

# The Psychology of Death and Dying in Later Life

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## INTRODUCTION

To review the psychology of death and dying in later life, it is vital to examine specific environmental and social matters that influence expectations and attributions regarding thanatology and aging; these environmental and social matters form the back story for

understanding and analyzing the current framework, particularly in post-modern secularized societies, affecting both societal and individual reactions to the prospects of mortality as we enter the last decades of life.

This chapter, therefore, examines first the secular, technological influences on contemporary understanding and experiences of death

and dying. Then attention is paid to individual expectations and fears about dying, including empirical data, clinical practices, and proposed policy changes for promoting a good death. Finally, attention turns toward bereavement, grief, and mourning in later life.

### **PART 1: SECULAR, TECHNOLOGICAL INFLUENCES ON UNDERSTANDING AND EXPERIENCING DEATH AND DYING IN LATER LIFE**

Two assumptions undergird contemporary thinking about mortality in developed countries. These two assumptions are (i) transformative sociocultural events have shaped contemporary attitudes toward and experiences of death and dying; (ii) the triumph of the biomedical model has altered dramatically individual expectations about living, about dying, and about death.

The transformative cultural events include the triumph of secular values, the dominance of science and technology, population changes and social controls, and the emergence of the biomedical model as the paradigm for health care practice (Benoliel & Degner, 1995; Starr, 1982). The triumph of secular values has meant a shift to a temporal, historical orientation and the appeal to human ingenuity to explain the universe into which we are thrown. Secular men and women believe in science, and accept as a starting point that human activities and decisions should be based on empirical evidence and facts rather than on an appeal to transcendent, extra-worldly powers. Thus, for instance, natural catastrophes such as the eruption of Mt. St. Helens in the 1980s and the tsunami that overwhelmed islands in the Indian Ocean in the early twenty-first century are explained by knowledge of geology and physics, not as vengeful acts of an angry or capricious divinity. Of some irony is that adherence

to secular values is associated with greater anxiety about death than is found in persons with strong religiosity (Corr & Corr, 2012).

The second transformative cultural event is the dominance of science and technology in contemporary society (Benoliel & Degner, 1995). Two major changes of immeasurable significance provide indicators of this second event: social mobility and an increased standard of living. Based on access to vehicular, rail, and air transportation, residents in developed countries have expectations of mobility; persons are not confined to small geographical locations but can travel at will, not only within large urban areas but within their country and to other countries. While extending possibilities, such mobility has also impacted relationships within immediate and extended families. My experience is a case in point: my parents grew up in and lived primarily for the first 36 years of their lives in a small town in Michigan; we moved in 1947 to Cheyenne, the first members of a large extended family to migrate across country; we moved over the next 16 years to Denver, Des Moines, and Phoenix as my father accepted positions of increasing responsibility and authority as a physician in charge of physical medicine departments for Veterans Administration hospitals; now my older sister lives in Denver, my younger sister in New Zealand, and I live in Brooklyn. This example underscores my contention that one of the impacts of social mobility on the psychological experience of dying is loss of physical contact with immediate and extended family members.

An increased standard of living, manifest by products of technology readily available to ordinary (i.e., non-affluent) persons, has also led to an underlying expectation that technological ingenuity will eventually find a way to fix any problem. Considered from a secularist point of view, one of the most pressing problems is mortality; and technology, married to medical research and practice, has worked to

push back barriers to continued existence, such as by manufacturing artificial organs enabling otherwise doomed persons to continue living, at least for a while.

The third transformative cultural event involves population changes and controls. Science and technology have contributed to an increase in the total population and to the length of time most persons live. These dramatic effects were partly the product of efficient and effective measures to handle food, water, shelter, and waste disposal; medical science and practice learned how to overcome infectious diseases, such as typhoid, diphtheria, pneumonia, smallpox, measles, and tuberculosis. Mortality statistics indicate that in the first two decades of the twentieth century at least 40% of all deaths were due to infectious diseases, and that over 53% of all reported deaths were to persons 14 years of age and younger; whereas life expectancy in 1900 was 47, life expectancy now is nearly 80. Deaths in 1900 were typically sudden, taking a week or less from the onset of the illness to the end. Today the typical death is due to a slow, lingering, progressive process resulting from a chronic condition such as cancer, heart disease, or circulatory problems (Corr & Corr, 2012; WHO, 2013).

