At its simplest, death is the absence of life. It is unavoidable, comes hand-in-hand with life, and is the final state of the lifespan. In this chapter, we examine death and death-related issues across the lifespan, including evolving definitions of death, how people of varying ages understand and experience death, and the bereavement processes. The circumstances that surround death and its timing in the lifespan have changed radically over the past century, alongside advances in life expectancy.
Learning Objectives

19.1 Identify ways in which death has been defined and end-of-life issues that may arise.
19.2 Contrast children’s, adolescents’, and adults’ understanding of death.
19.3 Discuss the physical and emotional process of dying as it is experienced over the lifespan.
19.4 Summarize typical grief reactions to the loss of loved ones and the influence of development on bereavement.

Patterns of Mortality and Defining Death

> LO 19.1 Identify ways in which death has been defined and end-of-life issues that may arise.

Most babies born in 1900 did not live past age 50, but infants born in the United States today can expect to live to about age 80—and even longer in some countries, such as Japan (85 years) (Central Intelligence Agency, 2018). The rapid decline in mortality rates over the past 100 years can be attributed to advances in medicine and sanitation. Many once-fatal conditions and diseases are now treatable. In 1900, the leading causes of death were infectious diseases, specifically pneumonia and flu, tuberculosis, and gastrointestinal infections (National Institute of Aging, 2011). Today, each of these illnesses can be prevented and treated.

Mortality

In the United States, mortality across all ages declined 60% between 1935 and 2010 and about an additional 2% through 2014 (Hoyert, 2012; Kochanek, Murphy, Xu, & Arias, 2017) (see Figure 19.1). People of all ages demonstrate a reduced mortality rate, but as you can see in Figure 19.2, the risk of dying has especially plummeted for infants and young children, with a 94% reduction in death rates among children ages 1 to 4, compared with a 38% decline for adults age 85 or more from 1960 through 2010 (Hoyert, 2012). Similar changes have also occurred in the United Kingdom and other Western countries (Mathers, Stevens, Boerma, White, & Tobias, 2014; Office for National Statistics, 2014). Today women are less likely to die in childbirth, infants are more likely to survive their first year, children and adolescents are more likely to grow to adulthood, and adults are likely to overcome conditions that were once fatal.

As shown in Figure 19.3, the leading causes of death vary by age. Infants under a year of age are most likely to die from genetic, prenatal, and birth complications, with sudden infant death syndrome the third most common cause of death. Childhood deaths are most often due to accidents, illnesses, and, alarmingly, homicide (which is most often the result of child maltreatment).

Adolescents and adults through age 44 are most likely to die from unintentional injuries, such as falls and traffic accidents, but most often from drug overdose. In early adolescence, suicide is the second leading cause of death and remains so in early adulthood and into the mid-30s. Illnesses are a leading source of mortality throughout life, but homicide is a more common source of injury death from ages 15 to 34.

Over middle adulthood, cancer, heart disease, and injury become the top three causes, respectively. Suicide, the number four killer of adults ages 45 to 54, becomes less common in the later middle adulthood years, dropping to eighth place. Chronic illnesses
such as diabetes and diseases of the liver and respiratory system emerge as sources of mortality in midlife, particularly late midlife. Older adults over the age of 65 are most likely to die of chronic illnesses, with heart disease as the number one killer, followed by cancer. Alzheimer's disease emerges as the fifth most common cause of death in adults age 65 and older.

Although unintentional injuries are the leading causes of death through age 44, the most common sources of injuries vary with age. For example, accidental suffocation is common in infancy and childhood, and drowning is a top source of unintentional death from childhood through early adulthood, becoming less so in middle adulthood. Unintentional poisoning, most often through drug overdose, is the second leading cause of injury death from ages 15 to 25 and the leading cause of injury deaths throughout early and middle adulthood, from ages 25 to 64. The opioid crisis is responsible for most overdose deaths, as discussed in the Lives in Context feature.

**Defining Death**

The actual moment of death is not easy to determine. In prior centuries, death was defined as the cessation of cardiopulmonary function. A person was dead once the heart stopped beating,
FIGURE 19.2
Death Rates by Age and Sex in the United States, 1955–2014

Source: Sherry et al., 2017

FIGURE 19.3
Leading Causes of Death, by Age, 2016

Source: National Center for Injury Prevention and Control, CDC.
The Opioid Epidemic

Over the past two decades, the use of prescription and nonprescription opioid drugs has skyrocketed in the United States and Canada. Opioids are a class of strong painkillers, including prescription drugs such as oxycodone and illegal drugs such as heroin. Commonly prescribed to treat severe pain, opioids are highly addictive, leading many adults to continue their use to ease withdrawal symptoms or for recreational purposes. Individuals unable to obtain or afford prescriptions often transition to nonprescription opioids, most often heroin. The transition from prescription pills to heroin use may be influenced by the desire to get a more potent high and by heroin being easier to use, cheaper (given the low cost of heroin in the United States), and more easily available compared to prescription opioids (Martins, Santaella-Tenorio, Marshall, Maldonado, & Cerdá, 2015).

In addition to being highly addictive, opioids carry a high risk of overdose. Opioids have a sedative effect and, in high doses, can impair the part of the brain that regulates breathing, slowing and ceasing breathing, leading to death. Drug overdose deaths have increased rapidly since the late 1990s and are now the leading cause of death from young adulthood into middle adulthood, more than traffic accidents and gun-related deaths. It is estimated that two thirds of overdose deaths are from opioids and one half are from prescription drugs (Centers for Disease Control and Prevention, 2017; Katz, 2017). The greater social acceptance of prescribed opioids, as compared with illegal opioids, contributes to the problem. Moreover, overdoses continue to rise, increasing up to 30% in some areas of the United States from July 2016 through September 2017 (Centers for Disease Control and Prevention, 2018). Canada has experienced similar increases, with a 2017 report noting that emergency department visits as a result of opiate overdose rose 1,000% in the 5 years prior (Ubelacker, 2017).

As we have discussed, the trend over the past century is toward longer lives, but in 2015, for the first time in recorded history, life expectancy fell—and in 2016, it fell again, from 78.7 to 78.6 (Kochanek, Murphy, Xu, & Arias, 2017). The decline in life expectancy is influenced by the increase in overdose deaths in adults under age 50.

In the United States, opioid addiction and overdose are exponentially more prevalent and have increased more rapidly in White non-Hispanics compared with African Americans and Hispanics (Martins et al., 2015; Seth, Scholl, Rudd, & Bacon, 2018). African Americans and Hispanics have been less likely to receive prescriptions for opioid medication (Singhal, Tien, & Hsia, 2016). One recent study suggested that medical students who held false beliefs about biological differences between Blacks and Whites, such as in pain tolerance or likelihood of addiction, were less likely to advocate prescribing strong painkillers to Black patients as compared with White patients (Hoffman, Trawalter, Axt, & Oliver, 2016). In this way, it is argued that racial bias may have protected people of color from the opiate epidemic (Ballesteros, 2017).

Deemed an epidemic by the U.S. Department of Health and Human Services, federal attempts to curb the opioid crisis focus on improving access to prevention, treatment, and recovery services; increasing the availability of overdose-treating drugs to prevent overdose deaths; and regulating and reducing the prescription of opioid drugs for pain (U.S. Department of Health and Human Services, 2018).

It is recommended that physicians and medical staff be trained to consider alternative medications and to recognize the symptoms of addiction. Physicians and pharmacists are encouraged to contribute to prescription drug monitoring databases to track prescriptions and patient use of opioid medications. In practice, the effects of prescription monitoring programs are mixed, as they are implemented inconstantly (Finley et al., 2017; Matusow, Rosenblum, & Parrino, 2018).
The highly addictive nature of opioids makes treatment very difficult. A combination of medical and behavioral treatment is most effective. Medical treatment includes prescription and monitoring of drugs to ease withdrawal symptoms. Behavioral treatment teaches patients strategies for avoiding opiates and managing physical and emotional symptoms of withdrawal and desires for use. Given the strong addictive effects of opiates, behavioral treatments are less likely to be successful in the absence of medical treatments to aid symptoms of physical withdrawal (Kolodny et al., 2015).

**What Do You Think?**

1. What might draw individuals to use opioid drugs? Do adolescents, adults, and older adults have similar reasons?

2. How might treatment be tailored to the diverse needs of adolescents, adults, and older adults?

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now referred to as **clinical death**. When the heart stops beating, blood, and thereby oxygen, no longer circulates throughout the body and permanent brain damage can occur after 3 minutes of oxygen deprivation (Dennis, 2008). However, today’s medical practices, including the widespread dissemination of cardiopulmonary resuscitation (CPR) techniques, have permitted many people to regain a heartbeat and be “revived” from clinical death. A heartbeat is no longer a clear marker of life or, in its absence, death.

Advances in technology have led to new ways of defining death. As mechanical ventilators became commonplace in operating rooms and intensive care settings, it became possible to artificially maintain patients who had irreversible injuries, to keep patients alive on ventilators. It is possible for the heart to continue to beat even though the person cannot eat, think, or breathe on his or her own. Therefore, more precise definitions of death are needed. A 1968 physician-led committee at Harvard Medical School concluded that patients who meet criteria for specific severe neurological injuries may be pronounced dead before cardiopulmonary cessation occurs (Harvard Medical School Ad Hoc Committee, 1968). **Whole brain death** refers to the irreversible loss of functioning in the entire brain, including the higher and lower brain regions, the cortex and brainstem, without the possibility of resuscitation (McMahan, 2001). Whole brain death may occur prior to clinical death (Burkle, Sharp, & Wijdicks, 2014). Death is declared if all criteria are met and other conditions that may mimic death, such as a drug overdose or deep coma, are ruled out. Patients who are brain dead may be temporarily sustained artificially for the purpose of organ donation.

The President’s Commission for the Ethical Study of Problems in Medicine, Biomedical, and Behavioral Research (1981) established the criteria used to diagnose whole brain death:

1. No spontaneous movement in response to stimuli
2. No spontaneous respiration for at least 1 hour
3. Total lack of responsiveness to even the most painful stimuli
4. No eye movements, blinking, or pupil responses
5. No postural activity, swallowing, yawning, or vocalizing
6. No motor reflexes
7. A flat electroencephalogram (EEG) for at least 10 minutes
8. No change in any of these criteria when they are tested again 24 hours later

The 2008 report of the President’s Council on Bioethics reaffirmed the whole brain definition of death. Under the Uniform Determination of Death Act, all 50 U.S. states and the District of Columbia apply the whole brain standard in defining death, thereby permitting a person to be declared legally dead and removed from life support.

The most controversial definition of death looks beyond the whole brain standard. In the late 19th century, several researchers and physicians noted instances in which brain damage caused a cease in cortical functioning while the heart continued to beat. The cortex is the part of the brain most vulnerable to conditions of anoxia, the loss of oxygen. Inadequate blood supply to the brain after heart attack, stroke, drowning, or traumatic brain injury can irreparably damage the cortex while leaving the brainstem intact and functional. The neurons of the brainstem often
survive stressors that kill cortex neurons (Brisson, Hsieh, Kim, Jin, & Andrew, 2014), resulting in cortical death, or a **persistent vegetative state (PVS)**, in which the person appears awake but is not aware, due to the permanent loss of all activity in the cortex (Laureys et al., 2010). Despite cortical death, PVS patients retain an intact brainstem, which permits heart rate, respiration, and gastrointestinal activity to continue.

