Dying, Death, and Bereavement
2nd Edition
A Challenge for Living

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Editors

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Inge Baer Corless, RN, PhD, FAAN, a graduate of the Bellevue Schools of Nursing in New York City, attended Hunter College and graduated from Boston University with a bachelor's degree in nursing, the University of Rhode Island with a master's degree in sociology, and from Brown University with a PhD in sociology. As a Robert Wood Johnson Clinical Scholar, Dr. Corless did postdoctoral study at the University of California, San Francisco. She has held academic positions at Russell Sage College, the University of Michigan, the University of North Carolina, Chapel Hill, as well as her current position at the MGH Institute of Health Professions at the Massachusetts General Hospital. Dr. Corless served as program director of St. Peter's Hospice in Albany, NY, and as a short-term consultant for the World Health Organization at the Western Pacific regional office. A Fellow of the American Academy of Nursing, Dr. Corless has written on hospice, end-of-life care, and HIV disease. Dr. Corless co-edited, with Dr. Mary Pittman, AIDS: Principles, Practices, and Politics, and, with Dr. Barbara Germino and Dr. Pittman, Dying, Death, and Bereavement: Theoretical Perspectives and Other Ways of Knowing, and the first edition of this book. Dr. Corless co-edited, with Zelda Foster, The Hospice Heritage. She coauthored, with James T. Corless, to produce their two daughters, Theresa Lola and Patricia Irene.

Barbara B. Germino, PhD, RN, FAAN, has had an eclectic career in nursing that has included patient care in three major medical centers, a community hospital, a 25-bed hospital on Kodiak Island, Alaska, and in home care; teaching in four university schools of nursing; and research on individual and family responses to life-threatening illness, including interventions to enhance their ability to manage problems and uncertainties, facilitating quality of life. Early work with chronically ill patients, and critical experiences, especially those with people who were dying with cancer, stimulated interests in life-threatening illness and dying. The opportunity to do her doctoral work with Jeanne Quint Benoliel, whose work had inspired her over many years, was a crucial experience. With colleagues in nursing and social work, she developed and teaches an interdisciplinary graduate course in death, dying, and bereavement across the life-span. She is currently Professor at the School of Nursing, University of North Carolina at Chapel Hill, and holds the Carol Ann Beerstecher-Blackwell Chair of Thanatology. She is actively involved with the Carolinas Center for End of Life Care, working on a 3-year project to enhance end-of-life care awareness, knowledge, and delivery across the Carolinas.

Mary Pittman, DrPH, is President of HRET (Hospital Research and Education Trust) and a member of the executive staff of the American Hospital Association. Prior to assuming the leadership of HRET in 1993, she was President and CEO of the California Association of Public Hospitals. Her areas of interest are community health and access to vulnerable populations. She has provided education and training on a range of issues, e.g., program evaluation, substance abuse program development, and community health program implementation. She has over 20 years experience in community-based program planning and design and has developed numerous public policy and legislative proposals to expand access and quality of health care to underserved populations. Mary has served as principal investigator on a number of research and demonstration grants. She is co-chair and founder of the Coalition for Healthier Cities and Communities. Mary has co-authored two books, AIDS: Principles, Practices and Politics, and Death, Dying, and Bereavement. She received master's degrees from the University of California-Berkeley in Public Health and City and Regional Planning, and her doctorate from UC-Berkeley in Public Health Administration. Mary serves on the boards of a number of organizations, as well as on many national advisory committees.
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Foreword

Dame Cicely Saunders

Trained as a nurse during World War II and being invalided out, Dame Cicely Saunders obtained a war degree at Oxford and became a medical social worker. Concern for the pain control of dying patients, and the distress of their families, moved her to study medicine, and in 1958 she began work among the patients of St. Joseph’s Hospice. The experience there was one of the roots of St. Christopher’s Hospice, which she founded, together with a small group, and which opened in 1967. From the start, it was planned as a teaching center and a focus of research in the control of pain and other distress in terminal illness. This work has been recognized worldwide and was the catalyst for the hospice movement.

Dame Cicely has received a number of honorary degrees, including Honorary Doctorate of Science from Yale in 1969, Lambeth Doctorate of Medicine from the Archbishop of Canterbury in 1977, Doctorate from the Open University in 1978, and Honorary Doctorate of Law, Columbia University, New York, in 1979. She has been a member of the Attendance Allowance Board since it started; and from 1973 to 1978 was a member of the Medical Research Council. Dame Cicely was awarded the Templeton Prize for Progress in Religion in 1981. Other honorary degrees have followed, including honorary doctorates in law and civil law from Oxford and Cambridge Universities in 1986.

Dame Cicely is an honorary fellow of the Royal College of Physicians, the Royal College of Surgeons, and the Royal College of Nurses. She was awarded the British Medical Association’s Gold Medal for Distinguished Merit in July 1987, and was made a Freeman of the London Borough of Bromley in October 1987. In 1988, she was made an honorary fellow of the Royal College of Psychiatrists. In 1989, Dame Cicely was awarded the Order of Merit by Her Majesty the Queen.

Over 40 years ago, I had the opportunity and privilege of accompanying an isolated man who talked through his thoughts and feelings with me during the last 2 months of his life. A Jew from Warsaw, he had lost his
family and believed that he had made no impact on the world during his short life of 40 years. The first ideas of hospice developed during our conversations, and for me they are summed up in two of his phrases. The first referred to the fact that he would leave me a small legacy—a founding gift for a then nameless place. He said, "I'll be a window in your home." The second was a response to my offer to read him something from the Old Testament, as he was quietly returning to the faith of his fathers. His response was, "No, thank you. I only want what is in your mind and in your heart." At the time, it was a specific challenge to which I tried to respond, but later I came to see it as a demand on us all for everything we could bring, of thought, experience, and skill, to the care of people facing death, to be offered together with personal concern. Setting these two demands, together with the idea of a window, challenged the beginnings of hospice to be open to many adventures and developments, focused always on close attention to individual people, their needs, and their potentials.

The story since February 1948, when David Tasma died "at peace" in the freedom of the spirit, as he told me, has been one of surprising growth. This book brings together much of the experience of many workers during these years, all facing the demands on mind and heart in a spirit of openness. The original vision seems to have the capacity to keep its recognizably addressing the same concerns in our diverse cultures and settings. Those of us who work in the field of death, dying, and bereavement have tried to listen to those people who are facing their individual journey through this part of life. From them we all continue to learn and find inspiration, whether we are concerned with researching and developing ever-improving symptom control, more understanding of psychosocial and existential tensions and possibilities, or better ways of sharing in what surely has to be the work and support of an interdisciplinary team.

