rather than forcing something into—the mind. This dialect method was perfected rather than invented by Socrates. Zeno of Elea (born the same year as Socrates) had already introduced the art of questioning as a way to reach the truth. Socrates had the extra knack of making powerful people uncomfortable by undermining their assumptions with his deceptively simple questions. Bystanders found it amusing to see how people with exaggerated opinions of their knowledge became flustered as Socrates' casual, low-key questions eventually exposed their errors. The victims were not amused, however, and they did not forget.

Plato and Socrates

It is Plato's *Dialogues* that provide most of what has come down to readers through history about the life and thought of his mentor. There are no

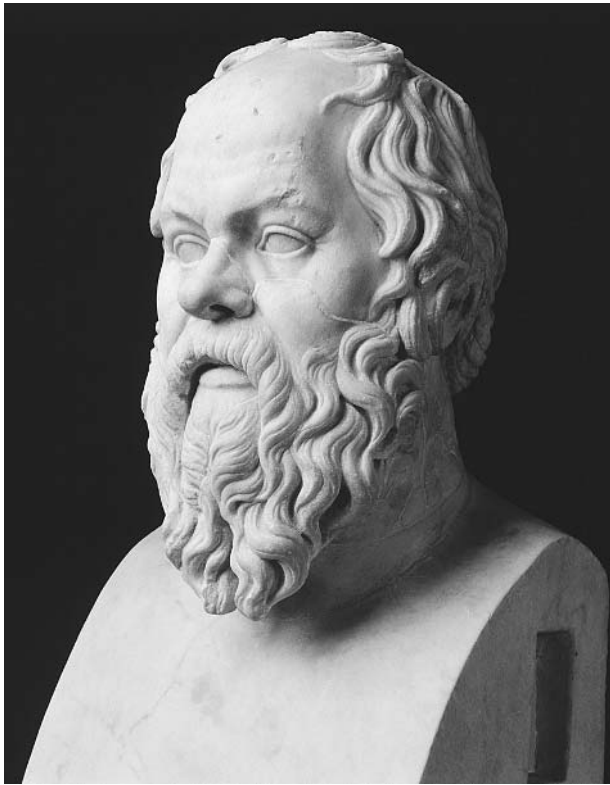
books written by Socrates, only his appearance as the main character in Plato's writings and, to a much lesser degree, in plays written during or after his life. There is no way of knowing for sure how much is “pure Socrates” and how much is Plato. The dialogues were not intended as fastidious reportage of actual events and conversations; they were imaginative riffs on ideas and people. *Symposium*, for example, takes readers to a banquet in which Socrates and his friends entertain and compete with each other to solve the mysteries of love. Plato's *Dialogues* offer episodes and scenes through which his philosophical points could be made through the characters themselves. His first generation of readers could separate fact from fancy, but this has become much more difficult for the following generations who lack insiders' knowledge of the political, historical, and philosophical milieu of Socrates' Athens.

Plato's account of Socrates offers a remarkable vision of a society superior to any previously known in one of the most influential of the dialogues, *The Republic*. A rational, managed, and futuristic society is portrayed where even genetic selection and psychological testing exist. The resonance of this imagined society can be felt in many spheres of life in the twenty-first century, including the ever-shifting boundaries between science and science fiction. One of the early masterpieces of philosophy, this dialogue ranges from vigorous discussions of the nature of justice to the recesses of a shadowy cave where readers are challenged to determine the definition of reality. Neither in his life nor in his *Dialogue* appearances does Socrates demand overthrow of the establishment or express disrespect to the gods. However, his relentless questions raised anxiety and created enemies.

The Death of Socrates

The faithful soldier, the relatively faithful husband, the good companion, and the subtle and witty philosopher all were now in their seventieth year of life and awaiting execution.

Socrates had inadvertently given his enemies an excuse for retaliation. The case against him was so insubstantial that it should have been immediately dismissed. He was accused of impiety, although he had never cursed the gods, and accused of corrupting the young, a charge so far-fetched that it was hard to keep from laughing out loud.



Socrates believed that a teacher should not besiege students with a barrage of words but instead help people to discover and articulate their own hidden knowledge. ARALDO DE LUCA/CORBIS

What gave the accusations their power was the undercurrent of annoyance at Socrates' habit of raising questions that set too many minds to thinking and could possibly destabilize the establishment. He was blamed for the current state of unrest against the establishment and even accused of being a traitor. These were "trumped-up" charges that Socrates expected the court to overturn. Even when convicted, he could have avoided a serious penalty by saying the right words and admitting some fault. This he would not do: Instead, he stood before them unrepentant and free-spirited. Few of his fellow citizens had expected the death penalty to be enacted. Something had gone wrong with the process of rebuking this distinguished gadfly, and now they would have to go through with the embarrassing act of taking his life.

It would not have been difficult for Socrates to escape. His friends were eager to spirit him away to a safe island, and the authorities seemed inclined to look the other way. Socrates would not accept such a plan, however, much to the distress

of his friends. In *Phaedo*, he told his friend that there was nothing to fear. Death will turn out either to be a long sleep or, even better, the entry to a splendid new form of life. Socrates's ability to accept his death with equanimity became a model for wisdom and courage on the verge of death. He lived his philosophy to the last moment, treating the unfortunate jailer with kindness as he brought forward the cup of deadly hemlock. He bid an affectionate farewell to his friends. When Crito asked, "But how shall we bury you?" he replied:

Any way you like—that is, if you can catch me and I don't slip through your fingers. . . . It is only my body you are burying; and you can bury it in whatever way you think is most proper. (*Dialogues* 1942, p. 150)

Socrates quaffed the contents of the cup, described the changes occurring in his body—the rise of cold numbness upward from the feet—and died peacefully. At least that is the scene reported in *Phaedo*. Some doubt has been cast in late-twentieth-century scholarship. The medical historian William B. Ober notes, along with others, that Plato described an event he did not witness: He was too upset to see his friend's death. More significantly, perhaps, hemlock usually produces a variety of painful and distressing symptoms. Perhaps Plato sanitized the actual death to create a more acceptable memory-scene, or perhaps Greek physicians had mixed hemlock with a gentle sedative in the farewell cup for Socrates' journey to philosophical immortality.

See also: GOOD DEATH, THE; IMMORTALITY; JESUS; LAST WORDS; PHILOSOPHY, WESTERN; PLATO

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ROBERT KASTENBAUM

SOUL BIRDS

Belief in metempsychosis or the transmigration of souls into other living beings is ancient. In Western tradition, one of the most common sites for a formerly human soul to inhabit is that of a bird. Such birds are invariably also ominous, in its original sense of prophetic, the rationale being that the dead, as spirits, know both past and future. They are ominous also in its secondary meaning of “boding ill.”

At sea, such soul birds include the storm petrel (*Hydrobates pelagicus*). Storm petrels, as their name suggests, were taken as a sign of approaching bad weather, so sailors saw them as helpful and considered it unlucky to shoot one. Moreover, into the nineteenth century, perhaps later, many seamen believed that petrels should be spared because they harbored dead sailors’ souls.

Seagulls (*Laridae*), too, warned of approaching storm. An extension of this was the belief that they cried before a disaster. As with petrels, in West European fishing communities it was thought unlucky to kill a gull; and, as with petrels, some said they embodied the souls of fishermen and sailors, especially those who had drowned. Belief in gulls as soul-birds was still active in coastal districts of Great Britain and Ireland up to at least the late nineteenth century.

Other birds were also thought to house souls. Among East Anglian fishermen, the spirits of the drowned were believed to migrate to the gannet (*Morus bassanus*). From the eastern seaboard of the United States comes the story of a waterman on Chesapeake Bay who shot three ducks as they flew in to land. They fell into the marsh, and he could not find them. That night, a gale sprang up and blew for three days. When it was over, he returned to the marsh and in the water, where the ducks fell, lay three drowned sailors.

Sometimes the belief in transmigration has carried penitential implications. Aboard French ships



In the nineteenth century soul birds, such as petrels, gulls, and albatrosses, were considered useful because they were a sign of approaching bad weather and, as their name suggests, carried the souls of drowned fisherman and sailors. U.S. FISH AND WILDLIFE SERVICE

both storm petrels and shearwaters were known as *âmes damnées* (“souls of the damned”), the subtext being that, like some ghosts, part of their punishment after death was to continue to haunt the earth. Muslim seafarers in the nineteenth century similarly said that the Manx and Mediterranean shearwaters (*Puffinus puffinus* and *Puffinus yelkouan*) of the eastern Mediterranean were inhabited by damned souls, a belief possibly suggested by their dark plumage.

It is sometimes claimed that deep-sea sailors believed that the albatross brought bad weather and that killing one was unlucky because the souls of sailors reposed in them. However, these beliefs cannot be proved as existing before Samuel Taylor Coleridge’s “The Rime of the Ancient Mariner” (1798):

At length did cross an Albatross,
Through the fog it came;
As if it had been a Christian soul,
We hailed it in God’s name.

Coleridge is said to have based the mariner’s shooting of the albatross—an act that brought doom on his ship—on an episode in Shelvocke’s *Voyages* (1719). But in *Voyages* the bird was a black albatross, shot by someone who “imagin’d, from his colour, that it might be some ill omen.”

Whether or not the superstition against shooting albatrosses generally began with Coleridge, it was never widespread: They were regularly shot at by ships' crews, who, among other things, made their webbed feet into tobacco pouches.

On land, the themes of ominousness and transmigration are attached to corvids, specifically crows and ravens, which were not always distinguished. From classical times to the present day, the raven (*Corvus corax*) and crow (*Corvus corone*) have been thought birds of ill omen. A document written in England between 680 and 714 C.E. reported that once, when King Edwin (585–633 C.E.) was on his way to church, a crow “sang with an evil omen.” The king stopped to listen until Bishop Paulinus had a servant shoot the bird. He later showed it to the catechumens (converts before baptism) in the church to prove that heathen superstitions were worthless, since the bird did not know it was its own death that it was prophesying.

Elsewhere in Europe, the souls of the unbaptized were supposed to transmigrate into ravens; in Languedoc, France, it was wicked priests who turned into ravens when they died, something suggested, no doubt, by their black garments. In Britain, traditions of metempsychosis were attached to both the raven and the red-legged crow or chough (*Pyrrhocorax pyrrhocorax*) in connection with King Arthur. A belief that he had not died is expressed in medieval literature and later folklore in three different forms: that he had been taken to Avalon to be healed of his wounds; that he was sleeping in a cave, variously located in Britain; and that he had been enchanted into a crow or raven. This last was said by the Spanish writer Julian del Castillo in 1582 to have been common talk among the English. The incurably romantic Don Quixote had heard it and asked:

Have you not read, sir, . . . the famous exploits of King Arthur . . . of whom there goes an old tradition . . . that this king did not die, but that by magic art he was turned into a raven; and that . . . he shall reign again . . . ; for which reason it cannot be proved, that, from that time to this, any Englishman has killed a raven? (*Cervantes* 2001, 1:5:130)

This taboo against killing ravens was still current in Cornwall at the end of the eighteenth century, when a young man walking on Marazion Green,

near Penzance, with his “fowling-piece” on his shoulder, saw a raven and fired. An old man nearby immediately rebuked him, saying that he should not have shot at the raven because Arthur lived on in that form.

King Arthur is the archetypal protector of Britain, and there is probably a connection between this tradition of his transmigration and the custom of keeping six ravens at the Tower of London, instituted by King Charles II (1630–1685). The ravens are a palladium (national talisman); it being said that, so long as there are ravens at the Tower, Britain cannot be conquered. Some anxiety was caused during World War II by rumors that the ravens had fallen silent and had not croaked for five whole days.

See also: AFRICAN RELIGIONS; MIND-BODY PROBLEM; OMENS

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JENNIFER WESTWOOD

SPIRITUAL CRISIS

Humans typically assume the world to be a benevolent place; we regard ourselves with favorable self-esteem, and attempt to minimize chance in determining life events by believing in an abstract sense of justice, personal control, or a spiritual force that brings order to a potentially chaotic world. Illusory as these beliefs may be, as long as they go untested, they provide a stable cognitive framework for making sense of an individual's experiences and for providing meaning and purpose to his or her life. However, in facing a life crisis, such as confronting one's own death or the death of one dearly loved, these assumptions and beliefs may shatter, may be turned upside down, and

might no longer be useful as a foundation to understanding the world or one's place in it.

For example, what happens to our beliefs in personal control of our world when confronted with our own death or when forced to respond to a loved one's painful illness, over which personal control is futile? Or how can a parent continue to assume that the world is just and fair, or that people get what they deserve, or that there is a loving God, after experiencing the death of a child by sudden infant death syndrome, random gunfire, or an automobile accident? Confused, depressed, and devoid of insights, answers, or coping skills, one can find oneself on the brink of a spiritual crisis.

Spiritual crisis or spiritual emergency is recognized by the American Psychiatric Association as a distinct psychological disorder that involves a person's relationship with a transcendent being or force; it might be accompanied by assumptions related to meaning or purpose in life. The disorder may be accompanied by any combination of the following symptoms, which include feelings of depression, despair, loneliness; loss of energy or chronic exhaustion not linked to a physical disorder; loss of control over one's personal and/or professional life; unusual sensitivity to light, sound, and other environmental factors; anger, frustration, lack of patience; loss of identity, purpose, and meaning; withdrawal from life's everyday routines; feelings of madness and insanity; a sense of abandonment by God; feelings of inadequacy; estrangement from family and friends; loss of attention span, self-confidence, and self-esteem; and frequent bouts of spontaneous crying and weeping.

As fundamental beliefs are brutally strained and the rules that previously guided our lives are nullified, distress builds, until we are challenged to deal with the crisis. In this effort some individuals will rely on long-held religious beliefs for guidance; some will embark on a spiritual quest in search of newer ways of finding meaning in life; some will reject religion and become bitter; and some will turn to philanthropic and other caregiving activities in the struggle to find solace and a renewed sense of purpose.

Spiritual Crisis and Loss: The Death of a Child

Parents mourning the death of their child are especially prone to spiritual crisis because the bond between parent and child is so powerful and unique.

Most bonds between individuals are contractual—people enter the bonds based on an understood group of mutual obligations. The bond between spouses or friends, for instance, is contractual and, as such, may be abandoned if the interactions are no longer reciprocal and mutually satisfying. The bond between a caring parent and a helpless child is, obviously, not reciprocal. As with religious obligations or duty to God, to ancestors, or to an abstract principle, it is the sacred or spiritual nature of the parent-child relationship and its underlying assumptions that makes mourning the death of a child such a long, agonizing, and, at times, transformative process.

The parent's search for meaning in the child's death often results in the formulation of religious loss rationales. In their study of grieving parents, Cook and Wimberley isolated three parental loss rationales: reunion, reverence, and retribution. The most frequently used rationale was the notion that the child had gone to heaven, where parents and the dead child would eventually be reunited (reunion). Another frequent explanation was that the child's death served some religious purpose, for example, as an inspiration for parents to do good works (reverence). Finally, in some cases, the child's death was interpreted as a punishment for the sins of the parents (retribution).

In another study of bereaved parents participating in a chapter of Compassionate Friends, a support-group for parents-in-mourning, Dennis Klass found that nearly all the parents in the group rejected simple loss rationales, such as that their child's death was God's will, and instead confronted their spiritual crisis by creating new assumptions. Klass discovered that, in many cases, profound forms of psychospiritual transformation were an integral part of the healing process for bereaved parents. He states, "Many of these parents-in-mourning find solace in connections with that which transcended the physical and biological world, and with their perception of an underlying order in the world. These spiritual aspects of the resolution of the grief were central elements in the parents' rebuilding of their lives to be able to live in a changed world." Confronted with a profound and intense spiritual crisis, the bereaved parents in this study were forced to undertake a spiritual quest for individual meaning and solace and to "transcend the human limitations they find in the

death of their child. They reveal what people in . . . ‘the extreme situation’ do and what all persons must do” (Klass 1995, p. 264).

Spiritual Crisis and the Search for Meaning

Other strategies for finding spiritual meaning exist for persons who cannot reconcile the “why” of their loss through traditional or modern religious doctrine. Some people may become involved in philanthropic, political, or caregiving work that relates to the illness or manner of death experienced by their loved one. By so doing—coping actively with the spiritual crisis rather than passively—the mourner may discover meaning in the loss, as if to say, “This death was not in vain.”

The American businessman and philanthropist George Soros, for example, contributed more than \$200 million to charitable projects, including the Project on Death in America, following his own spiritual crisis following the death of his parents. “I chose the culture of dying as one of the areas I wanted to address . . . because of my experiences with the death of my parents, both of whom I was very devoted and [to] loved dearly” (1995, p. 2). Soros was not present at his father’s death:

I let him die alone. The day after he died I went to my office. I didn’t talk about his death. I certainly didn’t participate in it. After reading Kübler-Ross, I learned that . . . I could have held his hand as he lay dying. . . . I just didn’t know that it might have made a difference—for both of us. (1995, p. 3)

Years later, confronted with a second spiritual crisis involving his dying mother, Soros was present and participated in her dying: “I reassured her. Her dying was really a positive experience for all of us.” The attempt to bring meaning to these experiences of loss prompted Soros to found the Project on Death in America with the goal of promoting “a better understanding of the experiences of dying and bereavement and by doing so help transform the culture surrounding death” (1995, p. 2).

These quests for meaning, whether they involve an affirmation of long-held religious beliefs, a search for new spiritual insights, or philanthropic work, often continue beyond the grieving process into the larger mourning process and include revising and restructuring one’s assumptions

regarding his or her own existence; integrating memories and meanings associated with the deceased into new ways of relating to the world; restoring one’s self-esteem and sense of self-mastery; and exploring transformations in one’s spiritual beliefs and practices.

Spiritual Crisis and the Experience of Dying

Because humans are essentially order-seeking creatures, the reality of dying presents a powerful cognitive upheaval to our sense of self and an intense challenge to our spiritual beliefs and assumptions. Perhaps we cannot imagine what it will be like to die, but we can easily imagine what it might be like to no longer cope, feel vulnerable and helpless, be dependent on others to meet our everyday physical needs, and to feel like we are no longer in charge of our own lives. We know what happens when we are admitted to hospitals. We are literally stripped of almost everything that is familiar—clothing, routine, personal objects—and we are told when to eat and sleep. Even when treated in a courteous manner, there is still an undeniable sense of dependency and vulnerability.

For the patient who is hospitalized for a short stay and a cure, the feeling of loss of control may be fleeting and masked by the visits of family and friends—and the good news of a successful treatment. The terminal patient, however, is in a much more vulnerable and tenuous position and much more likely to experience a spiritual crisis connected to the loss of integrity, control, and human connection. For many persons facing imminent death, coping strategies provide comfort and a sense of meaning within the context of traditionally held religious beliefs. For example, in a study of the role of spirituality in persons with AIDS, researchers found that it is not uncommon for AIDS victims to be drawn even closer to their traditional religious beliefs, including beliefs in a caring, higher power; the value of life; the importance of support from religious laypersons and close friends; living an ethical life; the importance of facing death; and the presence of an inner peace in identifying a meaning to their lives. Likewise, the greater religiosity of older persons, those most likely to die in modern societies, has been interpreted by some as evidence of such spiritual needs.

Another study of fifty hospitalized cancer patients also revealed that many found comfort and

meaning in traditional religious beliefs, but over half had concerns involving spiritual issues connected with long-held religious beliefs; about one-third were actively struggling with a spiritual crisis. The crisis, according to respondents, involved conflicts between religious views, as when dying patients experience anger toward God or believe that their illness is somehow due to their sins; loss of religious support from their congregation or a particular minister; pressure to adopt a different religious position, as when a husband urges a dying wife to adopt his particular religious conviction; and, an all but obsessive preoccupation with religious/spiritual questions in an effort to understand what is happening to them in the process of dying.

Spirituality and Needs of the Dying

The psychologist Abraham Maslow viewed human motivation as consisting of needs ranging from those related to basic survival, such as needs for food and water, to “higher” psychological needs, such as the need for love, knowledge, order, self-fulfillment, spirituality. Maslow wrote of the need for “something bigger than we are to be awed by” (1971, p. 105). Exploring these higher reaches of human nature is always difficult, but is especially challenging in the midst of coping with one’s own dying.

An important feature of Maslow’s theory is the idea that some needs are more fundamental than others and need to be at least partly satisfied before other, higher needs become active. Thus, in living our dying, one must first satisfy his or her basic physiological needs (e.g., hunger, thirst, pain control) and safety needs (e.g., living in a secure, nurturing environment) before being motivated to satisfy needs higher up on the pyramid. Once physiological and safety needs are met, people begin striving to satisfy emotional needs (e.g., the need to receive affection from others and to feel part of a group) and self-esteem needs (e.g., the need to feel positively about oneself and to be esteemed by others). Finally, at the top of the pyramid, is the need for self-actualization—the desire to attain the full use of one’s potential in acceptance of self, others, nature, and spiritual yearnings and insights. Based on his work with the dying, the German thanatologist David Aldridge contends that abandonment, suffering loss of hope and meaning, and the transitions from living to dying

are essentially spiritual, not solely physiological, psychological, or social. He argues that in many instances, all of these contexts are interlinked in coping with a spiritual crisis.

Kenneth Doka has identified three principal spiritual tasks for those who are dying: First, the need to find the ultimate significance of life. Answers do not necessarily have to be found in religious beliefs, but an inability to find meaning can create a deep sense of spiritual pain. The dying person’s belief system can give a sense of purpose in life and help sustain personal values. Second, the need to die an appropriate death. People who are dying need to accept their death within a framework that is congruent with their values and lifestyle. In some cases, individuals may need help in making decisions about the way in which they will die. Guidance from a special friend or from someone they recognize as a spiritual leader may be helpful in developing cognitive coping strategies. Third, is the need to transcend death; transcendence can be achieved through renewed assurance of immortality in religious doctrine, new spiritual insights, or the acknowledgement of future generations in recognizing that their deeds will live long after they die. To find meaning in the final moments of life, to die appropriately, consistent with one’s own self-identity, and to find hope that extends beyond the grave may be among the most important cognitive transformations humans can experience during a crisis of spirit.

Spiritual Crisis and Hospice Care

Because many spiritual and existential aspects of human existence become magnified as death approaches, spiritual care has been an integral part of the hospice movement since its inception. For this reason, hospice clergy have been central to the work of the hospice team in caring for the dying. Clinical observations suggest that hospice clergy have two important roles to play in caring for the terminally ill—spiritual guide to the dying patient and teacher for family members and health care professionals about death and dying. All team members must attend to the physical, social, psychological, and spiritual needs of the patient and family members as death becomes imminent and questions and fears arise. But the chaplain, as a representative of faith and spirituality, must serve as a resource to the patient, family members, and staff.

Gentile and Fello believe that many of the patients to whom hospice chaplains minister have become estranged from formal religious beliefs and practices and hope to reconnect themselves with their spiritual roots. A chaplain with a caring and compassionate nature may, with sensitivity and discretion, facilitate the dying person's exploration of spiritual issues and thus allow the patient to die with greater dignity.

Spiritual Transformation, Faith, and Joy

For many persons, coping with and overcoming a profound crisis of spirit involves faith; that is, the willful suspension of humans' order-seeking, controlling behavior. People simply agree to accept that there is some greater order, purpose, structure, and meaning that is not self-evident in the seeming absurdity of events such as the premature death of a loved one. The exercise of faith and the acceptance of an order beyond one's control does not mean he or she concedes free will or relinquishes the desire to be in control. People achieve their greatest control over the living when they choose to exercise faith. When confronted by a grieving parent whose child has died and who asks, "Why has God done this to me?," there is no satisfactory answer. However, when the mourner has worked through the grieving/mourning process, there may be an emergence of faith and a willingness to accept one's suffering as a part of some greater pattern that escapes the cause-effect logic of his or her scientific worldview.

In fact, having met the challenges of a spiritual crisis, many mourners are able to identify positive, joyful, and triumphant aspects of their mourning experience. Kessler, for example, discovered that many of her subjects regarded the mourning process as liberating: Over half mentioned feeling freed from previously limiting ties. Many subjects in the study felt that they had become stronger and more confident people. Shuchter also found that after two years, the majority of widows and widowers studied were able to regard their spiritual crisis as "growth-promoting." Their experiences enabled them to reflect on their personal values, put things in a new perspective, and appreciate more important things in life. They perceived themselves to be more realistic, patient, sensitive, autonomous, assertive, open, and spiritual in their everyday lives.

In resolving the spiritual crisis, according to Klass, "The person feels his or her life is more authentic, more meaningful, the person's thinking is 'set straight' or true, and his or her actions toward others are right and true" (1995, p. 244). Such insights into leading a meaningful, spiritually based life have been codified in various religious traditions, as in the doctrine of Christianity, the dharma of Hinduism, the Tao of Chinese religion, and the notions of right living, action, and intention embedded in the Buddha's eightfold path to enlightenment.

Conclusion

Research reveals that during periods of profound loss, one's cognitive world may be turned upside down. The assumptions that guided one's life—that life is fair, that people get what they deserve, that God is benevolent, that the old die before the young, and so on—are strained and sometimes shattered. This collapse in beliefs and assumptions about the world and one's place in it can lead to a spiritual crisis. Whether faced with our own imminent death or in coping with the death of a loved one, we confront the challenge of reconstructing our assumptions about the world.

People have much to learn about spiritual experience, cognitive upheaval, and psychospiritual transformation in the face of death; however, they do know that personal philosophies, religious belief systems, spiritual explorations, and the search for meaning are especially important at such times. Professional and voluntary caregivers are becoming more aware of these spiritual needs and the obstacles that prevent some individuals from fulfilling them.

This new research on dying, mourning, and spirituality suggests that the ways in which people rediscover meaning—such as belief in traditional religious doctrine, the afterlife, reincarnation, philanthropy, or a spiritual order to the universe—may be less important than the process itself. In other words, in the midst of dealing with profound loss in our lives, the ability to re-ascribe meaning to a changed world through spiritual transformation, religious conversion, or existential change may be more significant than the specific content by which that need is filled.

See also: ARS MORIENDI; DYING, PROCESS OF; GOOD DEATH, THE; GRIEF; HOSPICE OPTION; IMMORTALITY; IMMORTALITY, SYMBOLIC; KIERKEGAARD, SØREN

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SPIRITUALISM MOVEMENT

Spiritualism is the belief that the living can communicate with the dead. The belief in a spirit world and the living's ability to correspond with the spiritual realm probably dates to antiquity. Spirit contact is facilitated when an individual is on his or her deathbed. James Crissman notes in his study of the dying process in Central Appalachia that several dying people had contacts, visual and/or auditory, with a friend or relative who had been deceased for many years. Some had encountered biblical characters.

The two greatest premodern spiritualism influences were Emanuel Swedenborg (1688–1722) in Sweden and Andrew Jackson Davis (1826–1910) in America. A well-known scientist and clairvoyant, Swedenborg reported being in constant communication with the spirit world throughout his life. Davis, a clairvoyant, while in a mesmeric (hypnotic) trance, could communicate with the spirit world and accurately diagnose medical disorders. While in a trance he supposedly foresaw the coming of the spiritualist movement.

The modern spiritualism movement began in March 1848 when Catherine and Margaretta Fox, after encountering numerous disturbances in their new home in Hydesville, New York, where they lived with their parents, devised a way of communicating with a spirit via the use of a tapping system. The sisters claimed to have discovered that the spirit causing the problem had been robbed, murdered, and buried in the house several years prior to the date that the Fox family moved into the

home. Several neighbors were brought into the house to substantiate the fact that the Fox family had communicated with the dead. The press popularized the actions of the Fox sisters and the sisters capitalized on that popularity by turning their abilities to communicate with the dead into a stage act. They attracted the backing of the showman P. T. Barnum, who took them to New York and made them stars. The Fox sisters enjoyed several years of fame as mediums.

Following the events in Hydesville, spiritualism became a major international social movement. The Hydesville rappings demonstrated organized communication, the natural mediumistic abilities of certain people, and that communication could be enhanced through the use of a code. The major protagonist was a medium, someone capable of communicating with the dead, who served as the intermediary between the individual wishing to converse with the dead and the spirit of the deceased.

The most common form of communication with the spirit world became the *séance*, which typically took place in a darkened room with participants sitting in a circle holding hands. Occasionally, the medium would be tied to a chair with his or her legs secured, to prevent the use of the extremities to falsely produce ghostly phenomena. The environment of the *séance* might include sounds of various kinds, the appearance and disappearances of small physical objects, the medium talking in various voices, furniture moving about the room, and a spirit materializing in a temporary physical form.

Other *séance* effects utilized since 1848 are spirit bells and horns, electronic (flameless) candles, lightning and thunder, animated objects such as books or candles, and spirit photography. Methods of communicating with the spirit world, whether or not there is a *séance*, have included crystal balls, tarot cards, rapping or tapping a code, mental telepathy, a mesmeric or hypnotic trance, the Ouija board, and automatic writing.

The Hydesville incident led to the establishment of many independent churches and philosophical organizations whose main objective was to advance the ideas of spiritualism. A small group of spiritualists met in the Corinthian Hall in Rochester, New York, on November 14, 1849. As others realized they had psychic powers, the



According to New Age spiritualists, crystals contain healing and energizing powers, in addition to promoting communication with spirits. PHIL SCHERMEISTER/CORBIS

movement grew. The First Spiritual Temple was established by Marcellus Ayer in September 1885. According to Reverend Simeon Stefanidakis, a proponent of spiritualism and author of *About the First Spiritual Temple: Hydesville*: “The Church became an immediate success, with a membership of over 1,000 people” (2001, p. 3).

The spiritualism movement made its way to England in 1852 via a Boston medium, Mrs. Hayden. It was very popular during the Victorian and Edwardian historical eras. The scholar Jenny Hazelgrove notes that it was also popular between the two world wars: “It continued to flourish in the interwar period, given a massive boost by the great war, which left many people desperately seeking to contact the spirits of loved ones killed in that conflict” (Hazelgrove 2000, p. ix). It was strengthened in this time period by support from several members of the Anglican Church. By 1900 the spiritualist movement was dying but enjoyed a minor revival during World War I, and by 1920 spiritualism finally lost its momentum, never again receiving the same level of notoriety—despite the fact that numerous well-known individuals such as *Sherlock Holmes* author Sir Arthur Conan Doyle and the well-known scientist Sir Oliver Lodge attempted to influence the spiritualist movement’s popularity at the beginning of the twentieth century.

The spiritualist movement naturally drew many critics. First, there were those who did not believe in the continued existence of the spirit, and therefore scoffed at any notion of communicating with what did not exist. Second, many considered talking with spirits to be a form of mental disorder.

Criticisms were strong among members of the medical profession, especially those interested in explaining the human mind. The scholar Alex Owen stated that “the new specialists in insanity were swift to categorize a belief in spiritualism as symptomatic of a diseased mind” (Owen 1989, p. 139). Third, a number of charlatans, whose actions were revealed to be tricks, contributed to the movement’s discrediting. This argument was strengthened in 1888 when, in an appearance in New York, Margaretta Fox said that spiritualism was a false science and that she and Catherine had been faking phenomena ever since they had been in practice. Fourth, some people have rejected the idea of communication with the dead because they fear the unknown, which may upset the stability, order, and understanding of the world in which they live. Fifth, numerous men and women rejected spiritualism because of a socialized fear of spirits. Through socialization, people in Western societies, particularly the United States, learn to fear ghosts, goblins, demons, witches, and other members of the spirit world. They avoid cemeteries because ghosts of the dead may prevail and generally believe that morgues and funeral homes are scary places because spirits may still be present.

While some Christians have been able to reconcile their religious convictions with a belief in spiritualism, the most vehement criticisms have come from organized Christian groups. While many of the criticisms mentioned have been expounded by organized religions, most opposition to communicating with the dead comes from passages in the Old and New Testaments of the Bible. Numerous passages—including Exodus 22:18, Leviticus 19:31, Leviticus 20:6, and Deuteronomy 18:10–12—provide warnings that communicating with the spirits of the deceased is wrong and condemned by God. The contention is that communication with the dead is to be done through Jesus Christ, not some self-professed medium. There are strong warnings of false prophecy, the existence of malevolent spirits, necromancy and demonic possession, and engaging in spiritualistic methods that make it easier for the devil (or demons) to gain control of one’s mind and body. Several religious figures have argued that spiritualists place God in a secondary or nonexistent position. Finally, several religious groups, especially the Catholic Church, were critical of the important role of women in the spiritualist movement and its strong feminist theme.

There was even a belief among some spiritualists in a female or perhaps an androgynous divinity.

There are several organized spiritualist groups in existence. In the United States in the 1990s there were about 600 congregations with a combined membership of more than 210,000 individuals. The largest organizations include the International General Assembly of Spiritualists, headquartered in Ashtabula, Ohio; the National Spiritual Alliance of the USA in Lake Pleasant, Massachusetts; and the National Spiritualists Association of Churches in Lily Dale, New York.

See also: COMMUNICATION WITH THE DEAD; DEATHBED VISIONS AND ESCORTS; GHOSTS

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STAGE THEORY

The stage theory of dying was first proposed by the Swiss-American psychiatrist, Elisabeth Kübler-Ross in her book, *On Death and Dying* (1969), is perhaps the single theoretical model that is best known to the general public in the entire field of studies about death and dying (thanatology). In its simplest form, this theory claims that dying people will proceed through five stages: denial, anger, bargaining, depression, and acceptance. More broadly, the theory maintains that other individuals who are drawn into a dying person's experiences, such as family members, friends, professional care providers, and volunteer helpers, may also experience similar "stages of adjustment."

Origins of the Theory

Kübler-Ross explained in her book that she was a new faculty member in psychiatry at a Chicago-area teaching hospital in the fall of 1965 when four theological students seeking assistance with a student project approached her. They had been assigned to write about a "crisis in human life" and had chosen to examine death as "the biggest crisis people had to face" (p. 21). In order to tackle this topic, she agreed to help them gain access to and interview some dying patients. According to Kübler-Ross, she encountered unexpected resistance from the physicians and others who were responsible for the patients whom she and her students wanted to interview: "These doctors were both very defensive when it came to talking about death and dying and also protective of their patients in order to avoid a traumatic experience with a yet unknown faculty member who had just joined their ranks. It suddenly seemed that there were no dying patients in this huge hospital" (p. 23).

Eventually, however, some suitable patients were found, and Kübler-Ross developed a procedure whereby she would approach likely candidates, secure their permission, and then interview them about their experiences, while the students and others who came to observe would do so from behind a one-way glass mirror. Following the interviews and the return of the patients to their rooms, the group would discuss the patients' responses and their own reactions.

On Death and Dying is based on interviews with approximately 200 adult patients during a period of less than three years. Examples from the interviews, along with the clinical impressions and the theoretical model that Kübler-Ross formed from these experiences, were subsequently reported in her book.

Stage Theory of Dying Examined

The theoretical model that Kübler-Ross developed from her interviews postulated that with adequate time and support, dying persons experience or work through five stages, including *denial*, often expressed as "No, not me, it cannot be true," is described as an individual's unwillingness to acknowledge or broad rejection of the fact that he or she is actually dying; *anger*, typically expressed as "Why me?," is a protest acknowledging at least in some degree that the individual is dying but simultaneously objecting or complaining that it is not fair or right that it should be happening; *bargaining*, often expressed as "Yes me, but . . .," is less outraged and more resigned to death while focusing (whether realistically or unrealistically) on what might be done to postpone death or to have it occur at a time or in ways that are more acceptable to the individual; *depression*, which involves a great sense of loss and which can take the form of "reactive depression" (responding to losses the individual has already experienced) or "preparatory depression" (emphasizing impending losses, including the anticipated loss of all love objects); and *acceptance*, described as "almost void of feelings" (p. 113), a "final stage when the end is more promising or there is not enough strength left to live" (p. 176).

A valuable addition to this five-stage theory, which is often overlooked, is the observation that "the one thing that usually persists through all these stages is hope" (p. 138) and the comment

that “it is this hope that should always be maintained whether we can agree with the form or not” (p. 265).

Understanding Stage Theory of Dying

Kübler-Ross sought to address a dehumanization and depersonalization that dominated the experiences of the dying persons with whom she came into contact. She believed that dying was often a lonely, impersonal experience for such persons, and thus an unnecessarily difficult burden for them to bear. In fact, Kübler-Ross found that most of her patients feared dying even more than death itself. For those who were isolated in their dying and who felt unable to help themselves or to find reasons to be hopeful, Kübler-Ross offered them a constructive opportunity by asking them to help teach others about their experiences. She was especially concerned that dying persons should share their experiences with and become teachers to their professional caregivers and their family members. At the same time, she asked others not to be judgmental about the reactions dying persons have to their experiences, but to try to enter into their perspectives and understand the origins of those reactions.

The theory that resulted was essentially an effort “to categorize crudely the many experiences that patients have when they are faced with the sudden awareness of their own finality” (p. 29). The “stages” within that theory were themselves understood by Kübler-Ross as “reactions,” “defenses” or “defense mechanisms,” “coping mechanisms,” and “adaptations and defenses.” At one point, Kübler-Ross wrote that these stages “will last for different periods of time and will replace each other or exist at times side by side” (p. 138), while in another place she stated, “these stages do not replace each other but can exist next to each other and overlap at times” (p. 263). The stages are, in other words, a fairly loose collection of psychosocial reactions to experiences associated with dying. As such, they remind us that dying is a human process, not merely a series of biological events. Also as such, they are not confined solely to dying persons, but may be experienced by others who enter into the worlds of those who are dying.

As initially proposed, the five stages in this theory were described in very broad terms. Denial and acceptance, for example, were presented as essentially mirror opposites, with the other three stages

functioning mainly as transitional reactions experienced while moving from denial to acceptance. Both denial and acceptance were formulated in ways that permitted them to apply to a spectrum of reactions: from a complete rejection of one’s status as an ill or seriously ill person to an unwillingness to admit that one is dying or that one’s death is more or less imminent; and from acknowledgment, resignation, and acquiescence to welcoming.

Of denial, Kübler-Ross wrote, “Denial, at least partial denial, is used by almost all patients, not only during the first stages of illness or following confrontation, but also later on from time to time” (p. 39). More importantly, she added this further comment about denial: “I regard it [as] a healthy way of dealing with the uncomfortable and painful situation with which some of these patients have to live for a long time. Denial functions as a buffer after unexpected shocking news, allows the patient to collect himself and, with time, mobilize other, less radical defenses” (p. 39). Not everyone who took up this theory viewed denial in this constructive way.

Like denial and acceptance, anger, bargaining, and depression as the other stages in this theory were said to vary in their intensity, character, and focus. Individuals will differ, for example, in whether or not they experience anger, what arouses their anger, the object(s) on which it fixes, its degree, whether it is rational or irrational, and how it is expressed. One troubling feature of anger is that it is said to be “displaced in all directions and projected onto the environment at times almost at random” (p. 50).

As for bargaining, this reaction seems to reflect a view that one can postpone death or manipulate one’s experiences of dying usually through more or less explicit promises involving a prize and some deadline: “I will faithfully follow the prescribed regimen you prescribe, if it will only ward off my death”; “I will pray each day, if you will preserve me from this awful fate”; “I need to stay alive until my son is married.” Promises are usually addressed to presumed authorities, such as God or a physician, but Kübler-Ross noted, “none of our patients have ‘kept their promise’” (p. 84).

Criticisms of the Stage Theory of Dying

There are essentially three distinct types of criticisms that have been raised against the stage theory of dying. First, some commentators have noted

that empirical research has provided no support for this model. Kübler-Ross herself offered nothing beyond the authority of her clinical impressions and illustrations from selected examples to sustain this theory in its initial appearance. Since the publication of her book in 1969, she has advanced no further evidence on its behalf, although she has continued to speak of it enthusiastically and unhesitatingly as if its reliability were obvious. More significantly, there has been no independent confirmation of the validity or reliability of the theory, and the limited empirical research that is available does not confirm her model.

Second, the five sets of psychosocial reactions that are at the heart of this theory can be criticized as overly broad in their formulation, potentially misleading in at least one instance, insufficient to reflect the full range of human reactions to death and dying, and inadequately grounded for the broad ways in which they have been used. The expansive way in which these five reactions are formulated has already been noted. Kübler-Ross did not, of course, invent these five reaction patterns; her inspiration was to apply them individually to the human experiences of dying and facing death, and to link them together as part of a larger theoretical schema. Among its peers, the trait of depression seems most curious as an element in a healthy, normative process of reacting to dying—unless it really means “sadness”—since clinical depression is a psychiatric diagnosis of illness. Moreover, just as Kübler-Ross seems sometimes to acknowledge that a particular individual need not experience all five of these reactions, so one need not believe there are only five ways in which to react to dying and death. Finally, Kübler-Ross has applied this theory to children and to bereavement in ways that are not warranted by its original foundations in interviews with dying adults.

Third, the theory can be criticized for linking its five reaction patterns together as stages in a larger process. To a certain extent Kübler-Ross seems to have agreed with this point since she argued for fluidity, give and take, the possibility of experiencing more than one of these reactions simultaneously, and an ability to jump around from one “stage” to another. If that is true, then this is not really a theory of stages, which would require a linear progression and regression akin to the steps on a ladder or the calibrations on a thermometer or a hydraulic depth gauge. In short, the

language of “stages” may simply be too restrictive and overly specific for what essentially appear to be a cluster of different psychodynamic reactions to a particular type of life experience.

This last point is particularly important because if this theory has been misused in some ways, its most unfortunate mishandling has come from those who tell dying persons that they have already experienced one of the five stages and should now “move on” to another, or from those who have become frustrated and complain about individuals whom they view as “stuck” in the dying process. When coupled with the limits of five categories of reaction to dying, this schematic approach tends to suppress the individuality of dying persons (and others) by coercing them into a rigid, preestablished framework in which they are expected to live out an agenda imposed on them at the end of their lives. That is particularly ironic and unfortunate since Kübler-Ross set out to argue that dying persons are mistreated when they are objectified and dealt with in stereotypical ways. As she insisted, “a patient has a right to die in peace and dignity. He should not be used to fulfill our own needs when his own wishes are in opposition to ours” (p. 177).

One serious evaluation of this stage theory of dying by Robert Kastenbaum raised the following points:

- The existence of these stages as such has not been demonstrated.
- No evidence has been presented that people actually do move from stage one through stage five.
- The limitations of the method have not been acknowledged.
- The line is blurred between description and prescription.
- The totality of the person’s life is neglected in favor of the supposed stages of dying.
- The resources, pressures, and characteristics of the immediate environment, which can make a tremendous difference, are not taken into account.

As a result, what has appeared to be widespread acclaim for this theory in the popular arena and in certain professional quarters contrasts with sharp criticism from scholars and those who work with dying persons.

What Can Be Learned from Stage Theory of Dying?

Charles Corr has suggested that there are at least three important lessons to be learned from the stage theory of dying. The first lesson is that those who are coping with dying are living human beings who will react in their own individual ways to the unique challenges that confront them and who may have unfinished needs that they want to address. The second lesson is that others cannot be or become effective providers of care unless they listen actively to those who are coping with dying and work with them to determine the psychosocial processes and needs of such persons. And the third lesson, a point that Kübler-Ross always stressed, is that all individuals need to learn from those who are dying and coping with dying in order to come to know themselves better as limited, vulnerable, finite, and mortal, but also as resilient, adaptable, interdependent, and worthy of love.

Reflecting at least in part on the stage theory of dying, some writers have called for broader task-based or contextual theories of dying that would strive to offer more respect for the individuality and complexities of the many different ways in which persons live out their experiences of dying and of coping with dying. Various contributions have been made toward developing such broader theoretical frameworks, some emerging from lessons learned in reflecting on the stage theory of dying, but no final theory has yet been developed.

See also: DYING, PROCESS OF; KÜBLER-ROSS, ELISABETH; LESSONS FROM THE DYING

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STROKE

As the third major cause of death and disability in America and the leading neurological disorder for morbidity, stroke is a major public health problem.

The incidence of strokes is predicted to become worse as the percentage of the aging population, which is predominantly affected, increases. Stroke (or “brain attack”) is defined as an acute neurological dysfunction, usually focal in nature, which can be explained by either occlusion of a feeding artery to the brain or the rupture of such a vessel.

Ischemic strokes result from blood clots that originate from more proximal arteries to the brain such as the carotid bifurcation in the neck or even from the heart. The neurological deficits with ischemic strokes depend upon several factors—one being the size of the clot. With large clots, larger arteries with a larger area of brain to feed will be affected, leading to greater neurological impairment. Second, the specific vessel(s) is occluded. If the artery to the speech area is occluded, the patient will be unable to talk, so-called aphasia; or if the artery to the area controlling arm and leg movements is occluded, the patient will become paralyzed on the opposite side. Third is the rapidity of artery occlusion. The cause of clot or thrombus formation is most commonly due to atherosclerotic disease or hardening of the arteries, but other conditions exist that make the blood clot, such as abnormal conditions causing the blood to be very sticky, or what is termed prothrombotic states. With vessel rupture, the two most common conditions are aneurysms, which lie primarily in the subarachnoid space surrounding the brain, and intracerebral hemorrhages, which most commonly result from longstanding uncontrolled hypertension. Other conditions associated with vessel rupture include abnormal formation of arteries and veins.

Strokes, like heart attacks, are most commonly caused by atherosclerosis or hardening of the arteries. The major risk factors for atherosclerosis are high blood pressure (hypertension), smoking, diabetes mellitus, increased lipids (hypercholesterolemia and hypertriglyceridemia), stress, sedentary lifestyle, and obesity. These risk factors are mostly treatable, and therefore greater public health programs to educate the general public are generally viewed by health care practitioners as a partial solution to the problem. Risk factors for less common hereditary conditions predisposing to vascular, cardiac, and thrombotic disorders that result in strokes require preventive intervention as well, with the most common treatment being the

thinning of blood (also known as “anticoagulation”). Use of DNA analytical techniques to identify as a yet unknown combination of gene defects leading to strokes as well as a large number of proteins, which also in combination can lead to strokes, an area called proteomics promise to identify stroke-risk predisposition more precisely and at an earlier age.

In addition to knowing one’s stroke risk factors, individuals should be aware of stroke symptoms so that urgent workup and appropriate treatment can be instituted, possibly reversing neurological deficits. For example, use of the thrombolytic agent (clot buster) tissue plasminogen activator (tPA) has been proven to be the first statistically significant drug to reverse the effects of a thrombus or embolus causing stroke symptoms. But because this treatment must be instituted within three hours of stroke onset, this short timeframe means that the public, the emergency services, and treating physicians must develop a rapidly responding medical system that can triage and treat patients quickly. Other stroke syndromes that can benefit from therapeutic intervention include intracerebral hemorrhages (bleeding) with surgical evacuation of the clot, particularly cerebellar hemorrhages, and subarachnoid hemorrhages due to berry aneurysms with surgical or interventional ablation of the aneurysm. Embolic strokes, especially from cardiac sources, such as rhythm abnormalities, particularly atrial fibrillation, are prone to cause embolic strokes, and these can be prevented with anticoagulation.

See also: CAUSES OF DEATH

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FRANK M. YATSU

SUDDEN INFANT DEATH SYNDROME

In typical cases of sudden infant death syndrome (SIDS), an infant between the ages of two to four months is found dead with no warning, frequently

during a period of sleep. Because the typical victims are previously healthy infants with no record of any serious medical problems, their sudden death is all the more shocking and devastating. Some have said that this type of death is “a cosmic slap in the face” to parents, grandparents, other adults, and siblings who had previously delighted in the child’s birth and growth, and plans for his or her future.

Definition

Sudden infant death syndrome—called “SIDS” by many professionals, but also termed “crib death” in the United States or “cot death” in some other English-speaking countries—is “the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history” (Willinger, James, and Catz 1991, p. 681).

Three aspects of this definition are worth noting. First, an accurate diagnosis of this syndrome requires a thorough investigation, including an autopsy (preferably performed by a medical examiner or forensic pathologist who is experienced in diagnosing infant deaths), along with a careful examination of the history and circumstances behind the death (including interviews of parents and others involved in the care of the infant, collection of items from the scene of death, and meticulous evaluation of all of the information obtained). Hasty or incomplete diagnoses can sometimes confuse SIDS with deaths resulting from child abuse or other causes. Such errors can compound burdens placed upon parents and other survivors of SIDS if they are wrongly accused of child abuse, just as they may cloak abusive situations under the more benign diagnosis of SIDS.

Second, a diagnosis of SIDS is essentially an exclusionary diagnosis, one that is made by ruling out all other possible causes and then recognizing the distinctive patterns of this cluster of events. A “syndrome” is precisely a familiar constellation of events arising from an unknown cause. Third, although no definitive diagnostic indicators unmistakably identify recognized abnormalities in SIDS that are sufficient to cause death, there nevertheless are some biological, clinical, and historical or circumstantial markers commonly found in this

syndrome. These common but not universal markers include:

- tiny red or purple spots (minute hemorrhages or petechiae) on the surface of the infant’s heart, in its lungs, and in its thymus;
- an increased number of star-shaped cells in its brain stem (brain-stem gliosis);
- clinical suggestions of apnea or pauses in breathing and an inability to return to normal breathing patterns; and/or
- circumstantial facts such as a peak incidence of SIDS at two to four months of age, which declines to almost nonoccurrence beyond one year of age.

Markers such as these, when identified by a competent, thorough, and experienced physician, justify recognizing SIDS as an official medical diagnosis of death.

Incidence

During most of the 1980s, SIDS accounted for the deaths of approximately 5,000 to 6,000 infants per year in the United States. From 1988 to 1999, however, SIDS rates fell by more than 52 percent in the United States, and the number of SIDS deaths declined to 2,648 in 1999.

In terms of the overall number of live births each year, SIDS is the leading cause of death in the United States among infants between one month and one year of age. For all infants less than one year of age, SIDS is the third-leading cause of death, following only congenital anomalies and short gestation/low birthweight.

Researchers have drawn attention to other aspects of the incidence of SIDS deaths, but those variables have not yet been sufficient to establish differential diagnoses, screening procedures, or preventive measures for SIDS. In fact, SIDS is a sudden and silent killer, often associated with sleep, but apparently involving no suffering. Characteristically, SIDS deaths show a pronounced peak during the colder months of the year: January through March in the United States or six months later in the southern hemisphere. Epidemiological studies suggest that SIDS is somehow associated with a detrimental prenatal environment, but infants who are at risk for SIDS cannot be distinguished from those who are at risk for many other

health problems. In general, at-risk infants include those with low birthweight or low weight gain and those whose mothers are less than twenty years of age, were anemic, had poor prenatal care, smoked cigarettes or used illegal drugs during pregnancy, and had a history of sexually transmitted disease or urinary tract infection. But none of these factors is sufficient in predicting how, when, why, or if SIDS will occur.

In terms of social, racial, or other categories, SIDS appears in families from all social groups. Approximately 60 percent of all SIDS deaths are those of male infants. The largest number of SIDS deaths (approximately 70%) occurs in infants between two and four months of age, with most SIDS deaths (approximately 90%) taking place by six months of age.

The “Back to Sleep Campaign”

In the early 1990s research suggested that infants might be at less risk for SIDS if they were laid to sleep on their backs (supine) or sides rather than on their stomachs (prone). That idea ran contrary to familiar advice that favored infants sleeping prone in order to reduce the risk that they might regurgitate or spit up fluids, aspirate them into their airway, and suffocate. Some health care professionals and family members still seem to believe that prone sleeping is best for an infant, but the new research suggested that infants who sleep on their stomachs are at far greater risk of SIDS than they are of other problems.

Accordingly, in April 1992, the American Academy of Pediatrics (AAP) Task Force on Infant Sleep Position concluded it was likely that infants who sleep on their backs and sides are at least risk for SIDS when all other circumstances are favorable (e.g., when sleeping on a firm mattress without overheating, loose bed covers, or soft toys nearby). As a result, the AAP recommended that “healthy infants, when being put down for sleep, be positioned on their side or back.”

In June 1994 a national “Back to Sleep Campaign” was initiated in the United States. A joint effort of the U.S. Public Health Service, the AAP, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs, the campaign seeks to employ literature, the media, and other avenues to raise professional and public awareness about the

importance of sleep positioning as a way to reduce SIDS. SIDS Resources, Inc., in Missouri, provided one local example of how this campaign can be implemented in a simple but effective way by developing and distributing to new mothers tiny T-shirts for infants with the legend on the front of their shirt, “THIS SIDE UP . . . while sleeping.”


Subsequently, the AAP revised and strengthened its recommendation by emphasizing that positioning infants on their backs is the preferred position for their sleep at night and during naps. The AAP acknowledged that it is acceptable to allow infants to sleep on their sides because that is significantly better for them than sleeping on their stomachs, but side sleeping without proper support is a less stable position for an infant and thus not as desirable as back sleeping.

Dramatic and sustained reductions in SIDS deaths in the United States and many other countries are associated with initiatives like the “Back to Sleep Campaign.” Unfortunately, they have not applied equally to all racial and cultural groups in America. For example, it has been noted that African-American mothers are “still significantly more likely to place their infants prone” (Willinger, et al. 1998, p. 332). This reluctance to place infants on their backs for sleep appears to be directly correlated with less significant declines in SIDS death rates among African-American infants than among infants in other groups in American society.

Research

Research on SIDS is extraordinarily difficult, facing many problems that have long frustrated scientific investigators. For example, in SIDS there are no living patients to study because the first symptom of SIDS is a dead baby. In addition, risk factors for SIDS are not strong or specific enough to permit identification of high-risk groups as subsets of the general infant population in which the natural history of a disease can be followed with smaller numbers of subjects. And there are no naturally occurring animal models for SIDS. As a result, SIDS is currently unpredictable and unpreventable, although it is possible to modify some risk factors for SIDS deaths.

Most researchers now believe that babies who die of SIDS are born with one or more conditions



It's enough to make any parent lose sleep.

SUDDEN INFANT DEATH SYNDROME, or SIDS, claims the lives of nearly 6,000 infants in the United States every year. In fact, SIDS is the leading cause of death in infants one month to one year old.

But you can help reduce the risk of your baby's dying from SIDS simply by placing it on its back or side to sleep.

Talk to your doctor about SIDS and how you can help reduce the risk. For more information, write Back to Sleep, P.O. Box 29111, Washington, D.C. 20040, or call, toll-free:

1-800-505-CRIB

National Heart, Lung, and Blood Institute
National Institute of Child Health and Human Development
U.S. Public Health Service
American Academy of Pediatrics SIDS Alliance Association of SIDS Program Professionals

This poster informs the public about SIDS, the leading cause of death in the United States for infants between one month and one year of age, and offers information on its prevention. MICHAEL NEWMAN/PHOTOEDIT

that make them especially vulnerable to stresses that occur in the normal developmental life of an infant, including both internal and external influences. The leading hypothesis for study is delayed development of arousal, cardiorespiratory control, or cardiovascular control.

Meanwhile, research based on epidemiology and pathology has dispelled numerous misleading and harmful myths about SIDS (e.g., it is not contagious and does not run in families) and has also ruled out many factors that have been thought at various times to be the causes of SIDS. For instance, it is known that SIDS is not the result of child abuse. Likewise, SIDS is not caused by vomiting and choking, minor illnesses such as colds or infections, or immunizations such as those involved in DPT (diphtheria, pertussis, and tetanus) vaccines. Nor is SIDS the cause of every sudden infant death.

Bereavement

Any sudden, unexpected death threatens one's sense of safety and security because it forces one to confront one's own mortality. This is particularly true in an infant death because the death of a very young child seems an especially cruel disruption of the natural order: It seems inconceivable to most people, especially to new parents, that children should suddenly die for no apparent reason. The lack of a discernible cause, the suddenness of the tragedy, and the involvement of the legal system also help to make a SIDS death especially difficult for all those it touches, leaving a great sense of loss and a need for understanding.

As a result, in addition to tasks that all bereaved persons face in coping with grievous personal loss, those who have lost a child to SIDS face additional challenges. No postdeath intervention can be expected simply to dismiss such difficult challenges. However, classification of an infant's death as an instance of SIDS—naming it as an occurrence of a recognizable syndrome—may help provide some partial framework for understanding. This diagnosis can also go a long way toward easing the unwarranted guilt of survivors who might mistakenly imagine that they had somehow contributed to the death or that they could have done something to prevent it. SIDS survivors, especially parents and grandparents, are likely to require much information about the syndrome and extended support in their bereavement. Contact with others who have experienced a similar death may be particularly useful. Explaining the death to a surviving child or subsequent sibling will demand empathy and skill.

Education and Support

There is a great need at many levels in society for SIDS education and support. First responders (i.e., emergency medical personnel, dispatchers, police officers, and firefighters), day-care providers, funeral directors, and the clergy need to understand the differences between their clinical, legal, and human tasks. They must also recognize the different priorities that pertain to preventive tasks on the one hand and to emergency or follow-up tasks on the other. Counselors of all kinds must appreciate that those who are bereaved by SIDS are likely to have distinctive needs for information both about SIDS and about their own grief reactions and

coping processes. For example, counselors will want to know how to validate the experiences of SIDS survivors, enable them to obtain access to medical resources, and introduce them to other SIDS survivors. Further, counselors will want to help those affected by SIDS to be patient with others experiencing their own unique bereavement from the same loss, and to assist them in moving on. Adult survivors may need help in explaining SIDS losses and grief reactions to siblings and other children, and in addressing questions related to a possible subsequent pregnancy. SIDS support groups and bereavement-support groups in other settings (e.g., a church or hospice program) may need guidance in meeting the special needs of those touched by SIDS.

See also: GRIEF: CHILD'S DEATH, FAMILY; MORTALITY, INFANT

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SUDDEN UNEXPECTED NOCTURNAL DEATH SYNDROME

Since 1977 more than a hundred Southeast Asian immigrants in the United States have died from the mysterious disorder known as sudden unexpected nocturnal death syndrome (SUNDS). SUNDS had an unusually high incidence among recently relocated Laotian Hmong refugees. All but one of the victims were men, the median age was thirty-three, all were apparently healthy, and all died during their sleep. Despite numerous studies of SUNDS, which have taken into account such varied factors as toxicology, heart disease, sleep apnea and other

sleep disorders, genetics, metabolism, and nutrition, medical scientists have not been able to determine its exact cause. Medical opinion appears to favor an impairment of the electrical pathways and specialized muscle fibers that contract the heart. It is widely held, however, that some type of intense stressor is likely an additional risk factor.

The medical folklorist Shelley Adler postulates that a supernormal nocturnal experience that is part of Hmong traditional beliefs can trigger the fatal syndrome. The experience is referred to as a “nightmare,” not in the modern sense of a bad dream, but rather in its original denotation as the nocturnal visit of an evil being that threatens to press the very life out of its terrified victim. Hmong refugees in the United States experience a culture-specific manifestation of the universal nightmare phenomenon. The Hmong Nightmare (known as *dab tsog*) causes cataclysmic psychological stress, which can trigger sudden death. Although the Dab Tsog attack in Laos is related to the worldwide nightmare tradition, the peculiar stresses of Hmong refugee experience transformed its outcome. The power of traditional belief in the nightmare—in the context of the trauma of war, migration, rapid acculturation, and inability to practice traditional healing and ritual—causes cataclysmic psychological stress to male Hmong refugees that can result in SUNDS.

See also: CAUSES OF DEATH

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SHELLEY R. ADLER

SUICIDE

Suicide exists in all countries of the world and there are records of suicides dating back to the earliest historical records of humankind. In 2000

the World Health Organization estimated that approximately 1 million people commit suicide annually. Suicide is among the top ten causes of death and one of the three leading causes in the fifteen-to-thirty-five-years age group worldwide. In the United States, where suicide is the ninth leading cause of death (and where the number of victims is 50% higher than the number of homicides), the Surgeon General in 1999 issued a *Call to Action to Prevent Suicide*, labeling suicide “a significant public health problem.”

Suicide is a tragic phenomenon that has preoccupied professionals from a variety of disciplines. Deaths by suicide have broad psychological and social impacts on families and societies throughout the world. On average, each suicide intimately affects at least six other people, and if the suicide occurs in the school or workplace it can significantly impact hundreds. Suicide’s toll on the living has been estimated by the World Health Organization in terms of disability-adjusted life years, which indicates the number of healthy years of life lost to an illness or event. According to their calculations, the burden of suicide is equal to the burden of all wars and homicides throughout the world. Despite progress in controlling many other causes of death, suicide has been on the rise—becoming one of the leading causes of death.

The taking of one’s own life is the result of a complex interaction of psychological, sociological, environmental, genetic, and biological risk factors. Suicide is neither a disease nor the result of a disease or illness, but rather a desperate act by people who feel that ending their life is the only way to stop their interminable and intolerable suffering.

Despite the magnitude of social damage caused by suicide, it is a fairly rare event. Suicide rates of between 15 to 25 deaths per 100,000 population each year may be considered high. Most people who are seriously suicidal, even those who attempt suicide, rarely have a fatal outcome (although, in the United States, 500,000 people annually require emergency room treatment because of their attempts). For each completed suicide (a suicide that results in death) there are at least six or seven suicide attempts that result in hospitalizations and, according to community surveys, for each completed suicide at least 100 people report that they attempted suicide without being hospitalized as a suicide attempter. Furthermore, if one

asks in a community survey if people seriously considered suicide, about one person in twenty-five says that they have done so.

Research shows that the vast majority, at least 80 percent, of persons who died by suicide had been or could be diagnosed as suffering from a mental disorder, usually mood disorders and depression. People who suffer from the mental disorders of depression and manic depression, alcoholism, or schizophrenia have between a 4 percent and 15 percent lifetime risk of suicide. These mental disorders do not “cause” suicide, but people with mental disorders are at much greater risk of committing suicide. For this reason, the diagnosis and treatment of mood disorders, alcoholism, and schizophrenia may prevent suicides.

Besides mental disorders, there are numerous other risk factors that help identify who is at greater risk of suicide. The most important risk factor is gender, with men in Europe and the Americas committing suicide about five times more than women even though women are more likely to attempt suicide. People with some physical illnesses have greater suicide risks. In most countries, men over the age of seventy-five have the greatest risk of suicide of all age groups. Those who live alone or are separated are more vulnerable to suicide, including divorced, widowed, and single people. Also at higher risk are individuals who have lost a job.

Various situational factors also increase the risk of suicide. Individuals who are exposed to suicide in real life or through the media have a higher likelihood of suicidal behavior. Research on firearms and the availability of other means of suicide has shown that if a method is readily available a death by suicide is more likely to occur. For this reason control of firearms and reducing access to other preferred means of suicide, such as putting up barriers on bridges and getting rid of medications in the home of a suicidal adolescent, may help prevent suicides.

The crisis situation in which a person attempts or commits suicide is often precipitated by a stressful life event. Suicides are more likely to occur after an argument with family members or lovers following rejection or separation, financial loss and bereavement, job loss, retirement, or failure at school. Usually these events are “the last straw” for a suicidal person. They are generally not what caused the

suicide but what resulted in an increased likelihood that the suicide would occur then.

People who consider suicide generally feel ambivalent about ending their own life. It is this ambivalence that leads desperately suicidal people to talk about their plans as they “cry for help.” Telephone help lines, therapists, and friends strengthen the will to live of ambivalent people by helping them explore other options for changing their situation.

The psychoanalyst Edwin Shneidman described the mental state of suicidal individuals experiencing unendurable psychological pain and feelings of frustration. According to Shneidman, suicide is seen as the only solution to their problems, one that results in stopping intolerable feelings. Besides feeling ambivalent, suicide-prone individuals tend to have what he calls “constriction”—rigid and persistent preoccupations with suicide as the solution to their problems. These individuals believe that the drastic option of ending their own life by suicide is the only way out unless others help break this pattern of constricted thought.

Many countries, including the United States, have created national suicide prevention programs that utilize a variety of strategies. These programs involve a variety of actions. Some prevention methods begin very early, teaching young children ages five to seven how to better cope with everyday problems. Other programs focus on teaching high school students how to better recognize signs of suicide in friends and how to obtain help. Actions also focus upon educating “gatekeepers,” such as physicians, counselors, and teachers, who may come into contact with suicidal persons. The World Health Organization publishes resources on preventing suicide in its web site (www.who.org), and Befrienders International has extensive information on suicide and its prevention available in several languages at www.befrienders.org.

See also: SUICIDE BASICS; SUICIDE INFLUENCES AND FACTORS; SUICIDE OVER THE LIFE SPAN; SUICIDE TYPES

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SUICIDE BASICS

EPIDEMIOLOGY *Danielle Saint-Laurent*

HISTORY *Norman L. Farberow*

PREVENTION *Brian L. Mishara*

WARNING SIGNS AND PREDICTIONS

Brian L. Mishara

EPIDEMIOLOGY

Suicide, voluntarily taking one's own life, occurs in every country in the world. In Western societies, suicide is recognized as a leading cause of early death, a major public health problem, and a tragedy for individuals and families.

Epidemiology of Suicide

According to the World Health Organization (WHO) in 1999, suicide is among the top ten causes of death for all age groups in North America and the majority of northern and western European countries; it represents 1 to 2 percent of total mortality. Analysis of the mortality figures (see Tables 1 and 2) reveals important differences in the mortality rate between various countries and age groups.

The suicide rate in industrialized countries has increased since the beginning of the twentieth century and reached very high levels in many European countries and North America. The rise in suicides parallels the gradual increase in urbanization and education. It is also known that a major part of the increase in the suicide rate can be attributed to those people under forty years old.

Epidemiological knowledge about suicide in the world is limited to countries that report suicide statistics to WHO. The majority of countries in Africa, the central part of South America, and a number of Asian countries do not report data on suicides. What epidemiological data are available can often vary in quality. According to Ian Rockette and Thomas McKinley, the misclassification of suicide leads to underreporting. Classifying suicides as unintentional poisonings, drownings, or undetermined deaths is not unusual.

Underreporting and misclassification can be explained by social attitudes toward suicide, religious disapproval, and recording procedures. Some countries have a system whereby coroners can investigate unnatural deaths. In other countries a certificate is simply signed by the doctor. Autopsies also vary from one country to the next. For example, the autopsy rate is very high in Australia but very low in Germany. When there is no stigma associated with suicide, those close to the deceased are more likely to reveal information and characteristics about the deceased that would lead to a more accurate classification.

Suicide and Gender

In almost all countries for which statistics are available, suicide is more frequent among men than women (see Tables 1 and 2), a trend that prevails in most age groups. In a number of countries, a trend toward an increase in suicide has also been observed among men but not women. The gap in rates between men and women is smaller in Asian countries. Contrary to other countries, the suicide rate in China is higher among women than men in both rural and urban areas. However, the male-female suicide ratio is lower than in most countries.

Women's resistance to committing suicide may be explained by the strong role they play in family life, even if they work outside the home; their tasks prevent them from becoming socially and emotionally isolated. Women also seek medical treatment more often than men, increasing their chances of having any psychiatric problems detected and treated early. Conversely, men seem more vulnerable to losing their professional identity, a calamity often aggravated by solitude and loss of contact. Certain harmful behaviors linked to suicide, such as alcoholism and drug addiction, are especially common among men.

TABLE 1

| Suicide rates per 100,000 inhabitants, men and women of various countries | | | | |
|--|-------------|------------|--------------|--------------|
| Country | Year | Men | Women | Total |
| Argentina | 1996 | 12.4 | 3.3 | 7.5 |
| Canada | 1997 | 20.0 | 5.1 | 12.4 |
| Costa Rica | 1995 | 11.8 | 2.3 | 7.0 |
| Cuba | 1996 | 28.2 | 12.9 | 20.3 |
| Mexico | 1995 | 7.3 | 1.0 | 4.0 |
| United States of America | 1997 | 19.7 | 4.5 | 11.7 |
| Hong Kong | 1996 | 16.7 | 9.2 | 12.9 |
| Israel | 1996 | 9.9 | 3.0 | 6.3 |
| Singapore | 1997 | 17.1 | 8.6 | 12.6 |
| Austria | 1997 | 30.1 | 18.6 | 9.0 |
| Belarus | 1997 | 66.8 | 10.2 | 36.0 |
| Bulgaria | 1997 | 24.5 | 9.4 | 16.4 |
| Estonia | 1996 | 68.9 | 13.0 | 38.4 |
| Finland | 1995 | 44.0 | 11.8 | 27.4 |
| France | 1996 | 29.0 | 9.8 | 18.8 |
| Germany | 1997 | 21.7 | 6.8 | 13.7 |
| Greece | 1997 | 5.9 | 0.1 | 3.4 |
| Hungary | 1995 | 53.6 | 15.0 | 32.5 |
| Ireland | 1996 | 20.4 | 3.7 | 11.9 |
| Italy | 1995 | 11.6 | 3.3 | 7.2 |
| Kazakstan | 1997 | 62.8 | 10.7 | 35.0 |
| Kirgyzstan | 1997 | 18.0 | 3.7 | 10.8 |
| Netherlands | 1995 | 13.2 | 6.4 | 9.7 |
| Norway | 1995 | 19.2 | 6.4 | 12.7 |
| Poland | 1996 | 26.1 | 4.7 | 14.9 |
| Portugal | 1997 | 10.2 | 2.5 | 5.9 |
| Romania | 1997 | 23.2 | 4.2 | 13.4 |
| Russian Federation | 1997 | 69.9 | 11.7 | 38.4 |
| Spain | 1995 | 12.4 | 3.3 | 7.5 |
| Sweden | 1996 | 19.5 | 7.9 | 13.6 |
| Ukraine | 1997 | 54.6 | 9.4 | 29.7 |
| United Kingdom | 1997 | 11.2 | 3.1 | 7.1 |
| Australia | 1995 | 19.7 | 5.2 | 12.3 |
| New Zealand | 1996 | 24.2 | 6.0 | 14.8 |

SOURCE: World Health Organization, 1999.

Suicide and Age

According to David Lester, the suicide rate increases with age among men and varies with age among women. In industrialized countries, the rate is higher for women in their middle ages. In poor countries, the suicide rate is higher among young women. In many industrialized countries and even in small communities, statistics show an increase in suicide among young people, especially among young men. In many areas, namely North America, suicide is the leading or second leading cause of death among young males. Suicide among children under the age of twelve is rare. The incidence of suicide rises sharply at puberty; the highest youth suicide rates occur during adolescence or early adulthood. The increase in suicide among youth dovetails with an overall rise in youthful depression. In addition, the earlier onset of puberty induces adult stresses and turmoil at an earlier age,

including sexual activity and the abuse of alcohol, tobacco, and drugs.

Methods of Suicide

Methods of suicide vary greatly among different countries, depending on cultural traditions and social and political conditions. According to Canetto and Lester, the use of firearms in suicide deaths is definitely higher for both men and women in the United States than in Canada. This is mainly due to the large number of firearms in circulation and the absence of restrictions on access to them. In many countries, the use of firearms in suicide deaths is higher in rural areas than in urban ones because there are more hunters in rural areas.

Another interesting example of the link between methods and their availability is that of domestic gas in England used for exhaust poisoning. When England lowered the toxicity of domestic gas, suicide by this method was eliminated in the country and suicides decreased by one-third. Other countries such as Switzerland, Ireland, and Scotland have also reported changes in the suicide rate following the detoxification of gas.

There are also major differences in how men and women in Western countries commit suicide. Many men shoot and hang themselves while women tend to poison or hang themselves. In industrialized and developing nations, women most frequently use chemical products intended for agriculture.

Theories

Suicide has been the subject of many studies dating back to Émile Durkheim's *Le Suicide* (1897). At the dawn of the twenty-first century, however, no theory on suicide has been accepted by a majority of researchers.

Suicide may be associated with various pathologies. In Western societies, for example, suicide is considered to be a reflection of the social ills associated with crises such as unemployment, insecurity, weakness, or the loss of income, all of which contribute to the breakdown of family ties and the mental and physical isolation of individuals. Suicide often leads to various forms of exclusion in Western societies, in particular social isolation.

Although Durkheim's theory has been influential, it has not gained universal acceptance as an

TABLE 2

| Suicide rates per 100,000 inhabitants of various countries, men and women by age group | | | | | | | | | |
|---|-------------|-------------------|-------|-------|-------|---------------------|-------|-------|------|
| Country | Year | Men (ages) | | | | Women (ages) | | | |
| | | 15–24 | 25–44 | 45–64 | 65 + | 15–24 | 25–44 | 45–64 | 65 + |
| Argentina | 1996 | 8.8 | 9.8 | 18.5 | 28.7 | 3.4 | 2.9 | 5.0 | 6.2 |
| Canada | 1997 | 22.4 | 25.0 | 25.5 | 23.0 | 4.5 | 6.6 | 7.6 | 4.5 |
| Costa Rica | 1995 | 11.8 | 16.3 | 15.2 | 9.2 | 4.0 | 2.9 | 3.1 | 0.0 |
| Cuba | 1996 | 14.2 | 25.3 | 33.8 | 83.8 | 13.1 | 12.9 | 15.3 | 26.6 |
| Mexico | 1995 | 7.6 | 8.4 | 8.0 | 1.8 | 2.0 | 1.1 | 1.1 | 1.1 |
| United States of America | 1997 | 18.9 | 23.8 | 22.5 | 33.9 | 3.5 | 6.0 | 6.5 | 4.9 |
| Hong Kong | 1996 | 11.8 | 17.9 | 20.1 | 34.1 | 7.5 | 8.3 | 9.0 | 27.4 |
| Israel | 1996 | 8.6 | 9.7 | 10.4 | 26.9 | 1.8 | 2.6 | 3.9 | 8.4 |
| Singapore | 1997 | 9.1 | 17.8 | 17.8 | 44.9 | 8.5 | 2.4 | 8.1 | 21.8 |
| Austria | 1997 | 24.3 | 30.9 | 35.8 | 68.2 | 4.8 | 8.7 | 12.8 | 20.8 |
| Belarus | 1997 | 32.9 | 79.3 | 116.5 | 81.3 | 6.7 | 9.8 | 16.4 | 17.8 |
| Bulgaria | 1997 | 14.1 | 18.5 | 33.4 | 63.5 | 4.8 | 7.3 | 12.1 | 29.0 |
| Estonia | 1996 | 34.9 | 72.6 | 120.8 | 84.2 | 7.8 | 9.9 | 22.5 | 28.8 |
| Finland | 1995 | 36.6 | 60.1 | 56.5 | 51.9 | 8.4 | 16.4 | 17.0 | 11.0 |
| France | 1996 | 12.8 | 35.6 | 36.8 | 58.5 | 4.2 | 10.5 | 16.3 | 17.4 |
| Germany | 1997 | 12.9 | 22.4 | 29.2 | 45.3 | 3.2 | 6.3 | 10.7 | 16.7 |
| Greece | 1997 | 2.8 | 7.0 | 7.6 | 9.7 | 0.8 | 0.8 | 1.4 | 2.0 |
| Hungary | 1995 | 19.2 | 56.6 | 77.6 | 112.8 | 3.8 | 13.1 | 23.1 | 41.2 |
| Ireland | 1996 | 25.4 | 32.0 | 19.7 | 15.8 | 4.5 | 5.3 | 5.4 | 1.3 |
| Italy | 1995 | 7.3 | 11.2 | 14.5 | 29.8 | 1.6 | 3.1 | 5.2 | 7.7 |
| Kazakstan | 1997 | 46.5 | 74.8 | 96.1 | 80.4 | 12.6 | 11.0 | 13.1 | 18.5 |
| Kirgyzstan | 1997 | 20.6 | 26.2 | 42.6 | 35.9 | 4.0 | 4.8 | 7.6 | 11.1 |
| Netherlands | 1995 | 9.2 | 16.9 | 16.7 | 20.9 | 4.4 | 7.6 | 8.8 | 10.3 |
| Norway | 1995 | 22.6 | 22.0 | 22.9 | 28.8 | 5.5 | 7.6 | 8.9 | 7.4 |
| Poland | 1996 | 17.2 | 31.8 | 41.6 | 30.8 | 2.9 | 4.7 | 8.4 | 7.0 |
| Portugal | 1997 | 4.3 | 9.3 | 11.0 | 32.2 | 1.2 | 2.3 | 3.7 | 6.4 |
| Romania | 1997 | 10.7 | 28.1 | 37.1 | 28.5 | 2.6 | 3.6 | 7.3 | 7.4 |
| Russian Federation | 1997 | 53.5 | 87.2 | 97.0 | 97.7 | 9.0 | 11.6 | 15.8 | 24.8 |
| Spain | 1995 | 8.7 | 12.1 | 14.4 | 32.3 | 2.1 | 2.8 | 5.1 | 8.5 |
| Sweden | 1996 | 12.0 | 22.6 | 29.1 | 32.8 | 4.6 | 8.0 | 14.0 | 12.6 |
| Ukraine | 1997 | 26.6 | 63.3 | 89.3 | 80.3 | 4.8 | 8.6 | 15.4 | 20.4 |
| United Kingdom | 1997 | 11.1 | 16.2 | 12.9 | 12.5 | 4.9 | 4.4 | 4.0 | 0.0 |
| Australia | 1995 | 23.1 | 27.9 | 21.6 | 21.4 | 6.1 | 6.7 | 7.0 | 5.1 |
| New Zealand | 1996 | 37.8 | 33.3 | 21.5 | 28.6 | 13.9 | 6.0 | 5.9 | 5.3 |

SOURCE: World Health Organization, 1999.

exhaustive framework. His theory contributes to the understanding of how social integration and cohesion influence suicide. Durkheim explained how individual pathology was a function of social dynamics and the underlying reason for suicide occurrence. The anomic suicide defined by Durkheim is associated with societal crises of economic or social nature. Suicide existed before the acculturation, exclusion, and complex changes characteristic of Western societies. In smaller communities, suicide is not associated with social alienation and urbanization, according to Tausignant. In some of these smaller communities, suicide is often a means of making amends or seeking redemption in the eyes of the community. In this context, suicide is a social regulator rather than an anomic gesture. People who commit suicide in these smaller communities appear not to live on

the fringe of society, but are socially integrated in their society.

In addition to social factors, individual and biological factors are also associated with suicide, notably the presence of psychiatric problems. People who suffer from depression or other mental problems are statistically more at risk of suicide than the rest of the population. However, though mental disease is a risk factor that increases the probability of suicide, it does not itself explain the occurrence of suicide. Other individual syndromes associated with suicide are antisocial behavior and the abuse of drugs and alcohol. More recent studies have also linked genetic and biological factors to suicide, such as gender and serotonin production problems.

To counter the problem of suicide, many countries have set up prevention programs that focus

on early detection of mental disease and more adequate treatment of potential victims. Other programs seek to purvey more accurate information about the problem through the media. Legislation restricting the use of firearms, the restriction and control of toxic substances, and the detoxification of domestic gas are the most common and successful preventive measures in advanced industrialized countries.

See also: DURKHEIM, ÉMILE; HOMICIDE, EPIDEMIOLOGY OF; SUICIDE; SUICIDE BASICS: PREVENTION; SUICIDE INFLUENCES AND FACTORS: ALCOHOL AND DRUG USE

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HISTORY

Although suicide has been recorded in both written and oral records in the history of man from primitive times on, no word existed for the phenomenon until the seventeenth century. According to the *Oxford English Dictionary*, the word *suicide* was first used in 1651, but Alfred Alvarez reported in 1972 that it appeared in Sir Thomas Browne's *Religio Medici* in 1642. The *Oxford English Dictionary* states that the word *suicidium* was actually derived by combining the Latin pronoun for "self" and the verb "to kill." The word sounds deceptively Latin, but Henry Romilly Fedden, in his 1938 book *Suicide*, stated that the Romans described the act using Latin phrases, such as *vim sibi inferre* (to cause violence to oneself), *sibi mortem consciscere* (to procure one's own death), and *sua manu*

cadere (to fall by one's own hand). Early English also used phrases, such as self-murder, self-destruction, and self-killer, all of which reflect the early association of the act with murder.

Primitive and Traditional Societies

There is reliable evidence that suicide was present in most primitive tribes around the world, almost always associated with evil spirits, revenge, and unappeased anger. These attitudes in the form of superstitions and fears of magic found their way into Christianity as taboos that have persisted to this day. Attitudes toward suicide, however, have shown great variability depending on the culture and the part of the world. In primitive societies suicide was variously used as a means to exact vengeance, as a way of placing responsibility for the death on the person who had supposedly caused it, and as a way of embarrassing an adversary.

In other cultures suicide was not only tolerated but actually encouraged. The Goths and the Celts believed that to die naturally was shameful. Vikings unlucky enough not to die in battle fell on their own swords or jumped off cliffs in order to be able to enter Valhalla (the great hall of Odin for slain heroes in Norse mythology). And some Eskimo tribes believed it was better to kill oneself before growing feeble because people entered the next life in the same condition they left this one. In a number of societies tradition demanded that wives, retainers, servants, and ministers kill themselves so that they could continue to administer to the needs of their master after he died. Sometimes there was competition among the wives to be the first to follow the husband in death because that privilege identified his favorite. In Hindu India, the practice of *suttee*, the suicide of a widow by self-immolation on the funeral pyre of her husband, is reported to continue in some rural parts of the country, although it has long since been outlawed. Generally, however, the Hindu attitude toward suicide is ambiguous, condemning it but calling it justified in special cases, such as when a person has lived a full life or has achieved a special level as an ascetic.

In early Oriental sacred writings, suicide was viewed with contradictory attitudes that both encouraged and condemned it. In ancient China the ceremonial sacrifice of widows was almost as commonplace as it was in India; it was also reported to occur frequently because of the wretchedness of

people's lives. In Japan, Buddhist tradition institutionalized suicide with several kinds of *seppuku*, a ritual form of disemboweling oneself that was used to admit failure, atone for a mistake, or avoid humiliation. Among the samurai, the professional warriors of feudal Japan, *seppuku* was incorporated into an ethical code known as *Bushido*, which required the warrior to follow his dead lord into the next life, to regain honor when revenge was not possible, and to avoid execution by the enemy in a lost battle. Brahmanism was sympathetic to suicide in that its philosophy incorporated denial of the body and the separation of the body from the soul in the intensive search for knowledge. Mohammedism condemned suicide with great severity, calling suicide a rejection of the divine will, which was expressed in many different ways and to which humans must submit themselves at all times.