The PVS patient is neither clinically dead nor meets the criteria for whole brain death. He or she remains biologically alive despite lacking the capacity to regain awareness and cognitive capacities. The patient may open his or her eyelids and show sleep-wake cycles but does not show cognitive function, as indicated by measures of brain activity, such as MRI, EEG, and positron emission tomography scans (Bender, Jox, Grill, Straube, & Lulé, 2015). Loved ones may be misled by spontaneous reflexive movements of the arms and legs and random facial expressions to believe that the patient is capable of cognitive functions and experiences emotions (Cranford, 2004). However, reflexes are controlled by the spinal cord and lower regions of the brain that are not involved in conscious awareness. When the condition first appears, it is referred to as a vegetative state, but after 4 weeks, the patient is diagnosed with persistent vegetative state (The Multi-Society Task Force on PVS, 1994). Approximately 30,000 U.S. patients are held captive in this condition (Brisson et al., 2014).

Although the medical community typically defines a PVS patient as dead given the irrevocable lack of awareness and loss of cortical function, PVS does not meet the criteria for whole brain death (and, thereby, death) and is not recognized as death by U.S. legal statute (McMahan, 2001). Canada and several other countries, however, acknowledge cortical death (Teitelbaum & Shemie, 2016). Supporters of the cortical definition of death argue that the cortex is responsible for what makes us human—thought, emotion, and personality. From this view, when higher cortical functions have ceased, these capacities are lost. Courts require authoritative medical opinion that recovery is not possible before terminating life-prolonging activities (Cranford, 2004). Several lengthy and dramatic court cases have caused many people to consider and communicate their own wishes regarding how they want to die.

### End-of-Life Issues

People of all ages desire a sense of control in what happens to them, whether it is as simple as an infant’s choice of play toy or as complex as an older adult’s choice of living situation. This is especially true when it comes to the many decisions that surround death. **Dying with dignity** refers to ending life in a way that is true to one’s preferences, controlling one’s end-of-life care (Guo & Jacelon, 2014; Kastenbaum, 2012).

#### Advance Directives

Planning and communication are key to helping people die with dignity. The individuals’ wishes must be known ahead of time because dying patients are usually unable to express their wishes. Without prior communication, dying patients often cannot participate in decisions about their own end-of-life care, such as pain management, life-prolonging treatment, and memorial services. These decisions will likely be made by the persons who surround them—spouse, children, family members, friends, or health care workers—and these persons may well have views that differ from those of the patients. The Patient Self-Determination Act (PSA) of 1990 guaranteed the right of all competent adults to have a say in decisions about their health care by putting their wishes regarding end-of-life and life-sustaining treatment in writing.

Advance directives, including a living will and a durable power of attorney, are an important way of ensuring that people’s preferences regarding end-of-life care are known and respected.

A **living will** is a legal document that permits people to make known their wishes regarding medical care if they are incapacitated by an illness or accident and are unable to speak for themselves. The individuals can identify what, if any, medical intervention should be used to prolong their lives if they are unable to express a preference. For example, should artificial respiration or a feeding tube be used? They can also explicitly designate the medical treatment they do not want. A **durable**
power of attorney for health care is a document in which individuals legally authorize a trusted relative or friend (called a health care proxy) to make health care decisions on their behalf if they are unable to do so. It is important to have both a living will and a durable power of attorney, as they each fulfill different functions.

Determining final wishes and communicating them in advance directives can ease the process of dying, both for dying persons and for their families. **Advance directives** permit patients to take control over their health care, their deaths, and what happens to their bodies and possessions after death. They facilitate communication about health care needs and preferences and can reduce anxiety on the part of patients (Nelson & Nelson, 2014). Advance directives foster patients’ autonomy and help them to retain a sense of dignity as they die. Caregivers benefit from advance directives because an understanding of the patients’ wishes can help in decision making and in reducing stress, emotional strain, and, potentially, guilt (Radwany et al., 2009).

Despite the many benefits of advance directives, they are underused. Overall, about one quarter of U.S. adults have written some form of advance directive (Rao, Anderson, Lin, & Laux, 2014). Older adults are most likely to have completed advance directives (about 50%), and they are typically the ones to initiate conversations with family members about end-of-life issues (Pew Research Center, 2009). About one third of 50- to 64-year-old adults and only about one fifth of 30- to 49-year-old adults report having written down their wishes for end-of-life treatment. Yet advance directives are not just for the old or the ill. Many argue that it is the healthy—especially the young and healthy—who benefit most from living wills and health care proxies (Khan, 2014). Young people and their families are often unprepared for the decisions that may accompany the sudden loss of decision-making capacities and consciousness, such as from an accident or serious illness. Advance directives can spare spouses and families the anguish, guilt, and potential conflict among family members of making decisions for a loved one without knowing his or her wishes.

**Euthanasia**

Through a living will, one might articulate when life-prolonging care may be withdrawn and under what conditions euthanasia is acceptable. **Euthanasia** ("easy death") refers to the practice of assisting terminally ill people in dying more quickly (Jecker, 2006; van der Maas, 1991). It is controversial, but the courts have permitted euthanasia in many hopeless cases, such as that of a patient named Nancy Cruzan. On January 11, 1983, then 25-year-old Nancy Cruzan lost control of her car, was thrown from the vehicle, and landed face down in a water-filled ditch. She was resuscitated by paramedics after about 15 minutes without breathing. After 3 weeks in a coma, Nancy was diagnosed as being in a persistent vegetative state. She remained alive as a PVS patient until 1987, when Nancy’s parents asked that her feeding tube be removed. Although a county judge authorized the request, the state of Missouri contested it. The resulting Supreme Court decision in **Cruzan v. Director, Missouri Department of Health**, held that treatment can be refused in extraordinary circumstances, but clear and convincing evidence of Nancy’s own wishes would be needed. The court accepted testimony from friends and family that Nancy had told them she would not want to live in a disabled condition. Nancy Cruzan died 2 weeks after her feeding tube was removed, in December 1990. The Cruzan case was pivotal in supporting the right-to-die movement.

Distinctions are commonly made between passive and active euthanasia (Jecker, 2006). **Passive euthanasia** occurs when life-sustaining treatment, such as a ventilator, is withheld or withdrawn, allowing a person to die naturally, as happened in the case of Nancy Cruzan. In **active euthanasia**, death is deliberately induced, such as by administering a fatal dose of pain medication. More than two thirds of U.S. adults and 95% of physicians support passive euthanasia (Curlin, Nwodim, Vance, Chin, & Lantos, 2008; Pew Research Center, 2013). Most adults say there are at least some situations in which they, personally, would want to halt medical treatment and be allowed to die. For example, 57% say they would tell their doctors to stop treatment if they had a disease with no hope of improvement and were suffering a great deal of pain. And about half (52%) say they would ask their doctors to stop treatment if they had an incurable disease and were totally dependent on someone else for their care. Yet, about a third of adults (35%) say they would tell their doctors to do everything possible to keep them alive—even in dire circumstances, such as having a disease with no hope of improvement and experiencing a great deal of pain (Pew Research Center, 2013). These are difficult questions, and there is no clear consensus on solutions.

**Physician-Assisted Suicide**

**Physician-assisted suicide** is a type of voluntary active euthanasia in which terminally ill patients make the conscious decision that they want their life to end before dying becomes a protracted
process. Patients receive from physicians the medical tools needed to end their lives. The patient self-administers the medication. Physician-assisted suicide is legal in the Netherlands, Luxembourg, and Switzerland (Grosse & Grosse, 2015) and is often tacitly accepted in other countries. Until recently, assisting a suicide was illegal throughout North America; however, Canada adopted physician-assisted suicide starting in 2016, and physician-assisted suicide is legal in several U.S. states (Fine, 2015; Ollove, 2015).

The most widely publicized cases of physician-assisted suicide involved Dr. Jack Kevorkian, a Michigan physician who helped over 100 terminally ill patients end their lives. In 1989, Kevorkian created a “suicide machine” that allowed a patient to press a button to self-administer anesthesia and medication that stops the heart. In 1998, Kevorkian was arrested after a segment televised on the program 60 Minutes aired in which he assisted in the death of a 52-year-old man who suffered from a terminal neurological disease. Although it was flagrantly displayed on television, the procedure was illegal and led to Kevorkian’s arrest, trial, and conviction on second-degree murder charges. He was released from prison in 2007 after serving 8 years of a 10 to 25-year sentence. He died in 2011 after being diagnosed with liver cancer.

As of 2018, the practice of physician-assisted suicide is legal in the U.S. states of California, Colorado, Hawaii, Montana, Oregon, Vermont, and Washington and the District of Columbia (Ollove, 2018). Oregon was the first U.S. state to legalize assisted suicide. Under Oregon's Death With Dignity Act, enacted in 1997, terminally ill Oregonians may end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.

Under the Oregon law, an adult Oregon resident who has been diagnosed by a physician with a terminal illness that will kill the patient within 6 months may request in writing a prescription for a lethal dose of medication for ending the patient’s life. The patient must initiate the request and must be free of any mental condition that might impair judgment. The request must be confirmed by two witnesses, and at least one of them (1) must not be related to the patient, (2) must not be entitled to any portion of the patient’s estate, (3) must not be the patient’s physician, and (4) must not be employed by a health care facility caring for the patient. After the request is made, a second physician must examine the patient’s medical records and confirm the diagnosis. If the request is authorized, the patient must wait an additional 15 days to make a second oral request before the prescription can be written.

Since the Oregon law was enacted in 1997, a total of 1,749 people have had prescriptions written, and 1,127 patients have died from ingesting medication prescribed under the act (Oregon Public Health Division, 2017). Eighty percent of the 1,126 patients who died were over the age of 65, and the median age at time of death was 73. Over three quarters had been diagnosed with cancer. The top three concerns reported by patients as influences on their decisions were being less able to engage in activities to enjoy life, loss of autonomy, and loss of dignity (Oregon Public Health Division, 2017).

The Oregon Death With Dignity Act has permitted many suffering adults to end their lives on their own timetable; however, physician-assisted suicide remains controversial in the United States. As shown in Figure 19.4, most U.S. adults in 2016 (69%) agreed that euthanasia should be legal and that doctors should be allowed to end a patient’s life by painless means. Moreover, 51% said they would consider ending their lives if faced with terminal illness (Swift, 2016). Yet debates regarding physician-assisted suicide are unlikely to be resolved at any time soon.