Seven years as an RN volunteer in one of the early Protestant homes (St. Luke's Hospital, originally Home for the Dying Poor, opened in 1893), followed by another 7 years as a physician in St. Joseph's Hospice (opened 1905), gave me opportunities to meet and listen to innumerable patients, to observe the regular giving of oral opiates at St. Luke's, and to introduce this method of giving analgesics to St. Joseph's Hospice. It enabled me to monitor our improving clinical practice and development with a retrieval system involving 1,100 patients, and to lay the medical foundations of St. Christopher's, opened in 1967 as the first home care and teaching hospice. A Christian as well as a medical foundation, its aim was "to express the love of God to all who come, in every possible way, in skilled nursing and medical care, in the use of every scientific means of relieving suffering and
distress, in understanding personal sympathy, with respect for the dignity of each person as a human being, precious to God and man” (Aim & Basis, 1965). Emphasis was laid on the fact that all those working in the hospice would give their own contribution in their own way, in a spirit of freedom, while patients would seek their own way to peace, without any pressure. Emphasized, too, was that it would be group work, open to further development.

It was not long before such a religious foundation was challenged by those wishing to enter this field without any such commitment. Certain of our own calling, but concerned to open doors as well as windows, we refused to be dogmatic, concerned only that anyone in this field must expect his or her own philosophy to be challenged and to be faced with the difficult questions that may arise from people who are calling on their own resources in crisis. That the spiritual element of the “total pain” complex included far more than any form of personal religion became obvious, as its physical, emotional, and social elements were also addressed with developing experience.

From the beginning, hospice learning and attitudes have formed bridges. First, the bridges between people as staff and volunteers have enabled these people to listen to their patients and families. The way forward must surely come in the same fashion. Patients are the true founders of the hospice movement and the field of related studies and development. Our moves into the future will be safeguarded if we go on listening, aware that the words of one individual or family may open up a whole new scene.

Building a bridge to researchers, and, in due course, to enter this field ourselves has also been important. Early meetings with such pioneers as Beecher, Eddy, and Houde were followed by productive contact with Melzack and Wall. In an editorial in the influential journal Pain, Wall (1986) wrote, “The immediate origins of pain and suffering need immediate attention while the long-term search for basic care proceeds. The old methods of care and caring had to be rediscovered and the best of modern medicine had to be turned to the task of new study and therapy specifically directed at pain” (p. 1). The challenge to continue to look at all aspects of suffering still faces us, and we have to back up our demonstrations of effective relief with research studies that are widely published. Our teaching must be objectively based, and we should be offering our patients continually improving understanding and therapy, all focused on their own personal possibilities of growth through loss.

Workers in the field addressed in this comprehensive book also have a responsibility to build bridges into the community, both professional and
general. That so many dying people all over the world are ineptly treated faces us with an almost overwhelming challenge, as does the isolation enforced on them and their bereaved families by the disregard of the public. Hospice is about living until the end, still as part of the community. And perhaps developed countries have much to learn from projects in developing countries around the world.

As we learned to demonstrate something of what could be done by what has come to be termed palliative medicine, we could begin to build effective bridges with the acute services. We have had to discover when and how to draw in other specialties and learn from them, as well as to educate from our standpoint. In no way are we to take the high moral ground, but we need to meet effectively as we come from our different professional backgrounds and across the disciplines.

We will often have appropriate treatment to offer between the two extremes of all life-prolonging intervention possible and the threat of legalized, active shortening of life, with all its social dangers. We have to earn the attention and respect that will draw us in for the right patients at the right time. The hospital support or palliative care team can have a central role in this area, and is charting an important way forward.

Our whole field has not only been about need, but, above all, about achievement. We are concerned that a person should live this part of life, whether in dying or in bereavement, to the maximum potential, not only in physical ease or activity, but also in family relationships and in addressing the most important inner values. A time of crisis can be a time of growth, often at surprising speed, of resolving long-standing problems and of reconciliation, both with oneself and with those around. Hospice workers find that the freedom from distress they aim to give, by their treatment and hospitality, opens up new space for personal development. Bridges are built among the conflicted families who are more and more often referred to us, in recognition of what we try to offer.

Good communication can facilitate unexpected sharing and response and develop the growth through loss we so often see. Here, I believe we reach the central and most positive area of our concerns. We have all been inspired by those we have seen bringing unexpected gains out of loss, whether it be of health, life, or bereavement. It may come out of distress that is painful to share as we try to maintain the bridge between us. The rewards come from the resolutions that happen surprisingly frequently—but not always. At times, we can only stay beside unresolved problems or, at best, trust that what we have offered is the best we can, hoping it is good enough. A lifetime's difficulties may remain unchanged, and it would be unrealistic to expect anything else.
It is the individual's inner values that matter when there is only a limited time left, or when the most important person has died. The spiritual dimension encompasses searches for meaning in many varied ways. We have never been concerned that the people we serve should see things our way; rather, they should discover or reinforce their own way, asking for help if they wish, with freedom from any pressure or obligation. We have found that not only is our own search for meaning continually stimulated by the often desperate situations we face, but also that this constant challenge helps develop a climate of shared discovery and hope.

References

Dying, Death, and Bereavement: A Challenge for Living: has been developed at a time when individuals, by dint of geographical and circumstantial placement, are confronted by many problems not of their own making. Whether it be malnutrition created by the sequestering of food stuffs by rival war lords, the ethnic cleansing of former neighbors by individuals called to arms under the religio/political banners of leaders with xenophobic motives, violence and terror brought by anticipated and unanticipated attack, or death by disaffection and neglect of the homeless in the inner city or the rural poor, modification of the external environment has a direct effect on the well-being of every individual.

When the source of the disability is chronic, long-standing disease, the manipulation of the external environment is less significant than the readjustment of the internal environment—whether by surgery, drugs, radiotherapy, or some other means. When such mechanisms are ineffective the individual and concerned others are confronted with a challenge for living—dying, death, and bereavement.

It is the more constrained, less problematic world condition, sans the chaos of military and political machinations, that primarily, is the context
for the consideration of dying, death, and bereavement in this volume. All of the complexity of dying as a result of a chronic disease is magnified by poverty, homelessness, starvation, and fratricidal battle.

Perhaps it is only when the right to live is vouchsafed that the right to die can become an issue. Were the right to die taken for granted, there would be a need to rally for the right to live.

The sanctity of life under-girds a number of practices. The call for assisted suicide while recognizing the right of the individual to self-determination contributes to the erosion of the responsibility of the citizen and the state not to engage in life-depriving activities. Furthermore, the shift from determination by self to determination by others is subtle. Given that most individuals do not wish to burden family members, partners, or friends with the care required as a result of prolonged illness, assisted suicide may seem obligatory (even noble!) to the dying person. These questions have been given renewed attention as a consequence of the efforts of Dr. Jack Kevorkian and others to assist suicides of individuals with various diseases, some in the early stages, others chronic rather than characterized by immediate decline.