The triumph of the biomedical model is the fourth transformative cultural event affecting our psychological responses to death and dying. The biomedical model is a conceptual framework that looks to material reasons, primarily biochemical, to explain and understand disease. This model sees diseases as physiological and biochemical deviations from established norms; the body is seen as a complicated, highly organized set of inter-related physical systems. The biomedical model triumphed because it was enormously successful in producing new knowledge and conquering medical ailments. Practitioners within the biomedical model view death as the enemy: their primary intent is to rescue persons from acute illnesses, their principal criterion of success is

to save (or prolong) life, and their ultimate goal is to gain control over death. On the whole, most people in secularized, developed countries view life, disease, dying, and death within the conceptual scaffolding provided by the biomedical model (Benoliel & Degner, 1995; Starr, 1982).

Practices formulated within the biomedical model introduced new forms of dying within institutional settings. In the first part of the twentieth century, most persons died at home surrounded by family members. By the 1950s the majority of deaths occurred in hospitals or medical centers, and the dying person was surrounded by strangers and was hooked up to many devices. While the percentage of deaths in institutional settings has fluctuated somewhat over the past 60 years, by 2010 the majority of deaths still occurred in institutions (hospitals, medical centers, or nursing homes) with the person surrounded by strangers and hooked up to medical devices (Corr & Corr, 2012; United States Census Bureau, 2013).

## PART 2: INDIVIDUAL EXPECTATIONS AND FEARS ABOUT DYING, INCLUDING EMPIRICAL, DATA, CLINICAL PRACTICES, AND PROPOSED POLICY CHANGES ABOUT A GOOD DEATH

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Following a Piagetian model of cognitive development, psychologists have examined the understanding of death attained by children, adolescents, and adults. Prior to attaining the stage of concrete operations, a human being is said to be incapable of comprehending that death is irreversible, final, and universal; further, relevant causes of death elude understanding prior to the attainment of concrete operations. Those criteria (irreversibility, finality, universality, and causality) are said to comprise a mature understanding of

death (Corr, 2010). These four criteria fit well an empiricist set of expectations about reality. However, when children maintain that death leads to noncorporeal continuation in an afterlife, that understanding of death is said to mark an immature understanding (Speece & Brent, 1996). What is of considerable interest is that noncorporeal continuation is a criterion applied to death by the majority of adults in the United States and in many other countries (Birren, 1991).

A supposition is that once attained, a mature understanding of death remains stable. Kastenbaum (2000) not only brings under scrutiny the notions of maturity and immaturity as applied to knowing what death is, but also points out the ethnocentrism present in the Westernized, secular assumptions about understandings of death. Further, building on the Eriksonian construct of wisdom developing in the later years (Erikson, 1959), Kastenbaum concluded that in their later years adults produce “more sophisticated conceptions of death... as a facet of deepening wisdom” (2000, p. 71) open to mystery.

Changes over time from adolescence into old age can be tracked in how people “play with the thought of death” (Kastenbaum, 2000, p. 72). The idea of playing with constructs about mortality brings us to the notion of denial. Aries (1974) argued that the denial of death is a dominant framework influencing contemporary Western attitudes, making death both forbidden and titillating.

One idea proposed to explain denial of death is regret theory (Landman, 1993), which in its bare bones is a rehashing of Janis and Mann’s (1977) notion of “satisficing” as a psychological measure to minimize decisional uncertainty. In effect, regret theory asserts that—when faced with decisions with consequences for the future—humans learn to balance among competing choices, choosing what to do based on the relative value alternate choices present. Thus, the decision whether to see a specialist to learn what is causing a tremor in one’s hands

could be put off because doing nothing is convenient and provides reassurance that nothing worrisome is going on. However, the person could choose to see the specialist because the tremors have become too pronounced to be ignored and are affecting normal daily behaviors such as writing and dressing.

A typical information-processing approach used to explain thinking about death is “awareness versus habituation or denial” (Kastenbaum, 2000, p. 72). Awareness versus habituation or denial involves desire for information and use of automatic defense mechanisms against anxiety. This hypothesis maintains that openness to distress, even activation of empathy toward another’s pain, depends on one’s level of security (Kastenbaum, 2000). The notion here is that willingness to consider mortality is moderated by the extent to which individuals can protect themselves from anxiety. A corollary to this hypothesis could well be found in the desensitizing effects of exposure to media violence found in children and in adults (Bartholow, Bushman, & Sestii, 2006; Smith & Donnerstein, 1998); that is, to protect themselves from the horrors of witnessing violence, people increase their conscious boundaries of what is acceptable, in effect, dismissing the threat that at an earlier time would have been upsetting.