Hospice
The desire to die with dignity, minimal pain, and on one’s own terms has advanced the hospice movement. Hospice is an approach to end-of-life care that emphasizes dying patients’ needs for pain management; psychological, spiritual, and social support; and death with dignity (Connor, 2018). The philosophy of the hospice approach does not emphasize prolonging life but rather prolonging quality of life. Although death occurs most often in hospitals, most dying people express the desire to die at home with family and friends (Weitzen, Teno,
Fennell, & Mor, 2003). Dying persons have needs that set them apart from other hospital patients, and hospital settings are often not equipped to meet these needs. Rather than medical treatment, dying patients require palliative care, focusing on controlling pain and related symptoms. Hospice services are enlisted after the physician and patient believe that the illness is terminal, and no treatment or cure is possible.

Hospice services may be provided on an inpatient basis, at a formal hospice site that provides all care to patients, but they are frequently provided on an outpatient basis in a patient’s home (Connor, 2018). Outpatient hospice service is becoming more common because it is cost-effective and enables the patient to remain in the familiar surroundings of his or her home. Home hospice care is associated with increased satisfaction by patients and families (Candy, Holman, Leurent, Davis, & Jones, 2011). Whether hospice care is given on an inpatient or outpatient basis, the patient care team typically includes physicians, nurses, social workers, counselors, and volunteers.

Hospice services permit dying patients to remain in their home, comfortable, and feel a sense of control in the death process. Counseling services help families assist the dying person, cope with their own needs, and strengthen connections with the dying person. Hospice services permit death with dignity that honors a loved one’s wishes.

Figure 19.4: Physician-Assisted Suicide

When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?

<table>
<thead>
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<th>Year</th>
<th>% Should</th>
<th>% Should not</th>
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<td>42</td>
<td>58</td>
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<tr>
<td>1999</td>
<td>37</td>
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<td>57</td>
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<tr>
<td>2015</td>
<td>45</td>
<td>55</td>
</tr>
</tbody>
</table>

Source: Dugan, 2015.

Thinking in Context 19.1

1. Evaluate the right-to-die concept. In your view, what is the value of this concept? How well is it embodied in advance directives, euthanasia, physician-assisted suicide, and hospice? Which of these approaches do you endorse, if any?

2. What advantages and disadvantages do you see to choosing hospice instead of standard medical care? Should some patients be required to transition to hospice? Why or why not?

3. From a bioecological perspective, discuss contextual factors that contribute to the declining mortality rate. Provide examples of influences at each bioecological level with particular attention to exosystem and macrosystem influences.
and counselors who act as spiritual and bereavement counselors who support the patient in facing his or her impending death and help the patient’s loved ones cope with the loss.

CONCEPTIONS OF DEATH ACROSS THE LIFESPAN

» LO 19.2 Contrast children’s, adolescents’, and adults’ understanding of death.

There are many ways of conceptualizing death, and cultural beliefs about the nature of death vary. For example, many cultures within the South Pacific do not differentiate death as a separate category of functioning. Melanesians use the term mate to refer to the very old, the very sick, and the dead; all other living people are referred to as too (Counts & Counts, 1985). Other South Pacific cultures explain that the life force leaves the body during sleep and illness; therefore, people experience forms of death over the course of their lifetime before experiencing a final death (Counts & Counts, 1985). The Kwanga of Papua New Guinea believe that most deaths are the result of magic and witchcraft (Brison, 1995). The Hopi Indians of North America view life and death as phases of a cycle, with death representing an altered state.

Many children and adults in various cultures express beliefs in noncorporeal continuation, the view that some form of life and personal continuity exists after the physical body has died (Kenyon, 2001). For example, a spirit may endure, life may persist in heaven, or a soul may be reincarnated into another body. These beliefs are consistent with the doctrine of many religions and can coexist with mature understandings of death as the irreversible and inevitable ceasing of biological functioning (Corr & Corr, 2013). Researchers generally agree that, in Western cultures, a person has a mature understanding of death when the following four components are understood (Barrett & Behne, 2005; Kenyon, 2001; Panagiotaki, Nobes, Ashraf, & Aubby, 2015; Slaughter & Griffiths, 2007).

1. **Nonfunctionality**, the understanding that death entails the complete and final end of all life-defining abilities or functional capacities, internal and external, that are typically attributed to a living body.

2. **Irreversibility**, the understanding that the processes involved in the transition from being alive to being dead and the resulting state of being dead cannot be undone. Once a thing dies, its physical body cannot be made alive again.

3. **Inevitability**, the understanding that death is universal, that all living things will someday die.

4. **Biological causality**, the understanding that death is caused by events or conditions that trigger natural processes within the organism and that it is not caused by bad behavior or wishes.

Children’s Understanding of Death

Children do not understand loss and death in the same way as adults, but they often have a more mature understanding of these events than many adults expect (Gaab, Owens, & Macleod, 2013). Even infants can sense that something unusual is happening when the adults around them grieve. They notice changes in the emotional tone of their families, changes in caregivers, and the degree to which their emotional needs are met or interrupted (Leming & Dickinson, 2016). Young children, similarly, perceive events around them before they have developed the ability to understand or explain them.

Children encounter death in many ways. Grandparents, parents, other important adults, siblings, and friends may die. Pets are often children’s first experience with unconditional love, and most children will experience the death of a pet as a significant experience (Leming & Dickinson, 2016). Children have more exposure to death and death themes than many adults realize. They overhear adults talking about the deaths of elderly relatives or public figures. Television reports describe car

Children visit a relative’s grave during the día de los muertos celebration.

ALFREDO ESTRELLA/AFP/Getty Images
crashes, homicides, disasters, and war. Death is a common topic in television programs. Considering such exposure to the subject of death, it is not surprising that children's play is riddled with death-related themes (Bettelheim, 1977; Opie & Opie, 1969). We have seen that play is the work of childhood, and as such, it is a way that children make sense of the world, including death (Corr, 2010b). Children often act out crashes with their cars or killing with toy soldiers. Death themes appear in children's rhymes, songs, and fairytales (Lamers, 1995). The song “Rock-a-Bye, Baby” culminates with a falling cradle (Achté, Fagerström, Pentikäinen, & Farberow, 1989), and the child's prayer “Now I lay me down to sleep” asks for safekeeping against danger and death. The wicked stepmother demands Snow White's heart as proof of her death, and the big bad wolf in the “Three Little Pigs” falls down the chimney of the third pig's house into a pot of boiling water. Death themes in rhymes and play may help children work through fears related to loss in safe ways.

Young children between the ages of 3 and 5 tend to view death as temporary and reversible. They believe dead things can become alive spontaneously and as the result of medical intervention, after eating or drinking, and by magic, wishful thinking, or prayer (Corr, 2010b; Slaughter, 2005). They may imagine that the person who has died is actually still living but under alternative circumstances (Barrett & Behne, 2005; Slaughter & Griffiths, 2007). They may describe death as sleep, with the corresponding ability to wake up, or a trip from which a person can return. They may personify death as a figure, a spirit that comes and “gets” you (Leming & Dickinson, 2016). They may believe that only people who want to die or who are bad die. Before they understand nonfunctionality, children view dead things as possessing reduced or diminished capacities but retaining some functions such as the ability to feel hunger pangs, wishes, beliefs, and love (Bering & Bjorklund, 2004). Before they understand the inevitability of death, young children think that there are actions they could take to avoid death, such as being clever enough to outsmart it or being lucky (Speece & Brent, 1984). A mature understanding of biological death gradually emerges alongside cognitive development.

The understanding that death is final, irreversible, and inevitable typically emerges between 5 and 7 years of age, corresponding to the transition from preoperational reasoning to concrete operational reasoning in Piaget's theory. Biological causality is the most complex element of the death concept and the final element to be acquired, emerging as early as 6 or 7, but more typically in late childhood (Bonoti, Leondari, & Mastora, 2013; Slaughter & Griffiths, 2007). Advances in executive function are closely related with the emergence of a biological theory of death as these cognitive capacities permit the abstract thinking needed for mature conceptions of death (Zaitchik, Iqbal, & Carey, 2014). Typically, an understanding of the biological nature of death is mastered by about age 10 (Bonoti et al., 2013; Renaud, Engarhos, Schleifer, & Talwar, 2015). Research comparing White British, Muslim British, and Muslim Pakistani children suggests that this pattern of change in biological explanations for death occurs cross-culturally (Panagiotaki et al., 2015). Such findings are consistent with those from children in Australia (Slaughter & Griffiths, 2007), the United States (Lazar & Torney-Purta, 1991), and Israel (Schonfeld & Smilansky, 1989).

Despite cross-cultural similarities in biological conceptions of death, there are contextual differences in children's exposure to death, and these differences influence children's conceptions of death. Some children receive more exposure to death through media depictions of war, accidents, and devastating living conditions. Others experience death firsthand. Many children in all parts of the world, including North America, are exposed directly to violence within their families and communities and may witness or be aware of traumatic events and deaths at home and in their neighborhoods. Children who reside in war-torn and poverty-stricken nations often experience multiple losses (Masten, Narayan, Silverman, & Osofsky, 2015). How children make sense of these events and how they understand death changes with age and experience. Children who have direct, personal experience of death tend to show a more advanced and realistic understanding of death than their peers (Bonoti et al., 2013; Hunter & Smith, 2008).

How parents talk to children about death, and whether they talk about death, influences children's understanding. Parents of young children, ages 3 to 6, tend to believe that their children hold misconceptions about death. They avoid talking about death, believing that children are not capable of grasping or coping with it (Miller & Rosengren, 2014; Nguyen & Rosengren, 2004). U.S. parents often shield their young children from death by not taking them to funerals or memorial services, controlling their access to death in television and movies, and talking with them about death minimally, indirectly, or not at all (Miller & Rosengren, 2014). Parents are most likely to report having discussed death when the child has experienced a death of some kind, regardless of age; more conversations took place as the child's age increased (Renaud et al., 2015).
Culture is a powerful influence on conceptions of death. European American parents, for instance, tend to shield their children from death. In contrast, Mexican and Mexican American parents are likely to believe that children should become familiar with death and are likely to include them as active participants in rituals related to death, such as wakes and funerals (Gutiérrez, Rosengren, & Miller, 2014). These attitudes are supported by traditional Mexican practices, such as the día de los muertos (Day of the Dead), a national holiday held each year from October 31 to November 2. At this time, dead relatives are said to return to their homes to eat, drink, and visit with the living. The celebration includes images such as skeletons in festive outfits engaging in everyday activities: dancing, playing instruments, getting married, and so forth. Children participate with other community members in celebrations and vigils held in cemeteries (Gutierrez, 2009). The día de los muertos holiday is intended to welcome the dead and to celebrate death as the continuation of life. It is not surprising that young Mexican American children are more likely than their European American peers to attribute biological and psychological properties to the dead (Gutiérrez et al., 2014).

Culture also influences individuals’ views of spirituality, which in turn affect their views of death. Children often develop spiritual or religious explanations in addition to biological explanations for death (Legare, Evans, Rosengren, & Harris, 2012). Still, the extent to which children use religious or biological terms may vary by culture (Harris & Gimenez, 2005; Nguyen & Rosengren, 2004).