The concern of persons who contemplate death by their own hands is one of doing an ineffective job of it and thereby not dying. Presence of a responsible individual assures completion but makes the survivor vulnerable to prosecution if complicity involved assistance. These issues are not easily resolved, nor should they be. Both Churchill and Corless and Nicholas touch on these issues. Related to these questions of control of the end of life is the concern that individuals neither be kept alive interminably in a persistent vegetative state nor resuscitated when there is no hope of recovery. Various mechanisms for advance directives have been instituted so that the individual's wishes may be heeded, thus relieving the family and health-care providers of concerns and litigation that either too much or too little was done. These directives, which Lund Person addresses in her chapter on regulatory issues, are a response to technological capability of life extension in situations without the capacity for meaningful interaction.

The impact of politics and economics as well as history on these issues is significant. These influences are present in some of the other subjects addressed in this book. The ever-present politics of care is explicitly addressed by Preston, Tang and McCorkle in their chapter on symptom management. The constraints imposed by shrinking resources aggravates some of the tensions between different professions. Issues resulting from reduced resources and different care-giving stances are discussed by Foster and Davidson.
Issues and approaches in working with the terminally ill and subsequently with the bereaved constitute the major focus of this book. Whether the topic is communication, life review, helping children, or the role of physiotherapy, the authors share their visions of how and what is helpful to those who are dying and those who are or will become bereaved.

Prognosticating is always a hazardous activity. The future of thanatology and of palliative care are elaborated by Churchill and Doyle, a respected philosopher and a medical educator. If in fact their future becomes our present, we are likely not to remember their foresight. If, however, events unfold in ways considerably different from what was foretold, then these chapters are most likely to seem out of step even though a number of the other chapters examine current and future issues. Thus Churchill and Doyle deserve special appreciation for their willingness to help us prepare for the future, along with Lund Person, who examines regulatory issues, and Wass and Corr, who discuss death education for children and for adults.

Indeed death education for children and for adults may enable us to meet the challenges of death and bereavement and our own dying with equanimity and grace, with hollering and bellowing, and with gratitude for the gift of life. All of this presumes a life fully lived and not foreshortened by acts of personal violence, war, or the scourge of disease. That is not to say that individuals who have not lived long have not lived life fully. Rather that the challenge for the dying person and the bereaved is greater than under more sanguine circumstances. Whatever the circumstances, dying, death, and bereavement constitute a challenge both to and for living. Dying, Death, and Bereavement: A Challenge for Living has the immodest aim of equipping individuals to confront these challenges effectively. Fortunately, we do so together with other concerned individuals in the context of an increasing interest in meeting these challenges.

Each for his own memorial
Earned praise that will never die
And with it
The greatest of all sepulchers
Not that in which
His Mortal Bones are laid
But a home
In the Minds of Men

Netherlands American Cemetery
Margraten, The Netherlands
As this is being written, Americans, the British, and Iraquis, as well as others, are dying in the many wars around the globe. We look forward to the day when the concern of the day is once more focused not on creating new cemeteries for the remains of fallen soldiers and civilians caught in war, but on death due to old age. May the challenge for living be one of living a productive life so that the dying, death and bereavement is for a life well and fully lived.
Richard T. Sabo
Born August 4, 1964
Younger brother of Donna
Elder brother of Christopher
Born and raised in northwestern New Jersey
Graduated high school in 1982
Served in the United States Navy 1982–1984
Currently living in Bangor, Maine
What else can I tell you?
I'm a self-professed gear head; I enjoy riding motor
Cycles, snowmobiles, and any other gas-powered con-
veyances. Spent 8 years
Working in healthcare as a certified sterile-processing
and distribution
Technician.
Have spent most of my adult life doing construction (labor/heavy
Equipment operator/mechanic).
My brother committed suicide on December 9, 2001.
I love and miss him!!!

Pain
Richard T. Sabo

Today I died of a broken heart
My world
My life
Ripped apart

Forever now your soul is freed
Forevermore mine will bleed

Never again to feel your touch
The need I have is oh so much

You are the one who is my brother
In this life there will be no other

A river of pain runs through my soul
Today I died of a broken heart
We acknowledge all of those who contributed to this book directly and indirectly. We are grateful for the ongoing support of our families—Inge’s daughters Theresa and Patricia and “son” Rick; Barbara’s husband Vic, daughter Laurie, son Michael, and granddaughter Talia; Mary’s husband David and sons Mark and Scott and daughter Kate. We are also grateful to Ruth Chasek, our editor, for her unstinting support, as well as Matt Fenton, Skip Wright, Janice Stangel, and Joanne Honigman and the unnamed others who resuscitated a project that faced interminable challenges including the loss of diskettes enroute to the printer while the first author (I. B. Corless) was on sabbatical in South Africa. While dying, death and bereavement are truly challenges for living, bringing this book to life entailed its own set of challenges. As with living, there is an end—in this case publication. Thank you to all who made it happen.
Part One

The Challenge of Understanding Death
Deborah Lees Holtorf became interested in health care when she served in the Peace Corps in West Africa in the mid 1960's. She graduated from Massachusetts General Hospital School of Nursing in 1970, and received her Master of Public Health degree from the University of Pittsburgh in 1979. After spending a number of years working in community and school health, Deborah returned to MGH Institute of Health Professions, graduating with her Master of Science in Nursing and becoming certified as a pediatric nurse practitioner. She currently works in the pediatric and adolescent unit of the Joslin Diabetes Center in Boston, MA.

I wrote "Artists" while taking a course taught by Dr. Corless. My father-in-law died the same week a required journal entry was due. When I sat down to write the entry, "Artists" emerged instead. Thankfully, Dr. Corless accepted the substitution for the usual journal entry.

The nurses called Dorothy to tell her that you were doing poorly. Dorothy needs to get dressed and eat some breakfast. She is 83 years old and sensible. She will probably even bring a sandwich for the long haul. I will go ahead, leaving Dorothy with her capable sons. In the hospital parking lot, summoning strength to leave her car, sits your daughter, Mary. I speak to the front seat window: "Let's go."

