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Theories of Death and Dying

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Death is a state of the total disappearance of life. Dying is a process of decay of the vital system, which ends with clinical death. In modern medicine, the flat line in the record of electroencephalography (EEG) or lack of brain function is most commonly considered as a criterion of death. Death is an irreversible cessation of the functions of organs that are necessary for life.

Until the end of the nineteenth century, the issue of death and dying was the area of interest, first and foremost of the philosophy, religion, and medicine. Among the pioneers of research on death and dying in the social sciences were psychoanalyst Sigmund Freud (1915) and sociologist Emile Durkheim (1952). The primary wave of scientific interest in the nonmedical aspects of death, however, only occurred in the 1960s with publications and research on the social reaction to death and on the interactions of dying people with the environment.

Currently, there are a few approaches to research on death and dying: a clinical, a humanistic, a psychological, an anthropological, and a sociological perspective (Copp 1998; Bryant and Peck 2009).

The clinical approach focuses on caring for a dying patient. This perspective includes elements such as the patient-clinician relationship, negotiation with the caregiver team, and the establishment of a plan. These steps have various effects on the clinician's activity (Cassell 2004).

The humanistic orientation includes at least three different concepts of death: essentialism, existentialism, and culturalism (Pihlstrom 2007). Death also has its prominent place in the philosophical concepts and theories. There is even the traditional view that philosophizing is thinking and meditation on death, because death is a reference point for discussion of the most important questions about the meaning of life. The philosophical perspective focuses on topics such as the definition of death, questions about immortality, the harm of death, and moral and ethical issues (Feldman 1992).

In the history of philosophical thought, death was perceived in various ways. It was disregarded, for example, by the Epicureans, who proved that "if there is death then I do not

exist" and "if I am living, then the death does not exist." Thus, it cannot be so experienced, and this means that there is nothing to worry about for humans. Similarly, Socrates saw no point in fear of death, since the death of the body is not important when there is a soul, and it will be released at the time of the death of the body. Death was also treated very seriously; for example, Plato concluded that philosophizing was simply a preparation for dying and death.

Centuries later, Descartes, as the father of modern philosophy in the seventeenth century, introduced the concept of substance. He saw death only as of the end of carnality, while after the death of the body the human remains a thinking substance. A continuation of this vision was described by Spinoza. He emphasized that wisdom should be seen in reflections about life, not about death.

The existentialists in the twentieth century understood the meaning of death in a similar fashion. For them, awareness of mortality was the basis for a full life that should be an important topic to think about for everyone. The existentialists, by rejecting the objectivity, emphasize the value of the individual. Soren Kierkegaard (1989), one of the most influential representatives of existential philosophy, believed that people moving away from their own "I" are falling into despair. He divided despair into two forms. The first is the despair of infinity, otherwise known as fantasy. People flee into a world of fantasy by an escape from reality and their existence, which leads them to delve into the imaginary life. The second type of despair is the despair of finitude. The real world scares people, which leads them to plunge into the real world and to become a cog in the existing world. Very few people have the ability to choose at the right moment the appropriate and the most important purpose in life, and even at the risk of losing other purposes, they can seek to achieve this single and most important goal. According to Kierkegaard, the most important objective can be only God.

Modern philosophers such as Vladimir Jankelevitch (1966) also analyzed the issue of death. For Jankelevitch, death is a necessary and irreversible process while life is suspended between nothingness before life and nothingness afterlife. Death exists in life and gives meaning to life. If there were no death, then there would be no life. Awareness of the finiteness of life gives meaning to life as a challenge and task. Meanwhile, mortality is that condition with which everyone must be reconciled because it is a natural state of affairs.

Death and dying from the anthropological perspective was analyzed by evolutionists, the French sociological school, the British functionalist school, and, as a part of the model of the rites of passage, by Arnold van Gennep (Green 2008). The psychological perspective focuses on the discussion of the meaning of death; individual and social responses to death; individual

differences in responses to loss; contextual influences on grief and bereavement; as well as developmental aspects of death at the different stages of the life course (children, adolescents, adulthood, and later life) (Corr, Nabe, and Corr 2009).

The sociological focus on death and dying includes various concepts and topics. Among others, these are death as a measure of life; differences between societies and their views of death; death as a mechanism of social control; institutional influences on cultural death systems; memorialization, collective immortality, and symbolic immortality; the social status and experiences of those who die or are dying; the stigma associated with dealing with death; grief, bereavement, and the social status of those who survive; and legacy work (Parsons 1963; Glaser and Strauss 1965; Stephenson 1985; Kearl 1989).

In 1969, Elisabeth Kubler-Ross published *On Death and Dying*, which became a milestone in contemporary psychological thanatology and psycho-oncology. This work marked the beginning of a public discussion about dying and death and led to consideration of support for dying people and their families. The most significant achievement of the author was the creation of an original concept of stages of dying, which outlines the sick person's attitude toward death. The multiplicity of stages of dying reflects the emotional state of the patient. Emotional experiences are crucial in determining the present phase.