The Jewish Tradition

Suicide among the Jews is generally infrequent, mostly because the value of life itself was so highly emphasized in the Torah. In the Old Testament of the Bible, a Jew is allowed to transgress every religious commandment in order to save his life except in cases of murder, incest, and the denial of God. Suicide was wrong, but was acceptable in instances of imminent capture and torture, apostasy, and shame or dishonor. Neither the Hebrew Bible nor the New Testament condemns nor condones suicide—nor does either contain the word *suicide*. The occasions of such deaths are described simply, briefly, and factually: Samson brought the temple of the Philistines down upon himself in order to kill his captors (Judg. 16:28–31); Saul, facing capture, disgrace, and torture in a defeat by the Philistines, fell on his own sword (1 Sam, 31:1–6); and Abimelech, not wanting the disgrace of being killed by a woman, killed himself (Judg. 9:54); Ahithophel chose to hang himself after he supported Absalom's unsuccessful revolt against King David (2 Samuel 17:23); Judas Iscariot simply "went and hanged himself" (Colt, 1991 p.153).

The Jews were involved in a number of mass suicides. In an early instance, Josephus, the Jewish general who later became a Roman historian, decided to surrender to the Romans when his army was defeated. His soldiers argued they should all kill themselves instead. They were able to overcome Josephus's arguments and proceeded to kill

each other, but he was able to survive by persuading the last remaining soldier that the two of them should save themselves. The best-known occasion was the death in 74 C.E. of 960 Zealots who defended Masada through three years of siege by the Roman army and, facing capture, were persuaded by their leader, Eleazar Ben Zair, that death by their own hand was better than the slavery they faced when captured.

The Egyptians, Greeks, and Romans

The first recorded reference to suicide comes from ancient Egypt (about 4,000 years ago) in *The Dispute between a Man and His Ba*, in which a man describes the injustice and greed of his times to his *ba*, or soul, which has threatened to leave him if he kills himself, thus depriving him of an afterlife. There was no dishonor associated with the act of suicide itself, for death was seen as a mere passage from this life to the next and as a convenient way to avoid excessive pain or dishonor. The dead were considered coequals with the gods and to have the same physical and emotional needs as the living.

Suicide among the ancient Greeks and Roman varied widely with respect to tolerance and legal restrictions. The primitive attitudes of horror and condemnation for suicide were preserved in the lower classes, but the upper classes were more tolerant and accepting. Four motivations appeared most often: the preservation of honor, the avoidance of excessive pain and disgrace, bereavement, and patriotism. The major concern was honor, whatever the origin, such as patriotism, pride, or protecting one's virtue.

Among those opposing suicide, the Pythagoreans disapproved because it interfered with the regular orderly process of transmigration of souls on Earth, skewing the process. Socrates (c. 470–399 B.C.E.), possibly the most famous of Greek suicides, actually opposed suicide, reasoning that humans belonged to God, so suicide was destruction of God's property. Both Aristotle (384–322 B.C.E.) and Plato (c. 428–348? B.C.E.) condemned suicide but made exceptions, such as intolerable disgrace, unavoidable misfortune, or extraordinary sorrow. Aristotle felt that people belonged to the state, which made suicide a punishable act against the state. Plato considered a person to be a soldier of God, so the suicide deserted God, not the state.

Suicide to avoid suffering was considered cowardice and weakness of character; suicide was acceptable, however, in cases of incurable illness or when God had summoned the soul. The Epicureans and Stoics, on the other hand, considered suicide an appropriate escape from the sufferings of physical illness and emotional frustration. For them neither life nor death was as important as one's right to decide about both. The manner of death was important, and suicide was often a carefully chosen validation of the principles by which one had lived.

Among the Romans, Pliny the Elder (23–79 C.E.) considered the existence of poisonous herbs as proof of a kindly Providence because they allowed a person to die painlessly and quickly. Suicide among the Romans became more and more economically oriented. The right to commit suicide was denied to a slave because it was considered a financial loss to the master. Likewise it was denied to a soldier because it weakened the armed forces. If a civilian committed suicide while under arrest, the state was deprived of taxes and services so punishment consisted of forfeiture of the estate. Suicide among the upper classes, however, was acceptable, in part because the attitude toward death had become so casual and public that death itself had little or no meaning. The records contain the names of many notables in Roman history who chose suicide to avoid defeat or dishonor or out of grief, including the poet Lucan (39–65 C.E.); the defeated general Cato (95–46 B.C.E.); Petronius (d. 66 C.E.), the gifted playwright and author; Paulina, the wife of Seneca (4 B.C.E.–65 C.E.), who was allowed to kill himself when sentenced to death by the emperor Nero; and Nero (37–68 C.E.) himself.

Pre-Reformation Christianity

Christianity has contained markedly opposing attitudes toward suicide over time. The early era found suicide not only tolerated but also embraced by the church. Life was difficult, and the objective in life became to avoid sin and gain entrance before God and live there forever. Martyrdom was a quick way of achieving this eternal salvation. It guaranteed redemption for all sins incurred before death and was a way to provide for the members of the martyr's family, who were then taken care of by the church for the rest of their lives. As a result, martyrdom was eagerly sought, oftentimes by deliberately provoking the Roman authorities.

In the fourth century C.E., as Rome's influence declined, the attitude of the church underwent several changes. The church's attitude toward suicide became progressively more hostile, moving from tentative disapproval to severe denunciation. St. Augustine, writing in *The City of God* in the fourth century, declared that suicide was murder; that no private person could assume the right to kill anyone, including herself; that suffering is sent by God and is to be endured; and that suicide is the worst of sins because it precludes any possibility of absolution.

A series of church councils in the next several centuries progressively increased the condemnation and punishments with pronouncements denying funeral rights, forbidding burial within church cemeteries, and denying the saying of mass for the deceased. The penalties and the denial of burial rights suggest a reemergence of some of the early pagan horror of such deaths and were the basis for many of the practices that appeared later in many countries, such as desecrating the corpse of a person who committed suicide, mutilating the body, and burying it in a crossroad with a stake through the heart. In the thirteenth century, Thomas Aquinas summarized the position of the church in *Summa Theologica*. He stated that suicide was absolutely wrong because self-destruction was contrary to a person's natural inclinations; because a person has no right to deprive society of his presence; and because people are God's property so it is up to God, not people, to decide on life and death. Dante's *Inferno* (part of *The Divine Comedy*, which was completed in 1321) depicted the attitude of the time by showing the suicides condemned to eternal unrest in the woods of self-destruction.

Renaissance, Reformation, Enlightenment

With the Renaissance and the Reformation of the fifteenth through seventeenth centuries came a marked shift in the attitudes toward suicide. Values in religion began to change as German religious reformer Martin Luther's (1483–1546) arguments emphasized personal inquiry and responsibility and raised questions about the absolutism and obedience demanded by the church. Italy experienced a revival of learning, and a number of writings helped soften the absolute condemnation of suicide. Among these, English poet John Donne's *Biothanatos* (1644) is considered the first defense of suicide in English. Shakespeare incorporated fourteen suicides into his eight tragedies. Most of

this change took place in the upper classes, with the lower classes remaining staunchly against suicide and continuing the custom of mutilation of the corpse all the way into the nineteenth century. The Industrial Revolution of the eighteenth century and the rise of commercialism resulted in a drastic change in the attitude of society toward the poor. Economic failure became a mark of sin, with the good being rewarded with prosperity and the poor becoming social and moral outcasts. In a 1732 incident, Richard and Bridget Smith killed their daughter and hanged themselves, leaving a bitter note blaming their fear of worsening poverty.

Writers and philosophers in this period through the eighteenth and nineteenth centuries (later known as the Enlightenment) wrote learned discourses on suicide. Some of these were sympathetic and focused on the rights of the individual. Such works included the English clergyman Robert Burton's *Anatomy of Melancholy* (1621) and the Scottish philosopher and historian David Hume's *An Essay on Suicide* (1783). Others held to the familiar arguments of duty to the state, the virtue of suffering, responsibility to the family, and the preservation of life as a primary law of nature. Among this group of writings was the German philosopher Immanuel Kant's *The Metaphysics of Ethics*.

The last half of the eighteenth century and the first half of the nineteenth became known as the Romantic Age because of the impact the Romantic poets of that era had on the concept of death. The suicide by poison of the English poet Thomas Chatterton (1752–1770) at age seventeen was taken as a model—premature death in blazing genius—in which youth, death, and poetry became synonymous. According to George Howe Colt, writing in his 1991 book *The Enigma of Suicide*, “The poetic sensibility was too good for this world; it was best to burn brightly and to die young, like a shooting star” (Colt 1991, p. 81).

The greatest change in the nineteenth century was the association of the word *disgrace*, a social value, with suicide. Survivors felt disgraced and the status of the family in the community sank. As suicide became more and more associated with mental illness, it was more often hidden, especially among the upper classes. The family thus often had the dismal choice of identifying their suicidal beloved one as either a weak sinner or a

disturbed lunatic. Debates about social responsibilities versus individual rights and about the relationship between civilization and mental illness became common.

Studies appeared in two major domains—statistical (social) and medical (at first neurobiological and later psychological). Relationships between suicide and epidemiological factors, such as age, sex, marital status, socioeconomic class, occupation, and climate, were investigated. Some studies of suicide explored possible links of social factors with physiological symptoms (e.g., pulmonary conditions, cancer); others linked the social factors with behavioral and relational factors (e.g., trouble at home, intense worry, poverty, misery, alcoholism). French physician Jean-Étienne Esquirol, author of *Mental Maladies* (1838), maintained that suicide was almost always a symptom of insanity but was not a disease per se. Italian physician Henry Morselli, author of *Suicide: An Essay on Comparative Moral Statistics* (1881), held that suicide was primarily the result of the struggle for life and nature's evolutionary process. He concluded that suicide could be lessened only by reducing the number of people, and that could be accomplished only through birth control. Morselli blamed Protestantism, free discussion, and individualism for the increasing number of suicides.

Near the end of the nineteenth century, Émile Durkheim's *Suicide* (1897) established the field of sociology by offering the first comprehensive theory of suicide. Durkheim's theory postulated that two basic social forces exist and interact within any society—regulation and integration. Societies that were chaotic and confused produced “anomic” suicides; societies characterized by excessive constraints were likely to develop “fatalistic” suicides; societies in which the individual felt alienated and separate would have “egoistic” suicides; and in societies in which there was overidentification with the values or causes of a person's group, the suicides would be “altruistic.” Durkheim's theory stimulated a continuing array of sociological-statistical investigations. It has been modified in innumerable ways, none of which seriously challenged his basic underlying theory.

Twentieth Century and Beyond

The early twentieth century was distinguished by the radical new innovations introduced into the

field of psychiatry by psychoanalysis, especially in the study of the motivations and dynamics of suicide. The psychoanalytic approach of the Austrian neurologist Sigmund Freud delved into the individual searching for hidden conflicts, repressed memories, and complex defenses in a proposed new conceptual structuring of the personality into three layers: id, ego, and superego. Freud's first formulation of suicide, found in his essay “Mourning and Melancholia,” developed from his studies of melancholia and depression. In this work, Freud contended that suicide resulted from rage originally directed against a loved one but now acted out on an image of that person that has been incorporated into the self. Not completely satisfied with this formulation, Freud later proposed, in his book *Beyond the Pleasure Principle* (1922), that suicide was an expression of the death instinct (Thanatos), which existed in continuous conflict with the life instinct (Eros), and which became more powerful in situations of extreme emotional distress.

The American psychiatrist Karl Menninger, in his 1938 book *Man against Himself*, extended Freud's concept of the death instinct and hypothesized that three elements exist in constantly shifting patterns in all self-destructive behavior—the wish to kill, the wish to be killed, and the wish to die. Other psychoanalysts formulated theories consistent with their own concepts of the important elements in personality development.

Investigations into the problems of suicide continued through the first half of the twentieth century with relatively little interest professionally or concern by the public, despite suicide as a mode of death appearing consistently in the list of the top ten causes of death in the United States. The establishment in 1958 of the Los Angeles Suicide Prevention Center, which provided a model for immediate consultation, guidance, and assistance to the suicidal person in the community by means of the telephone, initiated a belated reawakening of interest in the phenomenon. Since then, activity in the field has grown exponentially with the founding of various national professional associations, an international association, and several professional journals that publish articles primarily on suicide. Research is exploring various aspects of suicide with questions that sound strikingly similar to the questions raised in previous centuries. These questions are epidemiological, demographic, biological, constitutional, neurological, psychiatric,

psychological, psychodynamic, and sociocultural in nature, and the questions explore such areas as mental illness, prevention, public health, individual rights, family obligations, treatment, and survivor relationships. The sinner/criminal suicide of yesterday is recognized today as a complex, multifaceted biopsychosociocultural phenomenon.

See also: SUICIDE; SUICIDE INFLUENCES AND FACTORS: CULTURE; SUICIDE TYPES: THEORIES OF SUICIDE; WIDOW-BURNING

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PREVENTION

Suicide prevention involves actions to intervene in an individual's suicidal pattern or mindset as well as a variety of public health measures to reduce the incidence of suicidal behavior in a community. There are many ways to prevent suicides. Suicides are the result of a combination of multiple risk factors, including mental disorders, personal characteristics, inadequate coping skills, and environmental variables, such as recent losses, lack of social support, and availability of lethal means. Any activities that help reduce risk factors, such as

treating mental disorders and psychiatric difficulties, increase one's ability to cope with stressful situations and problems. Preventing or treating alcoholism and drug abuse and ensuring that people develop good social support systems have some effect in preventing suicides. National strategies that focus upon decreasing the number of deaths by suicide in a country generally take a combined approach, in which various types of complementary programs and services are provided in order to decrease the incidence of suicide.

Primary Prevention of Suicide

Suicide prevention may focus on primary prevention, which involves developing skills or reducing risk factors in order to prevent people from becoming suicidal. Primary prevention strategies can either focus on an entire population or specific high-risk groups. An example of a primary prevention program that focuses on the general population is National Suicide Prevention Week—a week of activities in which media reports and a publicity campaign focus on teaching the general population how to get help, give help, or identify suicide risk. Another example of primary prevention for a large population is a high school program, in which teachers, support staff, and students learn about suicide, particularly how to know when a student is at risk and how to find and use available resources for oneself and for others.

Some primary prevention strategies focus on suicide, such as in the previous example of a high school suicide prevention program. However, many primary prevention strategies do not focus directly on suicide but are concerned more with general risk factors, such as poor coping skills or stress related to school examinations. For example, research studies indicate that adolescents who attempt suicide have fewer coping strategies than adolescents who do not attempt suicide. The Reaching Young Europe program, called "Zippy and Friends," is offered by the Partnership for Children in different European countries. As a twenty-four-week program, it focuses upon teaching coping skills to young children. Although suicide is not mentioned in this program, it is assumed that children who can better cope with everyday problems will eventually be at lower risk of suicide because problematic situations will not become so severe that they will consider detrimental behavior or engage in behavior to end their own lives.

Primary prevention strategies that focus on high-risk groups try to identify people who are more likely to commit or attempt suicide. For example, high-risk groups include persons in custody, young gays and lesbians, persons who previously attempted suicide, and persons with mental health disorders, notably mood disorders such as depression, as well as schizophrenia, and alcoholism. Sometimes prevention programs for high-risk groups focus on all people in that risk group. For example, a program for Native people may focus upon the entire community and aim to develop better intergenerational cooperation and establish an identity using role models from traditional Native practices.

Public education programs generally focus on reducing the stigma associated with seeking treatment and providing social support for those who are depressed and suicidal. They may involve a popular spokesperson who is open and frank and whose discussions of suicide may encourage others to seek professional help and talk about their problems with friends and loved ones.

Secondary Prevention

Secondary prevention strategies involve interventions with people who are already suicidal or at high risk of suicide in order to reduce the probability that they will commit suicide. Suicide prevention hotlines and telephone crisis intervention services are regularly available in most developed countries and many less developed parts of the world. These centers vary from “active listening” services, where people can talk about any problem, to more specifically focused suicide prevention organizations that evaluate suicidal risk and urgency in all calls and focus their efforts on helping suicidal persons, friends and family members of suicidal persons, and sometimes persons bereaved by suicide. They are generally based upon the belief that suicide is a means of coping with a seemingly impossible and interminable situation or problem and suicidal people are ambivalent about using suicide as a solution.

Ambivalence in the suicide-prone is expressed in their desire to seek some other means of diminishing their anguish or problems. This leads them to contact a telephone help line. Suicide prevention help lines generally begin by assessing the urgency of the situation, that is, whether or not the

person is likely to commit or attempt suicide in the near future. If the urgency is high, trained personnel may then focus upon seeking short-term solutions, such as sending an ambulance during an attempt or getting immediate help in a crisis situation. If the urgency is less high, they may focus upon exploring alternative means to resolve the caller’s problems, or they may simply offer compassionate empathic listening. It is assumed that being able to talk about one’s problems with a compassionate stranger helps the callers better understand what is going on, feel better about themselves, and encourages them to learn about other services that are available in their community. There is evidence that hotlines do help many callers. Although it is difficult to prove, studies indicate that help lines prevent suicide attempts and completed suicides.

There is substantial evidence that reducing the availability and lethality of means of suicide has a preventive effect. The risk of suicide in a home where there is a firearm is five or six times greater than in a home without guns. Countries that have adopted strict gun control regulations appear to have reduced suicide rates. Although someone who is determined to commit suicide can always find some means of completing the suicide, some people prefer certain methods and are less likely to kill themselves if those methods are not readily available. Furthermore, in a crisis situation, the availability of lethal means greatly increases the probability that a death by suicide will occur. Reducing the availability of means is not limited to gun control or making sure that firearms are taken out of the home of someone who is suicidal. Other prevention methods include constructing barriers on bridges to prevent people from jumping, constructing “suicide pits” beneath the rails of subway train lines so that people who jump in front of trains are less likely to be killed, and educating parents to dispose of potentially lethal medications in the homes of suicidal teenagers.

One of the most promising methods of suicide prevention is what is called “gatekeeper” training. Gatekeepers are people who may come into contact with suicidal individuals in their daily work, such as clergy, police officers, custodial personnel, teachers and school personnel, and physicians. Very often, these individuals receive little or no specific training in the identification of suicide risk and how to help suicidal individuals. Gatekeeper

training involves not only information about assessing risk and intervening with suicidal people, but generally provides information on referral and help available from other services within their community, including treatment of depression, alcoholism, and drug abuse.

There has been much public health interest in training physicians to identify suicidal individuals and depression. This interest was enhanced by results from the Island of Gotland in Sweden, where a physician training program focusing upon the recognition and treatment of depression and suicide was evaluated. This training program resulted in increased identification and treatment of depression and a decrease in suicides on the island. Research has shown that as many as 50 percent of those who commit suicide consult a physician in the month before their deaths. For this reason, physician training is considered an important means of suicide prevention.

People who attempt suicide are at least a hundred times at greater risk of a future suicide attempt and dying by suicide than persons who have never attempted suicide. Suicide attempters who are treated in hospitals often do not appear for their first or second outpatient appointment after they leave the hospital. There are few follow-up programs that focus upon changing the circumstances that contribute to the increased risk of suicide before an attempt. One of the problems with the follow-up of those who have attempted suicide is lack of coordination and collaboration between different community services and agencies. In many suicide prevention centers, over 50 percent of callers also receive professional mental health services, but there is often little communication or collaboration between the different agencies. National strategies for suicide prevention often focus upon coordination of all services within a community and the development of protocols for collaboration to facilitate referrals between agencies.

Suicide Prevention in a Place Where a Suicide Has Occurred

When a suicide occurs in a school or at the workplace, there is an increased risk of another suicide or suicides occurring in the same environment. Public health officials have developed several programs to prevent the so-called contagion of suicide following such events. It is usually thought that the

risk of more suicides increases because people who are bereaved by suicide are more vulnerable. Also, there is a tendency to identify with the suicide victim and fantasize about obtaining all the attention that the suicide provoked. For these reasons, several programs have been developed to prevent increased suicidal behavior in schools or workplaces where a suicide has occurred. These programs usually involve offering help to those who are troubled by the suicidal death and helping educate people about the nature of suicide and the resources for prevention. In any program following a suicide (often called “postvention programs”) it is important to be aware that too much public attention to the event may help glorify the suicide in the eyes of vulnerable suicidal people. Successful programs do not have a fixed agenda about how to deal with a suicide event, but rather emphasize an understanding of the individual needs of people who were exposed to the suicide. They also focus on the need of family and friends to grieve in an appropriate manner.

Social Interventions

Suicide is an intentional behavior whose expression is greatly influenced by the cultural milieu. In some cultures suicides are common; in others they are rare. Although in Western cultures men commit suicide more often than women, there are areas of the world, such as China, where a significant portion of suicides are by women who do not want to be a financial burden to their families. In some cultures, including the United States and Canada, some people have killed themselves in a copycat manner following the publicized suicide of a rock star. The option of killing oneself under specific circumstances is acquired at a young age. In each culture, children learn when and how people kill themselves. In most Western countries children’s first experiences with suicide are from exposure to television and other media depictions of fictional suicides and suicide threats, including suicides in popular cartoons. One may ask if it is possible to prevent suicides within a society by modifying the way the option of suicide is transmitted from generation to generation and changing attitudes and knowledge about suicide within the society.

A large body of research has shown that media depictions of suicides result in an increase in suicidal behavior by those who identify with the suicide victim. The emphasis in research on media



The East Japan Railway Company installed a large, stainless steel mirror in one of its Tokyo subway stations to prevent suicidal passengers from leaping onto the tracks. The purpose of this innovative method of prevention is to make people see their reflection in the mirror and think again about their suicidal behavior. AFP/CORBIS

and suicide has generally been negative: that is, it explores how media, such as television, newspapers, and the cinema, actually increase the incidence of suicide. There have been no studies of how the media may help prevent suicide. Researchers question if it is possible to reduce suicidal behavior in a society by developing media depictions and social campaigns that aim to change attitudes about the acceptability of suicide. These “positive” advertising campaigns are represented by National Suicide Prevention Days or Suicide Prevention Weeks, in which there is an objective of educating the population about the tragedy of suicide and how suicide may be prevented. Evaluations of the Quebec Suicide Prevention Week indicate that this national educational campaign’s target population retained the positive messages the campaign conveyed. Although it is difficult to change attitudes and beliefs in a society, they can change over time. For example, the twentieth century has seen impressive changes in attitudes toward women’s rights, women’s participation in society, and sex role stereotypes. Similarly, one could

imagine that attitudes toward suicide as an acceptable “way out” in certain circumstances could change if appropriate actions were taken to educate the population and influence how suicide is perceived.

See also: SUICIDE; VARAH, CHAD

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WARNING SIGNS AND PREDICTIONS

Suicide is a rare event. Most suicidal people find other solutions to their problems and do not attempt or commit suicide. Because of the large number of suicidal persons and small number of suicides, individual suicides are impossible to predict in a reliable manner. However, there are a number of warning signs that can help determine if a person is at risk. Many more people will always be identified as at risk than actually attempt or commit. Since the outcome is irreversible and tragic, it is best to take all indications of suicide risk seriously.

Who Is at Risk?

Although people with any characteristics can commit suicide, some people are more at risk of suicide than others. People who can be identified as having the following characteristics are more likely to be suicidal than those of the general population.

Persons with mental disorders or psychiatric problems are at great risk of suicide, particularly those suffering from clinical depression. Alcoholics and drug abusers are another category of individuals at great risk. Suicide risk may be greater for persons who discontinue medication they are taking for mental health problems. People who have previously attempted suicide are at greater risk of attempting suicide again than those persons who have never attempted suicide, primarily because the problems that led to the first attempt may not have been resolved.

People who have experienced a recent major loss, such as death of a close friend or relative, divorce, or separation or loss of a job, are at greater risk than the general populace. Also, people whose close friends have committed suicide or have a family history of suicide are at great risk, as are people who are in physical ill health.

Warning Signs

It is rare that a person who attempts or completes a suicide does not give prior indications of his or her suicidal intentions. This is because relatively few persons who commit suicide do so impulsively without having thought about ending their own lives beforehand for days, weeks, or months. Suicides rarely occur because of a sudden traumatic event. However, people at risk of suicide who experience a sudden traumatic event are at much greater risk of ending their lives at that time.

People who are suicidal are often seen as having changed their personality or humor recently. Changes include depression or apathy, pessimism, irritability, or "not seeming to be themselves." There may be changes in eating patterns (eating much more or stopping eating) and sleeping habits (sleeping much more or being unable to sleep, particularly waking up early and not being able to get back to sleep).

Suicidal people often feel lonely, misunderstood, helpless, hopeless, worthless or ashamed, guilty, and/or full of hate for themselves. These feelings are not normal, even for a person who has a mental disorder or psychiatric illness. They are indications that something is desperately wrong.

Any behavior that may be interpreted as "preparing" for death may be an indication of suicidal intent. For example, suicidal persons may put

their personal affairs in order and update or write a will. Even more direct preparations include giving away important objects (particularly if the person makes statements like, “I won’t need them anymore” or “I don’t care about them anymore”). Sometimes people say good-bye or express feelings in a way they never did before (e.g., “I never really told you how much I care about you; I just wanted you to know”).

Another danger sign of suicide is a preoccupation or interest in obtaining means for killing oneself. The purchase of a gun or getting hold of potentially lethal medications may be an indication of suicidal intent. Tying nooses in a rope or occupying dangerously high places are other possible indicators. Some people review web sites that provide information about how to kill oneself, or investigate what constitutes a lethal dose of medication. These and other dangerous behaviors are important indications that a suicide might be imminent. Some suicidal people write suicide notes that they may leave around where others might see them. Leaving a suicide note where it can be found beforehand or making “obvious” preparations may be interpreted as an expression of the suicidal person’s ambivalence. Although the person intends to die, there is also some hope that someone will find the note or identify the risk and help find a solution to his or her problems before a suicide attempt.

Most suicidal persons express their suicidal intentions to others beforehand. These expressions may be in the form of direct suicide threats (“I can’t stand it and I’m going to kill myself”) or they may be much less direct (“Sometimes I think it’s not worth going on”). Suicidal persons may be indirect in the communication of their intent because they are afraid of how a friend or family member will react. Depending upon the reaction, they may continue to confide their thoughts and plans or they may change the subject.

What To Do If There Are Warning Signs

Whenever a person gives some of the above indications that he or she may be suicidal, others may be of great help if they talk to the person about how he or she is feeling. Unfortunately, most people hesitate to ask questions or talk about suicide because they are afraid that they will say or do the wrong thing. Often they feel that they may make

things worse or even cause someone who is vulnerable to get the idea to commit suicide. However, mental health practitioners maintain that this does not happen. Suicide is not something someone can suggest by asking questions about what a person is thinking and feeling and whether or not a person is thinking about suicide. Conversations about suicide serve the purpose of communicating to a person who is considering whether or not he or she should end life that someone else is interested in helping—despite the fact that the suicidal person is thinking of doing something that most people find unable to speak about. Most people feel quite relieved that they are able to talk openly about suicide and the problems they are having.

Discussions about suicide should focus on resources the person already has available. Does the person have a confidant or friends with whom he/she can talk about the problem or get help? Is the suicidal individual seeing a mental health professional or other health care provider who can be of help? Conversations can be helpful if they explore alternative ways to help with the situation.

When confronted with a suicidal person, mental health practitioners uphold that it is important to stay calm and listen empathically to what the person is saying. Despite the possibility that the attempt may not be serious or the person may be manipulative, it is important to take the situation seriously and to ask questions to find out how serious the intentions really are. Friends and helpers should ask specific questions about risk factors such as previous attempts and mental health problems. Generally, people who know when and how they are going to commit suicide are at much greater risk than people whose plans are vague and uncertain. For this reason it is useful to ask if the person has considered how and when he or she plans to commit suicide. Asking such a direct question can do no harm and can provide important information. If the person knows how and has the means at hand, the risk is great and immediate help is needed. If a person has a means of suicide available, such as a firearm or lethal medication, it is important to remove the means from the home. Concerned parties should consult a suicide prevention service or agency or skilled health or mental health care provider who is knowledgeable about suicide. If a person is at high risk, that is, the person appears to be ready to take his or her own life soon, it is best to stay with the person or have

someone else stay with the person during this crisis period.

It is not useful to get angry or panic. Nor is it useful to be falsely encouraging by saying things like, "I'm sure that everything will be all right." Also, it is best not to belittle or trivialize the problem by saying, for example, "I'm sure other people have been in much worse situations and they never thought of killing themselves." No matter how unimportant the problems may seem to an outsider, they may be sufficiently serious in the mind of the suicidal person for the person to consider taking his or her own life. A mature listener should not make promises he or she cannot keep or insist that things will change if he or she is not certain. One should not swear to keep secret a person's suicidal intentions. Saving a person's life is more important than betraying a confidence.

Not all suicides are preventable. However, people who give indications that they are suicidal usually experience great ambivalence about whether they should kill themselves or not. If a person wants to commit suicide without telling anyone or indicating what he or she intends to do, there is nothing anyone can do to prevent it. However, people who do give indications that they are suicidal, despite their insistence that they must complete this act, are generally experiencing ambivalence about whether or not this is the only way to stop their anguish or painful situation. In these circumstances it is important to talk with the person and offer help so that the ambivalence against committing suicide may be strengthened in the short term by the presence of a caring friend. However, in the long run suicidal persons need to take steps to resolve underlying problems. This may involve starting or continuing help from a mental health professional, trying to resolve a drinking or drug problem, or learning to expand coping skills. Identifying suicide risk and offering help is the first step in the process of helping suicidal individuals decrease their risk of suicidal behavior.

See also: SUICIDE BASICS: PREVENTION; SUICIDE OVER THE LIFE SPAN

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BRIAN L. MISHARA

SUICIDE INFLUENCES AND FACTORS

ALCOHOL AND DRUG USE *Michel Tousignant*

BIOLOGY AND GENETICS *Robert D. Goldney*

CULTURE *Michel Tousignant*

GENDER *Silvia Sara Canetto*

INDIGENOUS POPULATIONS *Ernest Hunter, Desley Harvey*

MEDIA EFFECTS *Steven Stack*

MENTAL ILLNESS *Michel Tousignant*

PHYSICAL ILLNESS *Brian L. Mishara*

ROCK MUSIC *Laura Proud, Keith Cheng*

ALCOHOL AND DRUG USE

Between 30 and 50 percent of persons who die by suicide have a dependence on alcohol or drugs or have shown a pattern of abuse of those substances. The data from four large studies in four different countries confirm this statistic. In a Finnish study led by Markus Henriksson covering all ages over the entire country, diagnoses of dependence and abuse were present in 43 percent of the cases, twice as often in men (39%) as in women (18%). In another study conducted in the United States (San Diego), alcohol abuse was found in 55 percent of cases. Alain Lesage's team in Quebec concluded that 30 percent of male suicide victims below thirty-five had alcohol-dependence problems and that a similar percentage suffered from drug dependence, with a com-

bined dependence rate around 45 percent. Even in South India, where alcohol is difficult to find, Laskmi Rajkumar found in the city of Chennai (formerly Madras) that 35 percent of suicides showed signs of alcoholism.

Almost all the alcoholics who commit suicide also suffer from severe mental health problems. In the Finnish study, half of the suicides with alcohol dependence also had a depressive disorder and almost as many had a personality disorder that entailed difficulty in curbing impulsive behavior. In a large 1992 American study research of male alcoholic suicides, directed by George Murphy, researchers found that 72 percent had a depressive disorder and less than a quarter were free of any psychiatric disturbance. The probability that an alcoholic will die by suicide varies from 2 to 6 percent, which is far above that of the American population (1.3%) or the American population without any psychiatric problem (around 1 per 100,000 per year or less than 0.2%).

With respect to illegal drugs, a 1992 study done in New York City found that 15 percent of New York suicides tested positive for cocaine. In Norway Ingebor Rossow found that nearly 3 percent of a group of patients from both sexes treated for drug dependence had died by suicide after only ten years. Younger people from both sexes have a higher risk, and among them drug abuse leads to suicide more quickly than does alcohol abuse.

Attempted Suicide

Alcohol and drugs also have a major influence on attempted suicides. In a survey sponsored by the National Institute on Alcohol Abuse and Alcoholism in 1992, Deborah Dawson found that those who had frequently become inebriated were more likely to experience suicidal thoughts or to actually try to kill themselves. One out of seven persons who were frequently intoxicated reported suicidal thoughts or attempts compared to 4 percent for other current drinkers. The level rose to 20 percent for those who only used sedatives, tranquilizers, cocaine, or stimulants and to 25 percent in cases of multiple drug use. The link between marijuana and attempted suicide was well documented in a New Zealand study that found that one out of six persons who made serious attempts at suicide were seriously dependent on marijuana.

Slow Death and Overdoses

Many people wonder if the use of alcohol and drugs is a way of committing suicide by “slow death.” Most persons who abuse these substances are taking them chiefly as a kind of self-medication to reduce their stress. This seems to be more the case with men than with women. A woman who takes to alcohol has often failed to find relief from drugs such as tranquilizers and is more likely to be desperate and vulnerable to suicide. Alcohol also leads to a greater risk of slow death from cirrhosis of the liver and of accidental deaths associated to risk-taking behaviors. Alcohol and drug abuse is also associated with a much higher risk of dying by homicide.

The problem of drug overdose is somewhat different. Young homeless adults often attempt suicide by overdosing on illegal drugs. A Norwegian survey by Ingeborg Rossow and Grethe Lauritzen (1999) has shown that nearly half of more than 2,000 drug addicts admitted for treatment reported having experienced at least one life-threatening overdose and that they were six times more likely to have made a suicide attempt than those who had not overdosed. Coroners are still reluctant to classify these deaths as suicides given the difficulty in distinguishing accidents from voluntary gestures.

Alcohol and Drugs As a Cause of Suicide

Do alcohol and drugs directly cause suicide by significantly diminishing the reasoning of the person at the time of the suicide? In the absence of personal data, it is difficult to know if those who drank before committing suicide did so to have the courage to commit suicide. There is evidence, however, to show that alcoholics who commit suicide usually don't act only on the spur of the moment. George Murphy has analyzed the issue of alcohol and impulsivity in a series of ten cases where the person had committed suicide within hours of a very stressful life event. In only two cases was there evidence of an unexpected impulsive act. In six other cases the person had communicated some time before the event his or her intent to die. However, even if the person had considered suicide before, we cannot rule out the possibility of the alcohol triggering an impulsive act. Long-term consumption of alcohol leads to depression, which in turn increases the probability of suicide, according to Murphy's study.

But it takes on average more than nineteen years of chronic alcoholism and seven years of depression before reaching this end, which leaves plenty of time for treatment and prevention.

If suicide is closely associated with alcohol, is there a direct link between an increase in alcohol consumption and the suicide rate in a population? Despite many attempts to prove this idea, an American study found that the sale of spirits, but not of beer or wine, correlated with increased suicide statistics. The fact that countries that were former members of the Soviet Union have both high rates of suicide and alcoholism supports the hypothesis of a direct link. But we have to wait for more information from China, which has a high incidence of alcoholism and low incidence of suicide, to have a more complete picture. If Islamic countries have both low rates of alcohol and suicides, there are countries such as Mexico or Jamaica where alcohol consumption is high and suicide rates relatively low. One likely explanation is that intoxication in these countries more often take place during religious or social rituals and that these contexts may lessen the adverse consequences of drinking.

The Psychosocial Context

As George Murphy and E. Robins warned physicians in 1967, "The physician should be aware of the critical periods of break in relationships (divorce, separation, mourning) in their alcoholic patients." Later studies comparing cases of alcohol and drug suicide with other suicides have since concluded that the breakup of a love relationship in the six weeks before suicide had more of a causal impact in the alcohol and drug group, perhaps because many alcoholics have suffered rejection and abandonment during childhood and might therefore be more vulnerable to the emotional trauma of separation. Another hypothesis is that the alcoholics progressively enter a process of social isolation, especially during the year before a suicide. Therefore, they may be more vulnerable to a key loss. A Finnish study by Heikkinen found that family discord (38%), financial problems (28%), and marital separations were the chief precipitants of suicides among alcoholics. Persons with an alcohol or drug problems who die by suicide have often alienated friends and family and therefore have little social support.

Murphy and his team studied the differences between alcoholics who committed suicide and other alcoholics living in the community. They found that two-thirds of the suicides had had at least four psychosocial risk factors as against only 1 percent in the community alcoholics. Those who committed suicide were twelve times more likely to suffer from a major depression (58% vs. 5%), three times more likely to be unemployed (54% vs. 18%), to live alone (45% vs. 17%), to lack social support (75% vs. 26%), or to have previously made suicide threats (79% vs. 23%). Almost all the suicides were very heavy drinkers (97%), twice as many as in the community alcoholic sample. Two-thirds of the suicide cases had four of these risk factors compared with only 1 percent in the community group of alcoholics. Young people with a drug problem who commit suicide are also much more likely to have had a brush with the law, to have a firearm available at home, or to suffer from depression.

Prevention and Intervention

If alcohol and drugs are closely related to suicidal behavior, we cannot conclude that all abusers are at risk. Those who also suffer from depression or a personality disorder are the ones in real danger. Consequently, the treatment of the addiction should also target the other psychological problems. One challenge is to communicate to adolescents that despite the immediate good feelings alcohol or drugs may facilitate, an unpleasant, depressive mood often accompanies abuse. We should recognize that both drugs and alcohol can sometimes alleviate suffering and despair. Limiting alcohol consumption to social rituals may help to minimize the damage in some societies. Furthermore, if alcoholics are working and are supported by their environment, the risk of committing suicide significantly decreases. Both professionals and family members should also realize that alcoholics, especially if middle-aged, are very vulnerable to loss and rejection and that they can benefit from increased social support.

The low suicide rate in Islamic countries that limit access to alcohol, contrasted with high rates in the alcohol-consuming West, suggests a direct link between suicide and alcohol abuse. The solution in most countries is not one of repression but rather publicizing the statistical association of suicide with alcohol and drug abuse.

See also: SUICIDE INFLUENCES AND FACTORS: GENDER, MENTAL ILLNESS; SUICIDE OVER THE LIFE SPAN: ADOLESCENTS AND YOUTHS, THE ELDERLY; SUICIDE TYPES: INDIRECT SUICIDE

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MICHEL TOUSIGNANT

BIOLOGY AND GENETICS

The possibility that biological and hereditary factors could be related to suicidal behavior has been written about for over 200 years. For example, in 1790 Charles Moore stated that the "propensity to suicide . . . by attacking successive generations of the same family proves itself to be hereditary"; in 1881 in the English translation of his Italian work, *Suicide: An Essay on Comparative Moral Statistics*, Henry Morselli wrote a chapter entitled "Influences

Arising Out of the Biological and Social Condition of the Individual"; and in 1892 the physician Daniel Hack Tuke noted that "examples of hereditary suicides have occurred" (Goldney and Scholdann 2000, pp. 181, 184).

There has been considerable debate about the relative importance of biological and hereditary factors as opposed to sociological determinants, and this has led to a split between these two broad explanatory approaches to suicidal behavior. However, twenty-first-century scientists generally recognize that there is a far more subtle interplay between such factors than had previously been understood.

Despite the early descriptive work, it was not until the 1970s that biological and hereditary contributions to suicidal behavior were given a firm scientific basis. In 1976 the Swedish researchers Marie Asberg, Lil Traskman-Bendz, and Peter Thoren demonstrated a lowered level of five hydroxy indole acetic acid (5-HIAA) in the cerebrospinal fluid (CSF) of suicide attempters who had used violent methods, and suggested that it may be a biochemical suicide predictor. This was important as CSF 5-HIAA is a breakdown product of serotonin, one of the neurotransmitters associated with mood and behavior disturbances. In 2000 Traskman-Bendz and John Mann reviewed subsequent studies from a number of different centers, and found that there is general agreement within scholarship that those people with low CSF 5-HIAA have a higher likelihood of committing suicide. They also noted that other primate studies have shown a relationship between low CSF 5-HIAA and aggression.

The importance of serotonin transmission has also been demonstrated by postmortem studies, where in 1995 Victoria Arango, Mark Underwood, and John Mann reported reduced binding to serotonin transporter sites in the ventral prefrontal cortex of the brain of completed suicides compared to those who died from other causes.

The activity of another neurotransmitter, dopamine, has also been examined by measuring the growth hormone response to apomorphine in depressed persons, some of whom later suicided. In 2001 William Pitchot and his Belgian colleagues reported a significantly lower response in eight male depressed patients who suicided compared

to eighteen depressed patients who had never attempted suicide, leading them to conclude that dopamine was involved in the biology of suicide in depression.

Further evidence of the importance of neurotransmitters and the hypothalamic-pituitary-adrenal axis has emerged from a fifteen-year follow-up study of depressed patients who had had the dexamethasone suppression test during their initial assessment. In a 2001 study conducted at the University of Iowa, William Coryell and Michael Schlessler reported that 7 of the 8 suicides out of 78 patients had been nonsuppressors of cortisol, a biological indicator of their depressive condition. They reported that nonsuppression increased the likelihood of future suicide fourteenfold.

The role of corticotropin-releasing factor (CRF) has also been examined in completed suicides. Researchers have reported a reduction of CRF binding sites in the frontal cortex of the brain. Although not all studies concur with this finding, the role of CRF may still be important, as studies reviewed in 1999 by Christine Heim and Charles Nemeroff have demonstrated that early life stress produces persistent elevated CRF activity, which is associated with increased reactivity to stress in adult life. They suggest that stress at critical stages of development in people with a genetic predisposition could result in neurobiologically vulnerable adults who were more likely to develop mental disorders following exposure to further stress.

The hereditary basis to suicide was first convincingly described by Fini Schulsinger and his colleagues in 1979 in a Danish adoption study, which examined individuals who were separated at birth from their biological relatives. Using a matched control design, more of the biological relatives of the adopted suicides committed suicide compared to the biological relatives of adopted controls. Subsequent research has suggested that the genetic factor could be related to impulse control independent of mental disorder. Since Schulsinger's early study, there have been important developments in genetic studies that have been reviewed by others. For example, in 2000 Alec Roy and colleagues reported that in 399 suicide twin pairs in the literature, there was 13.2 percent concordance for suicide in the 129 identical (monozygous) twins, compared to 0.7 percent concordance for suicide in the 270 non-identical (dizygous) twin pairs.

The extent of the possible contribution of genetic factors to suicidal behavior has been illustrated well in a 1998 study of 5,995 Australian twins. In a sophisticated logistic regression analysis, which allowed for sociodemographic, personality, psychiatric, traumatic event, and family history variables, no less than 45 percent of the variance in suicidal thoughts and behavior was related to genetic factors. Furthermore, after controlling for those variables, a history of suicide attempt or persistent suicidal thoughts in a co-twin remained a significant predictor of suicidal thoughts and behavior in identical twins, but not in non-identical twin pairs.

Other genetic studies have focused on possible associations between suicidal behavior and genetic variance in the serotonin system. In particular, the enzyme tryptophan hydroxylase (TPH), which is the rate-limiting enzyme in the synthesis of serotonin, has been examined in detail. In a 2001 review and further study, Gustavo Turecki and colleagues noted that most research has been carried out on those who had attempted suicide. They investigated 101 suicide completers and could not replicate previous research, although they found another genetic variation to be more frequent in suicides than in normal controls. They referred to "the substantial role that the gene that codes for TPH may play in the neurobiology of suicidal behavior," but it is not clear whether it is related to psychiatric disorders or to personality traits such as impulsivity (Turecki 2001, p. 98).

Biological and hereditary factors do not operate independently, and do not inevitably lead to suicide in any individual, even if there is a strong family history of suicide. Rather, they can only increase the susceptibility of some individuals to react more severely to stress. The relationship between stress and neurobiological reactions has been reviewed from an ethological perspective, and there are persuasive primate as well as human studies that have added weight to the theory of Robert Post in 1992 about the role of stress in producing depression, the psychiatric condition most frequently associated with suicide.

The finding of significant biological and genetic determinants of suicidal behavior does not negate the importance of the individual and his or her psychosocial environment. Therefore the results of any of the individual studies referred to

need to be considered with caution, and integrated into science's existing psychosocial understanding of suicidal behavior.

See also: SUICIDE; SUICIDE INFLUENCES AND FACTORS: GENDER, MENTAL ILLNESS

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ROBERT D. GOLDNEY

CULTURE

Anthropology, comparative psychiatry, and psychology have contributed with their specific approaches to better analyze the cultural processes leading to suicide. This rich literature presents new ways of understanding the causes and the influences of suicide on the models of explanation and on specific ways of prevention.

Universality of Suicide

Suicide has been known to humanity since the beginning of time and can be found in the mythologies and legends of the great civilizations. There was a Mayan goddess named Ixtab who protected those who had died by suicide. In Virgil's *Aeneid*, Dido, queen of Carthage, took her life after Aeneas reluctantly left her to continue his mission. Several suicides are depicted in the Bible, but most characters profiled were trying to avoid a life-threatening and shameful situation like falling prey to the enemy.

Suicide was present in many cultures before any contact with the conquering Europeans. The Maoris of New Zealand were known to have had a high tolerance toward suicide. There was a famed cliff where people would jump and the port of Whangaroa presumably took its name from a word meaning suicide. The scholar Fredrick Maning believed that as early as 1843 suicide occurred every day among this people. A famous legend told of TeAohuruhuru, a young bride of great beauty, who

had been dishonored by her husband when he unveiled her naked body to friends while she was sleeping. As revenge, she drowned herself in front of his boat.

In a 1985 overview of the Bimin-Kuskusmin and other groups of New Guinea, the anthropologist Fitz Poole found that their contemporary high rates of suicide had preceded acculturation and suicides were present during a period when intertribal warfare and cannibalism were not yet eradicated. Poole estimated that as much as 10 percent of deaths over the last six generations were by suicide. During a trip around 1970 he counted thirty suicides, which accounted for 57 percent of all deaths. The men who committed suicide were mostly in their early twenties and were trying to avoid making war; the women were stressed by the high number of male victims and by being forced to participate in cannibalism.

Cross-Cultural Picture of Suicide

Many countries report their suicidal rates to the World Health Organization (WHO). These rates are difficult to compare because the methods of recording vary between countries and even within geographical areas of a single country. For instance, the Indian sociologist Soltamin Aleem reported in 1994 that the rate was near 25 per 100,000 annually in the state of Kerala, a state of Southwestern India with a relatively high level of education and distribution of income, and below 1 per 100,000 in the state of Bihar, which is paradoxically one of the poorest states of India. For this reason, the anthropologist Robert Desjarlais concluded that the variations between nations were dependent upon the ability of local institutions to complete valid investigations. He quoted two field studies in North India that yielded rates three to five times the national rates.

The most recent rates reported to WHO in the year 2001 show that the highest ranking countries, with a rate above 16 suicides per 100,000 individuals per year, cover a large area, including the Baltic states, some countries of the former Eastern Europe, the federation of Russia, China, Japan, and Sri Lanka. In Western Europe, the rates are in the same range for Austria, France, and Switzerland. The rest of Western Europe, as well as the United States and Canada, was in the category of between 8 and 16 suicides per 100,000 per year, which also includes Australia and India. The countries from

Latin America are in the lower range, with the exception of Cuba. The majority of the governments from the African continent did not report any data.

Rates of suicide also tend to vary little when members from a culture migrate to another country, as was found in Australia and the United States, at least during the first years of settlement, and they tend toward the rate of the host country as the years progress. The rates of suicide also vary within the ethnic groups of one country. For example, the rate for the large Hungarian community in Romania is more similar to that of Hungary than to that of the rest of Romania. The African-American population of the United States has a slightly lower rate than the national rate despite the group's lower average income. In the southwestern states, the rate is half for Latinos as compared to Anglos. However, a 1999 study on youth by the Centers for Disease Control showed that Latinos were more likely than African Americans or European Americans to have seriously considered attempting suicide. Consequently, the portrait of suicide and culture in the United States may change significantly in the upcoming decades of the twenty-first century.

Two reports from 1960 show that suicide was far from unknown in sub-Saharan Africa even before the end of colonization. Local reports from Uganda, Zambia, and South Africa illustrate a significant presence of suicide there, with a rate around 10 per 100,000. For example, the anthropologist Ellen Brown reported twelve cases among the Sara Nar of Chad, which corresponds to a rate of 20 per 100,000.

Suicide and the Mental Health of a Society

The rate of suicide is one of the many factors that reflect the mental health of a population. Suicide often indicates how a certain range of people with psychiatric or adaptation problems are excluded from social or family life rather than providing a good estimate of the happiness of a population. The rates of depression, alcoholism, or suicide attempts are more reliable indices of the mental state of a population. However, a suicide rate cannot be a good argument against a sociopolitical system. During his presidency, Dwight D. Eisenhower had been critical of the social democratic system in Sweden on the grounds that Sweden had a high suicide rate when, in fact, the Swedish rate had reached a peak during the country's period of capitalism.

Conceptions of Suicide across Cultures

The cultural attitudes of tolerance toward or repression against suicide probably influence individual choices about committing suicide. Sometimes a religion condones certain forms of sanctified suicides while condemning this mode of exit from life for the common people. The Hindu religion is a good example. In 1998 the anthropologist Karin Andriolo described how the Hindu society considered taking one's own life as a welcomed departure when a person had reached a state of perfection. In "The History of Suicide in India," Upendra Thakur documented many characters of high and low origin who committed suicide in narration of the religious texts. However, during the period of *Dharmasastras*, one of the sacred books, suicide was determined to be a sin and the suicide victim deprived from death rituals. In the modern period, suicide is viewed as shameful for the family.

In Bangalore, India, women are often accused of being the cause of suicide as shown in a 1998 survey conducted by Michel Tousignant, Shekhar Seshadri, and Anthony Raj. If women commit suicide, they are said to be ashamed of having transgressed a rule; if men commit suicide, they are thought to have been the victim of some form of abuse at the hands of a woman. This article also mentions that *sati*, the suicide by the self-immolation of a widow on her husband's pyre, is still romanticized by a wide section of the Indian population. There is a ban on *sati* and it has been determined that some modern cases of *sati* were not suicides but rather disguised homicides.

In Haiti public perception is that suicide is extremely rare. In this society, suicide is unacceptable among the poor because it is considered an example of letting down friends in their fight against the adversities of life. On the other hand, in 1998 the anthropologist Jeanne Marecek, working in Sri Lanka, found little tolerance of suicide despite the high rate in this country. The population attributes this gesture to the conditions of life, such as unemployment or romantic problems, and people are usually ready to give support to persons who have made an attempt.

In sub-Saharan countries many traditional religions view suicide as impure. In Uganda people avoid coming into contact with the corpse of a person deceased by suicide and in Rwanda survivors burn the person's possessions. A Senegal

oral tradition requires that someone who comes across a person who died by suicide should make a sacrifice, and in Nigeria the body is buried on the spot, without any ritual.

Theories

The French sociologist Émile Durkheim's theory about suicide, which came into prominence at the end of the nineteenth century, was cultural. His argument claimed that regions with the highest rates of suicide were in a relative state of anomie; that is, situations where the rules guiding a society were either absent or weak. Similarly, societies with a relative absence of social integration were considered hardest hit by suicide. One of his points was that Jews and Catholics had low rates because they formed more cohesive groups, while Protestants had high rates because their relationship to God was more personal. This theory is still useful in understanding how rates are becoming higher in rapidly acculturating groups such as the Aboriginal peoples of Northern Canada, Greenland, Brazil, and the Melanesian islands. The rapid change from a nomadic to a sedentary life, the spread of alcoholism, the lack of access to modes of production, the changing patterns of family structure, abuse and incest, and racial discrimination from the dominant society are often the elements of the cultural breakdown.

However, the fact that people committing suicide are mostly young males calls for a less global explanation. The sociologist Francis Hezel has shown that suicide, as well as alcoholism in Melanesia, is a way of escaping social contradictions by young people with little faith in their future. The younger generation is often schooled to foreign values, far away from their families, and is later scorned by parents who have lost their moral authority over them. Not being able to adopt any model, these young people choose not to participate in life by committing suicide.

In China and in India where the rate of female suicide is very similar to that of males (in contrast to the ratio of one to four in many countries), women move to their in-laws' homes after marriage. One likely explanation of female suicides is that when repeated conflicts take place, not only is it shameful and in some cases impossible for the women to return to their families, they are threatened to be deprived of contact with their children.



In a form of ritual suicide, Buddhist monks in Saigon who protested the violence demonstrated by the Ngo Dinh Diem government during the Vietnam war died by self-immolation in an open public square. BETTMANN/CORBIS

According to the Beijing-based journalist Shuhua Jia, women in rural areas rarely enjoy a marriage based on love and whole families are forced to live in one-room apartments.

In Western countries, men often commit suicide after the end of their marriage, sometimes after a long period of alcoholism when they have alienated their friends and relatives by their conduct. Here, they are the ones who are estranged from their children and who find themselves in a state of solitude and low social support.

Scholars confess the theoretical challenge in explaining why suicide is nearly absent in certain societies. In North Africa as well as in sub-Saharan Africa, many authors have identified the low prevalence of guilt and the habit of projecting aggression onto others rather than criticizing oneself, as well as the tendencies to express stress in bodily symptoms rather than by emotional means. These modes of expressing stress may eventually protect against depression and suicide.

The 2000 review of the sociologist Steven Stack on religion and suicide has contributed to a

different perspective on some of Durkheim's ideas. First, there is mixed support in the United States for the hypothesis that Catholics are more protected from suicide than people from other religions and no support for this statistic is found in Canada. Reanalysis of data from 1905 to 1910 in the Netherlands suggests that Catholics may have been hiding some of their cases of suicide. However, a survey of seventy nations has shown that a high rate of Islamics in the country was associated with a lower suicide rate. There is some evidence that religious commitment may be a protective factor despite the fact that many studies have refuted this hypothesis. The connection between religion and suicide is weak and most studies indicate little about the religious status of those who have committed suicide, making it difficult to analyze the connection.

Prevention and Intervention

One of the most promising interventions has come from Sri Lanka in a project asking volunteers to travel to villages where suicide is spreading and to support families in which a member has died from

suicide. In the United States, the Centers for Disease Control issued guidelines for Aboriginal communities that can be used with similar groups. Scholars maintain that prevention should be done both at the community level, to promote the sense of pride and efficacy of the group, and at the individual level, to follow up with those who are recognized as threatened, such as in schools and in emergency services. Because social scientists often find a situation of social rejection within certain ethnic groups, or the marginalization of certain persons within these groups, efforts to valorize these cultures is a first step toward preventing suicide.

In 1999 the researchers Michael Phillips, Huaqing Liu, and Yanping Zhang reported that there are more than 300,000 suicides a year in China. There is little recognition of depression and it is estimated that only 5 percent of the cases of clinical depression are currently treated. They proclaim that a wider access to treatment of depression and support would help prevent suicide. Since the rate is higher in rural areas where emergency medicine is not readily available, the researchers maintain that there should be a better control of pesticides, which is one of the most readily available and lethal ways of dying by suicide in that country.

Approximately 1 million people die from suicide each year around the world. Suicide is becoming an international public health concern on the same level as illnesses such as malaria. Researchers are in a position to verify that the experience of some cultures is being repeated elsewhere. For example, the suicide contagion experienced among rapidly acculturating Aboriginal peoples has started to appear in Brazil. Because of this prevalence, there is an urgency among social scientists to address suicide as soon as it appears among certain people groups, and to rapidly apply learned lessons in order to suggest methods of prevention.

See also: DURKHEIM, ÉMILE; SUICIDE; SUICIDE BASICS: HISTORY; SUICIDE INFLUENCES AND FACTORS: INDIGENOUS POPULATIONS

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MICHEL TOUSIGNANT

GENDER

Consistent with current scholarship, gender, like race, is conceptualized as a social construct rather than as an attribute of individuals. It is what cultures make of the fact that a person is a woman or a man. Gender is also what cultures define as appropriate behavior for women and men across a variety of situations, including situations of distress. Finally, gender, like race, is a status variable determining a person's location in the social hierarchy, including the barriers and resources that a person will likely encounter.

Patterns of Suicidal Behavior by Culture

In the United States women and men tend to engage in different kinds of suicidal behavior. Women are more likely to engage in nonfatal suicidal behavior, while men are more likely to die as a result of a suicidal act. In 1998 the researchers Silvia Sara

Canetto and Isaac Sakinofsky called this phenomenon the gender paradox of suicidal behavior. United States gender patterns of suicidal behavior are similar to those found in other English-speaking countries, such as Canada and Australia. They are different, however, from those observed in a variety of other countries. For example, in Finland and in India, men have similar rates of nonfatal suicidal behavior as women. Furthermore, in China, it is women who typically die of suicide. China accounts for 21 percent of the world's population, 44 percent of the world's suicides, and 56 percent of the world's female suicides. Exceptions to the male predominance among those who die of suicides are also found within some ethnic communities in the United States. For example, according to a 1997 San Francisco study by Julia Shiang and colleagues, Asian-American women aged eighty-five and older have twice the rates of suicide mortality of same-aged Asian-American men.

Suicide methods are culturally specific. Common suicide methods in one culture may be unusual in another. Women and men tend to use the methods that are culturally permissible for them in their culture, not just those that are accessible. In some cultures, women and men use different suicide methods; in other cultures they use the same methods. Since the 1990s firearms have been the most common method of suicide in the United States with both women and men. However, they account for a greater proportion of men's than women's suicides (two-thirds vs. one-third). By contrast, in Canada women still prefer poisoning as a method of suicide, and men firearms. However, Canadian men's preference for firearms as a method of suicide is lower than that of U.S. women. In addition, among the Inuit of Canada, an Aboriginal hunting community, the most common method of suicide is hanging, despite the widespread availability of firearms.

Adolescent Suicidal Behavior in the United States

Gender patterns of suicidal behavior vary by age across the life span. In the United States adolescent girls are two to three times more likely to report being suicidal than adolescent boys. Suicidal ideation appears to be particularly common among Mexican-American youth. Adolescent girls are also more likely than adolescent boys to engage in nonfatal acts of suicidal behavior by an average ratio of

three to one. Approximately one in ten adolescent girls reports having engaged in suicidal behavior. Gender differences in nonfatal suicidal behavior are not found in all ethnic groups in the United States. For example, among native Hawaiians and Native Americans, adolescent girls report similar rates of nonfatal suicidal behavior as adolescent boys. Rates of nonfatal suicidal behavior appear to be particularly high among Mexican-American girls. Nonfatal suicidal behavior is more common among adolescents from lower socioeconomic classes such as adolescents whose parents are not as well educated. Homosexual adolescent males have high rates of nonfatal suicidal behavior, relative to heterosexual males. Rates of nonfatal suicidal behavior decline after adolescence in women and men.

Suicide rates in U.S. adolescent males exceed those of their female peers by a ratio of five to one. The gender difference in mortality holds across ethnicity, although suicide rates vary greatly from group to group. Native-American boys have higher rates of suicide than Native-American girls, although the latter have higher rates of suicide than European-American boys. No definitive information is available on rates of death by suicide among homosexual males.

Adult Suicidal Behavior in the United States

For women, suicide rates remain low throughout the life span, with a small peak around forty-five years of age. For men, on the other hand, rates of suicide increase after sixty years of age. This is particularly true among males of European-American backgrounds. The female-to-male suicide ratio for those aged sixty-five and above hovers around one to six. There are ethnic variations in gender patterns of suicide mortality across the life span. For example, rates of suicide for Chinese-American women rise after the age of forty-five, and reach a peak in late adulthood.

Explanations for Gender Patterns of Suicidal Behavior

Most theories of gender and suicidal behavior have overlooked the local and international cultural variability in patterns of gender and suicidal behavior. Overgeneralizing from U.S. national trends, theorists have asked questions like, Why do women engage in more suicidal behavior and why do men die of suicide, instead of questions like,

Why are women in some cultures more likely than men to engage in suicidal behavior? or Why are men in some cultures more likely to kill themselves than women? As a result, most theories fail to account for the variations in gender patterns of suicidal behavior found both within and beyond the United States. For example, it has been argued that suicide in older adults is a response to the losses of aging (e.g., reduced financial resources, widowhood, and poor health). This theory does not take into account that in some cultures rates of suicide are low in both older women and older men. It also fails to explain why in many countries, including the United States, suicide is rare in older women, despite the fact that that older women experience more social, economic, and health problems than older men.

The theory of cultural scripts, which is based on the observation of a correspondence between cultural norms and behavior, addresses cultural variations in gender and suicidal behavior. According to this theory, individuals tend to engage in the behaviors (including suicidal behaviors) that are meaningful and permissible for people like them in their culture. Each culture has its own models and rules for suicidal behavior. There are specific conditions under which suicidal behavior is expected, and by whom. In other words, there are different scripts of suicidal behavior. These scripts define the scenario of the suicidal act (including the actor, the method, the precipitants, and the themes) as well as the consequences of the suicidal behavior. When suicidal behavior becomes a possibility, these scripts, transformed and individualized, provide a blueprint for action.

What are the cultural scripts of gender and suicidal behavior in the United States? Studies indicate that it is considered unmasculine to admit to suicidal thoughts. Nonfatal suicidal behavior is considered less masculine and less potent than fatal suicidal behavior. "Feminine" persons are expected to "attempt" suicide more than "masculine" persons. Males are particularly critical of other males who survive a suicidal act. Studies also show that killing oneself is seen as a masculine and relatively strong act: Male suicide is not judged as less wrong or less foolish than female suicide. Men who kill themselves are viewed as better adjusted than women who kill themselves, independent of the reasons for the suicide. Men are also more likely to agree with and accept a suicidal decision than

women. These meanings and attitudes have been particularly well documented among adolescents and young adults.

Given these gendered messages about suicidal behavior, some scholars are not surprised by the fact that in the United States females are more likely to engage in nonfatal suicidal behavior but are less likely than males to kill themselves. The association of femininity and nonfatal suicidal behavior may be a factor in women's high rates of nonfatal suicidal behavior. At the same time, the association of suicide with masculinity may protect females against killing themselves. Research has also shown that identification with behaviors considered feminine, independent of sex, is associated with increased risk for nonfatal suicidal behavior. For example, homosexual and bisexual males who score high on a measure of conventional femininity are more likely to have a history of nonfatal suicidal behavior.

Prevention

The data on cultural scripts of gender and suicidal behavior suggest new directions for the prevention of suicidal behavior both in educational programs as well as in interventions with suicidal persons. Social scientists and health care professionals believe prevention programs and clinical interventions should educate about the epidemiology of gender and suicidal behavior across sexual orientation, social class, and culture. These prevention programs should assess beliefs about gender and suicidal behavior. Furthermore, they should challenge potential dysfunctional beliefs, such as the idea that nonfatal suicidal behavior is an acceptable way for young women to cope with problems, or the idea that killing oneself is powerful and masculine.

In terms of prevention, a promising finding is that androgynous persons tend to view the decision to kill oneself as foolish, independent of the reason for the suicidal wish. They also report less agreement, acceptance, and sympathy for such a decision. Researchers believe it may be that androgyny is associated with greater cognitive and behavioral resourcefulness and flexibility. This is not surprising given that androgynous persons are high in conventionally feminine traits, such as expressiveness, as well as in conventionally masculine traits like instrumentality. These findings suggest that suicide prevention programs may be more

effective if they address the limitations that gender ideologies impose on coping, and if they encourage the development of androgynous behavior.

See also: GRIEF; GENDER; SUICIDE; SUICIDE BASICS: EPIDEMIOLOGY; SUICIDE INFLUENCES AND FACTORS: GENDER

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INDIGENOUS POPULATIONS

In the mid-1990s, during the course of a national commission into indigenous affairs, the Royal Commission on Aboriginal Peoples released a special report on Aboriginal suicide, stating:

Collective despair, or collective lack of hope, will lead us to collective suicide. This type of suicide can take many forms, foreshadowed by many possible signs: identity crisis, loss of pride, every kind of dependence, denial of our customs and traditions, degradation of our environment, weakening of our language, abandonment of our struggle for our Aboriginal rights, our autonomy and our culture, uncaring acceptance of violence, passive acknowledgment of lack of work and unemployment, corruption of our morals, tolerance of drugs and idleness, parental surrendering of responsibilities, lack of respect for elders, envy of those who try to keep their heads up and who might succeed, and so on. (*Royal Commission on Aboriginal Peoples 1995, p. 38*)

Chief Jean-Charles Piétacho of the Mingan First Nation, whose submission is included in a special report from 1995 on Aboriginal suicide for the Canadian Royal Commission on Aboriginal Peoples, might have been speaking of indigenous suicide in any of the nations with histories of Anglo-settler colonialism. The indigenous peoples of Canada, the United States, Australia, and New Zealand were all exposed to colonization, dispossession, and depopulation through disease and violence. This was, arguably, most recent and devastating for Aboriginal Australians. Among the outcomes of these histories are levels of disease and ill health that are worse than for nonindigenous nationals. Using the crude proxy of the gap in life expectancy between indigenous and non-indigenous peoples in each nation, health inequality is also greatest for Aboriginal Australians, being

shorter by nearly two decades. In all four countries, indigenous suicide has been recognized and systematically addressed as a major health issue in Australia only since the 1990s. Finally, indigenous suicide in all four countries occurs against a backdrop of increasing national rates of suicide for young men. For each of these countries, overall suicide rates for men between the ages of fifteen and twenty-four are high in comparison with most other industrialized nations, ranging between 20 and 40 per 100,000 in the early 1990s, with New Zealand followed by Australia being the highest of the four. While indigenous suicide in each of these four societies will be considered, for the reasons suggested above, particular attention will be given to Aboriginal suicide in Australia.

Patterns of Suicide Rates

Increasing rates of young male indigenous suicide in the United States have been documented from the 1950s, with rates varying across the nation from 8 to 120 per 100,000. Contemporary rates for young people are some three to four times higher than for the nation as a whole, with two-thirds of all indigenous suicides between the ages of fifteen and thirty-four being male. Violent means are the norm with firearms being responsible for over half of all indigenous suicides. A similar picture is found in Canada with a significant increase in suicide rates for indigenous young adult males in the 1970s. In 1987 the National Task Force on Suicide in Canada reported that suicides accounted for 15 to 20 percent of all violent deaths of native people in the early 1980s, with 60 percent of suicides occurring in those aged fifteen to twenty-four, at a male to female ratio of three to one. As in the United States violent means are common, but with a greater and increasing proportion of deaths as a result of hanging and with the proportion of deaths from firearms declining. As noted earlier, New Zealand as a nation has the highest suicide rate for young men of any of these four countries. Even so, Maori suicide rates were 50 percent higher for young men aged fifteen to nineteen years in the mid-1990s, with rates for males aged fifteen to twenty-four having peaked in 1989 at 49 per 100,000. Violent means, particularly hanging, are the norm and, as in Australia, attention has been brought to this issue as a result of deaths in custody.

In Australia indigenous suicide has been recognized as a major issue only since the late 1980s,

having been brought to public attention by the Royal Commission into Aboriginal Deaths in Custody. Although the excess of indigenous suicide deaths in custody eventually was found to be a result of the massive overrepresentation of Aboriginals among those in police and prison custody, the attention and coverage of hanging was intense and supported the development of public perceptions and understandings of Aboriginal hanging that included a political dimension. It was a series of suicides in the custody of the State of Queensland in the mid-1980s that led to the formation of the Royal Commission, and in that state suicide in the wider Aboriginal population subsequently increased some fourfold between 1992 and 1996. For the period 1990 to 1995 that state had a suicide rate of 14.5 per 100,000, with the Aboriginal and Torres Strait Islander rate being 23.6. The elevated rate is entirely accounted for by the increased indigenous male suicides among those aged fifteen to twenty-four (112.5 per 100,000) and those aged twenty-five to thirty-four (72.5 per 100,000), with these figures being 3.6 and 2.2 times, respectively, the rates for the state as a whole. Australian indigenous suicide is not only increasing and concentrated among young adult males, it is also unevenly distributed geographically and temporally with "waves" of suicides affecting particular populations at different times. This suggests a condition of community risk mediated by individual vulnerability to harm (including accidents, homicide, and other alcohol-related problems), of which suicide is but one manifestation.

Explanations for the Higher Suicide Rates

While explanations for suicide rates in indigenous populations are diverse and complex, all of the studies of this phenomenon emphasize the impact of the breakdown of cultural structures, processes, and integrity. Almost all such interpretations link these influences on culture to colonization and its consequences for social and family functioning as was summarized by the Canadian Royal Commission:

Commissioners have concluded that high rates of suicide and self-injury among Aboriginal people are the result of a complex mix of social, cultural, economic and psychological dislocations that flow from the past to the present. The root causes of

these dislocations lie in the history of colonial relations between Aboriginal peoples and the authorities and settlers who went on to establish “Canada,” and in the distortion of Aboriginal lives that resulted from that history. (*Royal Commission on Aboriginal Peoples 1995, p. 2*)

In Australia the historical context includes a period of enormous social change through the 1970s. Previously, indigenous lives and communities had been controlled through racist legislation, which began to lift only in the late 1960s. The next decade was characterized by political and social instability, the lifting of restricted access to alcohol, rapidly increasing rates of violence and accidents, high rates of incarceration, and many other manifestations of continuing turmoil and disadvantage, with serious consequences for the stability of family and community life. Aboriginal Australians who have taken their lives usually have been young men who grew to maturity during or since that period. They are members of the first generation to be exposed to the developmental consequences of widespread instability, much of which reflects the indirect effects of heavy alcohol use (particularly on paternal roles and, consequently, on male identity).

While such factors are critical to interpretation at a population level, they are mediated by effects on individuals. In a 1997 review of studies across these societies, Valerie Clarke, C. James Frankish, and Lawrence Green identified an association between suicide and factors relating to substance use and compromised mental health and self-esteem. The misuse of alcohol, particularly binge drinking, is a consistent association, as Anne Graham and her colleagues explained: “the script for ‘drinking’ in many indigenous communities includes binge drinking, anger over perceived past grievances and injustices, and suicidal ideation and injury” (Graham, et al. 2000, p. 13).

Most interpretations also highlight persistent social disadvantage. Studies in the early twenty-first century suggest, however, that the predisposition to suicide by vulnerable youth is influenced not only by absolute living standards but also by how they view their circumstances relative to those around them. Interpretations from Australia and Hawaii show that indigenous youth cite the widening gap between indigenous and Western cultures as an important factor in indigenous suicide.

A final consideration in explaining suicide rates in indigenous communities is that of “meaning.” In indigenous settings, particularly in Aboriginal Australia, the occurrence of suicide and the circumstances of the indigenous communities mean that many people, including children, will have witnessed the aftermath of suicide. Clustering and the death by hanging of children, some as young as eleven years of age, in such communities suggests a powerful communicative and imitative dimension. At least in Australia, the communicative dimension of suicidal behavior has been influenced by events such as the Royal Commission into Aboriginal Deaths in Custody and by portrayals of hanging (as art, caricature, and graffiti) that associate hanging with political ends.

Intervention Programs

Intervention programs are necessarily informed by the service and policy frameworks in relation to suicide prevention and indigenous health across the four countries. These are significantly different. For instance, whereas there is a national Indian Health Service in the United States, in Australia indigenous health is largely the province of state health departments and, to a lesser extent, commonwealth-funded, community-controlled health services. Furthermore, initiatives related to indigenous suicide are encompassed within different national policy initiatives. For example, the Brighter Futures Program of Health Canada drives broad-based programs that address the social and cultural circumstances of young Native Canadians. In Australia there is as yet no nationally implemented indigenous health and well-being strategy, but partnerships with Aboriginal and Torres Strait Islander people form a key action area in the national framework for the prevention of suicide and self-harm.

Such differences aside, there has generally been a transition in each nation from crisis-oriented interventions targeting at-risk individuals toward broader, multileveled strategic approaches. This was exemplified by the recommendations of the Canadian Royal Commission: “A comprehensive approach must include plans and programs at three levels of intervention: 1) those that focus on building direct suicide crisis services; 2) those that focus on promoting broadly preventive action through community development; and 3) those that focus on the long-term needs of Aboriginal people

for self-determination, self-sufficiency, healing and reconciliation within Canada” (Royal Commission on Aboriginal Peoples 1995, p. 75). The commission reported that to be effective, programs should be community driven, holistic, and situated in a broad problem-solving approach. They should also balance crisis management with social agendas, place priority on children and youth, train Aboriginal caregivers, and encourage community-wide involvement.

In Australia suicide continues to increase in Aboriginal communities and is functionally inseparable from the wider picture of higher rates of disease, premature mortality, and social disadvantage. Perhaps because suicide has most recently emerged in Australia, the responses have remained ad hoc and largely crisis oriented although veiled by the ambiguous or evasive title of “life promotion” programs. There is, however, increasing recognition in policy and service planning of the need for a strategic balance of targeted and functionally accessible services and broad social interventions. For the indigenous peoples of each of these nations, empowerment and investment in the long term is needed to ensure the security of the environment of indigenous children.

See also: CAUSES OF DEATH; SUICIDE

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MEDIA EFFECTS

Widespread coverage of a suicide in the media has long been thought to be capable of triggering copycat suicides in the mass public. In fact, more than forty scientific papers have been published on the impact of suicide stories in the media on suicide in the real world. However, there have been some inconsistencies in the findings of this research. Some studies find significant increases in suicide after a widely publicized suicide story, while other research finds no effect. The following entry reviews the research evidence with four goals in mind. First, what hard evidence is there for a copycat effect? Do suicidal people actually imitate suicides in the media? Second, how can this association be interpreted? What are the major theories that have been used? Third, what scientific generalizations can social scientists construct from the existing studies through a comprehensive analysis?

Direct Evidence for a Media Impact

In 1774 the German poet Johann Wolfgang von Goethe’s *The Sorrows of Young Man Werther*, a novel where the hero commits suicide due to a failed love affair, was banned in many European locations. It was perceived as responsible for imitative suicides in such places as Italy, Leipzig, and Copenhagen. Systematic scientific investigations on copycat suicide began with the work of the doctor David Phillips of the University of California in the

1970s. The largest possible copycat effect found was for Marilyn Monroe. During the month of her suicide in August 1962 there were an additional 303 suicides in the United States alone, an increase of 12 percent. In general, however, highly publicized stories increase the U.S. national suicide rate by only 2.51 percent in the month of media coverage.

Most of the evidence for a copycat suicide effect is very indirect and usually weak. That is, associations are drawn between the presence of a suicide story and a rise in the social suicide rate. This rise is often demonstrated to be independent of other social conditions such as season, year, holidays, and the state of the economy. However, it typically is not known to what extent the people committing suicide are aware of the suicide story and if it had anything to do with their suicides.

Nevertheless, there is some convincing evidence for a direct copycat effect. For example, in the book *Final Exit* (1993), a guide to suicide for terminally ill persons, asphyxiation is the recommended means of suicide. In the year that *Final Exit* was published, suicides by asphyxiation in New York City rose by 313 percent from 8 to 33 suicides. Further, a copy of *Final Exit* was found at the scene of 27 percent of these suicides. Michel Tousignant and his colleagues studied seventy-one coroner's reports on suicides in Quebec in the month following a publicized suicide and found direct evidence of probable copycat effects. They determined that at least 14 percent of the suicides in the month following a widely publicized suicide of a popular Quebec journalist were at least partially linked to the story. For example, a number of the suicides were found with a copy of the suicide story nearby. In some cases the victim stated explicitly to significant others that he or she was going to imitate the suicide of the hero. Ninety percent of the suicides used the same method (hanging) as the role model in the story.

Explanations of Media Impacts on Suicide

Explanations of media impacts on suicide have generally been framed in terms of social learning theory. The simplest rendition is the imitation explanation, which argues that suicide stories are advertisements for suicide. Simply put, one learns that there are troubled people who solve their problems (e.g., divorce, terminal illness, dishonor)

through suicide. Mentally troubled persons in society may simply copy the behavior of troubled people in the suicide stories. The content and presentation of suicide stories may be secondary to the basic message conveyed about problem solving. Research using this model generally lumps all varieties of stories together, making no distinctions among subtypes by celebrity status, age, gender, occupation, or other characteristics.

A more complex set of explanations revolves around the learning process of differential identification. To the extent that people identify with a type of story, that type would be expected to have more of an impact. For example, men may be more apt to copycat the suicides of men than the suicides of women. If people tend to copycat the suicides of superior people, they would be expected to copy the ones of famous celebrities more than the suicides of ordinary people. Americans may identify more with the stories about American suicides than foreign suicides.

A third variety of explanation focuses not on story characteristics but on audience mood. Although this is the most understudied explanation for copycat suicide, the central thesis is that stories that appear when suicide-like conditions are high in society (e.g., high unemployment, high divorce, and low church attendance rates) have more of a copycat effect because more people are on the verge of suicide. Further, stories that appear in periods when suicidogenic conditions and moods are low will have less of an impact on copycat suicide.

Empirical Generalizations about Media Impacts on Suicidal Behavior

The researcher Steven Stack provides the only quantitative analysis of the findings of research studies to date. Stack's 2000 review is based on 293 findings contained in 42 scientific articles on the subject. There are essentially six solid generalizations that can be made about the conditions that maximize the relationship between the media coverage of suicide and suicidal behavior, including the characteristics of the suicide victim in the story (whether or not he or she is a celebrity), whether or not the suicide is real or fictional, the medium of coverage (newspapers or television), the dependent variable (suicide attempts or completions), the historical period of the analysis, and the amount of coverage of the suicide story. Two generalizations

can be made on factors unrelated to the finding of a copycat effect: age range in the dependent variable and year of publication of the study.

Celebrity suicides. Studies that measured the presence of stories regarding well-known entertainment and political celebrities were 14.3 times more likely to uncover a copycat effect than studies that did not do so. Researchers argue that suicide stories about such well-known people (e.g., celebrities, U.S. senators, and U.S. cabinet members) spark a greater degree of identification than stories about the suicides of other persons. The entertainment celebrity, in particular, has the greatest impact on copycat suicide. According to a reference group approach, if a celebrity figure with all her fame and fortune cannot endure life, the suicidal person may ask, “Why should I?” Along these same lines, a 2001 study of a well-known and respected journalist in Quebec has been associated with a substantial rise in suicide.

Real vs. fictional. Stack’s analysis found that studies based on real suicide stories are 4.03 times more likely to report copycat effects than studies based on fictional suicides. For example, the several works on the four television movies about teenage suicide that aired in 1984 generally found no imitative effect. People may identify with true-to-life suicides rather than make-believe suicides in movies or daytime television dramas.

Medium of coverage. Unlike televised suicide stories, newspaper suicide stories can be saved, reread, displayed on one’s wall or mirror, and studied. Television-based stories on suicide typically last less than twenty seconds and can be quickly forgotten or even unnoticed. Detailed studies of suicides occurring during media coverage of suicide have often found copies of suicide news stories near the body of the victim. Stack’s analysis found that research based on televised stories was 82 percent less likely to report a copycat effect than research based on newspaper stories.

Dependent variables. While the models in suicide stories are almost always completers, Stack’s analysis found that studies based on completed suicides as the dependent variables were 94 percent less likely to find a copycat effect than studies based on suicide attempts as the dependent variable. Possibly those persons most susceptible to copycat effects are those who are less determined to die.

Period effects. Research has been based on three principal historical periods: 1910–1920, 1929–1939, and 1948–1996. Research based on the 1930s is 93 percent less likely than 2001 research to find a copycat effect. This may be due to the lack of television to echo the stories covered in the radio and print media. However, it may also be due to the presence of massive social movements for social and economic change (e.g., labor movement) that may have distracted otherwise suicidal people from thoughts about suicide.

Amount of suicide coverage. Generally speaking, research has found that the greater the coverage of a suicide story the greater the chances of finding a copycat effect. Stack’s analysis distinguished between studies based on one network’s (e.g., ABC, CBS, NBC) coverage of suicides versus studies based on two or three network stories. The former were 84 percent less likely to find a copycat effect.

Age-specific suicide rates. Hypothetically, certain audiences (e.g., the very young and impressionable or the high-suicide-risk group of elderly white males) may respond more to publicized suicide stories than their counterparts. Stack’s analysis distinguished between studies based on a dependent variable measuring youth suicide risk (ages 10 to 34), middle-aged suicide risk (ages 35 to 64), and elderly suicide risk (aged 65 and over). Studies based on young people were no more likely than studies based on the elderly to find a copycat effect. Further, studies based on middle-aged people were also not any more likely to find a copycat effect. However, nearly all studies in this vein did not match the age of the suicide victims in the stories with the age of the victims in the suicide rate being analyzed. Further work will be needed in order to systematically assess the impact of age identification on age-specific suicide rates.

Year of story publication. Sometimes as statistical techniques advance and standards for publication increase, relationships between an X and a Y variable may emerge or disappear. Stack’s analysis found, however, that year of publication of a study was unrelated to the presence of a copycat effect.

Suicide Prevention: Media Guidelines

Professional organizations, including the American Association of Suicidology, have often prepared guidelines for the media to follow in presenting

suicide story content. For example, they often advise the media not to mention the method of suicide and to avoid presenting photos of the suicide victim. It is not clear to what extent these guidelines were ever empirically validated. However, there is only one systematic study on this issue.