The doctor is quiet and kind, addressing Mary: "Maybe Ed had a little stroke or a seizure, because he is no longer responding to us. We aren't having any luck keeping the fluid out of his lungs. We could take him downstairs to the ICU for more aggressive treatment, but I don't think that will add to his quality of life. Will your mother be here soon?"
You lie still in white sheets, your breathing rapid and ragged. Overnight your arms and hands have swollen with the fluid that your heart no longer has the energy to keep pumping. The doctor says you respond only to pain, but he is not sure why. I speak into your ear. "Ed, it's Deb. I'm here with Mary. Dorothy and the boys are coming. You are very sick." You pause in your labored breathing. A grunt, a nod—we know you are with us.

The little room fills with your children. Mary, your youngest, is a blower of glass. Gently curved vases and riotously spotted ornaments grace our lives. Bob, the middle child, takes the wood of trees and smooths it into tables and cabinets. Gerry, the oldest, my husband, is a painter of woodland scenes with autumn-colored grouse camouflaged by leaves. He is a writer of stories in which gnomes and men fish from deep dark country streams side-by-side.

Dorothy, your wife of 55 years, photographer of our world, is perched beside you, on the arm of a recliner. If she sits in the chair, her arthritic knees will betray her when it is time to get up again. Her eyes contact mine. "Well, Deb, what do you think?"

Who am I to stand in the wings and coach your family in playing out this last act? My hands too often break glass. I am the lusty alto in a choir of angels, the fledgling ice skater of small leaps and big bruises. My best thoughts are inclined to be trailing just behind my spoken words. My mantra is borrowed from a Buddhist nun, Pema Chodron. "Refrain, refrain," I chant to myself, to restrain the energy that so often rules.

The other day, you reminded me of the many hours we have spent in emergency rooms together during the past couple of years. You know I am your advocate. You know I will not lie to you, even if my translation of the truth of the moment is blunt and clumsy. But you are still there. This act is for you to direct, not me. You are the fixer of things. Your creations have always been symbolic of a more profound role. Your big hands are now too swollen to hold the gadgets you have crafted to glue our daily lives together. You have been a wonderful husband and father, Ed. Don't leave yet, we still need you. A small voice in me giggles when I think of the legacy you left your oldest. "No, Gerry, I don't think that old pot looks good as a lampshade, even if you do paint it green." You have been a wonderful husband and father, Ed. Don't leave yet, we still need you.

I speak in your ear again, not to intrude, but to break through your concentration on breathing and being. It is important that you hear me now. "Ed, your heart is very weak, and your body is filling up with fluid. We can move you down to the ICU and try to get rid of the fluid, but we
Artists
don't know if we can keep it off. There probably is not a lot the doctors
can do to make you feel better for very long. Do you want to try?"
The final act has its hero. You are emphatic. "No!" you grunt, shaking
your head side to side. You have spoken eloquently to everyone in the
room, including the gentle doctor who stands in the doorway. Thank
you, Ed.

I now have clear words for Dorothy. "Ed is dying. I think you need to
sit with him, touch him, and tell him how much you love him." My
assumption arises from so many years of knowing the two of you.

The rest of us huddle with the doctor, while Dorothy holds your hand
and tells you what she needs to. There will be morphine if you are in pain
or very anxious. Later in the day you will ask for it, but right now you
indicate that you are comfortable. Would you like your IVs removed? You
nod your approval. We leave little heparin locks to use if you need the
morphine. I don't think they will bother you.

The trappings of acute illness are carried out of the room. IV poles,
monitors, and nebulizers are replaced by chairs and ice chips. Your nurse
checks in frequently. You and she communicate well. She wants you to
be comfortable and safe, and you seem to understand that.

Your family is not sure what to do now that the scenery has been changed.
Modern medicine has departed, leaving your family to a communion as
old as life itself. Now what?

I look at the faces of your wife and children. You have eased their
suffering by making your wishes so very clear. The remaining time will
be devoted to your dying. Will it be hours or a day or two? We cannot
accompany you into death, but we want to be with you as long as possible.
Can I help, or should I refrain? Too late, the words are already flowing.
To my own ear, their loudness shatters the air.

"I will miss having Ed next door. When we first moved in beside your
folks, thinking I was all alone, I would vent my frustration at the various
obstacles in my path with a stream of words that no woman of Ed's
generation was supposed have heard. His laughter would ring back at me
from across the field. Moments later, I would be laughing too."

Your children's faces are surprised at first, then animate. "Do you remem-
ber the time . . . ?" "I'll never forget the. . . ." "Dad was there when. . . ."
"Ed was always. . . ."

We know you are there. We know you are listening. We tell our stories,
and we speak to you directly. Dorothy cradles your hand. As it turns out,
you have only a few hours left to live. Soon you will let us know that you
are uncomfortable and would like medication. I leave you with your wife
and children. Your breathing becomes relaxed and peaceful as you slip
away from your family. Conversation quiets and focuses more on those
who will continue to live for a time. You have kept your family with you
as long as possible. It is time to say good-bye.
Communicating About Death and Dying

Albert Lee Strickland and Lynne Ann DeSpelder

Albert Lee Strickland is a professional writer whose multidisciplinary interests in thanatology are reflected in his coauthorship of The Last Dance: Encountering Death and Dying, a college text now in its sixth edition. He is a former editor of The Forum Newsletter, published by the Association for Death Education and Counseling, and is a member of the International Work Group on Death, Dying, and Bereavement and of the Authors Guild. His publications on death and dying include The Path Ahead: Readings in Death and Dying, an anthology co-edited with Lynne DeSpelder.

Lynne Ann DeSpelder is an educator, author, and counselor. A professor at Cabrillo College, she developed and taught one of the first interdisciplinary courses on death and dying in California. Certified by the Association for Death Education and Counseling as a death educator and as a grief counselor, she was instrumental in developing that organization’s Education for Certification program. Her first nationally published popular writing on death appeared in the November 1977 issue of New Age magazine. She is coauthor of The Last Dance: Encountering Death and Dying (6th ed.), as well as numerous other publications, and is a member of the International Work Group on Death, Dying, and Bereavement.

Waiting to speak with a patient who has completed a series of diagnostic tests, a physician ponders how to break the news of a potentially fatal
condition. A parent wonders how to tell a young child about the unexpected death of a beloved relative. Reviewing videotaped coverage of an airliner crash, the editor of a television news program contemplates which segments should be broadcast on the evening news. On the job, the death of an associate's spouse causes co-workers to question how to express their condolences. Before entering the room of a patient nearing death, a nurse hesitates for a moment to consider how to frame the words that express sensitivity to the family's situation. Encounters with dying, death, and bereavement present special challenges to us as communicators.

The Communication Process

Our understanding of the world is generated through communicating, which is an ongoing process that involves the exchange of messages and meanings between individuals (Penman, 2000). Communication is not merely a series of incidents pasted together like photographs in a scrapbook; rather, it is like a motion picture in which meaning is derived from the unfolding of an interrelated series of images (Adler & Rodman, 1991).