The first stage of dying, according to Kubler-Ross, is denial (1969). The patient is trying to find an excuse to undermine the credibility of information about the incurable disease, looking for an escape in isolation; one is convinced that the disease cannot affect one. However, the sick person often makes the manifestation of attitudes only when there are other people with whom they establish contact and adapt them to their expectations. A person simulates well-being in front of those who do not accept the condition and opens up interaction with those who accept the condition.

The second stage is anger. The patient is characterized by ambivalence, anger, rage, and resentment. The victims of anger are bystanders, especially medical personnel, but also family and loved ones. The patient treats them indifferently, without joy, and with irritability, and sometimes provokes conflicts and creates difficulties for carers.

The third stage is bargaining. The patient is aware of their state of health and the seriousness of the situation and tries to bargain with God. For the prolongation of life, the person confronting death at this stage offers a change of attitude and behavior, for example, dedication to the Church or civic activity to postpone the death.

The fourth stage is depression. The long-term illness is associated with the loss of strength,

beauty, and self-service capabilities, which causes depression. This condition deepens with the awareness that the death is getting closer, which results in denial, anger, and bargaining to the final acceptance of the death. The patient focuses on what will happen rather than on the past.

The last and final stage is acceptance. The patient does not show jealousy toward the living and healthy any longer, and accepts their fate. They wonder about impending death with quiet anticipation. At this stage, the patient may grieve over the loss of loved ones, want only their presence, even where meetings are often limited to silence. The patient needs to be aware of the presence of another human being.

Another concept about dying by E. Mansell Pattison (1977) is based on the intensity of the anxiety induced by the awareness of impending death. Phases described by the Pattison paradigm do not specify the typical behavior of the patient. They are individualized, like emotions. The dynamics of anxiety are dependent mainly on the potential proximity of death, a sense of the time remaining, which regulates taking of appropriate mechanisms to mitigate the fear of death.

However, Pattison argues that we can distinguish individual phases of dying based on a criterion of an anxiety curve and its course. The first stage, called the acute phase of the crisis, is initiated by the realization of the inevitability of approaching death. The consequence is an initial increase in anxiety, which, at an individual level, begins to decrease gradually depending on the effectiveness of defense mechanisms. The chronic life-death phase is the time to adapt to the changing conditions of life that are a consequence of the physical transformation of the body and lead to some restrictions and dependence on third parties. The patient is excluded from the further activity. This phase is characterized by intensive medical therapy that brings both hope and despair. Medical interventions that are supporting or lifesaving are gradually reduced with the approach of the moment of death. The terminal phase is mainly characterized by accepting death, a current state, and the irreversibility of the situation. This stage is the time of further isolation from the environment. The patient turns away from the outside world. The patient is mentally and physically absent from others, delves into their inner world.

A different approach to the phases of dying was presented by Avery D. Weisman (1984). This psychiatrist identified three stages of confrontation with the impending death of the terminally ill person. All phases are characterized by the simultaneous denial and acceptance of death. The first phase is the emergence of the first alarming symptoms indicative of the seriousness of the situation, even though the diagnosis is not yet known. The patient is prone to self-deception to restrict access to thinking about death. In the second phase, the diagnosis is

already clear, and the patient is subjected to the intensive medical therapy. The next stage is characterized by the apparent decline of the body and deepening exhaustion of the patient, whose attitude is moving towards acceptance of death.

Gerhard Riemann and Fritz Schutze (1991) proposed the so-called biographical trajectory in which they identified six sequences. The first sequence is called the buildup of trajectory potential. In fact, it is difficult to determine the start of this phase. It occurs when a person sees signs of the oppressive conditions of life. There is a confrontation with information on health status, feelings of the patient, and, at the same time, with the frequent denial of the situation. The people surrounding the sick person often deny the actual state of health, and the patient is trying to find out the truth. The patient is suspicious, analyzes all the received information about the health status, even scraps of sentences and communications, to reach the truth. This desire to come to the truth may be, however, only a game and the desire to ensure that one is healthy.

The second stage is crossing the border with an intention to a conditional state of mind. It is a phase in which one realizes the hopeless situation and enters a state of apathy. At this stage, the patient's conversation concentrates on issues of little importance. Addressing the expeditious matters is a form of moving away from a fundamental concern about health.

The third step, referred to as the precarious new balance of everyday life, is characterized by a simplistic view of the world. Anger, helplessness, and resentment may occur here. The fourth stage is the breakdown of self-orientation, in other words, it is the loss of control over oneself and the environment. One feels alienated, loses control of oneself and the environment, while other people become strangers.

The fifth phase involves attempts to coming to terms with the trajectory. This stage is lived in the full consciousness of the patient. In the end, there is a sixth stage referred to as a practical work upon or escaping from the trajectory. It may be time to seek the meaning of life. It may also take the form of escape from the present life situation.

The theory of crisis by Gerald Caplan (1964), assumes that one is experiencing a developmental and situational crisis. The latter arises due to the occurrence of traumatic circumstances. Consequently, problems with coping with traumatic situations lead to social, psychological, and physical disintegration. The theory of crisis allows for interpretations of the status of people experiencing such proximity to death, for example, the terminally ill. The foundation of this theory is the imbalance between the ensuing problems and the available means to solve them. Near to the actual death tension, frustration, hopelessness, internal integration, discouragement, and resignation are inevitable. The crisis forces the dying patient to

develop a new directory of behavior that will contribute to tackling the key problem.

