DYING AND THE MEANINGS OF DEATH: Sociological Inquiries

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Abstract
This review takes off from the remarkable decline in mortality as one of the most striking features of the social history of the past century. Most deaths now occur not among the young but among the old. Death, thus postponed, is taking on new meanings for both the individual and society. Three lines of sociological inquiry over the past two decades, together with an extensive bibliography, are critically reviewed. First, the literature on dying and the self includes dying as a social process, dying trajectories, attitudes toward death, and the potentially mortal impact of such social stressors as retirement, residential relocation, and economic change. Second, a broad and often confusing literature deals with bereavement, grief, and the meaning of loss by death to surviving significant others, touching upon such topics as the “broken heart syndrome,” widowhood, types of death and bereavement, and anticipatory grief. Third, sociological inquiries examine the norms and social structures found in all societies for defining and managing dying and the consequences of death.

Although no satisfactory “sociology of death” has yet been written, four influential theories of death-in-society are noted: by Parsons, Blauner, Marshall, and Fox. On balance, the review sees a promising future for sociological inquiries on death and dying and concludes that the meanings of death are in a process of continuing transformation. Some of the key questions yet to be answered are: Will socialization for death become a recognized reality? Will dying persons seek to maintain an even greater sense of autonomy? Will passive euthanasia create fewer moral dilemmas? Will suicide continue as “the final alternative” for increasing numbers of older people? Will new patterns of bereavement emerge for the future population of widows? Will new caring environments for the terminally ill be institutionalized? Will the concept of a “good” death gain wider acceptance? An agenda for continued sociological inquiry appears to be in hand.

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0360-0572/83/0815-0191$02.00
INTRODUCTION
Death is both inevitable and irreversible. It is the one personal event that the individual can never report. Throughout history death has been universally regarded as an event of social significance, and every known culture has had rules and norms for defining death as the ultimate rite de passage, and for dealing with its consequences. Yet during the 20th century both the phenomenon of death and its social meanings have been transformed, creating unprecedented opportunities for sociological inquiry.

The remarkable decline in mortality is one of the most striking features of the social history of the past century. Life expectancy at birth in the world as a whole has increased from almost 30 years in 1900 to well over 50 today. Over two thirds of the improvement in longevity from prehistoric times to the present has occurred in the very brief period since 1900, as Preston (1976) has shown. Most deaths now occur not among the young but among the old. In the United States, people aged 85 and over account for only 1% of the total population but for 17% of all deaths (J. Brody, in press). Death, thus postponed, has taken on new meanings for both individual and society: Death is no longer purely adventitious (Parsons 1963); fewer lives “are truncated before the major stages of education, work and family building are completed” (Preston 1977); fatalism has given way to a heightened sense of predictability and control (cf. Lofland 1978).

As this dramatic postponement of death has come upon us with such rapidity, it is not surprising that social norms and social institutions have lagged behind; that popular interest in death and popular confusion about its meaning have virtually exploded; and that, as many earlier understandings of death have been vitiated, sociologists have only now begun a reassessment. Over the past two decades a massive and often confusing literature, both scholarly and quasi-popular, has been produced by historians, philosophers, theologians, social critics, journalists, nurses, ethicists, thanatologists, psychologists, and sociologists (cf. Fulton 1976, 1981; Pollak 1979–80). Some book titles suggest the range and character of this literature: No More Dying, Life After Life, The Way We Die, Death As a Fact of Life, The Immortality Factor, Facing Death, Death and Obscenity, Death: A Practical Guide for the Living, Living Your Dying.

This review makes no effort to sort through this “collective bustle,” as Lofland (1978) has called the modern day discovery of death. Instead the review identifies and presents selected examples of three lines of sociological inquiry pertaining to death and dying: (a) the self and its ultimate separation from social existence, (b) bereavement, grief, and the meaning of loss by death to surviving significant others, and (c) norms and the social structure, as dying and the postponement of death are defined, managed, and organized in a changing society.
DYING AND THE SELF

For the dying, the scarcity of time, which Moore’s (1963) calls “the ultimate scarcity,” takes on overwhelming significance since it threatens the self. As Robert Fulton (1976a), one of the pioneers in the sociological study of death, puts it, “Death asks for our identity.”

Dying as a Social Process

One focus of sociological concern with dying and the self is on the experience of dying. Although surprisingly little is known about the actual circumstances of dying [but see Cartwright, Hockey & Anderson, (1973) for one British study of the trend away from home deaths and the nature of support from relatives and friends], several studies give important insights into the dying process among patients who are sentient and among older people who are aware of their own finitude.

THE AWARENESS OF IMPENDING DEATH, AND DYING TRAJECTORIES A ground-breaking book by Glaser & Strauss (1965) asked whether people can die socially before they die biologically, and what this means for human relationships. For these authors the essential distinction between social and biological death lies in the awareness of an impending separation of self from others. Based on the behavior of dying patients and their caretakers, four types of awareness are identified: “closed”—the dying person does not recognize his impending death even though others do; “suspected”—the dying person suspects what the others know and attempts to confirm or invalidate this suspicion; “mutual pretense”—each understands the significance but pretends that the other does not; and “open”—both are aware and they act on this awareness relatively openly. In the first three types, there is no meaningful relation between the biological and the social status of the dying person, in contrast to the fourth type where an “open awareness” of the impending death permits unfettered interaction between the dying person and the prospective survivors. In this situation mutual support can develop and negotiation of the final phase of life becomes possible. With family and friends, previously unspoken affirmations of appreciation and love can be expressed, financial arrangements for heirs cooperatively attended to, old enmities ended. The dying and the surviving together may even make decisions about the conditions under which death will take place.

Other studies distinguish “stages” in the dying process. In a subsequent work, Glaser & Strauss (1968) develop “dying trajectories” involving the certainty and timing of impending death: (a) certain death at a known time, (b) certain death at an unknown time, (c) uncertain death but a known time when certainty will be established, and (d) uncertain death and an unknown time when these questions will be resolved. As each terminal case unfolds and the
expectations fluctuate back and forth among the various parts of this typology, the meanings attached to dying vary.

Perhaps the most widely known work on the "stages" of dying was published in 1969, not by a sociologist but by the Swiss psychiatrist, Elizabeth Kübler-Ross (1969). She, too, evolved her thesis through interactions and interviews with dying patients, but her results are quite different from those of Glaser & Strauss. She concluded that each individual needs "time to work through the different reactions (or stages) which enable him to cope." The five stages are: denial, anger, bargaining, depression, acceptance—all essentially individual rather than social in nature.