Communication is a two-way, interactive, and transactional process (Williams, 1989). To say that it is interactive means that messages can be readily, or even simultaneously, exchanged between parties to the communication. To say that it is transactional refers to the evolutionary nature of the process by which the present message influences subsequent exchanges. Communication is a process of give-and-take, an ongoing activity between persons who function alternately as the source and the receiver of meanings or messages. In broad terms, it is a process that includes a source, a message, and a receiver (Littlejohn, 1999).

Communicating effectively requires attention to nurturing and maintaining the communication process (Luckmann, 1999). Especially important are developing the requisite trust, achieving clarity about motives, and establishing an appropriate context for successful communication. A person's attitudes, beliefs, values, needs, preferences, goals, capabilities, experiences, and communication styles all influence how he or she will send or receive a particular message (Kaplan, 1989; White & Robillard, 1989). As a result, people of different cultures sometimes experience difficulties in communicating clearly with one another. The key to overcoming these difficulties is to accept the other person's fundamental humanness and to continue efforts to communicate. Understanding the styles of communicating used by others makes it possible to create shared experiences and meanings (Smith, Hernandez, & Allen, 1971).
The ability to alternate between different styles of communicating is termed *code switching* or *style switching*. This involves identifying what is appropriate in different situations and modifying one's speech, as well as nonverbal and other communication behaviors, to achieve a good fit within the interactional context (Robinson, 1998). Having an awareness of each other's "codes" is vital for achieving clear communication. Effective communicators have positive self-concept, assertiveness, open-mindedness, empathy, and the ability to use a variety of communication strategies appropriately.

Consider the case of a young widow who was referred for counseling by her physician because she was reportedly "not doing too well." When the young woman entered the counselor's office for her initial session, she sat down rigidly on the couch, bracing herself, with legs extended and her arms crossed. The counselor opened the session by saying, "I understand you've experienced a big change in your life recently." Through clenched teeth, the young woman said, "Yeah, my old man ate it on Highway 17." Matching the young woman's language and communication style, the counselor said, "It sounds like that really pissed you off." Exploding out of her rigid position, the young woman let go with a volcanic torrent of expletives: "Yes, I'm damned angry; he was drunk and ran off the road, leaving me alone with four kids under the age of five and no insurance or any kind of security." Then, breaking down into tears, she sobbed, "God, I must be going crazy; how can I be furious at someone who's dead?"

Matching the young woman's language and communication style allowed the counselor to quickly establish a rapport that promoted effective communication. It readily became evident that this young widow was very much in touch with her feelings about the circumstances of her husband's death, even though her feelings were conflicted and confused. By paying close attention to the communication process, the counselor facilitated the expression of these feelings—a crucial step on the path to resolving grief.

Nonverbal Communication

It has been said that one cannot *not* communicate (Bavelas, 1984; Watzlawick, 1984). The truth of this statement is evident when we consider the broad range of nonverbal as well as verbal modes of communicating. Indeed, nonverbal communication is an inseparable part of the total communication process (Knapp & Hall, 1997; Phillippot, Feldman, & Coats, 1999). Although we usually think of nonverbal communication as applying
only to the sphere of interpersonal interactions, it actually functions in a broader context. For example, in the international arena, nonverbal communication is used by hostile states without diplomatic relations as a means of signaling intentions and desires (Berridge, 1994). Relaxing restrictions on trade may signal a desire to improve relations; the movement of military forces may send a threatening message.

Nonverbal communication is typically divided into three components: paralanguage (features of speech beyond the basic language symbols, including tone of voice and rate of speech), kinesics (gestures, eye gaze, facial expression, touch, body posture, and movement), and iconics (objects that convey meaningful information, such as clothes and jewelry). Labels such as MD and RN, as well as titles such as doctor, nurse, and patient, are examples of symbolic identifiers that influence the process of communication. Space and time (proxemics) can be added to this list of nonverbal cues. Consider, for example, the time it takes a caregiver to respond to a patient’s request for help, or the physical distance established when a physician stands behind a desk while conversing with a seated patient.

When a nonverbal message contradicts the verbal message, it creates a sense of inconsistent or incongruous communication. Because nonverbal cues tend to operate at an unconscious level, they are commonly assumed to be more trustworthy than words. Nonverbal messages are difficult to censor or falsify. Therefore, the nonverbal component of a communication may determine the ultimate impact of a message.

Verbal Communication

In considering the relationship between verbal and nonverbal communication, being aware of the distinction between low-context and high-context cultures is helpful (Hall, 1976; Robinson, 1998). Low-context communication cultures rely heavily on the verbal part of a message, which is often elaborate, highly specific, and detailed. People tend to communicate in a direct fashion, paying little attention to the nonverbal and contextual aspects of a communication. In low-context cultures, a high value is placed on individualism, independence, autonomy, and self-reliance.

In contrast, high-context communication cultures rely heavily on nonverbs and the circumstances or context of a message, which involves letting the point of the message evolve indirectly, rather than stating it explicitly. By “stalking” the issues, rather than directly stating them, the speaker demonstrates skill and arouses the hearer’s interest (Asante, 1998).
People in high-context cultures attend to nuances of behavior (or "vibes") and to social context, as well as the "group identification" or understanding shared by those who are communicating. High-context cultures value collectivism, cooperation, harmony, and loyalty to the group.

It is easy to imagine how these differences in communication styles might lead to misperception and misunderstanding when people with contrasting styles interact. People from high-context cultures often view those from low-context cultures as excessively talkative, whereas people from low-context cultures often view those from high-context cultures as nondisclosing, mysterious, and even sneaky (Robinson, 1998). Caregivers, in particular, need to appreciate that communication styles differ, especially as they relate to cultural distinctions, and resist evaluating a person's way of communicating on the basis of ethnocentric judgments that interfere with effective communication.

Turning to the language people use when talking about dying or death, we find that euphemisms, metaphors, and slang comprise a large part of "death talk" (DeSpelder & Strickland, 2002, pp. 13–14). Substitutions of vague words or phrases for ones considered harsh or blunt are often used to keep death at arm's length by masking its reality. Loved ones "pass away," and the deceased is "laid to rest." However, the use of euphemisms and metaphors does not necessarily imply an impulse to deny death or avoid talking about it. Sometimes they express subtler, deeper meanings. Terms like "passing," for example, convey an understanding of death as a spiritual transition within some religious and ethnic traditions. Nevertheless, plain talk about death is subverted when euphemisms devalue and depersonalize death. Instances of this occur, for example, when soldiers killed in battle are described as "being wasted" or when civilian deaths are termed "collateral damage." Listening carefully to how language is used provides information about the speaker's attitudes, beliefs, and emotional state. Becoming aware of the metaphors, euphemisms, and other linguistic devices that people use when talking about dying and death allows for greater appreciation of the wide range of attitudes toward death and promotes flexibility in communication.