Becker (1973) wrote that successful cultures develop frameworks that enable individuals to cope with the immobilizing threat of death. One framework in our society is provided by the biomedical model which makes death the enemy and leads to institutionalized death denial illustrated by refusals to accept futility when a life-threatening condition is no longer responsive to treatment. The push back against such institutionalized death denial, manifest primarily in the development of the modern hospice movement and the growing clamor for insuring “a good death,” is examined later in this chapter.

Death anxiety has been studied at considerable length. Correlation studies with a variety

of populations have produced differing results about the associations between death anxiety and several demographic variables: an inverse relationship between self-esteem and death anxiety, nonsignificant associations between socioeconomic status and death anxiety, a diversity of results regarding religious beliefs and death anxiety as well as gender and death anxiety, and nonsignificant findings about family structure and death anxiety (DePaola, Griffin, Young, & Neimeyer, 2003; Kastenbaum, 2000; Missler et al., 2011–2012; Neimeyer, 1994).

Attachment bonds were involved in associations between death anxiety and elderly females, namely, unlike men, “women showed greater fear for the death of loved ones and for the consequences of their own death on their loved ones” (Missler et al., 2011–2012, p. 358). As for correlations between death anxiety and being old, “no support can be found for the proposition that elderly adults live with an elevated sense of fear, anxiety, or distress centering on the prospect of their mortality” (Kastenbaum, 2000, p. 123). On the contrary, acceptance of death rather than fear or anxiety was a dominant finding, particularly among the old-old. At the same time, an extensive examination of research studies about the elderly and death anxiety uncovered direct associations between death anxiety and psychological difficulties, physical problems, and being institutionalized, but found no relationships between death anxiety and age, gender, or religiosity (Fortner & Neimeyer, 1999).

Another way of looking at human awareness of death is what psychologists have termed a “mortality schema” (Lawton, 2001). Coming to a mature understanding of death, humans realize “I too will die.” While this existential awareness has been examined under the guise of “terror management theory” (Greenberg & Arndt, 2012), a related concept is the idea that each of us develops a mortality schema about our own likelihood of dying. When in good health, a person’s mortality schema remains

preconscious or unconscious; Lawton (2001, p. 593) refers to it in these circumstances as latent. As one’s health deteriorates and the end of life appears nearer, one’s mortality schema becomes manifest. If a manifest mortality schema induces depression or anxiety, the person will incur greater risk to make unreasonable decisions, such as at one extreme foregoing treatment that likely will help or at the other extreme refusing hospice and insisting on aggressive treatment despite the advice of informed medical personnel.

Individual desires about dying do not match the empirical reality about dying. For instance, when surveyed about what they desire the typical respondent wants to die at home, wants a quick and painless trajectory of dying, wants to be surrounded by loved ones, and wants to be conscious and alert until the end (Kastenbaum, 2000). The reality is far different. Most persons die in an institution (a hospital, medical center, or nursing home), are marked with several debilitating conditions, die from a chronic illness over a lingering trajectory, surrounded by strangers, and in pain (Chapple, 2010; Nuland, 1994).

Individuals say it is not death that bothers them. They fear dying in unremitting, excruciating pain, in unfamiliar surroundings, lacking dignity, and alone (Corr & Corr, 2012; Kastenbaum, 2012). These fears match what has been uncovered about dying (Chapple, 2010; Nuland, 1994). Recognition of the realities that characterize dying in institutions has led to efforts to increase the prospects that persons die “a good death.”

Hospice is the primary effort within the mainstream medical establishment to address squarely the realities that persons with terminal illnesses typically die in unalleviated pain, surrounded by strangers, and in unfamiliar settings. The basic principle of hospice is that someone who is dying is a living person who deserves to be treated with dignity; the intent is to promote quality of life by alleviating



pain so that the prospect for a good death is enhanced. Hospice focuses on the end-of-life, and it affirms the sacredness and value of life (Connor, 2009; Corr & Corr, 2012).

Hospice organizes care for the dying around a holistic framework that attends to six fundamental aspects of existence. These six aspects are the physical, behavioral, emotional, interpersonal, cognitive, and spiritual. Pain can occur in one or more of these fundamental aspects to existence, and thus the hospice team focuses on the whole person, not just on one aspect such as the physical.