Harris and Gimenez (2005) found that belief in the afterlife among Spanish children increased between the ages of 7 and 11, along with religious explanations for death. However, children were more likely to offer religious explanations for death in response to vignettes highlighting religious themes than in response to vignettes highlighting medical themes indicating that children hold multiple conceptions of death, depending on context. Children who grow up in cultures that endorse both religious and biological views of death may hold explanations about death that appear incompatible, such as biological irreversibility and religious or spiritual continuity (Gutiérrez et al., 2014; Panagiotaki, Hopkins, Nobes, Ward, & Griffiths, 2018; Panagiotaki et al., 2015). It is not until later in development, particularly adolescence, that children gain the cognitive competence to integrate these ideas. For more on the cultural beliefs about the nature of death, see the accompanying Cultural Influences on Development feature.

Adolescents’ Understanding of Death

Adolescents often describe death as an enduring abstract state of nothingness that accompanies the inevitable and irreversible end of biological processes (S. B. Brent, Lin, Speece, Dong, & Yang, 1996). Adolescents’ understanding of death reflects the intersection of biological, cognitive, and socioemotional development. As adolescents experience the rapid biological changes of puberty, this process may heighten their awareness of the inevitability of the biological changes of life. Although adolescents are cognitively aware that death is universal and can happen to anyone, at any time, this awareness often is not reflected in their risk-taking behavior. Instead, adolescents are prone to the personal fable (see Chapter 11), viewing themselves as unique and invulnerable to the negative consequences of risky behaviors, including death (Alberts, Elkind, & Ginsberg, 2007). The risk-taking behavior characteristic of adolescence is a form of cheating death, an event that is perceived as a distant, but unlikely, possibility.

Adolescents’ advances in abstract reasoning are reflected in their interest in considering the meaning of death, as well as whether some psychological functions, such as knowing and feeling, persist in a dying person after biological processes have ceased (Noppe & Noppe, 2004). Adolescents and adults across cultures often share a belief in an afterlife, whether religious or supernatural in origin (Bering & Bjorklund, 2004). This belief often arises in childhood, but it is in adolescence that we are first able to simultaneously hold a mature biological understanding of death as the end of all body functions alongside cultural and religious beliefs about an afterlife (Panagiotaki et al., 2018). The two conceptions coexist and can be called upon as needed depending on the situation and what adolescents are trying to explain (Legare et al., 2012). For example, the Vezo people in rural Madagascar believe that dead ancestors are present among the living, watching and guiding (Astuti & Harris, 2008). Vezo children tend to emphasize biological explanations for death, but adolescents and adults hold both biological and spiritual explanations, reflecting their cognitive abilities to hold two differing perspectives at once.

Adults’ Understanding of Death

Conceptions of death change in subtle ways over the course of adulthood. Young adults begin to
Cultural Rituals Surrounding Death

There is great variability in cultural views of the meaning of death and the rituals or other behaviors that express grief (Rosenblatt, 2008). Perhaps the most well-known death rituals were practiced by the ancient Egyptians. They believed that the body must be preserved through mummification to permanently house the spirit of the deceased in his or her new eternal life. The mummies were surrounded by valued objects and possessions and buried in elaborate tombs. Family members would regularly visit, bringing food and necessities to sustain them in the afterlife. Egyptian mummies are the most well known, but mummies have been found in other parts of the world such as the Andes mountains of Peru (Whitbourne, 2007).

The Bornu of Nigeria require family members to wash the deceased, wrap the body in a white cloth, and carry it to the burial ground (Cohen, 1967). In the French West Indies, the deceased’s neighbors wash the body with rum, pour a liter or more of rum down the throat, and place the body on a bed (Horowitz, 1967).

In South Korea today, a small minority of people still choose to employ the services of a mudang (Korean “shaman”) to conduct a lengthy ritual known as Ogu Kut, in which the mudang summons the deceased’s spirit into the ritual space; expresses the latter’s feelings of unhappiness through song, dance, and the spoken word; and encourages the bereaved to express his or her own grievances within symbolic psychodrama. Once the emotional ties between the bereaved and the deceased have been loosened, prayers for protection are offered to various deities, and the mudang guides the spirit toward the Buddhist paradise. Finally, the deceased’s earthly possessions are cremated and the bereaved are left better able to move on in their lives (Mills, 2012).

Death rituals vary among religions. Among Hindus, a good death is a holy death, one that is welcomed by the dying person, who rests on the ground and is surrounded by family and friends chanting prayers (Dennis, 2008). Buddhists believe that the dying person’s task is to gain insight. Death is not an end, as the individual will be reincarnated in the hopes of reaching nirvana, an ultimate, perfect state of enlightenment. Among Jews, the dying person remains part of the community and is never left alone before or immediately after death. Christians generally believe that death is the entry to an eternity in heaven or hell and thereby is an event to be welcomed (generally) or feared (rarely). In Islam, death is united with life, because it is believed that the achievements and concerns of this life are fleeting, and everyone should be mindful and ready for death. Muslim death rituals, such as saying prayers and washing the body, aid in the dying person’s transition to the afterlife.

What Do You Think?

1. In your view, what purpose do death rituals fulfill?
2. Given the ethnic and religious diversity in the United States, many people have opportunities to learn about different cultural and religious approaches to coping with death. What customs, if any, have you observed?
apply their mature understanding of death to themselves. The personal fable declines, and as they take on adult roles, young adults begin to acknowledge their vulnerability. Risky activity declines and young adults’ behavior begins to better align with their understanding of the inevitability of death.

An awareness of death increases as individuals progress through middle adulthood, when they are likely to gain experience through the deaths of parents, friends, siblings, and colleagues. As midlife adults watch their children take on adult roles and as they become aware of their own aging bodies and minds, they develop a more personalized sense of their own mortality and the inevitability of the life cycle (Doka, 2015). The awareness of death can cause midlife adults to reevaluate their priorities, often leading them to pursue a sense of generativity, the need to give back and leave a lasting legacy (McAdams, 2014). Midlife adults who look beyond their own losses to consider the profound meaning of their absence to significant others, such as spouses and children, may be deeply saddened by the thought of their own death.

Older adults are likely to have exposure to death many times over. With the deaths of many friends and family members, older adults may become socialized to the nature and inevitability of death (Cicirelli, 2002). They often talk about aging and death, perhaps helping them to prepare for the inevitability of their own death (Hallberg, 2013). They also spend more time thinking about the process and circumstances of dying than the state of death, as compared with midlife adults (Corr, 2019).

Cross-sectional and longitudinal studies suggest that death anxiety declines over the lifespan; older adults tend to report lower levels of death anxiety than young and middle-aged adults (Chopik, 2017; Russac, Gatliff, Reece, & Spottswood, 2007). Advances in psychosocial development, such an increasing ability to manage negative emotions, influence how older adults approach death, and may account for their reduced anxiety compared to younger adults. In addition, religion, specifically a religious sense of hope (e.g., the conviction that their religious beliefs will bring opportunities or make things turn out well), reduces death anxiety among older adults (Krause, Pargament, & Ironson, 2016). The psychosocial task of older adulthood is to consider the meaning of life and death. Engaging in life review and establishing a sense of ego integrity help older adults reduce regrets and construct a sense that their lives have been well lived (Erikson, 1982).

### DYING AND THE EXPERIENCE OF DEATH

**» LO 19.3 Discuss the physical and emotional process of dying as it is experienced over the lifespan.**

When does dying begin? How does it occur? How is it experienced? These are questions that are challenging to answer. In the following sections, we consider the biological changes that occur with death, as well as the cognitive and socioemotional experience of death, and finally we consider how people experience their own deaths.

### The Dying Process

There is great variability in the *dying trajectory*, or the rate of decline that people show prior to death (Cohen-Mansfield, Skornick-Bouchbinder, & Brill, 2017; Lunney, Lynn, Foley, Lipson, & Guralnik, 2003). Dying trajectories vary by duration and descent and can be categorized into four patterns. The first trajectory is the *abrupt-surprise death*, which is sudden, unexpected, and instantaneous, such as an accident, a shooting, or a heart attack, or, in the case of infants, sudden infant death syndrome (see the Applying Developmental Science feature). As shown in Figure 19.5, the person shows normal functioning until a steep, catastrophic decline occurs, bringing a sudden death without warning. The dying person and his or her family have no time to prepare or adjust beforehand. A second trajectory, the *short-term expected death* is a steady predictable decline due to a terminal illness such as cancer. A third dying trajectory is referred to as an *expected lingering death* because it is anticipated but prolonged, such as in the case of frailty and old age. The fourth trajectory is referred to as *entry-reentry*
Deaths, because slow declines are punctuated by a series of crises and partial recoveries; the dying person may have repeated hospital stays, returning home between stays. The dying trajectory influences adaptation on the part of the dying person and his or her family. Typically, the short-term expected death is most predictable and most likely to be experienced in hospice care as the lifespan is clearly identified as limited. Lingering and entry-reentry deaths are prolonged. They can tax caregivers’ coping skills as such deaths are often not afforded hospice care until death is imminent.

Predictable changes and symptoms occur in the dying person hours and days before death; however, people vary in the number and severity of symptoms (Gavrin & Chapman, 1995). Toward the end of life, many people lose their appetite, which is often distressing to family as the patient may show dramatic weight loss. People suffering from lengthy illnesses, such as cancer, AIDS, and neurodegenerative disorders, often show extreme weight loss and the loss of muscle mass, known as cachexia (W. J. Evans et al., 2008). As death is imminent, the person sleeps most of the time, may be disoriented and less able to see, and may experience visual and auditory hallucinations. Many terminally ill patients experience declines in cognitive function in the weeks prior to death.

The dying person may experience pain, shortness of breath, irregular breathing, nausea, disrupted bladder and bowel function, and lethargy (Gavrin & Chapman, 1995). As the person is closer to death, he or she will lose interest in and the ability to eat, drink, and talk, as well as show reduced mobility and drowsiness (Lichter & Hunt, 1990). Breathing will be difficult and the person may experience dry mouth and difficulty swallowing. Breathing becomes noisy, a gurgling or crackling sound with each breath that is referred to as the death rattle. The average time from the onset of the death rattle to death is
The leading cause of death of infants under the age of 1 is sudden infant death syndrome (SIDS) (Bajanowski & Vennemann, 2017). SIDS is the diagnostic term used to describe the sudden unexpected death of an infant less than 1 year of age that occurs seemingly during sleep and remains unexplained after a thorough investigation, including an autopsy and review of the circumstances of death and the infant’s clinical history (Task Force on Sudden Infant Death Syndrome, 2016).