One study that analyzes whether or not the guidelines are empirically validated was done by Phillips and his colleagues who studied characteristics of thirty-two televised suicide stories and their impact on teenage suicide in the United States. Twelve aspects of story content were measured, and included mention of the method of suicide, picture of the victim in normal life, picture of the victim's body or coffin, and whether or not the motive was specified. None of these characteristics of the stories was associated with significant increases or decreases in suicide risk. That is, for example, stories that mentioned the method of suicide were no more likely to be associated with increases in teenage suicide than ones that did not mention the method.

From the present review of empirical generalizations, social scientists believe that media guidelines should focus on the amount of coverage given to the story. The media might best control suicide by having fewer and shorter stories on the subject. Further, moving them to the inside pages of newspapers might also help reduce suicide risk. Because the suicides of celebrities are by far the most likely to trigger copycat effects, it has been suggested that perhaps the media should pay less attention to these "newsworthy" suicides. Researchers believe coverage in the print media should be reduced because it triggers more copycat suicides than the electronic media.

Finally, the mention of the negative consequences of suicide (e.g., pain and disfigurement) in suicide stories might reduce the imitative effect. These features of suicide are typically not included in suicide stories. One exception is the case of the late 1970s mass suicide at Jonestown where bloated and rotting bodies were shown in news stories and suicide declined. The Jonestown-triggered drop in suicide may not translate to suicide stories not dealing with cults; however, this one neglected aspect of the presentation of suicide stories may offset any copycat effect if it were enacted as part of a media policy.

See also: CHILDREN AND MEDIA VIOLENCE; SUICIDE

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STEVEN STACK

MENTAL ILLNESS

The term *mental illness* involves emotional suffering and/or with some degree of incapacity to perform a job or maintain fruitful social relationships. The illness most commonly associated with suicide is major depression, which is typically accompanied by chronic sadness, loss of energy, and an inability to tackle daily activities. Although none of these symptoms necessarily leads to suicide, most suicides experience one or more of them. Two other mental illnesses often associated with suicide are schizophrenia and manic depression or bipolar disorder, both of which can involve mental confusion and usually require hospitalization. Alcoholism and drug addiction, with their attendant loss of control over emotions and actions, are also associated with suicide. Personality disorders involving an inability to control anger and impulses have also been noted among suicidal patients.

Clearly mental illness does not always lead to suicide or even to suicidal thoughts. Some 30 to 40 percent of Americans experience some form of mental health problem during their lives, but only 1.5 percent of Americans die by suicide each year. Thus, the overwhelming majority of people with mental health problems do not take their own lives. Even if such people are given to suicidal ideas, the likelihood of their acting on those ideas is remote.

The majority of persons who commit suicide have experienced serious difficulties with their parents during childhood. More than half have

been rejected, abandoned, or physically or psychologically abused. These early adversities may make them more likely to mistrust other people and less able to face difficulties such as marital separation or financial distress.

If most mental health problems do not lead to suicide, most suicidal persons do suffer from mental health problems. Studies from the United States, Canada, India, Taiwan, and Finland show that 90 percent of suicides have had a psychiatric problem during the year before their death. At least one-third were seen by a psychiatrist, and a majority of them had more than one problem (e.g., combination of drug abuse and depression).

Mental Health Problems Commonly Associated with Suicide

Almost half of suicides suffer from severe depression, and some researchers claim that as many as 10 percent of those suffering from a depression will eventually die from suicide. Yet depression alone will not trigger a suicide. For instance, twice as many women as men suffer from depression, but, in the Western world, men are three to four times more likely to die from suicide. People who suffer from melancholy, irritability, and lack of appetite—all well-known signs of depression—are not necessarily high risks for suicide. Those who suffer from more severe forms of depression, involving insomnia, memory difficulties, and unkemptness—are at greater risk for suicide. Erkki Isometsä and her colleagues in Finland have found that only 3 percent of those who committed suicide and were suffering from depression had received adequate treatment with antidepressant medication.

The most salient indicator of suicide risk among depressives is the feeling of hopelessness. This feeling is not an essential element of depression, but it appears when friends and family members lose patience with the victim of depression. Having some form of family or community support is a key to preventing depression. Countries with a strong tradition of community support often have low rates of suicide even if they have experienced civil wars and generally high rates of depression.

Suicide results in 10 to 15 percent of the cases of those suffering from schizophrenia or manic depression. According to various studies, one quarter

to one-half of persons with manic depression attempt suicide. One of the reasons why these patients are at such a high risk is because they often abuse drugs and alcohol to relieve the tensions resulting from their mental symptoms. The period of greatest risk is the five years following a hospital stay. Finally, those who are more depressive than manic are at a correspondingly greater risk of suicide.

Schizophrenics are more likely to commit suicide at a younger age, with only one-third taking place after age forty-five. Careful research does not support the widely held belief that persons with schizophrenia decide to kill themselves when they are feeling better, as a means of avoiding a relapse into their previous emotional agonies. On the other hand, four out of five commit suicide during periods of aggravated confusion and depression. It is also important to note that 40 percent of schizophrenic suicides were not taking their antipsychotic drugs as specified. Alcohol abuse is not common among schizophrenics, but they usually require less alcohol intake to experience inebriation. The most common feature of schizophrenic suicide is recent hospitalizations. Such hospital stays are typically repeated and brief and often coercive—many of them the result of previous suicide attempts.

Mental Illness and Stages of Life

Suicide increased among adolescents and young adults in Canada and many countries of Northern Europe in the latter part of the twentieth century. Many experts associate this increase with a rise in depression in this younger age group during the same period. Adolescents do indeed now suffer from depression as much as adults do (more, according to some studies), and half of adolescents who die by suicide suffer from depression. According to one study, adolescent depression may last for just a short period before the final act, leaving little time for intervention.

For older people, physical ailments are an important variable in suicide rates, but their frequency of psychiatric problems is just slightly less than in younger age groups. A serious handicap or illness is also a source of depression because it threatens self-esteem. In contrast to younger age groups, older people who die by suicide are more likely to suffer only from depression and seldom

have multiple mental health problems. This circumstance renders their depression easier to treat.

The Role of Mental Illness in Suicide

Even if suicide is closely linked to mental illness, it does not follow that a rise in the rate of mental illness will bring about an increase in suicide since, as we have seen, the majority of people with some form of mental illness do not take their own lives. Furthermore, some countries with a low rate of suicide have a high rate of mental illness.

Can suicide, then, be attributed to new types of mental illness brought on by social change? For instance, psychiatrists have taken increasing note of the phenomenon known “borderline personality,” a disease characterized by high impulsivity and a sense of emptiness, which now accounts for twenty percent of psychiatric inpatients. Drug abuse and social exclusion may contribute to the severity of this condition, which presents a correspondingly higher risk of suicide because of its association with impulsive behavior. For this very reason suicide can be highly unpredictable and thus difficult to prevent. With some impulsive persons, fewer than twenty-four hours elapse between a traumatic episode such as a separation and a suicide attempt. This trait of high impulsivity is not only an element of mental illness; it may result from experiences of abandonment and abuse suffered during childhood. In this regard, observations on social primates early maternal deprivation leads to self-injurious behavior later on in life. The chemistry of the brain is likely to have a role in the transmission of this reaction.

When impulsivity is a major symptom of mental illness, parents, especially single mothers, often have less success in intervening in the case. Increasingly permissive child-rearing methods seem to have aggravated this problem because many parents—not only those with mentally ill children—find it increasingly difficult to control and socialize children’s aggressive behavior.

Society’s attitudes of exclusion toward mentally ill persons can also make them more vulnerable to suicide. Once consigned to asylums, increasing numbers of the mentally ill now find themselves relegated to fending for themselves in the harsh milieu of metropolitan inner cities, perhaps interrupted by repeated short stays in hospitals in times of crisis. The health services other than hospitals are often insufficient to ensure that these patients

have a decent quality of life. And among psychiatric patients, those who die by suicide tend to have been abandoned by their families.

Recent scholarship has identified a series of indicators for suicide risk in mental patients that have little to do with any specific psychiatric illness. The main characteristic is the state of hopelessness. The second is obsession with a single problem, a state referred to by suicidologists as “tunnel vision.” The third indicator is social withdrawal, and the fourth is avoidance of activities.

Some genetic factors related to impulsivity have also been identified as a possible key to suicidal behavior, especially in cases of manic depression or bipolar disorder. But this genetic component cannot explain sudden changes in the rate of suicide in a population.

Finally, that the burden of psychiatric illness is aggravated by the onset of a physical illness in suicide. Some 40 percent of suicide victims suffer from a serious physical illness such as cancer or a neurological disorder.

Prevention and Intervention

Suggested preventive measures vary widely. An increase in antidepressant prescriptions in Sweden, Denmark, and Hungary has been accompanied by a decrease in suicide. However, during this period Scandinavian countries have also developed elaborate psychosocial suicide prevention programs. In contrast, in China, where the suicide rate is high, only 5 percent of those suffering from depression receive proper care. Antidepressant medication can become a factor in reducing suicide in the future, especially if accompanied by some form of psychotherapy and adequate social support.

As of 2002, more programs have been developed by psychiatric teams to follow up patients after a hospitalization for a suicide attempt. A plan to provide those persons with a green card giving priority to crisis intervention services in case of emergency has produced positive results in England.

About one-third of people who commit suicide are under psychiatric care. Many of them are not easy to treat, and they do not always take prescribed medications as indicated. More than three-quarters do not manifest any suicidal intent to their doctor, making screening very difficult. Yet new treatment methods for some of the most difficult

suicidal cases, self-centered and impulsive alcoholic men, are bringing some hope. For example, the program implemented by Anthony Bateman and Peter Fonagy in England requires an extensive professional investment in group and individual therapy lasting over a year and a half, but this is less costly than the medical treatment of repeated suicide attempts.

See also: SUICIDE; SUICIDE BASICS: EPIDEMIOLOGY; SUICIDE INFLUENCES AND FACTORS: BIOLOGY AND GENETICS, CULTURE

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MICHEL TOUSIGNANT

PHYSICAL ILLNESS

According to a variety of studies suicide is more common among people suffering from physical illness. In addition, people with irreversible illnesses are much more likely to take their own lives than healthy individuals. Still, a minority of those who suffer from physical illnesses take their own lives, invariably well under 8 percent. Nevertheless, not all physical illnesses are related to increased suicide risk. Therefore it is important to understand why some individuals who are physically or terminally ill commit suicide while others do not.

Common Physical Illnesses Related to Suicide

In 1986 the researcher Francis Whitlock summarized the results from fifteen published research studies of suicide which include information on

physical illnesses and found that when psychiatric and geriatric patients are excluded about one-third of persons who died by suicide had a physical illness at the time of their death. The studies varied, reporting 25 to 70 percent of patients as having a physical illness. Furthermore, the physical illness could be conceived as an important contributory cause of the person's death in between 11 percent and 51 percent of the cases. Almost a decade earlier, the researchers Donna Myers and Charles Neal reported that psychiatrically ill persons who committed suicide were, in almost 30 percent of the cases, also physically ill. Illnesses that are related to increased suicide risk include epilepsy, cerebral disease, Huntington's chorea, Parkinson's disease, cancer, gastrointestinal disease, renal disease, and AIDS (acquired immunodeficiency syndrome).

Epilepsy. A study conducted in England found that the risk of death by suicide among epileptics is 5.4 times greater than in the general population and about 5 percent of deaths by people suffering from epilepsy were suicides. The risk of suicide in females with epilepsy is twice that of males. There is little research indicating why those people suffering from epilepsy have a higher suicide risk.

Head injuries and cardiovascular disease. Major depression is associated with cerebral disease. Therefore, because of the significant link between depression and suicide, it is not surprising that there is a greater risk of suicide among persons who have sustained head injuries or who have had cardiovascular disease and also have symptoms of clinical depression. In a 1980 study conducted by Francis Whitlock and Mark Susskind, there was a six times greater prevalence of cardiovascular disease among suicide victims than the general population.

Huntington's chorea. When it was originally named in 1872 Huntington's chorea was described by George Huntington as a disease "with a tendency to insanity and suicide" (Adams 1994 p. 262). According to Whitlock, although about 7 percent of noninstitutionalized patients with Huntington's disease will eventually die by suicide, this is still a much greater proportion than in the general population. More than half of the suicides occur when individuals first showed signs of the early stages of the illness.

Parkinson's disease. In 1955 the researcher Peter Sainsbury found that the number of cases of Parkinson's disease among the suicides in England

was 200 times greater than persons not suffering from Parkinson's disease. He interpreted the greater suicide risk as being associated to the higher rates of depression among Parkinson's sufferers.

Cancer. Studies indicate that there are fifteen to twenty times more people suffering from cancer who eventually commit suicide than those who do not suffer from cancer. Although one might expect that people with cancer would commit suicide fairly late in the development of the disease when they were more debilitated or experiencing more pain and suffering, studies show the opposite: The highest rate of suicide appears to be in the first year after the patient has received notification of the diagnosis. Most cancer patients are chronically depressed (80%), but so are suicide victims who are matched according to various epidemiological factors but do not have a cancer history (82%). In a 1995 review of studies indicating the prevalence of depression in cancer patients, the researcher Mary Lynch found that between 3.7 percent and 58 percent of cancer patients could be diagnosed as suffering from depression. However, only 5 percent of depressed cancer patients die by suicide.

Medical professionals know little about why some cancer patients who are depressed end their lives by suicide and others do not. Most researchers stop looking further once they determine that the person was depressed. When one considers the cause of depressive symptoms in cancer patients, one finds that depression is sometimes secondary to organic causes such as side effects of anti-cancer drugs and other pharmacological therapies. Depression may be a reaction to the crisis of having cancer or a reaction to pain and suffering that is not sufficiently controlled. In 1983 the researchers Letie Hansen and Charles McAler found that health care professionals were more likely to condone suicide in terminal cancer patients than in patients with other diagnoses. They found that the acceptance of suicide in their patients was more likely to occur if the practitioners had a high degree of death anxiety themselves.

Gastrointestinal disease. There are between two and one-half and eleven times higher rates of peptic ulcers among suicide victims than in the general population. Medical researchers interpret the high rate of peptic ulceration among suicide victims as being due to alcoholism, since gastritis and ulceration of the upper gastrointestinal tract are

found in those people who have a history of alcoholism. Further, alcoholics have a high risk of suicide with or without gastrointestinal disorders.

Renal disease and hemodialysis patients. Depression is common among patients with end-stage renal disease and hemodialysis patients. There is an at least 100 times greater suicide risk among dialysis patients than nondialysis patients. These rates would be higher if those who stopped treatment or failed to follow the treatment program were included as suicides in these studies.

AIDS. In a 1999 review of all studies on AIDS and suicide published to date, Brian Mishara concluded that there is a high risk of premature death by suicide among AIDS patients. However, there appears to be an even greater risk among people who first learn they are HIV (human immunodeficiency virus) positive and do not have any symptoms. There are results from autopsy studies that suggest that persons who inaccurately thought they had AIDS have committed suicide.

Explanations of the increased suicide risk among AIDS patients have focused upon depression. However, alternative explanations include the possibility that those who become HIV positive are more often from groups with a high risk of suicide to begin with, including homosexual men and intravenous drug users. Other hypotheses have included the possibility that the symptoms and pain associated with AIDS are related to increased suicide risk, or that diminished meaning of life or coping abilities associated with AIDS are related to suicide risk. In a longitudinal investigation of persons with AIDS conducted from 1998 to 2001, Mishara found that although depression and several other factors were associated with greater suicidal contemplation, when all the factors were analyzed together, the only significant ones that remained were the ways people with AIDS cope with problems and meaning of life.

Other physical illnesses. Several physical illnesses that one might expect to be associated with greater suicide risk have not been proven to increase the risk of suicide. For example, people with multiple sclerosis appear to have a relatively low suicide risk. Persons suffering from senile dementia and Alzheimer's disease do not have an increased risk of suicide and in fact may have fewer suicides. In the case of senile dementia and Alzheimer's disease, the lower suicide risk may be related to an

inability to complete a suicide in those who are disabled by the disease or, alternatively, it may be that persons with senile dementia are not necessarily suffering. It is not clear whether or not there is a higher prevalence of suicide among persons suffering from cardiovascular diseases or hypertension. There have been cases of suicides among people with cardiovascular disease and hypertension, and in these instances medical professionals have suggested that medications used for the treatment of hypertension and cardiac disease may induce depression in many cases and thus may increase the risk of suicide.

People with disabilities and chronic non-life-threatening illnesses are frequently diagnosed as having clinical depression. Some researchers feel that their diagnosis is an error because many of the symptoms of these diseases are also used to classify a person as depressed. Despite the frequent diagnosis of depression, there is no research evidence to confirm the hypothesis that persons with physical disabilities or chronic non-life-threatening illnesses are more likely to attempt or complete suicides than healthy individuals. A possible exception to this is people who suffer from asthma for whom there are clinical descriptions of deaths by suicide related to anxiety associated with the condition's symptoms. However, hard data on the number of persons suffering from asthma who commit suicide are not available.

Possible Explanations for the Link between Suicide and Illness

How can researchers, medical professionals, and social scientists explain the increased risk of suicide among people with serious or chronic physical illnesses? Most studies focus on the presence of depression and consider depression as if it were a "cause" of the suicide. However, depression is present among all suicide victims—those who are physically ill as well as those who are in good health. Furthermore, only a very small percentage of people who are depressed commit suicide and only a small percentage of people who are physically ill and depressed end their lives by suicide. For most people it seems logical to be depressed when a person suffers from a serious illness such as cancer or a physical disability. However, the depression may be a side effect of the illness itself or of medications used to treat the person. In some cases patients may be depressed because of their

physical environment; for example, patients in a hospital are more depressed than patients who are terminally ill and treated in a hospice environment or in their own homes.

Researchers believe it would be worthwhile to identify depression among those who are physically ill and then identify the causes of the depression. Once the causes of the depression are determined, treatment would be indicated. In some instances treatment may include prescribing an antidepressant medication or changing or adjusting the dosage of medication the person is currently taking. In other instances counseling or psychotherapy can be helpful. However, professionals must not overlook the possibility that the quality of life in terms of daily experiences and interpersonal interactions may be related to the depression as well. Furthermore, side effects of the illness may be better treated or improved and this may have an important effect upon depressive reactions.

The second major explanation of increased suicide risk is that it is associated with direct consequences of the illness, usually pain and suffering. In the case of cancer, uncontrolled pain is related to suicidal behavior. There is a general consensus in the medical profession that if a physician administers adequate pain control a patient's desire to hasten death by suicide may significantly decrease. Despite the link between pain control and suicide in cancer patients, it is not obvious that there is a link with pain in other illnesses. For example, in people with AIDS pain and suffering do not appear to be related to suicidal intentions.

There has been little research completed on the relationship between suicide and how people cope with their illnesses. The few investigations that exist suggest that how people cope with their illnesses and the social support they receive may be important factors in determining whether or not those who are seriously, chronically, or terminally ill desire to continue living.

Conclusions

Physical illness is not invariably associated with greater suicide risk; however, many people with physical illnesses have a much higher risk of suicide than the general population. Many illnesses and physical disabilities may not be experienced as negatively as the general population believes. For

example, in the case of people with physical handicaps and many chronic degenerative diseases, the time when there is a greater risk of suicide varies, depending upon the particular handicap or disease. In the case of AIDS and with some cancer victims, there appears to be a greater risk of killing oneself after learning about the diagnosis, rather than later when the illness results in serious symptoms and handicaps. The timing of the suicide suggests that it may not be the illness that results in increased suicide risk, but rather people's fears about the future and concerns about living with or dying from the illness. These fears may be alleviated or reduced by professional counseling and support from family and friends during the early stages when the person first learns of the diagnosis.

It appears that patients participating in hospice and palliative care programs are less likely to end their lives prematurely by suicide. If this fact were confirmed, it would suggest that greater availability of such palliative care may have an important preventive effect. However, hospice programs and palliative care are often only available to persons identified as "terminally ill" who have discontinued all treatments to prolong life. Many seriously ill persons do not benefit from the advantages of palliative care programs because they fail to meet criteria for being "terminally ill" or they have chosen to continue treatments despite the advances of their illness. Wider availability of hospice care programs as well as good palliative care services for those who are not yet terminally ill or for those who have chosen to continue treatment may have a significant effect in preventing suicide with people who are physically ill.

It does not appear that the jurisprudence legislation in the Netherlands since the mid-1980s legalizing euthanasia has resulted in either a decrease or an increase in suicide among persons who are physically ill. Based on clinical knowledge, the best ways to prevent suicide among people who are physically ill are to develop protocols for identifying the potential sources of depression and to develop more effective means of treating depression. Furthermore, educators must change physicians' attitudes regarding suicide, since research shows that physicians are more likely to feel that a suicide is "justified" when a person is seriously or terminally ill. These attitudes may hinder appropriate identification and treatment of clinical depression. Besides treating depression it is important, particularly

among cancer patients, to ensure that there is adequate pain management and control. Furthermore, any activities that improve the quality of life, social supports, and the amount of communication with family that are possible to employ would most likely result in preventing suicide.

See also: AIDS; COMMUNICATION WITH THE DYING; GOOD DEATH, THE; PAIN AND PAIN MANAGEMENT; SUICIDE; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE, RATIONAL SUICIDE; SYMPTOMS AND SYMPTOM MANAGEMENT

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In one of several controversial lawsuits that blame rock music for a suicide death, Ozzy Osbourne, at a 1986 press conference in Los Angeles, denied all allegations that his song "Suicide Solution" was responsible for the death of a young boy who shot himself. BETTMANN/CORBIS

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ROCK MUSIC

Suicide as a rock music trope can have many meanings, including rebellion against established social norms, sometimes to the point of nihilism; criticism of authority figures, such as teachers, politicians, and parents; and evocation of emotional traumas. Often these songs use sarcasm to register disenchantment with society, family, interpersonal relationships, or life itself. In much the same way that Jonathan Swift's "A Modest Proposal" suggests that the starving Irish should eat their plentiful children, many rock songs suggest suicide, whether intentionally or unintentionally, as a response to the listeners' troubles.

Beginning in the 1980s, a series of wrongful death lawsuits focused public attention on the purported link between rock music and suicidal behavior. It seemed to many that rage-filled, overtly anti-establishment songs were actively encouraging adolescents to commit suicide. The rock group

Judas Priest was alleged to use "subliminal" messages encouraging suicide. In the late 1990s concerns about the effects of music lyrics and controversial artists like Marilyn Manson resulted in a public hearing before the U.S. Senate. While no wrongful death suit has been prosecuted successfully against an artist and no empirical evidence exists that rock music in general, or any artist in particular, has directly caused any teen suicides, controversial music and musicians remain under scrutiny from scholars and officials who suspect a connection.

Although some may believe that only the most angry and nihilistic music includes suicidal themes, instead, it has been used by a wide variety of artists. Simon and Garfunkel, in their landmark 1966 album *The Sounds of Silence*, included two songs about suicide. One of them, "Richard Cory," is an adaptation of the well-known Edward Arlington Robinson poem that describes a community's shock when a rich and well-respected person commits suicide. Written in the turbulent 1960s, this song challenges the assumption that financial success is the measure of happiness. A very familiar song is "Suicide is Painless," the theme to the

movie and television show *M.A.S.H.* While mainly known in its orchestral version, the lyrics describe the despair and hopelessness of suicidal depression. However, perhaps the most famous suicide song is decidedly non-mainstream Ozzy Osbourne's "Suicide Solution." The song lyrics, when taken out of context, can be interpreted as pro-suicide, but, in fact, the song as a whole is an ironic description of alcohol abuse as slow suicide: "Wine is fine, but whiskey's quicker / Suicide is slow with liquor."

Current research indicates that those most vulnerable to suicide often suffer from severe psychopathology, substance abuse, and/or extreme psychosocial stress. Hence, some analysts contend that music steeped in nihilism and social alienation may simply reinforce a suicidal predisposition stemming from other factors. Others point out that a vulnerable listener's extreme identification with a rock star whose behavior is suicidal or self-destructive can lead to imitation. A mitigating factor is the type of media coverage of celebrity deaths; since the 1994 suicide of Nirvana member Kurt Cobain, there have been confirmed reports of attempted or completed suicides by fans of his music and lifestyle, but not nearly the number feared. As long as there are rock stars whose music and lives romanticize the daring and rebellion of self-destructive behavior, their possible influence over the lives of their devoted followers will continue to raise questions and concerns.

See also: SUICIDE INFLUENCES AND FACTORS: MEDIA EFFECTS; SUICIDE OVER THE LIFE SPAN: ADOLESCENTS AND YOUTHS

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LAURA PROUD
KEITH CHENG

SUICIDE OVER THE LIFE SPAN

ADOLESCENTS AND YOUTHS *Brian L. Mishara*

CHILDREN *Brian L. Mishara*

THE ELDERLY *Diego De Leo*

ADOLESCENTS AND YOUTHS

Suicides of the young, those who have most of life's highlights to experience, are profoundly challenging to cultural systems. Considerable soul searching was triggered in the United States when, between the mid-1960s and mid-1980s, the suicide rates of its ten- to fourteen-year-olds nearly tripled while doubling among those aged fifteen to nineteen. Although the suicide rates for adolescents in the United States and Canada are lower than for other age groups because adolescents die infrequently from physical illnesses, by the end of the twentieth century suicide was the second greatest cause of death in adolescence, after (mainly automobile-related) accidents.

The term *youth* is often considered to end several years after adolescence, with twenty-first-century tendencies setting the upper limit for "youth" at age twenty-five or older. In the United States, males aged fifteen to twenty-five commit suicide at least five times as often as females, although females are much more likely to attempt suicide. This difference has been explained in different ways, including male preferences for more violent and more lethal methods; male tendencies to keep problems to themselves and not confide in others

nor use health and mental health services as frequently; increased male vulnerability to mental health problems; socialization into male stereotypes and “macho” role expectations. During the 1990s suicide rates began to decrease among those aged fifteen to nineteen except among African Americans. The decrease may be attributed to better identification and treatment of mental disorders in youth, increased awareness of suicide and access to suicide prevention resources, or other sociocultural changes in American society.

Risk Factors Related to Adolescent and Youth Suicide

Mental health professionals have identified those factors that pose the greatest risk to adolescents and youth suicides. Youths who attempt and commit suicide generally have several risk factors, which are combined with the ready availability of a lethal means and the lack of suitable sources of help.

Social and economic environments. The family is one of the earliest and most significant influences in a young person’s development. There have been numerous studies of family troubles associated with youth suicidal behavior, including early parental loss, parental mental health problems, parental abuse and neglect, and a family history of suicide. In addition to chronic family troubles, there are usually precipitant events closer in time to a suicide attempt, many of which involve the family. These precipitants include serious conflicts with family members or divorce of parents, perceived rejection by one’s family, and failure of family members to take an adolescent’s talk about suicide seriously.

The school constitutes an important influence on youth. It is therefore not surprising that a history of school problems and the stress of disruptive transitions in school are potential risk conditions for youth suicidal risk behavior, as well as failure, expulsion, and overwhelming pressure to succeed.

The influence of peers on young people’s behavior can sometimes be greater than that of family and school. There is a risk of copycat suicidal behavior in adolescents who have been exposed to a peer’s suicide. This contagion effect is most pronounced for vulnerable youths who tend to identify strongly with someone who has committed suicide in their environments or in mass

media. Common precipitating events in youth suicidal behavior include rejection from peers, the breakup of a significant relationship, or the loss of a confidant. Furthermore, adolescents and young people who fail to act when confronted with a suicidal peer, by dismissing it as insignificant or failing to inform an adult, can increase the risk of suicide.

Poverty in children and youth heightens the risk conditions for suicide, including school problems and failures, psychiatric disorders, low self-esteem, and substance abuse, all of which can increase vulnerability to suicide and suicidal behavior.

Physical environment. Having immediate and easy access to lethal means to kill oneself increases the risk that a suicide will occur. Firearms are common methods of male suicides in the United States, and young women are increasingly using guns to kill themselves. Having such an instantly lethal method available increases the risk that vulnerable young people may kill themselves impulsively.

Additional risk factors. The researcher Jerome Motto suggested that the increased use of alcohol and drugs might have been a significant factor related to the rise of youth suicide since the 1970s. According to David Brent, at least one-third of adolescents who kill themselves are intoxicated at the time of their suicide and many more are likely to be under the influence of drugs.

A history of previous suicide attempts and the presence of a psychiatric disorder are among the most important and well-established risk factors for youth suicidal behavior. As many as 10 percent of suicide attempters eventually die in a later suicide attempt. Depression is a major mental health problem associated with suicide. In addition, impulsive behavior, poor problem-solving and coping skills, alcoholism, and homosexual orientation also increase the likelihood of suicidal behavior.

Prevention

No single risk factor alone is sufficient to result in a suicide. Youths who attempt and commit suicide generally have several risk factors that are combined with the ready availability of a lethal means and the lack of suitable sources of help.

Primary prevention. Primary prevention consists of actions to prevent suicidal behavior before people develop a high-risk or a suicidal crisis. Most

youth and adolescent suicide prevention programs have focused on school-based activities where adolescents receive training in identifying signs of suicide risks and how to best react to suicidal peers. Some programs also identify resources to help with suicide and encourage young people to talk with adults if they feel that they or their friends are feeling suicidal. Young people are specifically encouraged not to keep a “secret” confession of suicidal intentions to themselves. Controversy surrounds the usefulness and effects of school-based suicide prevention programs. Few programs have been the subject of rigorous evaluations and not all programs have had positive results. Research indicates that programs that provide a variety of resources within the school and community, including specially trained teachers, mental health services and counselors, and information and training for parents, may be of more benefit in preventing suicidal behavior.

In addition to school-based programs, many primary prevention approaches have focused on key persons who may come in contact with potentially suicidal youth. These persons, called “gatekeepers,” include school staff, child welfare workers, community volunteers, coaches, police, family doctors, and clergy members. Training usually involves information on taking suicide threats seriously and asking specific questions to assess suicide risk, identifying behavior changes that may indicate increased suicide risk, better identification and treatment of depression and other mental health problems, and providing information about resources to help with suicide and other community youth problems.

Intervention

Given their higher risk of suicide, particular treatment should be given to persons who attempt suicide. Unfortunately, many young suicide attempters do not receive adequate follow-up after they are discharged from the hospital. Successful programs for young people who are hospitalized for suicide attempts involve treatment in the community by counseling, therapy, and/or medication after their discharge. The most effective programs treat more than just the suicidal individual but also involve the person’s family in developing a long-term strategy to reduce the factors associated with suicidal behavior. Very often, young people do not want to continue with treatment after an attempt and they may tell others that they are better or that

they want to move on in their life and ignore the “mistake” they have made. Despite this, it is important to ensure that there is regular long-term follow-up after any suicide attempt in order to treat the underlying problems and reduce the likelihood of a subsequent attempt.

After a suicide occurs in a school setting, it is important that the school react in an appropriate manner to the suicidal death in order to allow other students to grieve the death and prevent a contagion effect of others imitating the suicidal behavior. Many schools have established protocols for “postvention” which often use a “critical debriefing” model to mobilize members of the community following a tragic event, including a suicide by a student. These protocols define who will act as a spokesperson for the school, how to identify students and family members who are particularly vulnerable or traumatized by the event, and how best to help them, as well as general activities in the school to allow for appropriate mourning and discussions in order to understand what has occurred. Each suicidal event is unique and any general protocol must be adapted to the specific circumstances and the school environment. After a suicide schools should provide information and help facilitate access to skilled individuals who may help those troubled by the event. However, it is also important for those in authority not to glorify the suicide by having long extended commemorative activities that may communicate to some vulnerable suicidal students that committing suicide is an effective means of having the entire school understand their grief or problems. It is important that commemorative events emphasize that suicide is a tragic event, that no one is better off for this having happened, that help is readily available, and that most suicides can be prevented.

See also: SUICIDE INFLUENCES AND FACTORS: GENDER, MEDIA EFFECTS, ROCK MUSIC; SUICIDE OVER THE LIFE SPAN: CHILDREN; SUICIDE TYPES: SUICIDE PACTS

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BRIAN L. MISHARA

CHILDREN

Children develop an understanding of suicide at an early age and that follows their understanding of what it means to die and to be dead. Although children very rarely commit suicide before adolescence, they almost invariably witness suicide attempts and suicide threats on television. In addition, they talk about suicide with other children.

Children's Understanding of Suicide

Research indicates that by age seven or eight almost all children understand the concept of suicide. They can use the word *suicide* in conversations and name several common methods of committing suicide. Younger children, as young as ages five and six, are generally able to talk about

"killing oneself," even if they do not know the meaning of suicide, and learn the unsettling effects of such talk on adults. By age seven or eight almost all children report that they have discussed suicide with others on at least one occasion, and these discussions are almost invariably with children their own age. In one 1999 study conducted by Brian Mishara, half of all children in first and second grade and all children above second grade said that they had seen at least one suicide on television. These suicides usually occur in cartoons and involve the "bad guy" who kills himself when he has lost an important battle with the "good guy." Children also experience suicide attempts and threats in soap operas and adult television programs. Surveys of parents have found that 4 percent of children have threatened to kill themselves at some time.

In Western cultures, children ages five to twelve rarely have positive attitudes toward suicide. At all age levels, children consider suicide an act that one should not do; few feel that people have a right to kill themselves. When there is a suicide in the family, children usually know about it, despite parents' attempts to hide the fact by explaining that the death was an accident. For example, in studies conducted in Quebec, Canada, by Mishara, 8 percent of children said that they knew someone who had committed suicide, but none of the children said they were told about the suicidal death by an adult.

Children's Understanding of Death

Although children understand death and suicide at a young age, their conceptions of death often differ from an adult understanding. Very young children do not see death as being final (once someone is dead, he or she may come back to life), universal (everyone does not necessarily die someday), unpredictable (death cannot just happen at any given time), nor inescapable (taking the right precautions or having a good doctor may allow someone to avoid dying). Furthermore, for the youngest children, once someone is dead he or she may have many characteristics that most adults reserve for the living, such as being able to see, hear, feel, and be aware of what living people are doing. These immature understandings of death change fairly rapidly, with children learning at a young age that death is a final state from which there is no return. Also, children learn at an early age that all people

must die someday. However, as many as 20 percent of twelve-year-olds think that once a person has died, he or she is able to have feelings or perceptions that living people experience.

Children's View of Suicide

It is naive to think that young children do not know about suicide. However, the image that children get from television is different from what occurs in the vast majority of suicides in the real world. Those who commit suicide on television almost never suffer from severe depression or mental health problems, they are almost never ambivalent about whether or not they should kill themselves, and it is rare that children see suicidal persons receiving help or any form of prevention. This contrasts with the reality in which mental health problems are almost always present—where there is tremendous ambivalence and the fact that persons who consider suicide rarely do so, as most find other ways to solve their problems.

Prevention and Intervention Approaches

To counter such misconceptions and to reduce suicidal behavior later in life, several preventive strategies have been tried. One provides accurate information about suicide to children in order to correct erroneous conceptions that children may develop from their television experiences or discussions with other children. Another focuses upon children's coping abilities. Research on adolescents and young adults who attempt suicide indicates that they have fewer effective coping strategies to deal with everyday problems. Although it may take many years before programs begin teaching young children that there is a link between effective coping and long-term suicide prevention effects, this approach has had promising short-term effects in increasing children's abilities to find solutions to their problems and improve their social skills. For example, the Reaching Young Europe program, called "Zippy and Friends," is offered by the Partnership for Children in different European countries. Developed by the prevention organization Befrienders International (and now run by Partnership for Children), Zippy and Friends is a twenty-four-week, story-based program for children in kindergarten and first grade that teaches through games and role play on how to develop better coping skills. Short-term evaluation results

indicate that, when compared to a control group of children who did not participate in the program, participants had more coping strategies, fewer problem behaviors, and greater social skills.

Research results suggest that it may not be appropriate to ignore self-injurious behavior in children and suicide threats because of the belief that children do not understand enough about death and suicide to engage in "true" suicidal behavior. According to official statistics, children almost never commit suicide. However, perhaps more children commit suicide than coroners and medical examiners indicate in reports. They may classify some deaths as accidental because of the belief that children are too young to know about death and suicide and are only "playing," or to spare parents the stigma of suicide. Nevertheless, there are numerous case histories and several investigations of factors related to suicidal behavior in children. Studies on the social environment generally focus on the greater likelihood of suicidal behavior in children from families where there is parental violence or sexual abuse, or have family histories of alcohol and drug abuse, depression, and suicidal behavior.

Depression in children appears to be a risk factor for suicide, although depressive symptoms in children are difficult to recognize and diagnose. Symptoms of depression in children include long-lasting sadness, which may be linked with frequent crying for little or no apparent reason, monotone voice, and seeming to be inexpressive and unemotional. Other possible symptoms include the development of inabilities to concentrate and do schoolwork, being tired and lacking energy, social withdrawal and isolation, refusing to continue to participate in games and group activities, not answering questions or having long delays before answering, and a variety of "somatic" complaints. These somatic complaints include sleep difficulties such as insomnia, frequent nightmares, and incontinence, anorexia, stomach pains, and complaints of physical difficulties that seem unfounded. Often depressed children seem anxious and may have multiple phobias or fears. Some children try to fight against depression by acting out or being angry a lot of the time. In these cases, the depressive symptoms are generally also present. If a child has several of the preceding symptoms, or symptoms are intense and long lasting, consultation

with a professional is indicated. This is particularly true if a child threatens to commit suicide or becomes interested in suicide methods, such as tying nooses or playing suicide games with other children or with dolls.

It can also be beneficial to ask direct questions to a child who talks about suicide. Questions might include: "Are you thinking of killing yourself?" "Have you thought about how you would do it?" "Do you think you might really commit suicide?" Despite common adult beliefs that asking questions might "put ideas" in a child's head, if a child threatens suicide, the child almost always knows about suicide and it is impossible to suggest suicide behavior by talking about it. It is also important to ask suicidal children what they think will happen after a person dies. If the child gives the impression that one can return from the dead or being dead is like being alive, it may be useful to correct this impression or describe in some detail what it means to die and be dead.

One should seek advice from a mental health professional if a child has symptoms of depression and/or threatens suicide. It is also important to talk about what occurred when a child experiences a suicide in the family or in the family of friends or at school. Such discussions may begin by asking a child what he or she thinks about what occurred, including why the child thinks the person committed suicide and what the child thinks it is like to be dead. Often children have a good understanding of what has occurred, a fairly realistic notion of what happens when one dies, and a negative attitude toward suicidal behavior. However, in the event that a child glorifies or trivializes a death by suicide or feels that the suicide victim is "better off" now, it is important to continue the discussion to clarify the nature of what occurred and if necessary seek counseling or professional help. It is also important for children to be able to express their feelings about a loss by suicide (even if those feelings include "unacceptable" feelings such as anger at the person for having left). It is important for children to develop an understanding of the suicide as being a tragic avoidable death and not a situation with which the child can easily identify.

Although suicidal behavior in children is rare, one should not minimize suicidal threats and attempts in children, and it is important to be aware of persistent indications of depression in children.

See also: CHILDREN AND ADOLESCENTS' UNDERSTANDING OF DEATH; CHILDREN AND MEDIA VIOLENCE; LITERATURE FOR CHILDREN

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BRIAN L. MISHARA

THE ELDERLY

Until the 1970s suicide was most common among the elderly, while in the twenty-first century younger people have the highest suicide rate in one-third of all countries. Reasons for such a change are unclear; however, many countries of different cultures have registered an increase in youth suicide that has been paralleled by a decline in elderly rates. Since the 1970s, the decline in elderly suicide has been particularly evident in Anglo-Saxon countries, and especially among white males in United States (around 50%). Proposed explanations have considered improved social services, development of elderly political and social activism,

changing attitudes toward retirement, increased economic security, and better psychiatric care. By contrast, the lack of specific services for the elderly in Latin American countries may account for the increase in suicide rates in recent years. Moreover, the spontaneous support provided by traditional family structure has been progressively declining without being replaced by alternative sources of formal support or any better education on coping with age.

Despite tremendous cultural variability across nations, suicide rates in the elderly remain globally the highest for those countries that report mortality data to the World Health Organization (WHO), as shown in Figure 1. In general, rates among those seventy-five years and older are approximately three times higher than those of youth under twenty-five years of age. This trend is observed for both sexes, and it is steeper for males. Suicide rates actually present several distinct patterns in females. In some nations, female suicide rates rise with age, in others female rates peak in middle age while, particularly in developing nations and minority groups, female suicide rates peak in young adults. Based on 2001 data, half of all suicides reported in women worldwide occur in China.

Suicide is most prevalent among male subjects, and remarkably so at seventy-five and more years of age. Particularly in the Western world, this seems to contrast with the poor health and social status experienced by elderly women that results from more compromised psychophysical conditions secondary to greater longevity, poverty, widowhood, and abandonment. To explain this difference, social scientists have suggested that women might benefit from better established social networks, greater self-sufficiency in activities of daily living, and commitment to children and grandchildren.

General Characteristics of Suicide in the Elderly

There are characteristics that are particular to this age group. Older people are likely to suffer from a physical or mental illness, and in general tend to plan their suicides rather than act on impulsivity. The suicide methods chosen by elderly persons (including women) are generally violent with a high degree of lethality, expressing strong suicidal intention. The most common self-destructive methods are by hanging, firearms (particularly in the

United States), jumping from high places (particularly in Asian metropolitan cities like Hong Kong and Singapore), self-poisoning (especially with medicine, benzodiazepines, and analgesics, among women), and drowning.

In most cases of elderly suicides, the act is performed at home alone. When suicide notes are left, they usually contain financial dispositions and burial instructions. The notes indicate a high degree of determination, accurate planning, and emotional detachment.

Underreporting of Suicidal Behavior in the Elderly

Suicide mortality data usually carry an underestimation of their real number, a phenomenon that is thought to be particularly frequent in the elderly. For a variety of reasons, there may be reluctance to call a death a suicide, particularly in those regions where religious and cultural attitudes condemn suicide. In general, a suicide may be voluntarily hidden to avoid public stigmatization for social convenience, for political reasons, to benefit from insurance, or because it was deliberately masked as an accident. Suicide can also be misclassified as an undetermined cause of death or as a natural cause (e.g., when people neglect to take life-sustaining medications).

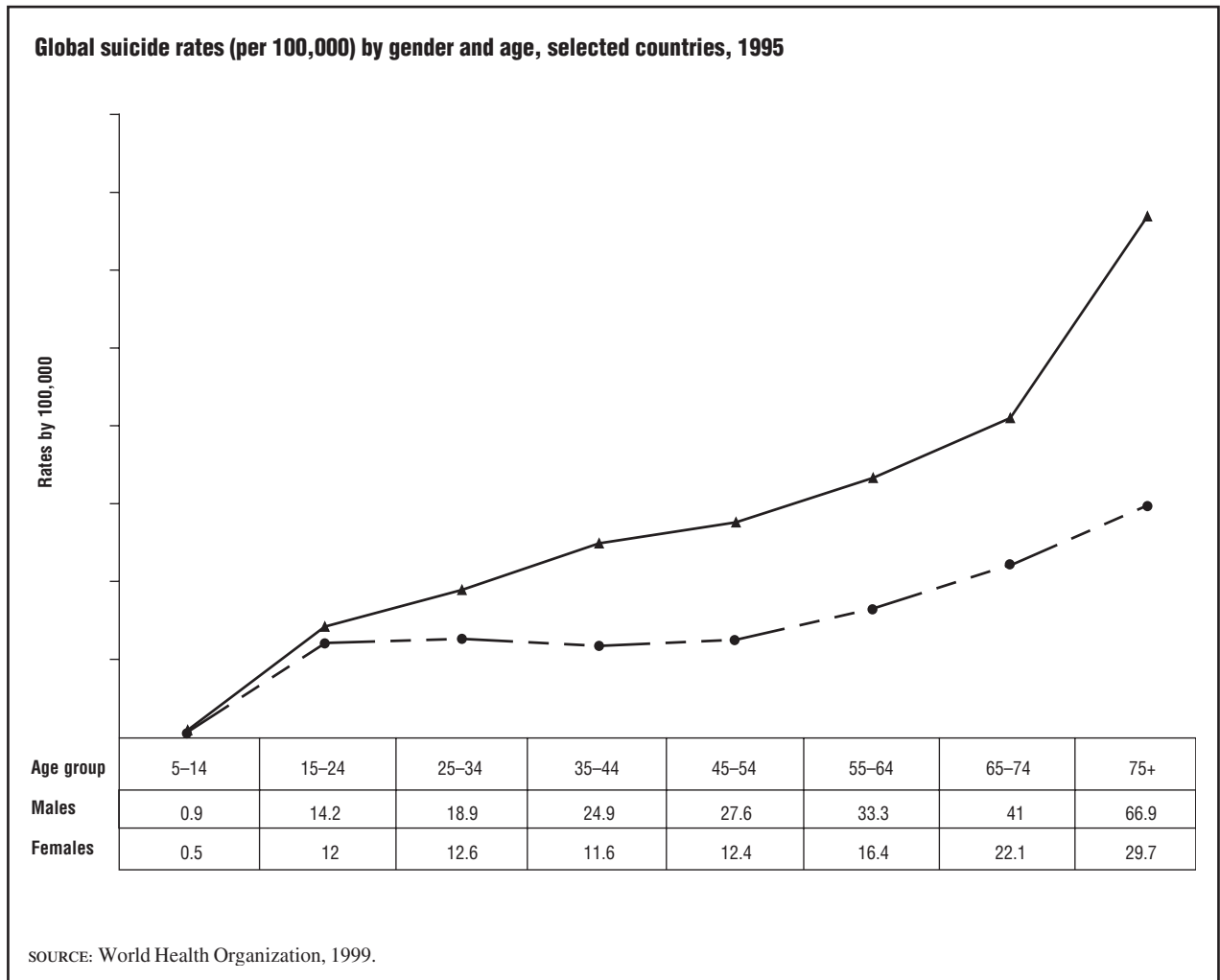
Suicide can also go unrecognized when people overdose on drugs, starve themselves to death, or die some time after their suicide attempt (in these cases usually it is the clinical cause of death which is officially reported), or in cases of euthanasia or assisted suicide.

High-Risk Factors in Suicide among the Elderly

Although the majority of elderly persons may be suffering from psychiatric disorders at the time of suicide, the large majority of them who commit suicide do not have a history of previous suicidal behavior. In addition, researchers found that only a small percentage of psychologically healthy individuals have a "desire to die."

Psychopathology. Psychiatric pathology represents the most important risk factor for suicide in the elderly. Over three-fourths of elderly victims

FIGURE 1



are reported to suffer from some sort of psychiatric disorder at the time of their death. Mood disorders are highly associated with suicidal behavior at all ages but appear to play the most fundamental role in suicide in older adults. A study conducted by Harris and Barraclough in 1997 revealed that the mean suicide risk in subjects affected by major depressive disorder and dysthymia (a less severe form of mood disorder) was, respectively, twenty and twelve times higher than expected, in relation to the general population. An excess risk persists into old age, during which time the combined suicide risk is thirty-five times higher than expected. Most elderly victims suffered from major depression: 67 percent of suicides were aged fifty or over in a 1991 study by Yates Conwell and colleagues; 83 percent in those aged sixty-five and over in the 1993 study by Clark and Clark; and 44 percent of

the over-sixty age group in the 1995 research by Markus Heriksson and colleagues.

The predominant role of mood disorders in increasing the risk of a serious suicide attempt suggests that elimination of these disorders could reduce the incidence of serious suicide attempts by up to 80 percent, particularly among older adults (sixty years and over), where the association between mood disorder and suicide attempts is stronger. However, the underrecognition and undertreatment of depression in older adults in the community is very common.

Older persons often do not present with the classic symptomatology. Nearly half of them lack a depressed mood (one of the most recognizable symptoms) in the clinical presentation. Furthermore, given the frequently simultaneous presence

of a physical illness, often masking the symptoms of depression, older persons may deliberately deny symptoms such as suicidal ideation. The problem of underrecognition of elderly depression is exacerbated by very low rates of antidepressant treatment. Even if physicians recognize that the depression may need treatment, they are often concerned about adding to the already complex regimen of medications.

Similarly, identification of persons at risk of suicide is also particularly problematic in the elderly. The lack of forewarning of suicide attempts in elderly suicide leads to particular importance being placed on the detection of suicidal ideation. Recent research examining suicidal ideation in seventy-three completed suicides found that 38 percent had expressed their suicidal intent to their doctor prior to their death. However, when consulting with friends and confidants of the deceased they found that 85 percent had communicated their intent. Several patients had denied their intent to suicide to their doctor. These figures highlight the difficulty in detecting suicidal ideation in older patients in a primary care setting, as well as advocating consultation with close ones when suicidal ideation is suspected.

Alcohol abuse and dependence are present according to different studies in 3 to 44 percent of elderly suicide victims, which is higher than the general population of the same age, and are more common among those aged sixty-five to seventy-four. The combination of drinking and depression may produce a very high risk of suicide in the elderly, especially where drinking is a maladaptive coping mechanism. Only a small number of elderly suicides were suffering from schizophrenia or other psychotic conditions, and the same holds true for personality disorders. Suicides may generally be associated with the personality trait of "lower openness to experience," inability to form close relationships, tendency to be helpless and hopeless, inability to tolerate change, inability to express psychological pain verbally, loss of control, and feelings of loneliness, despair, and dependence on others.

Finally, the role of anxiety disorders seems to be relevant only as an added condition, especially in conjunction with depression. Likewise, dementia hardly features on the diagnostic list of suicides. It has been proposed that in the early stages of

Alzheimer's disease there could frequently be suicidal ideation, but cognitive impairment may impede realization. Loss of insight from the very beginning of the disorders is more marked among subjects with deeper involvement of frontal lobes.

Physical illness. There is controversy as to the influence exerted by physical illness on suicidal behavior. In a study by McKenzie and Popkin (1990), 65 percent of older adults were afflicted by a severe, chronic physical pathology at the time of suicide and 27 percent suffered from persistent, severe illness. Because these conditions were likely to reduce autonomy and necessitate a change of lifestyle, they may induce symptoms of depression, helplessness, and hopelessness, particularly among men and those over seventy-five. Lack of trust in medical intervention and endless suffering were commonly found in depressed elderly suicides. However, the constant co-presence of a structured depressive disorder or other psychiatric pathology (e.g., substance abuse) suggests that physical illness alone does not bring about suicide outside of a psychopathological context. Researchers have suggested that most physical illnesses presenting an increased risk of suicide were associated with mental disorders, substance abuse, or both, and that these factors may be a link between medical disorder and suicide.

Recent studies reported increased suicide rates across cancer patients, especially in the first months after diagnosis and in men. However, among them a high prevalence of psychopathology has also been identified (e.g., severe depression, anxiety, and thought disturbances). An important aspect of suicide risk in relation to physical illness has to do with how patients feel about their illness and their unique fears. In most cases their fears are a manifestation of a deeper psychological problem.

Life conditions and events. Widowed, single, or divorced people are overrepresented among elderly suicide victims, particularly among men. The relatively low suicide rates for married people may reflect not only the companionship of marriage, but also its outlet for aggressiveness.

Up to 50 percent of elderly suicide victims, particularly women, are reported to live alone and to be lonely. Generally speaking, suicidal elderly have been found to have fewer resources and supports and to have less contact with relatives and friends

than the younger. However, some researchers claim that apart from more frequent losses and the presence of physical illness in the elderly, there is no particular excess of social isolation and stressful life events, compared to youth. Suicide in the elderly could be related to a narcissistic crisis due to the inability to tolerate the accumulation of minor day-to-day failures. Suicidal behavior may then be precipitated by these events in conjunction to depression or alcohol abuse.

Retirement does not constitute an important suicide risk factor per se, unless it is abrupt and involuntary, particularly in the case of white men under seventy-five and in subjects who lack the flexibility to deal with role change or health and social support. Socioeconomic decline does not appear to be as important a risk factor for the elderly suicide as it is in younger populations. Conversely, bereavement very frequently represents a stressful life event in late life, and the death of a close relative or friend is a very important factor in precipitating suicide. Risk appears to be higher when it concerns the loss of a spouse, especially if it is sudden. Men seem to be more exposed than women.

Biological factors. The study of aging brain processes showed alterations of synaptic conduction and neurotransmitters systems, such as a reduction in dopamine and norepinephrine content in various areas of the brain of the elderly and an increase in monoamine-oxidases, the enzymes that eliminate those neuro-hormones. The hypothesized higher vulnerability of elderly people to depression and suicide could be related to a defective compensatory mechanism, which may favor onset and chronic course of psychopathological process. It has been suggested that impaired regulation of the hypothalamus-pituitary-adrenal axis and alterations in the circadian rhythm, both common in the elderly, may in turn play a part in inducing suicidal behavior.

Prevention and Intervention of Suicidal Behavior

Preventative initiatives include the introduction of social security programs, reduction in the percentage of elderly persons living below the poverty line, the development of flexible retirement schemes, and improved health care availability. Greater opportunities for relations with peers and better access to recreational facilities may provide

support for urban elderly people and facilitate role transition typical of old age, including retirement and children leaving home. A systematic monitoring of physical health seems to be particularly important, in the light of its possible impact on suicidal behavior.

Identifying suicidal ideas and tendencies among the elderly is a first goal of fundamental importance. Abilities to detect mental suffering should be improved by appropriate training and educational programs, addressed particularly to general practitioners and other health professionals, such as nurses and social workers. Particular emphasis should be placed on recognition of early and atypical symptoms of psychopathology in the elderly (particularly depression in men) and on the need to eradicate passive therapeutic attitude and old-fashioned fears about psychotropic drugs to allow adequate treatment of potentially reversible mental illness. Some nonpharmacological approaches to the treatment of senile depression might also be considered, particularly cognitive therapy and interpersonal psychotherapy.

Suicide prevention programs and general mental health facilities are underutilized by elderly suicide victims. Reasons range from poor information available to the public, conviction that these services are costly, and the low credibility given by older adults to all types of agencies or institutions. An attempt to overcome elderly people's reticence to contact centers for collecting alarm signals has been through the use of active outreach programs. One such program is the "Tele-Help/Tele-Check Service" established in the Veneto region of Italy, where most disadvantaged elderly people (by loss of autonomy, social isolation, poverty, and/or poor mental health) are actively selected within the community by general practitioners and social workers. They are then assisted with at least two phone calls per week from well-trained personnel. This program is associated with a statistically significant decrease in the number of expected deaths among the elderly.

Ongoing strategies are more successful with female subjects. A possible explanation for success involves the generally more pronounced attitude of women to communicate their inner feelings and receive emotional support. Especially in Western cultures, men are less willing to express their emotions. Thus, it is more likely that males at risk are

more often underdiagnosed and undertreated, especially by general practitioners, than their female counterparts. The most promising avenues include the development of crisis intervention techniques that are able to modify the male client attitude and environment in a way that promotes in them more adaptive strategies.

Individuals affected by the suicide of a relative or close friend experience emotional stress requiring special attention, as they too are at high risk for suicide. The most important differences in the grief experience of suicide survivors compared to survivors of accidental or natural deaths concern the associated stigma of the suicide and its ramifications: feelings of guilt, blame, embarrassment, shame, loneliness, and social isolation. Supportive interventions should therefore pay special attention to the elderly, be they survivors of peer suicides or younger individuals (children, grandchildren), bearing in mind that older adults rarely take advantage of formal crisis intervention and support facilities. A particularly important role in identifying needs and organizing the feasibility of such intervention could be assumed by general practitioners, who are often the only contact elderly people actively seek or request of health and social services.

See also: SUICIDE BASICS: EPIDEMIOLOGY; SUICIDE INFLUENCES AND FACTORS: GENDER, MENTAL ILLNESS; SUICIDE TYPES: THEORIES OF SUICIDE

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DIEGO DE LEO

SUICIDE TYPES

INDIRECT SUICIDE *Brian L. Mishara***MURDER-SUICIDE** *Marc S. Daigle***PHYSICIAN-ASSISTED SUICIDE** *Robert Kastenbaum***RATIONAL SUICIDE** *Brian L. Mishara***SUICIDE PACTS** *Janie Houle, Isabelle Marcoux***THEORIES OF SUICIDE** *David Lester*

INDIRECT SUICIDE

Suicide, perhaps the most obvious type of avoidable death at any age, is an intentional act that quickly results in death. However, there is a wide range of indirect suicidal behaviors in which death results gradually rather than immediately, and in which the degree of intentionality is less obvious than in an overt suicide attempt.

Defining Indirect Suicidal Behavior

Robert Kastenbaum and Brian Mishara, in their discussion of the concept of premature death and its relationship to self-injurious behavior, suggested that behaviors that shorten life are varied in form and widespread. They recognized that in one sense all human behavior affects a person's life expectancy. Some obvious examples of potentially life-shortening behavior include smoking cigarettes, taking risks when driving, and ignoring doctors' orders. On the other hand, life span can be prolonged by exercising regularly, eating well, using care when crossing the street, and driving an automobile in good condition equipped with air bags while always wearing a seat belt.

Indirect suicidal behavior is thus a matter of probabilities rather than certainties. Not taking one's heart medication or crossing the street carelessly will certainly increase the probability of a

premature death. However, the timing of the occurrence of a subsequent heart attack is unknown; some people cross recklessly and live a long life, while others are hit by a car and die the first time they are not careful. Similarly, smoking cigarettes is clearly associated with a reduction in life expectancy, and most people know this, including smokers. However, as many smokers will point out, there is usually a case of a person someone knows who has smoked for decades and lived to old age.

Suicides are often deemed indirect where there is no immediate and clearly identifiable intentionality. The pioneer suicidologist Edwin Shneidman spoke of “subintentioned death” and “indirect suicide” (1981, p. 234). He felt that orientations toward death, or “toward cessation,” fall into four categories, which include intentioned, subintentioned, unintentioned, and contraintentioned. Suicide is by definition generally considered to be intentioned. Accidental deaths are unintentioned, and his category of “contraintention” includes people who feign death and threaten death. He specifies four groups of persons who have subintentional orientations. First, there is the “death-chancer” who gambles with death by doing things that leave death “up to chance.” Suicidal behavior in which there appears to be a calculated expectation for intervention and rescue are examples of this form of subintentional suicidal behavior.

The “death-hastenings” are individuals who unconsciously aggravate a physiological disequilibrium to hasten death. Death-hastenings may engage in a dangerous lifestyle, such as abusing the body, using alcohol or drugs, exposing themselves to the elements, or not eating a proper diet.

The “death-capitulators,” by virtue of some strong emotion, play a psychological role in hastening their own demise. These people give in to death or “scare themselves to death.” Shneidman includes in this category voodoo deaths and other deaths in which psychosomatic illness and higher risk of complications (e.g., high blood pressure and anxiety) increase the probability of an early death.

Shneidman’s fourth and final category is the “death-experimenter,” who does not wish consciously to end his or her life but who appears to wish for a chronically altered or “befogged” state of existence. This includes alcoholics and barbiturate addicts.

Interpretations by Freud and His Followers

Although Freud did not discuss indirect suicide, he developed the concept of the death instinct later in his life. It was his student Karl Menninger who elaborated on the concept of a death instinct, Thanatos, which he viewed as being in constant conflict with the opposing force of the life instinct, or Eros. According to Menninger, there is an inherent tendency toward self-destruction that may, when not sufficiently counterbalanced by the life instincts, result in both direct and indirect self-destructive behavior.

Norman Farberow expanded upon Menninger’s theory and developed a classification system for what he called “indirect self-destructive behavior.” Farberow felt that direct and indirect self-destructive behaviors differ in many ways. The impact of indirect self-destructive behaviors is most often long-term and frequently permanent, so that only the results are clearly apparent. Unlike direct suicidal behavior, indirect self-destructive behavior is not linked to a specific precipitating stress; hence this behavior is not sudden or impulsive. Unlike completed suicides and suicide attempts, indirect self-destructive behavior does not entail a threat to end one’s own life; nor does it involve clear messages that indicate a death wish. Indirect self-destructive people are generally self-concerned and unable to invest much of themselves in a relationship with significant others. They are often alone and have limited social support systems. In contrast, the suicide attempts of the direct self-destructive are often related to the loss of a significant other.

Studies of Other Species

Humans are the only species who engage in intentional self-destructive behavior. Philosophers generally limit the possibility of voluntary and intentional self-destruction to the human race. Nevertheless, self-initiated behaviors that result in harm and death do occur in other species. These behaviors, while obviously self-destructive, do not have the characteristic of conscious decision-making that is unique to humans. Nevertheless, they may ultimately result in injury or death. Researcher Jacqueline Crawley and her colleagues present a review of ethological observations of self-sacrificing deaths in some animal species—usually in defense of territory. Parental behavior may be at

the core of many altruistic behaviors, with parents in many species performing some forms of self-sacrifice for the survival of their offspring.

When environmental conditions become stressful for animals, such as for those confined in zoos, self-mutilation and refusal to eat may result. Similarly, pets that are boarded at a kennel or have lost masters to whom they were very much attached may refuse to eat or may mutilate themselves. Crawley speculates that similar dynamics may explain the increased incidence of self-destructive behavior in humans who are imprisoned. More humane care in institutional settings can result in an elimination of self-destructive behaviors in animals. Crawley speculates that greater nurturing and caring behavior may similarly reverse many of the stress-related, self-injurious behaviors in humans.

Research Studies

Indirect suicidal behavior has been studied in several populations. For example, researchers Carol Garrison and colleagues conducted a survey of a community sample of 3,283 American youths in the range of twelve to fourteen years of age. They determined that 2.46 percent of males and 2.79 percent of females engaged in “nonsuicidal physically self-damaging acts” (Garrison 1993, p. 346). Those who engaged in these behaviors had more suicidal ideation, were more likely to have been suffering from a major depression, and had more frequently experienced recent misfortunes.

The researcher Yeates Conwell and his collaborators found that although suicide is rare in nursing homes, indirect self-destructive behaviors, such as refusing to eat or not taking life-sustaining medications, are commonplace. Reviews by McIntosh, Hubbard, and Lester suggest that more elderly persons may die from indirect suicide than from direct suicidal behavior.

Larry Gernsbacher, in his book *The Suicide Syndrome*, speaks of individuals who engage in what he calls “a suicidal lifestyle.” He includes in this category alcoholics and drug addicts. These behaviors are considered to be expressions of unconscious suicidal motivations. Gernsbacher asks, “What better way for him to express his self-hatred than to destroy himself with alcohol? How could he more effectively express his vindictiveness than to inflict

on those about him the consequences of his addiction? What better way to express his hopelessness than to drown his life in drink?” (1988, p. 175).

In *The Many Faces of Suicide: Indirect Self-Destructive Behavior*, Farberow presents chapters by different authors on a wide variety of indirect suicidal behavior. The contributors discuss physical illnesses “used against the self,” including self-destructive behavior in diabetics, “uncooperative” patients, self-destructive behavior in hemodialysis patients, spinal cord injury, and coronary artery illness. Several chapters are concerned with drug and alcohol abuse and their relationship to indirect self-destructive dynamics. Hyperobesity and cigarette smoking are also analyzed as possible ways of increasing the probability of a shortened life. Similarly, gambling, criminal activities, and deviance are judged forms of indirect suicides. Criminals and delinquents often put themselves in situations where there is a high risk of a premature death. Finally, a variety of stress-seeking and high-risk sports activities draw on unconscious or subconscious motivations to risk death or to test one’s ability to master death.

Conclusions

It may be that direct intentional acts that result in death (i.e., completed suicides) constitute only a small proportion of the various human behaviors that result in premature death. Perhaps these behaviors are, as Freud and Menninger hypothesized, the result of an intrinsic human proclivity to self-destruction that is locked in constant combat with an inherent motivation to preserve life at all costs. Perhaps indirect suicidal behavior is simply part of one’s cultural baggage, with different societies encouraging or condoning certain forms of risky and dangerous activities, such as engaging in high-risk sports or having unprotected sex with a high-risk partner. Perhaps, as several research studies indicate, indirect suicidal behavior may be linked to treatable depression, stressful life events, and more obviously identifiable suicidal thoughts and intentions.

It is clear that indirect suicidal behaviors can decrease when the surrounding environment improves; for example, offering patients better treatment in a nursing home. Research in the twenty-first century indicates that it is important to be aware of indirect suicidal behavior and to understand it as a

signal of treatable problems. Such vigilance cannot only improve lives, it can save them as well.

See also: FREUD, SIGMUND; MARTYRS; REVOLUTIONARIES AND "DEATH FOR THE CAUSE!"; SUICIDE

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BRIAN L. MISHARA

MURDER-SUICIDE

The relationship between suicidal behavior and other forms of violence is not always clear. In the case of murder-suicide (or homicide-suicide), however, the two acts are directly associated. The typical definition of "murder-suicide" is "homicide followed within a week by the perpetrator's suicide."

In most cases, there is an intimate relationship between perpetrator and victim. Murder-suicide is uncommon, ranging in rate from 0.05 per 100,000 inhabitants in Scotland or New Zealand to 0.55 in Miami. According to the descriptive typology proposed by Nock and Marzuck, it falls into four main categories: spousal/consortial murder-suicide, filicide-suicide, familicide-suicide, and extrafamilial murder-suicide. Spousal/consortial murder-suicide is the most common type in Western countries. Committed primarily by males acting out of morbid jealousy and/or revenge, it usually occurs when the victim attempts to end the relationship, often in the context of verbal violence. In the United States, males perpetrate 57 percent of simple spousal homicides but 90 percent of spousal murder-suicides. The reason for this imbalance is that for women, spousal homicide is a desperate means of deliverance from an abusive relationship, whereas for men it is often a way to maintain control over their partner unto death. Compassion can sometimes motivate murder-suicide among spouses or cohabitants, especially in cases involving the frail and elderly. These "altruistic" mercy killings often assume the semblance of informal suicide pacts.

Filicide-suicide—killing one's own children before killing oneself—is the most common form of murder-suicide committed by women in Japan. Globally, women commit most filicides, but men are more likely to commit suicide after filicide. If a woman's victim is an infant who is less than six months old, the perpetrator usually suffers from serious postpartum depression or psychosis. Often such filicidal mothers view their infants as extensions of their own tortured psyches and hence claim the altruistic motive of rescuing their children from future emotional torments.

Even less common is familicide-suicide, in which the perpetrator kills all family members before committing suicide. In extrafamilial murder-suicide, the victims can be related to the perpetrator but not by consanguinity. It is the rarest form of

murder-suicide but the one with the highest social toll per incident.

Most types of murder-suicide involve morbid forms of attachment between perpetrator and victim, especially when the relationship is threatened with dissolution, and/or impulsive personality traits. Depression, too, is a common factor in murder-suicide, as it is in simple suicide, although most depressives are not suicidal or homicidal. Murder-suicide is one of two special types of dyadic (paired) death, the other being the suicide pact. Alan Berman developed a more psychodynamic typology of murder-suicide that covers both types, classifying them according to four categories: erotic-aggressive, unrequited love, dependent-protective, and symbiotic.

Murder-suicide is hard to predict and prevent because of its rarity and apparent suddenness. Among various psychiatric treatments, the most successful preventive approach involves diffusing the intensity of the spousal relationship.

See also: HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; HOMICIDE, EPIDEMIOLOGY OF; SUICIDE TYPES; SUICIDE PACTS, THEORIES OF SUICIDE

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MARC S. DAIGLE

PHYSICIAN-ASSISTED SUICIDE

Physician-assisted death did not begin with the 1993 government-sanctioned process in the Netherlands, nor with the first such acknowledged action by the pathologist Jack Kevorkian in the United States. The practice of ending the life of a

suffering patient was so well established by the fifth century B.C.E. that opponents were motivated to mount a strenuous counterattack. The Hippocratic oath offered a landmark definition of the physician's responsibilities. Included was the key statement: "I will give no deadly medicine to anyone if asked, nor suggest any such counsel." In modern times, this controversial practice has become most commonly known as physician-assisted suicide. Some forensic experts and prosecuting attorneys, however, classify these deaths as homicides. The neutral term, physician-assisted death, leaves the question of whether the practice is actually homicide open for consideration.

History of Physician-Assisted Death/Suicide

There is no way of knowing how many physicians have abided by this stricture and how many have lent death a hand through the centuries. Concerned about possible consequences, physicians who have assisted death generally have not spoken openly of these actions. It is clear, however, that some physicians have been easing some patients toward death. These deaths have not necessarily occurred immediately after a medical intervention. Often the preference has been for a medication that reduces respiration or other vital functions in a gradual manner. If this technique functions as intended the patient drifts into a drowsy, painless state of mind until passing away.

In "mercy killings," as these actions have sometimes been described, it is usually assumed that the patient was (a) dying, (b) suffering severely, and (c) asking urgently for the relief. In practice, though, each of these conditions can be difficult to assess. For example, was this person of sound mind in making the request, or was judgment clouded and confused? Were there ways to relieve this person's suffering short of death? How accurate was the diagnosis and prognosis—was this person actually on a nonreversible terminal trajectory?

Furthermore, the medical interventions have not always proven effective. In twenty-first-century medical practice a patient is sometimes given medication to reduce agitation. There can be the unfortunate effect of a terminally ill person continuing to experience pain but now being unable to move or communicate. Even the passive form of euthanasia—withdrawing treatment rather than

making a direct intervention—can fail. This was demonstrated, for example, in the landmark case of Karen Ann Quinlan, a young woman who never regained consciousness after lapsing into a coma in 1975. More than a year later a court ruled that she could be disconnected from the ventilator. It was assumed that she would then die almost immediately. However, the young woman remained in a persistent vegetative state for another ten years. Although this episode predated the emergence of the assisted death movement in the United States, it demonstrates that medical expertise in ending a life cannot be taken for granted.

Physician-assisted suicide entered the spotlight of public opinion in the 1980s as this practice was given a limited form of judicial acceptance in the Netherlands. Jack Kevorkian became the central figure in physician-assisted death in the United States in the 1990s. Many other nations have also been wrestling with this controversy. The Parliament of the Northern Territory of Australia, for example, approved assisted suicide in 1996, but a year later was overturned by the Australian Senate, which forbade all its territories from passing any such measures. Although significant cultural differences exist in response to the assisted death issue, the practice itself and the basic controversy can be identified by focusing on events in the Netherlands and the United States.

Physician-Assisted Death As an Alternative to Prolonged Suffering

Advances in health care have raised expectations. Many life-threatening conditions, such as smallpox, have been prevented by public health measures; others respond to skillful treatment. Nevertheless, dying people often have experienced uncontrolled pain and other distressing symptoms. A growing number of critics placed blame on the medical profession for isolating and neglecting the dying person, who reminded doctors of their still-limited ability to restore health. One major response was the development of the hospice or palliative care movement, in which relief of pain and provision of comfort were the top priorities. The other major response was the attitude conveyed by such phrases as “death on demand,” “right to die,” and “deliverance.” The Hemlock Society and other organizations not only argued the case for suicide but provided information on how to proceed. Suicide

and suicide attempts had already become decriminalized. Although religious and moral sanctions remained in place, there was increasing public toleration for a terminally ill person who sought to avoid further suffering by suicide.

Physician-assisted death came out of the shadows as some patients requested and some physicians proved willing to lend a hand. Why could not people who were resolved to end their lives do so for themselves? Two factors were certainly involved and another factor probable: (1) In some terminal conditions the individual did not have the physical ability to take his or her own life (e.g., an advanced stage of Lou Gehrig’s disease); (2) some people were concerned that their suicide attempts would fail and only increase their suffering, and thus medical expertise was needed; and (3) case studies suggest that some people felt the need for approval and authorization from a physician, thereby releasing them from any moral hesitation. The basic need was for relief both from current suffering and from the prospect of additional suffering throughout the terminal phase of life. Many patients and family members expressed the opinion that when physicians could no longer restore health and prevent death, they should provide relief from suffering.

Arguments For and Against Physician-Assisted Death

The liberty interest was often presented as the legal and philosophical foundation for assisted death. The Fourteenth Amendment to the U.S. Constitution includes a due process clause whose provisions have been affirmed by the courts in many decisions over the years. The chief justice of the Supreme Court concluded in *Missouri v. Cruzan*, “the choice between life and death is a deeply personal decision of obvious and overwhelming finality” (Baird 1989, p. 184) and therefore protected by the Fourteenth Amendment. Citizens have a right to autonomy that the state cannot overcome without proving a compelling interest for so doing.

A few arguments against physician-assisted death state that (1) religion and the state consider life to be sacred (this does comprise a compelling interest that overrides individual choice); (2) legalizing assisted death even in the most appropriate cases would push society down the “slippery

slope” to large-scale abuse of this practice; (3) physicians would lose public trust if they are seen as executioners as well as healers; and (4) palliative care can prevent or reduce terminal suffering, therefore assisted death is not necessary. There are counterarguments to all of these; for example, claims that life is considered sacred are contradicted by some actions of church and state; the argument that effective regulations can prevent abuse of the assisted death option; and the position that not all terminal conditions can be significantly eased by palliative care.

Another controversy centers around the most appropriate term for this practice. *Physician-assisted suicide*, the most frequently used term, implies that the decisive action is taken by the patient. Critics say that this is an attempt to gloss over the truth: The physician prepares the materials and places them at the disposal of the patient. It is, therefore, not any kind of suicide, but something closer either to euthanasia or murder. (The Michigan coroner who investigated the deaths involving Kevorkian classified them as homicides.)

The Netherlands Experience

The world has been observing developments in the Netherlands since physician-assisted death first received a limited kind of toleration in the 1980s. A physician was found guilty for ending her mother's life at her request. Her sentence was one week in prison. In 1984 the Dutch Supreme Court decided that physician-assisted death is acceptable if the following conditions are met: (1) The patient has been determined as incurably ill from a medical standpoint; (2) the patient's physical or spiritual suffering is unbearable or serious to the patient; and (3) the patient has indicated in writing that he or she desires to terminate life or that he or she wants to be delivered from his suffering.

This ruling had an uneasy coexistence with other provisions of Dutch law that had been established a century before; specifically, the statement: “He who deliberately incites another to suicide, then assists him therein or provides him with the means is punished, if the suicide follows, with a prison sentence of at most three years or a fine of the fourth category” (Henk 2001, p. 9). The semi-approved practice of assisted death also had a divided response within both the health care community and the general public. After years of study

and debate, the Dutch Parliament voted to legalize assisted death. Additional criteria were established: (1) The patient's request must be determined to be voluntary, well-considered, and lasting (an advance directive or living will is acceptable); (2) a second physician must be consulted; (3) parental consent is required for people under the age of sixteen; and (4) the intervention itself must be in a medically approved manner. Physicians who function within the framework of these rules are free from criminal prosecution.

There remains heated controversy about the scope and manner in which physician-assisted death has been practiced in the Netherlands. About 2,000 cases of physician-assisted suicide are reported in the Netherlands, a small proportion of the approximately 135,000 total deaths. Advocates claim that there is no evidence that a slippery slope has developed because physicians are conscientiously following the guidelines. Opponents note that about half of the patients do not make an explicit request because they are no longer mentally competent or other reasons exist. Advocates reply that in these instances there is other basis for decision making (e.g., family request), and that the medical procedures shorten the patient's life by only a few hours or days. Opponents also argue that there are many more cases than reported and that it is in these cases that abuse of the law occurs.

Assisted Death in the United States

Kevorkian has been the most prominent person in the assisted death movement in the United States since 1987. A critic of the medical establishment's treatment of dying people, he promised to deliver them from their suffering and made himself available to all who might desire his services. In *Prescription: Medicide* (1991) Kevorkian listed the rules that he believed should be followed; they include calling for psychiatric consultation, calling for pain specialist consultation, allowing a twenty-four-hour waiting period after final request, conducting extensive patient counseling, and stopping the process if there is any sign that patient is ambivalent.

Surprisingly, perhaps, he expressed a strong emotional reaction against the specific act by which a person's life is ended: “Performance of that repulsive task should now be relegated exclusively to a device like the Mercitron, which the doomed subject must activate. What is most important is that

the participation of doctors or other health professionals now becomes strictly optional. . . . A doctor no longer need perform the injection” (Kevorkian 1991, pp. 233–234). It seemed odd to speak of the dying person in both a melodramatic (“doomed”) and distant (“subject”) manner when his intent was to preserve human dignity. Critics also accused Kevorkian of trying to evade personal responsibility by replacing his own hand on the hypodermic needle with a device (also known as “the suicide machine”) that provided first a muscular relaxant, then a drug to halt the action of the heart.

Many testimonials were given in appreciation of Kevorkian’s services. He was described as a caring and sensitive person who had provided the blessing of pain relief. Public opinion was divided, but has moved toward increasing acceptance. In 1950 one-third of survey respondents agreed with the statement, “Physicians should be allowed to end the lives of patients with incurable diseases if they and their families requested it.” In the 1990s the approval rate increased to two-thirds.

Numerous attempts were made to find Kevorkian guilty of criminal behavior, but none succeeded until he provided a television news program with a video in which he gave a lethal injection to a man in an advanced stage of Lou Gehrig’s disease (amyotrophic lateral sclerosis). The man and his family were grateful but, as Kevorkian had expected, he was found guilty of second-degree murder and sentenced to a term of ten to twenty-five years in prison. Kevorkian often said that he welcomed legal actions against him as a way of awakening the public and forcing a change in the system. Judge Jessica Cooper of Oakland County, Michigan, noted that Kevorkian was not licensed to practice medicine at the time he administered the lethal injection. It was also her opinion that the trial was more about Kevorkian’s defiance of the legal system than it was about the moral and political issues associated with euthanasia.

Research Perspective on Kevorkian’s Practice

Studies of Kevorkian’s practice of assisted death produced critical findings. Most of the people whose deaths were assisted by Kevorkian were not terminally ill. Most were not in severe pain. A gender bias encouraged death: In the general population, women are much less likely than men to

commit suicide; most of Kevorkian’s patients were women who were depressed and dependent. This profile does not fit the population of terminally ill people, but it does fit the population of people who make nonfatal suicide attempts. The inference drawn was that Kevorkian attracted unhappy people who might otherwise have found other solutions to their problems. Kevorkian did not recognize or treat the depression that was experienced by many of the people who requested his services, nor was Kevorkian trained in palliative care and he provided little or no help in trying to reduce pain by methods other than death. Kevorkian functioned without adequate medical consultation. In fact, he violated all the rules that he himself proposed for assisted death in *Prescription: Medicide* (1991).

A 2000 study found that only one-fourth of Kevorkian’s patients were terminally ill, as compared with 100 percent of those who requested physician-assisted suicide since this procedure became legally accepted in Oregon. The researchers conclude that Kevorkian’s procedures did not provide adequate clinical safeguards to prevent the physician-assisted deaths of people who were not terminally ill.

Assisted suicide has often been criticized as an extreme and unnecessary measure that could be avoided in most instances by compassionate and informed care. Other physicians have perhaps criticized it most severely for presenting death as a treatment or therapy. The physician and scholar Thomas Szasz also observes, “a procedure that only a physician can perform expands the medicalization of everyday life, extends medical control over personal conduct, especially at the end of life, and diminishes patient autonomy” (Szasz 1999, p. 67).

Although Kevorkian’s influence should not be underestimated, the assisted death movement has taken other forms that incorporate due process, extensive consultation, and compliance with existing laws and regulations. Whatever the future might hold for assisted death it is more likely to be worked out through the ballot, legislative acts, and consensus.

See also: EUTHANASIA; HIPPOCRATIC OATH; HOSPICE OPTION; KEVORKIAN, JACK; NATURAL DEATH ACTS; PAIN AND PAIN MANAGEMENT; SUICIDE INFLUENCES AND FACTORS: PHYSICAL ILLNESS

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ROBERT KASTENBAUM

RATIONAL SUICIDE

The question of whether or not suicide can sometimes be rational is a controversial topic that has been the subject of considerable debate among mental health practitioners, scholars, and laypeople alike. Some suicides are obviously irrational, for example, when a schizophrenic man kills

himself because he hears voices commanding him to do so. However, the possibility that some suicides may be rational can be debated on both philosophical and scientific grounds.

In 1964 the philosopher Jacques Choron defined rational suicide as being when there is no psychiatric disorder, there is no impairment of the reasoning of the suicidal person, and the person's motives appear to be justifiable or at least understandable by the majority of contemporaries in the same culture or social group.

Choron's first requirement that there is no psychiatric disorder eliminates the majority of suicides, since most persons who die by suicide suffer from a mental disorder, such as clinical depression, alcoholism, or drug abuse. Given these data, rational suicide, if it exists, is a phenomenon that can only characterize a small minority of suicides. Even the most vocal proponents of rational suicide exclude persons suffering from mental disorders. In his defense of the Hemlock Society's support of rational suicide, the society director Derek Humphry stated in 1986 that there is another form of suicide called "emotional suicide or irrational self-murder." The Hemlock Society view on emotional suicide is to prevent it when you can. The Hemlock Society, which supports rational suicide, specifically does not encourage any form of suicide "for mental health or unhappy reasons" (1986, pp. 172–176).

Even when the suicide victim does not suffer from a serious mental disorder, some suicides may still be irrational by any standard; for example, when the suicide victim is in a temporary state of extreme agitation or depression or his or her views of reality are grossly distorted by drugs or alcohol, or a man whose wife has just left him, has a loaded gun in his house, and then consumes great quantities of alcohol that distorts his judgment may become highly suicidal even though he was not suffering from a previous mental disorder. There still remains the question of whether or not some suicides can be considered rational.

The psychiatrist Ronald Maris has argued that suicide derives from one's inability or refusal to accept the terms of the human condition. He argues that suicide may effectively solve people's problems when non-suicidal alternatives may not do so. Although no suicide is ever the best alternative to the common human condition, for some individuals

suicide constitutes an individual's logical response to a common existential human condition.

The researcher and ethicist Margaret Battin, while admitting that no human acts are ever wholly rational, defines rational suicide in terms of the criteria of being able to reason, having a realistic worldview, possessing adequate information, and acting in accordance with a person's fundamental interests. Battin indicates that meeting the criterion of "ability to reason" may be very difficult to establish because of research and anecdotal information indicating that persons who commit suicide often leave messages that are illogical and tend to refer to themselves as being able to experience the effects of their suicide after their death as if they were to continue to be alive.