The notion of a good death possesses different meanings contingent on the assumptive worlds dominant in a society. In some societies, such as in Japan or among Navajo Indians, an underlying psychological concern is whether the deceased suffered the wrong kind of death and will wreak vengeance upon the living (Goss & Klass, 2005). In Christianity the idea of a good death refers to what happens to the deceased following death. In some societies, such as mainstream America, there is a growing belief that the health care system is obliged to make possible a good death (Emanuel & Emanuel, 1998; Institute of Medicine, 1997).

In twenty-first century secular societies a good death refers to how one experiences dying. The emphasis is on how a person's life ends. Thus, given the realization that the fears about dying in pain, alone, and in unfamiliar surroundings are the rule rather than the exception, efforts have been exerted to change how medical personnel respond to dying patients. The first systematic effort was the prestigious SUPPORT study (1995).

The SUPPORT study was carried out over 2 years in the 1990s in five teaching hospitals in the United States. The focus was on end-of-life preferences, medical decision-making, and interventions with persons diagnosed with a life-threatening illness. Observations in the first year of the study included substantial shortcomings in communication between dying patients

and medical personnel, overuse of aggressive treatment at the very end of life, and unalleviated pain (some inflicted by the medical team) in the last days of life. The second year of the study was aimed at correcting these issues by providing specially trained consultants to insure four objectives—all aimed at alleviating persons' psychological fears about dying. The objectives were (i) hospital staff would know patients' end-of-life preferences, (ii) medical staff would employ better pain control, (iii) communication between patients and physicians would improve, and (iv) hospital staff members' understanding of outcomes of care would be patient-oriented. None of these objectives was achieved. The SUPPORT investigators concluded that "greater individual and societal commitment and more proactive and forceful measures may be needed" (p. 1591) to offer better experiences to seriously ill and dying patients.

Undeterred by these unpromising outcomes from the SUPPORT study, some prestigious organizations launched separate efforts focused on making a good death the expected result in American medical practice. First, the *Institute of Medicine (IOM) (1997)* began a campaign that defined a good death as one "free from avoidable distress and suffering for patients, families, and caregivers" (p. 5); in this definition it is important to note the outcomes of a good death are seen to affect more than the person who is dying, and that a good death will free family members and caregivers—which includes medical personnel—from avoidable distress and suffering. In its discussion of a good death, the IOM also noted that a good death conforms to the wishes of patients and families and remains "reasonably consistent with clinical, cultural, and ethical standards" (p. 5).

In tandem with the IOM paper on providing a good death, the Commonwealth Fund and the Nathan Cummings Foundation, two prominent non-profit organizations focused on health care and social justice, sponsored an extensive, multidimensional examination of a

good death (Emanuel & Emanuel, 1998). The Commonwealth-Cummings project authors argue that medical training should include making a good death the standard of care. Such care needs to start with helping physicians become comfortable in being with the dying, competent in giving quality care to the dying, promoting quality of life, and allowing terminally ill persons to die a good death rather than keeping them alive at all costs (Emanuel & Emanuel, 1998).

The Commonwealth-Cummings project asserted that providing a good death—and by inference, promoting quality of life for dying patients—requires attention to six interlinking aspects of life-threatening illnesses: physical symptoms, psychological symptoms, spiritual/existential beliefs, economic demands and caregiving needs, social relationships and support, and hopes and expectations. The close links between this multidimensional perspective and the holistic framework of the modern hospice movement will not be lost on readers.

The authors almost immediately drew attention to the interactive nature of these six aspects of an illness. Thus, “Patients who are depressed or who are experiencing existential meaninglessness can have a lower threshold for pain” whereas “patients who have spiritual fulfillment or good mechanisms to handle caregiving needs may report less bothersome symptoms” (Emanuel & Emanuel, 1998, p. 22). Longitudinal studies have uncovered that most quality of life indicators diminish as people enter further into the end stages of a terminal illness. Rather than dying a good death, a significant percentage of persons (as high as 70% in some studies) die in pain, isolated, surrounded by strangers, and in unfamiliar surroundings (Lawton, 2001).

The notion of “quality of life” plays a central role in much of the discussion about promoting a good death. For instance, Lawton (2001) embraced holism as a sound approach for encompassing the multiple domains of an

individual’s quality of life. There is strong similarity between Lawton’s notion of quality of life and the holistic dimensions enumerated in end-of-life models for promoting a good death by the IOM, the Commonwealth-Cummings project, and obviously the modern hospice movement. Specifically, to the three domains of the physical, social, and psychological, Lawton adds perceived quality of life, that is, “subjective analogues of social QOL such as family quality, friends quality, time quality, and economic security” (Lawton, 2001, pp. 599–600).