Of greater sociological interest is the work of another psychiatrist, E. Mansell Pattison (1977), who examines the proposition that an interval of "living-dying" typically follows the crisis experienced by the self upon learning from good authority that the time of death will occur within a predicted number of hours, days, weeks, months, or even years. Pattison identifies the clinical prescriptions for dealing with the living-dying interval and for enabling the self to deal with such fears as loneliness, loss of others, and loss of identity. In calling for social-emotional support systems for the dying, Pattison says that the essential task is "to retain self-esteem and respect for the self until death" (see also Rodabough 1980).

DEALING WITH IMPENDING DEATH Other studies of dying as a social process consider such topics as selfhood and the need for autonomy, the fear of dying too soon, and socialization for dying. For example, in an essay on "The Shadow of Death over Aging," Pollak (1980) examines the capacities of older people for adaptation, relearning, and renewal during the current era in which life has been lengthened by social change and technological advance. Stressing the need for autonomy, Pollak says of terminal cases that "having had no autonomy over being born, at least they can exercise a measure of autonomy over dying. Simply turning to the wall or not cooperating with physicians, nurses, and aides can be an exercise of the autonomy."

Contrary to widespread belief, fear is not necessarily the outstanding feature in the psychological anticipation of death (cf. Lester 1967; Pollak 1979–80). As Diggory & Rothman (1961) suggested over 20 years ago, when persons do fear their own death it is largely because death would eliminate the opportunity to achieve goals important to the self.

Systematic sociological attention has been paid to the self-as-dying by Victor Marshall [for the relationship between awareness of finitude and disengagement, see also Chappell (1976) and Sill (1980)]. Not only has Marshall conducted first-hand research on how the self deals with impending death, he has also taken an impressive step in bringing sociological theory to bear (Marshall 1980).

Making use of such concepts as legitimation of biography and the life-course
reminiscence, Marshall made a point of not drawing upon clinical evidence when he set his research in a retirement village (Marshall 1975a,b). All of the residents were in their later years and the problem was to explore the social processes and mechanisms through which individuals manage to make sense of the self and to legitimate their own deaths. Guided by the theoretical perspectives of Berger, Luckmann, Goffman and others, Marshall spent many weeks on site, carrying out intensive interviewing and field work. Because all of the residents participated in a “socially shared reality” they were, in effect, being socialized for impending death.

In assessing his findings, Marshall is confident that socialization for impending death is a workable reality. He finds, though he is cautious about generalizing from his small study, that death can be accepted as appropriate for the self when “consensus is developed between an individual and his community.”

**Attitudes Toward Death**

Supplementing case studies of the dying experience are large sample surveys of people’s attitudes at varying ages and stages of life. As growing proportions of the population live into the later years and predictable or “on-time” deaths tend to become the rule, increasing numbers of people are in a position to contemplate their own deaths. During the last 20 years or so sociologists have concerned themselves with questions related to the social meanings people in their everyday lives attach to death and the process of dying: How salient is the topic of death? What images of death do people carry in their heads? Which preparations, if any, do people make in anticipation of death? [For an earlier review, see Riley (1968).]

The first national United States survey of attitudes toward death was conducted in the early 1960s (Riley 1970), with interviews carried out by the National Opinion Research Center. Approximately ten years later the study, with some additional questions, was repeated. This research, in assessing something of the content of everyday thoughts about death, found that most people at all ages held nonthreatening images of death (“death is sometimes a blessing,” “death is not tragic for the person who dies, only for the survivors”), whereas only half agreed that “death always comes too soon,” and only one tenth that “to die is to suffer.”

Although few attitudinal changes were found between the two studies, there was a significant increase in the extent to which thoughts of death intrude upon the everyday lives of people. People were asked how often they thought about the uncertainty of their own lives or the death of someone close to them. In the 1960s one third reported “often” to this question; ten years later this proportion had risen to better than four out of ten—a significant though not overwhelming increase in so short a period. More importantly, this salience of death as a topic of thought, while it increased among persons of all ages, increased especially
among those in the later years of life. This increasing interest in death suggests that people are far from reluctant to confront harsh realities. Thus in the mid 1970s, perhaps reflecting medical advances in prolonging life, the majority of the sample agreed with the statement “Each person has the right to die with dignity” (95%), and that “If a patient is dying, a doctor ought to tell him” (67%); whereas only 26% agreed that “Doctors should use any means for keeping a patient alive, even after the patient is no longer himself.”

In the same investigations we also began to study some of the practices related to anticipation of death. One of the questions asked of the national sample was: “Do you feel it’s best to ignore the subject of death, and not to try to make any kind of plans for when that time comes, or do you feel it’s best to try to make some plans about death?” Our early prediction, based upon hunches about the pervasiveness of the so-called death taboo, had been that only a minority of the population would give planning as an answer. It was, therefore, something of a surprise to have 85% (no change between the two studies) reply that they thought it was better to make some kind of plans. More specifically, about one out of every three adults reported having made a will; about the same proportion had made some kind of funeral or cemetery arrangement; over half had made a point of talking about death with those closest to them; and some 80% had made some kind of financial plans. In all four respects, older respondents were more likely than their younger counterparts to have made plans in preparation for death, though at every age some people had made plans [for historical changes toward a more rational view of death, see Zelizer (1978)].

Among the subsequent cross-section surveys is one of middle-aged and older people in Los Angeles by Bengtson, Cuellar & Ragan (1977) that asked respondents directly, “How afraid are you of death?” While 63% responded “not at all afraid” and only 4% “very afraid,” the proportions expressing fear decreased sharply by age categories. It is unclear whether this finding is to be explained in terms of some gradual resolution of the problem of death, which is sometimes experienced as a crisis of the middle years, or, as Marshall (1980) suggests, in terms of some need of the individual to legitimate his biography as his awareness of finitude begins to become intense. No consistent differences by socioeconomic status were documented in the Los Angeles study, but Riley’s studies strongly suggest that education may be the critical variable in moderating anxieties and fears about death. Excellent models for ethnographic studies of cultural variations are available (Kalish & Reynolds 1976).