One of the basic criteria for being able to act rationally is the ability to use logical processes and to see the causal consequences of one's actions. It can be argued that many suicides do not accurately foresee the consequences of their actions. Furthermore, one can ask the philosophical question of whether or not it is possible to foresee the final consequence of suicide, which is to know what it is like to be dead. Battin suggests that when one imagines oneself dead, one generally imagines a view of one's own dead body surrounded by grieving relatives or located in the grave, which presupposes a subject being around to have those experiences. This may be an indication that one does not accurately imagine death. However, Battin points out that two classes of suicides are not necessarily irrational: first, those with religious or metaphysical beliefs that include the possibility that one goes on to have humanlike experiences after death; and second, persons whose reputation and honor are of primary importance, such as the case of the Japanese suicide of honor by a samurai who had been disgraced.

There is also the question of what is considered rational decision making. According to *Webster's New World Dictionary of American Language*, rationality is "exercising one's reason in a proper manner, having sound judgement, sensible, sane; not foolish, absurd or extravagant; implying the ability to reason logically, as by drawing conclusions from inferences, and often connoting the absence of emotion." This definition implies a degree of autonomy in the decision-making process, the presence of abilities to engage in logical and

reasoned thought processes, and the absence of undue influence on the decision-making process by external factors. In a 1983 review of contemporary philosophical writings on suicide, the scholar David J. Mayo presented the definition that a rational suicide must realistically consider alternatives concerning the likelihood of realizing goals of fundamental interest to the person and then choose an alternative which will maximize the realization of those goals. More than a decade later Brian L. Mishara argued that the most important human decision making is more emotional than rational, including the most significant choices in life, such as whom a person marries and what career a person chooses. If important decisions have a predominantly emotional basis, what would lead one to expect that the paramount decision of ending one's life could then be different and more rational? Those who argue for rational suicide generally insist that the act must occur when a person is experiencing interminable suffering. Mishara argued that in the presence of severe suffering true rational decision making is even less likely to occur; the emotions associated with the suffering compromise one's ability to reason rationally.

Battin's second criterion for rational decision making is that the decision is based upon a realistic view of the world. She points out that there are multiple worldviews that vary depending upon cultural and religious beliefs; what appears to be irrational for some is considered quite rational in other cultural contexts. Her third criterion, adequacy of information, may be questioned because of the effect of one's emotional state on the ability to look for and see the full picture. Still the suicidal person's actions cannot be seen to be more inadequately informed or less rational than in any other important moral choices.

Battin's criterion of avoidance of harm is essentially the justification that organizations such as the Hemlock Society propose as their fundamental justification of rational suicide. They cite the cessation of the harm of unbearable suffering as the most common reason for suicide. The organization lists grave physical handicap that is so constricting that the individual cannot tolerate such a limited existence as a second reason. This justification goes against the Christian religious tradition that purports that pain and suffering may serve some constructive purpose of spiritual growth, has some meaning, or is part of God's plan.

The decision to end one's life when terminally ill is frequently construed as rational. The acceptance of ending life when extreme pain or handicap is experienced assumes that no relief for the pain is available and that the severe handicap may not be better tolerated. Derek Humphry defends people's "right" to refuse to experience even a "beneficent lingering" and to simply choose to not continue to live any longer when they are terminally ill.

Battin's final criterion of being in accordance with a person's fundamental interest raises the question of whether one can actually satisfy any kind of personal interest by being dead (and not around to be satisfied). Nevertheless, some individuals have long-standing moral beliefs in which the decision to foreshorten life under certain difficult circumstances is clearly condoned as in their interest.

The concept of rational suicide may sometimes be confused with the concept of "understandable" suicide. David Clarke's work suggests that the concepts of rationality and autonomy are less useful than the concepts of "understandability" and "respect" when considering the expressed wish to die. However, what an outsider considers to be understandable or respectful of a person's wishes is not necessarily congruent with the suicidal person's experience. In some situations, when outsiders often feel that a person would be "better off dead," persons who actually experience those circumstances feel differently. For example, despite popular beliefs, very few persons who are suffering from terminal and severely disabling chronic illnesses actually consider or engage in behavior to end life prematurely.

Debates concerning rational suicide usually center around society's obligations to provide easier access to suicide under certain circumstances. If one accepts the possibility of rational suicide, there is also an implicit moral acceptance of suicide under the circumstances in which rational suicides may occur. However, developing criteria for when a suicide can be considered rational is not an easy task. What constitutes unbearable suffering for one person may be an acceptable level of discomfort for another. Furthermore, individuals differ to the extent that rationality is an important component of their decision-making process. On what basis may one say that rational decision making is more justifiable than emotional decisions?

Most suicidologists choose to try to prevent suicides that come to their attention, assuming that rational suicides, if they exist, are rare, difficult to identify, and merit interventions to challenge their reasoning.

See also: PHILOSOPHY, WESTERN; SUICIDE; SUICIDE INFLUENCES AND FACTORS: MENTAL ILLNESS

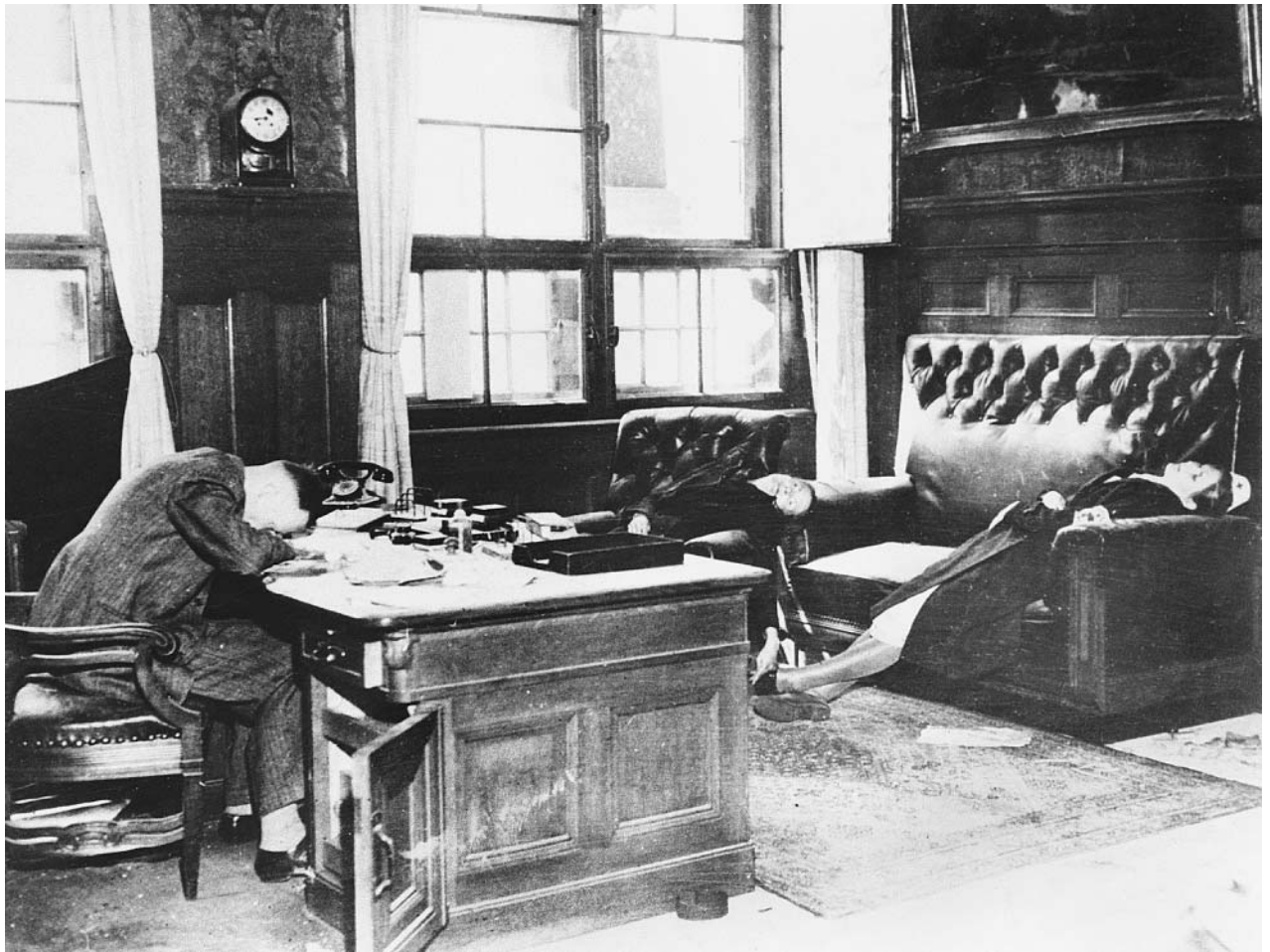
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BRIAN L. MISHARA

SUICIDE PACTS

A suicide pact is a mutual agreement between two or more people to die at the same time and usually at the same place. This is a rare phenomenon that occurs in less than 1 percent of suicides in the Western world. However, suicide pacts are a little more prevalent in the Eastern world where they represent approximately 2 to 3 percent of deaths committed



Nazi mayor Alfred Freyberg, his wife, and eighteen-year-old daughter (wearing Nazi armband) died by poison in a suicide pact before the Allies captured Leipzig, Germany, in 1945. BETTMANN/CORBIS

by suicide. Because suicide pacts are rare, they are difficult to study. Despite their rarity and the fact that suicide pact victims generally choose nonviolent suicide methods, suicide pacts are generally lethal and the chances of survival are low.

Suicide Pact Commonalities

Suicide pacts have some common characteristics. The suicidal persons have a close and exclusive relationship, often free of significant bonds to family or friends. The isolation can be caused or exacerbated by a recent retirement, loss of work, disease, or social rejection—for example, two lovers or two friends who are not permitted to be together. The suicide pact is often triggered by a threat of separation of the dyad, death of one of them, or social and familial restrictions on seeing each other. The

fear of losing the relationship with the other person motivates the majority of suicide pacts.

The dyad is generally composed of a dominant person who initiates the suicide pact and convinces a more submissive person to agree to this plan. The dominant member is usually the most suicidal member and the dependent person is the most ambivalent. In most cases, the male plays the dominating role. However, there are no indications that someone can become suicidal only due to the suggestion of another person.

Most suicide pacts use poisoning. This nonviolent method allows the synchronization of the deaths and, at the same time, allows the pact members to change their minds. It appears that when the pact is aborted it is frequently because the passive member changes his or her mind and saves

the instigator, sometimes against his or her will. However, some researchers claim that the dependent member may ask the dominant one to kill him or her in order to not survive and be left alone.

The prevalence of mental disorders is lower in suicide pacts than in individual suicides. However, researchers have found that at least one member of the dyad usually suffers from depression, borderline or antisocial personality traits, or substance abuse. Physical diseases are frequently observed, particularly in older suicide pact victims. Often, at least one pact member has attempted previously or has been exposed to the suicide of a close relative. This has led some researchers to suggest that suicide pacts are related to suicide clusters (a series of suicides in the same community) because there is a contagion effect. Besides these commonalities, some important differences exist. Three types of suicide pacts can be identified: the love pact, the spouse pact, and the friendship pact.

The love pact. Generally the love pact occurs between two young lovers who are faced with the threat of separation as imposed by their parents or society. There are some cases of love pacts in the Western world, but this type of pact is particularly frequent in the Eastern world where there are strict rules concerning dowry and marriage. For example, in India and Japan many young people are forced to break off a love relationship to marry the person that their parents have chosen for them. Some of these young lovers view suicide as the only way that they can stay together. Lover suicide pacts are often also seen as rebellion against parental authority and linked to the intense guilt of giving priority to one's own desires instead of respecting social conventions.

The spouse pact. Typically occidental, the spouse pact is the most prevalent. Generally it occurs between a husband and a wife, aged fifty or older, who are childless or not living with their children. At least one of them is likely to be physically ill. In most cases, there is interdependence and devotion to one another and the couple engages in a suicide pact because neither member wants to be separated by the other's death. However, the members are sometimes motivated by the fear of chronic pain or fear of losing their physical and mental integrity because of old age. Usually, a dominant/dependent relationship is present.

The friendship pact. The friendship pact has a lower prevalence. Usually it takes place between two or three adolescents of the same sex. This type of pact appears to be less planned and results in less lethality than adult suicide pacts. Attempters tend to share similar life stories; for example, they have been separated from their parents since childhood because of parental divorce or the death of a parent. As a result, adolescents see each other as a narcissistic double and this dynamic seems to be a mutual facilitator. In the days before the suicide members of the pact stay together almost all of the time, in isolation from the rest of society. This social withdrawal prevents them from seeking help. The dominant/dependent relationship seems to be less prevalent in the friendship pact.

Prevention of Suicide Pacts

Numerous risk factors associated with individual suicides are linked to suicide pacts. For this reason, it is important for health practitioners and loved ones to pay attention to general signs of suicide risk, such as major behavioral or emotional changes, sleeping or eating disorders, disposal of important possessions, loss of interest and energy, substance abuse, and hopelessness. One should also be watchful for signs of suicide pacts, such as the isolation of an older couple with a physical illness or emotionally unhealthy exclusive relationships in young friends. Moreover, the people who engage in suicide pacts often talk about their plans to family and friends.

Mental health practitioners suggest that one asks direct questions to verify suicide intentions and plans, such as, "Are you thinking of suicide?" "Did you plan your suicide (i.e., decide when, where, or how to do it)?" The more the suicide is planned, the more important it is to be direct and act quickly. One should be empathic and warm with a suicidal person, and try to find new solutions or alternatives to the person's problems, and encourage him or her to seek professional help if needed. Finally, despite the fact that suicide pacts share a lot of characteristics with individual suicides and are a rare phenomenon, health practitioners believe that education programs on suicide prevention should incorporate information on suicide pacts and guidelines for preventing suicide pact behavior.

See also: SUICIDE INFLUENCES AND FACTORS: PHYSICAL ILLNESS; SUICIDE OVER THE LIFE SPAN: ADOLESCENTS AND YOUTHS; SUICIDE TYPES: THEORIES OF SUICIDE

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THEORIES OF SUICIDE

Theories of suicide have been formulated mainly by psychologists and psychiatrists. This analysis began a century ago with Sigmund Freud's psychoanalytic theory. Sociologists have since proposed theories, based upon the work of Émile Durkheim, that explain the variation in suicide rates over nations and over regions within those nations. These seminal theories are the foundation for more recent theories developed by suicidologists that account for both individual suicides and suicide rates within a society.

Early Theories of Individual Suicide

Suicide is an uncommon behavior, occurring in less than 50 out of every 100,000 people in nations with the highest suicide rate. Explaining and predicting such infrequent occurrences has proved to be very difficult. The major theories of personality and systems of psychotherapy have not addressed the etiology of suicide to any great extent, with the exception of Sigmund Freud's psychoanalytic theory. Freud never considered the psychodynamics

underlying suicidal behavior to any great extent. Brief mentions of suicidal behavior can be found throughout his writings, however, and in 1967 the psychiatrist Robert Litman attempted to document and synthesize these dispersed thoughts.

By 1910 Freud had recognized many clinical features of suicidal behavior: guilt over death wishes toward others, identification with a suicidal parent, refusal to accept loss of gratification, suicide as an act of revenge, suicide as an escape from humiliation, suicide as a form of communication, and the connection between death and sexuality.

The more systematic views began with his discussion of melancholia. The essential feature of suicidal behavior is that the person loses a loved object, and the energy withdrawn from this lost loved object is relocated in the ego and used to recreate the loved one as a permanent feature of the self, an identification of the ego with the lost object. Litman called this process ego-splitting.

Freud's formulation is phrased in the more archaic version of his theory. In more modern terms, the person has already introjected some of the desires of the loved one. Children introject desires of their parents, and adults introject the desires of their lovers. In this way, it is as if part of one's mind is also symbolic of one's loved ones. Once this person is lost (e.g., by death or divorce), a person still possesses those introjected desires, and thus the lost loved one remains symbolically as part of the living person's own mind. This process can lead to suicide when the person also harbors hostile wishes toward the lost object, for now one can turn this anger toward that part of one's mind that is modeled upon and symbolizes the lost object.

A later development in Freud's thought was the postulate of the existence of a death instinct, an instinctual drive toward death that is balanced by the life instinct. The death instinct is primarily masochistic, and the individual tries to externalize the instinct as aggression or sadism. However, when there are cultural forces opposing sadism, the instinct is turned back onto the self. In 1961 the psychoanalyst Samuel Fetterman stressed that neither the life instinct nor the death instinct could really function independently of each other, but that they were always fused in variable amounts.

Litman pointed out that this later development moves to a very general level of discourse and focuses on the universal elements of humankind's

lot. Thus it is not clear how such a process can explain why some people kill themselves whereas others do not. At best, it provides a mere restatement of this fact. The earlier formulation was more heuristic in that it did propose a developmental process leading to suicide.

Freud's Influence on Theorists

Freud's postulate of a death instinct can be seen as a product of his era. Early in the twentieth century, every psychological theorist felt the need to explain why humans behaved at all. Therefore, they all proposed energy concepts in their theories. After Donald Hebb's classic book *The Organization of Behavior* (1949), psychological theorists no longer felt it necessary to explain why humans behaved. Rather, the motivational question focused on why humans do one action rather than another.

Freud's hypothesis of a death instinct had a great influence on thinking about suicide. For example, in 1938 the psychiatrist Karl Menninger suggested that suicidal motivation can be seen behind behaviors that at first glance are not obviously suicidal. Menninger noted that some people shorten their lives by choosing self-destructive lifestyles, such as alcohol or drug abuse, heavy cigarette smoking, and engaging in other destructive behaviors. He called such behaviors "chronic suicide." He noted that some people appear to focus their self-destructive impulses on specific parts of their bodies, leaving their minds unimpaired. For example, a person may blind himself or lose an arm in an industrial accident. Menninger saw the death instinct as behind such behaviors, and he called them "focal suicide."

The result of Menninger's ideas has resulted in some interest on the part of suicidologists in indirect self-destructive behavior, as in Norman Farberow's book *The Many Faces of Suicide* (1980), and other works on life-threatening behavior in general and the official journal of the American Association of Suicidology is called *Suicide and Life-Threatening Behavior*, indicating a broader focus than suicide per se.

Maurice Farber, a psychologist, proposed that the tendency to commit suicide is a function of the extent of the threat to acceptable life conditions experienced by the individual, the individual's sense of competence, and therefore the individual's degree of hope. Aaron Beck, a psychiatrist

who has developed a system of counseling known as Cognitive-Behavioral Therapy for those suffering from depression and anxiety, and his associates later developed an inventory to measure hopelessness. Subsequent research has shown that hopelessness, which is one component of the syndrome of depression, is a much more powerful predictor of subsequent suicidal behavior than other components of the syndrome.

In 1996 Edwin Shneidman, the founder of the American Association of Suicidology, defined "lethality" as the likelihood of an individual committing suicide, while "perturbation" referred to the level of upset or distress that the individual was experiencing. Shneidman later called the subjective experience of perturbation "psychache." Shneidman suggested that the way to reduce the lethality of individuals was to reduce their perturbation. He also proposed that all suicides share ten common qualities, which include the:

1. common purpose of seeking a solution;
2. common goal of cessation of consciousness;
3. common stimulus of unbearable pain;
4. common stressor of frustrated psychological needs;
5. common emotion of hopelessness-helplessness;
6. common cognitive state of ambivalence;
7. common perceptual state of constriction;
8. common action of escape;
9. common interpersonal act of communication of intention; and
10. common pattern of consistency of lifelong styles.

These preliminary theories have not been subjected to extensive empirical testing. Instead most psychological research on suicidal behavior is based on the simple additive effect of a variety of psychological and experiential factors, such as loss of parents through death, experience of sexual and physical abuse, low self-esteem, and depression.

Explaining Societal Suicide Rates

In contrast to the unpredictability of individual suicides, societal suicide rates are remarkably stable from year to year, and this stability makes it easier to account for societal differences.

Composition theories. In 1990 Hungarian sociologist Ferenc Moksony noted that one simple explanation of differences in suicide rates between nations is that the national populations differ in the proportion of those at risk for suicide. For example, typically in developed nations, suicide rates are highest in men, the elderly, and the divorced. Therefore, nations with a higher proportion of men, elderly, and divorced people will have a higher suicide rate. Societies may differ also in physiological variables (i.e., serotonin levels) and psychological/psychiatric variables (i.e., levels of depression and anxiety).

Social causation theories. The most popular explanations of social suicide rates focus on social variables. These social variables may be viewed in two ways: as (1) direct causal agents of the suicidal behavior, or (2) indices of broader, more abstract, social characteristics which differ among nations.

The most important theory for choosing relevant variables is the one that the French sociologist Émile Durkheim proposed in 1897. Durkheim hypothesized that suicide rates were determined by the society's level of social integration (that is, the degree to which the people are bound together in social networks) and the level of social regulation (that is, the degree to which people's desires and emotions are regulated by societal norms and customs). Durkheim thought that this association was curvilinear, with very high levels of social integration and regulation leading to *altruistic* and *fatalistic* suicide, respectively, and very low levels of social integration and regulation leading to *egoistic* and *anomic* suicide, respectively.

The sociologist Barclay Johnson suggested that the association is linear in modern societies, with suicide increasing as social integration and regulation decrease. Studies of nations have found that suicide rates are associated with such variables as the birth rate, female participation in the labor force, immigration, and the divorce rate.

Some investigators see these associations as suggesting a direct link between divorce or immigration and suicidal behavior. For example, divorce may be associated with suicide at the aggregate level because divorced people have a higher suicide rate than those with other marital statuses. Other investigators see the associations as suggesting that divorce and immigration are measures of a

broader and more basic social characteristic, perhaps social integration, which plays a causal role in the suicides of everyone in the society. In this latter case, societies with a higher rate of divorce, for example, should have a higher rate of suicide for those in all marital statuses, and this has been confirmed in the United States.

The other major social causation theory of suicide was proposed in 1954 by social scientists Andrew Henry and James Short, who assumed that the basic target of aggression for a frustrated person would be the frustrating object. What inhibits this outward expression of aggression and results in the aggression being turned inward upon the self?

At the societal level, Henry and Short argued that the primary factor was the extent of the external restraints on people's behavior. If these external restraints are strong, then frustrated individuals can blame others for their misery, and the outward expression of aggression (and, in the extreme, murder) is legitimized. On the other hand, if the external restraints on behavior are weak, then frustrated individuals can blame only themselves for their misery, and other directed aggression is not legitimized and must be inhibited, which increases the probability of the aggression being turned inward upon the self (and, in the extreme, resulting in suicide). Thus, in a multiethnic society such as America, the oppressed (namely, African Americans and Native Americans) may be expected to have higher rates of murder while the oppressors (European Americans) may be expected to have higher rates of suicide, a difference which is confirmed by crime and mortality rates.

Social stress. In 1969 the anthropologist Raoul Naroll proposed that suicide would be more common in members of a society who were socially disoriented; that is, in those who lack or lose basic social ties, such as those who are single or divorced. In this way Naroll's theory resembles Durkheim's theory. However, Naroll argued that because not all socially disoriented people commit suicide there must be a psychological factor that makes suicide a more likely choice when an individual is socially disoriented, and Naroll proposed that it was the individual's reaction to "thwarting disorientation contexts." These contexts involve a weakening of the individual's social ties as a result of the actions of other people or oneself (but not as a result of impersonal, natural, or cultural events).

Being divorced by a spouse or murdering one's spouse are examples of such contexts, while storm damage or losing a spouse to cancer are not. In thwarting disorientation contexts, some individuals commit *protest* suicide, which Naroll defined as voluntary suicide committed in such a way as to come to public notice. Societies differ in the extent to which they provide thwarting disorientation contexts, and so societies differ in their suicide rates.

Whereas Durkheim's theory refers to more steady-state characteristics of a society, Naroll's theory suggests the role of sudden and acute changes in a society: social stressors. Furthermore, Naroll's theory is phrased in a way that permits its applications to individuals as well as to societies.

The theories of societal suicide rates have been formulated more precisely and logically than the theories of individual suicide and have generated more successful predictions. Research findings from the 1990s to the present have not invalidated their assumptions, and the theories seem to predict suicide rather than psychiatric disorder in general. Henry and Short's theory has suggested that an appropriate comparison group for suicides would be murderers, a group that individual theories of suicide have ignored. The success of societal theories as compared to individual theories may be due in part to the relative stability (and therefore easier predictability) of social suicide rates as compared to the rarity and unpredictability of individual suicide.

See also: DEATH INSTINCT; DURKHEIM, ÉMILE; FREUD, SIGMUND; SUICIDE; SUICIDE BASICS: PREVENTION

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SUPPORT GROUPS

Support groups have become an important adjunct to the work of the medical and social support fields in addressing the needs of patients and families confronting the anguish of imminent death or the bereaved. Self-help groups provide a level of support that assists terminally ill individuals and their loved ones. Although some individuals need professional counseling and therapy, social support is a major element in coping effectively with life-threatening illness and bereavement.

The researchers Margaret and Wolfgang Stroebe suggest three areas in which support groups can be helpful. Groups can provide instrumental support; they offer help in dealing with practical matters such as funerals, household and personal needs, and even financial issues. They

also can provide emotional support. In the case of the bereaved, they can encourage the work of grieving. They provide an appropriate place to retell the story as long as the griever needs to do so. Self-help groups give validation support; by participating in them, one discovers what is “normal” in grief and thus understands that one is dealing with the same issues that many others have dealt with in their grief.

Being part of a support group has social importance. It is a way for individuals to maintain social contact. Often bereaved individuals will avoid many of their friends and become socially isolated. Going to a support group meeting and interacting with other people is an important activity for them. In many cases, the groups develop into friendship networks that may continue long after the need for the support system is gone. Phyllis Silverman, who began the Widow-to-Widow program, considers the friendships formed as bridges between the past and the future. She believes that people with similar problems can help and learn from one another. Her program was the first of the peer-support groups for griever and became the model for most other programs.

Psychologically the groups are helpful because they provide the outlet that grievers and individuals with life-threatening illness need, allowing people to freely express their feelings, fears, and dreams with others. The members of the group are ready and patient listeners. Seeing new members come into the group allows people to recognize the progress they have made. For new members, seeing others whose bereavement has been longer gives them an opportunity to see that one does move on in life.

Support groups take different forms. Some are time-limited, meeting only for a particular number of sessions. Others will go on indefinitely, with some people leaving the group and new people joining. Some support groups may have agendas that entail specific meetings in which a lawyer joins the group to talk about legal issues, a financial consultant talks about money management, and so on. Other groups rely solely on the participation of the group members. Groups are designed to be nonjudgmental and to not provide advice. Rather, they provide the opportunity for everyone to speak.

One of the early support groups for individuals facing life-threatening illness was Make Today Count, started by the journalist Orville Kelly in 1974. Many patients with life-threatening illnesses found themselves without people to talk to and share their feelings and experiences. Facilitators organize and get the meetings started, but the meeting itself belongs to the participants. Make Today Count chapters exist all over the United States.

In a similar fashion, numerous groups have developed to provide support to the bereaved. Perhaps the best known of these groups is Compassionate Friends. This organization assists families toward positive resolution of their grief following the death of a child. The organization has chapters nationally, most of which meet monthly.

Other well-known groups include Mothers Against Drunk Driving; Seasons, a suicide-survivor support group; and Parents of Murdered Children. In addition, most hospices provide support groups for both patients and families prior to a death and bereavement support groups after the death.

It is important to recognize that self-help support groups do not provide professional counseling. Rather, the support comes from the similarities between the experiences of the group members. Through the process of sharing, people can put their reactions into perspective. They have an opportunity to see how others have successfully dealt with many of the same issues they are facing.

See also: EMPATHY AND COMPASSION; GRIEF; SOCIAL FUNCTIONS OF DEATH

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See WIDOW-BURNING.

SUTTON HOO

The Sutton Hoo burial ground in East Anglia, England, provides vivid evidence for attitudes to death immediately before the conversion of an English community to Christianity in the seventh century C.E. Founded about 600 C.E., and lasting a hundred years, Sutton Hoo contained only about twenty burials, most of them rich and unusual, spread over four hectares. This contrasts with the “folk cemeteries” of the pagan period (fifth–sixth centuries C.E.), which typically feature large numbers of cremations contained in pots and inhumations laid in graves with standard sets of weapons and jewelry. Accordingly, Sutton Hoo is designated as a “princely” burial ground, a special cemetery reserved for the elite. The site was rediscovered in 1938, and has been the subject of major campaigns of excavation and research in 1965–1971 and 1983–2001. Because the majority of the burials had been plundered in the sixteenth century, detailed interpretation is difficult.

The Sutton Hoo burial ground consists of thirteen visible mounds on the left bank of the River Deben opposite Woodbridge in Suffolk, England. Four mounds were investigated by the landowner in 1938–1939; all are from the seventh century C.E., and one mound contains the richest grave ever discovered on British soil. Here, a ship ninety feet long had been buried in a trench with a wooden chamber amid other ships containing over 200 objects of gold, silver, bronze, and iron. The conditions of the soil mean that the body, timbers of ship and chamber, and most organic materials had rotted to invisibility, but the latest studies suggest that a man had been placed on a floor or in a coffin. At his head were a helmet, a shield, spears and items of regalia, a standard, and a scepter; at his feet were a pile of clothing and a great silver dish with three tubs or cauldrons. Gold buckles and shoulder clasps inlaid with garnet had connected a baldric originally made of leather. Nearly every item was ornamented with lively abstract images

similar to dragons or birds of prey. The buried man was thought to be Raedwald, an early king of East Anglia who had briefly converted to Christianity, reverted to paganism, and died around 624 or 625.

Investigations at Sutton Hoo were renewed in 1965 and 1983, and revealed considerably more about the burial ground and its context. In the seventh century, burial was confined to people of high rank, mainly men. In mounds five to seven, probably among the earliest, men were cremated with animals (i.e., cattle, horse, and deer) and the ashes were placed in a bronze bowl. In mound seventeen a young man was buried in a coffin, accompanied by his sword, shield, and, in an adjacent pit, his horse. In mound fourteen, a woman was buried in an underground chamber, perhaps on a bed accompanied by fine silver ornaments. A child was buried in a coffin along with a miniature spear (burial twelve). Mound two, like mound one, proved to have been a ship burial, but here the ship had been placed over an underground chamber in which a man had been buried.

Because the graves were plundered in the sixteenth century, interpretation is difficult. The latest Sutton Hoo researcher, Martin Carver, sees the burial ground as a whole as a pagan monument in which burial rites relatively new to England (under-mound cremation, horse burial, ship burial) are drawn from a common pagan heritage and enacted in defiance of pressure from Christian Europe. The major burials are “political statements” in which the person honored is equipped as an ambassador of the people, both at the public funeral and in the afterlife.

A second phase of burial at Sutton Hoo consisted of two groups of people (mainly men) who had been executed by hanging or decapitation. The remains of seventeen bodies were found around mound five, and twenty-three were found around a group of post-sockets (supposed to be gallows) at the eastern side of the burial mounds. These bodies were dated (by radiocarbon determinations) between the eighth and the tenth centuries, and reflect the authority of the Christian kings who supplanted those buried under the Sutton Hoo mounds in about 700 C.E.

See also: AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; BURIAL GROUNDS; CHRISTIAN DEATH RITES, HISTORY OF; CREMATION; QIN SHIH HUNG'S TOMB

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MARTIN CARVER

 SYMPATHY CARDS

Acceptable expressions of sympathy vary across cultures from open and varied displays of compassion to the denial of any sympathy for even a society's most troubled members. While many people take sympathy for granted, its expression is more characteristic of some cultures and at some times in history than in others. Expressing sympathy requires energy, time, and sometimes money, and becomes problematic under conditions of extreme hardship when one's own misery is paramount. Sympathy is functional for society, however, because it provides a social connection among people; without it, life's emotional climate becomes colder and harsher. Each society's "sympathy logic," or when, where, how, and over what lost relationship sympathy is to be expressed, becomes a part of its social order. Norms develop about sympathy attitudes and behaviors and who is to express such concern for whom. Through expressions of sympathy, people can be linked in ways that affect the social interaction of families, work forces, and entire communities, as well as the individuals involved. Thus, expressing sympathy can increase social bonds while denying it helps unravel the social fabric.

The refusal to offer sympathy has profound effects on human relationships. This social emotion of compassionate affinity, of being personally affected by another's grief or suffering, can only take place in real or imagined social interaction. Sympathy is a complicated, multifaceted emotional process requiring elements of empathy, sympathy sentiment, and display. Genuinely sympathetic persons imagine taking the role of the other, have some feeling about recipients of the sympathy and their plights, and engage in nonverbal (a look), verbal ("I am so sorry"), tactile (a hug), gift-giving (providing money after a job loss), or aid behaviors (cleaning house during illness) as symbolic displays of their sympathy. Within these broad general categories of expression, most cultures

have specific norms for the timing and displaying of sympathy to bereaved persons following a death. One form of showing concern for mourners is sending sympathy cards.

The Emergence of the Greeting Card

Most cultures view death as the most difficult type of loss humans experience, and expressions of sympathy in such traumatic circumstances can be difficult to convey. What does one say? How does one act when confronted with someone who is grieving? Matters surrounding death, once handled by family members and friends, have been given into the hands of professionals in modern societies. Increased standards of living, developments in medicine and science, urbanization, and affluence have allowed people in many nations to develop a degree of death denial not possible earlier in history, and people have become increasingly uncomfortable with and isolated from death. The introduction of sympathy cards in the nineteenth century offered an effective solution for maintaining social bonds in an increasingly technological and impersonal world.

In his *The Romance of Greeting Cards* (1956), Ernest Chase, a prominent figure in America's early greeting card industry, views the history of greeting cards as beginning with early human attempts to achieve or maintain relationships with others. Symbolic gestures of greeting, whether carvings on rocks, smoke signals, gloves, flowers, letters, or any others humans have devised, provided social connections in modern times in a manner elaborated upon and refined by greeting cards. As early as the 1600s, Valentine's cards were drawn, lettered, and sent, though not sold. The most popular holiday card, the Christmas card, originated in England in the 1800s and immediately captivated the public.

The Sympathy Card

Following a death, the surrounding emotion can be expressed in various ways, with each expression requiring a degree of investment and commitment. The sympathy card requires a minimum of both. In a sense, it is an expression of genuine concern without having to get involved. While other demonstrations of sympathy remain important, the pace of modern life, discomfort with death, widespread acquaintance, and mobility are

among factors that encourage impersonal, minimally committed sympathy display.

Although the sending of greeting cards has become common, some societies have not developed the custom. In 1971 Richard Rhodes, a book editing manager of Hallmark cards and contributing editor for *Harper's*, reported that the English were sending few cards at that time, while the Europeans sent fewer still. By the year 2000, sympathy cards were common in Western societies, with the United States leading in their usage. However, even in countries where sending cards is popular, sympathy cards may not be included. Late-twentieth-century China experienced a greeting card deluge, with hundreds of millions of cards produced. New Year's cards, Christmas cards, and cards for other happy occasions were popular, but sympathy cards did not exist. Instead, people sent sympathy telegrams, which were deemed a more appropriate display of support during sad and difficult times. By the 1990s electronic and computer-generated greeting cards had appeared around the globe, and numerous online companies offered free cards for public usage. Even so, electronic sympathy cards were not as rapidly accepted as those for other occasions. Apparently many people still felt that paper cards, like sympathy telegrams, indicated more appropriate support to the bereaved following a death.

Just as the greeting card industry has expanded in modern societies, so have the "sympathy margins," or the situations in which sympathy is to be felt and expressed. These margins vary across cultures and according to demographic variables such as age, gender, ethnicity, religion, and others. For instance, women continue to buy the large majority of greeting cards and are culturally expected to offer sympathy for a larger range of incidents and more minor difficulties than are men. Women also tend to extend sympathy for a longer period of time. Women have always been the mainstay of the greeting card market and have been the primary purchasers and senders of sympathy cards. In an attempt to attract ethnic markets, companies in the United States began to offer cards aimed at African Americans and Hispanics. At the end of the twentieth century, age-specific markets were developed, as were specific religious markets.

Early sympathy cards were often announcements of death, with "in loving memory of" or "in

affectionate remembrance of," followed by the name of the deceased. As with more modern cards, some were plain, whereas others used more elaborate drawings and imagery. Early cards sometimes featured tombstones with names and epitaphs. Sympathy cards from the mid- to late twentieth century used less overt imagery. These cards were sent to mourners to help soften the blow of death, and their colors, verbal content, and visual symbols became designed to reduce death's harshness for the bereaved. Their imagery has changed over time, with a movement from black and white to color and other alterations in content and presentation. Even into the twenty-first century, the words *death* and *dead* were virtually never mentioned. Modern views of tact and propriety led to a few standardized images.

Marsha McGee's 1980 groundbreaking content analysis of 110 American sympathy cards and a replication in 1998 by Charmaine Caldwell, Marsha McGee, and Charles Pryor of 137 cards found flowers to be the symbol most commonly used. Scenes depicting nature remained popular, while images such as seashells, rainbows, and butterflies generally increased over these two decades. Religious symbolism was used in only a small percentage of the cards analyzed in both studies. Dark colors and black were never used. Pastels were prominent, with bright colors increasing.

According to Hallmark's research division, by 2000 Americans alone were sending around 125 million sympathy cards each year. There were thousands of designs on the market, with card sending increasing each year. Sympathy margins had expanded, and cards were also designed for job loss, divorce, chronic illness and disability, and other experiences of loss for which sympathizers wished to show concern. Cards were aimed at grieving children as well as adults, and a huge array of sympathy cards for grieving pet owners continued to widen the market. Cards that expressed the message "thinking about you," in difficult times made up a rapidly growing market. Language had moved from poetry and verse to more conversational messages. Greeting cards are carefully designed to reflect what a society's people are thinking and feeling; Hallmark, like other companies working to keep ahead of market trends, developed and marketed cards appropriate for miscarriage, suicide, cancer, and other specific types of death when the public became receptive. Messages such as "When a special life ends

in such an unexpected way, it can be totally overwhelming . . . ,” and “Sorrow reaches even deeper when a loss comes so suddenly . . . ,” were offered to cushion the shock of different types of loss.

Research samples show most Americans would appreciate receiving sympathy cards. While people report that personal letters are better to send, few do more than write a note along with a card. Mourners have reported that the expression of concern from others is more important during bereavement than its form or its content. Sympathy cards remain one prominent means of expressing this concern. As electronic communication and international markets continue to expand into the twenty-first century, more and more mourners across the globe may find comfort from such messages of condolence. As a simple gesture of support, sympathy cards provide meaning to both senders and receivers. At the least, the sending of sympathy cards links people together and “reinforces a sense of community and solidarity in the wake of the calamity of death” (Lippy 1983, p. 107).

See also: DEATH SYSTEM; GRIEF; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE; METAPHORS AND EUPHEMISMS; MOURNING

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MARSHA MCGEE

SYMPTOMS AND SYMPTOM MANAGEMENT

Many physical and psychological symptoms accompany the end of life. In one study, 1,000 cancer patients had a median of eleven symptoms during the terminal phase of illness, many of which affect the patient’s quality of life. Assessment and management of common symptoms are thus integral to a balanced approach to end-of-life care. Because of the multidimensional nature of many symptoms, an interdisciplinary team approach to assessment and management is essential. Such an interdisciplinary team calls for the expertise of nurses, physicians, social workers, nursing assistants, spiritual care providers, and expressive therapists.

Prevalence and Relevance of Symptoms

Pharmacological and nonpharmacological efforts to alleviate the symptoms seek to accommodate the patient’s desires. For example, if a patient has requested to be as alert as possible until death, and if the same patient needs an antiemetic agent to control nausea and vomiting, the common side effect of sedation represents an unacceptable tradeoff to the patient. If, on the other hand, the patient desires total control of the nausea and vomiting, even at the expense of alertness, such medication would be appropriate. The goal of symptom management is quality of life.

Fatigue. Fatigue is the most prevalent end-of-life symptom, second only to pain. In a study by

Conill, fatigue was present in 80 percent of 176 palliative care patients. There is not a universal definition of fatigue. Patients often speak of weakness, easy tiring, or inability to perform the activities of daily living. According to death experts Linda Tyler and Arthur Lipman, fatigue is a multifaceted symptom. Tyler and Lipman identify the following causes of fatigue: anemia, pain, depression, insomnia, dehydration, metabolic disease process, and side effects of drugs, especially opioids that cause central nervous system (CNS) depression.

Patients may be reluctant to report fatigue because they are unaware that there is treatment for this symptom. A thorough assessment, examining patterns of fatigue, activity, sleep, and interpersonal relationships, is essential in determining appropriate interventions. Healthcare professionals must ascertain the impact of fatigue on the patient's and family's quality of life.

Nonpharmacological interventions include educating patients and families about the disease process and reviewing their goals of care. Energy conservation or rest periods, along with good sleeping habits, enable patients to "bank" energy for more active times. Patients can also conserve energy by using devices such as walkers, bedside commodes, and wheelchairs.

Pharmacological interventions, which address the underlying cause of the fatigue (e.g., antidepressants or antihistamines for insomnia), may decrease the fatigue a patient is experiencing. CNS stimulants, such as methylphenidate (Ritalin), are especially helpful in treating fatigue caused by opioid sedation. According to Tyler and Lipman, corticosteroids (dexamethasone) may be effective in treating this symptom, even when the etiology is unknown.

Anorexia. Anorexia is a loss of the desire to eat or a loss of appetite accompanied by a decreased food intake. It is frequently associated with cachexia and progressive weight loss. The etiology of the cachexia/anorexia syndrome is unknown and may involve numerous physiologic mechanisms.

Causes of anorexia include oral or systemic infection, which may produce discomfort during eating; unresolved pain; depression; and gastrointestinal symptoms such as chronic nausea and vomiting,

delayed gastric emptying, constipation, and/or diarrhea. As with other symptoms, treatment is based on the patient's goals. If eating is desirable, efforts to alleviate anorexia are initiated. Family and caregivers are taught about food preparation. If early satiety is a problem, serving smaller, frequent meals may be helpful. Under such circumstances it is important to eliminate strong odors while cooking.

Pharmacological interventions can stimulate appetite. Corticosteroids such as dexamethasone (Decadron) are cost-effective agents that enhance appetite and improve the sense of well-being. Appetite stimulants such as megestrol acetate (Megace) may be helpful. According to physician Walter Forman and educator Denice Sheehan, the cannabinoid dronabinol (Marinol) may also be effective, despite continuing controversy over its use for relief of gastrointestinal symptoms. Because eating is often a social event, the loss of appetite is emotionally trying for patients and caregivers.

Dehydration. Researcher Frederick Burge defines terminal dehydration as a clinical state in which dying patients are no longer able to consume adequate fluid volumes. According to nurse researcher Joyce Zerwekh, fluid deficits are common as a patient approaches death. Identifying the cause of the dehydration is not as important as identifying the goals of care of the patient and family. It is imperative that the patients and their caregivers be involved in all decisions related to food and fluids at the end of life. Artificial hydration should never become an end in itself.

Dehydration was once considered painful for dying patients. But there are many advantages to dying in a state of dehydration. As a patient becomes dehydrated, gastrointestinal fluids decrease, limiting nausea and vomiting. Lessened pulmonary secretions alleviate breathlessness and cough. Swelling of the hands and feet are less likely to occur because peripheral edema is reduced. Patients who are in a complete state of dehydration often experience the metabolic disturbance known as ketoacidosis, which seems to produce an analgesic effect that may improve a patient's sense of well being. Families are often more comfortable in an environment that limits the use of artificial hydration via tubes and machines. The relief of dry mouth is best achieved with ice chips. Families who want to be involved in caregiving appreciate the opportunity to moisten lips and offer ice chips.

Hospice and palliative care physician experts Fainsinger and Bruera report that hydration sometimes improves the quality of life of a dying patient, especially in cases of opioid toxicity or dehydration-induced confusion. Artificial hydration can be delivered by parenteral routes. Hypodermoclysis is the provision of fluids through a subcutaneous route (a small needle placed under the skin). Intravenous hydration provides fluids via the vascular system.

Constipation. Constipation, the abnormally infrequent evacuation of hard stool, occurs in 50 to 78 percent of adults (the average person has five to seven stools per week). Causes of constipation include side effects of medications, inactivity and weakness, intestinal obstruction from a tumor-compressed bowel, and fluid and electrolyte abnormalities such as dehydration, hypercalcemia, and hyperkalemia. In terminal patients constipation typically stems from multiple causes.

Nonpharmacological treatment may include altering food and fluid intake. Whenever possible, the patient should increase fluid intake and consumption of high-fiber foods. If the patient is close to death, pharmacological and/or mechanical treatments are preferable.

Medication-induced constipation can be treated with a stool softener/stimulant combination such as casanthranol with docusate (Pericolace) or senna (Senekot). A minimum goal is a bowel movement once every three days, regardless of intake. Constipation that is not secondary to a bowel obstruction calls for laxative therapy. About one-third of patients at the end of life require suppositories, enemas, and/or disimpaction to treat constipation despite the appropriate use of oral laxatives.

Constipation causes significant discomfort and embarrassment for patients. It can cause serious complications in the patient with advanced disease. Because it is such a common problem, prophylactic measures should be initiated in most patients. Prevention, aggressive assessment, and treatment are essential.

Nausea and vomiting. Nausea, with or without vomiting, occurs in 70 percent of terminally ill patients. Nausea is the unpleasant subjective sensation that results from stimulation of four major areas: the gastrointestinal lining, the chemoreceptor trigger zone in the fourth ventricle of the brain, the vestibular apparatus, and the cerebral cortex. Vomiting is a

neuromuscular reflex that occurs as a result of a variety of mechanisms stimulating the vomiting center.

There are several causes of nausea, including gastrointestinal, such as gastric dysmotility, bowel obstruction, and constipation; treatment-induced, such as medications, chemotherapy, and radiation therapy; metabolic disturbances, such as hypercalcemia, uremia, and infection; and CNS causes, such as pain and increased intracranial pressure must be determined. Nonpharmacological treatments include guided imagery techniques, relaxation, music therapy, and hypnosis. Other nonpharmacological measures include decreasing food odors, serving meals at room temperature, and encouraging good oral hygiene.

Nurse researcher Cynthia King reported the use of nine classes of antiemetic drugs to treat nausea and vomiting in hospice/palliative-care patients. Medications are available to manage gastrointestinal causes, treatment-induced causes, metabolic disturbances, and central nervous system causes. For example, the prokinetic agents such as metoclopramide (Reglan) enhance gastric motility. Serotonin 5-HT₃ receptor antagonists, such as ondansetron (Zofran), are used to block the neurotransmitter associated with treatment-induced causes. Phenothiazines and butyrophenones act primarily as dopamine antagonists and are most potent at the chemoreceptor trigger zone. Benzodiazepines work on the central nervous system, altering the perception of the nausea. Corticosteroids should be initiated in cases of increased intracranial pressure, hypercalcemia, or tumor-induced obstruction.

Patients may need more than one pharmacological agent to treat nausea and vomiting associated with multiple etiologies. For example, if the nausea is a result of tumor pressure on the gastrointestinal lining, pressure-reduction techniques are in order (e.g., coadministration of a corticosteroid to shrink the tumor burden along with a benzodiazepine to alter the perception of nausea).

Dyspnea. Dyspnea is a subjective symptom that involves a feeling of breathlessness or air hunger. The patient's perception of the degree of breathlessness is the only reliable indicator of the severity of the dyspnea, which occurred in 70 percent of terminal patients at time of admission to one study and 82 percent of patients one week before death. The causes of dyspnea vary; among them are anxiety, fear, airway obstruction, and infections such

as pneumonia, thick pulmonary secretions, and fibrosis of lung tissue arising from radiation, chemotherapy, and fluid overload. Tyler recommends nonpharmacological interventions such as improving air circulation with fans, air cooling, repositioning, breathing exercises, and limiting strenuous activities.

Providing reassurance is essential in relieving the patient's distress. Anita Tarzian, nurse researcher, suggests that the fear of suffocation that accompanies dyspnea may be related to the concept that life begins with a breath and ends with the lack of breath. According to Tarzian, dyspnea symptoms may be the first time a patient and the caregivers acknowledge the reality of impending death. Her study of ten nurses who cared for air-hungry patients revealed that as patients experienced air hunger, the families panicked along with the patients. It is important, therefore, to provide patients and caregivers with clear explanations of the nature of the dyspnea and to reassure them that relief is possible.

Pharmacological management usually focuses on the cause of the dyspnea. Oxygen, although widely used as a treatment for dyspnea, is indicated only when there is underlying hypoxia. Antianxiety medications such as diazepam (Valium) or lorazepam (Ativan) are useful if the cause of dyspnea is restlessness. Kemp suggests the use of bronchodilators (albuterol or theophylline) or expectorants (guaifenesin) if dyspnea is related to bronchitis, emphysema, or a lung condition. Steroids (prednisone or dexamethasone) may be used in cancer patients to decrease tumor swelling, which can alleviate obstructive causes of dyspnea.

Morphine, the most widely used pharmacological agent in treating dyspnea, is effective in improving the quality of the breathing. Health care professionals should explain to patients why opioids are indicated because they may not be familiar with their use in the management of dyspnea.

Insomnia. The National Institutes of Health defines insomnia as the experience of inadequate or poor quality of sleep. It entails difficulty falling asleep, difficulty maintaining sleep, waking up too early, or experiencing a nonrefreshing sleep. In one study 61 percent of dying patients reported sleep disturbances on admission to the study, and 50 percent reported sleep disturbances one week before death.

There are numerous causes for insomnia. The most frequent cause among dying patients is nocturnal pain. Other causes include depression, decreases in daily activity or daily napping, and side effects of medications, especially steroids. Alcohol and caffeine may also contribute to insomnia because of their stimulant effects.

Nonpharmacological treatments include relaxation therapy, stimulus-control therapy to minimizing daytime napping, and moderate exercise. Encouraging a patient to verbalize concerns to a caregiver may decrease insomnia related to fear and anxiety.

Among pharmacological approaches, insomnia caused by nocturnal pain is best managed by treating pain effectively throughout a twenty-four-hour period with benzodiazepines such as lorazepam (Ativan). CNS stimulants taken in early daytime hours may decrease daytime naps, thus improving nighttime sleep.

Neuropsychiatric symptoms. Neuropsychiatric symptoms that occur at end of life are extremely disturbing to patients and families. Among the most common are anxiety, delirium, and depression.

According to physician and death expert Susan Block, these symptoms are distinct from the normal sadness, grief, and worry that accompany the terminal phase of life. When anxiety, delirium, and depression are identified and treated early in course of advancing disease, the patient's quality of life improves markedly.

Depression. Depression occurs in 25 to 77 percent of the terminally ill population. Feelings of hopelessness, helplessness, depression, and suicidal ideation are not normal at the end of life and should not be ignored. The most effective management of depression includes a combination of nonpharmacological and pharmacological approaches. Nonpharmacological management emphasizes supportive counseling and psychotherapy, including discussing short-term goals, identifying and reinforcing strengths, and employing successful coping techniques. All members of the interdisciplinary team need to be involved with the plan of care to address the physical, emotional, and spiritual issues associated with depression.

The choice of pharmacological management is guided by the expected life span of the patient. When time is limited and an immediate reversal of

depression is desired, a rapid-acting psychostimulant, such as methylphenidate (Ritalin), is best. Selective serotonin reuptake inhibitors (SSRIs), such as paroxetine (Paxil) or sertraline (Zoloft), are highly effective but require two to four weeks to achieve a response. Therefore, the depressed, dying patient with less than three weeks to live should not be treated with an SSRI. Nor are tricyclic antidepressants, such as amitriptyline (Elavil), useful in such cases because of their delayed onset of therapeutic response and significant anticholinergic side effects such as constipation, dry mouth, and urinary retention.

Delirium. Delirium is “an etiologically nonspecific, global cerebral dysfunction characterized by concurrent disturbances of level of consciousness, attention, thinking, perception, memory, psychomotor behavior, emotion, and the sleep-wake cycle” (William Breitbart et al, 1998 p. 945). Often misdiagnosed as anxiety or depression, it occurs in up to 80 percent of dying patients. Early detection and treatment can lead to improved outcomes in the hospice/palliative-care setting.

There are multiple causes of delirium. Potentially reversible causes include metabolic abnormalities such as hypercalcemia, overwhelming systemic infection (sepsis), dehydration, or major organ failure. About 50 percent of patients have unknown etiologies and require empiric treatment. Nonpharmacological management is aimed at providing a comfortable environment. Measures to decrease anxiety and disorientation include encouraging the presence of family and familiar persons; a visible clock and calendar; a quiet, well-lit room; and the use of soothing music. Familiar sounds, smells, and textures offer comfort.

When a reversible cause for delirium is identified, pharmacological agents appropriate for the etiology should be initiated. Symptom management may be achieved through the use of butyrophenones such as haloperidol. Haloperidol, a blocking agent of the neurotransmitter dopamine, is usually effective in decreasing agitation, clearing sensorium, and improving cognition. However, there are circumstances, especially with terminal restlessness, when delirium can only be controlled with sedation. The use of pharmacological agents to sedate patients with terminal delirium requires serious consideration by the interdisciplinary team members, discussion with family about care goals,

and careful monitoring. Sedation should only be considered after an exhaustive trial of evidenced-based pharmacological interventions.

It is important to distinguish delirium from episodes of awareness of imminent death. In the final days of life, patients may appear confused to caregivers and family, speaking of trips, wanting to “go home,” talking of deceased family members, and reporting visions. Some health-care professionals believe that this confusion arises from physiological changes occurring during the dying process, while others consider it to be a spiritual experience. This imperfectly understood syndrome calls for sensitive exploration with the patient and family.

Anxiety. Patients often experience anxiety as their disease progresses and they face their final days. Anxiety may be evidenced by physical and/or cognitive symptoms such as shortness of breath, gastrointestinal distress, tachycardia, loss of appetite, irritability, and insomnia. A common cause of anxiety in the hospice/palliative care population is poorly controlled pain. Alleviating the pain often alleviates the anxiety, and no further treatment is necessary.

The most effective treatment is a combination of counseling therapy and pharmacological management. Goals of psychosocial intervention are to improve morale, self-esteem, and coping skills. Psychotherapy for patients at the end of life focuses on helping them deal with the anxiety of impending death. Fears and anxieties are best managed by the interdisciplinary team. All team members can address spiritual, practical, and emotional concerns.

In determining the need for pharmacological management of anxiety, the severity of the symptom is the most reliable factor. Patients with persistent apprehension and anxiety benefit from benzodiazepines, such as lorazepam (Ativan) and diazepam (Valium). Because many patients at the end of life are elderly, or have compromised renal and hepatic function, it is important to start with low doses of the benzodiazepines. Using lower doses also minimizes potential side effects.

Conclusion

Although symptoms in patients at the end of life increase in prevalence and severity with disease progression, they remain manageable with appropriate interventions. When patients’ physical distress is well managed, it is possible for them to focus on

their vision of a “good death.” According to Lipman, end-of-life care that incorporates individualized, evidence-based medicine will lead to compassionate care. Health-care providers who are not familiar with end-of-life symptom management can consult the extensive literature, or they can access a local hospice/palliative care team for suggestions. The passage from life to death can be immeasurably eased by a team approach that focuses on giving the patient emotional reassurance and symptomatic relief in harmony with his or her care goals.

See also: DYING, PROCESS OF; HOSPICE IN HISTORICAL PERSPECTIVE; HOSPICE OPTION; PAIN AND PAIN MANAGEMENT; PSYCHOLOGY

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TABOOS AND SOCIAL STIGMA

Death is the greatest mystery of life. Its inevitability has been a source of wonder, fear, hopefulness, and puzzlement throughout history. Humans, being the only species consciously aware of the inescapability of death, have sought from time immemorial to cope with this unique insight. In Western society the traditional patterns of death were shaped by an ancient attitude informed by simplicity, meaningful ceremony, and acceptance. The experience was public; that is to say, a caring community of family and neighbors ministered to the dying person. In the traditional context, death was conspicuously visible throughout society and people went to great lengths to remind themselves of how fragile life is. Reminders of mortality were everywhere, whether they be in literature, paintings, oral traditions, or the cemeteries and churches where the physical remains of death intersected with the daily activities of the community. In this convergence, death held sway over the imagination of individuals, and was a source of elaborate ritual known as the *ars moriendi*. In these ceremonies that characterized the traditional patterns of death, acceptance and openness were the most important qualities.

Traditional Views of Death Give Way to New Perceptions

Throughout the ages particular rituals, along with their participants and meanings, may have varied. Nonetheless, death, dying, and grieving in the traditional model were an important part of everyday

cultural practices. And the rituals they spawned connected dying and grieving persons to a broader community and set of meanings. In this way, the ordeal of dying was never just personal, it was communal. These great ceremonies, along with their deep religious and social meanings, accompanied dying persons into their deaths. They provided a sense of strength for the broader community that was being threatened by the loss of one of its members. Additionally, these traditional rituals were a healing balm to dying persons and their intimates, offering strength and comfort to both.

In the twentieth century, the social and psychological landscape was transformed, redefining American cultural, social, and personal experiences of death. The result of this transformation is that dying, once an integral and meaningful part of social life, has become a source of terror and thus largely vanquished from public visibility. Herman Feifel has argued that this change has produced the American “taboo on death.” Four major social trends are responsible: (1) the abdication of community to a pervasive sense of individualism; (2) the replacement of a predominantly religious worldview with one that is secular; (3) the sweeping power that materialism holds on the values, interests, and behaviors in modern society; and (4) the influential place of science and technology in daily life.

As individualism, secularism, materialism, and technicism have become driving forces in modern American culture, the experience of dying and its meanings have been dramatically recast. Specifically, as individualism replaces community in daily

life, community presence and support is withdrawn from the dying and grieving processes. Secularism as a way of life offers many opportunities and great pleasures, but is ultimately unable to offer meaning and comfort at the end of life. Like secularism, materialism poorly equips individuals and societies to grapple with the mystery of death. In addition, technological achievement and dependence have enabled humanity to actively fight against dying, thus forestalling death for countless numbers of individuals. In this technological framework, dying is no longer a natural, necessary, and important part of life. Rather, it is as if it has become an enemy. Success lies in its control and defeat; failure becomes defined as the inability to turn it away.

The New Model of Death

These social changes have given rise to a new model of death, wherein dying and grieving are atomized and disconnected from everyday pathways of life, leading to their social isolation. As the historian Philippe Ariès astutely observes, in this context, dying has become deeply feared and a new image has replaced the traditional patterns of acceptance: the ugly and hidden death, hidden because it is ugly and dirty. As death has become frightening and meaningless, a culture of avoidance and denial has correspondingly emerged. Specifically, it has led to widespread pretense that suffering, dying, death, and grief do not exist. When individuals are forced to confront these inevitable experiences in their personal lives, they typically do so without social support and the comfort of participatory rituals or shared meanings. A pattern of death entirely unfamiliar in the traditional era has hence emerged. It is rooted in a sense of separation from the dominant culture and profound feelings of shame, both of which exacerbate the suffering inherent in the experience of dying and grieving.

As the legitimation and comfort of traditional ways of dying have given way to meaninglessness, isolation, and shame, stigma has become attached to suffering, dying, death, and grief. The stigmatization of death, wherein the experience of dying has become shameful, has helped to create an environment in which comfort at the end of life is scarce, and where suffering rages uncontrollably against dying individuals and their loved ones. As



Female children were once considered a social stigma in China where “one-child” policies existed, and infanticide was common if a woman gave birth to a baby girl. With the hopes of curtailing infanticide rates, billboard posters in the community still encouraged “one-child” policies, but said that it was acceptable to have daughters. OWEN FRANKEN/CORBIS

thanatologist David Moller documents, this stigma is far more than an abstract intellectual concept. It is a part of the actual experience of dying in the modern era, as embodied in the voices of persons facing the end of their lives. The following extract contains words expressed by different individuals who because of serious illness were forced to confront their own mortality. They are indeed testimonial to the profound suffering that accompanies dying in the individualistic, secular, materialistic, and technocratic organization of American life:

Oh God the pain is so great. To go to sleep
and
feel normal, then to awake with such pain!
Why

has God deserted me? I want to die. I can't
live
with this newness. There are so many tubes in
my body. Every orifice. My hair is gone, my
head
a giant bandage. Why can't I just die?
. . . illness creates in me a desire to withdraw
from
society . . . I retreat to a resignation that most
things
in life are empty-colorless-undesirable.

Because of all this, most days I try not to look
in
the mirror, so I can still pretend that I look
like
anything other than a cancer patient.

It seems that everything keeps going back to
this cancer. It makes me feel so ugly, and
it's just so depressing.

I'm not myself anymore. Oh, the way I used
to be.

I can't even stand to look in the mirror
anymore

(tears begin to stream from her eyes).

I'm no good to anybody. Why am I living?

Why
doesn't God just let me die? I feel so useless,
and

I'm a burden to everyone. This is no way to
live.

The pain, oh why? I'm just no good.

Everything seems to lead me back to my
cancer.

Cancer, cancer, that's it! That's all there is.

I'm just wasting my life away. There's
absolutely

nothing positive happening. It's (having
cancer)

all just so time consuming. It doesn't make me
feel well . . . feel good or happy. It's boring
and

painful. Physically and emotionally, it's
confusing

and depressing. There's nothing positive! All it
does is hurt. Everybody!

(Moller 2000, pp. 26, 33–35, 144–155)

The portrait that surfaces from these voices is
one of agony and regret. It reflects an isolation and
terror that was unheard of during the eras of tradi-
tional death. Also emerging is a silhouette of evil,

whereby the body is being decimated by disease
and the very foundation of cultural and social life is
being attacked. The result is that dying people and
their loved ones often live in a state of social exile,
enduring their suffering in isolation. Simply, these
people suffer deeply and unnecessarily, and they
do so in a societal context where the very idea of
death has become inconceivable and unbearable.

See also: CANNIBALISM; DEATH SYSTEM; INFANTICIDE

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TAOISM

In Chinese, the term *Tao*, or *Dao*, which means “way,” can refer to phenomena as disparate as the proper mode of conduct in society to an abstract, transcendent order to the universe. Similarly, the Western term *Taoism* (or *Daoism*) refers to a number of distinct phenomena in China, all related in some sense to this concept of Tao. One of the more popular usages is as a reference to several

philosophical works of the Warring States and early Han periods, especially the *Zhuangzi* (*Chuang-tzu*) and *Laozi* (*Lao-tzu*, also known as the *Daodejing* (*Tao-te ching*), or *Classic of the Way and Its Power*). The *Chuang-tzu* welcomes death as merely one more stage in a process of ongoing transformation that affects all and is directed by the Tao. It speaks of death as a returning home that humankind resists out of ignorance and sees the individual living on after death dissolved in the many creatures of the earth. The famous parable of the author dreaming that he was a butterfly, then waking to wonder if he were now a butterfly dreaming of being a human, is a metaphor for this sense that temporal life is but an illusion and death an awakening.

The *Laozi*, on the other hand, speaks of death as an inauspicious event to be avoided and mentions self-cultivation techniques intended to prolong physical life. This viewpoint is much closer than the *Zhuangzi* (*Chuang-tzu*) to mainstream ancient Chinese thought on death. Life does go on in a shadowy, subterranean realm, but it is not joyful, and much effort was expended from an early period to forestall its arrival. By the third century B.C.E., there were programs of exercise, diet, sexual practices, and meditation intended to nourish the life force while alive as well as jade burial suits and tomb guardians intended to preserve the deceased in the other realm. Alchemy, the belief that the human form could be made eternal through the ingestion of various mineral-based elixirs, developed through the Warring States era, Han Dynasty, and about fifth century B.C.E. to sixth century C.E. Practitioners were initially adepts of the occult arts without a clear sectarian identity, but eventually these practices would make their way into the ritual canon of religious Daoism.

The Confucian view of death, by contrast, forsakes all hope for extraordinary longevity and focuses on the secure installation of the dead in the other world, where they would be administered by a bureaucracy that mirrored that of the living and supplied with the necessities of continued life through ancestral sacrifice. The dead were recalled and, some argue, kept alive by meditative visualizations in which the dead person was called into the consciousness as if still alive. The Confucians also promoted a metaphorical interpretation of sacrifice that elided the question of personal survival



Prayer cards, photographs, and ritual offerings, including a tea kettle, vases, and flowers, characterize a Taoist courtyard altar at the Lung Shan Temple in Taiwan. G. JOHN RENARD

and the ethical implications of a transactional relationship with the sacred.

Religious Taoism arose in the second century C.E., proclaiming a new pantheon of pure deities and a new, morality-based set of practices. The early Taoist church foresaw an imminent apocalypse in which the evil would perish and the faithful “seed people” would survive to repopulate a utopian world of Great Peace. Until then, ordained Taoists received celestial ranks that carried over into the world of the dead, assuring them a favored position of power and responsibility in the other world. Their offices might be in the cavern-heavens hidden within the world’s sacred mountains or in one of the many celestial heavens. Non-believers went to a profane world of the dead, where they were subject to a variety of dangers, including lawsuits from those they had wronged in either realm. Living Taoist priests could intervene on their behalf, using their authority as celestial officials to have suits dismissed and punishments curtailed.

Popular conceptions of the afterlife came to focus on existence in hells where retribution was exacted for sins during life. Taoists, like Buddhists, developed ritual methods to save the deceased from these torments, submitting written petitions to celestial officials but also employing ritualized violence to force their way into the hells in order to lead the deceased out. Major Taoist rituals of renewal (*jiao*) typically end with a Rite of Universal Salvation intended to save the dispossessed souls.

Twenty-first-century priests of the Taoist church survive in Taiwan, Hong Kong, and diasporic Chinese communities and have been reestablished in China. There are some movements in the West that claim this mantle as well, but most do not maintain traditional ritual practice. The philosophical works of the Warring States era, on the other hand, enjoy a wide following in the West, though the disparity in the teachings of the *Laozi* and the *Zhuangzi* are seldom appreciated. The dominant Chinese approach to death remains that of Chinese popular religion, which eclectically mixes the beliefs of Buddhism and religious Taoism with traditional Chinese views of death, the afterlife, and the soul.

See also: CHINESE BELIEFS; SHINTO

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TAYLOR, JEREMY

The Anglican bishop and writer Jeremy Taylor (1613–1667), one of the key exemplars of pastoral care and a gifted writer, was born and educated in Cambridge, England. He was ranked by the English poet Samuel Taylor Coleridge as the equal of Shakespeare and Milton. Taylor was probably ordained in 1633, the year in which he took his master's degree; he became a fellow of Gonville and Caius College and, two years later, a fellow at All Souls in Oxford. Shortly after being appointed the rector of Uppingham in 1638, he became the chaplain to the king of England on Laud's nomination; Laud also seems to have retained him as his own chaplain.

Taylor joined the Royalist army as chaplain when civil war broke out in 1642, and he was briefly imprisoned twice. In 1645 he became private chaplain to Lord Carbery at his Golden Grove estate. There, Taylor produced his greatest works, including *A Discourse of the Liberty of Prophecy* (1647), a call for Christian toleration that probably

alienated Charles I; *The Golden Grove* (1655), a collection of daily prayers; and the *Unum Necessarium* (1655), a work on sin and repentance. His two famous books of devotion, *The Rule and Exercises of Holy Living* (1650) and *The Rule and Exercises of Holy Dying* (1651), were intended to act as guides for those not served by local Anglican clergy because of the ejection of priests during the interregnum. At the Restoration in 1660, Taylor published his comprehensive manual of moral theology, the *Ductor Dubitantium*. That same year he was appointed bishop of Down and Connor; in 1661 he was appointed bishop of Dromore, in Ireland; and later vice-chancellor of Trinity College, in Dublin.

Although he seemed conventional in his relations with the royal and Episcopal authorities, Taylor aroused controversy because of his defense of Christian toleration and his allegedly Pelagian views on original sin and justification, both of which were attacked by the Scottish Presbyterian Samuel Rutherford. *Holy Dying* was written in the circumstances of the death of his wife, Phoebe, but was directed at a general audience as a self-help manual: "The first entire Body of Directions for sick and dying People, that I remember to have been publish'd in the Church of England." The importance of the text was not only in the quality of its prose but in the serenity of its ecumenical verdict: "Let it be enough that we secure our Interest of Heaven," Taylor wrote, "for every good Man hopes to be saved as he is a Christian, and not as he is a Lutheran, or of another Division." Taylor advocated daily self-examination by the Christian to avoid divine judgment, and especially the "extremely sad" condition of many "Strangers and Enemies to Christ." Thus, he concluded, "He that would die holily and happily, must in this World love Tears, Humility, Solitude, and Repentance" (Taylor, 2:1:3).

See also: CHRISTIAN DEATH RITES, HISTORY OF; GOOD DEATH, THE; MOMENT OF DEATH

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RICHARD BONNEY

TECHNOLOGY AND DEATH

What is fantasy one day may be reality the next. The Human Genome Project and cloning are the twenty-first century's newest ventures into the relationship of technology and death. The mapping of genes looks for medical advances to prevent disease, cure patients, and extend human life. The goal of curing or preventing diseases linked to one's genes is a major incentive for researchers and investment capital to drive technological change for the greater good. Utilitarian arguments challenge traditional principles and values that seek to limit the number of deaths in the process of change.

Success in developing cures for various diseases has universally given rise to the expectation that it is just a matter of time until medical scientists will discover cures for cancer, HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome), and other diseases. Supporters of change argue that society would benefit from more tax incentives, research grants, research centers, and educated researchers to meet these important challenges. Technology is not a concept set apart from society, as dramatically seen in medical, ethical, and political debates over human experimentation with somatic and stem cell cloning.

Technological Determinism, Cultural Lag, and Death

It is easy to recognize technology in society. It consists of devices, knowledge, and skills that can be used to control and utilize physical, social, and biological phenomena. A common intellectual error is to treat technology and society as distinct, independent entities. Technology, ideology, and social organization, while separate entities, are interrelated. This is particularly evident in the relationship of technology and death in modern and postmodern societies.

The argument that technology drives social change is not a new one. Great thinkers such as Karl Marx, Henri Saint-Simon, and William Ogburn made the argument that improvements in technology lead to social change in society. Ogburn further suggested that there is a social lag between inventions and adoption of the change in society. For Western societies, technological innovation is a

major source of social change that impacts dying and death.

Consider the social and cultural impact that is involved in "brain death" laws that were enacted in most states by 1980. The impetus for redefining "death" to include "brain death" (the cessation of electrical activity in the brain and brain stem while circulation and breathing are sustained by machines) is due to medical research in human organ transplantation, particularly of kidneys, a major advance in medical technology.

Early success in human organ transplantation began in North America in the 1960s with the "harvesting" of kidneys, and other organs, from cadavers. The donors were healthy persons who had died in an accident where medical (machine) support was available to sustain breathing and circulation. The need to change legal definitions of death to include brain death came to the fore when prosecutors began to charge harvesting surgeons with murder under existing laws. For the sake of the greater good, states began to adapt by passing legislation that allowed for collection of human organs when a person was "breathing" and had "a pulse."

Still other social changes have taken place in the face of blood-borne pathogens and other contagious diseases. HIV/AIDS and other diseases have caused medical personnel and embalmers to adopt defensive measures including protective clothing, gloves, masks, and different chemicals to shield themselves from these diseases. The threat of terrorism in biochemical attacks challenges and changes both governments and everyday behavior in citizens regardless of the number and types of deaths that result.

Technology As an Interdependent Variable, Death As the Dependent Variable

Most changes in technology are slow to be accepted, causing a social and cultural lag between the development of the innovation and its adoption. Examples include the reluctance of China to acknowledge the spread of HIV/AIDS and of Japan to enact brain death legislation in support of organ transplantation.

While many technological developments languish for lack of support due to cultural belief, social values, or "the bottom line," others are seen as

riding the tide of technological change. Medical information technology is accepted by some specialties as a way to be more efficient and accurate in treating patients and saving lives. High-tech medicine demands high-tech specialists to fight disease and challenge death.

The institutions of hospice and palliative medicine provide a holistic approach to caring for the dying person and support family and friends who are part of the support team. It is not uncommon for hospice observers to ask if one has to die to get that kind of quality care. Yet hospice provides care for only a small percentage of all patients who die in the United States and only in the last stages of dying.

Decisions by physicians, patients, and family members to reduce or stop aggressive medical treatments are not easy to make when high-tech medicine is standing by to try one more technique or treatment. Experimental protocols may be the only alternative treatment available, even though the study is being done to determine efficacy and side effects of the experimental drug.

Increasingly, aftercare grief support programs are available for family, friends, and others. These are provided in hospitals, churches, and funeral homes. With the widespread use of the Internet, cyber mourning has led to the development of web sites for those who are grieving. These include sites for those suffering from grief for the loss of a spouse, child, parent, friends, siblings, and even pets. Having the technology available does not mean that people will choose to use it, but as use of the Internet increases the use of such sites will also increase.

Technological and Values Congruence

Technological change may be supported or resisted by work, family, and politics. For example, some people believe that were it not for political considerations, public health problems such as HIV/AIDS or drug addiction could be solved or better managed. Others view traditional religious organizations as impediments to lifesaving medical inventions, such as cloning for medical cures.

Still other questions pose moral extremes: Should stem cell research be promoted or forbidden by legislation? Is abortion an evil to be avoided at all costs or a choice that respects the right of privacy? Is cloning research the hope of the future

or an ethical error? Should experimental drugs be readily available to all patients even before their efficacy and side effects are demonstrated? Marked incongruence arises and persists between elements of technology and social organization.

Advances in medical technology have led to public discussion and the legalization of assisted suicide only in Oregon and active voluntary euthanasia in the Netherlands. While the desire to live long has led to the adoption of medical technologies to greatly extend life, there has not been an accompanying adoption of means to medically manage individuals who choose not to live with the increased pain and suffering that sometimes come with extending one's life.

Interestingly, physician-assisted suicide was less of an issue when the average life expectancy was under fifty years and medical science very limited compared to twenty-first-century methods. Until the ability to keep one's body alive long after the brain was functioning normally, little discussion of advance directives was put forth. Though the adoption of advance directives has been slow, its use is increasing in an era of high-tech medicine and frequent litigation that drives up the cost of American health care.

Technology and Mass Destruction

Technology has allowed each generation the ability to create evermore-destructive means of warfare, such as the use of laser-guided missiles and nuclear weapons. Governments and radicals use biochemical and nuclear threats to confront social, economic, and political vested interests. Violent actions increasingly result in targeted mass destruction and deaths. After the 1960s there was a resurgence of racial and ethnic rivalries, tension, and hostilities throughout the world and especially in the United States during the 1980s. During the 1990s prejudice, violence, conflict, and discrimination were found widely throughout the world between black and white in South Africa; between Islamic Arabs and black Christians in Sudan; between East Indians and blacks in Guyana; between Chinese and Malays in Malaysia; between Kurds and Iraqis in Iraq; between the Krahn, Gio, and Mano ethnic groups in Liberia; among other places. The collapse of the former Soviet Union brought forth conflicts between Armenians and



A radiographer prepares a patient for an MRI scan, a technology that revolutionized medical imaging by using magnets and magnetic fields. The results of a scan can save a patient's life by providing useful information in detecting serious health conditions. PHOTO RESEARCHERS

Azerbaijanis as well as Slavic nationalism in the former Yugoslavia.

The twenty-first century has brought changes in Northern Ireland and South Africa and terrorist attacks have modified the world scene. The world, and the United States suddenly seems to be a much less safe place to live. The news of the world and its violence are available twenty-four hours a day. Events are televised as they occur. The world may not actually be more violent, but it appears to be if one follows the news media. Fear of mass death has led to fear of flying, public events, energy plants, and even one's work environment. Biological terrorism, nuclear destruction, smart bombs, and car bombings are part of conventional

conversations. Technology has brought death from the battlefield to where people live and work.

Death

Those who experience illnesses are generally thankful that their illnesses did not occur ten or twenty years ago. Improvements in medical technology are occurring at a rate that is challenging even the most basic definitions of what it means to be human or to simply be alive.

In the midst of a population that is aging, increasing in diversity, and becoming more affluent, the available technology for combating illness and death is forcing an examination of social values and medical structures that deliver curative and rescue technologies. Should stem cell research be conducted on human embryos? Should abortion be used to eliminate fetuses with birth defects or genetic diseases? The ability to conduct fetal surgery has changed many of the issues. How much medical intervention and money should be spent in caring for low-birthweight babies when they are the most likely to die? In 2000 many more low-weight premature babies survived who would have died in 1970. Technology will continue to challenge assumptions on these and many other issues surrounding medical technology and the care of the ill and dying.

Policies and practices continue to change as technology opens new issues to be discussed and debated. Policies related to biomedical technologies are shaped by public demands and expectations. The mass media, interest groups, and the legal, political, and religious systems all have input in shaping policy decisions concerning biomedical technologies. For example, the distribution of medical resources is heavily skewed toward the more powerful, technologically sophisticated nations and to individuals in the upper social classes in those same nations. Individuals with money and social status are more likely to receive medical interventions—a practice labeled “concierge medicine.”

Policy issues also include research and development. As of 2002 the U.S. government supports biomedical research. Strong efforts continue to attempt to block biomedical research for ethical and financial reasons. In 2001 Johns Hopkins had its biomedical research money temporarily rescinded because of public outcry over a death involving

the use of human subjects. Questions concerning who does research, who should be funded, and who should receive the benefits of the research will continue to spark controversy.

Adequate policy decisions require that goals be clearly conceptualized, as no policy is fair for all people. Policies that maximize the greatest good for the greatest number tend to prevail because of historical roots of American utilitarianism. Alternative values, principles, and lifestyles are often protected and respected as an expression of individual choice. Yet, the ability to pay for high-tech services is not distributed equally. Some segments in U.S. society may have a “right” to health care, such as Medicare patients, but this is not the case for all Americans. Claims about the “sacredness” of individual autonomy, self-determination, and personal privacy confront issues of public concern and even those of vested interests (e.g., tertiary insurance providers). While not everyone believes that life should be prolonged at any cost, collectively, they have yet to determine at what point the “technological fix” is not in the best interest of the patient or society.

The Future of Technology and Death

Forecasting the future is at best an inexact science, but it will include an explosion of advanced technology. How will this technology impact dying, death, funeral rituals, and disposal of the dead? Biomedical advances will impact how and when people die and allow many diseases to be conquered. Genetic engineering may make many illnesses obsolete, allow organs to be regenerated when defective, and provide modification to one’s genetic code to avoid disabilities and illnesses. Advances in technology might allow more precise definitions of when life begins and ends, which will facilitate ethical decision making.

Funeral rituals and grieving processes already include the use of technology via the Internet. One can chat online over grief, place memorials for pets, obtain information for aiding children and others who are grieving, and find information about funerals or related dying and death areas. The use of such technology can only increase in the future. Advances in technology have already made cremation a more reasonable alternative to burial and, for some, the deep-freezing of cryonics portends the

way of the future. Tradition may slow the acceptance of technology, but it will not stop the impact of technological change on the future of death.

See also: DEATH SYSTEM; MEMORIAL, VIRTUAL; NUCLEAR DESTRUCTION

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TERMINAL ILLNESS

See DYING, PROCESS OF.

TERRORISM

Terrorism refers to the illegitimate use of violence or intimidation to advance a group's interests. Examples include detonating explosives in public places, taking hostages, or assassinating politicians. Central to the concept of terrorism is that its objective is primarily ideological. Terrorists typically do not employ violence to gain wealth but rather to bring attention to political causes.

Because the term *terrorism* hinges on a distinction between legitimate and illegitimate use of violence, controversy often accompanies its use. For example, governments routinely use force to advance their interests, but do not characterize their actions as instances of terrorism. The bombing of the Alfred P. Murrah Building in Oklahoma City is readily identified as a terrorist act because it was undertaken by a very small group of individuals and not an entire government. Yet much more violent attacks directed against large cities during World War II are not characterized as acts of terrorism. Within a single conflict use of the term "terrorist" in news reports can reveal the political sympathies of the broadcaster or the government that released information about the attack. For example, in the American press violent events undertaken by Palestinians are far more likely to be characterized as acts of terrorism than equally or more violent actions taken by the Israeli military. This political component became very clear in the United States during the Reagan administration, which aided the Contra rebels who were waging a campaign of violence against the Sandinista government in Nicaragua. Officials in the American government characterized the Contras as "freedom fighters" while supporters of the Sandinistas portrayed them as terrorists.

The use of violence by small groups to advance their interests is not a twenty-first-century development. The term *terrorism* first appeared during the French Revolution and the Jacobin Reign of Terror. Similarly, many other words associated with terrorism (i.e., *thug*, *assassin*, and *zealot*) derive from groups alleged to have used violence and death to advance their political objectives.

Historically terrorism is thought to have passed through several distinct stages, from its origin among religious groups fighting to defend or advance their organization's beliefs, to secular

groups, whose objectives were clearly political. Traced by some historians to the French Revolution, this process of the secularization of terrorism continued throughout the twentieth century. Modern technology's ability to expand the audience for violent actions is thought by some analysts to have fueled terrorism's appeal, making nations with a free press particularly susceptible to the quest for media coverage. Twentieth- and twenty-first-century accounts of terrorism argue that it may have moved into a new period, as new technology allows small groups of individuals the ability to wield tremendous destructive power, and permits even faster coverage of that destruction to a wide audience, as evidenced by the terrorist attacks in the United States on September 11, 2001. Experts warn that such attacks are not limited to religiously motivated groups but can also include assaults stemming from personal grudges or psychopathological conditions.