What causes SIDS? It is believed to be the result of an interaction of factors, including an infant’s biological vulnerability to SIDS coupled with exposure to a trigger or stressor that occurs during a critical period of development (R. Y. Moon & Task Force on Sudden Infant Death Syndrome, 2016; Spinelli, Collins-Praino, Van Den Heuvel, & Byard, 2017). The first factor is unknown biological vulnerabilities, such as genetic abnormalities and mutations and prematurity, that may place infants at risk for SIDS. For example, a recent 10-year review of hundreds of SIDS cases in Australia confirmed that, although the underlying cause of SIDS remains unknown, mutations and genetic variants likely play a role (A. Evans, Bagnall, Duflou, & Semansarian, 2013). Second, environmental stressors or events that might trigger SIDS include risks such as having the infant sleep on his or her stomach or side, use of soft bedding or other inappropriate sleep surfaces (including sofas), bed sharing, and exposure to tobacco smoke (Carlin & Moon, 2017). One review of several hundred cases in the United Kingdom found that over a third of SIDS deaths infants were co-sleeping with adults at the time of death (Blair, Sidebotham, Berry, Evans, & Fleming, 2006). Finally, there are developmental periods in which infants are most vulnerable to SIDS. Most cases of SIDS occur between the second and fifth months of life (Bajanowski & Vennemann, 2017). Therefore, it is thought that SIDS is most likely to occur when the triple risks—biological vulnerability, triggering events, and critical period of development—converge (Filiano & Kinney, 1994; Spinelli et al., 2017).

Ethnic differences appear in the prevalence of SIDS, with Native Americans and Blacks showing the highest rates of SIDS in the United States, followed by non-Hispanic Whites. Asian American and Hispanic infants show lower rates of SIDS than White infants (Parks, Eck Lambert, & Shapiro-Mendoza, 2017). Ethnic differences in SIDS are likely due to differences in socioeconomic and lifestyle factors associated with SIDS, such as lack of prenatal care, low rates of breastfeeding, maternal smoking, and low maternal age. Cultural practices, such as adult-infant bed sharing, providing infants with soft bedding, and placing the sleeping baby in a separate room from caregivers, increase SIDS risk (Colson et al., 2013; Parks et al., 2017; Shapiro-Mendoza et al., 2014). However, ethnic differences in SIDS are complex and influenced by context. For example, in one study of infants, Mexican American U.S.-born mothers had a 50% greater rate of SIDS than infants of Mexican foreign-born mothers after controlling for factors associated with SIDS, including birthweight, maternal age, education, marital status, prenatal care, and socioeconomic status (Collins, Papacek, Schulte, & Drolet, 2001). Differences in acculturation and associated child care practices likely play a role in influencing SIDS risk, but they are not well understood (Parks et al., 2017).

As shown in Figure 19.8, SIDS declined dramatically in the 1990s after the American Academy of Pediatrics, based on data from Europe, Australia, and the United States, recommended that infants be placed for sleep in a nonprone position (i.e., a supine position: on their backs) as a strategy to reduce the risk of SIDS (see Figure 19.6) (American Academy of Pediatrics AAP Task Force on Infant Positioning and SIDS: Positioning and SIDS, 1992). Initiated in 1992, the “Back to Sleep” campaign publicized the importance of nonprone sleeping. Between 1992 and 2001, the SIDS rate declined dramatically in the United States and other countries that implemented nonprone/supine sleeping campaigns (Bajanowski & Vennemann, 2017; Bergman, 2015; R. Y. Moon &
about 16 hours (Peskin, 2017). Fluids may accumulate in the abdomen and extremities, leading to bloating. Psychological symptoms such as anxiety, depression, confusion, the inability to recognize family members, and delirium are common (Enck, 2003).

**Emotional Reactions to Dying**

People tend to show a range of emotional reactions to the knowledge that they are dying. After conducting more than 200 interviews with terminally ill people, psychiatrist Elisabeth Kübler-Ross categorized people’s reactions into five types or ways in which people deal with death: denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969). Although Kübler-Ross described these reactions as a series of stages, not everyone experiences all of them or proceeds through them at the same pace or in the same order (Corr, Nabe, & Corr, 2009; Kübler-Ross, 1974).

Upon learning that one has a terminal illness, the first reaction is likely shock. For most people, denial (“It’s not possible!”) is the first stage of processing death, reflecting the initial reaction to the news. The person may not believe the diagnosis, deny that it is true, and might seek a second or third opinion. Once the dying person realizes that he or she is terminally ill, anger may set in. Dying people might ask themselves, “Why me?” Feeling cheated and robbed out of life, the person may harbor resentment and envy toward family, friends, and caregivers, as it may seem unfair that others live while they must...
die. Anger is a very difficult stage, but with time and effort, most dying people manage and resolve their hostilities. The bargaining stage, like the other stages of dying, is common but not universal. The dying person bargains to find a way out. Perhaps a deal can be struck with God or fate. The dying person might promise to be a better person and help others if only he or she can survive. A parent might attempt to bargain a timetable, such as, “Just let me live to see my daughter give birth.” Eventually, when the person realizes that death cannot be escaped, prolonged, or bargained with, depression is common—especially as the illness becomes more evident because of pain, surgery, or a loss of functioning. Knowing it is the end brings profound sadness. During this stage, the dying person feels great loss and sorrow with the knowledge that, for example, he or she will never return to work or home, that all relationships will end, and that the future is lost. The person may feel guilt over the illness and its consequences for loved ones. Many dying people will tend to withdraw from emotional attachments to all but the few people with whom they have the most meaningful relationships. Sharing their feelings with others can help dying people come to an acceptance of death, the final stage. In this stage, dying people no longer fight death. They accept that death is inevitable, seem at peace, and begin to detach themselves from the world.

Although it is useful to think of these reactions to impending death as stages, a stage view ignores the relevance of context—including relationships, illness, family, and situation (Kastenbaum, 2012). Dying is an individual experience. The dying person has a myriad of emotions and must be allowed to experience and express them to come to terms with his or her grief, complete unfinished business with loved ones, and, ultimately, accept death (Corr & Corr, 2013). It is difficult to predict the psychological state and needs of a dying person as they vary greatly according to factors like age, experience, and the situation (Gavrin & Chapman, 1995). Many dying people experience a sense of calm toward the end, releasing denial, anger, and fear to die in peace (Renz et al., 2018).

### The Experience of One’s Death

Children, adolescents, and adults have very different sets of abilities and experiences that lead them to view the world in ways that are unique to their age group. We have seen that conceptions of death grow in complexity over time. How do children, adolescents, and adults experience their own deaths?

#### The Dying Child

Physicians and parents often find it difficult to talk to children about their prognosis and death (Bates & Kearney, 2015). As a result, children are less likely to develop a clear understanding of their condition and imminent death. Dying children who have been ill for a long time have been observed to show a maturity beyond their years (Leming & Dickinson, 2016). In a hospital setting, it is natural for children to acquire information about their disease during the progression of the illness, although parents and doctors are often unaware that they are doing so (Corr, 2010a). Children’s experiences are an important determinant of how they view the concepts of sickness, more so than age or intellectual ability (Corr, 2010b). A 3- or 4-year-old child who is dying might understand more about impending death than an older child who is well. Likewise, it is experience with the disease and its treatment that advances children’s awareness of dying (Bluebond-Langner, 1989; Cotton & Range, 2010; Hunter & Smith, 2008).

Children with life-threatening diseases tend to show a greater awareness of death than their healthy or chronically ill peers (Jay, Green, Johnson, Caldwell, & Nitschke, 1987; O’Halloran & Altmair, 1996). Anthropologist Myra Bluebond-Langner (1989) observed terminally ill 3- to 9-year-old children and noted that all became aware of the fact that they were dying before death was imminent. They also knew that death was a final and irreversible process, suggesting a mature concept of death. The children she studied showed awareness that they were dying by noting that they were never going back to school or that they would not be around for a birthday or holiday; some frankly said, “I am going to die.” Other researchers observed that not only did children know that they were dying before death was imminent, but many kept that knowledge a secret (Stevens, Rytmeister, Protor, & Bolster, 2010). Just as parents try to protect children, children may keep their knowledge that they are dying from their parents—perhaps in an attempt to protect them from distress.

Pediatricians, social workers, and parents should arrive at a shared understanding of how to approach a terminally ill child’s questions and what type of information is appropriate for the child. Because dying children tend to want to know about their illness and treatment (Bates & Kearney, 2015), experts advise that discussions about death should use concrete terms. Open-ended questions can gauge children’s knowledge, and children’s questions should be answered honestly and directly, in language suited to the child’s developmental level (Slaughter & Griffiths, 2007). Part of the process of discussing the child’s illness is simply being present for him or her. Children who are dying tend to express sadness and fears of loneliness, separation, and abandonment (Judd, 2014; Theunissen et al., 2007). Parents and loved ones are advised to stay with a dying child, reading, singing, holding, and sleeping with him or her.
The Dying Adolescent

Adolescents’ abilities for abstract reasoning translate into more mature conceptions of death, its finality and permanence (Greydanus & Pratt, 2016). However, adolescents’ responses to a terminal illness influence and are influenced by the normative developmental tasks they face. Adolescents tend to feel they have a right to know about their illness and prognosis, consistent with their emerging sense of autonomy (Pousset et al., 2009). The sense of invulnerability that is typical of adolescents can lead some to deny their illness or the need for treatment (Balk, 2009). The side effects of treatment, such as hair loss and weight loss or weight gain, can have devastating consequences for adolescents’ body image, often causing much distress (Bates & Kearney, 2015) or even leading them to shun treatment.

Like patients in other age groups, adolescents who are terminally ill often spend a great deal of time in hospitals or other treatment facilities. Given that peer relationships are critical influences on adolescents’ development and well-being, these lengthy absences can distance adolescents from their friends and make them feel increasingly different from their peers. Adolescents tend to focus on the social implications of their illness, such as their ability to attract a boyfriend or girlfriend, be rejected by peers, or lack independence from parents (Stevens & Dunsmore, 1996). Because of their illness, they may have few opportunities to exercise autonomy or experience independence, leading them to feel anger over what they are missing and their need to be dependent on parents and doctors.

As they begin to become aware of the future and develop a future orientation, dying adolescents may mourn the loss of the future. Many adolescents feel angry and cheated, that life is unjust (Corr, 2013). Given adolescents’ drive for autonomy, it is important that they are informed and involved in planning treatment and decision making (Decker, Phillips, & Haase, 2004; Dunsmore & Quine, 1996; Jacobs et al., 2015). Dying adolescents especially need to live in the present, have the freedom to try out different ways of coping with illness-related challenges, and find meaning and purpose in both their lives and their deaths (Greydanus & Pratt, 2016; Stevens & Dunsmore, 1996).

The Dying Adult

Dying young adults often feel angry and that the world is unfair; they have many developmental tasks that will be unfulfilled. The primary psychosocial task of young adulthood consists of developing relationships, specifically, a sense of intimacy (Erikson, 1959). A terminal illness can pose challenges to satisfying intimacy needs as it is difficult to form close and secure relationships when one is ill and has limited time left to live. Isolation and abandonment are often principal fears of young adults who are dying (Corr & Corr, 2013). Young adults also lose the sense of an unlimited future. Goals, plans, and aspirations are threatened.

Whereas young adults miss out on the future, midlife adults mourn losing the present. They often worry about abandoning family and not having completed their journey. The normative process of taking stock in midlife transitions from planning for the future to putting affairs in order. Midlife adults who are dying have a need to find ways to continue to meet their responsibilities to others, such as children, after they die.