Self-Destruction

The extreme case of the sociological relationship of the self to death is, of course, suicide. In addition to the many familiar sociological studies (e.g. Cavan 1928; Halbwachs 1930; Henry & Short 1954; Dublin 1963; Gibbs & Martin 1964; Douglas 1967), much of the recent work uses a Durkheimian
Durkheim’s framework. I do not review here the many criticisms and modifications of Durkheim’s theoretical position, which range from Merton’s (1938) classic restatement of the concept of anomie, to Pope’s (1976) incisive critique of Durkheim’s methodology, to the debate over research on status integration between Schalkwyk, Lazer & Cumming (1979) and Gibbs & Martin (1981). I report only on studies of societal and familial factors in suicide rates and on the influence of suggestion, as these promise to deepen sociological understanding of the relationship between death and the self.

SOCIAL FACTORS IN SUICIDE RATES Among the cross-national tests of sociological theories of suicide, one inquiry by Stack (1978) uses United Nations 1970 data on suicide from 45 countries. The study uses the following measures: industrialization, measured by the per capita gross national product; anomie, indexed by data on economic growth; and status integration, indexed by female labor force participation. Making use of multiple regression analysis, Stack reports that status integration is the most important negative correlate of suicide rates, exerting a much more powerful influence than either of the other two variables.

Another contribution to understanding of suicide has been made by Danigelis & Pope (1979), who focus their inquiry on family and marital status—a key element in Durkheim’s theory. These investigators analyze three data sets: Durkheim’s original data, World Health Organization data on 13 countries, and a data set for France (not employed by Durkheim) covering 9 census years. The data are used to test four hypotheses that predict an inverse relationship between social integration and suicide: (a) married persons are more integrated than single persons; (b) married persons are more integrated than widowed and divorced persons; (c) widowed and divorced persons are more integrated than single persons; (d) married and widowed persons with children are more integrated than married and widowed persons without children.

The investigators conclude that “Durkheim’s arguments are corroborated more often than not” and that, in general, familial integration is a powerful predictor of variations in suicide rates. But they report many exceptions and qualifications—particularly in respect to sex and age. For example, marriage appears to “preserve” men better than women, but the presence of children protects women better than men. While Durkheim reported a strong relationship between age and suicide on the theory that prolonged social isolation was necessary to “prove” that life was not worth living, Danigelis & Pope report that in respect to family influences “Comparison of age categories and examination of interaction effects showed that age makes little difference.” [See Miller (1979).]

THE INFLUENCE OF SUGGESTION Apart from the influence of status integration, Phillips (1974) has investigated the importance of suggestion in
influencing suicide rates. Durkheim had concluded that suggestion might operate in individual cases but could find no evidence that national levels were susceptible; and a 1972 review by Lester of the scanty literature came up with inconclusive evidence. Phillips (1974), on the basis of an analysis of published newspaper accounts of suicide in Great Britain and the United States over a twenty year period (1947–1968), reported a strong relationship between highly publicized suicide stories and suicide rates. (Phillips speaks of testing “the Werther effect,” alluding to the hero who committed suicide in a widely read and influential novel by Goethe.) The method used by Phillips was to plot on a month-to-month basis the number of suicides, the number of front page suicide stories, and the relationship between the two. His expectations of “excess” suicides during the month following the stories was not only met statistically, but he was able to show that the more important the suicidal figure the greater “the Werther effect.” In several related inquiries, Phillips has added to the evidence that reports of self-destruction tend to “cause” self-destruction. His most recent study (1982) traces the relationship between soap opera suicide stories and various types of “imitative” deaths. A related study by Bollen & Phillips (1981) examined the widely held belief that many motor vehicle fatalities are in reality disguised suicides. Using data from California and Michigan, these researchers found a strong relationship between publicized suicides and motor vehicle fatalities.

Whether or not the persons committing suicide in these studies are characterized by anomie, it is possible that a kind of perverse “social support” mechanism may be at work in such cases, as the suicidal person may gain motivation and strength from the influential others who have actually carried out the act.

Self-Management of the Time of Death

A small but interesting body of sociological research has focused on the implicit notion that people, for little understood reasons concerning the relationship of self to society, are sometimes motivated to manage the time of their own deaths. Proceeding on the implicit assumption that there is such a thing as “the will to live,” and without investigating the biological linkages that may be involved, this research is an extension of Durkheim’s general theory of social integration [compare the argument by Marshall (1980)]. If some are so detached from society that they commit suicide, others may be so attached that they postpone their deaths in order to participate in or witness occasions of social significance (Kalish 1970). It has been reported, for example, that both John Adams and Thomas Jefferson died on July 4th and that Freud died on Yom Kippur. [Note also several items in the psychiatric literature which suggest “anniversary reactions” (Hilgard 1953).]

As one test of this hypothesis, Phillips & Feldman (1973) propose that fewer deaths than would be expected occur during periods preceding such significant
social occasions as US presidential elections and the Jewish Day of Atonement (Yom Kippur). For the years 1904–1968, Phillips & Feldman plotted all US deaths for the months of September and October—months of intense political activity during election years—and demonstrated a statistical difference between the deaths for the “control” (nonelection) years and the election years. They concluded “that there is a statistically significant dip in US mortality before US presidential elections.” As a test of the Day of Atonement hypothesis, these investigators used mortality statistics for the United States and also for New York City because of its large Jewish population, concluding that “the New York City deathdip before Yom Kippur is larger than the US deathdip in that period.”

Closely related to research that shows lower mortality rates prior to important ceremonial occasions (the “deathdip” phenomenon) are a number of studies that suggest a relationship between birthdays and the time of death. In respect to famous persons, the theory is that their birthdays frequently receive public attention and are often occasions for expressions of respect and celebration (Phillips 1972). Thus Phillips & Feldman (1973) analyzed a sample of 1300 famous Americans from all periods of American history and found a statistically smaller number of deaths in the month prior to the birth month than would be expected (Incidentally, they also discovered a “deathpeak” in the month following.) This finding was replicated on four additional samples of famous persons.

Subsequently, the integrative effects of birthdays was extended to nonpublic persons on the theory that fame is not required for family members, relatives, friends, and neighbors to organize birthday celebrations in which persons are motivated to participate. In a study of “nonpublic” birthdays (Kunz & Summers 1979–80), a sample of 747 deaths in Salt Lake City was analyzed. Over a one-year period all obituaries on randomly selected days were coded for birthdates. The findings are striking. Fewer than 10% of the deaths occurred during the three months prior to the birthdate, whereas nearly half were reported during the following three-month period.