In contrast to individual acts of violence, the use of terrorism by small political organizations is thought to serve several functions: (1) It makes the group committing the terrorist act appear large and powerful, thus intimidating outsiders and boosting morale of the terrorist group's members; (2) it reveals the vulnerability of the target, whose apparent strength is thereby placed in doubt and whose authority may become undermined; (3) it can eliminate opposition; (4) it may start a chain reaction of assaults undertaken by sympathetic political groups; and (5) it cements the terrorists to the organization because individuals who commit acts of terror cannot leave the organization very easily.

The impact of media coverage of terrorist acts is mixed. On the one hand, most Americans greatly overestimate the threat of terrorism, probably due to media coverage of the subject. In fact, the chances of being killed in an automobile accident are more than one hundred times higher than the chance of being killed by a terrorist action while overseas. On the other hand, sustained terrorist attacks can produce a backlash against the perpetrator's cause, as occurred in 1999 when bombings of Moscow apartment buildings increased the hostility of Russian citizens toward Chechens, who were thought to be responsible for the blasts.

Attempts to combat terrorism include use of metal detectors and dogs at locales thought to be likely targets for attack. While these methods are

effective at reducing the frequency of terrorist acts, it appears impossible to protect targets completely against determined terrorists. Ironically, methods to offset terrorism exaggerate the public's perception of threat and thus advance one of terrorism's main objectives.

See also: DEATH SQUADS; TERRORIST ATTACKS ON AMERICA

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JONATHAN F. LEWIS

TERRORIST ATTACKS ON AMERICA

On the morning of September 11, 2001, four commercial jets departed from three airports for their scheduled flights. Within two hours each of the planes had crashed. No passengers or crew members survived. Approximately 3,000 people on the ground had also perished. These catastrophic events soon became known as the terrorist attack on America. The impact was felt far beyond the families, friends, and colleagues who had known a victim of the disaster. Witnesses to the events, rescue personnel, and the media agreed that nothing of this kind had ever occurred and that life in the United States would never again be the same. Significant and widespread changes did occur. Heightened concern for security and prevention, economic turmoil, and altered behavior patterns

(e.g., a sharp decline in air travel and tourism) were among these changes. This article provides an overview of the events and their consequences, but focuses on the response of individuals and societies to the sudden and unexpected deaths of many people.

The Events of September 11

At 7:59 A.M. American Airlines (AA) Flight 11 departed from Boston to Los Angeles with 81 passengers and 11 crew members. United Airlines (UAL) Flight 93 departed from Newark, New Jersey, just two minutes later; its 38 passengers and 7 crew members were heading to San Francisco. At 8:10 AA Flight 77 departed from Dulles Airport in Washington, D.C., with 58 passengers and 6 crew members en route to Los Angeles. Four minutes later UAL Flight 175 departed from Boston for Los Angeles with 56 passengers and 9 crew members. Within the space of fifteen minutes 266 people were about to meet their demise, with the four planes converted into lethal weapons by hijackers.

American Airlines Flight 11 struck the North Tower of the World Trade Center in New York City at 8:45 A.M. Sixteen minutes later UAL Flight 175 swept into the South Tower. AA Flight 77 crashed into a section of the Pentagon at 9:43 A.M. It was later determined that 184 Pentagon personnel were killed by the crash and ensuing fire. Officials would later say that its original target had been either the White House or the congressional building. UAL 93, the remaining flight, also crashed but did not cause any casualties on the ground. Several passengers, having become aware of the other crashes, resisted their hijackers. The plane came to crash about 80 miles southeast of Pittsburgh, Pennsylvania; its original target is still a matter of speculation.

The incredible sight of a passenger jet appearing out of the clear blue sky to strike the North Tower of the World Trade Center was at first taken to be a disastrous accident. It was obvious that the lives of many people were in jeopardy. First responders (firefighters, paramedics, police) rushed to the scene. The emergency rescue operation was already in action when the South Tower was also struck. The powerful impact hurled debris upon emergency personnel and their equipment. Onlookers had then realized that the expanding disaster was no accident: The World Trade Center, New York City, and the United States were under attack.



Smoke billowed from the World Trade Center towers after they were struck by two hijacked planes. The towers collapsed shortly thereafter and rescue efforts continued for weeks following the attack. REUTERS NEWMEDIA INC./CORBIS

The World Trade Center (WTC), one of the world's most important business districts, was devastated. The area would soon be known as "Ground Zero," often described as a scene from a nightmare with ruins stretching in every direction. Smoky clouds billowed along the streets. Buildings near the towers seemed in danger of collapsing upon the rescue teams and those who were trying to evacuate the area. Risking their own lives, the first responders, burdened by their equipment, ran up the staircases in the attempt to save those trapped in the buildings. Some survivors could be seen escaping from the towers either through their own efforts or with assistance from emergency personnel. However, witnesses were horrified to see people leaping to their deaths from the highest floors before major sections of the towers collapsed.

Millions of people throughout the nation and the world witnessed the tragedy and the chaos through television. Those who were on the scene would later report that no television camera could

communicate the intensity and breadth of destruction; nevertheless, television viewers saw enough of the major developments and the individual responses to realize that this was a catastrophe unique in the history of the nation—and one that would have a profound effect on the future.

It was immediately evident that many people had perished at the WTC. Early estimates were as high as 15,000. For sometime thereafter the death toll was estimated at about 6,500. It would prove very difficult to determine both the number of fatalities and individual identities. There was no master list of people (including visitors) who might have been in the towers at the time. Many bodies had been covered by heaps of debris; others could only be identified by fingerprints or dental records; and still others had been so devastated by impact and fire that all forms of positive identification seemed unattainable. The work of recovering the remains of WTC victims would be long and arduous, requiring the use of heavy construction machinery cranes and the painstaking exploration of

every possible site within the extensive Ground Zero area.

It was not until five months after the attack that New York City authorities could provide an official count of the deaths: 2,843. The evidence indicated that death had come quickly. No survivors were found after September 12, 2001 (despite some hasty news reports to the contrary). The city's health care facilities and providers had responded immediately and in force. Physicians and nurses made themselves available, ambulances stood at the ready, and blood supplies were increased. As the day drew into night it gradually became clear that there would not be an overwhelming wave of casualties in need of treatment. People who were caught in the attack either died quickly or were fortunate in escaping. Those waiting to provide emergency services reported feeling stunned and helpless as they realized that there were no lives they could save. Rescue workers at the site would continue their efforts vigorously for weeks even though they too realized that there was little hope for discovering survivors.

September 11 was also a day in which fear and uncertainty added to the shock and sorrow. It was generally understood that America had come under attack. An adversary capable of hijacking four jets and causing so much death and destruction in one morning might have other, perhaps even more catastrophic, plans in mind. The federal government acted quickly by grounding all other commercial airline flights, some for several days, and other security measures were put into place. What had happened within the span of two hours had taken many lives and, in the Manhattan towers, destroyed a symbol of American power—but it had also alarmed a nation that it might be in continuing peril from terrorist forces.

Loss, Sorrow, and Recovery

The impact of these deaths on family and friends could hardly have been more traumatic. There had been no expectation and therefore no preparation for the sudden loss of loved ones. It seemed beyond comprehension that a husband or wife would not be returning home from a day's work at the WTC. Even the families of firefighters and police, aware of the dangers of the profession, had to struggle with the fact that their worst fears had become real. "There is a big hole where my life used

to be," was a feeling expressed by many family members. What researchers now call traumatic grief is especially intense and devastating. The hammer blow of a violent and unexpected death increases the difficulty of moving on with life. Even people with strong coping skills are likely to feel overwhelmed and isolated.

For many of the affected families the situation was even more stressful. They could not even be sure that their loved one had died. As already noted, the nature of the catastrophe made it very difficult to recover and identify the remains of the victims. Some would never be firmly identified, leaving families suspended between hope and despair. Determined efforts were made to find possible victims who were listed as missing. Photographs of missing WTC employees and first responders were posted on improvised street bulletin boards and circulated throughout the city. Desperate hope that their family members had somehow escaped the catastrophe kept many people in a state of high tension that limited their ability to deal with the ongoing needs of everyday life.

Furthermore, even acknowledgement of the death often was not sufficient to enable family members to direct their energies to the reconstruction of their own lives. There was a powerful need to conduct a proper funeral and memorialization. Paying last respects to the deceased would provide a sense of closure and the starting point for the long and difficult process of recovery. Unfortunately, many bodies were not recovered. The efforts of firefighters to recover the bodies of their comrades were demonstrated day after day as, along with others, they labored in the Ground Zero ruins. Their impassioned search for both their own friends and all victims made clear the strong impulse to honor the dead. When human remains were discovered from time to time the workers would conduct their own improvised memorial service: an American flag placed on the site, and a moment of silence.

Family members felt the same need for closure, especially as hope for a miraculous survival became increasingly dim. Practical needs also became increasingly pressing. It was difficult to conduct the business of family life with a member who has absent yet not officially considered deceased. Financial matters were particularly stressful; for example, no income, but also no insurance or other

death benefits. After some time, the city of New York decided to issue death certificates upon request to families who had almost certainly lost a person in the WTC attack. One by one, next of kin had to make the painful decision to obtain a death certificate and thereby accept the loss but also have the legal and economic foundation to rebuild their futures.

The nation and much of the world shared in the grief experienced by families of the victims in New York City, the Pentagon, and Pennsylvania. The fact that they were not alone in their sorrow provided a measure of consolation although all had their private ordeals to endure. Numerous memorial services were held in local churches and national venues. Church attendance increased throughout the United States in the wake of the disaster as people sought meaning and comfort. There was also consolation in the heroism of the people who had braved the WTC inferno or resisted the hijackers over Pennsylvania. These demonstrations of character and courage became a model for many others.

The grief and the outpouring of compassion continued for weeks. The smoke still rising from Ground Zero was a constant reminder of the tragedy. There was also a subtle personal response on the part of many people. Perhaps Mayor Rudolph Giuliani of New York City was the most prominent person to express this response publicly when he mentioned that he had to face his own mortality issues while trying to do what he could in an official capacity.

America on the Attack

The national grief process was abruptly interrupted a month after the attacks. The government declared war on international terrorism, identified wealthy Saudi expatriate Osama bin Laden as instigator, and launched a military campaign against the al-Qaeda network and the Taliban regime in Afghanistan.

Media images of tearful families and memorial services were soon replaced with air strikes, Department of Defense press conferences, and speculations on the whereabouts of bin Laden. Energies bound up in shock and grief were released in the opportunity to go into action against an enemy who would slaughter innocent people. The Japanese attack on Pearl Harbor in 1941 was often mentioned as the only previous event that had been at

all comparable in scope and casualties but that, at least, had targeted military forces. The nation overwhelmingly endorsed this response to the terrorist threat and a surge of patriotism supplanted the earlier renewal of interest in religion.

The national transformation of grief and passivity into purpose and action had an invigorating effect. It also, however, provided the opportunity to turn away from uncomfortable reflections on personal mortality.

Integrating September 11 into American Life

In a sense, September 11, 2001, is not over. It is in process of becoming part of the continuing and enduring story of American life. The destruction and eventual rebuilding of the World Trade Center will command attention. The first responders with their self-sacrificing heroism will take their place among the people most admired in American history. The issue of national security versus individual rights will almost certainly remain salient. The debate is already well under way: How far and in what ways should security measures intrude upon privacy and freedom? This issue has been of concern since the establishment of the republic, but has been given heightened prominence since the attacks of September 11.

The violence of September 11 was the most destructive but not the first terrorist attack on American personnel and interests. A bomb placed in the WTC garage in 1993 caused only limited damage but killed six people. American embassies and military resources were attacked in Saudi Arabia, Kenya, Tanzania, and Yemen. Attempting to prevent further attacks by diplomacy, covert operations, and military force could become a long-term priority for the nation. These efforts will be influenced by the way in which the United States perceives and is perceived by people who hold radically different views of life. Few of the numerous commentators could offer credible insights into the minds of terrorist leaders, their beliefs, and grievances. There was also little evidence that terrorists understood the American experience and perspective on life. Whether the gap in mutual understanding will be reduced or increased is likely to have a profound impact on terrorist and counter-terrorist activities in the future.

On the personal level it remains to be seen if American life will continue with resilience along its

traditional path, shift into a more cautious and security-conscious pattern, or cultivate a broader and deeper sense of the human condition in all its mortal vulnerability and seldom-realized potential.

See also: DEATH CERTIFICATE; GRIEF: TRAUMATIC; GRIEF COUNSELING AND THERAPY; TERRORISM

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ROBERT KASTENBAUM

TERROR MANAGEMENT THEORY

While self-preservation is common to all species, the awareness of one's own mortality characterizes only human beings. This awareness presents a difficult problem for humans: how to manage the terror that accompanies this type of knowledge. According to proponents of terror management theory (TMT) the need for "terror management" is indeed a fundamental motivation of people as well as a main function of cultural systems. Building on

the anthropologist Ernest Becker's writings, TMT explains a large variety of human behaviors, such as intolerance vis-à-vis others, by relating these behaviors to the basic motivation to protect oneself against mortality awareness.

Formulations

Terror management theory was developed by the researchers Jeff Greenberg, Sheldon Solomon, and Tom Pyszczynski based on Ernest Becker's writings, in which the universality of death terror and the need to protect against it play an essential role. Psychologically, the protective function is accomplished via a cultural anxiety buffer that has two components. One component consists of the individual's conception of the cultural worldview and the faith one has in this worldview. The second component involves a sense of personal worth or self-esteem that is attained by believing that one is living up to the cultural system's standards of values.

The need for defense is particularly high when one is reminded of his or her mortality (mortality salience is increased) and when one's cultural system is threatened. In those cases one can expect negative reactions against those who are considered to embody the threat, such as individuals who belong to a different group, known as "outgroups," and positive reactions toward those who represent the cultural values, typically "ingroups." This implication of TMT was labeled the mortality salience hypothesis. A second implication, the anxiety-buffer hypothesis, states that strengthening the anxiety-buffer, for example boosting a person's self-esteem, should reduce this person's death anxiety.

Experimental Work

Numerous studies have provided supportive evidence for the mortality salience hypothesis. Reminding people of their own mortality was shown to increase their inclination to respond favorably to people who bolster their worldviews and to respond negatively to people who are different from them—an effect that was found in adults and also in children as young as age eleven. In these various studies death salience was achieved in a variety of ways, by asking people to imagine their own death, filling out death anxiety scales, or having

them visit a funeral home or watch a fatal car accident. Negative stimuli included violators of moral principles, such as prostitutes, out-groupers such as Jews and anti-American foreigners, or inappropriate use of cherished cultural symbols such as a flag or a crucifix. Generally, reminding people of their own mortality made them less tolerant vis-à-vis those stimuli. Liberally oriented respondents, however, became more tolerant toward a conservative target after being reminded of their own mortality. This apparent exception can be explained, however, based on the fact that tolerance is an important value for liberal individuals. They will tend, therefore, to emphasize this value more when death becomes more salient for them.

The work conducted as of 2002 on the anxiety-buffer hypothesis also supported TMT. In 1993, for example, the scholar Jeff Greenberg and colleagues found that positive personality feedback made people less inclined to deny the possibility that they may have a relatively short life expectancy.

Criticisms and Extensions of Terror Management Theory

Terror management theory was criticized for a variety of reasons. Experimental findings, such as increased intolerance toward out-groupers following reminders of death, can be explained using alternative theories. Thus the scholar C. R. Snyder suggests an interpretation based on the motivation to achieve control. Other criticisms were directed at the scope of TMT and at its claim to represent a general theory of motivation that provides an overarching explanation to a multitude of social motives. It was argued that either those human motives are not hierarchically arranged or that the hierarchy is not the one proposed by TMT—with terror management at the top. Even more drastically, some contended that death anxiety plays usually only a minor role in individual's behavior in everyday life.

An area of particular difficulty for TMT is the area of death anxiety in older age. Older adults appear to accept death more than younger adults, the opposite of what would be expected on the basis of considerations of death salience. Moreover, self-esteem may decline with increased age and, as a result, the use of it as a protective buffer may become more difficult. There is a need, therefore, to specify other protective mechanisms such as self-transcendence.

In addition, human creativity, growth, and genuine acceptance of death cannot be explained easily by TMT. For this reason TMT theorists have recently proposed a theory of growth that should complement TMT. The individual is striving not only to protect oneself against the terror associated with death awareness but, in addition, to develop and expand. Between the two motivations, to grow and to protect, there is a dynamic balance. Growth is also likely to engender awareness of one's limitations and, therefore, to make one more susceptible to death terror. On the other hand, the same growth, via creation of meaning, provides the means to deal with the terror.

Practical Implications and Evaluation

TMT connects fear of death to behaviors that appear to be conceptually very distant from death and dying, for example to prejudice and intolerance toward strangers. By doing this, the theory provides a useful tool for self-understanding. A good understanding of both the importance of death anxiety as a main motivation, and of the ways to protect against it, can allow one to achieve a double goal: defense against anxiety but not at the price of becoming intolerant toward others. From a theoretical viewpoint, it seems that TMT had to moderate somewhat its claims of being the fundamental theory of social motivation. This has been done both by recognizing the need to invoke other (expansive) motives, and by recognizing that mechanisms other than the one incorporated in the anxiety buffer may be used in dealing with one's awareness of mortality. Terror management theory can be viewed as a way to explain how the construction of meaning achieved by individuals within a culture fulfills the double function of protecting against fear of death and allowing, at the same time, creative expansion and development.

See also: ANXIETY AND FEAR; BECKER, ERNEST

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ADRIAN TOMER

THANATOLOGY

Thanatology is the study of dying, death, and grief. This study encompasses thoughts, feelings, attitudes, and events. Contributors to the growing knowledge of death-related phenomena include social, behavioral, and biomedical researchers as well as economists, health-care providers, historians, literary critics, philosophers, and theologians.

The word *thanatology* is derived from Greek mythology. Thanatos (death) and Hypnos (sleep) were twin deities. It was not until 1903 that distinguished scientist Elie Metchnikoff called for the establishment of a scientific discipline devoted to the study of death. He suggested that the life sciences would not be complete unless systematic attention was also given to death. Nevertheless, only a few scholars and educators followed his lead. Medical students had their obligatory encounters with cadavers but received almost no instruction in care for the dying, nor was death included in the curriculum for students of other professions and sciences.

The situation started to change following World War II, with its many casualties and haunted memories. Existential philosophers redirected attention to life-and-death issues. Researchers such as Herman Feifel challenged Western society's taboo on death, opening the way for improved communication. An international suicide-prevention effort responded to the anguish both of people contemplating self-destruction and their family and friends. The hospice movement introduced improved means of caring for dying people, and grief-support groups provided comfort to many who had been alone in their distress. Death education overcame early resistance to become a significant resource in both formal and informal settings. Thanatological challenges in the twenty-first century include the emerging issues of physician-assisted death, children's rights, and lifestyle behaviors such as excessive drinking, use of tobacco products, and unsafe operation of motor vehicles that

contribute to more than a million deaths a year in the United States.

See also: ANTHROPOLOGICAL PERSPECTIVE; CADAVER EXPERIENCES; CHILDREN AND THEIR RIGHTS IN LIFE AND DEATH SITUATIONS; DEATH EDUCATION; FEIFEL, HERMAN; HOSPICE OPTION; PSYCHOLOGY; SAUNDERS, CICELY; SUICIDE TYPES: PHYSICIAN-ASSISTED SUICIDE

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ROBERT KASTENBAUM

THANATOMIMESIS

Thanatomimesis is the simulation of death by a living creature. Perhaps the best-known example is "playing possum." Hunters and campers have observed that opossums sometimes feign death when threatened. This is accomplished by collapsing into a ball of inert fur. The head droops, the mouth hangs open and—most convincingly—the eyes are fixed in an empty stare. The most obvious explanation is self-protection: if a creature is already dead, why kill it? There is indirect support for this proposition from laboratory research in which opossums were shaken by an artificial dog jaw. The animals immediately took to shamming death, but their brain activity indicated a keen state of alertness, waiting for the danger to pass. At least some animals are capable of switching to a state of tonic immobility that contributes much to the appearance of death.

There has not been systematic research on thanatomimesis, but Charles Darwin observed thanatomimetic behavior in "seventeen different kinds of insects belonging to different genres, both poor and first-rate shamers" (Carrington and Meader 1911, p. 51). Darwin compared these acts with the postures taken when either his subjects or

others of their species were actually dead. He concluded, "the attitudes of the feigners and of the really dead were as unlike as they could possibly be" (Carrington and Meader 1911, p. 51).

Thanatomimesis has saved the lives of many people who escaped death on the battlefield or in other dangerous situations by pretending to be dead. The term itself is usually reserved for intentional efforts to escape harm. However, comatose or hypothermic people have also been misperceived as dead, especially prior to the development of improved methods of detecting physiological activity.

See also: BURIED ALIVE; CRYONIC SUSPENSION; DEFINITIONS OF DEATH

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ROBERT KASTENBAUM

THANATOS

See DEATH INSTINCT; GODS AND GODDESSES OF LIFE AND DEATH.

THEATER AND DRAMA

It is no surprise that dramatists throughout history have drawn such creative inspiration from the subject of death and dying. Because of the difficulty of confronting this topic on a personal level, death as portrayed on the stage remains a powerful magnet for theater audiences. Aesthetic theory suggests that art is a major tool in humanity's quest for self-understanding. Humankind's perennial preoccupation with its mortality and identification with the characters who are metaphorically standing in for us in this once-removed space of the stage allow for the collective exploration of this most difficult of subjects.



The pop musical Rent (1996) used the musical-theater version of La Bohème as its backbone, with similar themes of the AIDS epidemic, and artists, prostitutes, and homosexual characters living in New York's East Village. Sadly, Jonathan Larson, Rent's creator, died of an aneurysm between the dress rehearsal and opening night. ROBBIE JACK/CORBIS

Since Aristotle, the motif of death has permeated drama. The life and death of the hero of Greek drama was inextricably bound up with his or her sense of honor. This concept of dying for one's honor was carried through the Renaissance, particularly in Spain. In early medieval drama, liturgical plays ritualized death and dying with elaborate sets that depicted versions of the afterlife and the fires of hell. In these dramas, death was often seen as the great equalizer. In Greek and Elizabethan tragedies, the tragic flaw leading to the eventual demise of the hero was eagerly anticipated by audiences. There were the murders in *Oresteia* or *Oedipus*, and violent clashes in all of William Shakespeare's history plays.

In modern theater, there has often been a psychological as well as a real violence explored in dramatic literature. To Antonin Artaud, for instance, desire and death were a form of cruelty. His play *The Cenci* is about a girl who murdered

her father to avenge her rape by him. Hélène Cixous claimed that "with even more violence than fiction, theater, which is built according to the dictates of male fantasy, repeats and intensifies the horror of the murder scene which is at the origin of all cultural productions" (1969, p.133). Modern drama has undoubtedly sustained this fascination with representations of death and dying on stage, where it exploits the components of both narrative and symbol.

Some scholars have suggested that death depicted on the modern stage was an attempt to transcend the fear of death and deny its finality by experiencing it fully or empathetically in the safety of the once-removed. The symbolic death in the theater acts as a double of our real lives and thus provides a cathartic experience. Even in some modern theatrical styles that seek to distance the audience from conventional identification with characters, there may be, nonetheless, a purgative experience

for audiences. The plays and productions of Bertolt Brecht, for example, attempted to distance the audience from the narrative to enable viewers to maintain a critical perspective on the action on stage. But even in these distancing traditions, the audience is, in the end, at a sufficiently safe distance from the fiction of the play so that their actual lives triumph over the compressed and finite fiction of the stage. There may, therefore, still be a symbolic immortality possible through the semiotics of the stage.

Some suggest that the representations of death on stage offer one a kind of practice for one's own death, while others hold that the persistent theme of death on stage is a form of denial or avoidance. In her study of seventeenth-century drama, theater scholar Deborah Dogherty found that heroic characters enabled audiences to envision their own quest for immortality. Dramas of the Golden Age often involved a quest to overcome death a means of symbolic immortality, even if physical death was not overcome. This theatric development appears to be predicated upon Plato's insistence on a system of immortality wherein the soul exists before the body is born and is not, therefore, subject to death. Dogherty concludes, "As characters lived out their brief dramatic roles, the audience was reminded of the brevity of each individual's appearance in the ongoing drama of life, yet envisioned their own lives as somehow eternal" (1999, p. 2). In modern times, too, the conception of the immutability of the soul has persisted.

Although a character's death in theater may leave a void in the world, that absence is sometimes represented by a presence on stage. Since the ghost of Hamlet's father appeared to him, many plays have represented death with such ghostly apparitions. Isobel, in Judith Thompson's *Lion in the Streets* (1992), appears throughout the play and is visible to the audience although she is often invisible to other characters on stage. Raped and murdered before the story of the play begins, the prepubescent Isobel finally understands that she has died and become a ghost.

Even in children's theater, the convention of the ghostly apparition is common. Stage adaptations of Dickens's *A Christmas Carol* have featured characters from traditional white, ethereal garments to vaporous projections on a scrim. *Ghost Train*, written by Betty Quan and based on the

book by Paul Yee, recognizes the hundreds of Chinese workers who died building the Canadian Pacific Railway; the play presents a fourteen-year-old peasant girl who gives an account of her own father's death. After the father is killed, he returns to his daughter Choon-Yi as a ghost. Theatrically, the father is realized by a shadow/silhouette projected onto the scrim upstage:

CHOON-YI: What magic is this?

FATHER: The magic is yours.

CHOON-YI: (*running forward*) It is you!

FATHER *holds his hands up, shakes his head, stopping* CHOON-YI.

FATHER: No. You mustn't come closer.

CHOON-YI: What is it? Are you ill? Where have you been? I searched all over Salt Lake City, looking for you.

FATHER: I have left your world. I am no longer flesh and blood, but spirit.

CHOON-YI: No. It can't be. Nooooo.
(2000, p. 38)

Disease and dying have also become topics of contemporary theater, given the pandemic of modern diseases such as AIDS and cancer. Tony Kushner's *Angels in America* is one example of the terror of AIDS realized theatrically. Margaret Edson's award-winning *Wit* explores the complex of emotions yielded by a diagnosis of inoperable cancer. In this play, Vivian Bearing's journey is a redemptive one. Her experience of cancer and death leads her, paradoxically, to the light.

War and death in drama remain intricately entwined as well. Brecht's *Mother Courage and Her Children* is an example of life imitating art. This play about a canteen-woman serving with the Swedish Army during the Thirty Years' War (1618–1648) was written in 1939 but was not performed until 1949 because of Nazi suppression and thus came too late to serve as the warning Brecht had intended: In the course of the play, Mother Courage witnesses the deaths of all three of her children. Howard Barker's play *The Europeans*, another example of a war drama, is set in the aftermath of the climactic struggle between Christianity and Islam in the seventeenth century.

Many contemporary playwrights have explored the great massacres of the twentieth century. John McGrath's *Events While Guarding the Bofors Gun* concludes with a scene that has a soldier, caught in the futility of war, falling upon his own

rifle and bayonet. John Murrell's *Waiting for the Parade* explores the lives of five women who attempt to survive World War II at home. Death is omnipresent.

Drama critic Martin Esslin asserts that drama has become one of the principal vehicles of information, one of the prevailing methods of thinking about life and its quandaries. He maintains that drama is a mirror of real life: "The theater is a simulacrum—at its highest level, ordered and elevated to the status of art—of the real world and real life" (1987, p. 176). If, as Esslin believes, humans crave the collective artistic experience that theater can provide, these works also compel one to face the inescapable certainty of his or her own mortality. Paradoxically, of course, theater also reminds people of their great potential as living, sentient beings.

See also: GREEK TRAGEDY; OPERATIC DEATH;
SHAKESPEARE, WILLIAM

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KATHLEEN GALLAGHER

THEODOSIAN CODE

In 438 C.E. the Roman emperor Theodosius II (408–450 C.E.) published, in a single volume (*codex* in Latin), the general laws of his Christian predecessors beginning with Constantine I (306–337 C.E.). Roman law had always regulated the transfer of wealth from one generation to the next. The Theodosian Code reveals that, during the era when the empire was becoming Christian, emperors sought a greater share of that wealth for themselves and for the imperial Church through the control of wills and testaments. The law had also always punished violation of the tombs that lined the roads outside the city walls. The code's increasingly severe penalties for doing so suggest that the problem was getting worse. People were looting tombs for building materials and for marble to render into lime; and were digging up the bones of Christian martyrs. In 386 an imperial decree expressly prohibited the sale of these saints' relics.

Relics of the saints were a powerful symbol of Christian triumph over death. Their incorporation into urban churches first bridged the ancient borders between the cities of the living and the dead. In a similar way, the saints, who were present in their relics, bridged the communities of the living and the dead. Competition for their patronage at both earthly and heavenly courts created a market for their remains. The code's failure to restrict the cult of relics shows how helpless civil law could be against devotional practices supported by the populace and the Church.

See also: CHRISTIAN DEATH RITES, HISTORY OF

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FREDERICK S. PAXTON

THOU SHALT NOT KILL

The phrase “Thou shalt not kill” is well known throughout the world as one of the Ten Commandments. Originating in the Books of Exodus and Deuteronomy, this phrase was originally given to Moses and the Israelite people by God as one of the great commandments and is found in the holy scriptures of Jews, Christians, and Muslims. Seen as an admonition against murder, the sixth commandment often forms the philosophical foundation for arguments against suicide, capital punishment, abortion, euthanasia, war, and any other situation where one person might be inclined to take the life of another.

Translation of the Phrase

Traditional translations of this phrase into English have tended to use the word *kill*. Certain scholars have suggested that this is not the most accurate translation. The key phrase, often translated “to kill” (*rasab*), began in the twentieth century to be translated “Thou shalt not murder,” is seen in newer translations of the Bible such as the New Revised Standard Version. The scholar Terence Fretheim notes, “In view of certain passages (e.g., 1 Kings 21:19) it has been suggested that the verb means murder” (1991, p. 232). He goes on to note that this phrase can refer to unintentional killing (Deut. 4:41–42) or the execution of a convicted murderer (Num. 35:30). A growing number of scholars now agree that this term for killing in Hebrew that is used in the Ten Commandments is never used in Hebrew Scripture to refer to the type of killing that takes place in a war.

Hebrew language scholars agree that killing in war is different and not covered by this use of the phrase “to kill.” If one soldier is angry with another from his or her same army and shoots him or her, even in a battle, it would still be murder. However, to kill an enemy in the context of a “just” war is not directly covered in this passage. A majority of

the world’s religious traditions make this distinction, referring to “holy war” or “Jihad” as being acceptable. There are generally some criteria for this type of “just” war that, depending on the world tradition, generally reflects doing the work of God and/or serving the needs of justice in the world order. Historically this commandment is used as the foundation for an argument against going to war, by persons wishing not to serve in such a human conflict. However, to argue this point biblically requires other passages to support the argument.

The Ten Commandments were given to offer order in social relationships due to the understanding that, at the heart of all relationships, love is the model that is to be held up as ideal. Whether discussing God’s love, or the love of Jesus Christ for Christians, God and God’s prophets are the ideal of this message of love in the various faith traditions. Thus the various traditions understand Abraham, Jesus, and Mohammad, along with other key figures, as this type of model. Further, world religious traditions in general pray for world peace. The values of all three communities reflect the possibility of a world that is free of war and armed conflict. Finally, in each tradition there is a wide variance among interpreters of the various traditions as to what that criterion is. This is as true of Islam as it is of Christianity and Judaism. The complete criteria for a “holy” or “just war” are beyond the scope of what can be written in a book.

John Calvin, the Protestant reformer of the sixteenth century, summarized the meaning of this commandment by saying “that we should not unjustly do violence to anyone.” The Book of Numbers clarifies that which constitutes murder as stabbing or hurting another in anger or enmity, or killing another person for personal gain. The primary foundation of this commandment, according to Calvin, reflects the understanding that “undoubtedly God would have the remains of His image, which still shines forth in men, to continue in some estimation, so that all might feel that every homicide is an offence against Him” (Calvin 1993, p. 20).

An Assault against God

The prohibition against murder should be understood in the context that in some way human beings were made in the image of God. Therefore to murder a person is to murder God. There are a variety of ways to explain this from the world

traditions. God created the heavens and the earth. In doing so, God created humanity in God's image. Some Jewish and Christian scholars understand that with the Fall of Adam, or original sin, humanity was separated from God, yet something of God's image remains in each person. Some Islamic scholars suggest that the "essential sin is that of forgetfulness of God" (Renard 1998, p. 49). It is sin that separates human beings from the essential nature of humanity that is in the image of God.

To murder a fellow human being is to attack God. The implication is that it is a sin to assault God by killing any person. As such, the person will be judged accordingly by God. A more positive way to state the way human beings are to relate to one another comes from Matthew 7:12: "In everything do to others as you would have them do to you; for this is the law and the prophets." This is stated in Hebrew Scripture as Leviticus 19:18: "You shall not take vengeance or bear a grudge against any of your people, but you shall love your neighbor as yourself: I am the LORD." Muhammad said the same thing when he noted, "None among you is a believer until he wishes for his brothers and sisters what he wishes for himself" (Renard 1998, p. 49). Laws that are made by human beings do not offer the same type of universal agreement or sanctions if violated. For example, if human beings have created the law "Thou shalt not murder," then one should remember that in "Nazi Germany, and much of eastern Europe, it was acceptable to kill Jews, gypsies, homosexuals, the severely retarded, and any other group deemed inferior" (Renard 1998, p. 176). Laws made by human beings have sanctions that are of this world. Laws made by God have eternal sanctions. Believers find this latter prospect sufficient to serve as a deterrent to murder.

Not only is the person who commits murder subject to judgment by God, but, according to Hebrew Scripture, he or she is subject to judgment by human courts. Based on the first covenant between God and humanity with Noah, Noah suggests in Genesis 9:6: "Whoever sheds the blood of a human, by a human shall that person's blood be shed; for in his own image God made humankind." This admonition is made clear in the story of Cain and Abel when God says, "And the LORD said, 'What have you done? Listen; your brother's blood is crying out to me from the ground! And now you

are cursed from the ground, which has opened its mouth to receive your brother's blood from your hand'" (Gen. 4:10–11). In response to this first murder, God curses the very ground.

Capital Punishment, Suicide, and Abortion

Jewish and Christian teaching is mixed on the application of these Hebrew scriptures. "For example Jewish law and tradition maintain that the death sentence in a capital case is prohibited if the conviction is on the basis of a strong presumption or circumstantial evidence, even though it appears conclusive" (Schlessinger and Vogel 1998, p. 180). Other persons of faith suggest that the termination of life by the state is the same as any other murder. Capital punishment can be said to be sanctioned by Hebrew Scripture, but these passages alone are not followed without question by all believers. This is particularly true of Roman Catholicism, which is generally against capital punishment. A significant issue for those against capital punishment is the fear that the innocent will pay this ultimate price. Clearly the problem is that capital punishment is employed by human beings who make mistakes. "The Midrash, a compilation of ancient rabbinic reflections, summed up the problem very concisely: Those who are merciful when they must be cruel, will, in the end, be cruel to those who deserve mercy" (Schlessinger and Vogel 1998, p. 182).

Suicide, or the murder of one's self, is the next common application of the commandment. It is understood that God has placed the soul within an earthen vessel that needs to be taken care of. This would suggest that the human body does not simply belong to the person, but rather that the soul which houses the body belongs to God. Catholicism prohibits any kind of mutilation of the body. In Judaism even tattoos that permanently alter the body are prohibited. It has been widely known that until recently Roman Catholics had the lowest incidence of suicide, based on the admonition not to commit such an act.

Abortion is possibly the most controversial of the ramifications of "Thou shalt not murder." Both those who are pro-life and pro-choice would agree that it is murder to take a life. However, the heart of the dialogue is the controversy as to when life begins. On this point the Bible is unclear. Ammunition for this dialogue, however, comes from the Book of Exodus: "When people who are fighting

injure a pregnant woman so that there is a miscarriage, and yet no further harm follows, the one responsible shall be fined what the woman's husband demands, paying as much as the judges determine. If any harm follows, then you shall give life for life, eye for eye, tooth for tooth, hand for hand, foot for foot, burn for burn, wound for wound, stripe for stripe" (Exod. 21:22–25). The scholars Laura Schlessinger and Stewart Vogel note that the heart of the controversy is found in the implication as to who is hurt by the injury to the woman. In Judaism it is understood that this refers to the woman, while Christian interpretation often understands this to refer to the fetus. If it refers to the fetus, then the scripture suggests that any abortion is murder. If it refers to the woman, then it is less clear as to the abortion issue. Most arguments on this issue go on to discussion of the love of God for children. In Islam, "According to some religious scholars of the Hanafi legal school, abortion is permitted until the fetus is fully formed and ensoulment has occurred (about four months along, according to a Hadith)" (Renard 1998, p. 56).

The Ten Commandments have offered a set of rules that traditionally offer order to society. This order can become divisive when placed in public schools and buildings when it implies that the values of these religious traditions should be followed by all. The U.S. Constitution does not say that individuals cannot believe these rules in private, but it does say that the values and beliefs of one tradition should not be forced on all people through the First Amendment, which guarantees freedom of speech and freedom of religion. The sixth commandment offers a point of departure for ethical dialogue for all of those religions of Abraham. It is generally not taken out of context, but rather employed in the context of the entire scripture. As a part of the entire context of the messages as interpreted by Jews, Muslims, and Christians, the sixth commandment is an important rule for living.

See also: ABORTION; CAPITAL PUNISHMENT; HOMICIDE, DEFINITIONS AND CLASSIFICATIONS OF; MARTYRS; SUICIDE BASICS: HISTORY

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JAMES W. ELLOR

THRILL-SEEKING

Americans dangle from hang gliders and parachutes; they race their cars, powerboats, snowmobiles, and dirt bikes; they stand on their hands upon skateboards, climb rocks without safety ropes, and pay to bungee-jump off towers. Less adventurous "adrenaline junkies" ride roller coasters with lethal-sounding names like Roaring Lightning or Big Death.

Why, despite the well-publicized lethality of such recreational risk-taking, do people continue to engage in such behaviors? Is there perhaps some need to flirt with death in order to feel "alive"? Scholars have discerned a blend of physiological, psychological, social psychological, and cultural causes.

Three-quarters of adolescent deaths are caused by accidents, homicide, and suicide, indicating a propensity for lethal risk-taking. Accidents alone account for 60 percent of this total. Though most recognize adolescence as a developmental period when risk-taking is a common form of testing one's identity and abilities, such behaviors need not be life threatening. As accidental deaths became the leading cause of death in this age group (which was the only one in which mortality had increased since 1960), in 1987 the federal government and various foundations financed research to study the reasons for the reckless behavior.

Psychological paradigms predominated, with explanations focusing on adolescents' lesser ability to evaluate risk and a life cycle, developmental need for excitement that blunts comprehension of



Experts have found that risk-taking, like bungee-jumping, can be linked to two types of mutant genes. Other theorists say that thrill-seeking is related to a person's quest for immortality. ROBERT HOLMES/CORBIS

risk. In addition, as suicide rates nearly tripled from the mid-1960s to the mid-1980s among boys and girls age ten to fourteen, and doubled among those fifteen to nineteen, suspicions arose that a portion of lethal accidents might actually be “subintentioned suicides.” Similarly, increases in teenage smoking rates throughout much of the 1990s has coincided with teens’ increasing suicide rates, particularly among blacks.

Analysts also noted the role of sensation- or thrill-seeking personality types. Even in adulthood, such risk-takers are more prone to high-risk undertakings like parachuting from planes, risky business deals, substance abuse, or even criminal activity. Such risky business might have a biological underpinning. A 1998 UCLA study reported the discovery of two types of mutant genes underlying

compulsive novelty-seeking behaviors. The researchers claimed that 30 percent of the population is born with one of the thrill-seeking genes, and 20 percent with both. In addition, the neurotransmitter dopamine has been linked to sensation-seeking behavior and, at elevated levels, to drug abuse and schizophrenia. Richard Epstein and his fellow researchers found a link between novelty-seeking and a form of the D4 dopamine receptor gene.

Another psychological thesis is that a portion of such behavior stems from the quest for immortality. World-class athletes and those in the midst of a potentially lethal situation describe the sensation of transcendence while in “the zone,” which they describe as a timeless and deathless realm where everything seems to stop and go silent.

Risk-taking is also a means of attracting attention and thus enhancing self-esteem, as when teenage girls were found demonstrating their toughness by having unprotected sex with HIV-infected gang members in San Antonio, Texas. Thrill-seeking behavior has long been a way that young adult males have attempted to win the admiration of their peer groups and to attract members of the opposite sex. War is one traditional social solution for harnessing such drives by putting them into the service of the state.

The argument for a cultural component to thrill-seeking is reinforced by the absence of reports of extreme sports and other thrill-seeking activities in developing nations. For instance, in the late 1990s the world’s top-ranked male paragliders were from Austria, Japan, Switzerland, and Italy; the top women were from Denmark, Czech Republic, Japan, Great Britain, Germany, France, and Norway. Perhaps where death is a risk in everyday life, such contrived dangers are superfluous. In the past, society controlled the opportunities for such experiences: for example, in painful and challenging rites of passage and war, and in dangerous occupations as fishing, mining, and logging. Nature did her part with frequent bouts of lethal disease. Like animals in zoos, humans in modern societies do not face the environmental challenges for which they are hardwired.

A study comparing Indian males who had applied for Canadian immigration visas with a matched nonimmigrant group found that sensation-seeking and belief in an unpredictable world

were two of the personality types that distinguished the two groups. Given the fact that the United States is basically populated with immigrants (the 2000 Census found 10.4% of the population to be foreign-born) and their descendents, it would seem reasonable to assume that among the developed nations, the United States has a disproportionate share of thrill- or sensation-seeking personality types, as psychologist Frank Farley claims.

Countering such risk-taking appetites has been the trend in modern countries to eradicate risk, such as through seatbelt regulations, Pure Food and Drug Act, bankruptcy laws, and the U.S. Consumer Product Safety Commission. Warning labels abound, with laws requiring their placement on five-gallon buckets (so children will not fall in them and drown) and step-ladders (30% the price of which goes to cover potential liabilities). On the packaging of one brand of electric iron appeared “Do not iron clothes on body”; on a child’s Superman costume: “Wearing of this garment does not enable you to fly.”

Out of this sanitized and risk-free cultural setting emerged during the end of the century extreme sports, featuring such activities as dirt-jumping on bicycles, sky surfing, inline skating, freestyle motocross (which combines motorcycles and ski-like jumping), ice cycling, snowboarding, and skateboarding on half pipes—reactions against what the extreme skier Kristin Ulmer, in *The Extreme Game*, calls a “scaredy-cat culture.” Risk-taking became commodified leisure as the marketplace, seeking to profit from the new norm, generated extreme sports parks, new lines of clothing and footwear, nutritional additives, and televised X-games. The movement was significant enough that in 1999 the United States became the first country to honor extreme sports on its postage stamps.

See also: INJURY MORTALITY; SEX AND DEATH, CONNECTION OF; SUICIDE BASICS: EPIDEMIOLOGY; SUICIDE TYPES: INDIRECT SUICIDE

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MICHAEL C. KEARL

TIBETAN BOOK OF THE DEAD

Since its first English translation in 1927, the Tibetan guide to spiritual and mental liberation called the *Bardo Thodol* has been known in the West as the *Tibetan Book of the Dead*. The book has reappeared in several English-language versions since then, some based only loosely on the original. The text has thus lived several lives in English alone, appearing to be reborn time and again before new audiences, often with varying titles and content. Yet these recent lives are part of a much older cycle of rebirths. The original is believed to have been composed in the eighth century C.E. by the great master Padma Sambhava, then hidden away by its author for the salvation of future generations. The text was rediscovered six centuries later by Karma Lingpa, believed by some to be an incarnation of Padma Sambhava himself. Since the fourteenth century C.E. the text has occupied a central place in Tibetan Buddhism, giving birth to a large number of parallel, supplementary, and derivative texts.

W. Y. Evans-Wentz coined the English title for the 1927 edition on the basis of analogies he perceived with the Egyptian funerary text *The Book of Coming Forth By Day*, known in the West as the *Egyptian Book of the Dead*. Both the Tibetan and Egyptian Books discuss death and its aftermath. Yet their views of death are sufficiently different from

the Judeo-Christian tradition that the English titles are quite misleading.

This is particularly so in the case of the Tibetan *Book of the Dead*. The Tibetan title, *Bardo Thodol*, does not refer to death as such. *Thodol* means “liberation through understanding.” *Bardo* means a “between state,” an interval or transition between two mental states, whether experienced in life or after death. Hence the work’s Tibetan title (which might be translated more literally as *Liberation through Understanding the Between*) alludes to bardo states that may be experienced at any point over the cycle of life, death and rebirth, yet the work itself overtly discusses only the bardo states experienced during death, offering explicit instruction on how to navigate them.

It is difficult to appreciate the significance of the work’s overt content without a sense of its larger cultural context. The *Bardo Thodol* presupposes a cosmology of human experience in which existence is viewed as inherently fluid and impermanent, as involving a series of stages, of which death is merely one. The mind or soul continues to live after death, undergoing a series of experiences before rebirth. Human beings are believed to be able to guide themselves through the entire cycle by creating a more focused self-awareness through their powers of concentration, augmented, ideally, by means of meditation. The chief utility of meditation during life, or of the *Bardo Thodol* at the time of dying, lies in making the mind lucid enough to control its own passage over the cycle of life, death, and rebirth. The larger goal of these practices is to seek liberation from the suffering associated with this cycle, both for oneself and for others.

The Bardo States

Six main bardo experiences are distinguished in Tibetan Buddhism: Three are encountered during life and three are encountered after death. A single life span is itself a bardo state, a transitional zone in a larger cycle of rebirths. Dreams are bardo states that occur within the daily round, in the interval between falling asleep and waking; feelings of uncertainty, paranoia, and delusion are sometimes grouped with dreams on a looser interpretation of this second bardo state. A meditative trance is a third type of bardo state, an intermediate zone between ordinary consciousness and enlightened awareness. These are the main bardo states of life.

Death involves bardo states as well. On the Tibetan view, death is not an instantaneous event but a process taking several days, involving a successive dissociation of mind from body, which is manifested in characteristic outward signs. During this process, the conscious mind experiences three main bardo states.

The first of these, called the *Chikai Bardo*, is the experience of the death point, the moment at which the soul loses consciousness of objects and becomes aware only of itself. The experience is described as a vivid formless light emanating from all sides. At this moment, enlightenment lies close at hand, although one’s capacity to attain it depends on the extent to which one has achieved lucidity and detachment in one’s previous existence. For most individuals the vision of light can only be sustained for a brief interval, after which the soul, caught in desire and delusion, regresses toward lower levels of existence.

In the second state, called the *Chonyid Bardo*, the soul has visions involving a succession of deities: a series of beatific Buddhas in the first seven days, a series of terrifying deities in the next seven. The text describes these visions as projections of the mind’s own consciousness, often involving a tension within the mind itself. For example, the dazzling visions of the beatific deities are accompanied by duller visions of other beings that distract from the splendor of the former. To be thus distracted is to give in to anger, terror, pride, egotism, jealousy, and other weaknesses. In contrast, to ignore the minor visions and to embrace the more awe-inspiring deities is to attain spiritual salvation through the very act.

A mind that fails to overcome these weaknesses encounters the darker, more horrific deities of the latter seven days. Many of these visions are merely aspects of the Buddhas encountered in the first seven days, now made terrifying by the mind’s own weakness. Liberation is still possible here simply by recognizing these beings for who they are. Yet the act is also more difficult now because terror forces the mind to flee rather than to examine its experiences.

A mind that has failed to free itself by this point enters the *Sidpa Bardo*, the third, most desperate stage. Here the mind faces a host of hallucinations, including visions of pursuit by demons and furies, of being devoured and hacked to

pieces. A mind may linger here for many weeks—up to the forty-ninth day after death—depending on the faculties of the particular individual.

These experiences culminate in rebirth in some sentient form. Whether one is reborn as human or animal, or is relegated for a time to one of the many Tibetan hells, or whether one achieves liberation from the entire cycle of life and rebirth, thus attaining Buddhahood, depends on one's success in overcoming weakness over the course of the cycle.

Although the *Bardo Thodol* is a guide to the bardo states experienced after death, it can only be read by the living. It may be read in preparation for one's own death, or at the deathbed of another. Because the weaknesses attributed to the dead are all experienced by the living as well, a person learning to traverse the bardo states of death will learn to navigate better the bardo experiences of life as well. In this sense the book is a guide to liberation across the entire cycle of human existence as conceived in Tibetan Buddhism.

See also: DYING, PROCESS OF; EGYPTIAN BOOK OF THE DEAD; MOMENT OF DEATH; STAGE THEORY

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ASIF AGHA

TITANIC

When the supposedly unsinkable luxury liner *Titanic* hit an iceberg and sank in April 1912, killing 1,513 people, the disaster altered Western civilization's confidence in the very notion of progress. The *Titanic's* doom has been exactly recounted and re-created in countless books and documentaries, a Broadway musical, and three major motion pictures, the last of which, *Titanic* (1997), set records at the box office.

The early-twentieth-century equivalent of a space station or supercomputer, the *Titanic* was a vessel that inspired awe not only for its gargantuan dimensions and lavish accommodations but also for its claimed unsinkability, purportedly guaranteed by a double-bottomed hull with sixteen watertight compartments that would keep the ship afloat even if four were flooded, an unimaginable contingency.

Weighing 53,000 metric tons and measuring 882 1/2 feet long, the *Titanic* was the largest ocean liner of the era, and by far the most extravagant and splendid. It featured a theater, a variety of elegant restaurants, a reading and writing room, a gym, a barbershop, a swimming pool, a miniature golf course, ballrooms, and first-class cabins of unparalleled size and sumptuousness. The *Titanic* promised a dazzling voyage for those who could afford it—the top price for first-class passage was \$4,350 (about \$50,000 in twenty-first-century dollars). Its superabundance in nearly every particular was marred by one fatal deficiency: It carried lifeboats for only half of the ship's passenger capacity of 2,200.

Thus provisioned, on April 10, 1912, the *Titanic* set out from Southampton, England, on its much-heralded maiden voyage, bound for New York City. The ship's first-class passenger list was a roster of the elite of Anglo-American high society, politics, and industry, including the mining tycoon Benjamin Guggenheim; John Jacob Astor; Major

Archibald Butt; Isidor Straus, the head of Macy's department store, and his wife; Margaret Tobin Brown, the Colorado socialite later lionized as the "Unsinkable Molly Brown"; and the British aristocrats Sir Cosmo and Lady Duff Gordon.

Mindful that the *Titanic's* management company, the White Star Line, hoped to set a speed record on its first crossing, the ship's captain, Edward J. Smith, maintained a brisk pace, averaging 550 miles per day. Second Officer Charles H. Lightoller reflected the high spirits during the journey in the following diary entry: "Each day, as the voyage went on, everybody's admiration of the ship increased; for the way she behaved, for the total absence of vibration, for her steadiness even with the ever-increasing speed, as she warmed up to her work" (Warren 1960, pp. 279–280).

All throughout the day on Sunday, April 14, the *Titanic* had begun to receive telegraph reports of approaching icebergs. At noon, it received this message: "Greek steamer *Athenai* reports passing icebergs and large quantities of field ice today." At 9:30 p.m. another such warning arrived from the *Mesaba*: "Much heavy pack ice and a great number of large icebergs." That last message was never sent to the bridge because the ship's chief radio operator, Jack Phillips, was overwhelmed with requests for personal messages to be sent on behalf of the ship's passengers.

Nevertheless, Smith had ample warning of the danger that lay ahead, yet he unaccountably failed to reduce the ship's speed or post additional look-outs. At 11:40 p.m., Seaman Frederick Fleet, peering out from his fifty-foot-high perch, noticed a hulking white object in the distance, and the *Titanic* was heading directly toward it. He rang out the warning bell and called the bridge to announce, "Iceberg ahead." Less than a minute later, a mild shudder rippled through the great ship's starboard side as it grazed the side of the ice floe.

The impact was so mild that it did not even rouse some of the sleeping passengers. Lady Duff Gordon recounted the moment in these words: "I was awakened by a long grinding sort of shock. It was not a tremendous crash, but more as though someone had drawn a giant finger all along the side of the boat" (Mowbray 1998, p. 216). Laurence Beesley, a science teacher in second class, portrayed it as "nothing more than what seemed to be

an extra heave of the engines . . . no sound of a crash or anything else . . . no jar that felt like one heavy body meeting another" (Warren 1960, p. 27).

The ten-second encounter with the iceberg had left six seemingly slight gashes in the ship's steel hull, but they were sufficient to puncture and flood six watertight compartments and thus sink the fabled vessel. Later metallurgical tests revealed that the ship's steel was overly brittle and thus prone to fracture because of an excess of slag used in its manufacture.

The crew quickly became aware that the ship had, at most, a few hours left and began organizing the evacuation. Initially the first-class passengers greeted the news with bemused incredulity and seemed more concerned with extracting their valuables from the bursar than with leaving the warmth of a luxury liner for a tiny lifeboat adrift in the frigid open sea. When the first lifeboat was lowered at 12:45 a.m., it was less than half full. John Jacob Astor helped his wife into a lifeboat and graciously retreated when he was told that only women and children could enter it. Ida Straus decided that she would not avail herself of the safety of a lifeboat. She said to her husband, "Where you are, Papa, I shall be" (Mowbray 1998, pp. 205–206). She offered her coat to her maid, Ellen Bird, who proceeded to the lifeboat alone.

As the bow of the ship began to slip beneath the water at 1:00 a.m., the urgency of the situation became evident, and the pace of lifeboat launchings quickened accordingly. As that frantic hour wore on, Jack Phillips kept up his stream of SOS messages, adding, "Women and children on boats. Cannot last much longer." Benjamin Guggenheim stood on the deck with his valet, dressed in full evening attire. He told a woman waiting to board a lifeboat, "We've dressed up in our best, and are prepared to go down like gentlemen" (Biel 1996, p. 41).

At 2:20 a.m., the *Titanic's* boilers exploded; the ship went into a vertical position and then disappeared into the icy waters. As the lifeboats splashed in the desolate darkness, none of the survivors knew if an SOS had been received or if they would ever be rescued. At about 4:00 a.m. the lights of the *Carpathia* appeared on the horizon, and its crew immediately set to work hoisting the 700 survivors from their lifeboats. Of the 2,223 passengers



With approximately 1,500 people dead, London tabloids did not hesitate to let its citizens know about the sinking of the luxury liner, as printed in the April 15, 1912, edition of this newspaper. HULTON-DEUTSCH COLLECTION/CORBIS

and crew on board, 1,513 had perished. Many more lives might have been spared if another ship, the *Californian*, only ten miles from the *Titanic* at 11:40, had been alerted. But the *Californian's* radio operator had shut off his receiver and retired for the night just before the moment of impact.

The inquiry following the disaster noted the insufficiency of lifeboats and the captain's heedlessness in maintaining full speed in the face of repeated iceberg warnings. To prevent another such catastrophe, an International Convention for Safety of Life at Sea was convened in London in 1913 and established binding regulations that included lifeboat space for all passengers; mandatory lifeboat drills; and 24-hour radio watches on all ships.

The wreck of the *Titanic* was found in 1985 and has since been thoroughly examined through the use of unmanned submersible vessels. The grand ship's tragic story has assumed the proportions of legend, most recently in the Hollywood spectacle *Titanic* (1997). The film's worldwide

popularity helped to remind a new generation that the most advanced technology is easily humbled by the commanding powers of nature.

See also: DISASTERS; INJURY MORTALITY

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WILLIAM KAUFMAN

TOMBS

Death has inspired some of the world's most imposing and monumental architecture. Two of the seven wonders of the ancient world were tombs: the great pyramids of Egypt and the mausoleum of Halicarnassus. The latter was the tomb of Mausolus (hence the word *mausoleum*), the king of Caria (Asia Minor); it was constructed in the fourth century B.C.E. but no longer survives. The Egyptian pyramids have endured and are perhaps the most famous tombs of all time. Their sheer scale captures the power, wealth, and energy at the disposal of those who created them.

The word *tomb* derives from ancient Greek and was first employed by Homer to describe a tumulus or mound raised over a body. By transference, tomb has come to mean anything that is the last resting place of a corpse or cremated human remains. For this reason, the word *tomb* is often used interchangeably with *funerary memorial*, *funerary monument*, *mausoleum*, and even with *cenotaph* (an empty tomb), *gravestone* (a tomb marker), and *grave*. All can be said to perform some functions of a tomb.

A tomb is a structure built aboveground to house the remains of the dead. Many such structures are freestanding, but some exist within other buildings, most notably churches. Tombs often incorporate architectural features and sculpture into the design; many include identifying inscriptions and images; and some use extravagant decor and furnishings on the interior as well as the exterior.

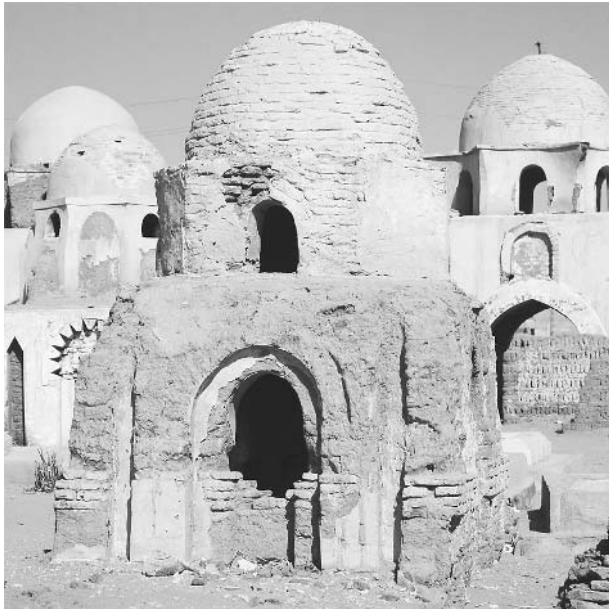
Tombs come in a myriad of shapes, forms, and sizes: there are pyramids, obelisks, mounds, rotunda, rock-cut tombs, house tombs, and temple tombs, to name a few; these may house the remains of a single person or many. Some types of tombs are characteristic of specific peoples and places, but funerary architecture has an eclectic nature that often borrows forms from past societies to

lend prestige to the present. Pyramid tombs may be associated with Egypt, but pyramids were also adopted in ancient Rome (e.g., that of Caius Cestius), in eighteenth-century England (e.g., that of the Earl of Buckinghamshire at Bickling, Norfolk), and in nineteenth-century America (e.g., the monument to Confederate soldiers in Richmond, Virginia). Most building types can be and have been adapted to house human remains and thus perform the function of a tomb.

The earliest impact of man upon the natural landscape was through funerary structures. The barrows and tumuli of the Neolithic period in Europe (c. 4000–3000 B.C.E.) or of the Mycenaean period in Greece (c. 1600–1200 B.C.E.), for example, were large tombs that basically consisted of a stone chamber covered by a massive mound of earth. We can judge that these were highly visible statements expressing the ability of the constructors to deploy manpower and resources, even when little else is known of the prehistoric societies involved.

Tombs are a striking way of asserting desired power and stability. Monumental tombs are not a part of all cultures, religions, or political systems, but where they occur, they are often associated with times of transition in power, a transition frequently triggered by the death of a ruler. This is well illustrated by the pyramids of the Egyptian pharaohs or the mausoleums of the Roman emperors or the medieval papal tombs. The first Roman emperor, Augustus (ruled 31 B.C.E.–14 C.E.), asserted his claims to rule in Rome by building a large circular mausoleum, a dynastic tomb designed to hold the remains of Augustus and his successors. The message was clear: Augustus and his family were in charge and they intended to remain so. In the twentieth century similar principles underlay the construction and maintenance of the tomb of Lenin. Reverence for the dead, and tombs that house them, can be a unifying factor and thus those holding power can draw authority and legitimacy by association with the tomb. From the top of the tomb that housed Lenin's embalmed remains, Soviet dignitaries watched the May Day parades; Lenin was literally under their feet and symbolically holding up the regime.

Tombs may function as symbols of power, but one should not isolate them completely from a more personal world of emotion and sentiment.



Although in Egypt, the Fatimid Tombs in this ancient Muslim cemetery are uncharacteristic of triangular pyramids usually found in that country. CORBIS

For past societies it can be difficult to reconstruct emotions. The Taj Mahal (“abode of the chosen one”) in Agra, India, was built during the 1600s by Shah Jahan for his wife, Mumtaz Mahal, and could be interpreted as a beautiful token of love inspired by grief. This may have been so, but its wider political and physical impact cannot be ignored. The Taj Mahal was part of a massive building project that asserted Mogul rule onto the landscape of northern India. This tomb and its beautiful gardens may also represent heaven on earth, uniting this life with the afterlife. Indeed, spiritual and religious beliefs may strongly influence tomb design. On the one hand religion can seek to control and simplify, designating permanent monumental structures as inappropriate. On the other hand religion can inspire great funerary architecture and play a fundamental role in the design, form, and location of tombs. The secure construction and interior provisions of the Egyptian pyramids were dictated by beliefs about the afterlife; the filling of European churches with tombs had its origins in a desire to gain proximity to God. Religion, power, and sentiment could all play their part in tomb construction as epitomized by the Taj Mahal.

In the case of more modest tombs, it is sometimes possible to view them less as public symbols

of power and claimed religious piety and more as personal statements of affection and familial duty. The tomb is a product of the human urge to remember; it is a focus for memory and a symbol of consolation to the bereaved. In nineteenth-century America and Europe, following cemetery reforms and the abandonment of overcrowded churchyards, there was a boom in tomb and gravestone construction because more people had the opportunity and ability to mark the graves of their loved ones. It was a fashion that did not last, since the same cemeteries came to be characterized by greater simplicity in the twentieth century.

Such changes in the significance and use of tombs reflect changes in society. But wherever and whenever they are constructed and on whatever scale, the public nature of a tomb must not be disregarded. A tomb may be commissioned from love and affection, but simultaneously its design, decor, and size are careful choices that convey important messages (even if indirectly) about the personal beliefs, wealth, status, and identity of the deceased and the survivors.

See also: BURIAL GROUNDS; CEMETERIES AND CEMETERY REFORM; CEMETERIES, MILITARY; CEMETERIES, WAR; CHARNEL HOUSES; GRAVESTONES AND OTHER MARKERS; MEMORIALIZATION, SPONTANEOUS; MEMORIALS, VIRTUAL; PYRAMIDS; QIN SHIH HUANG’S TOMB; VIETNAM VETERANS MEMORIAL

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VALERIE M. HOPE

TRIANGLE SHIRTWAIST COMPANY FIRE

The fire that swept through the Triangle Shirtwaist Company on March 25, 1911, caused 146 deaths. Not only was it New York City's worst factory blaze ever, it was the second deadliest of any kind (after the General Slocum conflagration), and one of the worst disasters to afflict a group of workers since the advent of the Industrial Revolution.

Located in lower Manhattan, just east of Washington Square Park, the Triangle Shirtwaist Company was a typical American sweatshop of the early twentieth century, when the labor movement and government regulation of business had yet to take firm hold in the United States. The company employed 500 women—mostly Jewish and Italian immigrants between the ages of thirteen and thirty-three who worked long hours under unsanitary and unsafe conditions for an average of \$6 a week. The Triangle Shirtwaist Company produced women's tailored shirts that were assembled on the top three floors of a ten-story building. Most of the exit doors were kept locked to enforce worker discipline, and fire protection was confined to twenty-seven buckets of water and a single fire escape.

At 4:45 P.M. on March 25, 1911, the sounding of the company bell signaled the end of another working day. As the workers assembled their belongings, someone yelled "Fire!" For reasons that remain obscure, flames had begun to sprout from a rag bin on the eighth floor, and several workers tried to douse them with the available buckets of water, but to no avail. Within minutes the entire eighth floor was engulfed in flames that fed on the abundant cotton fabrics. The 275 women on the floor bolted for the only exits: the two passenger elevators and the stairway.

The elevators, which only held ten people each, made enough trips to the eighth floor to vacate nearly all of its workers, many of whom staggered gasping onto the street, their clothing smoldering or partially burned. Most of the workers on the tenth floor managed to escape as well.

The workers on the ninth floor, however, were not as fortunate. The flames had raced upward and enveloped most of the ninth floor, where most of



The high death toll of the Triangle Shirtwaist Company fire was a result of locked doors and inadequate fire escapes. New federal safety regulations were established to reduce the likelihood of other such disasters. UNDERWOOD & UNDERWOOD/CORBIS

the additional 300 workers were struggling to escape from the rapidly igniting piles of cotton fabric. At first the women stampeded to the east stairway, but it was an impassable tower of flame. They then raced to get to the west-end stairway and passenger elevators, but the door was locked, and the elevator was slow in coming to their aid. The frantic women began to hurl themselves down the elevator shaft and out the ninth-floor windows, all of them falling to their death. In addition, those seeking to escape by the rear fire escape were

killed when the structure collapsed under their collective weight.

By that time, fire rescue teams had arrived, but their life nets simply ripped apart when struck by the force of three or four bodies at once. Moreover, their ladders were useless, extending only to the sixth floor, and the stream of water from their hoses reached only the seventh floor.

The public revulsion over the abysmal working conditions at the factory prompted the governor to appoint an investigative panel within a month of the fire. New York Senator Robert F. Wagner, Alfred E. Smith, and Samuel Gompers, the president of the American Federation of Labor, headed the Factory Investigating Commission. Five years of hearings and fact-gathering led to the passage of important factory safety legislation. Several months after the blaze the New York City government established the Bureau of Fire Regulation, which enhanced the fire department's powers to enforce fire

safety rules in factories. The tragedy proved to be a turning point in promoting the idea of government safety regulation of private enterprise in the United States.

See also: DEATH SYSTEM; GRIEF: TRAUMATIC; SOCIAL FUNCTIONS OF DEATH

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ROBERT KASTENBAUM



VAMPIRES

Historians document that vampires have most often been reported as inhabitants of shallow graves in the Eastern European countryside. Bram Stoker portrayed *Dracula* (1897), most renown of all revenants, as master of a gloomy and forbidding castle. For contemporary novelist Anne Rice, the French Quarter of New Orleans has long been a favorite milieu for the undead.

Perhaps the best place to find vampires is in the darker recesses of the human imagination. There is something about the image of the vampire that has attracted and fascinated as well as frightened and repelled. Understanding the vampire, then, may be a way of understanding some of the mysteries of the human psyche. Nevertheless, the vampire has not been constructed entirely of moonbeams and fantasies. There is a practical, down-to-earth side of the vampire that deserves careful attention.

Definition and History of Vampires

The vampire seems to defy the firm, mutually exclusive categories of being dead or alive. A vampire's biography begins with death. Furthermore, much of the vampire's time is spent as a corpse or corpse-impersonator. But at night, when the living lie themselves down, up rises the apparent corpse with its dangerous cravings. In the twenty-first century new definitional issues related to brain death, life support systems, persistent vegetative states, and the freezing of both embryos and cadavers (cryonic suspension) have blurred the boundaries

between life and death. It is also recognized that some structures, such as the mosaic tobacco virus, can exhibit the properties of either a living or non-living structure depending upon their situation. For much of history, though, it was the vampire who most daringly crossed and recrossed the borders between the living and the dead.

Vampires are sometimes referred to as "the undead" and sometimes as revenants, reanimated corpses that drink the blood of the living to preserve their own existence. Scholars currently believe that the word *vampire* derives from the Slavic language spoken in Serbia. The consensus is that *vampire* derives from the Slavic verb "to drink." The term was known in England in the late seventeenth century and entered other European languages early in the eighteenth century. Perhaps surprisingly, this term did not make its way to the supposed homeland of vampires—Hungary and Transylvania—until some time afterward.

The vampire (by whatever name) may have been with humankind since earliest times. In his *The Great Mother: An Analysis of the Archetype* (1963), the analytical psychologist Erich Neumann suggests that early civilizations had an intensely conflicted attitude toward both the earth and femininity.

In the myths and tales of all people, ages, and countries—and even in the nightmares of our own nights—witches and vampires, ghouls and specters, assail us, all terrifyingly alike. . . . This Terrible Mother is the hungry earth, which devours its own children. (Neumann 1963, pp.148–149)

Neumann offers many examples of rituals and artifacts to support his belief that the vampire is an ancient and universal symbol of the Great Mother swallowing up her own creations in order to recycle them in new form. However, this dramatic idea remains in need of more evidence for the supposed prevalence of vampirism in the ancient world and does not explain why males have been in the clear majority among vampire ranks (until the twentieth century). Scholars also reject the assumption that vampires are part of all world cultures. Native-American traditions, for example, have their own creatures of the night, such as the skinwalkers (restless spirits of the dead who sometimes make themselves visible), but these do not fit the precise profile of the vampire. A plausible case could be made for a widespread fear of the dead in many cultures, but not necessarily for belief in blood-sucking revenants.

It is clear that vampirism had a secure place in Slavic superstitions for many years before it became a household word with the publication of Bram Stoker's *Dracula* (1897). The author transformed these folk stories into a dark gothic romance. His leading character was inspired by a character he did not have to invent: Vlad Tepes, a fifteenth-century tyrant who slaughtered and sometimes tortured thousands of people. "Vlad the Impaler" was no vampire, though; he did his terrible deeds while alive and had a hearty appetite that did not include sucking blood. Stoker, using literary license, combined the historical Vlad with vampire legends and added a veneer of Victorian culture. Separating fact from fantasy became increasingly difficult as popular literary and theatrical vampires distanced themselves from their roots in anxiety-ridden folklore. Inquiring minds have therefore been following the trail of the vampire, classifying and explaining as best they can.

Folk and Literary Vampires

Classification and description are the first steps to shedding light on these dwellers in darkness. Of most interest to serious students of vampirism is the folk vampire. This is the creature who preceded the literary and commercial vampire. In general, the folk vampire is simpler, cruder, and less appealing than his civilized cousin; therefore, folk vampires are seldom cunning or sexy. Many are just thirsty, and not always particular about their

sources of nutrition. Rural vampires have been accused of rising from their graves to filch the blood of cows or other available livestock. Unlike the elegant Count Dracula, these revenants are foul-smelling and gross, as might be expected from those who, partially decomposed, spend much of their time in a grave.

Another common feature of folk vampires is that they are rarely, if ever, seen at work. The classic case for the existence of a local vampire is built upon (a) something bad that happened in the night and (b) discovering a corpse in its grave that did not appear sufficiently dead. The corpse might have flecks of blood on its face, especially the lips, and might seem to have changed position.

An important distinction can be made among folk vampires. Some are simple, brutish, and unfortunate creatures. Others, though, are corpses that have either been "vampirized" by evil forces or who have willed themselves to return and wreak vengeance on those they believe have wronged them. Not surprisingly, it is this more dangerous and evil form that has attracted the most attention. Vampire-finders, accompanied by the bravest of the brave and a representative of the church, sought and opened suspect graves and took measures to ensure that the inhabitants would henceforth remain in place. Decapitation and, of course, driving a stake through the heart, were among the specific remedies.

Literary and commercial vampires are generally more sophisticated and take better care of their appearances among the living. The sexual allure and prowess of vampires is almost entirely a literary embellishment, again owed chiefly to the Victorian imagination of Bram Stoker. There is little doubt that the popular success of vampires has been enhanced by their dangerous sexuality. These dark lovers were nearly perfect for a society that discouraged open expression of sexuality, especially for women. Vampires embodied both forbidden sexuality and escape from death but their wretched form of existence was punishment for their transgression.

Scientific and Philosophical Vampires

Another type of vampire has been created by those attempting to explain the creature on scientific grounds. The cultural historian Paul Barber has made a strong case for the vampire as a creature of



Friedrich Wilhelm Murnau's 1922 vampire film *Nosferatu* starred Max Schreck, who played the uncannily realistic vampire. The title is Slavic for "plague carrier," linking a history of European plagues and unexplained deaths to the fascination with vampirism. KOBAL COLLECTION

ignorance and circumstance. He notes that most people have little knowledge about the normal course of postmortem changes. Natural events may therefore be given supernatural explanations. Furthermore, bodies may emerge from the grave for a variety of simple if disquieting reasons. Because the most influential collection of vampire reports comes from rural areas of Eastern Europe, Barber offers the following alternative explanations to the folk belief in the reality of the undead.

- Animals dig up bodies from shallow graves.
- Flooding uncovers bodies from shallow graves.
- Grave robbers dig up corpses as they seek items or body parts for sale.
- People dig up corpses to move them to other places.
- Gases form in the corpse, sometimes causing postmortem movement.

- Some corpses decompose slowly for various reasons (e.g., cold temperature or death by poison).

It may be added that fears of being buried alive were widespread in the nineteenth and early twentieth centuries. Some of these fears were justified, for example, by an epileptic seizure or other loss of consciousness mistaken for death. Porphyria has been nominated repeatedly as a medical condition that produces pallor, giving the individual a somewhat bloodless appearance. The victims are highly sensitive to sunlight and therefore are likely to adopt lifestyles resembling the nocturnal vampire.

The philosophical (or inner) vampire has been created by those seeking to understand the meaning of vampirism in their own minds. Although the speculations have some grounding in fact, some are more appropriately offered as questions rather than answers. For example, is the vampire a sort of "middle man" who provides an image and focus point for all the organic recycling that occurs in nature through season after season and life after life? Is the vampire a concealed warning to humankind? Meaning, people should perhaps be content with one life and not grasp for more. Or, is it possible that within each person lurks an ancient and relentless archetype that seeks satisfaction in the most primitive ways despite one's learning, civilization, and moral development? However when one answers these questions, it is likely that the vampire will not be leaving its haunts in the human mind anytime soon.

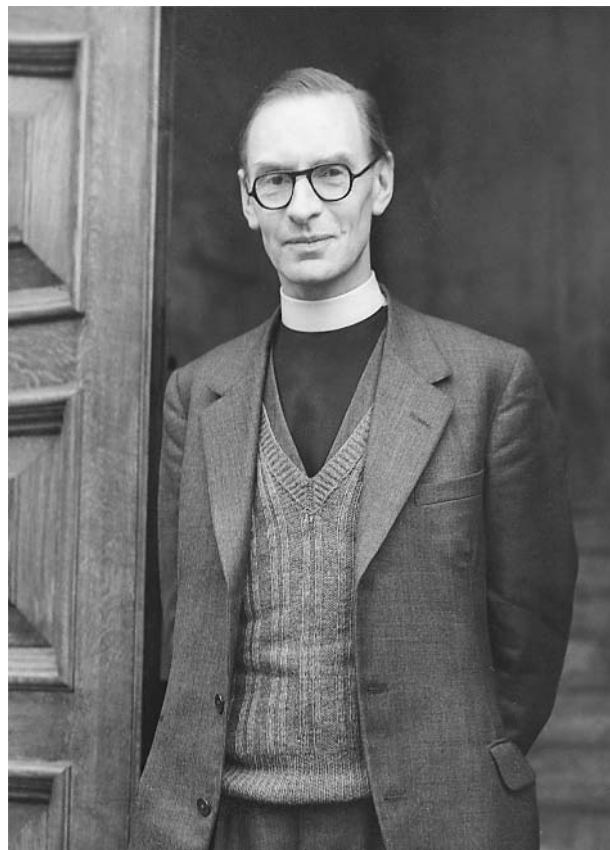
See also: AIDS; BRAIN DEATH; BURIED ALIVE; CRYONIC SUSPENSION; DEATH INSTINCT; DEFINITIONS OF DEATH; GHOSTS; GODS AND GODDESSES OF LIFE AND DEATH; HORROR MOVIES; LIFE SUPPORT SYSTEM; PERSISTENT VEGETATIVE STATE; PERSONIFICATIONS OF DEATH; SEX AND DEATH, CONNECTION OF; THANATOMIMESIS; ZOMBIES

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ROBERT KASTENBAUM



Reverend Chad Varah founded a worldwide movement of volunteers that offers emotional support to those who are suicidal and in despair. GETTY IMAGES

VARAH, CHAD

The eldest of nine children of an Anglican Church minister, Edward Chad Varah was born on November 12, 1911, in the small town of Barton upon Humber, County of Lincolnshire, England. He went on to read natural sciences at Keble College in Oxford, and later studied at the Lincoln Theological College, where he was ordained as a priest by the Church of England. In the culturally repressive atmosphere of the United Kingdom in the 1930s, Varah recognized the extent to which confusion and ignorance about many social issues, several still shrouded in taboo, contributed to the despair that often led to suicide.

One of Varah's duties as an assistant curate in 1935 spawned his lifelong commitment to suicide prevention. He officiated at the funeral of a thirteen-year-old girl who was so confused and isolated that she believed that the onset of menstruation was the sign of a mortal illness that would lead to a slow and painful death; the terrified girl killed herself. Deeply moved and upset by that suicide, Varah sought out other suicidal people in hospitals and within his parish, aware of the meager facilities for the suicidal and their frequent

reluctance to see a psychiatrist. He believed suicidal people needed a way of being in touch with someone to whom they could talk at any time of day or night that was right for them.

The opportunity to help such people arrived when Varah was appointed rector to St. Stephen Walbrook, the London church where he founded The Samaritans, a volunteer organization dedicated to befriending those going through emotional distress. Remembering the young girl, and seeking to minister to the suicidal despair so common in a large city like London, in 1953 Varah advertised in the press and opened the first drop-in center where emotionally isolated and distressed people could go to find a sympathetic ear.

Varah originally envisioned the service as a counseling program, but within months he recognized three crucial points, which include:

- a significant number of suicidal people had nowhere or no one to turn to for emotional and psychological support;

- the number of people seeking help far exceeded his ability to satisfy the demand; and
- most of the visitors wanted to talk to someone who would give them time and space, who would listen in confidence with acceptance and compassion to their deepest, most anguished thoughts.

To meet the huge response, Varah organized volunteers to talk with those waiting to see him. He soon observed interaction between the many and varied callers coming to talk and the lay volunteers who listened empathetically and acceptingly. He called the listening therapy “befriending.” One therapeutic model in the now-multifaceted approach to suicide prevention, it is a “response to an immediate emotional crisis by lay volunteers who are given professional support by appointed medical and psychiatric consultants” (Scott and Armson 2000, p. 703). At the end of the twentieth century there are thousands of volunteers around the world dedicated to befriending the suicidal in the manner first conceived in the 1930s by the visionary Varah.

See also: BEFRIENDING; SUICIDE BASICS: PREVENTION

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VANDA SCOTT

VIETNAM VETERANS MEMORIAL

The Vietnam Veterans Memorial is a tribute to the dead of the United States’ longest, most unpopular, and least successful war. Like the war itself, this memorialization was highly controversial, but the site has become the most frequently visited memorial in Washington, D.C., drawing over 4 million visitors annually.

American casualties in Vietnam began in 1959 and ended with the evacuation of Saigon in 1975. Never officially designated a war, the Vietnam conflict became increasingly unpopular as casualties and news coverage of the fighting increased. Those people who served in Vietnam returned to an unsupportive nation and a media that emphasized the social problems of its veterans.

There were few attempts to honor Vietnam veterans until 1978, when an insignificant and ambiguous plaque was placed behind the Tomb of the Unknown Soldier. One year later, Jan Scruggs (a wounded Vietnam veteran) founded the Vietnam Veterans Memorial Fund (VVMF), which sought private funds from both war supporters and opponents to build a memorial honoring the veterans but not the conflict.

The VVMF held an open competition for a memorial design that would: “1. be reflective and contemplative in character, 2. harmonize with its surroundings, 3. contain the names of those who had died in the conflict or who were still missing, and 4. make no political statement about the war” (Fish 1987, p. 3). A panel of distinguished architects and artists reviewed over 14,000 submissions, and on May 1, 1981, announced its unanimous choice: the design by Maya Ying Lin, a twenty-one-year-old Chinese-American undergraduate at Yale University.

Lin’s design was simple and elegant, consisting of two walls of polished granite (each 246 feet long) composed of seventy-four panels that gradually increase in height from eight inches to more than ten feet at the center, where they meet at a 125-degree angle. Shaped like an inverted V, the memorial is cut into a small hill sloping downward, invisible from most locations on the National Mall.

Although the design was supported by most veterans groups and won critical acclaim in the art

VENTILATOR

See BEFRIENDING; LIFE SUPPORT SYSTEM.



Maya Lin, a Chinese-American student at Yale University, designed the Vietnam Veterans Memorial Wall to be reflective—those stopping to read the names can see themselves reflected in the highly polished surface. In order of date of death, names of the over 58,000 American missing or dead are chiseled into the granite without reference to rank or branch of military service. CORBIS (BELLEVUE)

community, many veterans and conservative politicians were outraged at its selection. Critics targeted features that distinguished the design from other memorials, saying it was black instead of white, horizontal and in the ground instead of rising upward, abstract rather than a realistic depiction of soldiers or battle, and devoid of any patriotic symbols. The most influential of the critics was James Watt, Secretary of the Interior, who put construction on hold until the VVMF agreed to supplement the wall with more traditional patriotic symbols.

Lin's wall was dedicated on Veteran's Day in 1982; a flagpole with an inscription and emblems representing the branches of military service was added in 1983. A bronze sculpture by Frederick Hart entitled *Three Servicemen*, placed near the flagpole looking out toward the wall, was dedicated in 1984. The Vietnam Women's Memorial, a bronze sculpture created by Glenna Goodacre to

honor the women who served and died in Vietnam, was added in 1993. In June 2001 plans for another addition were unveiled by the VVMF. The In Memory Plaque will honor individuals who died prematurely because of war-related illnesses, including Agent Orange poisoning and post-traumatic stress disorder (PTSD). Despite these additions, Lin's wall remains the focal point of the memorial.