The horrific events of September 11, 2001, provide an instructive case study. Despite heroic efforts to find survivors alive and trapped in the rubble of the World Trade Center and the Pentagon, the lack of success was revealed in the linguistic shift from rescue to recovery. In daily conversations, people struggled to find the right word or phrase to adequately describe the events. Some called them "the terrorist attacks"; others spoke of "the events of September 11," "the bombing," "the tragedy," or simply
"it." Every word or phrase carries its own framework of associations, and different words or phrases may be appropriate for different groups of people. For example, whereas the word *tragedy* might be appropriate for the workplace, where people are focused on recovery, the word *attack* resonates more with police officers, firefighters, and military personnel, who viewed the experience as a direct assault. For some people, "September 11" or "9-11" became a shorthand way of referring to the sequence of events involving the World Trade Center, the Pentagon, and the airliner crash in Pennsylvania. One man said: "I've called it an attack, a tragedy, and a bombing.... But, in the end, the name which resonates the most for me is simply the date, September 11, because it was all of those things and more" (quoted in Angwin, 2001, p. A8). This groping for the right word or phrase is part of the natural evolution of language as people try to make sense of an event or situation for which they have no adequate conceptual framework; indeed, this search can be important to the process of coping with traumatic events.

Humor is another aspect of communication that can function as a way of coping with death (DeSpelder & Strickland, 2002; Hall & Rappe, 1995). Death-related humor comes in many different forms, from ironic epitaphs to so-called black or gallows humor, which may reflect a thumbing of one's nose at death, as if attempting to minimize its power and gain a sense of mastery over it. For caregivers, humor offers relief from stressful duties that involve frequent contact with dying and death. For example, emergency workers, and others who deal with life-or-death situations, tend to form communities within which insider or "backstage" humor is used as a strategy to cope with the emotional labor of their jobs (Shuler, 2001). At one teaching hospital, doctors avoided the word "death" when a patient died, because of concern that other patients might be alarmed if the news were to be communicated openly (DeSpelder & Strickland, 2002). One day, as a medical team was examining a patient, an intern came to the door with information about another patient's death. Knowing that the word "death" was taboo and finding no ready substitute, the intern stood in the doorway and announced, "Guess who's not going to shop at Wal-Mart anymore." Soon, this phrase became the standard way for staff members to convey the news that a patient had died.

Communication About Death in the Mass Media

Newspapers, magazines, books, television, and movies are the secondhand sources from which many people learn about death. The daily news usually
includes an assortment of accidents, murders, suicides, and disasters (Nimmo & Combs, 1985). Although the brief reports of death-related events on television or in newspapers seldom do justice to the actual range and depth of the human response to loss, sometimes media coverage of catastrophic events does provide a focal point for the grief of a community or nation. In the wake of the assassination of President John F. Kennedy or the explosion of the space shuttle Challenger, as well as, more recently, the terrorist attacks of September 11, 2001, television became a kind of "national hearth" around which viewers were symbolically gathered to contemplate the meaning of these tragedies. It is important to note, however, that coverage of death-related events by the media is sometimes accompanied by unwarranted intrusions on the bereaved. The journalistic impulse to "capture the experience" for viewers or readers may result in a second trauma for survivors, restimulating or possibly amplifying the pain brought about by the event itself. The line between public event and private loss is not always easily drawn.

Perhaps unavoidably, the media tend to present an incomplete picture of the human response to death and its meaning. Entertainment programs, for example, rarely deal with how people actually cope with a loved one's death or confront their own dying. Generally, such programs present a depersonalized image of death, an image that is usually characterized by violence (Gerbner, 1980; Tate, 1989). Consider the western or the detective drama, which glazes over the reality of death and leaves the impression that death need not be mourned. Or recall the Saturday morning cartoon as Daffy Duck is pressed to a thin sheet by a steamroller, only to pop up again a moment later good as new—reversible death! When told of his grandfather's death, one modern 7-year-old asked, "Who did it to him?" The image of death found in the media usually communicates the notion that death comes from outside, often violently. Death is portrayed as an accidental rather than a natural process.

Communicating with Children About Death

The attitudes toward death found in the media and in society generally play a major role in the socialization of children relative to dying and death (DeSpelder & Strickland, 2002). Parents and other adults sometimes communicate specific instruction about attitudes: "This is how we behave in relation to death." One woman recalled her mother's message that she should not look at the dead animals on the highway—"Put your head
down, children shouldn’t see that”—a clear communication about this
mother’s attitude about what constitutes appropriate behavior toward
death. At other times, the message is less specific: “Let’s not talk about
it...,” or the message is communicated subliminally, as with the notion
of replaceability. A child’s pet dies, and the parent says, “It’s okay, dear,
we’ll get another one.” Such messages may have unintended consequences,
as when a woman, recently bereaved by her husband’s death, was ap-
proached by her young child, who said, “Don’t worry, Mommy, we’ll get
you another one.”

In communicating with children about death, honesty is foremost. Sec-
ond, don’t put off introducing the topic. When the experience of a close
death precedes discussion, the explanation is charged with all the emotions
generated by the crisis, making the attainment of clear communication
more difficult. Third, set the level of explanation to the child’s powers
of understanding. By using as a guide the child’s interest and ability to
comprehend, an explanation appropriate to the child’s circumstances can
be provided.

Children tend to be very literal-minded. Metaphorical explanations can
be used to present a child-sized picture that aids understanding, but, unless
fact is separated from fantasy, a child may grasp the literal details rather
than the underlying message the analogy was intended to convey. A child,
told that her goldfish “went to heaven,” may make an elaborate picture of
the pearly gates and different sections of heaven—“Here is goldfish heaven,
this is cat heaven, and over here is people heaven”—an organized concept
that makes sense to a young child, but one that may cause confusion. If
you tell a 4-year-old that a person who has died is “up there,” and you
also remark that Santa Claus lands on the roof, the child may decide that
Santa Claus and the deceased person are great buddies. Children are apt
to point out any inconsistencies in what we tell them. When discussing
death with children, it is important to verify what they think you have
told them. Ask the child to tell you what he or she learned or heard you
saying about death. Indeed, the essence of these guidelines for discussing
death with children has broad application in other contexts involving
communication about death, dying, and bereavement.

Communication in the Context of Bereavement

When a death occurs, the first to learn about it, beyond the attending
medical team or emergency personnel, are usually members of the
deceased's immediate family. Those with the closest relationships to the deceased are notified first, followed by those with less intimate relationships. Ideally, this process of notification—a gradually widening circle of relatives, friends, and acquaintances—continues until everyone affected by the death is notified (Sudnow, 1967).