While the “deathdip” and the “birthday dip,” as identified by Phillips & Feldman, may indeed be a minor demographic phenomenon, its theoretical significance is potentially far-reaching as it points once again to the basic sociological link between self and society and suggests additional approaches to new understandings of that linkage. That the nature of this linkage is still obscure is shown by an ingenious study conducted by Margret Baltes (1977–78). Reasoning that the significance of ceremonial occasions might be a developmental phenomenon that would show up at some point during childhood and adolescence, she hypothesized no relationship between deaths and either birthdays or Christmas for children under age 10 whereas developmental theory would suggest emergence of some degree of the relationship for older children and adolescents.
Baltes plotted all deaths (for two age groups—under 10, and adolescents—for the years 1972–73 for ten states) against two criterion dates—birthdate and Christmas. Her results showed no differences between the “young” and “old” age groups, and the developmental hypothesis was rejected. Her study does raise the question for further research of when in the life course the self develops an awareness of finitude and when that awareness intersects with socially significant events.

Social Stressors and the Self

Countless sociological inquiries have addressed the social consequences for individual lives of such fundamental changes in society as rural-urban migration, wars, trends in retirement, institutionalization, industrial relocations, and economic depressions; and some attention has been paid to mortality as the dependent variable. Three lines of current inquiry are illustrative.

RETIREMENT AND MORTALITY From the growing literature on retirement and its consequences, it is not yet possible to draw consistent conclusions as to the impact of retirement upon subsequent mortality. Various small studies report that retirement is inherently a stressful life event that translates into higher death rates for retirees in contrast to those who continue to work. Other studies show the opposite: life-long work is the stressor and retirement serves as a moderator that enhances longevity. As the evidence becomes more extensive and the research methods more sophisticated, the particular conditions under which retirement may have negative or positive effects are becoming clearer. For example, Haynes et al (1978), in a longitudinal study of the mortality experience of “early” and “normal” retirees in a major industry, found the observed mortality rates of early retirees to be significantly higher than the expected rates, whereas among the “normal” retirees there was no difference between observed and expected rates. Data for the study were drawn from information available in company files: personnel, pension, and medical records, which were in sufficient detail to permit sophisticated analysis. The results of this study were interpreted to mean that mandatory “normal” retirement is not detrimental to survival; and that “excess” mortality following early retirement is related to previous health status. The situation, however, is not that simple. To be sure, some workers retire early for health reasons, but for others job dissatisfaction is undoubtedly a prior condition that may ultimately affect longevity. Similarly, among the “normal” retirees one suspects that some premature deaths may have resulted from the trauma of loss of status and meaningful work, but that these were not numerous enough to have exercised a significant impact on the modal patterns observed.

This and many other studies suggest socially patterned variations in the consequences of retirement for health and longevity.
DEATH AND RESIDENTIAL RELOCATION  Just as retirement may, under certain conditions, hasten the onset of death, relocation of frail elderly people has been postulated as a cause of excess deaths (cf. Riley & Foner 1968). One relatively recent series of studies raises new questions about the effects of geriatric relocation on mortality rates. Two sociologists, Jerry Borup & Daniel Gallego (1981), in analyzing these studies reported that in most instances of the relocation of nursing home patients to home care or other nonnursing home facilities, no adverse mortality consequences could be documented. In an investigation of their own these researchers reported a new experimental-control study in which the relocated group experienced decreased mortality!

Not surprisingly, these recent reports have come under considerable criticism, not only on methodological grounds but also for their policy implications (Gutman & Herbert 1976; Borup et al 1979; Bourestom & Pastalan 1981; Borup 1981). The issue is far from settled. In general, research is needed that specifies the conditions, and the kinds of patients, most likely to produce positive or negative outcomes.

ECONOMIC CHANGES AND MORTALITY  Again stimulated by Durkheim (1951), who found business cycles to be “correlated” with suicide rates, the influence of economic changes on social phenomena has long been of sociological interest. In the late 1920s, William F. Ogburn and Dorothy S. Thomas included suicide rates in their studies of the influence of the business cycle (Thomas 1927). Recent research activity in this area is exemplified in the work of Harvey Brenner. Making use of an economic change model, which incorporates long-term trends in economic growth, short-term economic instabilities, and “random shocks”, Brenner (1971, 1973, 1979; Brenner & Mooney 1982) has demonstrated complex statistical relationships to such phenomena as first admissions to mental hospitals, infant mortality, suicide, homicide, various indicators of morbidity, and mortality. A recent paper by Brenner & Mooney (1982) reports a 20-year study of economic change and cardiovascular mortality in Britain. Going well beyond the typical explanations of current declines in heart disease, which tend to emphasize behavioral risk factors and life-style changes, this analysis uses the economic change model, along with related risk factors, for predictive purposes for England, Wales, and Scotland during the period 1955–1976. A nontechnical summary of the results would run something like this: Economic growth is found to be the most powerful factor in the secular decline in mortality from heart disease, and recessions or short-term economic instabilities, both regional and national, are found to be regularly associated with increased mortality in each of the populations under study.

This general area of the impact of social stressors on mortality, with its puzzling implications for involvement of the self, calls for continuing sociological research.
DEATH AND THOSE WHO SURVIVE: BEREAVEMENT

Death for the individual means not only loss of the self but also the loss of others significant to that self. We turn now to those surviving or bereaved others and to some of the problems they encounter.

First, however, a conceptual issue must be cleared away. Much of the literature on death and dying fails to make a distinction between the stresses experienced by the dying and by the surviving. In the work of Kübler-Ross, for example, the dying and the survivors are assumed to experience similar responses. Feelings of anger, denial, and finally acceptance, all “stages” in some adaptive process, are presumed to be common to both. Obviously, they are not. As Rosel (1978–79) illustrates the point, “dying persons must cope with separation,” yet “coping includes the ability of caretakers (and survivors) to make the dying person comfortable.” [Compare the “counterpart transitions” experienced by the dying person and the survivor (Riley & Waring 1976).]

Bereavement has attracted several lines of sociological inquiry, including studies of the possible lethal consequences of loss of spouse, of the nature of widowhood, of the consequences for the bereaved of different types of death, and of anticipatory grief.

Death “Causes” Death?