The chief matter at stake for the Commonwealth-Cummings project is dealing with pain. The authors wrote about “total pain” (p. 22), suffering that blocks the prospect of a good death and results from either (i) distress in most if not all six aspects of an illness or (ii) overwhelming distress in one or two aspects. Here are specifics about each aspect.

### Physical Symptoms

Physical forms of pain have been studied extensively, and it is estimated that drug-related treatments effectively relieve physical pain in 95% of cases. The Commonwealth-Cummings project estimates that proper pain management remains unused in anywhere from 20% to 70% of dying patients. Besides pain, other distressing physical symptoms include nausea, insomnia, and vomiting.

### Psychological Symptoms

These symptoms include depression, anxiety, and anger. The Commonwealth-Cummings project notes that there are medical staff who discount the importance of alleviating these psychological symptoms because (i) they are not skilled in treating them and/or (ii) they consider such symptoms a normal part of dying. The authors (Emanuel & Emanuel, 1998) observe that there are several evidence-based approaches to treating depression, anxiety, and anger.

## Economic Demands and Caregiver Needs

There is sufficient research data to conclude that caring for a dying loved one imposes significant financial and emotional burdens on families (Saldinger, 2001; Saldinger & Cain, 2005). Links have been established between severe physical and psychological pain, the increase in demands on caregivers, and economic burdens felt by families (Emanuel & Emanuel, 1998; Hansson & Stroebe, 2007). The long-term outcome of economic demands and caregiver burdens can be that following a death the family is left less capable of coping; inferring that such conditions promote vulnerability to complicated grief is not only logical, but empirical research demonstrates early entrance to hospice fosters resilience against such complications in bereavement (Kris et al., 2006).

## Social Relationships and Support

Models of coping emphasize that a key adaptive task is to maintain links with other people, not only for solace and consolation but also for information as well as remaining engaged in the wider world (cf. for instance, Moos, 1986). The hospice experience attests to the value that social support plays in helping terminally ill persons and family members at the end of life. The Commonwealth-Cummings project said much more research is needed to determine the kinds of social support dying patients rely on. The authors also called for inquiries into whether and what types of social support beyond the family help the dying patient. In addition, if social support outside the family helps dying patients, attention needed to focus on how that support works (Emanuel & Emanuel, 1998).

## Spiritual/Existential Beliefs

This aspect of existence refers to how persons find meaning, purpose, and value in their lives. The assumption is that religion may form

part of this meaning making, but that spirituality and religion are not the same.

## Hopes and Expectations

Research studies and anecdotal reports document that some deaths tend to occur after important family events such as anniversaries, graduations, or births have occurred (Charles A. Corr, personal communication, November 19, 2013; Emanuel & Emanuel, 1998; Phillips & King, 1988). Some dying people hold on to see these moments. However, there is concern that patients tend to over-estimate their life expectancy and thus tend to put off advance care planning (such as selecting a health care proxy or making funeral plans) with their family members and physicians.

Using both focus group interviews and a national survey with a remarkable response rate of 73%, medical researchers learned what seriously ill patients consider very important attributes of a good death. The eight attributes endorsed by 80% or more of seriously ill patients were being mentally aware, being at peace with God, not being a burden to one's family, being able to still help others, praying, having one's funeral planned, not being a burden on society, and feeling one's life is complete (Steinhauser et al., 2000). See Table 24.1 for a breakdown of the percentage of the respondents who endorsed each attribute as very important for a good death.

Elements of personal dignity and personal autonomy as important aspects of a good death also surfaced, particularly in the focused interviews. Not only seriously ill patients but also family members and physicians overwhelmingly agreed on the importance of being prepared and knowing that one's family members were prepared. Being prepared took on such nuances as knowing clearly one's diagnosis, prognosis, and treatment options. A further element in a good death endorsed by focus group members was completing unfinished business, saying goodbye to important persons in one's



**TABLE 24.1** The Percentage of Seriously Ill Patients Who Endorsed Eight Attributes They Considered Very Important for a Good Death

Attribute	Patients
Be mentally aware	92%
Be at peace with God	89%
Not be a burden to family	89%
Be able to help others	88%
Pray	85%
Have funeral planned	82%
Not be a burden to society	81%
Feeling one's life is complete	80%

Steinhauser et al., 2000.

life, and talking about the meaning of death with someone willing to listen to a person express fears about dying (Steinhauser et al., 2000).