The wall's unique design promotes interaction. Hidden quietly in its recessed hillside, it invites the visitor to approach and move along it. The names, chiseled in half-inch-high letters, promote intimacy; visitors get close to read them and are encouraged to touch and take rubbings of the names.

For some visitors, interaction includes leaving objects. According to legend, the brother of a man who died in Vietnam left the first object at the wall; during its construction, he tossed a Purple Heart

into the wet concrete. Since then, over 500,000 nonperishable items left at the wall have been collected and are housed in the Vietnam Veterans Memorial Collection at the National Park Service Museum Resource Center.

Flags and flowers, the most frequent donations, are not collected, but all personal remembrances are carefully catalogued. Within the collection, military mementos are the most numerous, but more idiosyncratic gifts (e.g., a bicycle fender, a can of beer, a fishing pole) are common. Visitors and the objects they leave mirror the diversity of Vietnam experiences; war supporters and opponents as well those born after the conflict pay tribute at the wall. In this way, the memorial brings the nation together to a common place, but not a common understanding. While some see a memorial to fallen warriors, others see a challenge to war in the poignant demonstration of its costs.

Decades after its dedication, Americans continue to reflect on the conflicts of the Vietnam era at the wall. For the many psychologically wounded combatants, the wall is incorporated into their healing; therapeutic programs for veterans with PTSD often make visiting it part of their emotional healing. Efforts to extend the wall beyond its physical boundaries also demonstrate its significance. The Vietnam Veterans Memorial Fund began scheduling tours of the Movable Wall in late 1996 and to date more than 100 cities have been visited (as well as parts of Ireland). The Wall That Heals Traveling Museum and Information Center accompanies the half-scale replica on all of its stops and the Virtual Wall allows online visitors to see individual panels, click on names, leave e-mail notes, and request rubbings.

See also: CEMETERIES, MILITARY; CEMETERIES, WAR; LINCOLN IN THE NATIONAL MEMORY; MEMORIALIZATION, SPONTANEOUS; MUSEUMS OF DEATH

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PAMELA ROBERTS

VIKINGS

See SUTTON HOO.

VIRGIN MARY, THE

In Byzantine icons and Western medieval art, the most common deathbed scene is that of the Virgin Mary. In her study of Marian iconography, Gertrud Schiller reproduced more than 100 images of Mary reclining in bed surrounded by the apostles who grieve, pray, and in late medieval art perform the rites for the dying. In these images, Jesus either stands at the bedside or hovers above it, and holds Mary's soul in the form of a young child. This scene reflects the belief that Mary was the mother of Jesus, the incarnate Son of God, and therefore enjoyed the privilege of an especially holy death.

Yet the Bible says nothing about Mary's death. This silence, combined with growing devotion to Mary, allowed new material to flourish. The deathbed scene is derived from apocryphal narratives describing Mary's last days and dying, as well as her funeral, burial, resurrection, and assumption into heaven. Versions of this story survive in Syriac and Greek texts dating from the third to the fifth centuries. Emperor Maurice (582–602) set August 15 for the feast of Mary's Dormition (*Koimesis*, or "falling asleep") throughout the Byzantine church, and since the late seventh century the Roman church has celebrated Mary's Assumption on the same date. Once the feast was officially placed in church calendars, its narratives shaped preaching, doctrine, and art.

In the earliest surviving Greek sermon celebrating Mary's death, the bishop John of Thessalonica (610–649) claims to have edited the different accounts of her death and to tell "only what truly happened" (Daley 1998, p. 49). An angel told Mary that she would die in three days. She summoned



This thirteenth-century sculpture The Death of the Virgin, at the Strasbourg Cathedral in France illustrates Christ accepting the Virgin Mary's soul into heaven. The most popular images in medieval art of Mary's death are the deathbed scene and the coronation in heaven. GERALDINE DUCLOW

her relatives and friends to stay with her for two nights, and asked them to “sing praise instead of mourning.” The apostle John arrived, followed by the other apostles who had been carried on clouds from all corners of the earth. During the second night Peter preached, urging all present to “take courage” from Mary and to live virtuously in preparation for their own deaths. The next day Mary lay down in her bed, and Jesus arrived with many angels. When he and the angel Michael entered Mary’s room, “Mary brought the course of her life to its fulfillment, her face turned smilingly towards the Lord. And the Lord took her soul and placed it in the hands of Michael” (Daley 1998, p. 63). The funeral followed, but was delayed when an enraged chief priest attacked the bier; his hands stuck to the bier and were amputated until he repented, praised Mary in Hebrew, and was healed. Three days after the burial, the apostles opened Mary’s

sarcophagus, “but found only her grave-garments; for she had been taken away by Christ, the God who became flesh from her, to the place of her eternal, living inheritance” (Daley 1998, p. 67).

John of Thessalonica’s entire sermon, even the disturbing anti-Semitic incident of the chief priest, highlights the importance and power of faith in Mary—specifically in her dying and final transcendence of death itself, for the sermon presents an idealized portrait of Mary dying surrounded by those she loves, supported by Christian rites, and finally reunited with her divine Son who escorts her to reign with him in heaven. And as Peter’s preaching within the sermon makes clear, Mary’s dormition provides “a model of Christian death” (Daley 1998, p. 69).

The Greek narratives entered the West in a Latin version attributed to Melito of Sardis. In the

thirteenth century, Jacobus de Voragine combined several early sources in *The Golden Legend's* account of Mary's assumption; as the *Legend* became the most popular collection of saints' lives of the later Middle Ages, the story of Mary's death assumed new prominence in art and drama. While medieval artworks occasionally illustrate all the major events surrounding Mary's death, they usually limit themselves to two images: the deathbed scene and the coronation in heaven. These images appear in sculpture, stained glass, and manuscript paintings of the private prayer books known as books of hours.

Moreover, in the late Middle Ages the treatment of Mary's death itself takes a more contemporary and realistic turn. Especially in altar paintings, Mary dies within elaborately furnished fifteenth-century rooms, and the apostles perform the prayers and sacramental rites for the dying with a new urgency. As Schiller notes, beginning around 1400 Mary is shown not as having just died, but in the process of dying; and Christ himself is sometimes not in the picture. Similar developments occur in the mystery plays or religious dramas. For example, the York cycle's "Death of the Virgin" presents the full story of Mary's dying, but adds new, concrete details: Mary suffers a painful illness that she hopes will soon end, and John and her attendants openly grieve and need to be quieted by Mary herself. While retaining the exemplary qualities of Mary's death, these images and dramas bring the dormition closer to the realities of late medieval dying.

Although the feast of Mary's Dormition remains a major celebration in Eastern Orthodox churches, Western Christianity has turned away from Mary's death since the Reformation. Protestant churches have generally downplayed devotion to Mary, and Roman Catholicism has increasingly focused on her bodily assumption into heaven, which Pope Pius XII declared official doctrine in 1950. Curiously, Pius's declaration made no mention of Mary's death, and thus bowed to the claim of some Catholic theologians that she was taken bodily to heaven without dying.

Yet in narratives, sermons, images, and plays, the Virgin Mary's death has long offered a powerful, consoling image of the Christian's good death. This was especially the case in the decades before the Reformation when, as Schiller comments, art

highlighted Mary's "ability to help individuals who were about to die. Her death . . . was a model; the taking up of her soul by Christ gave consolation and hope: 'Pray for us sinners' was the daily prayer" (Schiller 1980, vol. 4, part 2, p. 133) to the Virgin Mary. For this reason, appeals to Mary also figured prominently in the fifteenth-century treatises on the *ars moriendi*, or art of dying. Like her exemplary life, Mary's dying has offered a model for Christian imitation and action.

See also: ARS MORIENDI; CHRISTIAN DEATH RITES, HISTORY OF; SAINTS, PRESERVED

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DONALD F. DUCLOW

VISUAL ARTS

Death has always been a patron of the arts. How else would humankind know about the superb arts of King Tutankhamen's ancient Egyptian era if it were not for the exquisite glittering painted and sculpted masterpieces found in his tomb? Likewise, human culture would know little about early Asian sculpture and gilded adornments if it were not for the glowing artifacts found in the burial halls of

the emperors of China. These art objects are symbolic translations of human thought and experience of past millennia and offer concrete evidence of those predecessors' beliefs about death and how they grieved.

Humankind has always turned to its earliest childhood memories when selecting a memorial for a loved one. As the visionary scholar Marshall McLuhan wrote in the 1960s, most people move into the future "looking through a rear-view mirror" (1997, p. 12). Artists, on the other hand, tap into a wavelength of the future. No illustration serves better to document the contrast than the creations of the Impressionist painters such as Paul Cézanne (1839), Claude Monet (1846), Berthe Morisot (1841), and Paul Renoir (1839), and the sculptors Augustus Saint-Gaudens (1848) and Auguste Rodin (1846). Although all of these artists were born in the early Victorian era, their compatriots were commissioning life-sized copies of sculptures and paintings created during the ancient Roman empire for their homes, public buildings, and memorials, as late as the early 1900s.

It takes a cataclysm to change the public's concept of appropriate new lifestyles as well as funerary art. Such a cataclysm rolled over Western consciousness in the aftermath of World War I, with its often futile destruction of a generation's most promising youth. It changed life irrevocably and forced public acceptance of a *Weltanschauung*, a new worldview, discovering the Impressionist art that had been there all the time.

The way humans face impending death and mourn losses induces the trauma that destroys thought. The poet W. H. Auden, grief-stricken by the death of the Irish playwright William Butler Yeats, compared his sense of desolation to the brutal weather: "He disappeared in the dead of winter / The brooks were frozen / and snow disfigured the public statues / the mercury sank in the mouth of the dying day / The day of his death was a dark, cold day" (1945, pp. 48–53). It is the artists who can give words and images to human devastation. Hopes, fears, and questions are invisible until they can be concretized into potent symbolic translations. Conferring posthumous fame on his friend and fellow artist, Auden is able to see beyond the physical decay and putrefaction of biological death: "Earth, receive an honored guest; /

William Yeats is laid to rest; Let the Irish vessel lie / emptied of its poetry" (Bertman 1991, p. 35). It is through the transmission by artists into potent symbolic translations that humankind's inner realities can be communicated and understood.

Religious and Cultural Influences

Human expression of the symbols of death is influenced by the religious and cultural milieu of the times. The Old Testament provides evidence that marking gravesites is an age-old tradition, as Genesis 35:7 reads, "And Rachel died in childbirth. Joseph set up a pillar on her grave while on the way to Ephreth." In 2001 an illustrated article in *Biblical Archaeology Review*, titled "Standing Stones in the Desert," indicates the kind of "pillar" that might have graced Rachel's grave created by pre-Israelite nomadic tribes in the arid desert of the Sinai. The more artistically sophisticated ancient Egyptians created professionally sculpted markers, such as the example of a stela for Mani-Nakhtuf and son (c. 1200 B.C.E.), which tries to guarantee these ancestors eternal life by "Praising the Moon, Thoth, Bowing down to the stars of heaven . . ." The ancient Romans of the first century C.E. in Alexandria, influenced by Egyptian customs, painted sweet and accurate portraits of those they loved on the shroud wrappings in which they were buried.

In his historically comprehensive book *The Hour of Our Death* (1981), Philippe Ariès brings readers to the beginning of Western culture and the iconography with which they are more familiar. He writes, "the Christians of the first millennia believed that the end of time was that of the glorified Christ as he rose to heaven as he sat on a throne . . . with a rainbow around it" reminding his audience of these words made real in the magnificently reverent sculptures on Chartres Cathedral in France (Ariès 1981, p. 97). The same devotedly held faith is illustrated in *The Goodman on His Death*, a woodcut from the fifteenth century, reminding the pious that they need not fear damnation. It implies, as well, that righteous believers would be resurrected at the time of their Lord's Second Coming.

The more successful medieval families were positive that their souls would be immediately translated at the moment of that miraculous event

because their position in life guaranteed a last resting place within the confines of a holy church. Just to make sure their rank was recognized, they reproduced their imposing status, in full regalia, in portraits sculpted in brass on their tombs. There were, of course, other concepts of sanctity. Puritans in England and in America saw death as a very grim reaper indeed. Their religion was full of warnings about the perils of hell, and very little about the blessings of heaven. The Americans commissioned their self-taught New World memorial carvers to recreate, on their tombstones, the ghastly skeletons rising from the biers that still frighten so many visitors of Great Britain's old cathedrals. They also had them inscribe on those old markers the frightening warning, "Death is a debt to nature due, which I have paid and so must you."

For a minimally educated population, a dictionary of images was etched into these stones. Images include down-pointed arrows (the dart of death), a descending dove, which represented the holy ghost, a snake with its tail in its mouth representing eternity, broken flowers representing a child's death, and a trumpeting angel, a more optimistic prediction of the resurrection of the soul. Co-existing with these grim conservatives, a milder, Protestant vision of life and death was portrayed by chubby angels who would surely carry the soul to heaven. This conception finally superseded its hell-ridden predecessors.

By the Victorian period, death had become an even more gentle visitor, demonstrated by marble creations of kinder, mostly female, angels who transported the soul to a divine paradise. And since, at that time, Americans decided that the republic duplicated the ancient Greek and Roman governments, sculptors were ordered to copy the urns and palls that graced the newly discovered Greco-Roman tombs. Only little children escaped these classical allusions—they were often represented as little lambs on little stones or full round figures of sleeping babies. Victorians also placed marble reproductions of these dormant infants in their parlors for remembrance. The practice of photographing deceased children, often as if they were sleeping and almost always surrounded by flowers, religious symbols, and special toys is as old as photography itself and suggests that remembrance photographs were important, valuable sources of solace for grieving families.

The Nineteenth and Twentieth Centuries As a Turning Point

When nineteenth-century excavators discovered the riches in Egyptian tombs, the fashion in home furnishings and memorials changed almost overnight. The Victorians duplicated the divans found in the pyramids for their parlors, and a forest of four-sided pointed structures arose in graveyards, nestled among the urns and palls of their predecessors. In the nineteenth century carvings of pet dogs, pairs of slippers, favorite chairs, books, and tools of the trades, such as fireman's hats and hoses, appeared on memorials.

Victorian artists did not discriminate against commissions for cemetery sculpture. Interested parties are just as likely to find a statue by Daniel Chester French in a cemetery as they are to stand in awe of his massive Lincoln in the capital in Washington. Though twenty-first-century fine artists rarely create memorials, they have continued to express their personal grief and cultural angst in their own work.

The wrenching images in Kathe Kollwitz's woodcut etchings express the conditions of German life after World War I. For an unforgettable demonstration of an artist's despair at humankind's inhumanity to fellow humans, one can stand, appalled before Picasso's *Guernica*, as a memorial to the martyred citizens of those victims of war. As Christina Schlesinger writes in *Grief and the Healing Arts* (1999), "Artists, poets, and painters are a natural resource for developing strategies of mourning. . . . [they] shape inarticulate feelings and bridge the gap between inner confusion and outer resolution" (p. 202).

In the twentieth century society has decided to curb ostentation and conspicuous displays of grief. Memorials no longer resemble the overblown sculptured pylons of the past, and instead, even for the most prominent, they resemble nothing so much as a bronze rectangular serving platter, containing only the name and death dates of the person remembered. There are notable exceptions—the stark Vietnam memorial in Washington, which has become a universally accepted icon of grief for a generation's lost youth, and the artists' cemetery at Green River in Long Island, New York, where the great painters, writers, and musicians of the 1930s are interred, such as Jackson Pollock, Joseph Lieberman, and Lee Krasner. Harkening back to the

massebab (sacred standing stones) mentioned in the Bible and in other ancient literature is the *Alphabet Garden*, 2000, a permanent memorial in Grafeneck, Germany, commemorating the victims of Hitler's 1940 "euthanasia experiments" that took place in that city. The sculptor Diane Samuels has inscribed in German a stone large enough to sit upon and reflect, "Please take my letters and form them into prayers." Other tiny stones nearby, are inscribed simply with letters X and A. Perhaps these representations of a bygone loss prove how much human beings have always needed a physical object only an artist can imagine into being. How similar are Joseph's millennia old pillar and the sinister ebony memorial to Holocaust victims displayed at the end of the film *Schindler's List* (1993).

On a road not imagined by McLuhan, grieving families and friends are setting up multipaged, illustrated dedicatory essays to the deceased on the Internet. An interest in death has also sprung up in the United States on web sites entitled Find-a-Grave, or mounted by historic cemeteries, such as Mt. Auburn in Boston and the National Trust for Historical Preservation. Working men and women have become proud enough of their livelihoods to commission stones that celebrate their labor as the carved ten-wheel vehicle commemorates the trucker Jackie Lowell Stanley (1949–1984), or the speaker's podium engraved with microphones and the logo of their first book *No Fear of Speaking* commemorates the work of the founders of the Speech Improvement Company. In less advantaged neighborhoods, grieving families are commissioning huge spray-painted murals on the walls of buildings to commemorate deceased family members. A remarkable album of these memorials, titled *R.I.P. Memorial Wall Art*, was produced in 1994 by Martha Cooper and Joseph Sciorra. Surely these spontaneous gestures indicate a hunger to break with the past and express a formerly shunned display of emotion.

Future Trends

Though dying, death, grief, and mourning are hallmarks of the human condition, their shapes and images have changed through the ages to a time when perhaps even the most acute observer cannot predict how they will be demonstrated next year. Humankind will continue to look to the visionaries—the artists—to document and update their thinking. The excesses of medical technology,

the dangers of managed care, and the case for euthanasia or assisted death graphically depicted in twenty- and twenty-first-century treatments of *Ars Moriendi* would have been unimaginable terrors to the engraver who created the peaceful closure depicted on the woodcut, "The goodman on his deathbed" (Bertman 1991, p. 17). Cartoons of the grim reaper as "the closure fairy" or standing in front of a store window displaying gardening tools deciding whether to purchase the scythe or its more costly counterpart, the mower, or captioned "A Look Ahead," lecturing on the statistics of future deaths, demonstrates the way comic art continues to flirt with death through the use of traditional imagery. Whether mourners are represented striking their heads, tearing out their hair, beating their breasts, scratching their cheeks until they bleed as they are depicted in Greek objects dating back to the early fifth century, or sewing panels for the largest ongoing community arts project in the world, the AIDS Memorial Quilt, the visual arts have enabled society to both commemorate the lives of deceased loved ones and to support the human endeavor to conceptualize, endure, and make meaning of loss, suffering, and death.

See also: ARS MORIENDI; BURIAL GROUNDS; CHRISTIAN DEATH RITES, HISTORY OF; DANCE; QIN SHIH HUANG'S TOMB; TOMBS; VIETNAM VETERANS MEMORIAL

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SANDRA L. BERTMAN

VOODOO

Voodoo is an animist religion that consecrates a cult to Loas (gods) and to the ancestors—the cult of ancestors constitutes a system of religious beliefs and rites which are used principally to reinforce the social system as well as the dependence of the family—and at the same time, voodoo spirits, guardians, deities, or forces of nature. Voodoo originated in Africa, specifically with the Fon, Yoruba, and Ewe tribes. Geographically, those ethnic groups can be found throughout Ghana, Togo, Benin, and Nigeria. More than a religion or a cult of death, voodoo plays a major role in everyday life through the symbolization of the African traditions for the Haitian people. Voodoo is far from a uniform worship, but evolved differently from one region to the next.



Voodooism is invested throughout Africa as evidenced by these voodoo dolls on display at a marketplace in Lome, Togo. CORBIS (BELLEVUE)

Voodoo is more than a synthesis of different African beliefs because it incorporates significant influences from Christianity. The word *voodoo* comes from the Fon language, spoken in Benin, meaning "a kind of power which is mysterious and, at the same time, fearsome." Voodoo is invested in all parts of Haitian life and has a considerable influence on each person and on each natural element. The voodoo pantheon consists of many Loas, which are generally associated with a Catholic saint. Despite the existence of these Loas, voodoo is essentially monotheist; in their conception, the Loas are neither more or less than the intermediaries between God and the human ones.

The cult of voodoo appeared in the New World with the African slave trade, which began in Haiti during the 1700s. The slaves brought with them these African traditions. There are also some variations of this cult in Brasilia and in Islands of Antigua. Voodoo involves a mix of different ethnic beliefs and it rapidly became an important element of cultural cohesion for the slaves, who came from different cultures and used different languages.

According to the tradition of voodoo, humans enter into communication with the Loas in a very ritualized manner. The Loas are capricious and they will only be of help if one comes into contact with them correctly through the elaboration of different rituals (according to the Loas one wishes to contact). The voodoo service takes place in the *oufo* (voodoo temple) and this ritual must be officiated by a *bougan* (priest) or a *mambo* (priestess). Voodoo adherents attribute illnesses and deaths to the wrath of angry ancestors—hence, the

considerable importance given to the ritual and appeasement ceremony. The voodoo ceremony embraces several elements, including music, dance, food offering, drumming, and animal sacrifices.

The ritual Rada, which is used in the initiation rite, involves the “Good Loas” who have come from Africa, and who represent the lost mystic world. Inside the voodoo ceremony, the Rada Loas are the first to be served; they represent the guardians of custom and tradition. The Rada Loas play an important function through the different healing processes and their principal characteristic is the fact that all of their actions are directed toward good. In opposition, the ritual Petro involves “Bad Loas,” which originated in Haiti. The Petro Loas are considered to be the masters of magic. They embody a kind of relentless force. As the ethnologist Alfred Métraux describes, “the word Petro inescapably conjures up visions of implacable force of roughness and even ferocity” (1972).

The Rada and Petro rituals use both defensive and offensive magic, and can help to obtain justice for someone who has been wronged. The ritual of possession, which appears in the Petro ritual, constitutes the most important way to connect the spirits or ancestors with human beings. A possession crisis appears when the voodoo practitioner is in a situation of marriage with a Loa and becomes his

“horse.” The possessed person suffers from amnesia, which is explained by the fact that no one can be at the same time god and human. This possession crisis generally appears in a ceremony called *Manger-Loa* and constitutes the major happening in the voodoo ceremony.

The voodoo conceptualization of the world involves the belief in continuity between life and death. In voodoo, death is perceived as a regeneration of all society if the various death rituals and the burial services are well executed. Also, considerable importance is attributed to dead persons and the regular maintenance of the tomb. Thus the cult of voodoo succeeds in attaining a reconciliation between the world of the alive and the world of the dead.

See also: ZOMBIES

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GENEVIÈVE GARNEAU



WACO

Public interest in the Branch Davidian movement reached unprecedented heights during the prolonged and ultimately violent standoff between federal authorities and the cult's members in the late winter and early spring of 1993. The Branch Davidian movement dates back to 1929, when Victor Houteff and his followers split off from the Seventh-Day Adventists. The Davidians moved to Mt. Carmel near Waco, Texas, in 1935. After Houteff died in 1955, a succession of leaders controlled the Davidian movement. In 1988 Vernon Howell, who later changed his name to David Koresh, became the movement's new leader.

Under Koresh's leadership, there was a heightened "sense of living in the end of time" (Bromley and Silver 1995, p. 56). Many researchers feel that Koresh saw the events in the New Testament book of Revelation as already unfolding. In Koresh's teachings, he became a central figure in humankind's future: He viewed the Branch Davidians as being responsible for the salvation of people living after Christ's crucifixion (Bromley and Silver 1995; Tabor 1994).

After years at Mt. Carmel, the Branch Davidians suddenly attracted the attention of law enforcement officials. Child-abuse allegations fueled interest in the group. As clinical child psychologist Lawrence Lilliston noted in 1994, it was easy for the public to believe the child-abuse allegations given society's dim view of people who join groups like the Davidians. Another motivation for such allegations involved child-custody disputes

that arose when one parent either left the movement or was never a member, according to the sociologists Christopher Ellison and John Bartkowski. Stories in the media alleging abuse abounded; however, Ellison and Bartkowski report that the media made these charges based on anecdotal evidence. Lilliston noted that there was little substantive evidence; in fact, an investigation by Protective Services in Texas turned up no evidence of abuse. However, Bromley and Silver report that Koresh did have sexual relationships with minors; furthermore, Koresh allegedly "avoided recording paternity on some birth registration forms, apparently to deflect official inquiries about the group's sexual practices" (p. 64).

Notwithstanding the authenticity of the child-abuse charges, they were not grounds for involvement of the Bureau of Alcohol, Tobacco, and Firearms (ATF) because such investigations do not fall under federal jurisdiction. Nevertheless, the ATF chose to investigate these charges while also listing illegal weapons as a justification for their involvement; however, the legitimacy of the weapons charges were also disputed.

Federal agents raided Mt. Carmel on February 28, 1993. A year later, according to Moorman Oliver, a retired criminal investigator who specialized in gang and cult affairs, the scene was chaotic and left questions unanswered regarding the actions of both parties. Perhaps the biggest controversy involves who fired the first shot. The accounts from the federal agents and the Branch Davidians differ on this issue, with both sides maintaining their innocence. When it was over, the raid left four



David Koresh joined the Branch Davidian cult in 1981 and became its official leader from 1988 until the federal raids in 1993. Claiming he received instruction from God, Koresh saw the events in Revelation as already unfolding during his leadership. AP/WIDE WORLD PHOTOS

federal agents and six compound residents dead, with Koresh suffering nonfatal injuries.

After the initial raid, a fifty-one-day standoff ensued. Federal agents made life difficult for compound residents—electrical service was shut off, medical care was denied, and grating noises were constantly broadcast over loudspeakers.

Nevertheless, the Branch Davidians remained in Mt. Carmel. James Tabor, a professor of religious studies who worked with federal agents during the standoff in an attempt to help them understand the belief system of the Branch Davidians, noted that the people inside the compound “were willing to die for what they believed, and they would not surrender under threat of force” (1994, p. 15). Tabor felt that Koresh believed he was living the events of Revelation. He felt that God had instructed them to wait inside until, at the end of the waiting period, they were to be killed by the federal agents. After continued pressure to end the standoff, Koresh informed agents that “he had been instructed by God to write an exposition expounding

the secrets of the seven seals of Revelations” (Tabor 1994, p. 18). Upon completion, he promised to turn himself over to the authorities; however, agents thought Koresh was stalling.

On April 19, 1993, federal agents stormed Mt. Carmel, citing poor conditions within the compound as their motive. Tanks bashed holes in buildings in order to deliver tear gas. Eventually, the compound was engulfed in fire, though the cause of the fire has been debated. Federal agents felt certain that cult members started the fires in an attempt to commit mass suicide. Another possible source for the fires that has been proposed involves lanterns being overturned by the tanks during the delivery of the tear gas (Lewis 1994; Oliver 1994). An official arson investigation into the cause of the fires blamed the Branch Davidians; however, the government’s decision to bulldoze the compound immediately after the investigation has been criticized by some because it prevented any further inquiries based on physical evidence into the cause of the fire (Lewis 1994). Former Senator John Danforth completed a fourteen-month investigation into the events at Waco in 2001. In his testimony before the Senate Judiciary Committee, he reported that the FBI was not responsible for the fires that ultimately killed seventy-four Branch Davidians, including twenty-one children.

Despite the findings of the arson investigation and the investigation by Danforth, some scholars do not agree with the conclusion that the Branch Davidians started the fires. Susan Palmer, an expert on religious suicides, feels that the mass-suicide explanation does not fit the evidence. Survivors of the fire “insist that there was no suicide pact” (p. 104). Furthermore, there were no suicide rehearsals, and there seemed to be no evidence of speeches by Koresh “exhorting martyrdom” (p. 107). Her analysis of the events points to mistakes made by federal agents as the likely cause of the Waco tragedy. A definitive answer regarding whether the fires resulted from mass suicide or from some form of ghastly accident may never be known.

See also: CULTS DEATHS; HEAVEN’S GATE; JONESTOWN

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WAKE

The need to mark someone's death as an event affecting a whole group of people who knew, or knew of, him or her is as fundamental to human life as the necessity to provide opportunities for

private grief. This kind of social gathering is usually referred to as a wake. It takes various forms in particular parts of the world. Because death is a potentially frightening subject and there are many taboos surrounding it, wakes are often low-key occasions. Their origins, however, are in behavior that is less inhibited, and it is this to which one must turn in order to understand their psychological and sociological importance.

Definitions of Wake and Their Implications

Broadly speaking, wakes are parties or social gatherings held in connection with funerals. These sometimes involve keeping watch beside the corpse and behaving in a demonstrative way, either by lamenting or merry-making. This implication of unruliness is widespread. According to *Brewer's Dictionary of Phrase and Fable* (1978), the wake is "a vigil celebrated with junketing and dancing." The word primarily means, of course, to prevent someone from sleeping, to wake the person up, to disturb the person's slumber and make it impossible for him or her to slip back into it. The "junketing and dancing" take place in order to wake the person up again. That is why, compared with ordinary social behavior, wakes stand out as wild and unrestrained: They have to be "fit to wake the dead."

From this point of view, then, "waking the dead" is carried out mainly for the benefit of the dead themselves, in order to restore them to wakefulness. To be the expression of a consciously focused intention on the part of the living is its ritual function. Not merely to give a dead person "a good send off," but to keep the dead properly moving in the right direction, instead of simply losing consciousness. In religious terms this means making sure that the person goes on living in the dimension of being he or she must now enter upon. In other words, the deceased must be awake among the dead, a state of affairs that is held to be beneficial to the deceased's survivors as well.

There is evidence of wake-related behavior in all parts of the world. The practice of "waking the dead" is ancient. For example, in Homer's *Iliad* both Hector and Patroclus are depicted as having had funeral feasts, which, if they resembled those of Achilles and Aeneas, included games and contests of skill. The practice of "funeral games" occurs as a common theme in accounts of funeral behavior throughout the world.

Everywhere the underlying intention of the wake is to honor the dead person. The Irish antiquarian Sean O'Suilleabhain believes that the intention was originally to avert the person's rage at having died: "It was an attempt to heal the wound of death and to do final justice to the deceased while he was still physically present. After the burial, the opportunity to do so would be absent" (O'Suilleabhain 1967, p.172). Thus, the practice is held to be an expression of a straightforward fear of dead people and what they are able to do to the living, in accordance with the world-famous anthropologist James Frazer's rationale of ancient funeral customs in his *Fear of the Dead in Primitive Religion* (1933) and the evolutionary doctrine of C. E. Vulliamy, who associates such ideas with a primitive mentality that most of the human race has now grown out of.

These definitions, however, fail notably to account for the "revelry" and "merry-making" that are essential parts of the word's definition. The wake is easier to define than to explain; along with fear and awe, thanksgiving and praise are easy to account for in religious ceremonies surrounding death and dying, but a determination to play games and invent ways of amusing the mourners seems rather more than out of place in such circumstances. Those who claim to understand such behavior at all tend to do so in terms of a reaction against sadness or a celebration of corporate optimism in the face of death—conviviality called upon to reinforce solidarity. One commentator speaks of "creating a space for 'irrational' grief to be acted out" (Toolis 1995, p. 18); another of "energy and activity" used to "anaesthetise the bereaved" (Clare 1995, p.7). From an anthropological point of view, however, the aim of the wake is not to disguise death or even to oppose it but to proclaim it: to proclaim the meaning of its presence for the social group in which it has occurred and to assert its human significance in the face of one's defensive attempts to play it down. The wake overcomes human defenses by demonstrating the provisional nature of life as individual women and men.

Wakes around the World

The wake appears as a holy time of uncharacteristic behavior that is symbolic of a world that has been reduced to disorder. The reversal of characteristic actions is often seen as a method of signifying to departing spirits that they must henceforth

find a new life for themselves. In fact, however, these "funeral reversals" have two purposes: Not only are they intended to confuse ghosts and stop them from finding their way back to the land of the living, but they represent the formlessness that characterizes the heart of the funeral process. The chaos through which the dead person must pass is reproduced in the chaotic reversals of social practice that occur during the mourning period, mirroring the contradictory emotions and impulses of bereaved individuals as they rebound between their need to suffer and be comforted, to remember and forget, in the urgency of their search for an escape from the anguish of the present. Thus symbols adopted to express discontinuity with the past and the affirmation of a new status and direction also carry a strong implication of present personal and social chaos. Such symbols and others indicating chaos are widespread throughout the world. In Ireland, for example, the wake was a kind of exaltation of unruliness. In 1853 James A. Prim, a learned member of the Royal Society of Antiquarians of Ireland, complained, "it is difficult to obtain precise details about the wake games because of their apparent obscurity" (Evans 1957, p. 290). He is quick to point out, however, that the obscurity was not indulged in for its own sake:

The peasantry had no idea of outraging propriety or religion in their performances, holding an unquestioned faith that such observances were right and proper at wakes, whilst under any other circumstances they would shrink with horror from such indelicate exhibitions. (*Evans 1957, p. 290*)

The obscurity and perversity belonged to the rite and were only to be regarded within the context of the rite as a whole. Prim described a game in which a mourner acts the role of a priest, the representative of all the forces of rationality and propriety, who enters into conflict with the master of the wake, a personage known as the Borekeen; the "priest" is first of all thoroughly discomfited and then finally expelled from the room. Again, in a game called Drawing the Ship out of the Mud, "the men actually presented themselves before the rest of the assembly, females as well as males, in a state of nudity" (Evans 1957, p. 291). In another favorite game, the women performers dressed up as men and "proceeded to conduct themselves in a very strange manner" (p. 291). Evans quotes

descriptions of similar occurrences at African wakes, in which the female members of a tribe assume the dominant role in the proceedings and behave with unaccustomed lewdness, wearing men's clothing as part of the general reversal of normal behavior. In the same way, among the Ndembu, according to the scholar Victor Turner, "a multiplicity of conflict situations is correlated with a high frequency of ritual performance" (Turner 1974, p. 10). Turner describes how "instead of coming against one another in blind antagonisms of material interest . . . [opposing social principles] . . . are reinstated against one another in the transcendent, conscious, recognisant unity of Ndembu society whose principles they are. And so, in a sense for a time, they actually *become a play* of forces instead of a bitter battle" (p. 71). The violence originates in frustration. It is the expression of a desire for obedience and conformity that cannot be satisfied.

In *Rituals of Rebellion in South-East Africa* (1954), Max Gluckman maintains that the purpose of such licensed outbreaks of violence and rejection is in fact to take nonconformity and dissent into the system by giving it the kind of social recognition afforded by all corporate rituals. "Such rituals of rebellion by canalising social tensions, perpetuate the established systems of political organisation" (p. 24). Thus, by its apparent exaltation of unruliness and perversity, the wake contrives to establish the primacy of that social order and stability which is sufficiently sure of itself to allow its opposite to be temporarily indulged. In itself, the very fact of public ritual asserts social order. Whatever the individual rite expresses is presented within the context of, and in relation to, the established fact of social belonging.

In Ireland, for example, up to the early years of the twenty-first century, the funeral wakes played a significant part in the social organization of Irish country life. The mere existence of such an institution was itself a symbol of anarchy. Wakes were officially deplored; however, they were secretly tolerated by the dominant Roman Catholic culture of the country. No doubt that the games described by O'Suilleabhain provided a welcome outlet for a variety of repressed feelings on the part of those who would have considered it inappropriate to express them while the deceased was still alive, even if they had been aware of harboring them at the time. The ceremonies with which a society greets the death of one of its members,

though they may resemble unconscious patterns in the psychological life of individuals, are not to be simply identified with those patterns. What is expressed in the Irish wake is not merely an opportunity for individual mourners to find release for their feelings, but something more sociologically significant. This difference is not mainly one of quantity—many people finding relief from the unconscious pressure of the love-hate syndrome—but of quality. The ambivalence expressed in the wake is not a symptom, not even a symptom that special circumstances have revealed as outward signs of an unconscious malady, but a proclamation, a conscious message. It is not concerned with past feelings and attitudes but with the state of affairs in the present. The chaos of the wake is a public statement made about the present state, not of the individual but of the world. The wake is society's way of saying that, to a greater or lesser extent, according to the size of the social group involved and the importance of the dead person's role with that group, the world has been radically and permanently changed. For the mourners themselves the integrity of existence has been shattered, and the wake is the public image of an existential chaos. The revelers, pugilists, and buffoons described by O'Suilleabhain as being present at Irish wakes proclaim that, as of now, in the poet William Butler Yeats's words, "Things fall apart, the centre cannot hold" (Yeats 1989, p. 124). Even given the possibility that somehow the world may be remade, it will never be the same again. And for the present, the wake's explicit message is the proclamation of chaos and confusion in the place of order.

Ireland provides specific examples of the kind of funeral behavior observed in Europe, Asia, North and South America, Africa, Australia, and the Indian subcontinent. The scholar Kevin Toolis's 1995 article in the *Guardian Weekend* bears eloquent witness to the fact that genuinely expressive wake practices still exist in Ireland. Toolis has experience of what O'Suilleabhain calls "the old funeral movements" in traditional ways of dealing with death persisting even in the twenty-first century in districts and neighborhoods within Great Britain. Generally speaking, however, as the communal expression of personal feeling has become more privatized in those parts of the world influenced by contemporary Western attitudes, the practice of providing funeral wakes has become

something of a rarity. From the point of view of bereaved individuals, families, and communities, this must be regarded as a deprivation, in that a powerful way of registering the significance of somebody's life, and the loss sustained by everyone as a result of that person's death, is no longer available to them. In its own way the "primitive" outrageousness of the wake was an expression of emotional honesty. In its absence, other ways must be found of coming clean about death.

Wakes in the United States

In his extensive study of the wake in the United States, particularly the Central Appalachian section, James Crissman found a variety of purposes for the death vigil in addition to "rousing the ghost," including friends and/or family staying up all night to keep insects, rodents, and cats away from the corpse. One example is given where "the cat got to the deceased and ate the fingers before it was discovered and removed" (Crissman 1994, p. 70). Among the more superstitious, there was a fear that members of the spirit world might carry the body away before it could be inhumed. In addition, some wakers guarded the corpse to deter "body snatchers" that might steal the body for medical purposes. Before embalming, the body had to be scrutinized continuously to make sure the person was actually dead. Another reason for the death vigil was that it was a time to pay one's respects to the departed and give comfort to the bereaved family. It also provided some people with a chance to socialize, and it gave family members a chance to adjust to the loss of their loved one before the corpse was placed in the ground. Finally, the wake sometimes served the purpose of guarding the body pending the arrival of a distant relative.

Psychologically speaking, funerals help human beings to die in the past so that they can live in the future. Wakes provide a crucial stimulus for the real personal changes on which personal growth depends. Certainly it would be profoundly valuable for the human understanding of funerals if the emotional effect of the wake could be studied and compared with the kind of funeral in which the expression of emotion is discouraged. In this vital area of human understanding of death, the field remains open for primary research; but wherever wakes survive, they act as powerful symbols of human reality as people struggle to express the reality of their experience of life and death.

See also: BURIED ALIVE; GRIEF: FAMILY; GRIEF AND MOURNING IN CROSS-CULTURAL PERSPECTIVE

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WAR

Most murders within the human species have been committed by soldiers in war. Though it remains a matter of debate whether the potential for warfare

is lodged in genes, culture, or both, humans are the only creature that intentionally kills its own kind for reasons of religious, economic, or political ideology.

Although war has been a near constant in the human condition (estimates are that over the last 3,500 years there have been only 230 years of peace throughout the civilized world), it is the past 100 years that will undoubtedly be remembered as the military century. Of all war fatalities over the past half millennium, fully three-quarters occurred during the twentieth century—including roughly 26 million in World War I and 53 million in World War II.

War is certainly one of the primary driving forces behind cultural evolution. Its history features the increasing lethality of its instruments as well as shifts in acceptable target populations. Primitive warfare was highly ritualistic, often with checks to ensure the killing did not become too efficient and with casualties limited to the group's most expendable segment: young males. Such conflicts in hunting-and-gathering societies often entailed little more than demonstrations of courage and occasional expropriations of another group's food, women, and children.

With the evolution of social organization, the stakes increased, along with the potential for mass killing. Armies of trained warriors numbering in the thousands were fielded thousands of years before the birth of Christ. Whole peoples were slaughtered by the Assyrians, Scythians, and the Huns under Attila. In the thirteenth century, the Mongols brought a reign of terror to central and western Asia, where entire populations of conquered cities were systematically massacred. Genghis Khan led the slaughter of an estimated 40 million Chinese to open the northern part of that country to nomadic herding. With the advent of total war, genocide became a strategic goal. Nevertheless, the heroic individual could still emerge from the mass of slaughter, and there was still contact, however bloody, between warriors and their victims.

Over the past 500 years, international affairs have been largely shaped by European and American innovations in military technologies and strategies. From the sixteenth and seventeenth centuries on, wars of religion and territorial grabs were to be transformed into wars of nationality. To protect "national interests," each state had to maintain

a military balance of power with other states. The Napoleonic era was notable for upsetting this balance through its exploitation of modern nationalism. The entire French civilian population was mobilized for war, producing a force so potent that it overran most of Europe. Never before had the world seen anything approaching the scale of mass war in 1812, when Napoleon entered Russia with a half a million soldiers and a thousand cannons. Yet, as Napoleon's failure in Russia showed, strategy combined with individual and collective valor still could overcome the numerical superiority of an enemy in an era that still featured cavalry attacks, infantry assaults, battle cries, and hand-to-hand combat.

Industrialization, technological innovation, and the strategy of mass war combined to relegate the heroic warrior to the annals of the past. During the U.S. Civil War, attempts to combine the Napoleonic tactics of charging in mass formations with the new factory-assembled instruments of death—specifically, breech-loading rifles (propelling bullets ten times farther than the muskets used by Napoleon's troops), land mines, and hand-cranked Gatling guns that fired 350 rounds a minute—led to the slaughter of more Americans than two world wars and the Korean and Vietnam conflicts combined. When Europeans turned their Maxim machine guns on each other in World War I, the individual soldier was reduced to an interchangeable, impersonal cog of massive industrialized killing machines. No Achilles or Hector could brave attacks originating from hundreds of feet beneath the sea or from thousands of feet in the air.

Before the outbreak of World War II, the bombing of civilians was generally regarded as a barbaric act. As the war continued, however, all sides abandoned previous restraints. War economies had to be created to support the millions on the front, employing women and the aged to replace the missing men. With so much of the population integrated within an elaborate wartime division of labor, distinctions between combatants and civilians were increasingly blurred. Aerial attacks on the great cities became standard strategy early in the conflict, carried out by bombers and later by Germany's unmanned V-1 and V-2 rockets. The war ended with the obliteration of Hiroshima and Nagasaki by atomic bombs; the crews brought about the death of over a third of a million Japanese civilians.



American soldiers move the body of a comrade who died in the 1968 bombing of the United States bachelor officers' quarters in Saigon during the Vietnam War. PUBLIC DOMAIN

Since World War II, the rule that soldiers should only kill other soldiers when in face-to-face combat also evaporated as civilians were increasingly drawn into the frays. In Vietnam, Americans killed unarmed women and children. Nearly 40 percent of the Panamanians killed in the 1989 U.S. Operation Just Cause invasion were civilians, as were three out of ten Croatians killed by Yugoslav Army and Serbian troops in 1991–1992, and over six out of ten casualties in Bosnia. The percentage of war-related deaths comprised of civilians increased from 14 percent in World War I to 67 percent in World War II to 75 percent in conflicts of the 1980s to 90 percent during the 1990s.

The twenty-first century began with the potential for nuclear, biological, and chemical holocausts. Despite the massive needs of the world community, governments continue to spend nearly a trillion dollars a year designing and perfecting the means by which to kill one another's citizens. The arms industry remains the world's largest manufacturing industry. Worldwide, for every dollar

currently spent per pupil for education, twenty-five are spent per soldier.

Postmodern warfare also features a reversal of past trends toward total war and deindividualized warriors. With the end of the cold war, military conflicts are no longer the preserves of nation-states but rather increasingly involve terrorists such as al Qaeda's mastermind Osama Bin Laden, crude paramilitary forces, and cruel clashes between ethnic and religious groups. The early twenty-first century was an era when a single individual could produce a strain of lethal bacteria or a chemical weapon capable of decimating an entire city. Ironically, the modern West's high-tech culture has bred a complacency about risk that has combined with the dense interdependencies of society's parts to render the most advanced societies especially vulnerable to disruption by an attack on only one of its parts—as when a computer virus is unleashed, a water supply infected, a power grid disrupted, or office buildings obliterated in kamikaze attacks by hijacked commercial jumbo jets.

See also: CEMETERIES, MILITARY; CEMETERIES, WAR;
DEHUMANIZATION; GENOCIDE

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MICHAEL C. KEARL

WASHINGTON, GEORGE

George Washington died in his bed at Mount Vernon, Virginia, on December 14, 1799. As a Revolutionary War hero and the new nation's first president, Washington's life and death led to his glorification as a key iconic, mythological figure in United States history. The death of this founding father posed a threat to the emerging social identity that could only be resolved by massive, communal ceremonies celebrating his life, and his essential contributions to the birth of the new nation.

Born on February 22, 1732, in Westmoreland County, Virginia, Washington's early life included working on the family plantation and a short stint as a local surveyor. The French and Indian War (1754–1763) offered the Virginian a new career opportunity in the military, where the young Washington was quickly promoted to lieutenant colonel. In 1755, at only twenty-three years of age, Washington became a colonel and was appointed commander in chief of the Virginia militia. He left the army in 1758 and returned to Mount Vernon, when he married Martha Dandridge Custis and entered the political arena as a member of Virginia's House of Burgesses from 1759 to 1774. During this

time Washington became a fierce opponent of British colonial policies, especially those relating to discrimination of colonial military officers and to western expansion.

Washington then served as a delegate to the First and Second Continental Congress (1774–1775), and in June 1775 Congress unanimously favored his appointment as commander in chief of the Continental forces. His leadership during the American Revolution, and his storied military exploits, including his crossing the Delaware River on Christmas 1776 for a surprise attack, contributed to his growing popularity as a both a warrior and civic leader. After the war Washington returned once again to Mount Vernon to work the land for a short time before leading the Virginia delegation to the Constitutional Convention and, eventually, assuming the office of presidency in 1789. Despite deep divisions in American political life during his first term, Washington was elected to a second term in 1792. After this term finished, he retired once again to Mount Vernon and remained there with Martha until his death in 1799, when he was entombed on the grounds.

Washington's death led to unprecedented levels of public mourning in the new nation. Rather than create debilitating social grief, his passing served as a critical source of cultural rejuvenation and optimism about the future of the young nation. In towns and villages throughout the land Americans celebrated his death with local ritual activities (which often included mock funerals) that produced deep and long-lasting forms of social solidarity uniting disparate regions in common cause to mark the occasion of his passing. Although these celebrations were tinged with sadness, they also provided significant opportunities for Americans to symbolize and celebrate both the mythic qualities associated with the man and the national virtues associated with the new republic.

Memorialization efforts began immediately, with the production of mourning art—which combined traditional genres of expression with innovative, more spontaneous expressions of sadness—playing a crucial popular role in efforts to publicly remember the national hero. The various symbolic motifs found in this art, ranging from ancient images of mourners in classical dress to Christian imagery invoking resurrection and redemption themes and common allegorical figures like

America, Columbia, and Father Time, gave citizens a shared frame of reference to imagine his life and continuing presence in American life after death. All of these motifs in mourning art produced at the time of his death reinforced the linkages between Washington, patriotism, and Christianity. The art also established a cultural link between death and the regeneration of national life that would prove to be so critical to the elaboration of a distinctly American form of civil religion, and that would be repeated throughout the course of American history with the passing of such critical political figures as Thomas Jefferson, Abraham Lincoln, and John F. Kennedy.

For artists, politicians, ministers, and other leaders, remembering the spirit of Washington translated into a spiritual practice that nourished nationalism and civic renewal. Rather than reaffirm social distance between classes, in death Washington added fuel to the fires of democracy and egalitarianism: His life not only taught Americans about virtues like hard work, love of country, and the value of home life, it conjured now-mythical stories about the birth of the nation and its future destiny. In addition to his central role in the political life of the nation, Washington could be understood as America's first celebrity. His death became a time for ardent fans to mourn collectively, and discover innovative rituals to worship his memory. The open forms of public display surrounding his death set the mold for later collective exhibitions of adoration, identification, and deification.

See also: BROWN, JOHN; CELEBRITY DEATHS; IMMORTALITY, SYMBOLIC; LINCOLN IN THE NATIONAL MEMORY; ROYALTY, BRITISH

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GARY M. LADERMAN



Construction of the Washington Monument began in 1848, although its design was significantly altered in 1876 to slightly resemble an Egyptian pyramid. The completed monument was opened to the public in October 1888; it stands just over 555 feet tall and an elevator takes visitors to the observation area in the pyramidian. CRAIG AURNES/CORBIS

WEBER, MAX

Max Weber (1864–1920) is one of the most influential and prolific writers of sociological theory. In conceptualizing modernity, Weber focused on the rationalization of the world where a society becomes dominated by cultural norms of efficiency, calculability, predictability, and control resulting in dehumanizing rationalization where the average man is less important than the clock and the calculator. Just as the fast-food industry has become rationalized, so have the industries associated with dying and disposal of the dead.

Although Weber never actually dealt with the issue of death, many theorists using this definition

of rationalization have shown that it can be extended to how society deals with death. As a society becomes more rational, efficiency in dealing with the dead becomes more important. There are funeral directors and other professionals who specialize in the systematic and routine caring for the deceased. Calculability is also evident in American society's view of death. Many actuaries and physicians focus on disease and death statistics in an attempt to better predict the causes and timing of death. The rationalization of society is evident in the demystification of death. Death is no longer "a journey to the next world" but simply an end to life. As a society moves toward rationality as its norm, death becomes a systematic and logical event, eliminating some of the most human aspects of dying.

See also: DEATH SYSTEM; SOCIAL FUNCTIONS OF DEATH

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JOHNETTA M. WARD

WIDOW-BURNING

The burning of wives on the funeral pyres of their husbands, widow-burning, commonly known as *sati* ("suttee" in English), has been practiced in India since at least the fourth century B.C.E., when it was first recorded in Greek accounts. It was banned by British colonial law in 1829–1830 and survived in the native Indian states until the late 1880s, when it was effectively eradicated, although extremely rare cases persisted into the early twentieth century. Since India's independence in 1947—or more precisely since 1943—there has been a spectacular revival of the phenomenon in four Northern Indian states: Bihar, Uttar Pradesh, Madhya Pradesh, and especially Rajasthan, a former stronghold of *sati*. Although the number of women who have committed *sati* since that date

likely does not exceed forty (with thirty in Rajasthan alone), an infinitesimal percentage of the female population, the reactivation of the practice has had considerable social and political impact, especially in the case of the "Deorala affair"—the burning of a young Rajput widow named Rup Kanwar in Rajasthan in September 1987. The nationwide trauma that followed this incident and the media coverage it received (in contrast to the relative indifference shown to the other cases) led the federal government to take legal action, issuing the Sati Commission (Prevention) Act a year later.

Sati was never a universal practice in India, even though the earliest statistics recorded by British officials in the late eighteenth and early nineteenth centuries were at times quite remarkable. Several reasons explain the high numbers logged in certain periods and regions of the subcontinent. For instance, a combination of external factors such as cholera epidemics and local customs, like the unbridled polygyny of Kulin Brahmans, might account for a portion of the 8,134 cases recorded in the Bengal Presidency alone between 1815 and 1828. Widow-burning is but one of a wide range of religious rituals implying self-mutilation and self-sacrifice observed by Indian men and women alike. Although death by fire has been the prevalent form of the ritual, cremation being the most common type of disposal of the dead among Hindus, *sati* could take the form of widow burial whenever the caste or community of the deceased called for it, as for example with the Jogi weavers of Bengal, or with the Jasnathis of Rajasthan, a lost branch of Ismaili Muslims who have reconverted to Hinduism.

The original meaning of the Sanskrit word *sati* was simply "faithful wife"; only later was the term applied specifically to the woman who immolated herself. In any case, it never referred to the rite or custom of widow-burning. It was the British who, at the close of the eighteenth century, officialized the confusion, expressed by many travelers before them, between the immolated woman and the sacrifice of widows. The Sanskrit language knows of no specific denomination for the practice and instead resorts to periphrastic and euphemistic expressions like "going with" and "dying with," when the widow is burned on the same funeral pyre as her husband, or "going after" and "dying after" when she is burnt on a separate pyre, these being the two major facets of the rite.

Also noteworthy is the fact that according to the Hindu belief system, the sati dies as a wife, eschewing the ill-fated, ominous, and impure state of widowhood: The “eye of faith,” combined with the “belief effect” of the ritual, makes the joint cremation of husband and wife appear to onlookers (and as far as one can tell, to the sati herself) to be a reenactment of their marriage ceremony. Through her sacrifice, the sati preserves the bodily and spiritual unity of the couple, affording the Hindu sacrament of marriage its ultimate and truest expression.

Placed in a broader context, widow-burning is but one among a variety of forms of funerary ceremonial, found in many parts of the world, that involve the voluntary death of certain categories of survivors. These people sacrifice themselves (individually or en masse) in the course of the obsequies of a higher-ranking person—a ruler, master, or husband. The belief underlying this body of suicidal practices (termed *altruistic* by Émile Durkheim in his 1897 classical work *Le suicide*) is that the deceased will enjoy the same goods and services in the beyond as he had on earth. He will need his mount and his weapons to wage war, food to assuage his hunger, and finery to set off his beauty and glory. In like manner, he will need to be accompanied by his servants, his counselors, and, finally, his wives.

What seems to lie at the heart of the practice of “following in death” is the settling of a debt of obligation and love (the two go together) binding the various parties to a common master. In ancient China, for example, all the categories of survivors mentioned above were buried with kings or great warlords, together with horses, offerings, and artifacts. Such was also the case in Scythia. According to some authors, the custom would have been introduced into India when Scythians (locally known as Shakas) conquered parts of its territory in the first century B.C.E. It would then have been exported from India to the kingdoms of Southeast Asia—mainly Java, Lombok, and Bali—where Hinduism became the state religion during the first centuries of the common era.

An alternative thesis maintains that widow-burning was indigenous to India but belonged to the same pre-Aryan wild clans and tribes as those that had introduced human sacrifice to propitiate bloodthirsty deities, as well as other equally “loathsome” rituals, into the Hindu canon of practice.

Following the same line of argumentation, the remarkable fact that neither the Vedas, the sacred revelation of ancient Brahmanism, nor such authoritative treatises on dharma as the *Laws of Manu* ever mention widow-burning, is taken as evidence for the repression of this barbaric custom by a civilized Aryan society, in which the widow was enjoined either to lead an ascetic life for the rest of her days or, if she had had no male issue, to cohabit with her husband’s younger brother until she begot one. These reconstructions tell readers more about the fantasies and ideologies of the people who conceived them than they do about the history of the practice itself. The aboriginal versus Scythian origin theories seem, in fact, to serve the same purpose: to remove sati rituals from the pure land of the Aryans and exile them into its darkest inner or outer confines. In this way, not only is India’s immaculate image as the golden land of spirituality and nonviolence preserved, but also the hard core of “barbarism” found in Hinduism is conveniently expelled and thereby repressed.

The latest version of this convenient scenario is the one used in the polemic following the 1987 burning of Rup Kanwar in Deorala. This was the last and most highly publicized of a series of widow immolations that took place in Shekhavati, a rural region of Rajasthan, one of India’s most underdeveloped and conservative states. The “Deorala affair” has been interpreted in a variety of ways according to the different viewpoints of the various actors in the controversy of Himalayan proportions. The proponents of secularism and women’s causes declared Rup’s immolation to be a patent case of murder in a plot in which the rural illiterate masses had been fanaticized by obscurantist forces and demonic agents belonging to specific castes (mainly the Rajputs and Marwaris) who were backing the revival of an outdated, outlawed practice to further their own interests, whether political, economic, or symbolic.

Commenting on the case and its extraordinary impact on a theretofore indifferent public, the Indian social psychologist Ashis Nandy has offered the following interpretation: The burning of Rup Kanwar became a cause célèbre because of her social milieu. Kanwar was born in a semiurban, well-to-do family from Jaipur, the state capital of Rajasthan, and had received a quite respectable education. The English-speaking and Westernized

elite that sought to protect itself from the backlash of acculturation by stigmatizing Hinduism and by conflating tradition with superstition, rural life with social backwardness, and belief with obscurantism—that same elite felt directly threatened by the sacrifice of a young woman whose level of education and social background linked her to an economically emerging social group. Kanvar's death could only trigger a defensive reaction because it demonstrated that the line of demarcation between barbarism and civilization, upon which the edifice of what Nandy has called "a new form of internal colonialism" (Hawley 1994) had been built, had proved very easy to cross.

Nearly nothing is known of sati's origin or of its spread across the Indian territory and social strata during the first millennium of the common era. The general opinion is that sati was originally only performed in Ksatriya milieus—by the women of kings, warriors, and persons who had died a heroic death—and that it was eventually adopted by other status groups of society in the course of the second millennium C.E. as the result of a change of soteriology; this is, for example, the position of the Indian historian Romila Thapar. Many invoke the well-known process of Sanskritization, as theorized by Indian anthropologist M. N. Srinivas in the 1950s, to account for this imitation of the royal model. It is true that the first accounts experts have—Greek sources from Alexander's time (Onesicritus and Aristobulos)—describe the competition between the wives of the warlord Keteus to burn themselves alive on their husband's funeral pyre. It is also true that widow-burning became, from the seventh century onward, a common feature and thus an emblematic caste-identity marker among the same Rajputs who claim to be the Ksatriyas, the "warrior caste," of modern India. However, this is hardly sufficient ground for claiming that this custom was originally the exclusive prerogative of the martial castes, especially when numerous early accounts, both textual and epigraphical, of other groups—from Brahmans at the top of the hierarchical scale down to middle, low, and even impure castes—practicing widow-burning.

Another problematic issue is the prevalence of widow-burning in those regions of India in which "Shakta" Tantrism has been the dominant form of religious belief and practice since as early as the ninth century C.E. It is in an area comprising the



This stone memorial in Jodhpur, Rajasthan, India, marks the location where several women committed sati. Leaving home for their funeral pyre, women dipped their hands in red pigment and left a symbolic mark of devotion and loyalty to their deceased husbands. BRIAN A. VIKANDER/CORBIS

modern states of Bengal, Orissa, Rajasthan, Gujarat, Madhya Pradesh, Karnataka, and Tamilnadu that are found at village boundaries memorial-hero and sati stones, sometimes stretching like vast funeral grounds as far as the eye can see. The presence of such memorials is actually the only means specialists have for approximately mapping sati, both geographically and historically. The overlap between Shakta devotionism and the spread of widow sacrifice raises a particularly difficult question for Indologists insofar as Shakta Tantra—with its transgression and reversal of the fundamental values of orthodox Hinduism—gives primacy to the female aspect of the godhead, the well-known Shakti of which Tantric practitioners and believers are worshippers—whence the term *Shakta*. Because, according to this religious system, every

woman is essentially the Goddess incarnate, and her female energy the source of life and salvation, it seems difficult at first to reconcile this worldview and ethos with the practice of widow-burning.

But the first question that arises with regard to widow-burning, a question that casts its long shadow across the entire field of its historiography, is that of knowing whether these immolations were voluntary acts or whether, on the contrary, women were forced to burn themselves—whether their immediate circle (family, priesthood, caste) and the dominant religious ideology they embraced did not force them, at the time of their declaration of intent and a fortiori in their hour of death, to mount the funeral pyre. This crucial element of the mystery of widow-burning is all the more intriguing inasmuch as the historical data provide as much evidence for the one hypothesis as for the other. According to the view one chooses to adopt, one will interpret widow-burning as a form of suicide, as a sacrifice, or as murder—a murder made all the more odious by the fact that it is also a matricide because it is the closest male relative of the deceased, the son, who lights the pyre on which his mother will be burned alive. When viewed as a murder, sati also takes on the dimensions of a collective homicide, being that thousands of men and women attend such events, and because the responsibility of the society as a whole is deeply implicated in it. At the opposite end of the spectrum, those Hindus who believe in “satihood” will view the ritual as a supreme act of selfless devotion and a manifestation of female sacredness, the sati literally becoming Shakti incarnate at her time of death and her burning a magical phenomenon of yogic self-combustion. In this perspective, her self-immolation is a sacrifice that, according to the Hindu belief system, entails no violence to the consenting victim.

Down to the present day, it is the dire fate of Indian widows in India that is invoked as the primary reason for existence of sati. Although widow remarriage has been authorized by law since as early as 1856, it was and still is rarely resorted to among higher or middle castes, or among groups that follow a strategy of embracing high-caste values and practices to collectively uplift themselves in the social hierarchy. An object of universal repugnance, the widow is required to lead a life of asceticism and self-mortification. In the higher castes, her head is shaved, and she is deprived of

every finery, every pleasure, and every comfort. Because she is the bearer of misfortune and impurity, she is excluded from domestic festivities, and even from the wedding of her own children. Her existence is but a monotonous succession of fasts, religious observances, and devotional practices.

It can, however, become a veritable trial, given the fact that the hatred and resentment of her in-laws, legitimized by the belief that the widow has “eaten” her husband—caused his death through her misconduct in previous births or in this life—knows no limits. She is subject to humiliation, insult, and abuse. She can be thrown out into the streets and, if her own family refuses to take her back, have no other recourse than to join a widows’ ashram at such holy sites as Vrindavan in Uttar Pradesh, or to make good on her reputation as a *whore*—a commonplace term of abuse for widows. The young widow is especially execrated, since it is judged that her unhappy fate is the result of abominable sins committed in a past life. Early widowhood was widespread in a society where life expectancy was notably low and where child marriage was common among certain castes and in certain regions until it was outlawed (the custom still persists in some rural areas of Rajasthan). So it is that a number of cases of women who committed sati before reaching puberty have come down to us, such as that reported in the late-seventeenth-century account of the French traveler François Bernier, who witnessed the burning of a twelve-year-old widow from Lahore who trembled and wept so vigorously that she had to be bound to finish the matter.

In sharp contrast to the miserable plight that would otherwise have befallen her, the bright prospect of the glory awaiting the woman who commits sati might have been a strong incentive to newly widowed Indian women; this was at least a widely shared idea. Not only was the sati ensured that her sacrifice—in which she would experience no pain—would bring her eternal bliss with her husband in the beyond, she was also persuaded that she would redeem the sins of seven generations in her father’s, mother’s, and in-laws’ lineages, and never be born again into the “impure” female sex. In castes and milieus where sati had become the ultimate criterion of a woman’s “wifely duty” and an icon of caste purity (and thereby, status), not only would family members, Brahman

priests, and bards insist that the widow take the solemn vow to burn herself, but tradition at large—as represented by myths, literature, hagiography, and rituals in which satis were worshiped as deities—and, of late, propaganda and political and caste-based activism, left her little chance to escape her fate.

Once the sati declared her intention to follow her husband in death she had to burn herself, even if the Hindu legal treatises that sanctioned this highly controversial practice allowed her to retract. Very often, the would-be sati would have to prove her resolution by enduring a preliminary ordeal, such as burning her finger in a candle flame without showing any sign of pain. This would be taken as proof of her possession by “sat”—by the essence of her being in her role as the perfect wife, a sati—a supernatural power that enabled her to heal, protect, and foretell the future; to curse and bring misfortune on her community or in-laws; as well as to produce wonders and miracles, such as the lighting of her own pyre. The utterance of the deadly vow set in motion a process of mythification, and in certain cases of deification, that reached its climax in the burning itself, a sacred event for believers, granting merit to family, performers, and onlookers alike. One may further surmise, on the basis of a number of indications, that the sati no longer perceived herself as a flesh-and-blood woman but rather as some sort of deity at the very least, a Shakti in the making. In demonstrable cases in which no violence was used, this process of objectification within the sati herself might explain, at least in part, how burning oneself alive—an act which continues to be repressed in the recesses of the unthinkable—could actually form a part of human experience.

See also: CREMATION; GENDER AND DEATH; WIDOWS IN THIRD WORLD NATIONS

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CATHERINE WEINBERGER-THOMAS

WIDOWERS

Although the death of a spouse is more common for women than for men, a man’s chance of becoming a widower increases as he ages. According to the U.S. Census Bureau in 2001, approximately 3 percent of the men capable of marriage are widowed compared to 12 percent of the women.

These proportions increase dramatically, however, among those sixty-five years of age and older (14% men versus 45% women) and even more so among those aged eighty-five and older where 43 percent of the men are widowers (compared to 80% of the women).

Often the widower experience is examined in light of similarities and differences between them and their female counterparts. Although there is a natural tendency to draw comparisons between widows and widowers, some features of “widowerhood” are unique and warrant special attention. It is also true that the course of bereavement among widowers is wrought with diversity and variability. The process of adaptation to the loss of their wives is rarely linear and is more aptly described as one of oscillation between good and bad days or even moments within a single day. Some cope more successfully than others who experience greater difficulty; however, there is a plethora of evidence that suggests that many ultimately demonstrate a high degree of resilience as time passes.

Oftentimes widowers’ experiences are affected by a variety of factors, including their age, the relationship with their children, how well they are able to assume new responsibilities, and how much emotional and material support is available from others. Similarly, the loss of a wife can have adverse consequences on the widower’s physical health. This too can vary depending on the widower’s prior health, his lifestyle, and to what extent he possesses the skills he needs to take care of himself. Finally, while many widowers have the resources and skills that enable them to eventually cope and adapt on their own, a significant few turn to more formal sources of help. Widowers’ motivation to seek assistance as well as the effectiveness of that help often is a product of their beliefs and expectations about how a man is to grieve and respond to loss.

What Widowers Experience

While women who lose their husbands often speak of feeling abandoned or deserted, widowers tend to express the loss as one of “dismemberment,” as if they had lost something that kept them organized and whole. The Harvard Bereavement Study, a landmark investigation of spousal loss that took place in the Boston area during the late 1960s, reported that widowers often equated the

death of their wives with the loss of their primary source of protection, support, and comfort. This went to the very core of their overall sense of well-being. It has been described as “being lost without a compass,” usually due to their profound loneliness but also because widowers often depended on their wives for many things like managing the household, caring for their children, and being their only true confidant. This sense of being lost is more profound when widowers need help but have difficulty obtaining or even asking for it. They also can experience ambiguity about the emotions they are feeling and the uncertainty of how to express them.

Emotional response. Similar to widows, bereaved husbands experience an array of emotions, such as anger, shock (especially if the death is unexpected), numbness, denial, and profound sadness. Unlike widows, however, grieving men tend to control their emotions (with the possible exception of anger), for instance, by holding back and crying less openly. Widowers, more often than not, will channel their energy into active coping and problem-solving strategies like work, physical activity, or addressing disruptions in the household. At other times they may prefer to be alone with their thoughts, whether thinking about the circumstances surrounding their wife’s death or reflecting on ways to cope with their new situation.

Widowers who experience the same emotions as widows but were raised with the belief that emotional control is a sign of strength often find themselves confronting an inner conflict about how to respond to a loss. The situation may instinctively call for a response that is emotional but the widower may not be socialized to express himself in that way. Adding to this confusion on the part of the widower is an assumption that there is only one way to grieve. Men usually express their feelings of grief in solitary ways, but this should not be construed as being any less intense than a widow’s grief. At the same time, to a varying degree, some widowers express their emotions more openly than others, suggesting that while some responses may be more typical, any one widower’s experience can be somewhat unique as well.

Mental health issues. Although not entirely conclusive, several studies suggest that widowers can be prone to depression after the death of their wives, especially when they are compared with

their nonbereaved married counterparts. On average, married men are less likely than married women to be depressed. Most epidemiological studies report that marriage tends to be protective for men in terms of depression and other mental health problems, largely because a supportive marital relationship buffers them from the negative impact of the stress and strains of everyday life. Bereavement, therefore, is more depressing for many widowers because they, quite simply, have more to lose than widows. This is based on the assumption that a man's spouse is often his primary source of social support. Consequently, although a widower may have been more apt to express his thoughts and feelings to his wife when she was alive, he may be equally unlikely to be so open to others. Widows more frequently use alternative sources of support that can protect them more effectively from potentially adverse effects of the loss and other stressors.

In some studies, many widowers are more recently bereaved than the widows are, most often due to differences in life expectancy and remarriage rates between men and women. Men usually are widowed at a later age and are more likely to die before being bereaved for a long period of time. Younger widowers usually have more opportunities to remarry, whereas widowed women will have fewer options for remarriage and remain widowed longer. Because the most difficult time usually is early in the bereavement process, the widowers who participate in these studies will have had less time than the widows to adjust to the loss and more likely will report being depressed when they are interviewed. Not all research, however, supports the conclusion that widowers suffer more depression than widows. Many of the gender differences regarding depression and other mental health outcomes are largely unexplained and consequently are inconclusive.

The degree of difficulty that widowers face can be dependent on when in their own life the loss occurs. Although not necessarily true of everyone, many widowers whose wives die around the same time that they are retiring from their occupation (or soon thereafter) can be prone to more difficulty. Married couples often have expectations about how they intend to spend their retirement years together. Those expectations can be shattered as newly bereaved widowers suddenly find themselves facing retirement alone, which could be a

source of depression or hopelessness. Conversely, men who are in their preretirement years might adapt more easily. They are typically still employed, could be more socially connected due to ties in the workplace, and might still have children in the home. Of course, these also can be potential sources of difficulty, particularly if relationships with children are strained or if assuming new responsibilities around the household interferes with the widower's effectiveness at work and elsewhere. Conversely, these life circumstances could represent a sense of feeling useful, involved, and being engaged in meaningful activity—all potential constructive coping mechanisms for the widower.

Health and Mortality among Widowers

Much of the research suggests that there is a greater prevalence of mortality and morbidity among the spousal bereaved compared to those who are currently married. Many of these same studies further report that the risk of becoming physically ill or dying soon after the loss of a spouse is greatest for widowers. The fact that men tend to be older when their spouses die could explain some of these findings. Although mortality is less common among younger widowers, the difference between their mortality rates and those of their married counterparts is greater than what is observed among older age groups, especially within the first six months of bereavement.

Why are some widowers at risk for illness and even death? One explanation is that married couples are exposed to the same environmental influences and often pursue similar lifestyles. If any of these have a negative impact on the health of one spouse, resulting in his or her death, a similar outcome could follow for the other. This explanation, however, fails to adequately explain the excess mortality observed among widowers compared to widows because the odds of illness and death would be similar for those whose health is similarly threatened. An alternative explanation involves the role of stress. Some believe that the degree of stress associated with spousal bereavement can suppress the immune system, rendering the bereaved more susceptible to disease and subsequent mortality unless they have adequate support to buffer the unhealthy effects of stress. Consequently, widowers who are unable to benefit from supportive relationships with others after their spouse's death can experience a potential negative

impact on their health. Furthermore, some widowers respond to stress by engaging in unhealthy behaviors like smoking, excessive alcohol consumption, and poor nutrition practices.

The health of widowers can suffer because they lack many of the skills that are important in self-care. Many tasks of daily living that are essential to health and well-being could go unaddressed by widowers if any of them were primarily the responsibility of their deceased wife. These could include meal preparation, shopping for adequate food, housekeeping, doing laundry, among other daily chores, all of which if left unattended for a long period of time are added sources of stress that could have adverse health consequences.

The division of labor concerning these tasks and skills tends to be defined according to gender, particularly among the older generations, but younger widowers often do not fare much better. Although many women participate in the workforce, they still are largely responsible for household management, cooking, and other tasks of daily living important for the care of the entire family. Widowers unskilled in these areas not only could find their health compromised for the reasons stated earlier, but also might feel less confident to meet the daily challenges of widowed life, which detracts from their ability to cope. Alternatively, those who learn to master many of these new responsibilities often cope more effectively and are at lower risk for poor health because they become more autonomous and eventually take better care of themselves.

How Well Widowers Adapt

Although not without its common elements, the process of adaptation to spousal loss can vary from individual to individual. While the most difficult times can be within the first six months to a year, some adapt more quickly whereas a few do not manage well for an extended period of time. Some characteristics, however, are associated with more successful adaptation. These include positive self-esteem, keeping busy with meaningful activity, having adequate opportunity for support and to share one's feelings, and a sense of being in control and confident in one's ability to cope effectively.

These attributes are largely independent of gender. The Harvard Bereavement Study, however, did make a distinction between social and emotional

recovery. The widowers in that study adapted emotionally to the loss at similar pace to the widows, although their strategies may have differed. Alternatively, the men tended to move more quickly toward social recovery—that aspect of adaptation that refers to the need to reorganize one's life. This often was driven by the necessity to balance their role in the workplace with those pertaining to managing a household and caring for children. This was a source of strain for some of them that adversely impacted their effectiveness on the job and they felt compelled to find a way to alleviate it.

This need to reorganize sometimes predisposes widowed men to remarry. Many use remarriage as a way to fulfill their need for companionship and to resume an active sex life. Some, especially those who are younger, also believe remarriage once again provides a partner to help them meet the multiple responsibilities of being a worker, father, and head of household. Whether or not widowers eventually remarry, however, is not necessarily an indicator of how well they coped with the death of their former spouse. It is true that some of those who remarry report lower stress levels and greater life satisfaction, but nearly half of these remarriages dissolve, especially if they occur more quickly after the prior loss. Widowers who do not remarry are equally capable of maintaining meaningful relationships and adapting successfully to their new life.

Like any life transition, becoming a widower is associated with its own set of challenges and tasks that need to be successfully met in order to adapt effectively. At first, this can be highly disruptive, but as widowers have opportunities to learn the skills to meet these new challenges (whether managing a household, tending to their children's needs, assuming new self-care responsibilities, or becoming more comfortable with how they express their emotions), they develop a greater sense of coping ability and feel more confident to meet future challenges. Many bereaved men over time demonstrate a high degree of resilience and some grow personally from the experience. While most manage to accomplish this on their own, however, others require some assistance along the way.

Support Systems

Most bereaved rely on their own personal resources as well as the support of others in their lives for the means to adapt and do not require

more formal assistance. For those experiencing greater difficulty, however, interventions like support groups and one-on-one programs can be effective, especially if accessed early in bereavement. While a small proportion of bereaved spouses in general participate in these programs, widowers as a rule are typically less receptive to them and often shy away from helping situations, at least at first. Consistent with their need to appear in control, especially regarding the display of their emotions, most widowers try to make it on their own even when they can benefit from outside help.

This is not to say that all widowers avoid participating in traditional bereavement interventions like self-help groups. Many, however, are not drawn to what they believe to be counseling interventions because they often perceive them as services designed primarily for women. Widowers are typically uncomfortable with environments where the open expression of emotion is encouraged because it is not consistent with their preferred way to grieve. Instead, researchers and practitioners suggest that bereaved men are more suited to active coping mechanisms that may include being engaged in meaningful activities. Programs that primarily feature such activities could have more appeal to widowers. Group walks and outings, for example, can be just as beneficial as traditional support groups because men who participate are able to interact and support one another in these situations and can do so more comfortably. Because the focus is on activity, however, as opposed to support or counseling itself, it is more consistent with many widowers' coping styles and is consequently less threatening. Because widowers use strategies that tend to be more cognitive than emotional in nature, they do well with books and other educational resources that help them help themselves.

Because of the unique problems widowers have assuming new responsibilities, they can benefit from programs that focus on skill-building and self-care education to help them successfully manage those tasks of daily living important to health, functioning, and independence. Issues of greater concern for widowers might include meal planning and preparation, housekeeping, and doing laundry. These programs can focus as well on more general health promotion topics like stress management, health screenings, immunizations, medication management, and physical activity, to name a few, that are equally relevant to widows

and widowers but often go ignored or neglected by them given their new situation.

Although most bereavement programs have differential appeal to widowers, the benefits of participating vary from widower to widower. Success rate usually depends on the level of difficulty they are experiencing, what resources they already have in place, their needs, and their own unique situation. Interventions are not a panacea and most eventually cope without them. Although the strategies they choose at times might differ, widowers are as likely as widows to cope and eventually adapt to their new lives.

See also: GENDER AND DEATH; GRIEF: ANTICIPATORY, TRAUMATIC; WIDOWS

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WIDOWS

The features shared by all widows are that they are women who have been married and whose husbands have died. Beyond that, there is such a great heterogeneity among widows that there is no way of predicting the lifestyle, support systems, and identity of any one woman. Many factors affect these aspects of widowhood, such as the characteristics of the society and community in which she lives, the personal resources with which she and her husband built their lives, the circumstances of his death, and the personal resources with which she modifies, removes, or adds social roles and social relations to her lifestyle and support systems. What she is and how she lives are highly influenced by her self-concept and the identities she takes on or is given by others in social interaction.

The characteristics of a widowed woman's world that influence her throughout life include the presence or absence of resources for its members and whether and how these are available to women—particularly to women in different marital situations. The resources vary tremendously by society, and are influenced by forms and complexity of social development, by family systems, and by degrees of equality of opportunity to use or refuse resources.

Widowhood in America

In the United States there are great variations in the lives and identities of widowed women based on the geographical and social characteristics of the communities in which they reside, and the social, service, emotional, and economic support these communities provide. Some communities are active in outreach programs; others require initiative

on the part of a member wishing to take advantage of them. An upper-class community provides very different opportunities to its members than a lower class or immigrant community. Ethnic and racial identities contribute their share of uniqueness to working within these support systems. Small towns offer different restrictions and opportunities than large cities for continuing and changing one's lifestyle. Personal resources include the ability to analyze a situation for what is needed or wanted and to reach these resources. Personal resources vary from woman to woman, but generally encompass economic support, personal ability to function, and approach to life, the status of the woman's health, and existing and future social and emotional support networks.

The Demographic Picture

According to the U.S. Census Bureau, there were 199.7 million persons aged 18 and over in the United States in 1999, up from 159.5 million in 1980. In 1999, 95.9 million were men and 103.9 were women, continuing the trend of many decades. Both the number of men and that of women increased by over 20 million between 1980 and 1999. Out of these, 2.5 million men and almost four times as many women were widowed. To a great extent the difficulties of remarriage by widows can be attributed to this disparity. In 1999 only 8.9 percent of the men and 10.5 percent of the women were widowed. Although both white and black widowed women formed around 10.8 percent of the total of women, only 10.8 of the whites but 37.9 percent of the black women never married. Only 6.5 percent of Hispanic women were listed as widows that year.

Only 2 percent of children under 18 years of age were living with a widowed mother in 1998. Eighty-one percent of female-headed households were headed by widows aged 65 or older. While the percentage of widowed men aged 65 and over remained between 13 and 14 percent from 1980 to 1999, the percent of women decreased from 51.2 to 44.9 percent, mainly due to the increase in the proportion of those who were divorced, from 3.4 to 6.8 percent. Divorced men also increased in percentage, but the vast majority remained married. The older age of widowed women is reflected in their lack of educational achievement. Thirty-seven percent of all widows, compared to 16.5 percent of the total American population, never

finished high school and a smaller proportion of the total never finished college or pursued post-graduate education. Many had been full-time homemakers or held only minimum-wage jobs so that their income in widowhood is dependent upon the husband's Social Security. As widowed mothers or older widows, they have the income of a new husband if they remarry, and informal exchanges of goods and services occasionally offer work for pay. However, many studies indicate that widows are not as poor as expected. Most live in metropolitan areas, while farm women move to small towns and those in retirement communities return to hometowns to be close to their children.

Traditional, Transitional, and Modern America

The situation of American widowed women can best be understood through the prism of social change in this society. Many Americans were socialized into varying degrees of the patriarchal systems, in the family and at large. In fact, as the American society became more complex and industrialized, gender segregation became extended from the home to the whole society. The social world became divided into what has been called "separate spheres," the private sphere of the home under the management of women, and the public sphere, worked in and managed by men. The latter sphere included the economic, educational, religious, and political institutions. In order to ensure the separation, a whole ideology of separate gender personalities and abilities was created and incorporated into the socialization of children, occupational, and other areas of life. Men were defined as natural leaders, logical, and able to invent complex systems. Women were defined as compassionate, emotional, and natural caregivers. It was therefore a waste to educate them with the tools needed to function in the public sphere. The two-sphere ideology carried the genders throughout life and obviously influenced marital, parental, and other social roles.

The Role of Wife

The situation of any widow is heavily influenced by her life as a wife and the circumstances by which she becomes widowed. Even in modern America, and with some of the variations noted, social class accounts for main differences in the role of wife.

Lower or working class wives are often tied into family or racial and ethnic networks, affecting relations between husband and wife and affecting members of the social circle associated with that role. This statement is dependent upon a definition of “social role” as a set of mutually interdependent social relations between the person at the center of the role and the social circle of all those from whom he or she acquires rights and to whom he or she has obligations because of being the center of that role. It makes a great deal of difference if a wife’s role includes active participation in her and her husband’s immediate and extended families, her husband’s coworkers and friends, neighbors, and the wider community. The husband’s family may offer rights and demand obligations that can even exceed his mutual exchanges when he was living.

One of the changes between traditional American families and those striving for new, “modern” lifestyles has been the decrease in importance of the husband’s extended family. This means that, although the family has lost much control over the woman’s behavior as both a wife and a mother, it is also less available to provide support. One of the consequences has been an increase in the importance of the woman’s family as a support system. In patriarchal, patrilineal, and patrilocal families the daughter moved away from her family of orientation upon marriage, and therefore the family was unable to both demand and supply support. In modern cases in which the mother-in-law is no longer close, the mother-daughter bond often increases in importance.

There are variations in working-class perceptions of the role of wife by social race. When asked how a wife influences her husband’s job, white women in the Chicago area stated that a wife should avoid nagging her husband, because that can create problems in his behavior at work, but expressed resentment over the authoritarian attitude and abuse by the husband. Conversely, African-American women felt that nagging is necessary or the man will not work consistently or take responsibility for the family.