A widely discussed proposition holds that a surviving spouse is at increased risk of dying following bereavement—variously referred to as “the broken heart syndrome” or the “loss effect.” As dramatized by Lynch (1977) in a major scientific and sometimes sentimental tract, “Loneliness and grief often overwhelm bereaved individuals, and . . . all available evidence suggests that people do indeed die of broken hearts.” Yet even Lynch notes the controversies that still surround the etiology of heart disease and premature death, and several analysts have noted the inconsistent data and flawed methodologies characterizing many of the studies. A measured review by Kastenbaum & Costa (1977), for example, concludes that the studies to date permitted only a “tentative acceptance of the proposition that bereaved adults are at greater risk than the nonbereaved.” A more recent review by Stroebe et al (1981) ends on the same note. These reviewers point to a possible selective bias: If marriages are homogamous in regard to health, the fact that one spouse dies shortly after the other could well be due to a shared or common health problem rather than to the trauma of loss or separation. Then there is the problem of age bias. Because there is a close relationship between age and mortality, the higher average age of the widowed must to some extent account for their higher mortality rate.

Attempting to overcome some of these biases, Helsing & Szklo (1981) probe further into the reportedly high rates of mortality following loss of a spouse.
Their findings, though limited to one area (Baltimore, Maryland), indicate that widowed males in every age category—but not widowed females—do suffer excess mortality even after such factors as education, smoking behavior, frequency of church attendance, and socioeconomic status are taken into account. There is no indication that these significantly higher rates are concentrated in the first six months, year, or two years after bereavement (as earlier studies had suggested). Moreover, this excess mortality among widowed males does not occur among those who remarry, but is concentrated entirely among those who remain unmarried. Among the bereaved of both sexes, mortality is relatively high for those living alone after the spouse dies and also for those moving into a nursing home (rather than moving in with other family members or not moving at all). This finding of reduced mortality associated with remarriage or living with others in the household is consistent with the hypothesis that social support mitigates the negative impact of bereavement.

Widowhood

Another line of sociological inquiry concerns widowhood, as a process of reacting to bereavement and learning to cope with it. Although Thomas Elliot, the so-called grandfather of bereavement research, published a paper in 1930 entitled “The Adjutive Behavior of Bereaved Families: A New Field for Research,” the new field was only sporadically cultivated until the mid 1960s, when Helena Lopata began a series of investigations that culminated in *Widowhood in an American City* (1973) and *Women as Widows: Support Systems* (1979).

Lopata had good reason to be dissatisfied with the then extant research on what it meant to be a widow (cf. Strugnell 1974). If there are methodological problems in studying “excess mortality” following the loss of a spouse, the difficulties are even more severe when such dependent variables as loneliness, anxiety, ill health, or self-identity are under examination. Mortality can be more precisely measured than can “disruption of social networks” or “lowered activity levels.”

Lopata (1973), in a rigorously designed study of the consequences of widowhood, commissioned the National Opinion Research Center to draw a representative sample of widows for the population of metropolitan Chicago. Despite the relatively small sample (301 cases), analysis by age, race, socioeconomic status, and recency of bereavement enabled Lopata to differentiate among subgroups of widows. For example, women over 65 were frequently found to have joined a “society of widows,” since at that age widowhood tended to be the norm (cf. Blau 1961). Young widows tended to suffer from being a “third wheel” in their social networks, which were made up largely of couples. Despite their wider social networks, middle-class widows tended to have more problems than lower-class widows, since their marriages...
had frequently been the more satisfactory. Social interactions tended to be especially low during the first year of widowhood. While widowhood did not appear to increase relationships with the immediate family, contacts with in-laws typically were curtailed.

Unlike many earlier studies that concentrated on the negative outcomes of bereavement, Lopata's research also identified some positive consequences of widowhood. Many widows experienced release from a particularly unhappy marriage, or from the anxieties of a long, painful and lingering illness, and were able to express a new sense of independence.

Concerned less with such differences among subpopulations and more with testing the widespread assumption that, on the average, the net effects of widowhood are negative, a study by Herbert Hyman (1983) suggests a new approach to this important topic. Hyman is impressed by two potential flaws in the research to date. First, in the previous studies the data were collected from widows as widows. For example, in Lopata's study (which Hyman rates among the best), the first two questions asked of respondents were: How long have you been widowed? What did your husband die of? The respondent is thus labelled as a widow and presumably responds within that context. The second problem is that of controls—a problem encountered also in analyzing the "broken heart syndrome." Hyman's solution to both problems is to rely entirely on a secondary analysis of data that were not collected for the purpose of studying widows.

Hyman makes systematic use of two data sets that provide measures of such dependent variables as "outlook on life," "social involvement," "feeling tone," "health status," and "finances." The first set is an aggregate of seven cross-section General Social Surveys conducted by the National Opinion Research Center. The second set consists of two longitudinal studies of political behavior conducted by the Survey Research Center at the University of Michigan. What Hyman does, in effect, is to construct a "double blind" design. The respondents were not asked about widowhood, nor did Hyman have any voice in selecting the items included in the questionnaires. He uses the data to "purify" and "refine" three categories of his independent variable: widows, married, divorced/separated. To avoid the problem that the bereaved, if they have died, are underrepresented in the cross-sectional studies, the longitudinal data are analyzed to compare the persistently widowed, the persistently married, and the recently widowed.

Hyman's conclusions are: On the average, widowhood does not produce massive negative effects, either temporary or enduring (though some widows, of course, do die following the death of their husbands).

This provocative analysis, which flies in the face of much research on widowhood, is bound to stir controversy and counterclaims. The ingenuity of the design, however, which attempts to solve the persistent problems of bias in
the collection of data and the lack of comparison groups in their interpretation, makes it a promising study, especially in the light of Helsing’s recent findings.

**Types of Death and Bereavement**

Within these net effects of widowhood observed by Hyman there are many variations. Not surprisingly, bereavement reactions have been found to differ according to the cause and circumstance of death. Two small longitudinal studies, reported by Wallace (1973) and Glick et al (1974), provide data that permit comparison of the experiences of widows who had lost their husbands from “natural” causes, from accidents, and from suicide. Using these two data sets, Sheskin & Wallace (1976) have opened new avenues for sociological research on the “fit” between bereavement responses and the circumstances of the precipitating death. When the death has been a “lingering” one, as in cases of terminal illnesses and of suicides preceded by debilitating depression, the widow’s recovery appears to be facilitated by the fact that she could begin to redefine her role and to assume new responsibilities prior to the death.