Older adults have a life to look back on. Their developmental task is to come to a sense of integrity after a successful life review (Erikson, 1982). Terminal illness may speed the process, adding stress, so that the elder may find it difficult to do the work involved in life review. Older adults are more likely than their younger counterparts to accept death, feel that it is appropriate, and be free of any sense of unfinished business. Older adults who are dying have a desire to close ties, to make peace with family, and to engage in legacy work, leaving something behind (Leming & Dickinson, 2016).

THINKING IN CONTEXT 16.3

1. Do you think emotional responses to dying follow a stage pattern? Why or why not?
2. Provide examples of how children’s, adolescents’, and adults’ developmental competencies and tasks influence how they experience death.
BEREAVEMENT AND GRIEF

» LO 19.4 Summarize typical grief reactions to the loss of loved ones and the influence of development on bereavement.

The death of a loved one brings on bereavement, a state of loss. It triggers an emotional response known as grief, which includes an array of emotions such as hurt, anger, guilt, and confusion. Mourning refers to culturally patterned ritualistic ways of displaying and expressing bereavement, including special clothing, food, prayers, and gatherings.

One of the first steps in mourning is to organize a funeral or other ritual to mark the occasion of the loved one’s death; such customs are different in various cultures around the world. Mourning rituals such as the Jewish custom of sitting shiva, ceasing usual activity and instead mourning and receiving visitors at home for a week, provides a sense of structure to help the bereaved manage the first days and weeks of bereavement. The process of coping with the loss of a loved one, however, is personal, complicated, and lengthy.

The Grief Process

There are no rules to grieving. People vary in the intensity of their reactions to loss and in the timing of their reactions. People grieve differently, and the same person may react differently to different losses. Some might feel intense but short-lived grief. Other people may find that grief lingers for many months. Sometimes grief may seem to resolve only to resurface periodically and unexpectedly. Grief is experienced and expressed in many ways, in emotions, physical sensations, and behaviors (Kowalski & Bondmass, 2008; Mallon, 2008). Physical responses such as tightness in the chest, feeling out of breath, stomach pains, and weakness are common manifestations of grief. A range of emotions, from anger, anxiety, loneliness, guilt, helplessness, and even relief, occurs. Behaviors such as looking for the person in crowds and familiar places, absentmindedness, sleep problems, avoiding reminders of the deceased, and loss of interest are common.

Grief is an active coping process in which the grieving person must confront the loss and come to terms with its effects on his or her physical world, interpersonal interactions, and sense of self (Buglass, 2010; Trevino et al., 2018). The person in grief must acknowledge his or her emotions, make sense of them, and learn to manage them. Most important, and most difficult, the grieving person must adjust to life without the deceased (Stroebe, Schut, & Boerner, 2010). He or she must adapt to the loss by establishing new patterns of behavior and redefining relationships with family and friends in light of the loss (Leming & Dickinson, 2016). The grieving person must construct a new sense of self that takes into account the loss of the deceased and how that loss has changed everyday life.

It was once believed that effective grieving required loosening emotional ties to the deceased, permitting the grieving person to “work through” the death (Buglass, 2010; Wright & Hogan, 2008). During a period of mourning, the survivor would sever attachments to the deceased and become ready for new relationships and attachments. Instead, in recent decades, theorists have come to view the bereaved person’s continued attachment to the deceased as normative and adaptive in providing a sense of continuity despite loss (Stroebe et al., 2010). Attachment is illustrated in several behaviors common among the bereaved, such as feeling that the deceased is watching over them, keeping the deceased’s possessions, and talking about the deceased to keep their memory alive. Successful adaptation entails moving toward abstract manifestations of attachment, such as thoughts and memories, and away from concrete manifestations, such as possessions (Field, Gal-Oz, & Bonanno, 2003). The deceased remains in mind, however. Grieving appears to involve learning to live with loss, rather than getting over loss.

Models of Grieving

Although people vary in how they experience loss, some theorists suggest phases or stages in grieving that are similar to the stages of emotional adjustment to death posited by Kübler-Ross (1969). People may traverse through several phases of mourning from shock, to intense grieving, to establishing a sense of balance, accommodating the loss into one’s sense of being (Buglass, 2010; Wright & Hogan, 2008). For example, the initial reaction to loss is most often shock, a feeling of being dazed, detached, or stunned by the loss. As the person realizes the magnitude of loss, intense feelings of despair arise. The bereaved person may question his or her sense of self in light of the loss. With persistence, the person begins to find a way of living without the loved one. Life will never be the same, but a “new normal” is created. Phases of mourning are useful in describing common reactions to loss; however, they represent a generalization and perhaps oversimplification of the process (Stroebe, Schut, & Boerner, 2017). The progression through grief is not linear; steps do not always occur in sequence, and there is no universal
timeframe for processing grief (Maciejewski, Zhang, Block, & Prigerson, 2007).

Other theorists view mourning as a set of tasks to accomplish. The bereaved person must accept the reality of the loss, experience the pain of grief, adjust to a life without the deceased, and develop a new life while maintaining an enduring connection to the deceased (Howarth, 2011; Stroebe et al., 2010). Completing the first task, overcoming the initial sense of denial of the reality of the loss, may be especially difficult if the death was sudden or if the deceased lived far away. As the individual accepts the reality, the pain of grief can become overwhelming. Successfully managing this task requires finding ways of experiencing the pain that are not paralyzing and realizing that grief is to be expected. Adjusting to life without the deceased means that the individual must manage the practical details of life, identify the roles that the deceased filled in the relationship and household, and come to terms with the fact that he or she will no longer fill those roles. For example, children require care even after a parent has died; the surviving spouse must adjust to this reality and determine how to fulfill the roles of the deceased partner. Fulfilling these roles can help many bereaved adapt productively by developing new skills and growing (Jozefowski, 1999).

The final task of mourning is to establish a new life that recognizes the enduring connection to the deceased, who will not be forgotten. This is often experienced as particularly challenging because the bereaved may not want to “move on” and may even feel it is disloyal to do so, but successful grieving entails learning how to live life without the physical presence of the deceased (Leming & Dickinson, 2016).

An alternative view of adaptation to loss emphasizes the stresses that accompany grief. According to the dual-process model of grief, bereavement is accompanied by two types of stressors (Stroebe & Schut, 2016). The first is loss oriented and comprises the emotional aspects of grief that accompany the loss of an attachment figure, such as managing emotions and breaking ties to the deceased. Restoration-oriented stressors represent secondary losses; these are the life changes that accompany the death, such as moving to a different residence, social isolation, establishing new roles, and managing practical details, such as paperwork. At any given time, the grieving person may focus on the loss-oriented stressors or the life changes that comprise the restoration-oriented stressors. Healthy adjustment is promoted by alternating focus between the two types. When the person is able, he or she confronts the losses, yet at other times the person may set that task aside to instead consider restoration (Stroebe & Schut, 2010). In this way, the grieving person adaptively copes as he or she is able, gradually moving forward. However, some bereaved individuals experience overload, the feeling that he or she has too much to deal with—whether too many losses, too many stimuli, too many stressors—and this can interfere with the grieving process (Stroebe & Schut, 2016).

Contextual Influences on the Grief Process

No two deaths are experienced in the same way. Deaths are interpreted and grieved differently based on a variety of factors, such as the age of the deceased, the nature of the death, and age of the bereaved. The death of a child or young adult is grieved more intensely and is viewed as more catastrophic than that of an older adult (Jécker, 2011). Younger and older adults judge a 19-year-old victim of a fatal car accident as a more tragic and unjust death than that of a 79-year-old victim (Chasteen & Madey, 2003). The young are grieved more intensely as they are viewed as robbed of the chance to experience significant life events such as falling in love or becoming a parent. They are not able to set and fulfill dreams. Generally, off-time deaths, especially those that occur much before our expectations, are particularly difficult (Moos, 1994).

The nature of the death influences how it is experienced and the grief process. Sudden, unexpected deaths are particularly challenging. Mourners are unprepared, with no support group in place. Many feel intense guilt and the need to assign blame and responsibility for accidental deaths. There is no chance to say goodbye or mend relationships. Anger is a common reaction, especially if the deceased contributed to his or her demise through poor decisions. Traumatic deaths, such as those from natural or manmade disasters, can leave losses that are difficult to make sense of. Feeling that a death is traumatic is associated with increased grief, depression, and loneliness (Tang & Chow, 2017).

When death is the result of a prolonged illness, it is no surprise, yet it is still a source of grief. Some theorists have posited the existence of anticipatory grief, feelings of loss that begin before a death occurs but are not fully realized (Coelho, de Brito, & Barbosa, 2018; Siegel & Weinstein, 2006). People grieve losses as they happen. For example, a spouse of a terminally ill patient might grieve the parenting help or physical intimacy that he or she has already lost and anticipate losing the relationship itself. Each loss generates its own grief reaction and mourning process. Knowing that death is to come permits the dying to make decisions, tie loose ends, and strengthen relationships. Although many people believe that
having the time and opportunity to prepare for loss will be less distressing, research suggests that this is not true (Coelho et al., 2018; Siegel & Weinstein, 2008; Sweeting & Gilhooly, 1990). All deaths are stressful, just in different ways.

Adjusting to the Death of a Loved One

Grieving is influenced by the relationship between the person and the deceased. Much of the literature on bereavement comes from studying those who have lost a spouse.

Losing a Spouse

The term widowhood refers to the status of a person who has lost a spouse through death and has not remarried. About one third of U.S. older adults over the age of 65 are widowed. Women who have lost a spouse (widows) live longer than men (widowers) and are less likely to remarry. Thirty-five percent of women over the age of 65 are widowed, as compared with 11% of men (Administration on Aging, 2014).

Losing a spouse begins one of the most stressful transitions in life. Widows have lost the person closest to them, a source of companionship, support, status, and income. Widowhood poses a challenge of renegotiating a sense of identity in light of the loss of the role of spouse, often the most long-lasting intimate role held in life. The identity development task posed by the loss of a spouse is to construct a sense of self that is separate from the spouse (Cheek, 2010; Naef, Ward, Mahrer-Imhof, & Grande, 2013). As in earlier periods of life, women who have a myriad of roles apart from spouse tend to fare better in adjusting to the death of a spouse than do women who have few roles, predominantly centered around their husbands. After becoming a widow, most older adults live alone, often in the same home. Those who relocate often do so for financial reasons, and they tend to move closer to children and grandchildren.