Death notices and obituaries published in newspapers are an important means of death notification for the wider community. People expect death announcements to appear in a timely fashion. When this does not occur, the results can be emotionally upsetting to those who knew the deceased. The person who learns about a death only after the final disposition of the body may regret not having been a participant in the communal ceremonies marking the death. Human beings experience a need to respond appropriately to the death of significant others. Because the mutual support offered by a community of bereaved persons is not likely to be as readily available to individuals after the initial mourning period, the belatedly notified person may feel isolated and alone in coping with his or her grief.

Death notification initiates expressions of mourning that communicate the fact that a person has been bereaved. Black armbands or distinctive mourning garb, as well as other signs and symbols, have been employed by various societies to distinguish the recently bereaved. Although many of these traditional signs of mourning are vanishing from modern societies, most people still believe that the bereaved deserve special consideration.

A woman who became involved in an automobile accident just a few days after the death of her child reported that she wished she could have had a banner proclaiming her status as a “mother whose child has just died.” Having no outward sign or symbol of her bereavement, she was subjected, as any of us would be, to the strain of waiting around and filling in seemingly endless forms. The social support elicited by nonverbal or symbolic signs of mourning can be helpful to survivors as they begin to cope with loss.

As people learn about the death of someone who has been significant to them, they tend to gather together for comfort and support in their mutual bereavement. The act of coming together is itself a symbolic communication that offers solace and attests to the reality that the bereaved are members of a caring community (Young, 1978). Gathering together for mutual support is integral to the events surrounding the funeral. This pattern of social interaction has important psychological implications for the bereaved. By corroborating the fact of a loved one's death and expressing the reality that the community has experienced a change of status, because of the death of one of its members, such social interaction facilitates the expression of grief.
The experience of loss is conditioned by a person's model of the world, that is, by his or her perception of reality and understanding about how the world works. An individual's personality and values, social roles and expectations, and relationship to the deceased all warrant consideration in determining how to communicate support in bereavement (Jackson, 1957). Giving the bereaved permission to experience and express complex and possibly conflicting thoughts and feelings is especially important. A person's response to loss encompasses myriad personal, family, and social factors.

During the early period of bereavement, a survivor's perceptions may be disorganized and events may seem unreal. This sense of disorganization or unreality is likely to be reflected in communication patterns. The bereaved may wish to talk incessantly about the deceased or may seemingly talk about everything but the confrontation with loss and circumstances surrounding the death. The response to loss is multifaceted and can be highly variable. Besides sadness, longing, loneliness, and sorrow, the bereaved may express strong feelings of guilt or anger (Bugen, 1977; Lindemann, 1944; Osterweis, Solomon, & Green, 1984). Movement toward healing in the wake of loss is facilitated by communication that takes into account the changing moods and circumstances of the bereaved. Being aware of the variety of responses associated with grief enhances our ability to cope with losses in our own lives, as well as to care for others who are bereaved. When loss is situated within a context of growth, so that what is lost can be integrated into one's ongoing life story, grief becomes a unifying rather than alienating human experience (Schneider, 1984).

Communication in the Context of Terminal Care

Physicians and other health professionals occupy a place of honor in society. Aesculapius, the first physician, according to Greek legend, was elevated to the pantheon of gods. Because of an intimate connection with the elemental human experiences of birth, life, and death, medicine and its practitioners enjoy symbolic importance (Hingson, Scotch, Sorenson, & Swazey, 1981). The lab coat of the attending physician, and the distinguishing uniforms of the nursing staff, are symbols that nonverbally communicate a sense of authority and power. Caregivers and patients may unwittingly conspire to perpetuate a pattern of paternalism in health care, whereby the caregiver assumes a parent-like authority over decisions affecting patients (Raffler-Engel, 1989; West, 1984).
One truism in medicine is that hope and a positive attitude play key roles in a patient's ability to cope with illness (Bessinger, 1988). Indeed, physicians may withhold certain facts about serious illness, out of concern that a full, open disclosure could lessen the patient's hopes of recovery. However, it is important to distinguish between framing a communication so that it corresponds to the patient's ability or willingness to learn the truth and glossing over or neglecting a full disclosure of the facts, out of a medical paternalism that subverts the patient's prerogatives.

When a medical condition involves a life-threatening diagnosis, the nature of the conversations between physician and patient has a significant bearing on the patient's decisions about treatment, as well as his or her ability to cope. From initially breaking bad news about a likely fatal diagnosis, until the last moments of life, patient-caregiver communications involve two interrelated tasks: one in which medical information is provided to the patient, and the other in which supportive dialogue centers on the patient's emotions and responses to the situation (Buckman, 2000). Physicians are obligated to provide information about the disease or threatening condition, offering details to the extent the patient wishes, so that the patient understands what to expect and the options that may be considered as treatment proceeds (Rosenbaum, 1978). Important to this process is establishing an atmosphere of openness and trust, to help mobilize the patient's will to live, which is a key element in any therapeutic effort (Gray & Doan, 1990a, 1990b; LeShan, 1969).

Most people say they would want to be informed if diagnosed with a life-threatening illness, and physicians generally acknowledge a responsibility to inform patients about the facts of a life-threatening condition. However, the question of when and how to tell can be difficult to answer (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1982a, 1982b). Presenting bad news in a way that avoids harming the patient's interests requires physicians to consider such factors as the patient's personality, emotional constitution, and capacity to function under stress. A survey conducted in the early 1960s showed a strong tendency on the part of physicians to withhold information about a potentially fatal diagnosis involving cancer (Oken, 1961). Descriptions of the disease were often couched in euphemisms, to temper the impact of the diagnosis, or adjectives were used to suggest that the cancer was benign. Accordingly, patients were told they had a "lesion" or "mass," or they were given a more precise description, such as "growth," "tumor," or "hyperplastic tissue." The tumor might be described as "suspicious" or "degenerated." In short, physicians explained the medical situa-
tion in very general terms intended to elicit the patient's cooperation in the proposed course of treatment.

Today, patients diagnosed with a potentially terminal condition are likely to learn the truth about their illness, and to learn sooner, than was the case in the past (Novack et al., 1979). Nevertheless, some details about an illness may not be disclosed unless the patient or a family member takes the initiative by asking specific questions. Furthermore, physicians are generally reticent when it comes to speculating about prognosis or outcome—matters that tend to be much less certain (Novack et al., 1989).