In contrast, unexpected accidents and most suicides are found to produce the most severe bereavement reactions: shock, bewilderment, despair, and often physical illness. In such cases, where widows must make sense of a world that has suddenly lost its meaning, recovery tends to be a long process and is frequently accompanied by overwhelming sorrow and loss of the sense of personal control. The reactions of widows whose husbands had taken their own lives was further compounded by self-blame, thus complicating and lengthening the adaptive processes of recovery.

**Anticipatory Grief**

Research on grief, as the affective pain or suffering often experienced in the bereavement process, has been heavily influenced by psychiatry. Most studies in the voluminous literature on this subject implicitly accept Lindemann’s (1944) classical “stages” of grief and the step-by-step “grief work” regarded as necessary for a resolution. Yet, unlike most functional psychiatric disorders, the cause of grief is unambiguous and clearly recognized, and the course of the disorder is highly predictable. Indeed, most widows today live long enough to “get through” the period of grief, though the outcome tends to be somewhat more problematic for widowers.

Of greater sociological interest than either “grief work” or the “stages” involved in resolving grief is the concept of anticipatory grief. Drawing upon sociological theory, particularly socialization theory, several scholars have argued that much grief work can be accomplished in advance of separation by death, with the consequence of blunting the subsequent pain of loss. Fulton & Fulton (1971) have pointed out that the mere fact of anticipating grief can often have positive consequences for the survivor. Neugarten & Hagestad (1976)
have argued that if the death is anticipated as legitimate, as being "on time," the subsequent experience of bereavement will be less traumatic. Gerber et al (1975) have demonstrated that the outcomes of anticipatory grief differ in short-term as compared with prolonged chronic illnesses. Scheff (1980) has suggested the possibility of building up "grief credits," so that one can anticipate loss on a day-to-day basis and not be overwhelmed when loss actually occurs.

Anticipatory grief, however, cannot be accepted uncritically as a unidimensional concept of general applicability. Both the quality and the intensity of the relationship to be broken by death must be considered. The supply of available support personnel for the soon-to-be bereaved will influence the process. Moreover, anticipatory grief itself may undermine intimate bonds at the very moment when they are most needed by the dying (Fulton & Fulton 1971). The absence of tears or expressions of concern may compel the patient to grieve not only for his own death but also for the seeming loss of his family's love.

DEATH IN SOCIETY

Sociologists have been variously concerned (cf. Blauner 1966) with social organizations and norms found in all societies governing the imperatives imposed by death: a corpse must be looked after; the deceased placed in a new status; vacated roles filled; property redistributed; the solidarity of the group reaffirmed; and the bereaved comforted. From the numerous and scattered studies, I select illustrations of the work on social organization, norms, demographic changes, and sociological theory. Many of these illustrations reflect institutional adjustments and disparities occasioned by the trend toward postponement of death.

The Social Organization of Death

Many studies of social organizations and arrangements for handling the dying and the bereaved, in contrast to the classic work of Glaser & Strauss (1965, 1968), have treated death as if it were a special kind of social problem.

ORGANIZATION FOR DYING In their analysis of "Dying as an Emerging Social Problem," Levine & Scotch (1970) provide an inventory of the insults often heaped upon the selfhood of dying patients in the interest of bureaucratic rules and efficiency: an unnecessary prolongation of life after its quality has completely deteriorated; restrictive options for therapy and treatment open to the dying person; stigmatization. As these researchers sum it up, "the dying patient is often defined as 'irresponsible.' It is tragic, . . . with so little time left, that the very meaning of life—consciousness, self-control, decision-making—
is taken away.’” In their view, the modern hospital is not organized to deal with the personal complexities of dying.

A detailed study of organization for dying and death in a modern public hospital, reported by Sudnow (1967), provides accounts of the cliches, truths, and half-truths found useful in dealing with the dying person. In even greater detail the study reports procedures for wrapping, ticketing, binding, cataloging and otherwise attending to the corpse, typically referred to by hospital staff as “the dirty work.” Sudnow describes all such procedures as matters in which efficiency is more highly valued than human dignity.

Since most contemporary hospitals are indeed highly technical complexes focused on cure rather than care, it is not surprising that alternatives to dying in hospitals and programs specifically designed for the care of the terminally ill are being developed and are receiving sociological attention (cf. Berdes 1978; Kalish 1976, 1981). The best known of the newly developing programs is the so-called “hospice”—an antithesis to hospital bureaucracy. In recent decades the British have developed the hospice as a free-standing facility, while in the United States the hospice “movement” is giving emphasis to care of the dying in the home. The unit of care is the patient and the family, presenting a major opportunity for sociological research. While no systematic study of the hospice movement has yet been made, Kalish (1981) has documented the need for caring organizations and related developments (see also Charmaz 1980).

THE FUNERAL Contemporary funeral practices have also been treated as a social problem. Following death, indignities have frequently been reported, with the bereaved rather than the dying as the victim. Nearly 20 years ago, two influential books, one by a sociologist [The American Funeral (Bowman 1959)], the other by a journalist [The American Way of Death (Mitford 1963)], precipitated a social reform movement, charging that death is being commercialized, that funeral directors often take advantage of grieving and confused survivors by advising that a “proper” funeral requires cosmetic embalming, time-proof caskets, and other costly accoutrements.

Such complaints by no means reflect the full range of sociological interest in how society is organized to deal with death (Durkheim 1912; Habenstein & Lamers 1963; Habenstein 1968; Pine 1975; Fulton 1976). Durkheim saw the funeral as a ceremonial assembly that served the purpose of reaffirming the solidarity of the group. Habenstein (1968) shows how the funeral channels the responses of the bereaved as a collectivity. “Mortal rite characteristically operate to give meaning and sanction to the separation of the dead person from the living, to help effect the transition. . . .” Moreover, the funeral serves the larger social purposes of publicly recognizing the legitimacy of such matters as succession and inheritance.
Changing Social Norms for Death and Dying

Like social organizations, norms pertaining to death and dying are also subject to change as society changes. Among the many sociological concerns (abortion, legal definitions of death, capital punishment, genocide, genetic engineering, homicide), certain strands of sociological research are particularly reflective of the current scene (cf. Riley 1978).