Middle-class wives of America living before the late nineteenth and early twentieth century, when women began to enter the workforce in large numbers, became highly dependent upon the husband—not only in the role of wife, but in all other social relationships. Men freed from educa-

tional and economic control of their family of orientation acquired the right to co-select their wives and move wherever they found it necessary. They then joined the “greedy institutions” of the occupational world (Coser 1974). This meant that the wife’s residence, the amount of economic resources she had available to her, and the people with whom she was likely to associate all became influenced by the husband’s job and its geographical and financial situation.

There was an interesting difference in how white and African-American middle-class women responded to the question as to the influence of a wife on her husband’s job. The latter were very conscious of the discrimination faced by the man in the outside world and sought to support him at home. Some of the white women stated that they themselves had no influence but that “those women on the North Shore” are influential and that companies insist on interviewing the wife before hiring the man (Lopata 1971, pp. 94–104).

The wife’s obligations to maintain, rather than raise, the family status is even more important in the case of the mid-century upper-class wife. Her background was often similar to her husband’s but she had to make sure that the residence, the children, and her own activities ensured their status within the community. Her voluntary contributions formed a major part of her role of wife, which included making sure that the children went to proper schools and ensuring that her children’s marriages did not pull down the family status. At the same time, all this activity could not interfere with the husband as a person, in his job, and in his own community action. Thus, as much as the middle-class wife, she took on the role of protecting the man from distracting family problems, assisting in status-maintaining behavior, such as the entertainment of important business associates, and sometimes even directly helping with his job in a subsidiary position.

Becoming Widowed

The extent to which the wife in the not-yet-modern times of the mid-twentieth century was dependent upon the husband for economic, locational, and social supports, the family’s position in the community deeply affected what happened when the husband became ill or incapacitate and died. It was hard for a widowed woman to retain the status she

gained vicariously from the husband or to continue activities that maintained her status. She was often dropped from his associations, and lost mutual friends if marriage to him had been the connecting link. Financial losses might require movement into another community, which was difficult for both her and the children. If she had been a homemaker without skills for obtaining a job, her social life may have narrowed. Although the husband's family was not likely to have been very important to her support systems, unless upper class inheritance was significant, their involvement in her network would not likely be expanded after his death. Membership in couple-companionate circles was made difficult by the asymmetry of membership, leaving her often out of the loop, or restricting contact to only wives during the daytime. All these changes affected her role as mother, as the social circle of her children decreased or changed due to all the consequences of the death of the husband/father.

Throughout the twentieth century, there was a great deal of scholarly debate whether sudden or prolonged death is more difficult for survivors. Sudden death leaves a lot of "unfinished business," in that all marriages go through periods of conflict or tension that remain unresolved, and can carry over into widowhood. On the other hand, prolonged death usually requires prolonged care by someone, usually the wife. Relatively few people die in hospitals or long-term care facilities, although most usually spend some time in these. The home caregiver experiences many problems, including heavy work, physical nursing, role conflict when there are children, having to support other relatives, or obligations to jobs. The patient can be very demanding and angry, causing tension in the emotional state of the wife. In addition, it is hard for someone to watch a significant other weaken, be in pain and deteriorate, physically and mentally. Prolonged care can also result in social isolation, as the social life becomes constricted and associates cease to visit and offer support. Estate problems or fear of family members can add conflict difficult to deal with in a time of stress.

Certain types of death and dying are especially difficult for survivors. Suicide is difficult because it is easy for the wife to blame herself for creating problems or not providing sufficient support. Others, especially the husband's family, are likely to blame her. AIDS patients provide additional strains,

due to both the myths and facts of disease transmission. Some forms of dying provide danger to the caregivers or others in the household, resulting in a protective stance by the wife, antagonizing the patient and other family members. Age of both the dying person and the caregiver is allegedly an important factor, partially due to what the scholar Bernice Neugarten defined as "on" or "off" time. According to Neugarten, people live according to a culturally and privately constructed time schedule. One is supposed to be able to experience certain events at specified times. Death in the late twentieth and early twenty-first centuries is supposed to occur when people are older, not in youth or allegedly robust middle age. Each ethnic and other socioculturally socialized group has its own interpretation of what is proper death, reason, time, and circumstance, and these notions all affect the grieving process and the widow's life role.

The situation of the actual death can also create problems for survivors and related people, often associated with the type and form of information received by the others. There are definite norms as to the transmission of such knowledge, to be followed by medical personnel, the police, and family members. Often a male member of the family, such as a son, is first informed with the obligation to pass on the news to others. Some hospitals have a special room in which the family is told of the last minutes of life and any messages from the dying. A particular problem exists when the death is not definite, as in missing in action cases during wars or if the body is not found.

Each culture has its own norms for closing off life with ceremonies of mourning in religious or public centers, cemeteries, or funeral parlors. In fact, the taking over of the ceremonies by funeral directors and staff is a relatively new phenomenon; family and religious leaders have served that function in the past. According to Geoffrey Gorer, death has become almost a pornographic subject, hidden from public view and discussion as much as possible, the ceremonies in countries such as America and England shorn down to the minimum (1967).

However, part of every ceremony surrounding death involves protection of those expected to be most affected, such as the children, parents, or spouse of the deceased. In some cultures with strong extended family ties, mothers are always

honored as the ones who suffer the most, even before the spouse or the children. Funeral cultures assume that the most affected cannot attend to all the arrangements for the funeral and burial, so that someone else takes over. The “role of widow,” in which duties and rights surround the woman with the assistance of circle members, has been narrowed in modern societies into a temporary one. Once it is considered finished, circle members of that role return to their own lives, leaving the widowed woman to work out her “grief work” pretty much on her own. Eric Lindemann, the first psychologist and psychiatrist who devoted himself to an analysis of what the survivors must do to adjust to death, defined this grief work as “emancipation from the bond of the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships” (Lindemann 1944). The death researcher Helena Lopata added a fourth necessary accomplishment: the reconstruction of the self-concept and the widow’s various identities in relationships with others. All of these are complicated processes, worked through in varying ways and time frames.

An initial study of older widows of the 1960s and 1970s found that the more education a woman had and the more middle class a lifestyle she and the husband built while he was well, the more disorganized her life became after his death. This is true mainly because Americans of this social stratum tend to be emotionally and socially in their various social roles mutually interdependent; so, much of the wife’s life depended on the husband as the center of her various roles. Thus, not only the role of wife, but other roles such as mother, member of both sides of extended families, friend, and neighbor experienced changes that had to be worked out in new ways. On the other hand, the more the woman had these multiple roles the more personal, especially individual, resources she had to reconstruct her whole self-concept, lifestyle, and social relations.

Husband Sanctification

One 1970s study of the role changes and support systems of widows dealt with the tendency of some widows to describe their husbands in highly idealistic terms. Certain parts of the interviews would reflect a marriage that was not perfect, often problematic, with which an idealized description

did not match. In order to address this discrepancy, the research team developed a “sanctification scale” of two parts. The first asked the respondent for degrees of agreement with polar terms such as *warm-cold*, *superior-inferior*, *honest-dishonest*, and *friendly-unfriendly*. The second was a relational segment asking for agreement with such statements as, “Ours was an unusually happy home” and “My husband was an unusually good man.” The final statement of this scale was, “My husband had no irritating habits.” There was great variation in the scores on the sanctification scale. Women who had a hard time in life, especially those people uneducated and living in poverty, tended to answer with extremes. People belonging to ethnic groups that sanctioned “speaking no evil of the dead” scored high. Those who defined life as hard scored low. Highly educated women would not agree with the final statement, nor did most married women upon whom the scale was pretested.

The process of sanctification performs several important functions for the widow. It removes the dead husband from current life into the safety of sainthood, and thus from watchfulness and the ability to criticize. Besides, if such a saintly man was married to her, then she must not be as bad as her depressive moments indicate. On the other hand, it has some negative effects. It can antagonize friends with living husbands who definitely have irritating habits. It can also discourage potential male companions who cannot possibly compete with the memory of such a saintly man.

Modern Identities and Self-Concepts

The need to reconstruct the self-concept and the identities given off or imposed by others is a complicated process that often lasts a long time. These concepts must be defined. For the purpose of this entry, identities are seen as those images of the person as she presents the self or as others see her.

According to the scholar Morris Rosenberg, a self-concept is “the totality of the individual’s thoughts and feelings having reference to himself [sic] as an object” (Rosenberg 1979, pp. 7–8). There is obviously a strong interconnection between identities, as used in social interaction and the self-concept. When life situations change, both of these aspects of the self must be reconstructed. Some identities are carried throughout life and influence one’s roles. The self and others use comparisons of

how that person behaves and is treated in that role in contrast to others. The person also evaluates the self and all these evaluations and interactions influence the self-concept.

Gender identities are pervasive throughout life, sex determined by others at birth and socialization is aimed at forming and maintaining appropriate gender. The same is true of social race as defined in American society. Other identities such as religion, ethnicity, occupation, community, and organization are acquired at different stages of life, voluntarily or by others. Finally, many identities arise out of special events, such as graduation or widowhood. Some of these are transformed into social roles, when the person acquires certain characteristics and a social circle from whom rights are granted and to whom obligations are met. In American society, gender—by this definition—is not a social role but a pervasive identity that enters, in more or less significant ways, into various social roles. The feminist and related movements have attempted to prevent gender identity from influencing important social roles, such as physician or astronaut. The traditional and transitional two-sphere ideology is difficult to change so the process of decreasing gender segregation is slow.

In the 1980s the scholar Lynn Lofland concluded that modern society makes the death of significant others, such as a spouse, more difficult than traditional societies, because it has narrowed down the number of persons with whom the self has multiple connecting blocks. Less than a decade later, the scholar Rose Coser argued that modern societies with multiple and complex social structures and relationships free the person, especially women, from dependence upon a small circle of associates who insist on obedience to norms and restrict opportunities to develop multidimensional life spaces. According to this perception of social change, American society is increasingly modern, in that opportunities for educational and occupational involvement have expanded, not for everyone, but definitely for many women. Although the basic responsibility for the home and children still falls on women, husbands and increasing segments of society are willing to open resources making women less dependent upon spouses for economic and social life spaces. This means that widowhood is no longer faced by women whose whole lives were limited to the home and children, but by women



Visiting the cemetery on Veterans' Day, a war widow polishes the marble of her husband's gravestone. JOSEPH SOHM, CHROMOSOHM INC./CORBIS

who have developed other abilities and broader social life spaces, enabling the reconstruction of self and life in new ways once the period of heavy grief has waned.

At the same time, if one follows Lofland's argument, individualization and the expansion of the variety of people available for interaction and social roles has been accompanied by the reduction of the number of persons with whom close, intimate building blocks and threads of connectedness of human attachment are developed. This increases the significance of each person who becomes close. Lofland concluded that grief is harder in the modern Western world when one of these few persons dies. This is particularly true if that person is a spouse. According to Peter Berger and Hansfried Kellner, marriage among middle-class couples involves a complex process of self, other, and world reconstruction, carried forth through constant conversation and other forms of interaction. Relations with others must be more or less transformed with couplehood. This means that the death of the partner necessitates another reconstruction, but the process has to be taken alone, with only partial support from others. The significant partner is not there to comment and either accept or critique the changes of the self and the world the widowed woman is trying to accomplish. The self as a wife exists only in memory and the future self planned before the illness and/or death is not possible. The present may be lonely and beset with other problems, such as shortage of finances, the grief of the children, and other challenges with which the widow may not be able to

cope. Friends and relations may start making demands as soon as the role of widow has withered.

The various forms and components of loneliness expressed by women in several of Lopata's studies accentuate the problems of self and world reconstruction. The widow can miss that particular person with whom a unique relationship was formed, having and being a love object, a companion in front of television, a sexual partner, an escort to public events, a partner in couple-companion friendship, someone sharing the household for whom meals and routines are planned, and even just a presence. The widowed woman must also deal with the identities imposed upon her by others. Elizabeth Bankoff's 1990 study of friendship among widows concluded that old friends could become troublesome if they insisted on the widow remaining the same. Many women thoroughly dislike the label "widow," with its traditional implication of an old, helpless woman who is perpetually in weeping grief. They also find it self-demeaning when associates do not consider them worthy of continued interaction. Thus, as the woman tries to change, often in uncertain and conflicting ways, people around her keep thrusting on her identities she may dislike and refuse to accept. The absence of the late husband may necessitate the survivor learning new skills and areas for building self-confidence—from caring for the family automobile to managing her finances.

The process of change in the self-concept is inconsistent and, like grief, has no clear-cut ending, as new situations and roles affect what has been reconstructed and old images remain in live memory. However, many studies have found widows very resilient. They deal with the pain of caring for a dying husband, the shock of the death, the need to learn to live in a world without the deceased, and the need to change relationships and reconstruct a new self-concept and identities.

Family Roles in Widowhood

The role of mother is obviously changed by the death of the children's father, but many factors affect the form and direction of such changes, including the number, gender, and ages of the children, as well as their prior relationship to the father, and the contributions or problems in the support system from the social circle of that role.

The woman may not have complete freedom in relating with her children. Even in the twenty-first century, in-laws may have definite ideas about how the children should be raised, especially if the family is prestigious and inheritance is involved. Ethnic and people of color groups may have definite ideas as to the rights of the husband's family over these children and their mother. The financial situation may influence what she can, or wants, to do with and for them. In the historical past of American society "charitable organizations" often interfered with the mother in the absence of father, sometimes even taking the children away from her, as happened to thousands of New York children sent to the Midwest at the turn of the twentieth century. It was not until 1905 that the society decided that children were best off with the mother and even passed a policy of "mother's pensions," which unfortunately were not available in many states. Amendments to the Social Security Act gave widows with minority children special funds, ending when the offspring reached adulthood. Neighbors, schools, even the police can impinge on the rights of mothers, allegedly guaranteeing safety and proper socialization.

Children can cause work for the mother, but they can also form a major source of support. As mentioned earlier, mother-daughter relationships tend to be closer in America than in some other societies and closer than the mother-son tie. This is particularly true in subcultures with strong gender-segregation norms. As the children and the mother age, role reversal can take place, with the children, and especially one child, taking over some of the household chores, contributing to the family finances, and caring for the parent. These modifications in relationships can be painful, or relatively easy, depending on the kind of bond between parent and child and the behavior and attitudes of others, especially other children. Children might cooperate by providing support, or withdraw, placing the burden on one offspring.

Lopata's studies found that widowed women received little support from their in-laws. One-fourth did not have such living relatives. Only one-third reported that they were helped by in-laws at the time of death, and only about one-third of the in-laws said that they visited the widow or invited her over. Although in-law contact with the children was more frequent, only one-half said that in-laws

gave the children gifts or money. These figures may indicate difficulties in the relationship while the connecting link was still alive, or else that one side or both felt the contact need not be continued. Widows reported that the grandparents were not active in the family. Of course, most of the widows in Lopata's studies were fifty years or older and the children were not of a dependent age.

The two Lopata studies came to one conclusion concerning the contribution of siblings questioned by the scholars Anne Martin Matthews and Shirley O'Briant. Respondents in Lopata's support systems study were given three chances to report someone as contributing to 65 different economic, service, social, and emotional supports, for a total of 195 possible listings. Only 20 percent had no living sibling, but relatively few even mentioned a sister or brother. For example, the highest percent of listings, only 14 percent, was made in response to siblings as givers of food, and 10 percent to siblings who help with rent or with decision making, perform housekeeping or sickness care, function as companions in holiday celebrations, or act as the person to whom they would turn in times of crisis. Twenty percent indicated that they helped a sibling with work outdoors, the highest of service supports. If a sibling appears in one support she (it is usually a sister) appears in several. Martin Matthews studied widows in Guelph, Ontario, which has a low mobility rate and O'Briant in Columbus, Ohio, in which mainly one sibling was active. Chicago is a large city, with high mobility and family dispersal, which may account for the relative absence of siblings in those support systems.

Other relatives do not appear often, especially in the lives of older widows, mainly because of their unavailability. This varies among the studies of various populations. However, more African-American than white widowed grandmothers took care of and even mothered their grandchildren. "Black grandparents were much more likely to take on a parent-like role with their grandchildren. . . . These grandparents saw themselves as protectors of the family, bulwarks against the forces of separation, divorce, drugs, crime—all the ills low-income black youth can fall pray [sic] to" (Cherlin and Furstenberg 1986, pp. 127–128). Lopata and Jessyna McDonald, who studied African-American families in Detroit, Indianapolis, Los Angeles, and Washington, D.C., in 1987, found many widows

living alone. One difference between white and African-American families was the fluidity of housing arrangements. African-American women may have children, grandchildren, even siblings and more distant relatives moving in and out, or she may move into their households more frequently than white women.

Women and Men Friends: Membership in the Community

Many widowed women, especially of the middle class, reported problems with married friends. Social events, whether at homes or in public places, tend to be built around friendships with couples. Respondents complained that they heard about dinner parties to which they were not invited. Some widows explained it in terms of jealousy of married friends who did not want an extra woman around their husband, or having a "fifth wheel" present (Lopata 1973, p. 151). More agreed that married friends were jealous of them than that the husbands actually propositioned. Such advances, if they happened, were met with anger. The widows often wanted male companionship, but not a sexual affair with a husband of a friend, endangering the other relationship. Also, many moved after the death of the husband and were located inconveniently to former friends. Bankoff reported that old friends were helpful only early in widowhood. New friends, on the other hand, accepted the widows as they were.

Close relations with men can become a problem for widowed women. Many simply do not want to enter into such interaction, and definitely not to remarry. They like freedom from prior constraints, do not want to take care of another sick man, and fear objections from children. Offspring often do not approve of such changes because of idealization of the father or inheritance concerns. In addition, of course, there is the ever-present knowledge of the statistical scarcity of available men the same age of most widows. Living men are either married or in poor health. Sexual relations themselves may be feared, with concern over physical appearance and experiencing emotions or difficulties of physical contact. Some widows do enter cohabitation arrangements, on either a part- or full-time basis, either in home or away. For the most part, widows who remarry desire such a relationship, lack inhibiting influences, are attracted

to a specific individual, and feel that they can gain from the relationship, whether economically or from a parenting perspective. Walter McKaine's *Retirement Marriage* (1969) found conservative attitudes among "remarrieds," many of whom had ethnic backgrounds in which marriage rather than personal independence was very important. He notes that success in these marriages involves affection and respect.

American society has created many organizations whose membership is open to participants. Some of these are focused on providing resources, advice, companionship, or social events to the elderly, and some to the widowed. The American Association of Retired People (AARP) has developed the Widow to Widow program and many communities have variations on such themes. Other groups in which marital status is not a known characteristic attract people with special interests. In the past, widows felt like members of a minority group, with myths and prejudices against them, but active life in the twenty-first century appears to diminish these attitudes.

Becoming and being a wife, and then a widowed woman, involves complex processes of self and other reconstruction and changes in relations with different circle members. These are heavily influenced by many factors, such as the characteristics of the society and the communities in which a woman lives, and her personal resources. Becoming a wife involves relating to the husband but also to a whole social circle of the role, its composition, rights, and duties. An important aspect of American society is its patriarchal and related bases, modified by new forms of complex development, including opportunities and restrictions of resources available to all women, wives, and then widows. Personal resources include the ability to analyze and seek out resources at any stage of life. Although widows have gone through the trauma of an ill or suddenly dead husband, grief, loneliness, and the need to reconstruct the self-concept and identities, those who had a multidimensional social life space have been able to build independent, even satisfying lives. Others obtain support systems from families, friends, neighbors, and their community's organizations, with varying degrees of satisfaction. There are unknown numbers of widows in modern American society and its communities who live a very restricted life, but their frequency

appears to be decreasing as societal resources become available not only in widowhood, but throughout life.

See also: CONTINUING BONDS; LOPATA, HELENA Z;
WIDOWERS; WIDOWS IN THIRD WORLD NATIONS

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HELENA ZNANIECKA LOPATA

WIDOWS IN THIRD WORLD NATIONS

In many traditional communities of developing countries (especially on the Indian subcontinent and in Africa), widowhood represents a "social death" for women. It is not merely that they have lost their husbands, the main breadwinner and supporter of their children, but widowhood robs them of their status and consigns them to the very margins of society where they suffer the most extreme forms of discrimination and stigma.

Widows in these regions are generally the poorest of the poor and least protected by the law because their lives are likely to be determined by local, patriarchal interpretations of tradition, custom, and religion. Unmarried women are the property and under the control of their fathers; married women belong to their husbands. Widows are in limbo and no longer have any protector.

Across cultures they become outcasts and are often vulnerable to physical, sexual, and mental abuse. It as if they are in some way responsible for their husband's death and must be made to suffer for this calamity for the remainder of their lives. Indeed, it is not uncommon for a widow—especially in the context of the AIDS pandemic—to be accused of having murdered her husband, for example, by using witchcraft.

The grief that many third world widows experience is not just the sadness of bereavement but the realization of the loss of their position in the family that, in many cases, results in their utter abandonment, destitution, and dishonor.

In some African cultures, death does not end a marriage, and a widow is expected to move into a "levirate" arrangement with her brother-in-law ("the levir") or other male relative or heir nominated by his family. The children conceived are conceived in the name of the dead man. In other ethnic groups she may be "inherited" by the heir. Many widows resist these practices, which are especially repugnant and also life threatening in the context of AIDS and polygamy. Refusal to comply may be answered with physical and sexual violence. While in earlier times such traditional practices effectively guaranteed the widow and her children protection, in recent decades, because of

increasing poverty and the breakup of the extended family, widows discover that there is no protection or support, and, pregnant by the male relative, they find themselves deserted and thrown out of the family homestead for good.

Widowhood has a brutal and irrevocable impact on a widow's children, especially the girl child. Poverty may force widows to withdraw children from school, exposing them to exploitation in child labor, prostitution, early forced child marriage, trafficking, and sale. Often illiterate, ill-equipped for gainful employment, without access to land for food security or adequate shelter, widows and their children suffer ill health and malnutrition, lacking the means to obtain appropriate health care or other forms of support.

However, there is an astonishing ignorance about and lack of public concern for the suffering of widows and their families on the part of governments, the international community, and civil society, and even women's organizations. In spite of four UN World Women's Conferences (Mexico 1975, Copenhagen 1980, Nairobi 1985, and Beijing 1995) and the ratification by many countries of the 1979 UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), widows are barely mentioned in the literature of gender and development, except in the context of aging. Yet the issues of widowhood cut across every one of the twelve critical areas of the 1995 Beijing Platform for Action, covering poverty, violence to women, the girl child, health, education, employment, women and armed conflict, institutional mechanisms, and human rights.

One explanation for the neglect of this vast category of abused women is the assumption that widows are mainly elderly women who are cared for and respected by their extended or joint families. In fact, of course, far from caring for and protecting widows, male relatives are likely to be the perpetrators of the worst forms of widow abuse. If they are young widows, it is imagined that they will be quickly remarried. In fact, millions of widows are very young when their husbands die but may be prevented by custom from remarrying, even if they wish to do so.

But in spite of the numbers involved, little research on widows' status exists (the Indian Census of 1991 revealed 35 million widows, but very little

statistical data has been collected for other developing countries). Despite a mass of anecdotal and narrative information, public policies have not developed to protect widows' rights. Despite the poverty that widows and their children experience, organizations such as the World Bank have not yet focused on this hidden section in populations.

Laws, Customs, Tradition, and Religion

Across cultures, religions, regions, class, and caste, the treatment of widows in many developing countries, but especially in the South Asian subcontinent and in Africa, is harshly discriminatory.

Patriarchal kinship systems, patrilocal marriage (where the bride goes to the husband's location), and patrilineal inheritance (where succession devolves through the male line) shore up the concept that women are "chattels" who cannot inherit and may even be regarded as part of the husband's estate to be inherited themselves (widow inheritance). Where matrilineal kinship systems pertain, inheritance still devolves onto the males, through the widow's brother and his sons.

Disputes over inheritance and access to land for food security are common across the continents of South Asia and Africa. Widows across the spectrum of ethnic groups, faiths, regions, and educational and income position share the traumatic experience of eviction from the family home and the seizing not merely of household property but even intellectual assets such as pension and share certificates, wills, and accident insurance.

"Chasing-off" and "property-grabbing" from widows is the rule rather than the exception in many developing countries. These descriptive terms have been incorporated into the vernacular languages in many countries, and even (e.g., Malawi) used in the official language in new laws making such actions a crime.

The CEDAW or "Women's Convention" and the Beijing Global Platform for Action require governments to enact and enforce new equality inheritance laws. Some governments have indeed legislated to give widows their inheritance rights. But even where new laws exist, little has changed for the majority of widows living in the South Asian subcontinent and in Africa. A raft of cultural, fiscal, and geographical factors obstructs any

real access to the justice system. Widows from many different regions are beginning to recount their experiences of beatings, burnings, rape, and torture by members of their husbands' families, but governments have been slow to respond, their silence and indifference, in a sense, condoning this abuse.

In India, many laws to protect women have been passed since independence. But it is the personal laws of each religious community that govern property rights and widowhood practices. The world knows of the practice of widow-burning (*sati*), but little of the horrors widows suffer within the confines of their relatives' homes, how they are treated by their communities, or their fate when abandoned to the temple towns to survive by begging and chanting prayers. There are approximately 20,000 widows in Vrindavan, the holy city; Varanasi; Mathura; and Haridwar.

Common to both regions are interpretations of religious laws, customs, and traditions at the local level that take precedence over any modern state or international law. Widows in any case, especially the millions of illiterate widows living in rural areas, are mostly ignorant of the legal rights they have.

Mourning and Burial Rites

All human societies have sought ways to make death acceptable and to provide opportunities for expressing grief and showing respect to the dead person. In societies where the status of women is low, the mourning and burial rituals are inherently gendered. Rituals are used to exalt the position of the dead man, and his widow is expected to grieve openly and demonstrate the intensity of her feelings in formalized ways. These rituals, prevalent in India as well as among many ethnic groups in Africa, aim at exalting the status of the deceased husband, and they often incorporate the most humiliating, degrading, and life-threatening practices, which effectively punish her for her husband's death.

For example, in Nigeria specifically (but similar customs exist in other parts of Africa), a widow may be forced to have sex with her husband's brothers, "the first stranger she meets on the road," or some other designated male. This "ritual cleansing by sex" is thought to exorcise the evil spirits associated with death, and if the widow resists this ordeal,

it is believed that her children will suffer harm. In the context of AIDS and polygamy, this "ritual cleansing" is not merely repugnant but also dangerous. The widow may be forced to drink the water that the corpse has been washed in; be confined indoors for up to a year; be prohibited from washing, even if she is menstruating, for several months; be forced to sit naked on a mat and to ritually cry and scream at specific times of the day and night. Many customs causes serious health hazards. The lack of hygiene results in scabies and other skin diseases; those who are not allowed to wash their hands and who are made to eat from dirty, cracked plates may fall victim to gastroenteritis and typhoid. Widows who have to wait to be fed by others become malnourished because the food is poorly prepared.

In both India and Africa, there is much emphasis on dress and lifestyles. Higher-caste Hindu widows must not oil their hair, eat spicy food, or wear bangles, flowers, or the "kumkum" (the red disc on the forehead that is the badge of marriage). Across the cultures, widows are made to look unattractive and unkempt. The ban on spicy foods has its origins in the belief that hot flavors make a widow more lustful. Yet it is widows who are often victims of rape, and many of the vernacular words for "widow" in India and Bangladesh are pejorative and mean "prostitute," "witch," or "sorceress." The terrible stigma and shame of widowhood produces severe depression in millions of women, and sometimes suicide.

Widowhood in the Context of AIDS

AIDS has resulted in a huge increase in widows, especially in sub-Saharan Africa. For sociological and biological reasons, women are twice as likely to contract HIV through vaginal intercourse as men. In southern Africa, the rates of infection for young women between ten and twenty-four years old are up to five times higher than for young men. This is significant for widows for a number of reasons. In addition to the normal social practice of older men marrying far younger women that prevails in some communities, there is a belief, held by many men, that having sex with a young girl or virgin will cure men of their HIV infection or protect them from future exposure. Anecdotal evidence suggests that this myth has significantly increased the incidence of child marriage and child rape. Such early marriage does not bring security

but serious risk and vulnerability to infection. Married thirteen- to nineteen-year-old women in Uganda are twice as likely to be HIV-positive as their single contemporaries. These child brides quickly become child widows bearing all the stigma of widowhood, the problems compounded by their youth and helplessness.

Widows whose husbands have died of AIDS are frequently blamed for their deaths because of promiscuity, whereas, in the majority of cases, it is the men who have enjoyed multiple sex partners but return home to be nursed when they fall ill. These widows may or may not be aware of their sero-positive (infected with the HIV/AIDS virus) status and may reject being tested, fearing the consequences of a positive result, which, with no access to modern drugs, can amount to a death sentence. Besides, the dying husband's health care will, in most cases, have used up all available financial resources so that the widow is unable to buy even the basic medicines or nutritious food needed to relieve her condition.

AIDS widows, accused of murder and witchcraft, may be hounded from their homes and subject to the most extreme forms of violence. A Help Age International Report from Tanzania revealed that some 500 older women, mostly widowed in the context of AIDS, were stoned to death or deliberately killed in 2000.

The poverty of AIDS widows, their isolation and marginalization, impels them to adopt high-risk coping strategies for survival, including prostitution, which spreads HIV. In the struggle against poverty, the abandonment of female children to early marriage, child sex work, or sale for domestic service is common because the girl, destined to marry "away" at some point in her life, has no economic value to her mother.

But widows are not exclusively victims—millions of surviving AIDS widows, especially the grandmothers, make exceptional but unacknowledged contributions to society through child care, care of orphans, agricultural work, and sustaining the community.

The international community, and especially the UN agencies such as WHO and UNAIDS, need to address the impact of AIDS on widowhood. So far, epidemiological studies have ignored them,



Widows comprise the majority of the poor who beg on the streets of Afghanistan's capital, Kabul. AFP/CORBIS

and one can only rely on a few small localized studies, mainly from Africa, to understand the consequences and options for millions of women and their children.

Widowhood through Armed Conflict and Ethnic Cleansing

Sudden, cruel bereavement through war, armed conflict, and ethnic cleansing is the shared trauma of hundreds of thousands of women across the globe. Widowhood is always an ordeal for women, but for war widows the situation is infinitely worse. Widows from Afghanistan, Mozambique, Angola, Somalia, Cambodia, Vietnam, Uganda, Rwanda, Sierra Leone, Bosnia, Kosovo, Sri Lanka, East Timor, Guatemala—old women and young mothers—provide testimonies of brutalities, rapes, homelessness, terror, and severe psychological damage.

There are a few actual statistics for individual countries on numbers of widows, but it is estimated that, for example, in Rwanda, following the genocide of 1994, over 70 percent of adult women were widowed. In Mozambique, following the civil war, over 70 percent of children were thought to be dependent on widowed mothers. Widows of

war are often uncared and invisible. Many widows, survivors of ethnic cleansing, have been victims of gang rapes or witnessed the death of husbands, sons, parents, and siblings. They eke out a bleak existence as traumatized, internally displaced persons or languish in sordid refugee camps, having lost not just their bread winner and male protector but also their worldly possessions. In the postconflict period, they remain in danger. To add to their problems, widows who have survived terrible hardships are often abandoned or ostracized by their relatives who refuse to support them. The shame of rape, the competition for scarce resources such as the family land or the shared house, places conflict widows in intense need. They are unable to prove their title to property and typically have no documentation and little expert knowledge about their rights. They bear all the burden of caring for children, orphans, and other surviving elderly and frail relatives without any education or training to find paid work. Widows in third world nations have the potential to play a crucial role in the future of their societies and the development of peace, democracy, and justice, yet their basic needs and their valuable contributions are mostly ignored. Where progress has been made, it is due to widows working together in an association.

Widows' Coping Strategies

What do widows do in countries where there is no social security and no pensions, and where the traditional family networks have broken down? If they do not surrender to the demands of male relatives (e.g., "levirate," widow inheritance, remarriage, household slavery, and often degrading and harmful traditional burial rites) and they are illiterate and untrained and without land, their options are few. Often there is no alternative to begging except entering the most exploitative and unregulated areas of informal sector labor, such as domestic service and sex work. Withdrawing children from school, sending them to work as domestic servants or sacrificing them to other areas of exploitative child labor, selling female children to early marriages or abandoning them to the streets, are common survival strategies and will continue to be used until widows can access education and income-generating training for themselves and their dependents.

Looking to the Future: Progress and Change

When widows "band together," organize themselves, make their voices heard, and are represented on decision-making bodies locally, nationally, regionally, and internationally, change will occur. Progress will not be made until widows themselves are the agents of change. Widows' associations must be encouraged and "empowered" to undertake studies profiling their situation and needs. They must be involved in the design of projects and programs and instrumental in monitoring the implementation and effectiveness of new reform legislation to give them property, land, and inheritance rights; protect them from violence; and give them opportunities for training and employment.

Widows at last have an international advocacy organization. In 1996, following a workshop at the Beijing Fourth World Women's Conference, Empowering Widows in Development (EWD) was established. This nongovernmental international organization has ECOSOC consultative status with the United Nations and is a charity registered in the United Kingdom and the United States. It is an umbrella group for more than fifty grass-roots organizations of widows in South Asia, Africa, Eastern Europe, and East Asia and its membership is constantly growing. EWD is focusing on the plight of millions of widows in Afghanistan—Afghan widows in refugee camps. An offshoot of EWD, Widows For Peace and Reconstruction, was set up in August, 2001 to represent the special needs of war widows and to ensure that their voices are heard in post-conflict peace building.

In February 2001 EWD held its first international conference, "Widows Without Rights," in London; participants, widows' groups, and their lawyers came from some fifteen different countries. EWD represents widows at UN meetings, such as the UN Commission on the Status of Women, and is a consultant to various UN agencies on issues of widowhood. At last, widows are becoming visible, and their groups, both grass roots and national, are beginning to have some influence within their countries.

However, much more work is needed to build up the capacity of widows' groups and to educate the United Nations, civil society, governments, and institutions, including the judiciary and the legal profession, on the importance of protecting the

human rights of widows and their children in all countries, whether they are at peace or in conflict.

See also: GENDER AND DEATH; WIDOWERS; WIDOWS

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MARGARET OWEN

WILLS AND INHERITANCE

Wills are an important means of assuring that a deceased person's property, or estate, will pass to his or her intended recipients. In addition to distributing property, a will is also useful for leaving a public record of ownership of real estate, for appointing guardians of the deceased's minor children, and for designating a personal representative, or executor, to administer the management of the estate until the deceased's debts, taxes, and administrative expenses have been paid and the remaining property has been distributed to the appropriate parties. A person who leaves a valid will is said to die "testate." To the extent that a person dies without a valid will that effectively disposes of all the

property owned at death, the person dies "intestate," and the law will determine the deceased's heirs for the purpose of distributing property.

In general, the laws of the state where the deceased lived at the time of death will govern disposition of personal property, although the state where real estate is located controls distribution of that property. Absent a will, state law also will govern the selection of a guardian for minor children and a personal representative of the intestate's estate. Both will and intestacy proceedings are supervised by a court in an administrative process known as probate; the tax consequences of testacy and intestacy are the same.

Although the intestacy statutes vary considerably among the states, there are some common features. In all states, a surviving spouse is an heir, and is entitled to a portion of the estate. If the deceased left children or other descendants, whether biological or adopted, in almost all states those descendants will share with the surviving spouse, or will take the entire estate if the deceased did not leave a surviving spouse. A number of states allocate the entire estate to the surviving spouse if the deceased did not leave surviving descendants, while others require the spouse to share the estate with the deceased's surviving parents and sometimes with the deceased's brothers and sisters and their descendants. When a person leaves no surviving spouse or descendants, the deceased's ancestors and their surviving relatives are designated as heirs. Relatives more closely related to the deceased are generally preferred to those who are more distant. In many states, heirship extends no further than the level of the deceased's grandparents and their descendants; if there are no relatives within those categories, the property is said to "escheat," or pass to the state.

The primary purpose of a will is to alter the intestate distribution of the deceased's property and allow the deceased, or testator, to designate who will take the estate. Through a will, a testator may leave gifts to charities or organizations and individuals (although not to animals), and is not limited to family members. Most states require that a testator be at least eighteen years old and of "sound mind." A will may be challenged, or contested, by those who would benefit if the will were invalid because of the testator's lack of mental capacity, fraud, influence by another party, or other

circumstance indicating that the document does not represent the testator's true intentions.

Usually wills must be written and properly witnessed by at least two people, according to the individual state's formalities. While all states recognize properly executed formal wills, about half the states also allow "holographic wills," which require no witnesses but must be written entirely or in substantial part in the testator's own handwriting. Because the requirements for holographic wills also vary from one state to another, they pose risks that the handwritten will may be invalid.

Although a properly executed will is a valid legal document, it does not transfer any assets until the testator dies. If an intended recipient predeceases the testator, that gift will fail unless the state has a statute that preserves the gift for designated substitutes. Similarly, if the testator identified specific items of property to be given to a recipient, the gift generally fails if the testator no longer owned that asset at the time of death.

While a testator may change or revoke a will until death, including amendments made by "codicil," or a partial revision of a will, each change or revocation must be done in a manner that satisfies the statutory formalities. A will may be revoked by physical act as well as a subsequent formal writing, such as a later will, but burnings, mutilations, and other physical acts upon the will must be accompanied by an intention to revoke; otherwise, the will remains legally valid despite its physical destruction. Furthermore, certain changes in circumstances will result in all or a portion of a will being implicitly revoked. Most commonly, divorce revokes a gift to a former spouse.

The laws of most states protect certain family members from disinheritance. Usually these protections apply exclusively to a surviving spouse, but some cover the deceased's children as well. The vast majority of states designate a spousal "elective share" that guarantees a surviving spouse a specified fraction, typically one-third, of the deceased spouse's estate. A spouse who is given less than that share may elect to take the statutory portion, after which the remaining property is distributed to the other will recipients. Furthermore, if the testator's will was drafted prior to marriage to the surviving spouse, the omitted spouse may be entitled to a portion of the deceased's estate. Although a person is not required to leave children

or other descendants anything if children are not specifically mentioned in the will, they may be regarded as unintentionally omitted and entitled to a statutory share. In many states, however, omitted children are not protected unless the last will was executed prior to the child's birth or adoption.

In order to avoid probate, which can be time-consuming and expensive, a person may transfer interests in property during life, while retaining considerable control over and benefit from the property. Such transactions are commonly regarded as "will substitutes," which frequently do not require the same degree of formality as a will but achieve a comparable result. Will substitutes include life insurance policies; payable-on-death designations in documents such as contracts, stock certificates, and bank accounts; joint tenancies with right of survivorship; and living trusts. While these types of instruments usually avoid probate, they typically do not result in tax savings and are frequently ineffective in avoiding a surviving spouse's elective share.

See also: END-OF-LIFE ISSUES; LIVING WILL

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SHERYL SCHEIBLE WOLF

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ZOMBIES

The phenomenon of zombies, the living dead, is one of the most popular aspects of Haitian voodoo that has created a morbid interest and has inspired myriads of movies. Voodoo is more than the sorcery or magic that is portrayed in movies or literature; voodoo is a religion, cult, healing process, and body of magical practice.

In voodoo practice, the *Bokor* is a sorcerer who uses evil forces to bewitch, and he can change a human being into a zombie. Essentially every *Hougan*, who is at the same time a voodoo priest, a doctor, and the intermediary between the community and the spirit world, is more or less a Bokor. In fact, the major difference between a Hougan and a Bokor is the nature of the bewitchment he or she performs.

To better understand the concept of zombies, one must first understand the Haitian conception of the duality of the soul. The *n'âmm* (soul) is principally divided into two distinctive parts: the *gro bonanj* ("big guardian angel") and the *ti bonanj* ("little guardian angel"). The *gro bonanj*, which represents the consciousness and the personality, is a spiritual substance connected with the world of living. When the individual passes away, the *gro bonanj* survives and joins the world of *lwa* (spirit) to eventually become a *lwa* himself. The second part of the soul, the *ti bonanj*, is the conscience or the spiritual energy of the person. This corresponds to the individuality of each human being and also corresponds to the individual will.

The most popular and well-documented hypothesis concerning how a person is changed into a zombie state is that of poison. The Bokor "work of the left hand" possesses the knowledge to constitute a powerful poison with a mixture of venom like tetrodotoxine, which is found in several puffer fishes. The victims sink into a state of catalepsy and passes for dead; however, it seems that the person is still aware of what occurs around him or her. The person is then buried alive.

At night the Bokor comes to help the person get out of the grave and captures the *ti bonanj*. He then administers an antidote that enslaves him. The Bokor can use the services of the zombie to carry out work in the fields or he can sell or rent his slave's services. This kind of zombie is the soulless body and the victim is "deprived of will, memory, and consciousness, speaks with a nasal voice and is recognized chiefly by dull, glazed eyes and an absent air" (Ackerman 1991, p. 474). The ethnobotanist Wade Davis suggests that zombie laborers were created to install order against antisocial individuals.

There exists a type of zombie of the soul, a disembodied soul of a dead person. In this case, the sorcerer uses the *gro bonanj* or the *ti bonanj* of the victims for magical purposes. The soul may belong to an individual who died in an accident or the sorcerer may use the soul of a sterile woman or even a soul that has been captured by a magical process and is enslaved. In any case, the soul must be stored in a bottle or jar and then the Bokor can either use it or sell it.

Whether myth or reality, zombies inspire an intense fear among the peasant Haitian population. The terror that is engendered by zombies is not the fear that they can be evil, but the fear that one might become one of them. In Haiti, a country that has known a long period of slavery with the Spanish and French colonizations until their independence in 1804, the fear of becoming enslaved has remained a part of their collective consciousness. The fear of being changed into a slave for the rest of one's life is a fear of being constrained to live without individuality, will, and conscience.

See also: BURIED ALIVE; PERSISTENT VEGETATIVE STATE; VODOO

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GENEVIÈVE GARNEAU

ZOROASTRIANISM

The phenomenon of death, or nonlife as it is called in the Zoroastrian holy scripture the *Gathas*, is a concept accompanying the advent of creation. At the dawn of creation, twin primal spirits manifested themselves. They were spontaneously active and through encounter with each other established life and nonlife. So it shall be until the end of the world. These two primal spirits, Good (*Vahyo*) and Bad (*Akem*), are opposed in thought, word, and deed. No coexistence between them is possible. This constitutes the concepts of cosmic/moral dualism in Zoroastrianism. In his spiritual vision, Zarathushtra also conceived of two kinds of existence and consequently two worlds (*Abva*): the spiritual (*Manbaya*) and corporeal (*Astavat*).

In the seventh century, after the Arab invasion of Iran and in order to avoid persecution, a significant number of Zoroastrians migrated to India where they became known as "Parsees." Although Iran and India continue to be the main strongholds of Zoroastrians, in the nineteenth and twentieth centuries many migrated and are scattered throughout North America, Europe, and Australia. These

Zoroastrians continue to preserve and practice their religion; however, expediency has compelled them to adapt certain practices and rituals, particularly those related to death and disposal of the corpse, to the requirement of their adopted country of residence.

Zoroastrianism is based on seven main precepts: (1) theological monotheism; (2) moral/cosmic dualism; (3) prevalence of the eternal law of truth; (4) existence of the bounteous good spirit; (5) operation of the law of consequences; (6) immortality of the soul or afterlife; and (7) final triumph of good over evil.

Zarathushtra designates the universal supreme creator, who is transcendent, immanent, and a-personal, Ahura Mazda (literally, "the lord of life and wisdom"). Ahura Mazda is defined by six cardinal attributes: (1) sublime wisdom (*Vabishhta Manab*); (2) truth, justice, and righteousness (*Asha Vabishhta*); (3) boundless constructive power (*Khsbatra Vairya*); (4) universal love, tranquility, and peace (*Spenta Armaity*); (5) wholeness and perfection (*Haurvatat*); and (6) immortality (*Ameretat*). Ahura Mazda is described in the *Gathas* as the giver (*Datar*) and the shaper (*Tasba*). Thus He (although in the *Gathas* the pronoun referring to Ahura Mazda is gender neutral) has not created the world, *ex nihilo*, but from His own existence. The Bounteous Good Spirit (*Spenta Mainyu*) that is in Ahura Mazda unfolds His immanence in its fullness, in His creation. Thus there is a unity of existence in Zoroastrianism. The teachings of Ahura Mazda, revealed to Zarathushtra, appear in the *Gathas* as holy hymns or mantra (*Manthra*), meaning thought-provoking words.

Immortality of the Soul

The *Gathas* describes the main constituents of a human being as body (*Tanu*) and soul (*Urvan*), which live for only a limited time in the world. At the time of death, the body transforms (or perishes) and the soul goes on to live its second existence. Death has always been an enigma. From extant unearthed records, the Egyptians were perhaps the first civilized people to conjecture that after death, human beings existed somewhere and somehow. However, there is consensus that Zarathushtra was the first to introduce the idea of an afterlife that was based on morality, with rewards for the good and suffering for the evil. In the

biblical period the Jews believed that the dead would continue to exist in a shadowy form in *sheol*, the abyss of the earth. After their liberation from captivity by Cyrus the Great in Babylon and their contact with Zoroastrians, the Jews gradually adopted the eschatological divine plan of salvation. This concept eventually appeared in Christianity and Islam.

Eastern religions differ drastically from Zoroastrianism in their notion of life after death. They generally believe in rebirth as a corollary of *karma*. So long as the karmic force (ignorance, desire, and attachment), which is the root cause of life, exists, the life process continues. Cessation of the life stream constitutes the ideal, at which point the purified self is nirvanized and immortalized. Immortalization means the merger into cosmic *nirvana*. In this sense, nonlife is eternal.

According to Zoroastrianism, Ahura Mazda first created the spiritual world. In His wisdom, He then created the corporeal world to manifest the spiritual world. Ahura Mazda created the universe in His Sublime Mind, shaped it in His Conscience (*Daena*), manifested it through His Benevolent Spirit, and set it into motion in accordance with the Eternal Law of Asha. He created human beings in his own spiritual image as His coworkers and friends and sparked them with God-like attributes to assist them in achieving self-realization, perfection, and immortality. He also granted them with faculties to discern between right and wrong in order to work for the progress of humanity and the advancement of the world. These faculties are the mind (*Manab*) or the ability to reason and think logically, the conscience (*Daena*), and intuition (*Baoda*).

Ahura Mazda vouchsafed human beings with freedom of choice, His greatest and most significant gift. Hence individuals have the right to choose between Good and Bad. In his justice, Ahura Mazda forewarned individuals of the happiness or the suffering that results from their choices, all in accordance with the Law of Asha. Although human beings are endowed with the potential for goodness, in the end the decision between right and wrong and good and evil is the individual's alone. As a result of this right of freedom, the material world did not remain harmonious like the spiritual world.

When life manifested itself, by definition, so did its twin nonlife or death. Similarly, with light came

darkness; with truth, dishonesty; with wisdom came ignorance; and so on. The good creations (i.e., truth, wisdom, health, and peace) are manifestations of the Benevolent Spirit of Ahura Mazda (*Spenta Mainyu*) while their twins are the display of opposition to the Benevolent Spirit. The opposing twins are collectively designated "Evil or Destructive Spirit" (*Angra Mainyu*, or later as *Abriman*).

In Zarathushtra's vision, life and nonlife, truth and lies, light and darkness, all exist and are real, as with two kinds of time: boundless time (*Zrvan Akarana*) and limited time (*Zrvan Daregbo Khvadhata*). In Zarathushtra's view, time and space condition existence in the world within the ambit of the Eternal Law of Asha. The outcome of the ethical struggle between Good and Bad is positive, evolutionary, and optimistic. The Zoroastrian doctrine envisages perpetuation of creation and creativity (the result of dynamism of the Benevolent Spirit) and progressive change (the result of dynamism of the Eternal Law of Asha).

Theodicy: The Origin of Evil

Theodicy, the explanation of the origin of evil without undermining the goodness and omnipotence of God, presents unsolvable problems in many religions. Doctrinal adversaries of the concept of theodicy, however, admit that the Zoroastrian doctrine offers the most rational explanation for the concept of evil. The appearance of evil is an inevitable phenomenon in the process in which the Benevolent Spirit of Goodness manifests itself. Nevertheless, the topic has aroused many debates, and consequently two opposing schools have emerged. One school, believing in moral dualism, considers evil as the creation of individuals who opt to oppose the Benevolent Spirit. In other words, evil is the negation of good and does not exist as an independent eternal force.

The other school, believing in cosmic dualism, maintains that both the Benevolent and the Evil Spirits are primordial. Accordingly, the evil acts of individuals are driven by an evil force and the conflict and clash continues up to the time when Good finally prevails. A subschool, a corollary of moral dualism, maintains that although Evil is no more than the negation of Good, it assumes an independent existence when it manifests itself alongside the Good and starts functioning independently (*Farhang Mehr*). Both cosmic and moral dualists

hold that Good ultimately prevails over Evil and that at that time, the world is renovated or “re-freshed” and characterized by peace and harmony. The two schools also agree that regardless of the origin of evil individuals ultimately decide whether to commit evil and as such will have to requite.

The Principle of Consequences and Divine Judgment

The *Gathas* does not speak of death, but rather of life (*Gaya*) and nonlife (*Aiyaiti*). The body, which is made of matter, may be alive or dead; the soul, however, never dies, experiencing one form of life in this corporeal world and another in the spiritual world. Zoroastrians believe in the survival of the soul after bodily death. The nature of the individual's other life is determined by the Law of Consequences, a corollary of the Law of Asha. The Law of Consequences is generally known as the principle of reward and punishment, whereby righteous acts in the world are rewarded with sustained happiness and evil acts, with misery.

In Zoroastrianism, the Eternal Law of Asha determines the consequences of an individual's acts and the fate of the soul after the individual's physical death. Asha is God's will. The individual's thoughts, words, and deeds in this world, through the exercise of one's free choice, set the consequences (*Mizhdem*) into motion and condition one's life and future according to the Law of Asha. Hence there is no predestined fate; the acts have predestined consequences.

Human beings seek happiness (*Ushta*) in life. Happiness originates in the Law of Asha, which prescribes a life of joy for the pious and eternal woe for the wicked. The *Gathas* warns individuals not to be deceived by ostensible or temporary victories that are illusory, nor to be disheartened by temporary defeats brought about by blows or condemnations from evil ears. In the end, the evil doers will pay for their arrogance and unjust acts.

The Nature of Consequences

The *Gathas* does not specify particulars on the nature of consequences nor does it mention specific rewards or punishment. Life in the hereafter is the continuation of life in the world. In this world, the righteous people (*Ashavan*) create the realm of righteousness (*Ashahya Gaeta*) that continues in the next existence. The concepts are indescribable

in detailed terms, rather the terms refer to the best existence, defined as everlasting joy, tranquility, and peace as against the worst existence, defined as everlasting woe and anxiety.

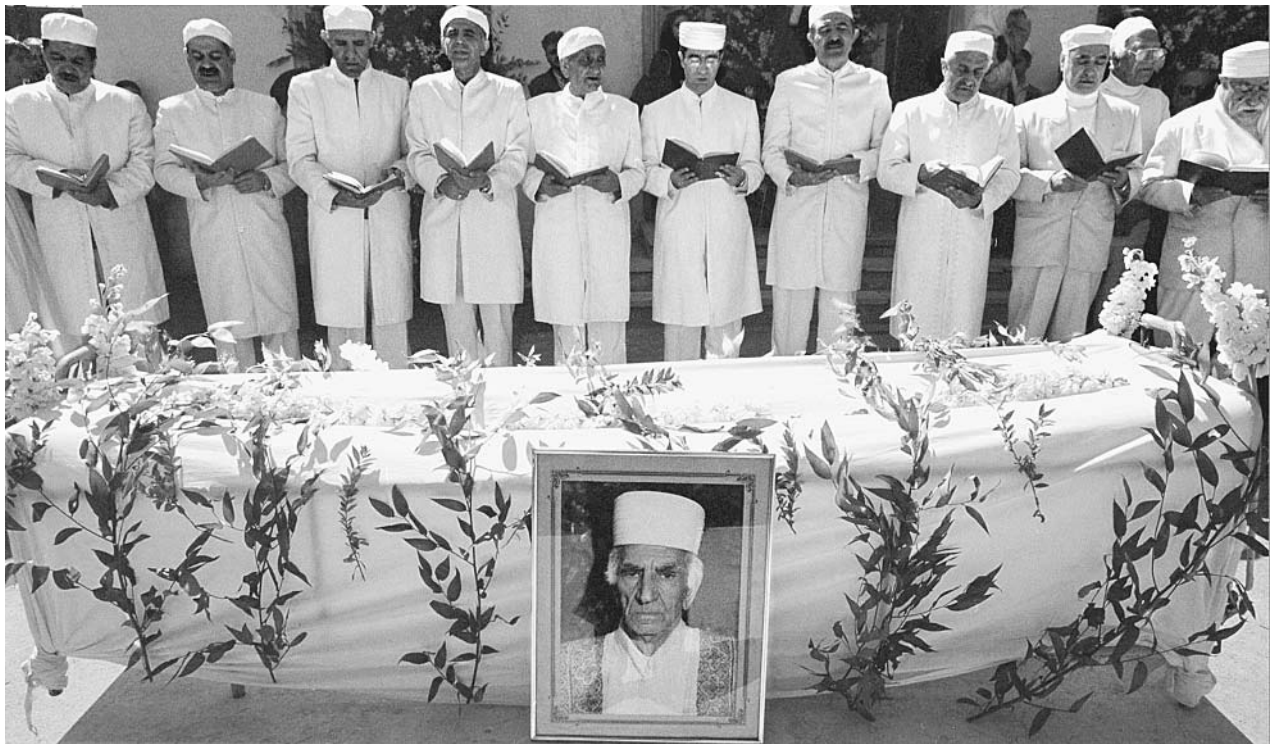
According to the *Gathas*, the souls of the righteous people go in a state of perfect happiness, referred to as the Abode of the Song (*Garō Demana*), also called the Abode of the Good Mind (*Vangheush Demana Manangho*) or the Abode of Endless Light (*Angbra Raosha*). The souls of the evildoers go to the Abode of Wickedness (*Druji Demana*), also referred to as the Abode of the Worst Mind (*Aschishtahya Daena Manangho*) and Worst Existence (*Achishta Abu*). These terms confirm that in Zoroastrianism heaven and hell are states of consciousness and not concrete geographical regions.

The Crossing Bridge: Chinavat

The *Gathas* alludes to a dividing line, a crossing boundary or bridge (*Chinavat*) between the two existences or the two worlds. No particulars about the shape or the locality of the bridge are provided. The term may have been used metaphorically indicating the end of one state of existence and the commencement of another or it may be a reference to a point of time when the final judgment is effected. According to the *Gathas*, the judgment takes place at death and before the deceased's true self or conscience (*Daena*) attempts to cross the bridge. On that occasion, the prophet will be present. This does not, however, imply the likelihood of any mediation on his part because there is no possibility of mediation or redemption by anyone. The predestined Law of Asha will run its course. The prophet's presence is simply a matter of good leadership; the soul of the pious will have an easy crossing and will be ushered into the next existence by his or her happy conscience as well as the prophet. The soul of the wicked will be led by his or her conscience to the worst existence.

The Intermediary Place between Heaven and Hell

It is not the *Gathas*, but the *Younger Avesta*, composed centuries after the prophet, which addresses the concept of human beings having a record with an equal number of good and evil acts; the *Younger Avesta* refers to an intermediary place



Zoroastrianism originated in ancient Iran sometime around 2000 B.C.E. In March 2000 at the Zoroastrian Qasr-e-Firoozeh cemetery in Teheran, Zoroastrian priests prayed at the funeral of the religious leader of the Iranian Zoroastrian community, Dastur Rostam Dinyar Shabzadi. AFP/CORBIS

called *Misvana Gatu*, where the souls of such persons reside. The reason the *Gathas* does not incorporate this concept is logically coherent. In Zoroastrianism each act has its own reward: potential happiness or suffering. The good and bad deeds are not added in the end of one's life to determine the level of reward or punishment. Recompense or retribution is not based on the excess of good deeds over bad deeds or the reverse. The concept of an intermediary place cannot be rationalized with the gathic doctrine.

Practices and Rituals Related to Death and the Disposal of the Dead

The method of the disposal of the dead is a controversial subject among Zoroastrians in the twenty-first century. The methods used are the system of the *Dakhma* ("Tower of Silence" as it is called by Westerners), the burial system, and, less frequently, cremation.

Dakhma is a stone-surfaced tower, built on an elevated earth outside town, on which the corpse is exposed to be devoured by vultures. The heavy bones left behind are either buried or placed in a

drain beneath the surface of the Dakhma where they are destroyed with chemicals. No Dakhma dating before the Arab conquest of Iran has been unearthed. Historians suggest that this practice started later in the Arab period to avoid desecration of the dead by the Muslims and that the low walls of the Dakhma increased during the period of the Turk and Mongol invasions. If the practice of using the Dakhma existed at all in the pre-Islamic period, as it is insisted by the Parsees in India, it must have been in order to preserve the environment, a concept Zoroastrians diligently observed; the Dakhma was used to prevent the pollution of soil and water and to avoid making land unusable for agriculture.

In 1937 the Zoroastrians in Iran started using the burial system along with the old system of Dakhma, but currently they use the latter almost to the exclusion of Dakhma. In contrast, the Zoroastrians of India still rely solely on the Dakhma. In the West, with some exceptions, the burial system and cremation are used.

Tradition requires the performance of certain rituals for the departure of the soul. According to

traditional belief (not specified in the *Gathas*), the soul of a dead person lingers on earth for three days and nights following the death and stays near the place where the head of the dead was resting immediately before death, recounting all the acts the person had done in his or her life. The righteous soul chants the sacred hymns, experiencing great joy while the wicked soul recalls the evil acts, experiencing great sorrow. At the dawn of the fourth day, the soul starts its journey to the next existence or world. At the Chinavat bridge, it is met with his or her conscience (*Daena*) that accompanies the soul to its final destination.

Certain prayers and rites are performed during the three days and at the morning of the fourth day. Remembrance ceremonies are performed on the tenth day following the death, thereafter on each thirtieth day of the month for one year and finally annually for thirty years. Jews also believed that the soul fluttered in the neighborhood of his or her house for three days.

Renovation of the World: Frasho-Kereti

The *Gathas* refers to the end of time. The *Haptanbaiti*, the immediate sequel to the *Gathas*, composed by Zarathushtra's immediate disciples, speaks of boundless time (*Zrvan Akarana*) and limited time (*Zrvan Daregbo Khvadbata*). Thus the reference to the "end of time" in the *Gathas* should be a reference to the latter—the end of the limited span of time one lives in this world and the transition into the other existence. That constitutes a turning point in life. For the righteous individuals this is the Great Turning Point that marks the attainment of their goal. Throughout their lives the righteous use their constructive power to advance the world, serve others, and work for the cause of peace. In doing so they seek to attain perfection (*Haurvatat*) and embrace eternity (*Ameratat*). At the Great Turning Point the righteous are ushered into the eternal spiritual existence. The righteous, through both individual and collective efforts, look to that event, which is the result of a long process of gradual progress toward perfection and immortalization. That event is called Refreshment of the World (*Frasho-Kereti*) and according to the Law of Asha this goal will be reached. That event will represent the final triumph of Good (*Spenta Mainyu*) over Evil (*Angra Mainyu*) and, as such, display the omnipotence of Ahura Mazda.

The Refreshment of the World is related to the concept of the Savior (*Saoshyant*). In the *Gathas*, the word *Saoshyant* is used in the generic sense, meaning "a group of saintly workers." They do not appear at set intervals but exist and operate at all times, in different capacities and with different effectiveness. Saoshyants are not of the same rank in righteousness or the role that they play in the perfection of the world. The Gathic Refreshment process is a gradual process resulting from the contributions of the righteous and the operation of the Law of Asha. Refreshment of the World is the apex of perfection of the existing world in its evolutionary process. The *Younger Avesta* has, however, changed the concept of Saoshyant, and thus Refreshment of the World, referring to three distinct saviors, who at given periods, arise and with big strides lead the world toward Refreshment. The last one is *Soshyos*, the Saoshyant proper, who gives the final touch to an almost-perfected world, heralding the final triumph of Good over Evil.

See also: AFRICAN RELIGIONS; AFTERLIFE IN CROSS-CULTURAL PERSPECTIVE; CHINESE BELIEFS

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FARHANG MEHR

APPENDIX



INFORMATION ON ORGANIZATIONS IN THE FIELD OF DEATH AND DYING

Mary J. Carvlin

Alcor Life Extension Foundation

The Alcor Life Extension Foundation (ALEF) is a nonprofit corporation that offers interested people the option of being cryonically suspended after their death. Cryonics is the process of preserving clinically dead people at very low temperatures, maintained in liquid nitrogen, in hopes of returning them to life and health when medical science has become sophisticated enough to do so. Starting in the latter part of the twentieth century there has been a trend toward neural (head only) preservation with the expectation that it will eventually be possible to reconstitute the whole body. The ALEF believes that researchers will someday find a way to halt and even reverse the aging process, with the opportunity for people to extend their lives for centuries.

The ALEF was founded in 1972 and had forty members in suspension by 2001. The ALEF publishes *Cryonics*, a quarterly magazine that deals with the topic of life extension, as well as such booklets as *Cryonics and Christianity*, addressing the religious concerns of Christians who may wish to become members.

Alcor maintains a number of full-time salaried employees and also relies on many volunteers. The organization states that the majority of the money it receives from its members is spent on clinical procedures, administrative overhead, research, and the Patient Care Fund. The fund is designed for maintaining and eventually restoring people who are in suspension. The cost of cryonic suspension at Alcor ranges from \$50,000 to \$120,000.

The Alcor Life Extension Foundation is headquartered at 7895 E. Acoma Drive, Suite 110, Scottsdale, AZ 85260-6916. They can be reached by phone at 877-GO-ALCOR or by e-mail at info@alcor.org. Additional information can be obtained through the ALEF web site: www.alcor.org.

American Academy of Hospice and Palliative Medicine

The American Academy of Hospice and Palliative Medicine (AAHPM) is an organization whose members are physicians committed to the role of hospice and palliative care in medical practice, education, and research. In particular, they seek to firmly establish hospice and palliative care as a formal role of medical doctors.

The AAHPM states its mission as achieving excellence in palliative medicine, preventing and relieving suffering among patients and families, providing education, establishing clinical practice standards, fostering research, facilitating professional development, and advocating for public policy.

The AAHPM was originally organized as the Academy of Hospice Physicians in 1988. Although a number of organizations exist for those interested in issues of hospice, the AAHPM asserts that it is the only organization in the United States for physicians dedicated to the advancement of hospice/palliative medicine in practice, research, and education. The academy expresses its intention to begin an organized discipline devoted to the specialties of palliative care and the management of terminal illness. The academy states its belief that the role of the physician includes helping even those patients who cannot be cured.

The academy conducts continuing medical education courses for members and provides peer support services to hospice and palliative care physicians. It also encourages accreditation of physician training programs in hospice and palliative care. The AAHPM works to educate the public regarding the rights of the dying and other issues affecting hospice and palliative medicine.

The American Academy of Hospice and Palliative Medicine is headquartered at 4700 W. Lake Avenue, Glenview, IL 60025-1485. They can be reached by phone at 847-375-4712 or by e-mail at aahpm@aahpm.org. Additional information can be obtained through the AAHPM web site: www.aahpm.org.

American Association of Suicidology

The American Association of Suicidology (AAS) brings together individuals and groups who are interested in advancing the study of suicide prevention and life-threatening behavior. Its members include psychologists, psychiatrists, social workers, nurses, health educators, physicians, directors of suicide prevention centers, clergy, and others from various disciplines.

The AAS was founded in 1968 and has five regional groups and is affiliated with the International Association for Suicide Prevention (IASP). The AAS holds an annual meeting each spring.

The AAS works to recognize and encourage suicidology, which is the study of suicide, suicide

prevention, and related aspects of self-destruction. The AAS promotes education, disseminates information through programs and publications, and cooperates with other organizations involved in suicidology.

The AAS has several publications that come with its membership, the most significant being *Suicide and Life-Threatening Behavior*, the official journal of the American Association of Suicidology. For three decades, the journal has provided a forum for professionals throughout the world to examine approaches to life-threatening behaviors. The journal investigates the complexity of suicidality and its treatment, addressing biological, statistical, psychological, and sociological approaches. The journal provides readers with the latest research on such topics as predictors and risk factors for suicidal behaviors. It also reviews important new resources in the field, including professional books, assessment scales, and international conference reports. Issues of the journal can be viewed on the Guilford Publications web site at www.guilford.com.

The American Association of Suicidology is headquartered at 4201 Connecticut Avenue NW, Suite 408, Washington, DC 20008. They can be reached by phone at 202-237-2280 or by fax at 202-237-2282. Additional information can be obtained at the AAS web site: www.suicidology.org

American Cancer Society

The American Cancer Society (ACS) is a voluntary health organization dedicated to controlling and eliminating cancer. The ACS seeks to prevent cancer and save lives through programs of research, education, patient service, advocacy, and rehabilitation.

The American Cancer Society was founded in 1913, and for more than eighty years has been the leader in cancer research. The ACS supports research through grants to individuals and institutions. The organization also supports service and rehabilitation programs for cancer patients and their families. It develops and directs educational programs for the public and for doctors and other health professionals. One of the primary goals of ACS is to provide the most accurate and current information on cancer. ACS promotes policies, laws, and regulations that benefit patients and families affected by cancer. The ACS publishes several annual reports and bimonthly journals that provide

medical professionals with important research and statistical information on cancer.

A national board of 124 volunteer directors governs the ACS. Half the directors are laypersons and half are doctors and scientists. Most society funds are raised in its annual community crusade during April, designated as Cancer Control Month by the U.S. Congress in 1938.

The ACS is headquartered at 1599 Clifton Road NE, Atlanta, GA 30329. It has seventeen chartered divisions throughout the country and over 3,400 local offices. Local programs established by the ACS serve to educate the public about cancer prevention, early detection, treatment, survival, and quality of life. Additional information can be obtained through the ACS web site: www.cancer.org.

American Cryonics Society

The American Cryonics Society (ACS) is an organization for people who are interested in extending life through cryonics. Cryonics refers to the freezing of clinically dead humans in anticipation of reviving the person when the necessary scientific and medical technology becomes available. A person held in such a state is said to be in cryonic suspension. Maintenance of the body involves placing and keeping it in a container filled with liquid nitrogen. As a membership-only organization, the American Cryonics Society contracts with other organizations for the suspension and caretaking of suspended bodies.

The cryonics movement began in 1962, receiving a boost with the publication of *The Prospect of Immortality* by Robert C. W. Ettinger in 1964. The book explores the arguments and ideas that have given rise to cryonics and is a founding book of the movement. The ACS was founded in 1969 as the Bay Area Cryonics Society, changing its name in 1985.

The organization helps interested people arrange for their own cryonic suspension. It promotes and sponsors research, education, and information about cryonic suspension, life extension sciences, and low-temperature medicine. It conducts programs to freeze tissue samples from endangered species for possible future cloning.

The ACS publishes *American Cryonics*, a semiannual journal that gives readers a summary of research and national news regarding cryonics.

They also publish the monthly *Immortalist*, featuring articles on cryonics, health, aging research, and science.

The American Cryonics Society can be contacted at P.O. Box 1509, Cupertino, CA 95015. They can be reached by phone at 800-523-2001 or by e-mail at cryonics@jps.net.

American Heart Association

The American Heart Association (AHA) is a national voluntary health agency organized to fight diseases of the heart and blood vessels. The AHA seeks to reduce premature death and disability from cardiovascular disease and stroke by sponsoring research, community services, and professional and public education on heart disease. The association coordinates efforts of the medical profession in its fight against heart and circulatory disease.

The AHA was founded in 1924 and has fifty-six state offices and nearly 2,000 local offices. It has about 26,000 active members, including several thousand physicians and scientists. About 2.5 million volunteers also participate in the work of the association. The American Stroke Association is a division of the AHA.

The association gains all of its financial support from the general public through contributions, mainly from its Heart Campaign held each February and its Heart Fund.

The AHA publishes current research in the monthly medical journal *Arteriosclerosis, Thrombosis, and Vascular Biology*. The AHA also publishes several other publications regarding cardiac medicine.

The American Heart Association is headquartered at 7272 Greenville Avenue, Dallas, TX 75231-4596. People can contact and make donations to the AHA by calling 800-AHA-USA1, or visiting them on the web at www.pfk.com/aha/DonateOnlineGeneral.asp. Additional information can be obtained through the AHA web site: www.americanheart.org.

American Hospice Foundation

The American Hospice Foundation (AHF) is a charitable nonprofit corporation that seeks to aid those who face life-limiting illness and significant loss. The foundation advances the hospice concept of care; that is, a family centered concept of health

care for people dying of an incurable illness. The hospice concept aims at easing the physical and psychological pain of the patient's illness so that the person can appreciate his or her remaining life. The hospice team includes the patient and his or her family, as well as physicians, nurses, social workers, members of the clergy, and volunteers. Hospice services may include nursing care and pain control, meal preparation, laundry, or shopping. This care may be provided at home, in a separate hospice medical center, or in a hospice unit of a hospital.

The AHF seeks to ensure the availability of hospice care for many who might otherwise not have such care available. The foundation aids programs that serve the needs of the terminally ill by supporting a range of community bereavement programs. The AHF promotes hospice benefits in health insurance and managed care programs, and fosters research on consumer needs. The American Hospice Foundation creates educational campaigns to aid bereaved employees and coworkers. It offers training and materials on grieving children for teachers and school counselors, and educational programs for clergy.

The American Hospice Foundation can be contacted at 2120 L Street NW, Suite 200, Washington, DC 20037. They can be reached by phone at 202-223-0204, by fax at 202-223-0208, or by e-mail at ahf@msn.com. Additional information can be obtained through the AHF web site: www.americanhospice.org.

American Lung Association

The American Lung Association (ALA) works to prevent lung disease and promote lung health. The association works to combat causes of lung problems, including smoking and environmental lung hazards such as air pollution.

The ALA was founded in 1904 to combat tuberculosis, and has become the oldest nationwide voluntary public health agency in the United States. The ALA has about 130 state and local affiliates.

The ALA provides public health education programs and materials on diseases such as lung cancer, emphysema, asthma, pneumonia, influenza, tuberculosis, and lung disorders in infants. It supports medical research and awards grants to medical professionals who specialize in lung health.

The work of the association is funded by public contributions, especially by its annual Christmas Seal Campaign. Additional funding comes from gifts and grants from corporations, foundations, and government agencies.

The ALA works to offer a variety of smoking control and prevention programs, some targeting adults and others intended for schools. ALA offers its Freedom from Smoking program, considered a top smoking cessation program.

In its work to fight lung disease caused by air pollution, the ALA led the fight for clean air, and became a key source of information on the hazards of air pollution. The association seeks to influence the laws and regulations related to lung health. It helped pass the federal Clean Air Act, as well as the law prohibiting smoking on airplanes.

Headquarters of the American Lung Association are in New York City. The ALA informs and educates the public about lung disease through its web site, public service announcements, news releases, and conferences. To reach a local American Lung Association office, call 800-LUNG-USA (800-586-4872). Additional information can be obtained through the ALA web site: www.lungusa.org.

Americans for Better Care of the Dying

Americans for Better Care of the Dying (ABCD) is a nonprofit organization committed to ensuring that all Americans receive adequate care at the end of life. The ABCD seeks to instill comfort, dignity, and meaning to the dying process for family members as well as their loved ones.

The organization was founded in 1997. Its goals are to reform current practices of caring for the dying, explore new systems for delivering care to the dying, and to shape public policy relating to end-of-life issues. It also seeks to improve standards of practice among professionals and greater reimbursement for end-of-life care.

ABCD aims to improve pain management, increase financial reimbursement, enhance care, support family caregivers, and change public policy. It helps organizations and individuals improve community care systems and assists health care organizations in implementing improvements. ABCD

helps build networks of interested parties so they can share their expertise.

Americans for Better Care of the Dying is headquartered at 4125 Albemarle Street NW, Suite 210, Washington, DC 20016. They can be reached by phone at 202-895-9485, by fax at 202-895-9484, or by e-mail at info@abcd-caring.org. Additional information can be obtained through the ABCD web site: www.abcd-caring.org.

American SIDS Institute

The American Sudden Infant Death Syndrome Institute (ASIDSI), often called the American SIDS Institute, is a nonprofit organization of health care professionals, researchers, and laypeople concerned about sudden infant death syndrome (SIDS), the unexplained death of an apparently healthy baby under one year of age. Members include families who have lost babies to SIDS. The precise cause of these deaths is not known, and ASIDSI supports efforts to identify the cause and cure of SIDS.

The American SIDS Institute was founded in 1983. The institute seeks to advance infant health through clinical services, education, research, and support for SIDS families. Its sponsorship of research programs includes conducting research on siblings of babies lost to SIDS who are at higher risk. The ASIDSI conducts seminars for health care professionals and laypeople and maintains a speakers' bureau.

Because there is no known cure for SIDS, the institute works to inform the public of risk factors for SIDS in order to reduce those risks. Known risk factors include premature birth to extremely young mothers, lack of prenatal care, and exposure of the mother to cigarette smoke, alcohol, or narcotics during pregnancy. Poverty, poorly ventilated rooms, soft mattresses, and too much clothing or covers at bedtime also increase a baby's risk for SIDS. By promoting such information, the ASIDSI helped reduce the numbers of SIDS deaths in the early 1990s.

The American SIDS Institute's headquarters are at 2480 Windy Hill Road, Suite 380, Marietta, GA 30067. They can be reached by phone at 800-232-SIDS or by e-mail at prevent@sids.org. Additional information can be obtained through the ASIDSI web site: www.sids.org.

Association for Death Education and Counseling

The Association for Death Education and Counseling (ADEC) is a multidisciplinary professional nonprofit organization dedicated to creating high standards in death education, bereavement counseling, and care of the dying. ADEC's primary goal is to enhance the ability of professionals and laypeople to be better able to meet the needs of those with whom they work in death education and grief counseling. ADEC works to promote and share research, theories, and practice in dying, death, and bereavement. The association aims to provide an arena for professionals of various disciplines to advance awareness of issues in dying, death, and bereavement.

The ADEC began in 1976, with the Forum for Death Education and Counseling, organized by a group of educators and clinicians. The organization grew into the Association for Death Education and Counseling. ADEC is the oldest interdisciplinary organization in the field of dying, death, and bereavement. Members of ADEC include educators, counselors, nurses, physicians, mental health professionals, clergy, funeral directors, and social workers.

The ADEC hosts an annual conference and provides professional resources for its members. It also publishes a member directory, a newsletter, and an annual book from its conference.

The Association for Death Education and Counseling is located at 342 North Main Street, West Hartford, CT 06117-2507. They can be reached by phone at 860-586-7503 or by fax at 860-586-7550. Additional information can be obtained by e-mail at info@adec.org or through the ADEC web site: www.adec.org.

Befrienders International

Befrienders International is a charitable volunteer organization that works to prevent suicide with its network of 357 centers worldwide. These centers, run by trained volunteers, offer a free service of nonjudgmental and completely confidential telephone, mail, e-mail, or face-to-face contact. Befrienders try to prevent suicide by providing a listening ear for people who are lonely, despairing, or suicidal. They try not to judge suffering people or tell them what to do, but just listen. They believe that listening saves lives, and by listening to a

suicidal person a befriender tries to help the person address a particular problem or pain.

Befrienders International was founded in 1974. By 2001 it had centers in forty-one countries. The organization supports and advises new and existing centers and offers its expertise and experience to other agencies. Befrienders International also initiates programs aimed at suicide prevention, including Reaching Young Europe, a program that teaches coping skills to young children.

Befrienders International is headquartered at 26-27 Market Place, Kingston upon Thames, Surrey KT1 1JH, England. They can be reached by e-mail at admin@befrienders.org. Additional information can be obtained through the Befrienders web site: www.befrienders.org. Through their web site, Befrienders International provides a comprehensive directory of emotional first aid help lines.

Brady Center to Prevent Gun Violence

The Brady Center to Prevent Gun Violence (BCPGV) is dedicated to reducing gun violence in the United States. The BCPGV began in 1974 when Dr. Mark Borinsky, a victim of gun violence, founded the National Council to Control Handguns (NCCH). In 1980 the NCCH was renamed Handgun Control, Inc. (HCI). After Jim Brady, the press secretary to President Ronald Reagan, was shot during an assassination attempt on the president in 1981, Brady's wife Sarah joined the cause. In 1983 the Center to Prevent Handgun Violence (CPHV) was founded as a sister organization to HCI.

The organization won several legislative battles, one of which led to the U.S. Congress banning bullets that can puncture police officers' bullet-proof vests. Congress also banned handguns that cannot be detected by airport X-ray machines.

In 1993 the Brady Bill, requiring a five-day waiting period and background checks on handgun purchases, was signed into law. President Bill Clinton signed into law the Violent Crime and Control Act of 1994, which includes the ban on manufacture and importation of military-style assault weapons.

Also in 1994, the CPHV helped launch Steps to Prevent (STOP) Firearm Injury, training doctors to counsel patients and their families about the risks of guns in the home. In 1996 CPHV launched Project Lifeline, a national network of health professional committed to public education on gun violence prevention.

In 2001 the CPHV launched a nationwide initiative to encourage state officials to use their consumer protection authority to regulate gun design. Also that year the CPHV was renamed the Brady Center to Prevent Gun Violence.

The Brady Center to Prevent Gun Violence can be contacted at 1225 Eye Street NW, Suite 1100, Washington, DC 20005. They can be reached by phone at 202-289-7319 or by fax at 202-408-1851. Additional information can be obtained through the CPHV web site: www.gunlawsuits.org.

Canadian Association for Suicide Prevention

The Canadian Association for Suicide Prevention (CASP) aims to help reduce the suicide rate and minimize the harmful consequences of suicidal behavior. CASP's main purpose and function is to facilitate, advocate, support, and advise. CASP does not provide formal therapeutic services, and it is not a crisis center.

In 1985 a group of professionals incorporated CASP. They responded to a need they saw for greater information and resources among communities in order to reduce the suicide rate.

CASP promotes broad-based information sharing on suicide intervention and research. It holds annual national conferences, publishes a newsletter, and creates service and research networks and directories. CASP advocates for governmental policy development pertinent to suicide prevention. The association also develops guidelines for use in other institutions, such as schools.

CASP seeks to develop excellence in research and service in Canada by giving annual national awards for outstanding contributions in research and service. The association also develops and administers standards for crisis and research centers and develops funds for specific projects.

CASP News, the organization's newsletter, is published in English and French three times per year.

The CASP office can be contacted at Canadian Association for Suicide Prevention, The Support Network, #301, 11456 Jasper Avenue, Edmonton, Alberta T5K 0M1. They can be reached by phone at 780-482-0198; by fax at 780-488-1495; or by e-mail at casp@suicideprevention.ca. Additional information can be obtained through the CASP web site: www.thesupportnetwork.com/CASP.

Canadian Palliative Care Association

The Canadian Palliative Care Association (CPCA) is a nonprofit organization whose membership is made up of individuals and hospice/palliative care programs from all ten Canadian provinces and three territories. The CPCA is the leading national association in hospice/palliative care in Canada. The association states its goal as leading the pursuit of "excellence in care for people approaching death so that the burdens of suffering, loneliness, and grief are lessened."

The association describes palliative care as involving four main components: pain management; symptom management; social, psychological, emotional, and spiritual support; and caregiver support. The organization defines palliative care as aimed at relieving suffering and improving the quality of life for those who are living with or dying from advanced illness or who are bereaved.

CPCA declares "to achieve its mission through: collaboration and representation; increased awareness, knowledge and skills related to hospice palliative care of the public, health care providers and volunteers; development of national standards of practice for hospice palliative care in Canada; support of research on hospice palliative care; advocacy for improved hospice palliative care policy, resource allocation and supports for caregivers."

CPCA funding comes from membership fees, corporate and individual donations, project grants, and contributions from charitable organizations and foundations. The CPCA publishes many fact sheets with titles such as "Palliative Care: A Fact Sheet for Seniors."

The volunteer board of directors of CPCA includes representatives from each of the provincial associations and five elected members at large. Various committees carry out related activities. Questions regarding CPCA can be e-mailed to info@cpca.net. Additional information can be obtained through the CPCA web site: www.cpcanet.net.

Candlelighters Childhood Cancer Foundation

The Candlelighters Childhood Cancer Foundation (CCCCF) seeks to educate, support, and advocate for families of children with cancer, survivors of childhood cancer, and the professionals who work with them. CCCC services include an information clearinghouse, resource database, peer support groups

for parents of children with cancer, and a long-term survivor network. A group of concerned parents of children with cancer founded CCCF in 1970.

Using volunteers who are lawyers, doctors, teachers, and insurance experts, Candlelighters' Ombudsman Program helps families and survivors of childhood cancer who experience difficulties in areas of insurance appeals, medical opinions, employment discrimination, and disability rights.

A program called Candlelighters Survivors of Childhood Cancer Program aims to provide a forum for young adult survivors of childhood cancer in the United States. These people can educate themselves on issues related to being a survivor and can interact with other survivors.

Candlelighters works to influence public policy by maintaining a presence in Washington, D.C., working in particular to support federal funding of cancer research as well as legislation and benefits that impact children with cancer. Candlelighters collaborates with many other organizations to create a stronger force for children with cancer.

CCCF's publications include *Candlelighters Quarterly*, a publication for parents and professionals, as well as a number of pamphlets aimed at helping children with cancer understand their condition and treatment. Parents may call the CCCF national office at 1-800-366-CCCF (2223) for referral to the local group nearest them. Local Candlelighters groups provide much of the organization's direct services to families, such as support groups and parent hospital visitation programs.