Of considerable concern are data from the SUPPORT study (1995) that physicians were wrong in at least 33% of cases regarding their patients' preferences toward cardiopulmonary resuscitation; further, spouses were found to agree at most in only 50% of cases involving dying patients' choices. The mismatch between what dying persons want and what medical staff as well as family members perceive they want underscore that promoting a good death as the medical norm necessitates increasing accurate, attentive communication between terminally ill individuals, the medical team, and the family (Lawton, 2001).

### PART 3: BEREAVEMENT, GRIEF, AND MOURNING IN CONTEMPORARY SOCIETY

#### Some Introductory Material

The term *bereavement* refers to a state of loss, such as the death of a friend; *grief* is the

term denoting reactions to bereavement, and *mourning* identifies expressions of grief (Oxford English Dictionary, 1989). Most research into bereavement has focused on older persons, primarily widows, and by far females are much more likely than males to participate in bereavement research (Hansson & Stroebe, 2007; Stroebe & Stroebe, 1989–1990).

Freud's grief work theory influences the preponderance of bereavement research and clinical practice. First presented in 1917 (Freud, 1957) and then brought into the mainstream of American clinical work by Lindemann (1944), the grief work theory maintains that recovery from bereavement requires consciously and persistently confronting distressing reminders of the death, withdrawing of one's emotional investment in the deceased, and forming a mental representation of the deceased that does not stir up pangs of grief. Freud's argument was that bereavement was an intra-psychic struggle between the Id and the Ego over the reality of the death. While not disavowing the need for confronting the distressing reminders, withdrawing attachment to the deceased, and forming a positive memory of the deceased, Bowlby (1969–1980) made sundered bonds of attachment the crux of bereavement and maintained recovery involved adjustment to an altered interpersonal environment rather than an intra-psychic struggle.

The most influential variations on Freud's model include the dual process model and the notion of continuing bonds. The dual process model accepts the grief work theory up to a point, namely, the need to confront distressing reminders of one's bereavement, and posits that the natural process of coping and recovery also involves engaging with the world of the living. The former process is termed a loss orientation, and the latter a restoration orientation. The authors of this dual process model note that grieving persons naturally oscillate between the two orientations (Stroebe & Schut, 1999).

For decades both clinical lore and the mainstream understanding of bereavement

maintained that severing emotional attachments to the one who died was a necessity to recover from bereavement, and as a corollary asserted that ongoing attachments to the deceased signified pathology. Work with bereaved adolescents and bereaved parents (Hogan & DeSantis, 1992; Klass, Silverman, & Nickman, 1996) as well as with bereaved children (Silverman, Nickman, & Worden, 1992; Worden, 1996) introduced the notion that remaining attached to the deceased, that is, a continuing bond, was not uncommon; in short, rather than a sign of pathology, continuing bonds to the deceased formed a normal response in the lives of many grievers. In very short time, the uncritical bandwagon acceptance of continuing bonds moved the construct from an important corrective to the notion of emotional withdrawal to a judgment that the lack of continuing bonds was a sign of pathology. Careful research examining types of attachment eventually introduced the understanding that secure attachments were associated with positive ongoing bonds but insecure attachments called for letting go of bonds to the deceased (Stroebe & Schut, 2005).

The myth that all deaths elicit ongoing distress has been put to rest. The deaths of oppressive, abusive husbands are greeted as liberating according to the testimony of several widows (Elison & McGonigle, 2003). The research of Wortman and Silver (1989) falsified the expectation that the deaths of loved ones would necessarily entail various forms of distress, including depression, and that only a period of working through one's grief would provide recovery from bereavement; this finding very likely is explained by the discovery of a resilient grief trajectory in which the majority of bereaved individuals quickly return to healthy functioning (Bonanno, 2009).