NORMATIVE DILEMMAS OF MEDICAL ADVANCE A dramatic example of changing medical attitudes toward death is to be found in the annals of the Journal of the American Medical Association. A 1961 study of doctors with terminal cancer patients showed that over 90% preferred not to confront such patients with the facts; by 1979, 98% of doctors said that it was generally their policy to tell cancer patients the truth about their condition. This shift over two decades may reflect a better understanding of the needs of terminal patients, the emergence of patients “rights,” or the widespread doctrine of “informed consent” in medical research. Whatever the explanation, it has apparently become easier for doctors to confront patients with harsh facts. [See also Carey & Posavac (1978); Schulz & Aderman (1978–1979).]

The problems of professional practice in dealing with death have been exacerbated by advances in medical technology and their social consequences, as noted by Renee Fox’s pioneering sociological inquiries in this area. In Experiment Perilous (1959) she describes an experimental ward in which doctors and patients were confronted on a daily basis with apparently imponderable problems arising from medical advances. Sixteen years later, with many new medical technologies available, Fox & Swazey (1974) showed the excruciating problems created by such therapeutic innovations as organ transplants (who donates, who receives?) and kidney dialysis (how to resolve the social, ethical, and economic dilemmas?) to be more severe.

NORMS AND THE MANAGEMENT OF DEATH As medical advances allow increasing control over the timing of death, and as the legal and medical professions take over much of this control, sociologists are concerning themselves with the “rights” of patients to refuse treatment. By the 1970s in the United States (see Ward 1980; Jorgenson & Neubecker 1981) there was substantial public acceptance of some form of passive euthanasia (the Gallup poll shows an increase in acceptance from 36% in 1950 to 53% in 1973). In 1979 a 59% affirmative answer was given to the question, “When a person has a disease that cannot be cured, do you think the doctors should be allowed by law to end the patient’s life by some means if the patient and his family request it?” (National Opinion Research Center). In another study (Haug 1978) of 411 persons enrolled in a prepaid medical care group, over 70% of respondents in every age category agreed with the statement, “when a person is in the last
stages of a terminal illness, the patient or his family should decide if further treatment should be continued.”

If terminally ill patients, when sentient, are destined to play an increasingly active role in determining the course of their last days or years, what are the beliefs and practices of their attending physicians? Breaking the long-standing Hippocratic tradition of silence, Diana Crane (1975) has brought this controversial subject more into the open. Her study samples over 3000 physicians on the central question: When should all possible measures be used to keep a patient alive, and when should treatment be withdrawn, permitting the patient to die? Substantial findings are reported in her appropriately titled book, The Sanctity of Social Life: Physicians’ Treatment of Critically Ill Patients. According to doctors’ reports and to actual hospital records, doctors do not respond to the chronically and terminally ill patient purely in terms of physiological considerations. Increasingly they respond in terms of social considerations—that is, in terms of the extent to which the patient is capable of some continued social functioning and meaningful interaction with others. Salvageability is the key criterion. A patient is generally believed to be salvageable if he or she can be restored to some measure of health. While Crane finds the practice of active euthanasia to be rare, she has clearly documented the incipient development of new norms for dying (see M. Riley’s 1978 analysis).

The Changing Demography of Death

Such changes in norms have paralleled the massive 20th century declines in mortality, with the consequent postponement of death for most individuals and the proliferation of older people in society. Sociologists have begun to examine the potential future extensions and the social implications of the changes.

POTENTIALS FOR POSTPONEMENT OF DEATH A ground-breaking set of studies by Samuel Preston and his collaborators has enlarged the data base and the scope of analysis of mortality and its causes and consequences. Preston et al. (1972) processed and published previously inaccessible data on recorded deaths in cause-of-death categories from 180 different populations. These data were then arranged in four types of tables which showed: (a) death rates due to the main causes of death, (b) the effects of these rates on length of life; (c) chances of dying from particular causes, and (d) demographic consequences of eliminating particular causes or sets of causes.

Subsequently, Preston (1976) brought this data base into one overall analysis: Mortality Patterns in National Populations. Two of Preston’s examples for the United States of the hypothetical elimination of particular causes of death demonstrate the potential relevance of such materials for the age structure of society and of social relationships. The elimination of cardiovascular disease, now the major cause of death in this country, would have a profound influence
on the conditions, circumstances, and consequences of dying: “Approximately 60% of persons age 60 would still have a living mother, and 38% a living father. A living parent for a 60-year-old means a living grandparent for a 30-year-old and a living great-grandparent for an infant. At age 80, 14% would still have one parent living.”

Surprisingly, the consequences for bereavement that would result from eliminating certain causes are very different from these results for dying persons. For females, the largest reduction in the prevalence of widowhood results from “removing violence as a cause of death, since this cause is heavily male-specific and its removal has little effect on the female age distribution. Many more husbands are saved when cardiovascular disease is eliminated, but such widows as there are tend to live much longer, with relatively little net effect on the prevalence of widowhood.”

SOCIETAL IMPLICATIONS OF THE POSTPONEMENT OF DEATH Such hypothetical projections are becoming increasingly useful as many social changes, including changes in health behavior and in medical knowledge, are indeed tending to postpone death from various causes. Sociologists are beginning to examine such alterations in death as these change the meaning of life. Following Karl Mannheim ([1928] 1952), who speculated about a society in which no one ever dies, Peter Uhlenberg (1980) relates mortality declines to such 20th century changes in the American family as the increasing independence of the nuclear family, the virtual disappearance of orphanages, the changing status of children, the decline in fertility, the rise in divorce, and the rise in societal support for the elderly.

Other analysts have shown the consequences of postponement of death for societal changes in the numbers of older people (Hauser 1976) and in the aging process itself. For example, M. Riley and her collaborators have codified social research findings on chronic diseases and the associated diminution in the social status of the aged (Riley & Foner 1968). Riley & Bond (1983) have demonstrated that certain contemporary physiological and psychological disabilities of older people are reversible or preventable through social interventions; and that other disabilities are in fact differences among successive cohorts and not, as widely believed, the inevitable consequences of biological aging. In effect, the suggestion is that morbidity might be postponed more nearly to the end of life; that the morbidity curve, like the mortality curve, might become “rectangularized,” replacing the current gradual decline of the curve of health and functioning during the last years of life.

This notion of “rectangularizing” the morbidity curve has been developed in detail by a physician, James Fries (Fries & Crapo 1981), who offers a scenario based on the following syllogism: (a) The human life span is fixed; (b) the age
at first infirmity will increase; (c) therefore, the duration of the infirmity will decrease. What might life be like in a "rectangularized" society? According to Fries, "there will not be an accumulation of debilitated elderly people exhausting the medical and social resources of the society. Although death and debility resulting from congenital defects and accidents will always be present, and some will consciously choose not to live out a natural life, . . . most persons in the rectangular society will succumb to relatively short-term illnesses in the final senescent period of life; natural death will occur at the end of natural life."