Candlelighters Childhood Cancer Foundation is headquartered at 3910 Warner Street, Kensington, MD 20895. They can be reached by e-mail at info@candlelighters.org. Additional information can be obtained through the CCCF web site: www.candlelighters.org.

CDC National Prevention Information Network

The CDC National Prevention Information Network (NPIN) provides information about HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome), sexually transmitted diseases (STDs), and tuberculosis (TB) to people and organizations working in prevention, health care, research, and support services. All of NPIN's services are designed to facilitate this sharing of information.

The Centers for Disease Control and Prevention (CDC), an agency of the Public Health Service, which is a division of the U.S. Department of Health and Human Services. The CDC works to protect public health by administering national programs for the prevention and control of disease and disability. The agency provides health information and statistics and conducts research to find the sources of epidemics. Established in 1946, CDC's headquarters and many of its laboratories are in Atlanta, Georgia.

NPIN staff serve a network of people who work in international, national, state, and local settings. All NPIN services are designed for reference, referral, and informational purposes only. NPIN does not provide medical advice or medical care.

Among the many topics on which the NPIN provides information is how HIV/AIDS, STDs, and TB affect groups such as African Americans, American Indians, Asians, Hispanics, incarcerated populations, people with disabilities, pregnant women, women, and young people. The agency provides information on statistics, trends, substance abuse, testing, counseling, travel, immigration, treatment, and support as they relate to these diseases.

The CDC National Prevention Information Network can be reached at P.O. Box 6003, Rockville, MD 20849-6003. They can be contacted by phone at 800-458-5231 or by e-mail at info@cdcnpin.org. Additional information can be obtained through the CDC NPIN web site: www.cdcnpin.org.

Center for Death Education and Bioethics

The Center for Death Education and Bioethics (CDEB) is a resource center that collects and archives academic materials concerned with the issue of death, dying, and bereavement in contemporary society.

The center was founded in 1969 as the Center for Death Education and Research at the University of Minnesota in Minneapolis. It was formed with the purpose of serving as a repository for materials concerning mortality. It was also intended as a center for the dissemination of literature and information to the academic and professional communities as well as to the public. The Center for Death Education later became affiliated with the Sociology/Archaeology Department of the University of Wisconsin in La Crosse.

The CDEB retains a large collection of journals, books, and articles concerned with death, dying, bereavement, terminal illness, hospice care, and related topics. Administrators of the center encourage users to visit the center and take advantage of its resources for their academic projects or personal interests. The center is open for certain hours of the week and by appointment at other times.

The CDEB sponsors *Illness, Crisis, and Loss*, a quarterly peer-reviewed journal published by Sage Publications. CDEB also sells brochures on grief and loss.

The Center for Death Education and Bioethics is located at 435NH, 1725 State Street, University of Wisconsin, La Crosse, WI 54601-3742. They can be reached by phone at 608-785-6784 or by e-mail at cdeb@uwlax.edu. Additional information can be obtained through the CDEB web site: www.uwlax.edu/sociology/cde&b/.

Children's Hospice International

Children's Hospice International (CHI) provides resources and referrals to children with life-threatening conditions and their families. The goal of CHI is to improve quality of life for the dying child and the ongoing, strengthened life of the family. It advocates on behalf of these children and families, helps to establish children's hospice programs, and provides education and training for health care providers.

Children's Hospice International was founded in 1983 as a nonprofit organization to provide a network of support and care for children with life-threatening conditions and their families. Very few hospice programs would accept children before the CHI worked to change that. Today almost all hospice programs in the United States are willing to consider accepting a child as a patient.

The hospice approach for children is a team effort that provides medical, psychological, social, and spiritual expertise. CHI recognizes the right and need for children and their families to choose health care and support whether in their own home, hospital, or hospice care facility. The organization works closely with medical professionals as a bank, providing technical assistance, research, and education.

The Children's Hospice International is headquartered at 901 N. Pitt Street, Suite 230, Alexandria, VA 22314. They can be reached by phone at

800-24CHILD or 703-684-0330, or by e-mail at chiorg@aol.com.

Concerns of Police Survivors

Concerns of Police Survivors (COPS) is a national nonprofit organization devoted to helping families and other survivors deal with the impact of police deaths. COPS acts as a support group for the survivors of law enforcement officers who have died suddenly and violently. Survivors include a police officer's squad partners and other such comrades and friends.

COPS was established in 1984 and grew to over thirty chapters by the end of the twentieth century. Grants from the U.S. Department of Justice help the organization continue and support some of its key efforts. COPS also receives funding from a number of organizations, including police unions, as well as from individuals.

COPS helps friends and families of slain officers through grief counseling programs. COPS aims to become a social network to help families recover from the shock and emptiness of death. Members are available to help one another in the immediate aftermath of an officer's death as well as for years to come.

The organization sponsors recreational camps, retreats, and other events for family members of all ages. Children aged six to fourteen can go to camps with their parents, and older children can participate in wilderness challenges designed to instill self-confidence and independence. COPS sponsors getaways for spouses of slain officers as well as outings for officers' parents. Many of these events are held at Lake of the Ozarks, Missouri. The national program raises money to provide for the camps, and local chapters cover transportation costs.

Official programs include national peer support, national counseling programs, national police survivors' seminars, scholarships, trial and parole support, and information on state death benefits. COPS also provides programs for agencies and raise public awareness.

The National Office of Concerns of Police Survivors offers information and accepts donations at P.O. Box 3199, S. Highway 5, Camdenton, MO 65020. They can be reached by phone at 573-346-4911 or by e-mail at cops@nationalcops.org. Additional information can be obtained through the COPS web site: www.nationalcops.org.

Council of Religious AIDS Networks

The Council of Religious AIDS Networks (CRAN) seeks to empower and mobilize faith communities to respond to the international HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) pandemic. Membership includes local, regional, and national faith-based, AIDS-specific ministries and organizations.

The council grew out of the AIDS National Interfaith Network (ANIN), a private, nonprofit organization founded in 1988. ANIN was created to secure compassionate and nonjudgmental support, care, and assistance for individuals with HIV and AIDS. The organization coordinated a network of nearly 2,000 ministries.

In 1993 representatives of ANIN met with the National Episcopal AIDS Coalition (NEAC), Disciples of Christ AIDS Network, Lutheran AIDS Network, and United Methodist AIDS Network to create a new organization. By their second meeting in 1993, the group had formally named itself the Council of National Religious AIDS Networks, a name that was later modified to the Council of Religious AIDS Networks.

Members of CRAN receive a newsletter that features information on AIDS legislation, upcoming events, and news from AIDS ministries nationwide. They also receive Action Alerts on time-sensitive issues of importance to AIDS ministries. The council hosts a web site that seeks to offer comprehensive and reliable information on HIV/AIDS and faith-based services, faith-based organizations, and communities of faith.

CRAN works closely with the United States Centers for Disease Control and Prevention in Atlanta, Georgia, and also seeks to coordinate efforts with AIDS organizations worldwide.

For further information, contact CRAN, c/o Dr. Jon A. Lacey, P.O. Box 4188, East Lansing, MI 48826-4188. Information can also be obtained by e-mail at info@aidsfaith.com or through the CRAN web site: www.aidsfaith.com.

Cremation Association of North America

The Cremation Association of North America (CANA) seeks to raise standards and ethics for cremation. Cremation, the practice of burning a dead body to ashes, has become increasingly common

in the United States and Canada. Most funeral directors can arrange a cremation, which often includes a funeral service before or after the burning. CANA seeks to increase public awareness and knowledge of cremation and memorialization. Its membership is made up of owners of cemeteries and crematories, funeral directors, industry suppliers, and consultants.

CANA began in 1913 as the Cremation Association of America, changing its name in 1977. CANA conducts research, compiles statistics, holds certification programs, and hosts a trade show. CANA publishes a quarterly magazine, *The Cremationist*.

The CANA code of cremation practice states: "In the practice of cremation, we believe: in dignity and respect in the care of human remains, in compassion for the living who survive them, and in the memorialization of the dead; that a cremation authority should be responsible for creating and maintaining an atmosphere of respect at all times; that the greatest care should be taken in the appointment of crematory staff members, any whom must not, by conduct or demeanor, bring the crematory or cremation into disrepute; that cremation should be considered as preparation for memorialization; that the dead of our human society should be memorialized through a commemorative means suitable to the survivors."

The Cremation Association of North America is headquartered at 401 N. Michigan Avenue, Chicago, IL 60611-4267. They can be reached by phone at 312-644-6610, by fax at 312-321-4098, or by e-mail at cana@sba.com. Additional information can be obtained through the CANA web site: www.cremationassociation.org.

Death Studies

Death Studies is a peer-reviewed journal that publishes papers on research, scholarship, and clinical work in the areas of bereavement and loss, grief therapy, death attitudes, suicide, and death education. *Death Studies* is published eight times each year. Its readers are comprised of professionals in universities, hospitals, hospices, and counseling centers who are interested in the major topics in the field of death and dying. Death Studies online archives date back to January 1997.

Article titles published by *Death Studies* include "Grief Communication, Grief Reactions and

Marital Satisfaction in Bereaved Parents”; “No-Suicide Contracts among College Students”; “Survivors’ Motives for Extravagant Funerals among the Yorubas of Western Nigeria”; “Exploration of the Relationship Between Physical and/or Sexual Abuse, Attitudes about Life and Death, and Suicidal Ideation in Young Women”; “Traumatic Stress and Death Anxiety among Community Residents Exposed to an Aircraft Crash”; “Firearms and Suicide: the American Experience, 1926–1996”; “Developing Beliefs That Are Compatible with Death”; “Israeli Children’s Reactions to the Assassination of the Prime Minister”; and “Parental Bereavement: The Crisis of Meaning.”

Death Studies is published by Taylor & Francis, a 200-year old international academic publisher. They have offices in London and other British cities as well as New York City, Philadelphia, Singapore, and Sydney. Prospective readers can visit the Taylor & Francis web site to browse the contents pages of *Death Studies* issues. Readers with institutions that subscribe to the journal can access the full text free of charge.

The editor in chief of *Death Studies* is Robert A. Neimeyer, Department of Psychology, University of Memphis, Memphis, TN 38152. Further information can be found at www.tandf.co.uk/journals.

Dougy Center for Grieving Children

The Dougy Center for Grieving Children is a nonprofit organization that provides families in Portland, Oregon, and the surrounding region, support for children, teens, and their families grieving a death. Through their National Center for Grieving Children & Families, they also provide support and training locally, nationally, and internationally to individuals and organizations seeking to assist children and teens in grief.

In 1982 the Center became the first in the United States to provide peer support groups for grieving children. The Center received national and international acclaim for pioneering a model for assisting children, teens, and families coping with the deaths of family members. Over 120 programs modeled on the Center have developed throughout the United States, Canada, Japan, England, Jamaica, Germany, and Rwanda.

The Dougy Center provides training nationally and internationally for companies and schools helping grieving children and teens coping with

deaths from natural causes or from violence in a community. The Center also trains groups in starting children’s grieving centers.

The Center publishes a guidebook series that grew out of their experience. Topics in the series include helping children and teens cope with death, children and funerals, helping the grieving student, and a guide for principals responding to deaths in school.

The Dougy Center is privately supported and does not charge a fee for services. The Dougy Center can be reached at 3909 SE 52nd Ave., Portland, OR 97286, by phone at 503-775-5683, by fax at 503-777-3097, or by e-mail at help@dougy.org. Additional information can be obtained through the Dougy Center web sites at www.dougy.org/about.html or www.grievingchild.org.

Elizabeth Glaser Pediatric AIDS Foundation

The Elizabeth Glaser Pediatric AIDS Foundation is a nonprofit organization dedicated to helping children with HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome). The foundation’s focus is on continuing research, especially on the effectiveness of drug treatments for children and decreasing their cost.

Elizabeth Glaser was a television actress who contracted HIV through a blood transfusion in 1981. By the time she was diagnosed, she had already passed the virus to her daughter Ariel through breast-feeding and to her son Jake during pregnancy. Ariel died in 1988, and Glaser herself died in 1994 at the age of forty-seven. She left behind her husband, Paul Michael, a Hollywood director and actor, and their son. Paul Michael was the only one in the family not infected. Jake remained HIV-positive but otherwise functioning.

After Ariel’s death the Glaser couple and several friends founded the organization to raise funds for pediatric HIV/AIDS research. Elizabeth became a vocal AIDS activist and a critic of what she saw as governmental inaction toward the epidemic. Paul Michael became chairman of the foundation board.

In its first ten years, the foundation raised \$75 million for pediatric AIDS research and treatment. The foundation supported a network of leading research institutions with an \$8 million grant. The institutions, which included Harvard Medical School/Children’s Hospital-Boston and Stanford School of

Medicine/Lucile Packard Children's Hospital, study treatments for serious pediatric illnesses. In addition, five Elizabeth Glaser Scientists are named each year by the foundation to receive up to \$682,500 in a five-year research grant. The foundation also funds other grants and scholarships.

The foundation accepts donations by phone at 888-499-HOPE (4673) or by mail to Elizabeth Glaser Pediatric AIDS Foundation, 2950 31st Street, #125, Santa Monica, CA 90405. Additional information can be obtained through the foundation's web site: www.pedaids.org/index.html.

European Association for Palliative Care

The European Association for Palliative Care (EAPC) promotes palliative care in Europe and acts as a source for professionals who work or have an interest in this field.

From its foundation in 1988 the EAPC grew to reach a reported membership representing over 23,000 people by 2001. The EAPC head office is situated at the Division for Rehabilitation, Pain Therapy and Palliative Care within the National Cancer Institute in Milan, Italy.

The stated objectives of the EAPC include: "Increase the awareness and promote the development and dissemination of palliative care at scientific, clinical and social levels; promote the implementation of existing knowledge; train those who at any level are involved with the care of patients with incurable and advanced disease; promote study and research; bring together those who study and practice the disciplines involved in the care of patients with advanced disease; unify national palliative care organizations and establish an international network for the exchange of information and expertise; and address the ethical problems associated with the care of terminally ill patients."

The official publication of the EAPC is the *European Journal of Palliative Care*. Launched in 1994, it is published in English and French and aimed at palliative care professionals. In addition, the association's communication strategy includes its web site, which it considers crucial for informing members and sharing information among members.

The European Association for Palliative Care is also referred to by the acronym ONLUS, based on its foreign language title. The mailing address of the EAPC is National Cancer Institute of Milan, Via

Venezian 1, 20133 Milan, Italy. They can be reached by e-mail at eapc@istitutotumori.mi.it. Additional information can be obtained in French or English through the EAPC web site: www.eapcnet.org.

European Journal of Palliative Care

The *European Journal of Palliative Care (EJPC)* is the official journal of the European Association for Palliative Care (EAPC). The association promotes palliative care in Europe and acts as a source for people who work or have an interest in the field of palliative care. The *Journal* publishes authoritative articles covering a range of palliative care issues and acts as a resource for palliative care professionals throughout Europe and beyond.

The *Journal* is produced in English and French editions, and is available by subscription only. The *EJPC* is a review journal, therefore it does not publish original research. Commissioned review articles are aimed at covering all aspects of the care of patients with incurable diseases. Contributions are taken from members of every discipline involved in palliative care.

The EAPC launched the *EJPC* as a quarterly publication in 1994. Since 1997 it has been published six times a year.

The *Journal* aims to help advance the skills and expertise of professions that include palliative care specialists, general practitioners, nurses, oncologists, anesthetists, pain specialists, geriatricians, AIDS (acquired immunodeficiency syndrome) specialists, psychiatrists/psychologists, and social workers.

The *Journal* is published by Hayward Medical Communications, whose editorial offices are located in London, England. Additional information can be obtained through the Hayward web site: www.hayward.co.uk. The mailing address of the EAPC is National Cancer Institute of Milan, Via Venezian 1, 20133 Milan, Italy. Additional information can be obtained in French or English through the EAPC web site: www.eapcnet.org.

Funeral Consumers Alliance

The Funeral Consumers Alliance (FCA) is a non-profit organization whose stated mission is to educate consumers and to establish, promote, and protect their rights in the planning and purchasing of funeral and memorial arrangements. The FCA

monitors the funeral industry with the goal of protecting consumer interests.

Groups called “memorial societies” existed in the early 1900s, when people joined together to ensure an acceptable level of standards for burial. In 1963 several such societies formed the Continental Association of Funeral and Memorial Societies. After the Canadian societies dropped out, members changed the name to the Funeral and Memorial Societies of America in 1996. In 1999 the organization’s board voted to consolidate its operations under the Funeral Consumers Alliance.

The FCA provides educational materials on funeral choice to increase public awareness of funeral options. It acts as a source of information for media coverage of issues on dying and death. The FCA lobbies as a consumer advocate for reforms at the national level and lends support for needed changes at the state or local level.

The Funeral Consumers Alliance publishes a quarterly newsletter that covers industry trends, legal issues, consumer information, and tips for local groups. The Funeral Consumers Alliance is supported by dues and donations from both local organizations and from individuals.

The Funeral Consumers Alliance is headquartered at P.O. Box 10, Hinesburg, VT 05461. They can be reached by phone at 800-765-0107. Additional information can be obtained through the FCA web site: www.funerals.org.

Hemlock Society

The Hemlock Society is a nonprofit organization devoted to helping people maintain choice and dignity at the end of their life. They believe that people suffering from irreversible illnesses must have access to peaceful means to hasten their death if they feel their suffering is unbearable. According to the Hemlock Society, “The primary means to accomplish this is with legally prescribed medication as part of the continuum of care between a patient and a doctor, although there are non-medical methods that are effective.”

The Hemlock Society was founded in 1980 by Derek Humphry. It has since become the oldest and largest right-to-die organization in the United States with almost 25,000 members in seventy chapters across the country.

The Hemlock Foundation funds the educational and charitable parts of the Hemlock operation. The Patients’ Rights Organization (PRO-USA) is Hemlock’s legislative arm. Its funds go directly into legislative efforts to change the law. Hemlock seeks to change laws in order to protect patients and physicians involved in hastening a death.

The society does not distribute the means to a peaceful death, but they make available written materials on such matters. Their publications provide information on advance directives, pain management, hospice care, and all options for a death in which the patient retains choice and dignity. Their education efforts also occur through their web site and about 12,000 annual phone inquiries.

The Hemlock Society can be reached at P.O. Box 101810, Denver, CO 80250-1810. Interested people can call 800-247-7421 for the location of local chapters or other information. The society can be reached by e-mail at email@hemlock.org. Additional information can be obtained through the Hemlock Society web site: www.hemlock.org.

Hospice and Palliative Nurses Association

The Hospice and Palliative Nurses Association (HPNA) is an international professional association with the mission of promoting excellence in hospice and palliative nursing. Its stated purpose is to exchange information, experiences, and ideas; to promote understanding of the specialties of hospice and palliative nursing; and to study and promote hospice and palliative research.

The Hospice and Palliative Nurses Association began as the Hospice Nurses Association in 1986 at a meeting of the Southern California Hospice Association. The organization grew after 1993 in response to HPNA’s formation of the National Board for the Certification of Hospice Nurses to develop a process to credential hospice nurses. The board became a separate organization, responsible for developing and overseeing the certification exam for hospice and palliative nurses. The national office of HPNA coordinates activities for the board.

The HPNA mission statement declares the organization’s role of promoting excellence in hospice and palliative nursing, promoting the highest professional standards of hospice and palliative nursing, studying, researching, exchanging information, experiences, and ideas leading to improved nursing practice, encouraging nurses to

specialize in the practice of hospice and palliative nursing, fostering the professional development of nurses, and promoting recognition of hospice and palliative care as an essential component throughout the health care system.

HPNA publishes the quarterly journal *JHPN*. The Hospice and Palliative Nurses Association is located at Penn Center W. One, Suite 209, Pittsburgh, PA 15276. They can be reached by phone at 412-787-9301 or by e-mail at hpna@hpna.org. Additional information can be obtained through the HPNA web site: www.hpna.org.

Hospice Association of America

The Hospice Association of America (HAA) is a national organization representing more than 2,800 hospices and many caregivers and volunteers who serve terminally ill patients and their families. Hospice is a family-centered concept of health care for people dying of incurable illnesses.

The hospice concept aims at easing the physical and psychological pain of the patient's illness so that the person can appreciate his or her remaining life. The hospice team includes the patient and his or her family, as well as physicians, nurses, social workers, members of the clergy, and volunteers. Hospice services may include nursing care and pain control, meal preparation, laundry, or shopping. This care may be provided at home, in a separate hospice medical center, or in a hospice unit of a hospital.

In 1996 the HAA's first special membership section, the Volunteer Hospice Network (VHN), was established to promote the growth, diversity, and development of volunteer organizations that serve people dealing with life-threatening illnesses and those who are grieving.

The HAA is the largest lobbying group for hospice in the United States, appealing to the U.S. Congress, the regulatory agencies, other national organizations, the courts, media, and the public.

HAA members can obtain expert advice from the HAA's legislative, regulatory, legal, research, and clinical specialists. A team of trained professionals works with the membership to advocate on behalf of hospices, caregivers, and those they serve.

HAA members receive a number of publications produced by the HAA. These publications include *Caring*, a monthly magazine covering all aspects of the hospice and home care field, and

Homecare News, a widely circulated quarterly newspaper that reaches the entire hospice and home care community.

The Hospice Association of America is headquartered at 228 Seventh Street SE, Washington, DC 20003. They can be reached by phone at 202-546-4759. Additional information can be obtained through the HAA web site: www.nahc.org.

Hospice Association of South Africa

The Hospice Association of South Africa (HASA) is an international palliative care association that coordinates the development of hospices in the South Africa region by providing a centralized source of information, education, and training. The HASA represents forty-nine hospices in South Africa.

The association is among the very few care services for the terminally ill in South Africa. Hospices are funded mainly by private donations, some of which have been raised through benefit events. Only a small part of hospice income is from the government. However, hospice service is free and available to all, regardless of age, sex, race, color, or creed. The Most Reverend Desmond Tutu, Archbishop Emeritus, is patron of the Hospice Association of South Africa.

The Hospice Association of South Africa is headquartered at P.O. Box 38785, Pinelands 7439, Western Cape, South Africa.

Hospice Education Institute

The Hospice Education Institute is an independent, nonprofit organization that serves members of the public and health care professionals with information and education about caring for the dying and the bereaved. The institute defines hospice as a philosophy of caring that respects and values the dignity and worth of each person and good hospice care as the practical expression of that personal and professional commitment. Hospices aim to cherish and emphasize life by helping patients live each day to its fullest.

Founded in 1985, the institute seeks to educate the public about the history of hospice, which dates back to the Middle Ages. In modern times a resurgence of hospice care was seen in the latter part of the 1900s. From 1974 to 1978 hospices and palliative care units opened across North America. In the 1980s, hospice care, usually emphasizing

home care, expanded throughout the United States, especially after Medicare added a hospice benefit in 1984 and after hospices began to care for people with advanced AIDS (acquired immunodeficiency syndrome).

From 1990 to 1999 almost 3,000 hospices and palliative care programs served the United States and soon there was well-established hospice and palliative care in Canada, Australia, New Zealand, and much of Asia and Western Europe.

The Hospice Education Institute is headquartered at 190 Westbrook Road, Essex, CT 06426-1510. Interested parties can telephone the institute at 800-331-1620 or 860-767-1620 to obtain information about good hospice and palliative care, to get referrals to hospices and palliative care organizations in the United States, or to discuss issues relating to caring for the dying and the bereaved. The e-mail address of the institute is hospiceall@aol.com. Additional information can be obtained through the Hospice Education Institute web site: www.hospiceworld.org.

Hospice Foundation of America

The Hospice Foundation of America (HFA) is a nonprofit organization that promotes hospice care and works to educate professionals and the families they serve in issues relating to caregiving, terminal illness, loss, and bereavement. The HFA provides leadership in the development and application of hospice and its philosophy of care. Through programs of professional development, research, public education, and information, the HFA assists those who cope either personally or professionally with terminal illness, death, and the process of grief. The Hospice Foundation of America seeks to enhance the role of hospice within the American health care system.

Hospice Foundation, Inc. was chartered in 1982 with the purpose of providing fundraising assistance to hospices operating in South Florida so that they could carry on their mission of providing compassionate care to dying patients. In 1990, with the help of a significant gift from Hospice Care, Inc., the foundation expanded its scope to a national level in order to provide leadership in the entire spectrum of end-of-life issues. The foundation board is made up of health policy experts. The HFA seeks to raise the visibility and credibility

of hospice and advocate for principles of hospice that may enhance the medical system.

In 1992 the foundation opened a Washington, D.C., office for its policy and program work, and in 1994 the board changed the name of Hospice Foundation, Inc. to the Hospice Foundation of America. The Foundation is supported by contributions from individuals and corporations, grants from foundations, and gifts from associations.

The Hospice Foundation of America is headquartered at 2001 S. Street NW, #300, Washington, DC 20009. They can be reached by phone at 800-854-3402 or by fax at 202-638-5312. Additional information can be obtained through the HFA web site: www.hospicefoundation.org.

Hospice Information

Hospice Information acts as a worldwide link and resource for any health professional or member of the public concerned with palliative care. The service seeks to promote sharing of experience by spreading current information. They also seek to enable patients and caretakers to find and obtain needed palliative care support. Hospice Information estimates that there are over 6,500 hospice/palliative care centers in about ninety countries. The organization has links with services in over eighty of these countries.

The Hospice Information Service began in 1977, founded by Dame Cicely Saunders at the first teaching hospice, St. Christopher's Hospice in London. The Service grew in response to an increasing number of inquiries about hospice received by St. Christopher's. The Service shortened its name to the Hospice Information in 2002, and remained linked to the Department of Palliative Care and Policy, a joint venture between St. Christopher's and King's College London.

Hospice Information publishes a quarterly newsletter, *Hospice Bulletin*, which highlights the work of international palliative care centers and informs readers of new services, especially those in developing countries. It publishes a "Directory of Hospice and Palliative Care Services in the UK and Ireland," the "Hospice Worldwide" directory, and fact sheets with titles such as "Facts and Figures: Latest Palliative Care Statistics" or "Building a Hospice." The Hospice Information web site features a listing of hospices and palliative care services worldwide for both professionals and the public.

Hospice Information is located at St. Christopher's Hospice, 51 Lawrie Park Road, London SE26 6DZ and Hospice House, 34 Britannia Street, London WC1X 9JG. Hospice Information can be contacted by e-mail at info@hospiceinformation.info. Additional information can be obtained through the Hospice Information web site: www.hospiceinformation.info.

Illness, Crisis, and Loss

Illness, Crisis, and Loss is a quarterly journal based on the stated premise that significant progress in the fields of life-threatening illness and thanatology will be achieved by bringing together the expertise of many varied professionals. The journal attempts to explore all aspects of grief, death, and loss by publishing peer-reviewed articles, book reviews, and essays related to these issues.

The journal is sponsored by the Center for Death Education and Bioethics (CDEB), a resource center that collects and archives academic materials concerned with the issues of death, dying, and bereavement in contemporary society. The center was founded in 1969 as the Center for Death Education and Research at the University of Minnesota in Minneapolis. The center later became affiliated with the Sociology/Archaeology Department of the University of Wisconsin in La Crosse.

Robert Bendiksen is the editor of *Illness, Crisis, and Loss* and director of the CDEB. The journal is published by Sage Publications, headquartered in London, England.

The range of subjects covered by the journal includes HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome), crisis intervention, death studies, ethical decision making, grief work, and palliative care of the dying. Specific sample topics include models of grieving, religion and spirituality, grief work with survivors of disasters, euthanasia, bioethics, and assisted dying.

Address correspondence to Dr. Robert Bendiksen, Editor, *Illness, Crisis, and Loss*, Center for Death Education and Bioethics, Soc/Arc Dept., 435 North Hall, University of Wisconsin, La Crosse, WI 54601-3742. The center can be reached by phone at 608-785-6781 or by e-mail at cdeb@uwlax.edu. Additional information can be obtained through the Sage Publications Ltd. web site: www.sagepub.co.uk.

International Association for Suicide Prevention

The International Association for Suicide Prevention (IASP), also called the Association Internationale pour la Prévention du Suicide (AIPS), is an organization for individuals and agencies of various disciplines and professions from different countries engaged in suicide prevention and research.

The goal of the association is to provide a common platform for the interchange of experience, literature, and information about suicide. It is also aimed at the wide dissemination of the fundamentals of suicide prevention in both professional and public circles. The IASP arranges for specialized training of selected people in suicide prevention. It encourages and facilitates research programs, especially ones that can be pursued through international cooperation.

The IASP was founded in 1960, and is financed by membership dues, voluntary contributions, and subsidies.

The IASP encourages the work of voluntary organizations, such as the network of suicide prevention telephone services. It also disseminates information on various other forms of crisis intervention, such as psychotherapy and drug treatment, aimed at suicide prevention. The IASP publishes a quarterly publication called *Crisis*.

World headquarters for the IASP are in Vienna, Austria. American headquarters are located at Rush Center for Suicide Prevention, 1725 W. Harrison Street, Suite 955, Chicago, IL 60612. They can be reached by phone at 312-942-7208, by fax at 312-942-2177, or by e-mail at iasp@aol.com. Additional information can be obtained through the IASP web site: www.who.int/ina-ngo/ngo/ngo027.htm.

International Association of Pet Cemeteries

The International Association of Pet Cemeteries (IAPC) is a nonprofit organization dedicated to the advancement of pet cemeteries everywhere. It pursues its goal mainly through public awareness programs.

There are more than 600 active pet cemeteries in the United States, most of which operate in conjunction with other pet-related business such as boarding kennels, grooming salons, training centers, and veterinarian hospitals. Some directors of human cemeteries have set aside a portion of their

grounds for pet burials. Some pet cemeteries operate on a full-time basis, specifically dedicated to the burial or cremation of pets.

Pat Blosser founded the International Association of Pet Cemeteries in 1971 in West Chicago. Member pet cemeteries are expected to maintain the highest business and ethical standards. The IAPC operates on a budget that is supported only by dues and other contributions from members. The International Association of Pet Cemeteries has no paid employees—volunteers do all of the association's work.

Members of the International Association of Pet Cemeteries can receive continuous education management consultation, use of the IAPC logo, public relations services, promotional materials, and membership plaques. Members also receive a subscription to *News and Views*. They may attend the IAPC annual spring convention and the annual fall seminar.

The International Association of Pet Cemeteries can be reached at P.O. Box 163, 5055 Route 11, Ellenburg Depot, NY 12935, by phone at 518-594-3000, or by fax at 518-594-8801. Additional information can be obtained through the IAPC web site: www.iaopc.com.

International Cemetery and Funeral Association

The International Cemetery and Funeral Association (ICFA) is an international trade association representing the cemetery, funeral, and memorialization industry. The ICFA's stated mission is to serve and support its members in order to help them succeed in business.

The International Cemetery and Funeral Association was founded in 1887 as the American Cemetery Association, an organization of cemetery owners and operators who wanted to provide a means for accomplishing more together than they could as individuals. The organization gained its present name in 1997 when the American Cemetery Association merged with the National Association of Cemeteries.

In its mission statement, the ICFA includes its commitment to prefinanced funeral and cemetery services and to providing consumers with better

value through open competition. It states its services to members as promoting high ethical standards, providing products and educational services, leading legislative, regulatory, and legal changes, encouraging members to promote the celebration of life, remembrance, and memorialization, and promoting cemeteries as guardians of a nation's heritage and as places of lasting tribute to the memory of the dead.

The ICFA reached a membership of more than 6,000 cemeteries, funeral homes, monument dealerships, crematories, and related businesses. The ICFA publishes a monthly journal, *International Cemetery and Funeral Management*. The ICFA offers members representation in the governmental arena, educational meetings, and other services and products to meet their needs.

The International Cemetery and Funeral Association is headquartered at 1895 Preston White Drive, Suite 220, Reston, VA 20191. They can be reached by phone at 800-645-7700 or by e-mail at gen4@icfa.org. Additional information can be obtained through the ICFA web site: www.icfa.org.

Journal of Loss and Trauma

The *Journal of Loss and Trauma* is published four times per year, bringing together scholarship on personal losses relating to family, health, and aging issues. The journal focuses on both psychological and physical health, as well as interpersonal losses within the contexts of extended family, community life, and society as a whole. In order to broaden the reader's perspective on loss and bereavement, and their pervasiveness in human life, the *Journal of Loss and Trauma* defines loss as a major reduction in a person's resources, whether personal, material, or symbolic, to which the person was emotionally attached. Types of loss covered include death and dying, dissolution and divorce, loss of employment, life-threatening diseases and long-term disability, loss of possessions, homelessness, recurring painful memories, disenfranchisement and stigmatization, losses resulting from war and violence, and aging.

The *Journal* highlights common as well as differing impacts of major losses while revealing commonalities of the various healing processes. Interdisciplinary in its approach, the quarterly publishes papers on experiments, case studies, discussions,

theoretical analyses, and essays on therapeutic approaches. Book reviews are also regular features.

The *Journal* was formerly called the *Journal of Personal and Interpersonal Loss*. Readers of the journal include academics and practitioners in the fields of psychology, counseling, thanatology, gerontology, nursing, anthropology, family studies, psychiatry, sociology, oral history, and organizational management as it pertains to job loss.

The *Journal* is published by Taylor & Francis, which is headquartered in London at 11 New Fetter Lane, London EC4P 4EE. Additional information can be obtained through the Taylor & Francis web site: www.tandf.co.uk.

Journal of Near-Death Studies

The *Journal of Near-Death Studies* is a quarterly publication produced by a nonprofit organization called the International Association for Near-Death Studies (IANDS). The *Journal* features scholarly reports on near-death experiences and similar phenomena, and is included in membership dues for IANDS. The term *near-death experience* refers to what reported by some people who come very close to physical death or who survive a state of clinical death. IANDS calls a near-death experience one of the most powerful emotional and psychological events known. The organization seeks to provide reliable information about near-death experiences, as well as information and support for those who have been through it.

IANDS describes its mission as responding to the need for information and support concerning near-death and similar experiences, and to encourage recognition of the experiences as genuine and significant events. Its stated goals are to enrich understanding of human consciousness and its relationship to life and death. IANDS responds to people's needs to integrate the physical, mental, emotional, and spiritual aspects of the near-death experience. Founded in 1981, it provides information about near-death experiences to researchers, academia, the health care community, and the public, encouraging research and serving as a networking organization for near-death experiencers, their families, and caregivers.

IANDS hosts an annual three-day conference for experiencers, researchers, and health care professionals. The association coordinates peer-support groups across the United States and

Canada to assist people who have experienced near death and need to reintegrate into daily life.

IANDS is headquartered at P.O. Box 502, East Windsor Hill, CT 06028. They can be reached by phone at 860-644-5216 or by email at office@iands.org or services@iands.org. Additional information can be obtained through the IANDS web site: www.iands.org.

Journal of Pain and Palliative Care in Pharmacotherapy

The *Journal of Pain and Palliative Care in Pharmacotherapy* is a professional quarterly journal that features information on end-of-life care. The publication includes original articles, reviews, editorials, commentaries, case reports, book and media reviews, news, and a meeting calendar.

The *Journal of Pain and Palliative Care in Pharmacotherapy* formed in 2002 from the merger of two other journals: the *Journal of Pharmaceutical Care in Pain and Symptom Control* and the *Hospice Journal*. The editors created the new title to reflect an increased focus on symptom control in end-of-life care. The international editorial board of the new journal includes over twenty experts in pain and palliative care from the fields of research, medicine, nursing, pharmacy, psychology, bioethics, and health policy.

The *Journal of Pharmaceutical Care in Pain and Symptom Control* was published quarterly beginning in 1993. It was a refereed journal concerned with issues of drug therapy in regard to its effectiveness, safety, cost, availability, delivery systems, ethics, health care policy, and other areas. These issues were addressed in relation to symptom control for both chronic and acute disorders. The *Hospice Journal*, which began in 1985, was the official journal of the National Hospice Organization. It addressed physical, psychosocial, and pastoral care of the dying.

The *Journal of Pain and Palliative Care in Pharmacotherapy* is published by The Haworth Press, 10 Alice Street, Binghamton, NY 13904-1580. Interested parties can obtain sample copies of the journal from that address. Single or multiple copies of all journal articles are available from the Haworth Document Delivery Service: 1-800-342-9678. The press can be reached by e-mail at getinfo@haworthpressinc.com. Additional information about

the *Journal* can be obtained through the Haworth Press web site: www.haworthpressinc.com.

Junior Chamber Family AIDS Network

The Junior Chamber Family AIDS Network was founded by members of the Jaycees to provide help for children and families affected by HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome). The organization allows young leaders to learn to mobilize community resources, build collaborative partnerships, provide volunteer support, and advocate for public policy change.

In 1995 members of the U.S. Junior Chamber of the Jaycees followed the Jaycee formula of national leadership and local solutions to address needs of children and families affected by HIV/AIDS. They formed a separate nonprofit organization called the Junior Chamber Family AIDS Network. Funding for the network comes from Jaycee chapters across the United States as well as private and corporate donations. The Jaycees stress individual development through leadership training and civic involvement. They learn to be leaders by working in community improvement programs.

The network maintains collaborative partnerships with three national organizations: Jaycees, Mothers' Voices, and Advocates for Youth. They also work with service providers in Missouri, Illinois, Michigan, Colorado, Oklahoma, and California.

Network services include providing child care, housing, case management, caregiver support, mental health treatment, and substance abuse treatment. Network volunteers help AIDS victims and families by hosting events, such as purchasing backpacks and school supplies for children, volunteering in direct service programs, creating residential facilities, and working to keep families together for as long as possible.

The Family AIDS Network is headquartered at 4 W. 21st Street, Tulsa, OK 74114. They can be reached by phone at 918-584-2481, by fax at 918-584-4422, or by e-mail at info@jcfamilyaidsnetwork.org. Additional information can be obtained through the Junior Chamber Family AIDS Network web site: www.jcfamilyaidsnetwork.org.

Last Acts

Last Acts is a campaign to improve care at the end of life. Its goal is to bring death-related issues into the open and help individuals and organizations pursue better ways to care for the dying. The organization believes in palliative care, which focuses on ways to ease pain and make life better for people who are dying and their loved ones. Palliative care means taking care of the whole person—body, mind, and spirit. It views death and dying as something natural and personal. The goal of palliative care is to provide the best quality of life until the very end of life.

Last Acts is a national effort to raise awareness about the need to improve care of the dying and to share issues and ideas at the national, state, and local levels. The honorary chair of Last Acts is the former first lady Rosalynn Carter. Last Acts' members comprise health care professionals, religious bodies, advocates, parents, educators, and health care institutions. They help partners find experts, schedule meeting speakers, and publicize their efforts.

Last Acts task forces address family needs, institutional change, professional education, palliative care, financing, and the workplace. Resource committees ensure that diversity, spirituality, public communication, standards development, and evaluation methods are incorporated in the work of each task force.

Last Acts works with policymakers and the news media to get and disseminate information about current policy issues. Last Acts sponsors national and regional conferences and publishes a quarterly print newsletter and special reports. Using electronic media, it conducts discussion groups on death and dying issues, distributes an e-mail newsletter, and publishes new information on its web site: www.lastacts.org.

Leukemia and Lymphoma Society

The Leukemia and Lymphoma Society is a national voluntary health agency dedicated to curing leukemia, lymphoma, Hodgkin's disease, and myeloma. The society is dedicated to improving the quality of life of patients with these diseases and their families.

Leukemia is a kind of cancer in which abnormal white blood cells multiply in an uncontrolled manner. It is a disease of the bone marrow and

other blood-forming organs. Lymphoma is lymphatic cancer. A well-known form of lymphoma is Hodgkin's disease, a type of cancer in which the lymph nodes and other lymphoid tissues become swollen. The disease can be fatal and its cause is unknown. The most common lymphatic cancer is non-Hodgkin's lymphoma. Cases of non-Hodgkin's lymphoma have risen steadily since the mid-1900s, as many people with AIDS (acquired immunodeficiency syndrome) develop this type of cancer. Myeloma is a cancerous tumor of the bone marrow.

The society was founded as the de Villers Foundation in 1949 by two parents who lost their only son to leukemia and recognized the need for an organization dedicated to finding cures for the disease. In 2000 the society changed its name from the Leukemia Society of America to the Leukemia and Lymphoma Society to emphasize its commitment to fighting all blood-related cancers. The society has close to sixty chapters across the United States.

The Leukemia and Lymphoma Society can be reached at 1311 Mamaroneck Avenue, White Plains, NY 10605. They can be reached by phone at 800-955-4572. Additional information can be obtained through the Leukemia and Lymphoma Society web site: www.leukemia.org.

Living Bank International

Living Bank International is a nonprofit organization dedicated to the enhancement of organ and tissue donation and transplantation. The mission of the Living Bank is to motivate and facilitate the commitment of enough organ and tissue donors so that no one must die or suffer for lack of a donation. The board and staff of the Living Bank are dedicated to increasing the number of registered-informed donors.

Founded in 1971, the Living Bank is the oldest and largest donor education organization in the United States, and the only national one that keeps computerized records of donor data for future retrieval in an emergency. The Living Bank also cooperates with and supports any group or organization whose activities generate more committed donors or facilitates actual donation.

There is a large donor/transplant community in the United States consisting of organizations that seek to educate would-be donors, issue donor cards, and register donor information for efficient

access and referral organ procurement organizations. The donor/transplant community also sends surgical teams into hospitals of the donors to take the donated organs and to transport the organs to hospitals where the chosen recipients wait. Transplant centers are located in authorized hospitals, where actual transplant operations take place.

Living Bank International is based in Houston, Texas. They can be reached by phone at 800-528-2971 or by e-mail at info@livingbank.org. Additional information can be obtained through the Living Bank International web site: www.livingbank.org.

Make-A-Wish Foundation of America

The Make-A-Wish Foundation of America exists to fulfill the wishes of children with life-threatening illnesses and to create moments of hope, strength, and joy for them. Although the foundation serves children diagnosed with life-threatening illnesses, many of these children survive their illnesses and go on to adulthood.

The foundation was created in 1980 by friends and relatives of a Phoenix, Arizona, boy named Chris Greicius who dreamed of becoming a police officer for a day. Officers of the Arizona highway patrol made his wish come true. Two of the officers, together with friends and Chris's mother, decided to offer that joy to other children with life-threatening illnesses. They formed the Make-A-Wish Foundation and the movement grew quickly throughout the United States and abroad. The foundation has international affiliates in Australia, Austria, Belgium, Canada, Chile, Costa Rica, Denmark, France, Greece, Hong Kong, India, Ireland, Israel, Japan, Mexico, Netherlands, New Zealand, Panama, Philippines, Taiwan, and the United Kingdom.

Since 1980 Make-A-Wish volunteers have granted more than 83,000 wishes worldwide. The foundation is funded primarily through corporate and private donations. Requests for wishes come from parents or guardians, from members of the medical community, and from children themselves.

For more information about the Make-A-Wish Foundation, call 800-722-WISH or visit their web site at www.wish.org. The web site provides a great deal of information and introduces ways to help, such as giving online, donating frequent flier miles, or volunteering for local chapters.

The Make-A-Wish Foundation of America is headquartered at 3550 N. Central Avenue, Suite 300, Phoenix, AZ 85012. Their e-mail address is mawfa@wish.org and the public relations e-mail address is comm@wish.org.

Mortality

The journal *Mortality*, an interdisciplinary peer-reviewed publication that focuses on the topic of human mortality, is of interest to academics in the fields of anthropology, art, classics, history, literature, medicine, music, sociolegal studies, social policy, sociology, philosophy, psychology, and religious studies. Death studies is an interdisciplinary medium. *Mortality* is also of interest to people professionally or voluntarily engaged in the health and caring professions, bereavement counseling, the funeral industries, and central and local government.

Mortality was started in 1996 and became of interest to international scholars and professional groups. Both new and established scholars in this field valued its interdisciplinary approach. *Mortality* aims to publish new material that is peer reviewed. The journal encourages debate and offers critiques of existing and classical work. The journal also promotes the development of theory and methodology. The journal seeks to develop substantive issues and research within an interdisciplinary context. It stimulates the growing awareness of the relevance of human mortality in personal and social life, in economic and institutional activity, and in systems of belief, ethics, and values. The journal editors pursue an international approach that invites articles addressing all historical periods and all subject areas.

Mortality is published by Taylor & Francis, which is headquartered at 11 New Fetter Lane, London EC4P 4EE. Additional information can be obtained through the Taylor & Francis web site: www.tandf.co.uk.

Mothers Against Drunk Driving

Mothers Against Drunk Driving (MADD) is a nonprofit voluntary organization whose focus is to look for effective solutions to problems of drunk driving and underage drinking, while supporting victims who have already experienced the pain of these crimes.

MADD was founded in 1980 by a small group of mothers and grew to one of the largest crime

victim organizations in the world. With over 600 chapters, MADD is one of the most widely supported and publicly approved nonprofit organizations in America. MADD's funding comes from individual donors, grants, bequests, and MADD's corporate sponsors. MADD works with corporations to promote awareness campaigns and programs designed to stop drinking and driving.

MADD compiles statistics and facts from a number of reliable and credible sources, including the National Highway and Traffic Safety Administration. MADD also tracks laws having to do with drunk driving and underage drinking, including which states currently have these laws, and how the laws vary from state to state.

Drunk driving research supports MADD's positions on key issues surrounding drunk driving. Many of these journals and studies have formed the foundation for laws and policies in place today. Since MADD's start, more than 2,300 anti-drunk driving laws have been passed. A 1994 study found MADD to be the most popular nonprofit cause in the United States, well liked by 51 percent of Americans. It ranked second among the most strongly supported charities and third on the most credible list.

Mothers Against Drunk Driving is headquartered at P.O. Box 541688, Dallas, TX 75354-1688. They can be reached by phone at 800-GET-MADD (438-6233). Additional information can be obtained through the MADD web site: www.madd.org.

National Association of People with AIDS

The National Association of People with AIDS (NAPWA) advocates on behalf of all people living with HIV (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome) in order to end the pandemic and the suffering it creates. The association's stated goal is to educate, inform, and empower all people living with HIV and AIDS.

NAPWA began in 1983 with the Patient Advisory Committee of the Second National AIDS Forum that was held in Denver, Colorado. One act of the committee was to adopt the term *people with AIDS* instead of *victim* or *patient*, which they saw as negative. The committee also created a set of recommendations for a more humane response to AIDS. The effort remained a loosely affiliated network.

NAPWA became incorporated in Washington, D.C., in 1987. From its place in Washington, the group sought to become an effective voice of people with AIDS at the center of national power.

NAPWA sponsors the National Call to Commitment Day, a grassroots action organized in collaboration with national, regional, and local organizations that serve the needs of people living with HIV and AIDS. Its goal is to increase federal funding to meet the needs of people living with and at risk for HIV.

The National Association of People with AIDS is headquartered at 1413 K Street NW, 7th Floor, Washington, DC 20005. They can be reached by phone at 202-898-0414, by fax at 202-898-0435, or by e-mail at napwa@napwa.org. Additional information can be obtained through the NAPWA web site: www.napwa.org.

National Center for Victims of Crime

The National Center for Victims of Crime (NCVC) is a leading advocate for crime victims in the United States. NCVC functions as a national resource center that seeks justice for crime victims. It does this by collaborating with local, state, and federal partners, and by pushing for passage of laws and public policies that create resources and win rights and protections for crime victims. The NCVC provides direct services and resources to victims, as well as training and technical assistance to victim service organizations, counselors, attorneys, criminal justice agencies, and other professionals. The National Center for Victims of Crime is a nonprofit organization supported by members, individual donors, corporations, foundations, and government grants.

The center was founded in 1985 and claims to have worked with more than 10,000 organizations and criminal justice agencies serving millions of crime victims by the early 2000s. The NCVC compiles statistics on crime and victimization and provides education through conferences, workshops, seminars, and videocassettes. The center also helps communities develop programs for victims of violent crimes. Among the center's most important services is providing crime victims and witnesses with direct assistance, such as social service referrals for crime victims.

The center maintains a database of over 10,000 organizations that link victims with key services, including crisis intervention, information, help through the criminal justice process, counseling, support groups, and legal counsel.

The National Center for Victims of Crime is headquartered at 2111 Wilson Boulevard, Suite 300, Arlington, VA 22201. People seeking an organization near them or any related referral can e-mail the service referral department at dskins@ncvc.org or call 800-FYI-CALL or 800-211-7996 (tty/tdd). The center also offers referrals for crime victims to attorneys for civil cases.

National Funeral Directors and Morticians Association

The National Funeral Directors and Morticians Association (NFDMA) is a nonprofit membership association of professional funeral directors and morticians.

The NFDMA began as the Independent National Funeral Directors Association in 1924. It was organized by a group of licensed funeral directors seeking to maintain high professional standards for the benefit of the public and their own business community. In 1926 the name was changed to the Progressive National Funeral Directors Association. In 1940 a merger with the National Colored Undertakers Association became the National Negro Funeral Directors Association. In 1957 NFDMA adopted its present name.

The stated objectives of the association are to foster research, conduct workshops and seminars, investigate funeral practices, develop and maintain standards of conduct designed to improve the business condition of its members, and maintain high standards of service for the benefit of the public. The association seeks to provide a continuing program of service and to develop and disseminate information beneficial to members and the public. The NFDMA promises to represent the common professional and business interests of its members before various federal, state, and local legislative, administrative, and judicial bodies throughout the United States.

The NFDMA awards an annual scholarship and they publish a quarterly magazine, *National Scope*, which is free to members.

The National Funeral Directors and Morticians Association is headquartered at 3951 Snapfinger Parkway, Suite 570, Omega World Center, Decatur, GA 30035. They can be reached by phone at 800-434-0958 or by e-mail at nfdma@nfdma.com. More information can be obtained through the NFDMA web site: www.nfdma.com.

National Heart, Lung, and Blood Institute

The National Heart, Lung, and Blood Institute (NHLBI) concerns itself with diseases of the heart, blood vessels, lungs, and blood, as well as with the blood supply in the United States. The NHLBI is one of the thirteen institutes of the National Institutes of Health (NIH), an agency of the U.S. federal government. The NIH is part of the Public Health Service of the U.S. Department of Health and Human Services. NIH conducts a broad range of biomedical research at its laboratories in Bethesda, Maryland, and provides funds for the training of research scientists. Elements of the NIH began in 1887, and it gained its present name in 1948.

The NHLBI is involved in many research efforts, including basic research, clinical investigations and trials, observational studies, and demonstration and education projects. The NHLBI is involved at the level of planning, conducting, and supporting such research programs. NHLBI research focuses on the causes, prevention, diagnosis, and treatment of heart, blood vessel, lung, and blood diseases and sleep disorders.

The NHLBI also conducts educational activities for health professionals, with an emphasis on prevention. The NHLBI seeks to spread information to the public, also emphasizing prevention.

The NHLBI coordinates its activities with other research institutes and federal health programs. It maintains relationships with institutions and professional associations, working with international, national, state, and local officials as well as voluntary agencies and organizations concerned with the heart, blood vessels, lung, and blood; blood resources; and sleep disorders.

People can direct health-related questions and requests for copies of publications to the NHLBI Information Center. They can be reached by e-mail at NHLBIinfo@rover.nhlbi.nih.gov. Additional information can be obtained through the NHLBI web site: www.nhlbi.nih.gov.

National Hemophilia Foundation

The National Hemophilia Foundation (NHF) acts as a leading resource on bleeding disorders information, also focusing attention on keeping the national blood supply safe. The NHF maintains that the number of people with hemophilia in the United States is 20,000. Hemophilia is a disease in which the blood does not clot normally, causing its victims, hemophiliacs, to bleed excessively if injured. The disease is hereditary and nearly all hemophiliacs are male. Because hemophiliacs often need blood transfusions, they are vulnerable to any disease that can be passed through the blood supply, such as HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome).

The National Hemophilia Foundation was established in 1948 with the goal of generating awareness about the disease of hemophilia and calling for greater research. NHF works closely with the National Institutes of Health, the Food and Drug Administration, and the Centers for Disease Control and Prevention (CDC) to advocate for such issues as blood safety, medical insurance reform, and continued funding for hemophilia treatment centers and research.

The NHF also works with the CDC to spread information and awareness about von Willebrand disease and other female bleeding disorders. Von Willebrand disease is a hereditary disease, similar to hemophilia but occurring among women, in which the skin bleeds for an abnormally long period of time when injured.

The National Hemophilia Foundation is headquartered at 116 W. 32nd Street, 11th Floor, New York, NY 10001. They can be reached by phone at 800-42-HANDI or by e-mail at info@hemophilia.org. Additional information can be obtained through the NHF web site: www.hemophilia.org.

National Hospice and Palliative Care Organization

The National Hospice and Palliative Care Organization (NHPCO) is committed to improving end-of-life care. The organization seeks to expand access to hospice care with the goal of enhancing quality of life for dying people in America, as well as for their loved ones.

Hospice is a family centered concept of health care for people dying of an incurable illness. The

hospice concept aims at easing the physical and psychological pain of the patient's illness, so that the person can appreciate his or her remaining life. The hospice team includes the patient and his or her family, as well as physicians, nurses, social workers, members of the clergy, and volunteers. Hospice services may include nursing care and pain control, meal preparation, laundry, or shopping. This care may be provided at home, in a separate hospice medical center, or in a hospice unit of a hospital.

In 1990 the World Health Organization defined palliative care, stating that it addresses not only physical pain, but emotional, social, and spiritual pain to achieve the best possible quality of life for patients and their families. Many hospice care programs have added palliative care to their names to reflect the greater range of care and services they provide.

The National Hospice and Palliative Care Organization was founded in 1978 as the National Hospice Organization and changed its name in 2000. The organization offers support for the terminally ill and their families and develops public and professional educational programs and materials to increase understanding of hospice and palliative care.

The National Hospice and Palliative Care Organization is headquartered at 1700 Diagonal Road, Suite 300, Alexandria, VA 22314. They can be reached by phone at 703-837-1500 or by e-mail at info@nhpco.org. Additional information can be obtained through the NHPCO web site: www.nhpco.org.

National Institute for Jewish Hospice

The National Institute for Jewish Hospice (NIJH) serves the needs of Jewish people who are terminally ill. The institute does this by providing free telephone counseling, making referrals, and training professionals in the needs of the terminally ill. The institute reaches out to families, businesses, and organizations concerned about seriously and terminally ill Jewish people.

NIJH was founded in 1985 to help alleviate suffering in terminal illness, death, and bereavement among Jewish people. Rabbi Maurice Lamm, a professor at Yeshiva University in New York City, is the founder and president of the National Institute for Jewish Hospice.

The institute serves as a resource center for terminal patients and their families, mainly providing information on traditional Jewish views on death, dying, and managing the loss of a loved one. The NIJH offers guidance and training to patients and interested hospice personnel, health care professionals, clergy, and family members who work with terminally ill Jewish people.

The NIJH provides materials to communities interested in setting up Jewish hospice care programs. The NIJH promotes its "Jewish Living Will and Durable Power of Attorney" document as covering the entire spectrum of Jewish thought regarding legal and medical ethics and offers it to anyone who wants a copy.

In addition to the Jewish living will, the NIJH publishes booklets and tapes that include: *Caring for the Jewish Terminally Ill*, *For Families of the Jewish Terminally Ill*, *Hemlock Is Poison for Society*, *How to Console*, *Introduction to Jewish Hospice*, *The Jewish Orphaned Adult*, *Realities of the Dying*, *Self-Healing and Hospice Care*, *The Spiritual Component Cannot Be Ignored*, *Strategies for Jewish Care*, and *The Undying Hope*.

The National Institute for Jewish Hospice is headquartered at Cedars-Sinai Medical Center, 444 S. San Vicente Boulevard, Suite 601, Los Angeles, CA 90048. They can be reached by phone at 213-HOSPICE or 800-446-4448.

National Institute of Diabetes and Digestive and Kidney Diseases

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) states that its mission is to conduct and support basic and clinical research on some of the most serious public health diseases. The institute supports much of the clinical research on the diseases of internal medicine as well as many basic science disciplines.

The NIDDK is one of the thirteen institutes of the National Institutes of Health (NIH), an agency of the U.S. federal government. The NIH is part of the Public Health Service of the U.S. Department of Health and Human Services. The NIH conducts a broad range of biomedical research at its laboratories in Bethesda, Maryland, and provides funds for the training of research scientists.

The diseases that the NIDDK concerns itself with are metabolic diseases such as diabetes, endocrine disorders, mineral metabolism, digestive

diseases, nutrition, urology and renal disease, and hematology. Basic research studies of the NIDDK include biochemistry, nutrition, pathology, histochemistry, chemistry, physical, chemical, and molecular biology, pharmacology, and toxicology.

The institute supports research through grants, career development, and awards. The Institute contracts with various institutions and companies for research and development projects.

In 1950 President Harry S. Truman established the National Institute of Arthritis and Metabolic Diseases as part of the Public Health Service. In 1972 the institute's name was changed to National Institute of Arthritis, Metabolism, and Digestive Diseases. In 1981 the institute was renamed the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases (NIADDDK). In 1986 the NIADDDK was renamed the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

The NIDDK is located at the NIH headquarters. The NIH is located at Building 31, Room 9A04 Center Drive, MSC 2560, Bethesda, MD 20892-2560.

National Kidney Foundation

The National Kidney Foundation (NKF) is a non-profit foundation with the stated mission of preventing kidney and urinary tract diseases, improving the well-being of individuals affected by these diseases, and increasing the availability of organs for transplantation. The foundation states six goals: to educate the public, support research, expand patient services, provide educational opportunities for professionals, influence health policy, and raise funds.

The NKF was founded in 1950. Kidney diseases include kidney infection, the most common kidney disease, which can also involve infection of the urinary tract and can lead to kidney failure. Other diseases of the body, such as high blood pressure and diabetes, can damage the kidneys. Cysts, kidney stones, and tumors can damage the kidneys, and kidney disorders can also result from birth defects, injuries, poisoning, or from certain medications.

Some kidney patients have their diseased kidneys replaced by a transplant. Because people can function with one kidney, some patients receive a replacement organ from a close relative. However, most transplant organs come from victims of accidental death.

The NKF works to increase the number of organs available for transplant through such efforts as their sponsorship of the Olympic-style games for transplant recipients, distributing donor cards, and counseling donor families in their grief.

The NKF gives monetary grants to physicians and scientists involved in research of kidney disease. The foundation offers free health screenings, rehabilitation programs for recovering kidney patients, support for patients and families, summer camps for children with dialysis, and financial aid for patients.

The NKF publishes *Advances in Renal Replacement Therapy*, a quarterly journal, and the *American Journal of Kidney Diseases*, a monthly.

The National Kidney Foundation is headquartered at 30 E. 33rd Street, Suite 1100, New York, NY 10016. They can be reached by phone at 800-622-9010 or by e-mail at info@kidney.org. Additional information, including the addresses of branch offices, can be obtained through the NKF web site: www.kidney.org.

National Native American AIDS Prevention Center

The National Native American AIDS Prevention Center is a network of Native Americans with the stated mission of stopping the spread of HIV and related diseases among American Indians, Alaska Natives, and Native Hawaiians, and improving the quality of life for members of their communities who are affected by HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome). The network works to eliminate sexually transmitted diseases and tuberculosis and seeks to improve Native American health status through empowerment and self-determination. The organization acts as a resource to native communities and supports community efforts by providing education and information services. The center also maintains a speakers' bureau and compiles statistics.

The National Native American AIDS Prevention Center was founded in 1987. Directors of the organization include people with HIV, tribal officials, public health professionals, health care providers, and substance abuse program administrators.

A primary goal of the National Native American AIDS Prevention Center is to establish working agreements with local service providers that help

HIV-infected Native Americans gain access to services. The network helps people find culturally familiar resources such as those using Native American spirituality and traditional healing. The network also offers cultural awareness training to service providers. The National Native American AIDS Prevention Center works in urban areas and on reservations.

The National Native American AIDS Prevention Center is headquartered at 436 14th Street, Suite 1020, Oakland, CA 94612. They can be reached by phone at 510-444-2051 or by e-mail at information@nnaapc.org. Additional information can be obtained through the National Native American AIDS Prevention Center's web site: www.nnaapc.org.

National Organization for Victim Assistance

The National Organization for Victim Assistance (NOVA) is a nonprofit organization that seeks to promote rights and services for victims of crime and crisis. Members include victim and witness assistance programs, criminal justice professionals, mental health professionals, researchers, former crime victims and survivors, and others committed to the concerns of victim rights and services.

NOVA was founded in 1975. In its role as advocate for victims, NOVA succeeded in such efforts as greatly expanding the number of victim compensation programs in the United States, so that by 1998 each state had such a program. In addition, NOVA helped write the Anti-Terrorism Act, enacted after the bombing of the Murrah Federal Building in Oklahoma City, which allowed the Office for Victims of Crime in the U.S. Department of Justice to use federal funds to help victims of terrorism and mass violence. NOVA also helped draft and pass the federal Victims of Crime Act of 1984. In its first twelve years, the Crime Victims Fund, based on the act, transferred about \$2.2 billion in federal criminal fines to state compensation and local assistance programs. NOVA also helped pass the Violence Against Women Act.

NOVA provides direct services to victims through a twenty-four-hour toll-free crisis line and community crisis response teams. They assist professional colleagues through training and educational programs.

The organization's mailing address is 1730 Park Road NW, Washington, DC 20010. NOVA can be

reached by phone at 202-232-6682 or 800-TRY-NOVA, or by e-mail at nova@try-nova.org. Additional information can be obtained through the NOVA web site: www.try-nova.org.

National SIDS/Infant Death Resource Center

The National SIDS/Infant Death Resource Center (NSIDRC) provides information and technical assistance on sudden infant death syndrome, also called SIDS or crib death, and related topics. Sudden infant death syndrome is the death of an apparently healthy baby under one year of age, the cause of which is unknown. In most cases, the baby is found dead a few hours after being put to bed. Even following an autopsy, a death scene investigation, and a thorough look at the baby's medical history, the cause of death cannot be found. In many countries SIDS is one of the leading causes of infant death.

The NSIDRC was founded in 1980 and was sponsored by the Maternal and Child Health Bureau (MCHB) of the U.S. Department of Health and Human Services.

NSIDRC seeks to promote understanding of SIDS and to provide comfort to those affected by SIDS. NSIDRC works with policymakers, parents, researchers, educators, medical and legal professionals, care providers, and counselors. NSIDRC's products and services include information sheets and other publications. NSIDRC also maintains a database of research and public awareness materials. NSIDRC distributes informational materials for the National Institute of Child Health and Human Development.

The National SIDS/Infant Death Resource Center is headquartered at 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182. They can be reached by phone at 703-821-8955 or 703-821-2098, or by e-mail address at sids@circlesolutions.com. Additional information can be obtained through the NSIDRC web site: www.sidscenter.org.

National Stroke Association

The National Stroke Association (NSA) is a nonprofit organization dedicated to issues concerning strokes, including prevention, treatment, rehabilitation, and research.

Stroke is a leading cause of death in the United States. Strokes are usually caused by blood clots

that block circulation to the brain. People at risk of stroke include those with high blood pressure, diabetes, high cholesterol levels, and a smoking habit. Depending on what area of the brain is affected, stroke victims may lose function of various parts of their bodies. Recovery usually includes professional rehabilitation services.

The National Stroke Association was founded in 1984. Soon after, the NSA produced a statement of guidelines for stroke prevention, published in the *Journal of the American Medical Association*.

The NSA acts as a resource for stroke victims and their families as well as health care professionals and health care institutions. The association works to prevent stroke through a number of programs, offering educational materials and assistance in the development of stroke support groups.

The National Stroke Association seeks to help create universal standards of care for stroke victims. The NSA promotes guidelines for American hospitals and works to keep health insurance reimbursement levels commensurate with increasing health care costs. The association works to place the problem of stroke on the national agenda as a top funding priority, collaborating with key organizations, institutions, and agencies throughout the United States on this and other goals.

The National Stroke Association is headquartered at 9707 E. Easter Lane, Englewood, CO 80112. They can be reached by phone at 800-STROKES. Additional information can be obtained through the NSA web site: www.stroke.org.

National Women's Health Resource Center

The National Women's Health Resource Center (NWHRC) is a nonprofit organization that aims to help women educate themselves about female health topics. The organization declares its dedication to helping women make informed decisions about their health and encouraging women to embrace healthy lifestyles to promote wellness and prevent disease. NWHRC works with leading health care experts and organizations to develop health materials specifically for women. The NWHRC began in 1988.

The center works to provide health care professionals with additional resources for their patients. NWHRC staff and its Women's Health Advisory Council, a group of health experts, seek to

provide professional perspective and commentary on women's health issues.

Through partnerships with health care, education, and advocacy organizations and government agencies, the NWHRC tries to promote timely issues concerning women's health. The NWHRC also seeks partnerships with such commercial entities as pharmaceutical and managed care companies, hospitals and other health systems, corporations, and media establishments. The NWHRC sponsors national public education initiatives, such as campaigns to educate women about contraception, menopause, heart disease, and osteoporosis.

The NWHRC produces a number of publications on a variety of women's health topics, including *The Book of Women's Health*, a home reference source. Its newsletter, the "National Women's Health Report," presents an in-depth review of a featured health topic each issue. The NWHRC also seeks to supply media sources with credible health information. The center maintains a database of nationwide health resources as well as a web site intended to be a full resource for women's health.

The National Women's Health Resource Center is headquartered at 120 Albany Street, Suite 820, New Brunswick, NJ 08901. They can be reached by phone at 877-986-9472 or by e-mail at info@healthywomen.org. Additional information can be obtained through the NWHRC web site: www.healthywomen.org.

Omega: The Journal of Death and Dying

Omega: The Journal of Death and Dying is a peer-reviewed journal that features articles about terminal illness, bereavement, mourning, the process of dying, funeral customs, and suicide. The journal accepts contributions from professionals in universities, hospitals, clinics, retirement homes, suicide prevention centers, funeral homes, and others concerned with thanatology, the study of death.

Omega is affiliated with the Association for Death Education Counseling (ADEC), a multidisciplinary, professional nonprofit organization dedicated to promoting excellence in death education, bereavement counseling, and care of the dying. ADEC works to promote and share research, theories, and practice in dying, death, and bereavement

and to provide a forum for professionals to advance the body of knowledge and promote practical applications of theory in these areas.

The journal seeks to meet the needs of clinicians, social workers, and health professionals who must deal with problems in crisis management—for example, terminal illness, fatal accidents, catastrophe, suicide, and bereavement. *Omega* covers topics in the fields of psychology, sociology, medicine, anthropology, law, education, history, and literature.

Omega: The Journal of Death and Dying is published by the Baywood Publishing Company, located at 26 Austin Avenue, Box 337, Amityville, NY 11701. They can be reached by phone at 800-638-7819 or by e-mail at info@baywood.com. Additional information can be obtained through the Baywood Publishing Company web site: www.baywood.com.

Oncology Nursing Society

The Oncology Nursing Society (ONS) is an organization of registered nurses and other health care professionals dedicated to excellence in caring for cancer patients. ONS states its vision as leading the transformation of cancer care through initiating and actively supporting educational, legislative, and public awareness efforts to improve the treatment of people with cancer.

ONS's stated mission is to promote excellence in oncology nursing and quality cancer care. It seeks to do this by providing nurses and other health care professionals with access to the highest quality educational programs, cancer-care resources, research, and support networks. ONS works with many other nursing and health-related organizations throughout the world to educate professionals and promote information sharing among nurses. The society also seeks to make the issue of cancer care a priority on the legislative and policymaking agenda.

ONS began with the First National Cancer Nursing Conference in 1973. In 1974, after a group of nurses attended a nursing session at a major cancer conference, it gathered names of more interested nurses and initiated a newsletter, which later became the *Oncology Nursing Forum*. The society was officially incorporated in 1975. The society publishes two journals, *Oncology Nursing Forum*, the official journal of the ONS, and *Clinical Journal of Oncology Nursing*.

The Oncology Nursing Society is headquartered at 501 Holiday Drive, Pittsburgh, PA 15220-2749. They can be reached by phone at 412-921-7373 or by e-mail at customer.service@ons.org. Additional information can be obtained through the ONS web site: www.ons.org.

Palliative Care Australia

Palliative Care Australia is a key organization for palliative care in Australia, whose stated goal is to work toward the relief of pain and suffering of dying people and the provision of the care they need. Palliative Care Australia defines hospice and palliative care as “a concept of care which provides coordinated medical, nursing and allied services for people who are terminally ill, delivered where possible in the environment of the person's choice, and which provides physical, psychological, emotional and spiritual support for patients, and support for patients' families and friends.”

Palliative Care Australia began in 1990 as the Australian Association for Hospice and Palliative Care, Inc. The organization sprung out of an affiliation of state palliative care associations who first came together at the Australian National Hospice Palliative Care Conference held in Adelaide in 1990.

Palliative Care Australia's aim is to provide a national forum for the exchange of ideas and information on matters relating to hospice and palliative care and to encourage the spread of information to the general community and to professional, paraprofessional, and volunteer caregivers through education and community awareness programs. It seeks to consult with government and health authorities on the needs of people with progressive and terminal illnesses and their families and caretakers. Palliative Care Australia advises hospice and palliative care organizations throughout Australia, assisting in the development of appropriate standards for hospice and palliative care in the country.

Additional information can be obtained through the Palliative Care Australia web site: www.pallcare.org.au.

Partnership for Caring: America's Voices for the Dying

Partnership for Caring: America's Voices for the Dying is a national nonprofit organization that brings together individuals and organizations in a

collaborative effort to improve how people die in American society. Among other services, Partnership for Caring operates the only national crisis and informational hotline dealing with end-of-life issues. The organization also provides state-specific living wills and medical powers of attorney.

Partnership for Caring is devoted to raising consumer expectations for excellent end-of-life care and increasing demand for such care. It is the only end-of-life organization that puts individuals and organizations and consumers and professionals together to create a combined effort that insists that society improves how it cares for dying people and their loved ones.

In 2000 Choice In Dying, an organization dedicated to making advance directives available, became Partnership for Caring: America's Voices for the Dying, which broadened its scope.

Partnership for Caring promotes a society in which death and dying are respected as significant life-cycle events. High-quality, complete palliative care, including hospice, would be assured. Support for the tasks required to achieve a satisfying level of life completion and closure would be provided for dying people and their loved ones.

The Partnership for Caring hotline number is 800-989-9455. People can contact the Partnership for Caring office if they need assistance regarding a specific end-of-life situation, to speak with legal staff, to obtain information on living wills and medical power of attorney, or to speak with a representative about publications or becoming a partner.

Partnership for Caring is headquartered at 1620 Eye Street NW, Suite 202, Washington, DC 20007. They can be reached by e-mail at pfc@partnershipforcaring.org. Additional information can be obtained through the Partnership for Caring web site: www.partnershipforcaring.org.

Project on Death in America

The Project on Death in America (PDIA) works to promote a better understanding of dying and to transform the culture and experience of dying and bereavement in the United States through research, scholarship, the humanities, and the arts. Its claims to foster innovations in the provision of care, public education, professional education, and public

policy. The PDIA seeks to help transform the culture surrounding death.

The PDIA is part of the Open Society Institute, which describes itself as "a private operating and grantmaking foundation that seeks to promote the development and maintenance of open societies around the world by supporting a range of programs in the areas of educational, social, and legal reform, and by encouraging alternative approaches to complex and often controversial issues." It was established in 1993 and is part of the Soros foundations network, a network of organizations created by the wealthy philanthropist George Soros. In 1994 Soros founded the Project on Death in America. He decided to give funds toward the problem of dying because of his own family experiences with death. The death of his parents "made me realize that there is a need to better understand the experience of dying," he said. The project seeks to encourage broader philanthropic support in the field of palliative care. The PDIA awards grants to academic professionals and others who are studying issues of death and dying.

Project on Death in America is headquartered at Open Society Institute, 400 W. 59th Street, New York, NY 10019. They can be reached by phone at 212-548-1334. Additional information can be obtained through the Soros/Project on Death in America web site: www.soros.org/death.

SHARE Pregnancy and Infant Loss Support

SHARE Pregnancy and Infant Loss Support is a nonprofit group with the stated mission of serving those whose lives have been touched by the tragic death of a baby through miscarriage, stillbirth, or newborn death.

The group's support includes emotional, physical, spiritual, and social healing. The secondary stated purpose of SHARE is to provide information, education, and resources pertaining to the needs and rights of bereaved parents and siblings. Its objective is to aid all of those in supportive roles, including family, friends, employers, church members, caregivers, and others.

SHARE began in 1977 at St. John's Hospital in Springfield, Illinois. The first support group met after one bereaved parent and several hospital staffers worked together. SHARE eventually grew to over 130 chapters internationally. SHARE helps

form local groups whose activities include holding monthly support meetings, providing lists of resources, developing keepsake kits, and developing parent-to-parent support.

SHARE publishes a number of publications, including *Caring Notes*, a quarterly newsletter. All information packets, correspondence, and support is free of charge for bereaved parents.

A major SHARE fundraising effort is soliciting for “love gifts,” which are monetary donations given in honor of someone or as a memorial to a baby, relative, or friend. People may send donations to National Share Office, 300 First Capitol Drive Street, Charles, MO 63301-2893. SHARE can also be reached by phone at 800-821-6819 or by e-mail at share@nationalshareoffice.com. Additional information can be obtained through the SHARE web site: www.nationalshareoffice.com.

Society of Military Widows

The Society of Military Widows is a national non-profit organization whose stated purpose is to benefit widows of members of all branches of the uniformed services of the United States whose husbands died either during active service or following retirement. The society provides moral support, advice, and referrals to help the widows of career military members return to normal living. The organization seeks to educate the American public concerning the problems and needs of military widows. It works for fair legislation and survivor benefit programs, monitoring legislation and programs affecting military widows in the U.S. Congress, Department of Defense, and Veterans Administration.

The society was founded in 1968 by Theresa Alexander to serve the needs of women whose military husbands died. In 1984 the society affiliated with the National Association for Uniformed Services, which represents a broad spectrum of military-related interests, in order to create a strong, unified legislative force.

The society publishes a quarterly newsletter, the *National Association of Military Widows*, and hosts an annual convention for its members. Widows eligible for membership must possess a valid URW (un-remarried widow) military identification card.

The Society of Military Widows is headquartered at 5535 Hempstead Way, Springfield, VA

22151. For questions related to a spouse’s death or about rights and benefits as a military survivor, the society can be reached by phone at 800-842-3451, ext. 3009 or by e-mail at benefits@militarywidows.org. Additional information can be obtained through the Society of Military Widows web site: www.militarywidows.org.

Suicide and Life-Threatening Behavior

Suicide and Life-Threatening Behavior is the official journal of the American Association of Suicidology (AAS), an organization of individuals and groups interested in the study of suicide prevention and life-threatening behavior. These members include psychologists, psychiatrists, social workers, nurses, health educators, physicians, directors of suicide prevention centers, clergy, and others from various disciplines.

The journal began in the early 1970s, and is published by Guilford Publications, known for its publications concerned with psychology, psychiatry, and the behavioral sciences. The journal is edited by Morton M. Silverman, M.D., from the University of Chicago, and includes scholarly research and clinical experience.

Suicide and Life-Threatening Behavior reaches professionals worldwide and employs an interdisciplinary approach, covering biological, statistical, psychological, and sociological approaches to suicidology. Article titles of the journal have included “Collaborating to Prevent Suicide: A Clinical-Research Perspective,” “Suicide Among Adolescents and Young Adults: A Cross-National Comparison of 34 Countries,” “Suicidality Patterns and Sexual Orientation-Related Factors among Lesbian, Gay, and Bisexual Youths,” “Stressful Life Events and Impulsiveness in Failed Suicide,” “Early Suicide Following Discharge from a Psychiatric Hospital,” “Loneliness in Relation to Suicide Ideation and Parasuicide: A Population-Wide Study,” “An Epidemiological Profile of Suicides in Beijing, China,” and “Are UN Peacekeepers at Risk for Suicide?”

Guilford Publications is located at 72 Spring Street, New York, NY 10012. They can be reached by phone at 800-365-7006 or by e-mail at info@guilford.com. Issues of the journal can be viewed on the Guilford Publications web site: www.guilford.com. The AAS is headquartered at 4201 Connecticut Avenue NW, Suite 408, Washington,

DC 20008. Additional information can be obtained through the AAS web site: www.suicidology.org.

The Compassionate Friends

The Compassionate Friends (TCF) is a nonprofit, self-help support organization for bereaved parents. The stated mission of TCF is to help families resolve grief resulting from the death of a child of any age. The organization also provides information for friends and family of the bereaved. The group has no religious affiliation or membership dues. TCF does not participate in legislative or political controversy and operates primarily through local chapters.

The Compassionate Friends was founded in 1969 in Coventry, England, following the deaths of two young boys when a hospital chaplain introduced the two sets of parents. They invited other newly bereaved parents to join them and soon organized as a self-help group. The chaplain helped develop other chapters around the world. The Compassionate Friends was incorporated in the United States as a nonprofit organization in 1978. There are now TCF chapters in every state, totaling almost 600, and hundreds of chapters in Canada, Australia, Great Britain, and other countries.

TCF offers help to bereaved siblings. Since many areas do not have TCF groups, the Sibling Forum is available online for siblings from all over the world. Interested siblings need to request the password by e-mail from rep@compassionatefriends.org.

The Compassionate Friends publishes a national magazine, *We Need Not Walk Alone*, available by subscription. They also publish brochures such as "When a Child Dies . . . TCF Can Help," "Caring for Surviving Children," "Surviving Your Child's Suicide," "When a Brother or Sister Dies," and "The Death of an Adult Child." The organization hosts an annual national conference in the United States.

The Compassionate Friends can be reached at P.O. Box 3696, Oak Brook, IL 60522-3696. Chapter information can be obtained by phone at 630-990-0010 or 877-969-0010. Information about Canadian chapters can be obtained by e-mail at TCFCanada@aol.com. Additional information can be obtained through The Compassionate Friends web site: www.compassionatefriends.org.

The National Organization of Parents of Murdered Children

The National Organization of Parents of Murdered Children (POMC) is a self-help organization that seeks to assist families that have had a child who has been murdered. The issues that the group involves itself with include keeping murderers in prison, assisting families with unsolved cases, promoting murder prevention programs, providing emotional support for families, and providing information and advocacy for any survivor of a homicide victim.

Parents of Murdered Children was founded in 1978, and offers support and friendship to those who have experienced the violent death of a family member or friend. It seeks to help survivors return to physical and emotional health. POMC also works to increase public awareness of the problems faced by those who survive a homicide victim. It provides information about the grieving process as it pertains to murder as well as information about the criminal justice system as it pertains to survivors of a homicide victim.

POMC establishes self-help and support groups that meet regularly. It distributes literature and provides guest speakers for organizations. It has created prevention programs to help stop violence. In its newsletter, POMC includes a schedule of parole hearings for prisoners serving homicide sentences.

Parents of Murdered Children is headquartered at 100 E. 8th Street, B-41, Cincinnati, OH 45202. They can be reached by phone at 888-818-POMC or by e-mail at natlpomc@aol.com. Additional information can be obtained through the POMC web site: www.pomc.com.

United Network for Organ Sharing

The United Network for Organ Sharing (UNOS) is a nonprofit organization that maintains the organ transplant waiting list for the entire United States. This is mandated by law and under contract with the U.S. Department of Health and Human Services. UNOS matches organ donors to waiting recipients 24 hours a day, 365 days a year. Every transplant program, organ procurement organization, and tissue typing laboratory in the United States belongs to the UNOS network.

UNOS was founded in 1984 and is responsible for developing policies governing the transplant community. This work is done by its forty-member

board of directors, comprised of medical professionals, transplant recipients, and donor family members.

UNOS is responsible for monitoring every organ match to ensure that it conforms to UNOS policy. UNOS members work together to develop equitable policies that give all patients a fair chance at receiving the organ they need. Recipients are not discriminated against on the basis of age, gender, race, lifestyle, or financial and social status.

All patients accepted onto a transplant program's waiting list are registered with UNOS, where a centralized computer network links all organ procurement organizations and transplant centers. UNOS maintains the database that contains all transplant data.

When an organ becomes available, UNOS coordinates the surgical teams that are involved. The computerized matching process locates best possible matches between donor organs and the patients who need them. The final decision rests with the patient's transplant team. If they decide the patient cannot use the organ for any number of medical reasons, the organ is offered to the next patient on the list.

The United Network for Organ Sharing is headquartered at 1100 Boulders Parkway, Suite 500, P.O. Box 13770, Richmond, VA 23225. Additional information can be obtained through the UNOS web site: www.unos.org.

World Health Organization

The World Health Organization (WHO) is an agency of the United Nations (UN) that assists nations throughout the world to build better health

systems. WHO establishes standards for many goods including food and medicines. It also creates standards for some medical procedures and environmental health. A major goal of WHO is prevention of disease. Toward this end, the agency works with governments to provide safe drinking water, adequate sewage disposal, and immunization against childhood diseases. WHO identifies important research goals and organizes researchers all over the world to achieve these goals. It helps name and classify diseases.

WHO was founded in 1948, three years after the United Nations formed, and has its headquarters in Geneva, Switzerland. It also has six regional offices in various parts of the world. WHO has about 190 member nations. Its main branches are the World Health Assembly, the Executive Board, and the Secretariat. The World Health Assembly meets once a year and consists of delegates from all of the member nations. The Executive Board advises the World Health Assembly and implements its policies.

WHO has library services that provide users with access to international health, medical, and development information resources. These are available to WHO headquarters, regions, and country offices, ministries of health and other government offices, health workers in member states, other UN and international agencies, and diplomatic missions. WHO library programs help regions and developing countries achieve self-sufficiency in providing information services to the health sector.

Additional information can be obtained through the WHO web site: www.who.int.

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