The trend toward greater disclosure is related to the importance now placed on obtaining a patient's informed consent to a plan of treatment. Informed consent is based on three principles (President's Commission, 1982a, 1982c): First, the patient must be competent to give his or her consent; second, consent must be given freely; third, consent must be based on an adequate understanding of the proposed treatment and its potential side effects. The values underlying informed consent include serving the well-being of patients and respecting their right of self-determination. Realizing these values requires that attention be given to the processes of communication between patient and practitioner.

Although coercive treatment is rare, caregivers may unwittingly exert undue influence on patients by means of subtle or overt manipulation. Routine medical care is often provided without explicit consent. When a patient enters a medical institution, his or her cooperation with caregivers is expected. The tacit communication may be that the patient has no choice about following the treatment plan. Thus, the nature of the communication process between patient and provider may determine the presence or absence of informed consent.

Patients vary about the degree of disclosure with which they feel comfortable. Some patients prefer to "let the doctor decide"; others seek to gain sophisticated medical knowledge by searching the literature regarding a treatment plan. Ultimately, informed consent does not mean inundating patients with a flood of facts; rather, it means treating patients as whole persons and respecting their unique preferences. The capacity to maintain healthy self-concept, to set goals and strive to meet them; to exercise choice, out of awareness of one's power to meet challenges; to engage in interactions with one's environment—all of these reflect a "coping capacity" that can sustain the will to live, even in the face of death (Weisman, 1984).

In an institutional medical setting, where patients are supposed to get well, the dying person may be treated as a deviant. Death may be seen as less a natural event than a medical failure. In this cultural context, biological death may be preceded by social death (Blauner, 1966; Cassell, 1974;
Sudnow, 1967). A pattern of avoidance, resulting from premature social death, is seen in the example of nurses taking longer to answer the bedside calls of terminally ill patients than to answer the calls of less severely ill patients (Bowers, Jackson, Knight, & LeShan, 1964). Avoidance is also evident in the evasive responses of some caregivers when patients attempt to initiate discussions about dying or death. These responses include reassurance (“You’re doing fine”), denial (“You’ve got nothing to worry about”), changing the subject (“Let’s talk about something more cheerful”), and fatalism (“We all have to die sometime”). Such responses present a marked contrast to the more helpful response of caregivers who display a willingness to discuss issues that concern patients who find themselves facing death (“What is happening to make you feel that way?”).

Contact that bridges the usual professional distance reduces the alienation that patients may experience in an institutional setting. Establishing continuity of care between at least one caregiver and the patient is an important step toward eliciting the trust and confidence that forms a foundation for effective communication (Donovan & Pierce, 1976; Quint, 1967).

A century ago, physicians and nurses did perhaps as much to console as to cure the patient. Indeed, consolation and palliative measures were sometimes all the practitioner could offer the patient. A caregiver who steps into the room, sits by the patient’s bedside, and demonstrates a willingness to listen, is likely to be more successful in providing solace and aid than the one who breezes in, remains standing, and quips, “How’re we today? Did we sleep well?”

Skillful communication is a key to caring for the whole person. Caring is not always synonymous with doing. Nor is effective communication synonymous with having “something to say.” The death of the body is a physical phenomenon, but the passing of a person is essentially nonphysical (social, emotional, psychological, spiritual); yet, these phenomena tend to become confused. Effective communication goes beyond caring for the person as a physical entity. It encompasses nonverbal as well as verbal communication. Actions, as well as words, are important. These insights about the communication process have application in all our relationships, whether or not the immediate context involves dying or death.

Communication Social Support

We cannot communicate without giving of ourselves, nor can we communicate without benefitting from the gifts of others (Shepherd, 2001). The
idea that communities are welded together by communication goes back at least to Aristotle's Politics (Depew & Peters). Thinking about the relationship between community and communication naturally leads to a consideration of social support, which refers to a process intended to help distressed individuals through the anxiety and uncertainty of difficult or painful life events (Albrecht & Adelman, 1987a). Figuring out the best way to support another person is not always easy or obvious. Nevertheless, in helping others make sense of themselves, their actions, and their situations during a crisis, the phrase "beginning to have an ear" is a helpful image (Albrecht & Adelman, 1987b, p. 255). Taking as a hint the fact that humans are endowed with two ears and only one mouth, listening is usually more important than talking.

When it is time to talk, saying what you mean is important. Being evasive, dishonest, or deceptive puts clear communication at risk. Effective communication does not require that the people who are communicating always agree with each other, but it does require a willingness to drop the protective guard that screens one's self and feelings from others.

Because communication is a two-way process, it takes a willingness to give as well as take from the interaction. This involves being open to each other's needs, as well as a readiness to not only hear the other person's spoken words, but also to "tune in" on unspoken levels of meaning that may be communicated by nonverbal and other behavioral "languages." When uncertainty exists about what the other person means, asking for clarification is better than to guess and guess wrong.

Although social support is usually conceived of as occurring at the level of interpersonal relationships, its aims and methods can be extended to encompass the larger community. Cynicism and radical individualism not only thwarts the giving and receiving of social support when people are in crisis, but it also undermines public dialogue about critical social and political issues that affect the common welfare. These unfruitful forces can be counteracted by a commitment to the common good and to a "dialogic civility" that respects multiple perspectives, with the goal of "keeping the conversation going" (Wood, 1999, p. xiii).

Modern technologies are expanding our options for communicating social support. Conventional face-to-face encounters are being augmented by the option of "reaching out and touching someone" via the Internet and electronic mail. Memorial pages and virtual cemeteries on the World Wide Web make it possible for individuals remote from one another to share their stories and acknowledge their losses. Soon after the collapse of the World Trade Center, many of the individuals who escaped wrote
personal accounts of their experiences and e-mailed them to friends and family members as a way of coping with grief and helping others (Davis, 2001). These personal essays were swiftly shared with millions of people, by virtue of lightning-fast e-mail chains that forged a global community. In some instances, persons unknown to the writers gained helpful information about loved ones through the e-mailed accounts.

In this time of horror, electronic mail was also used by groups of friends who set up e-mail circles to make sure people were accounted for, as well as to give and receive reassurance (Peterson, 2001). Children, too, made their voices heard in e-mails and on Internet Web sites. “Talking things through” on the Internet became a way for children, as well as adults, to begin coping with an unsettling tragedy. Reflecting on the various ways that individuals and communities communicated social support in the minutes, hours, and days following the terrorist attacks, one writer noted that it gave “proof that a great, vast net of humanity exists, a net of friendship and abiding concern” (Varadarajan, 2001, p. W13).

Discussion Questions

1. How does matching language and communication styles promote effectiveness in interactions involving dying, death, and bereavement?

2. Which components of the communication process do you believe are most significant in interactions involving dying, death, and bereavement?

References