Perhaps the greatest challenge to adjustment that widows and widowers face is loneliness (Kowalski & Bondmass, 2008). Although widowhood marks the loss of a confidant, older adults often maintain and even increase their social participation following spousal loss (Donnelly & Hinterlong, 2010; Isherwood, King, & Luszcz, 2012). In one study in the Netherlands, older adults experienced increased contact and support, especially from their children and siblings, over the first 2 years of widowhood, but the amount of contact and support began to decrease about 2.5 years after widowhood (Guiaux, van Tilburg, & van Groenou, 2007). Other research showed stability in the level of social support received over the 2 years after the loss of a spouse (Powers, Bisconti, & Bergeman, 2014). A prospective study followed widowed adults over an 18-month period and found that close social relationships tended to remain stable, but widowhood brought both losses and gains in social support, which influenced adaptation (Ha, 2010). Specifically, the quality and continuity of support provided by children influences adaptation to spousal loss. Adults who perceived positive support (such as feeling loved, cared for, and heard) from their children 6 months after the death of their spouse showed few depressive symptoms 18 months later. In contrast, negative support (e.g., feeling that children are too demanding or critical) that remains steady, increases, or is accompanied by declines in positive support over time is associated with anger and symptoms of depression and anxiety (Ha, 2010). Maintaining close relationships with family and friends gives widows a sense of continuity, which aids in adjusting to their loss.

Compared with their functioning prior to the loss of a spouse, bereaved adults show increased levels of depression, anxiety, stress, and more poor performance on cognitive tests measuring attention, processing speed, and memory (Rosnick, Small, & Burton, 2010; Ward, Mathias, & Hitchings, 2007). Grief has physical effects, including effects on the brain (see the Brain and Biological Influences on Development feature). The prevalence of anxiety and depression is especially elevated in the first year after the loss of a spouse, with about 22% of newly widowed individuals meeting the diagnostic criteria for major depression (Onrust & Cuijpers, 2006). Social interaction, and especially helping others, aids in reducing depressive symptoms. Specifically, widowed adults who help others by providing instrumental support show an associated decline in depressive symptoms for 6 to 18 months following spousal loss (Brown, Brown, House,
& Smith, 2008). Depression declines with time (Powers et al., 2014), and men and women typically return to prewidowhood levels of depression within 24 months of being widowed (Sasson & Umberson, 2014).

Widowhood also poses risks to physical health. The increased likelihood for a recently widowed person to die, often called the widowhood effect, is one of the best documented examples of the relationship between social relations and health (Elwert & Christakis, 2008). The widowhood effect has been found among men and women of all ages throughout the world. Widowhood increases survivors' risk of dying from almost all causes but is especially linked with cardiovascular problems.

Grief and the Brain

The experience of grief is often described as stifling, a metaphorical weight dulling one's senses and thought. Grief is associated with a variety of cognitive changes, such as reductions in attention, memory, processing speed, and verbal fluency (Rosnick, Small, & Burton, 2010). In one study, individuals experiencing symptoms of grief showed attentional biases toward words associated with the deceased as compared with other words (Freed, Yanagihara, Hirsch, & Mann, 2009). They also were less able to regulate their attention in response to reminders of the deceased. In addition, the strength of the attentional bias was associated with increased amygdala activity and reduced connectivity between regions of the brain that regulate attention and the amygdala, suggesting less control over their cognitive responses to emotional stimuli.

More serious and persisting grief is known as complicated grief, which includes a set of symptoms such as persistent intense yearning and longing for and disruptive preoccupation with thoughts of the deceased (Shear, Frank, Houck, & Reynolds, 2005). These symptoms are prominent and elevated at 6 months and beyond after the loss. In one study, compared with either normal-grief or no-grief groups, participants with complicated grief performed worse in domains of executive function and information processing speed, and they had a lower total brain volume as measured by structural brain imaging (Saavedra Pérez et al., 2015).

Neurological research suggests that complicated grief is experienced as pain. Bereaved individuals show increased activity in the anterior cingulate and the insula in response to reminders of the deceased. These regions tend to be activated in response to physical and social pain (such as rejection) (O’Connor, 2012). Other research showed that when individuals experiencing complicated grief viewed photos of the deceased, they showed more activity in the nucleus accumbens, an area related to rewards, than did bereaved individuals. For individuals with complicated grief, reminders activate reward circuitry, perhaps making it more likely that the individual will perseverate over the lost loved one, which may interfere with adapting to the loss (O’Connor et al., 2008).

In addition, the stress that accompanies grief may influence cognitive and brain function. Adult neurogenesis has been shown to occur primarily in the hippocampus, an area responsible for learning and memory (Mirescu & Gould, 2006; Schoenfeld & Gould, 2013). The hippocampus is richly endowed with receptors sensitive to glucocorticoids, hormones that are released in response to stress, and glucocorticoids play a role in regulating neurogenesis in adults (Egeland, Zunszain, & Pariante, 2015). In addition to its effects on the hippocampus, stress is thought to influence many neural processes, such as the maintenance of dendrites, neurotransmission, and overall plasticity (Mirescu & Gould, 2006; Schoenfeld & Gould, 2013). The stress that accompanies bereavement influences the emotional experience of grief and has neurological consequences with the potential to impair cognition.

What Do You Think?

1. How might the experience of grief illustrate the lifespan principle that domains of development interact?

2. What might be some implications of this principle for helping bereaved individuals?
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(Losing a spouse poses risks to mental and physical health for both men and women, but men tend to show more health problems, including an increased risk for dementia, and higher rates of mortality (Bennett, Hughes, & Smith, 2005; Gerritsen et al., 2017). Men tend to sustain a high level of depression 6 to 10 years after losing a spouse (Jadhav & Weir, 2017). In addition, widowers of all ages are at higher risk of suicide than their married counterparts (Erlangsen, Jeune, Bille-Brahe, & Vaupel, 2004). Men often rely on their spouses for maintaining relationships with friends and family, managing household tasks, and assistance in coping with stress and managing emotions—and when the wife is no longer present to fulfill these roles, men tend to have difficulty asking for assistance (Lund & Caserta, 2001). Widowers are more likely to remarry than are widows, partly because there are far more single elderly women than men, but also because men have fewer social outlets and sources of support than women (Carr, 2004).

The degree to which a spouse adapts to widowhood is influenced by a variety of factors, such as the circumstances surrounding the spouse’s death and his or her age (McNamara & Rosenwax, 2010). Death of a spouse following a long illness such as cancer or Alzheimer’s disease can evoke complex emotional responses because such illnesses involve drastic physical and mental deterioration and intense demands for caregiving (Rossi Ferrario, Cardillo, Vitario, Balzarini, & Zotti, 2004). In such cases, in addition to loss, the spouse may feel relief from watching a partner slip away and from the pressures of caregiving (Bonanno, Wortman, & Nesse, 2004). The complex intermingling of sorrow and relief may be confusing, and the widowed spouse may feel guilty. Losing a spouse in young or middle adulthood is likely experienced very differently than in old age; however, there is little research on off-time widowhood. Unfulfilled roles, unfinished business, and an unlived life can make adjusting to an early widowhood especially difficult. Younger widowed adults likely have been married fewer years than older widowed adults, and they probably have greater responsibilities for dependent children and jobs. These responsibilities can be stressful, but on the positive side, children and coworkers may provide comfort and emotional support to young widowed adults.

Adults vary in the degree to which they show resilience in the face of a partner’s death. Personal characteristics influence how people manage the transition to widowhood. Those who are outgoing, have high self-esteem, and have a high sense of perceived self-efficacy in managing tasks of daily living tend to fare best (Carr, 2019; Leming & Dickinson, 2016). One study of Australian adults who experienced spousal loss found that although about two thirds showed increased life satisfaction over time, only 19% and 26% of individuals showed resilience with regard to negative affect (e.g., feeling down, worn out, tired, or unable to be cheered) and positive affect (feeling full of life, energetic, peaceful, or happy), respectively (Infurna & Luthar, 2017b). About one third appeared to be resilient in terms of self-reported health and physical functioning. Very few adults showed resilience across all domains, and about 20% were not resilient in any domain, suggesting that losing a spouse may pose lifelong challenges to physical and emotional health (Infurna & Luthar, 2017b).

Losing a Child

The most difficult of deaths to grieve is the loss of a child. It violates the perceived order of natural life and compromises the continuity of the family life cycle. Parenthood is a developmental achievement that provides a sense of purpose and engenders a sense of identity in people (Cao, Mills-Koonce, Wood, & Fine, 2016). For parents, the loss of a child entails the loss of self and the loss of hopes and dreams for the child and the future (Wijngaards-de Meij et al., 2008). Parents grieve what could have been and what did not occur, the life their child did not have. In this way, they lack a sense of closure (Woodgate, 2006).

Research suggests that the age of the child has little effect on the severity of the grief. Parents, especially mothers, often experience severe grief after miscarriages, stillbirths, or the loss of a young infant (Adolfsson, 2011; Avelin, Rådestad, Säflund, Wredling, & Erlandsson, 2013; Robinson, 2014). Parents of neonates and young infants grieve for...
the infant and the lost attachment but also the lack of memories and being robbed of the opportunity to become a parent (Avelin et al., 2013; Cacciatoare, 2010). Parents of children of all ages mourn unfulfilled dreams, unfinished tasks, and the resulting void in the family.

Guilt is a common response to losing a child (Leming & Dickinson, 2016). Parents may question their adequacy in providing care. This is especially true if the death resulted from a preventable accident or when the causes of death are not understood, as in cases of SIDS. Loss of a child is associated with short- and long-term problems in physical health, mental health, and even mortality (Rogers, Floyd, Seltzer, Greenberg, & Hong, 2008; Song, Floyd, Seltzer, Greenberg, & Hong, 2010).

Bereaved parents tend to experience grief over a longer period than other bereaved people, with grief symptoms often lasting throughout the remainder of the parent’s life (Keesee, Currier, & Neimeyer, 2008; Rogers et al., 2008). Parents often have difficulty finding meaning in their loss as the loss of a child is often perceived as “senseless” (Keesee et al., 2008; Wheeler, 2001). Transforming their identity as parent represents a crisis as adults must reshape their sense of purpose, identity, and legacy (De Vries, Lana, & Falck, 1994). Parents typically struggle with this task for years, if not a lifetime. One study of 156 bereaved parents (on average about 6 years after the child’s death) found that only about half found a sense of meaning in the death (Lichtenthal, Currier, Neimeyer, & Keesee, 2010). While about half of bereaved parents might show a reduction in negative affect over time, less than half report high levels of life satisfaction, about one third report good health, and a fifth or less report positive affect and physical functioning (Infurna & Luthar, 2017a).

The loss of a parent influences siblings. They must reevaluate the meaning of family and their roles without the grounding role of their parents. The pattern of sibling relationships over the lifespan tends to intensify, such that good relationships often get better and, without the parent, poor relationships may worsen or disrupt. A parent’s death changes the fabric of family relations.

Bereavement in Childhood and Adolescence

Losing a loved one in childhood or adolescence brings special challenges to the process of mourning. Cognitive and socioemotional development influence how children and adolescents understand, make sense of, and adjust to loss.
Bereavement in Childhood

Like adults, children’s experience of grief is influenced by the deceased’s role in their life. Children’s grief is uniquely affected by their developmental level, including cognitive and socioemotional development, as well as their understanding of the nature of death (Corr, 2010b). Children’s first experience with death is often that of a grandparent. How this affects the child depends on his or her proximity to and contact with the grandparent. Children with close relationships to grandparents, who experience their grandparents as caregivers and sources of unconditional love, are more likely to find death traumatic than are children whose grandparents live far away and with whom they have less contact. Many children find seeing parents and other adults upset distressing, perhaps increasing their sense of loss. However, there are no rules for children’s grief (Leming & Dickinson, 2016).