How far the morbidity curve will actually become rectangularized cannot be known. There is much criticism of Fries's analysis (cf. Brody 1983) and much debate over the implicit assumption that the human life span is fixed—that there is a limit, though unknown, to the number of years that any human being can live. Thus Manton (1982) interprets current mortality statistics to imply that the life span, and not merely the average length of life, can be extended. [For longevity vs life span see Gordon (1979).] Yet to the extent that fewer and fewer deaths in the future may be preceded by long periods of debility and suffering, not only will the experience of dying change but also the very concept of death will take on new meaning.

Sociological Theories of Death-in-Society

Several sociologists have formulated conceptual explanations of some of the relationships between society and death—in particular the trends toward postponement of death. Key ideas from four selected "theories," all published during the last two decades, suggest the scope of sociological concern.

Talcott Parsons (1963; see also Parsons & Lidz, 1967; Parsons et al 1973) distinguishes between a current "active" orientation to death and an outdated "deviant" orientation. The latter derived from the fatalism of an earlier day when deaths were less predictable, more adventitious than they are now and when the typical fatalistic adaptation to death was denial. To the extent that the "active" orientation is characteristic of contemporary society, both the dying person and the survivors are expected to "face up" to death in realistic norms. With the societal emphasis on science and rationality, death marks the completion of an active life of effort and achievement. The bereaved are expected to do their "grief work" quickly and efficiently, drawing strength from the presumed fact that the deceased had also come to terms with the inevitable.

Robert Blauner (1966), in a far-ranging statement, explains how mortality and social structure interact to account for the meaning of death. I select only one illustration—how this meaning is expressed in bereavement. In societies where mortality rates are high, the threat posed by death to the social system is great, a threat reflected both in ritualistic mourning practices and in the social prescriptions activated when deaths occur. By contrast, in societies where the
mortality rates are low and most individuals live out their full life course, the deaths of particular leaders or particular family members are more predictable, hence less socially devastating. As a consequence, less consideration is given to the bereaved, as in the United States or Great Britain today. Appropriate expressions of grief and the length of the bereavement period do not follow widely accepted patterns (cf. Bowman 1959; Gorer 1965).

Victor Marshall (1980) undertakes to integrate the social processes of dying and of aging. He sees the meaning of death as taking shape within a dialectical perspective—the individual and society are both at work in the social negotiation of identity. In developing his thesis, Marshall formulates several concepts: For example, older people, in making sense of the process of dying, engage in “the legitimation of their biography;” and their “awareness of finitude” (the final realization that they will die) mediates between where they are in the life course and their self-concepts. Making empirical tests of some components of his theoretical position, Marshall states as propositions that death is regarded as preferable to: inactivity, to the loss of the ability to be useful, to becoming a burden, to loss of mental faculties, and to living with progressively deteriorating physical health and concomitant physical discomfort. While “death poses problems for individuals, . . . the response to death is never fully individual, for never is the individual completely divorced from society. . . .” [Compare Ernest Becker’s (1973) view of society as a symbolic action system in which man struggles to transcend death by being heroic.]

Renée Fox (1980, 1981) proposes that the relatively recent heightened interest in death may be serving a “rite of passage” function for the society: marking the occurrence of basic changes in our world view and easing our transition to a new theodicy.” Fox offers two explanations for this heightened awareness of death. The first rests in the dramatic development and utilization of biomedical knowledge, which serves as “a symbolic center of the unanswered (perhaps unanswerable) questions epitomized by the coexistence of powerful life-saving and life-prolonging activities. . . .” The second explanation lies in the demographic revolution, in which increasing numbers of people live closer to the end of the life span, so that dying has become a kind of “national experience.” These twin revolutions, the biomedical and the demographic, challenge some of the most fundamental beliefs in Western culture and give further support to the Fox hypothesis that “life and death are coming to be viewed less as absolute, hermetic entities, sealed off from one another, and more as different points on a meta-spectrum whose beginning and ending are ambiguous.”

Although Renée Fox has expressed some skepticism that a proper sociology of death can ever be developed, in this latest statement she has assembled, organized, and interpreted a range of relevant data for the purpose of deepening sociological understanding of death in society.
A CONCLUDING NOTE

The future of sociological inquiries on death and dying seems promising. The quality of research has improved perceptibly over the past two decades; excellent bibliographies (Fulton 1976b, 1981) are in hand and periodically updated; relevant social research instruments have been summarized (Marshall 1981); sociologists are making increasing use of demographic, archival, and historical data; admirable collections of relevant works—e.g. The Literature of Death and Dying, edited by Robert Kastenbaum, and the publications of The Foundation of Thanatology and of The Institute of Society, Ethics and the Life Sciences—are readily available; a data base on “The Last Days of Life” is being planned by the National Institute on Aging; a computerized bibliography is being prepared by the Palliative Care Foundation of Toronto; and the National Center for Health Statistics is establishing a National Death Index that will provide a new and important resource for sociological research.

In a society where (short of war) death is increasingly postponed, will those future inquiries provide support for some of the trends discerned in this review? Will socialization for death become a recognized reality? Will dying persons seek to maintain an even greater sense of autonomy? Will passive euthanasia create fewer moral dilemmas? Will suicide continue as “the final alternative” for increasing numbers of older people? Will new patterns of bereavement emerge for the future population of widows? Will new caring environments for the terminally ill be institutionalized? Will the concept of a “good” death gain wider acceptance? Will new medical technologies develop in response to the changing needs of geriatric populations? Will the period of disability prior to death be foreshortened? In short, are the meanings of death in process of continuing transformation? An agenda for continued sociological inquiries appears to be in hand.

ACKNOWLEDGMENT

My studies of the meaning of death were supported during 1978–1979 by the Center for Advanced Study in the Behavioral Sciences, where I was a Visiting Scholar; and over the years by The Equitable Life Assurance Society of the United States, which gave me freedom to work on this topic. To both institutions and to many individuals I owe large debts. I am especially grateful to Renée Fox, Victor Marshall, and Richard Kalish for their expertise, incisive comments, and helpful suggestions. As always, Matilda White Riley served as a true collaborator and critic.
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