Based on longitudinal research gathered in the Changing Lives of Older Couples (CLOC) study, three dominant patterns of responses over time to bereavement have been uncovered

(Bonanno, 2009). A plurality—and in some other studies a majority of persons studied—rebound quickly from the death of a spouse, other family member, or friend; by quickly is meant within a few weeks. It is not that the death does not matter to the griever, but more that the death does not shatter the person's assumptive world and challenge their coping skills when facing adversity. A second trajectory comprises how approximately 43% of persons respond to the death of a loved one; called a recovery trajectory, this pattern begins with difficulty adjusting to the death, but within 18–24 months a griever's distress noticeably lessens and the person more readily reengages in relationships with others and the wider external world. It is very likely that persons in a recovery trajectory are what Freud and many who have written about bereavement considered the typical or normal course of responding to a loss. The third trajectory, termed enduring grief, is found in around 12% of bereaved persons who have been studied. Persons in the enduring grief trajectory manifest what are known as symptoms of complicated grief; it is an element of clinical lore that without assistance from skilled professionals, primarily using cognitive behavioral therapy, persons in an enduring grief trajectory will continue to be “stuck in their grief.” More recently terms to identify complicated grief include *prolonged grief disorder* and *persistent, pervasive grief disorder* (Bonanno, Wortman, & Neese, 2004; Prigerson, Vanderwerker, & Maciejewski, 2008).

Debates have swirled within psychiatric and psychological circles about whether persons in the first 2 months of bereavement should be treated for clinical depression. From the early 1990s until 2013, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) excluded diagnosis (and, by implication, treatment) for depression in the first 2 months of bereavement unless the depression was related to something other than the death being grieved. The argument was that normal bereavement

mimics depression but that the central features of depression are absent; in short, the person does not feel utterly worthless or helpless. If after 2 months the bereaved individual manifests signs of clinical depression, the protocol was to use evidence-based procedures that are effective against clinical depression. The 5th edition of the DSM has removed this caution and now permits persons who are grieving to be diagnosed for clinical depression within the first 2 weeks of their bereavement ([American Psychiatric Association, 2013](#); [Shear et al., 2011](#)).

Within the past 20 years prominent bereavement researchers have become skeptical that phenomena central to bereavement were being examined. Several psychological markers of distress such as depression and anxiety were studied, but the question rose whether the core phenomena were being overlooked or overwhelmed with a focus on typical symptoms of psychological distress ([Burnett, Middleton, Raphael, & Martinek, 1997](#); [Neimeyer & Hogan, 2001](#); [Neimeyer, Hogan, & Laurie, 2008](#)). In longitudinal research with bereaved adults and children, a team of researchers led by Beverly Raphael winnowed core bereavement phenomena to 17 items that factor analysis indicated group into three distinct facets of loss: frequent thoughts and images of the deceased, a sense of acute separation, and distress related to reminders of the death.

The first category—frequent thoughts and images of the deceased—includes seven items such as intrusive thoughts about the deceased and preoccupation with thoughts and images of the deceased. The second category—a sense of acute separation—includes five items such as yearning for the deceased and feelings of distress when realizing the deceased will not come back. The third category—distress related to reminders of the death—includes five items such as loneliness attributed to reminders from photos or other sources and loss of enjoyment produced by reminders from photos or other sources. It is of central importance to note that

these core bereavement phenomena are seen as normal responses to the loss of a loved one, not pathological reactions ([Burnett et al., 1997](#)).

With that introductory overview about bereavement, I will turn to some of the specific findings regarding bereavement in the later years of life. One area of investigation has examined whether age presents a risk factor for poor bereavement outcomes. Do older adults fare worse than younger following the death of a loved one?

An underlying problem with much research into aging and bereavement is the lack of a developmental perspective; for example, there are studies that use cross-sectional designs, gather data retrospectively, and lack non-bereaved control groups ([Hansson & Stroebe, 2007](#)). However, some convincing studies have uncovered that younger adults are at greater risk of distress following the death of a spouse than are older adults. For instance, [Parkes' \(1972/1996\)](#) study of older and younger widows in Boston found poorer psychological outcomes in the younger and poorer physical outcomes in the older. Later gerontological studies have replicated these findings (for instance, [Murdock, Guaranaccia, Hayslip, & McKibbin, 1998](#); [Schulz et al., 2001](#)). In losses other than the deaths of spouses (such as the deaths of children), younger rather than older adults manifest more adaptive coping ([Rubin, 1993](#)).

Curvilinear outcomes suggest longer-term studies than a few months or even a year are needed to draw reliable conclusions about bereavement outcomes for older and younger adults. [Hansson and Stroebe \(2007, p. 65\)](#) have noted that more intense early reactions in younger adults ameliorate “whereas problems for older bereaved may be longer drawn out.” There is some evidence that mortality is a greater risk following bereavement for younger adults than older. However, confounding variables have been identified. One example is failing to take into account that healthier younger widows are likely to remarry: there is a strong

positive association between better health and longer life in widows who remarry.