Bereaved children often experience guilt. Many wonder if they caused the death to happen or if the loved one “went away” because of them. The degree to which children feel and express the fear that the death is somehow their fault varies with development (Wolfelt, 2013). This fear is most commonly and openly expressed by young children who are least able to understand the nature of death, but even older children worry. This is especially true in the case of sudden and accidental deaths. Children also worry about who will take care of them. If they conceptualize death as magic, they may fear that they are in danger. In cases of natural disasters and terror attacks, children may feel worry about threats to themselves and their family. The replay of such disasters on television and in the media may intensify children’s anxiety.

Bereaved children may experience grief for their parent for a longer period of time than do adults as they must grow up with the loss; their developmental milestones are affected, and the death robs them of emotional support from caregivers (Wolfelt, 2013). Many children strive to maintain a connection to the deceased parent by talking to him or her, feeling that the parent is watching them, dreaming of the parent, and holding on to symbolic objects—particular dolls, pictures, or the parent’s possessions.

Bereaved children need support, nurturance, and continuity in their lives. They need accurate information about the death and to have their fears addressed. Children want to know that they will be cared for. Adults should reassure children that they are not to blame, as well as provide support and listen (Corr & Corr, 2013). Children, especially younger children, will often require help in understanding and managing their conflicting emotions. Engaging in routine activities can help children gain a sense of normalcy despite all of the changes (Stokes, 2009).

Bereavement in Adolescence

Adolescents’ advancing cognitive abilities and their emerging sense of self influence how they grieve (Christ, Siegel, & Christ, 2002). Adolescents who lose a parent tend to feel intense loss, isolation, and the sense that the parent is irreplaceable and that loss cannot be overcome (Tyson-Rawson, 1996). Adolescents may be plagued by a strong sense that life is unfair. They are at risk to suffer social and interpersonal difficulties in adjustment, including internalizing symptoms such as anxiety and depression (Stikkelbroek, Boddem, Reitz, Vollebergh, & van Baar, 2016), yet often show a strong desire for others to include them and take interest in them (Mes vot & Leitner, 1992). Many feel a strong presence of the deceased in dreams and in daily life, which can offer a sense of comfort and support (Mes vot & Leitner, 1992).

Adolescents tend to have mature conceptions about death, but their experience of grief is often influenced by their ability to understand and manage their emotions as well as their experience of egocentric thought. The existence of the personal fable may lead them to view their grief as unique and incomprehensible—that others could not understand and certainly do not feel the way they do. Mourning adolescents commonly display intense emotional outbursts that are brief but cyclical, punctuated by periods during which they resume normal activity (Christ et al., 2002; Noppe & Noppe, 2004). Alternatively, some adolescents may suppress their emotions altogether, out of fear of a loss of control (Robin & Omar, 2014). Adolescents may retreat into themselves, reading and listening to music, or they may act out, engaging in risky behaviors. With each developmental shift, adolescents must reinterpret the death in light of their new cognitive and emotional understanding (D. A. Brent, Melhem, Masten, Porta, & Payne, 2012).

The tasks of grieving intertwine and potentially interfere with the normative developmental tasks of adolescence, such as developing a sense of emotional autonomy as well as intimate relationships with friends (Robin & Omar, 2014). Adolescents who were concerned with establishing a sense of emotional autonomy prior to the parent’s death may feel intense guilt. The grieving adolescent may find it challenging to develop a sense of autonomy while maintaining connection to the deceased parent, resulting in distress and often guilt. Grieving adolescents may...
feel that they are different from peers, and this “different” perception may impair their feelings of peer acceptance. They may also worry about how to act while grieving. Young adolescents who are concerned with peer acceptance may be reluctant to share their grief with friends, whereas middle and older adolescents who have formed intimate relationships with peers may find that support from friends can help them work through their pain (Dopp & Cain, 2012). However, if their friends do not understand their pain or are rejecting, the adolescent may be devastated and grieve not only the loss of the parent but of his or her friends too (Gray, 1989).

Bereaved adolescents need adults who are open to discussing whatever they would like to explore and who are careful listeners. Grieving adolescents commonly worry that they will forget the person they have lost (Robin & Omar, 2014). Adults should attend to the feelings that underlie what the adolescent is saying and help the adolescent to understand that their feelings are important, real, and normal. Adults can help them to find ways to remember the deceased and make meaningful connections that retain their attachment with the deceased loved one.

Death and loss are not easy topics to consider. We have seen that, regardless of age, both dying and grieving people have some common needs. All need to move past denial and accept the death, whether upcoming or having passed. Both the dying and grieving require help managing their emotional reactions to loss, including common physical reactions, such as stomachaches, headaches, and lethargy. People of all ages have a need to express their reactions to the loss and may need help identifying and articulating their reactions that may feel very strange and unfamiliar to them. Finally, the dying and the bereaved need to make some sense of the loss. The dying must connect to their loved ones and accept the loss. The bereaved, in turn, must find a way to maintain the connection to the deceased while moving on in their life, recognizing that in some ways, they will never be the same.

**THINKING IN CONTEXT 19.4**

1. Identify factors within the person and context that may influence the degree and duration of grief. Explain these influences.
2. From your perspective, is the process of adjusting to the death of a loved one continuous or discontinuous? (Review these terms in Chapter 1.)
3. Much of what we know about bereavement comes from studying people who have lost a spouse. From your perspective, what are some of the challenges in extending conclusions regarding widowhood to other forms of loss?

**APPLY YOUR KNOWLEDGE**

Lying in bed, 88-year-old Margaret wakes and takes in her surroundings. Her daughter and granddaughter are in the room, one reading a magazine and the other reading her phone. Margaret is fortunate to have a private room in her nursing home, where she has been living since she suffered a stroke. Life here is better than she expected. Her daughter urges her to eat, but she finds that she isn’t very hungry anymore. Margaret feels lucky to have family who live nearby and visit very often. Margaret’s children notice a change in their mother. She seems less sharp and each day seems a little bit more confused. She’s often too tired to talk and drifts in and out of sleep.

With time, Margaret sleeps nearly all of the time. In addition to her stroke-related impairments, she has congestive heart failure, which is not responding to treatment. A few days before her 89th birthday, the doctors tell Margaret’s daughter that the time is near. Margaret’s children and grandchildren gather in her room, waiting. They talk about old times and everyday life. Margaret is largely unconscious but now and then she calls out, moans, or talks to herself, reaching her arms out in front of her. As time goes on, her breathing becomes more labored and heavy with occasional gasps. Margaret’s children watch carefully and wait, attempting to talk with one another and retain a sense of normalcy. Finally, the room is quiet. Margaret’s children know that she is gone. After 88 years and surrounded by family, Margaret has died.

1. What type of death trajectory does Margaret show? Explain your reasoning.
2. How might Margaret’s 6-year-old grandchild understand her death? What might a child’s grieving look like?
3. What would you expect from a 16-year-old grandchild?
4. How might children and adolescents’ responses differ when considering a parent’s death?
5. How might the adult child grieve for a parent?
19.1 Identify ways in which death has been defined and end-of-life issues that may arise.

Clinical death occurs when the heart stops beating. Advances in medicine have led to a definition of death as entailing whole brain death. Cortical death, but survival of the brainstem, is known as a persistent vegetative state. Advance directives, including a living will and durable power of attorney, permit individuals to make their wishes regarding end-of-life care known. Euthanasia refers to the practice of assisting terminally ill people in dying naturally. Physician-assisted suicide occurs when terminally ill patients make the conscious decision that they want their life to end and seek assistance from a physician.

### Key Terms
- Clinical death
- Whole brain death
- Persistent vegetative state (PVS)
- Dying with dignity
- Living will
- Durable power of attorney
- Advance directive
- Euthanasia
- Passive euthanasia
- Active euthanasia
- Physician-assisted suicide
- Hospice
- Palliative care

### In Review
- What are three ways of defining death?
- What is a persistent vegetative state?
- What is dying with dignity?
- What are ways of controlling one’s end-of-life care?

19.2 Contrast children’s, adolescents’, and adults’ understanding of death.

Young children tend to view death as temporary and reversible. Children's understanding of death gradually emerges alongside cognitive development. Most adolescents evidence a mature conception of death as the inevitable and irreversible end of biological processes, yet they often have difficulty appreciating it as an inevitability for themselves. Adolescents and adults across cultures often share a belief in an afterlife, whether religious or supernatural in origin. Conceptions of death change in subtle ways over the course of adulthood. Young adults begin to apply their mature understanding of death to themselves, acknowledging their own vulnerability. The awareness of death can cause midlife adults to reevaluate their priorities, often leading them to pursue a sense of generativity. Older adults experience less anxiety about death than younger adults.

### Key Terms
- Noncorporeal continuation

### In Review
- What are four components of a mature understanding of death?
- How do children and adolescents’ understanding of death reflect their cognitive development?
- How does the conception of death change over adulthood?

19.3 Discuss the physical and emotional process of dying as it is experienced over the lifespan.

People tend to show a range of emotional reactions to the knowledge that they are dying, including denial, anger, bargaining, depression, and acceptance. Although described as stages, not everyone experiences all of them or proceeds through them at the same pace or in the same order. Children who are dying tend to express fears of loneliness, separation, and abandonment. Adolescents’ sense of invulnerability can lead some to deny their illness or the need for treatment. Dying adolescents mourn the future and have a need to live in the present and to be involved in planning treatment and decision making. Young adults often feel angry and that the world is unfair. Midlife adults tend to mourn losing the present, abandoning family. Dying midlife adults have a need to find ways to continue to meet their responsibilities to others after death. Older adults talk more about death, think about it more, have more experience with it, and are more likely to accept death and feel that it is appropriate.

### Key Terms
- Dying trajectory

### In Review
- What is the dying trajectory?
- What are physiological and emotional processes associated with dying?
- How do the concerns and needs of dying individuals differ with development?
Some theorists suggest phases or stages in grieving that are similar to the stages of emotional adjustment to death. Other theorists view mourning as a set of tasks to accomplish. According to the dual-process model, bereavement is accompanied by loss-oriented stressors and restoration-oriented stressors. Healthy adjustment is promoted by alternating focus between the two types of stressors. Bereavement is associated with increased levels of depression, anxiety, stress, and poor performance on cognitive tests and poor health. Bereaved parents often experience grief symptoms throughout their lives and often have difficulty finding meaning in their loss. Children’s grief is uniquely affected by their cognitive and socioemotional development, as well as their understanding of the nature of death. Adolescents tend to have mature conceptions about death, but their experience of grief is often influenced by their ability to understand and manage their emotions, their experience of egocentric thought, and their emerging sense of self.

Define bereavement, grief, and mourning.

What is the dual-process model of grief?

What are contextual influences on the grief process?

How does the relationship of the person to the deceased influence the grief process?

What developmental factors influence children’s and adolescents’ grief process?