Evidence has accumulated that widowers' mortality is at greater risk than is widows', particularly among younger men. There are, however, nagging concerns that the lack of long-term longitudinal studies in this area may have left uncovered issues of curvilinearity in bereavement symptoms (Hansson & Stroebe, 2007).

Comparing findings in outcome studies of older and of younger bereaved adults has led to confidence that the patterns of bereavement are quite alike in both clinical and non-clinical consequences. For instance, there are similar patterns in the report of loneliness, social isolation, struggles with self-efficacy, elevated physical and psychological signs of distress, mild to severe depression, and complicated grief. In both younger and older bereaved widows, research data, for instance, indicate "intense symptoms are to be expected in the first months post-loss, after which (with some important exceptions) they begin to subside as the individual adapts" (Hansson & Stroebe, 2007, p. 94).

A 3-year prospective study with a control group of married non-bereaved adults followed older adults whose spouses had died, and the researchers found signs of increased depression for the bereaved adults in the first year after the death. By the second year, most persons' depression symptoms had left. Compared to the married control group subjects, the percentage of bereaved adults manifesting depression was higher throughout the entire life of the study (Mendes de Leon, Kasl, & Jacobs, 1994). These findings from Mendes de Leon et al. have been replicated in other well-designed longitudinal studies examining depression in older bereaved adults: depression ameliorated in the third year following a spouse's death, particularly for widows who had been able to anticipate their husband's death (Byrne & Raphael, 1999; Carnelley, Wortman, & Kessler, 1999; Turvey, Carney, Arndt, Wallace, & Herzog, 1999).

The CLOC research project has provided extensive evidence documenting the differential bereavement outcomes for older adults based on the timing of the spouse's death (Carr, House, Wortman, Nesse, & Kessler, 2001). The results do not always favor anticipation over having been taken by surprise. While immediate negative effects, such as intrusive thoughts, were common when deaths were sudden and unexpected, extensive experience of a spouse's lingering dying in pain and suffering produced greater anxiety following the death than experienced over sudden deaths or over anticipated deaths that went smoothly. The problems for persons following a lingering, complicated death were attributed to the relentless build-up of stress when caring for a loved one and watching the person's decline. Amy Saldinger (2001) and her colleagues (Saldinger & Cain, 2005; Saldinger, Cain, Kalter, & Lohnes, 1999) have reported similar results in families with the deaths of young parents.

Hansson & Stroebe (2007) summarized the results of several studies that examined effects of caregiving on bereavement outcomes; the results suggested that for many caregivers, particularly for those persons who had support from others and who had attended to their physical and psychological needs, caregiving to the dying did not intensify their bereavement. However, among some caregivers the stress accumulated during the illness never lessened after the death. These studies which examined caregiving in cases of terminal cancer need to be placed against the much more pessimistic outcomes found for partners who provide care for Alzheimer's patients (Emanuel, November 17, 2013; Gonzalez-Salvador, Arango, Lyketsos, & Barba, 1999; Quayhagen & Quayhagen, 1988).

The attachment theory of bereavement refers to secure and insecure bonds (Bowlby, 1969–1980; Stroebe & Schut, 2005). Longitudinal research studies, most particularly the CLOC project, have found greater pining after and

yearning for the deceased exhibited in elderly persons whose marriages were marked by secure bonds and less yearning for and pining after in older adults whose marriages were marked by conflict (Carr et al., 2001). Stroebe and Schut (2005) argued from empirical data on types of attachment and bereavement outcomes that continuing bonds were to be encouraged when there had been a secure attachment but that bonds should be loosened when attachments had been insecure. Several widows, as noted above, documented that the deaths of their oppressive, overbearing husbands had been greeted with a feeling of liberation (Elison & McGonigle, 2003).

## CONCLUSION

In this chapter I examined issues involved with the psychology of death and dying in later life. The overarching socioenvironmental context imposed by the pervasive acceptance of science, technology, and the biomedical model was reviewed because of the influence this context has on understandings of death, on individual assumptions about reality, and on experiences with dying. Next, I paid attention to individual expectations and fears about dying, including empirical data and proposed policy changes for promoting a good death, with emphasis on quality of life perceived within a holistic framework. Finally, I turned attention toward bereavement, grief, and mourning in later life.

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