According to Caplan, experiencing the crisis can take place at four levels. At the first stage, one can deal with the crisis, using one's familiar mechanisms. The second level occurs when the fixed patterns do not lead to the desired effect, and the patient has a sense of impossibility. Then he or she builds new mechanisms, but if the strength of the perceived crisis is not falling under the influence of new interactions in the next stage, then the patient is mobilizing all possible resources, including external resources, to stave off the crisis and preserve personal integrity. The last level occurs when the target is not achieved despite all efforts, following the disintegration of personality.

Nowadays, a terror management theory (TMT) is considered to be the most comprehensive approach to describe death and dying. TMT was developed by the researchers Jeff Greenberg, Sheldon Solomon, and Tom Pyszczynski (Solomon, Greenberg, and Pyszczynski 1991; Greenberg, Koole, and Pyszczynski 2004) and refers to the existential ground of human life. Basic compounds of this theory are relations between mortality experience with the fear of death and the formation of defensive mechanisms to mitigate such a fear.

To understand the assumptions of TMT, it is important to clarify the concepts that are used by the authors in this research field: (1) mortality salience, that is, situations in which a person experiences thoughts of death, dying, and fragility of life; (2) worldview, that is, a set of beliefs, statements, values, and norms with which one identifies and the views, beliefs, cultural frameworks, collective system of meanings, accepted standards, value systems, and religious systems; and (3) self-esteem as an anxiety buffer, which is a mechanism that allows one to master the fear of death and to mitigate its potential effects.

Awareness of the inevitability of death influences everybody with a permanent concern, anguish, or the terror of death. It is so intense that it affects the psychological processes and social behavior of the individual. It is a state of paralysis, which can reduce the adaptation possibilities. A TMT involves the relationship between "animal" survival instincts coupled with a unique, only human attribute of mind capable of realizing the end of life. Uncontrollable fear can lead to negative consequences of reflection on mortality for the individual and community. Therefore, one is equipped with protective mechanisms aimed at mastering the destructive fear. For example, the ability to absorb the thoughts of death. For some people, to forget the fragility of life can become a stimulant that in a crisis offers a particular kind of distortion of reality so that at the expense of health, one can survive the suffering associated with awareness of one's mortality. According to TMT, people can also deny their fragility by taking care of their health

and fitness using appropriate diets and self-caring behavior that may guarantee a long and healthy life. A simple way may also be to avoid situations that make one reflect on mortality, but it is impossible to get rid of everyday existential stimulants, especially during late adulthood.

According to TMT, stimulating of "psychological substitutes" such as fear and mental disorders is an effect of a weak coping with thoughts about death. The goal of substitutes is to remove thoughts about one's death from the spotlight and to replace them with another. These mechanisms redirect the fear of death, before the occurrence of this unknown, tragic, unique, unexplored, and mysterious event. Thus, fear becomes something that may be controlled in some way. For example, fear of mice is not as dramatic and significant as the fear of death, and the object of fear is clearly defined.

However, according to TMT, the most important strategies and buffers to mitigate the fear of death are measured to increase self-esteem and to appeal to patterns existing in a given culture. The internalized cultural pattern has an effect on the structuring of the personality of the individual and its function in society. The standards of a particular worldview are the basis for calming anxiety and a guarantee of security because the activity according to the cultural standards ensures symbolic immortality. Religions provide the promise of immortality, for example, through eternal life in another world without death. Therefore, there is a need for convergence of the existence of particular moral systems, symbolic constructions, and cultural standards of the self that present the person as valuable by conformity with a worldview. This symbolic immortality gives the consciousness of leaving a younger generation, valuables, intellectual heritage, cultural heritage, art, and all these elements of culture that allow one to survive and develop. Thus, an immortal particle of oneself will remain in later generations, in buildings, works of art, collected material possessions, and memories.

TMT suggests that individuals in situations of displaying their mortality show a greater endorsement and a stronger relationship with their worldview and those who share it, as well as an intensified reluctance to other competing ways of seeing the world. This behavior occurs because representatives of competing worldviews are perceived as a threat to one's worldview, which is at the same time a buffer to protect one against the threat of death. A strong feeling of mortality activates a mechanism for reducing the fear of death. These mechanisms mobilize the system of representing moral or religious beliefs and creates a buffer calming any fear of death by ensuring that one will meet the prime need, which is a sense of self-worth in the standards of a particular culture. It should be noted that when there is a high opinion of oneself at the

moment of clarity before death, there is no need to identify with the environment.

The second defensive strategy, according to TMT, is the concentration on maintaining or increasing self-esteem. This strategy does not require an accurate self-assessment, but simply a high self-esteem. People, by engaging in activities for their worldview, at the same time strengthen their self-esteem and protect this feeling. Moreover, a high level of self-esteem is a measure in the fight against the fear of death, which reduces the impact of thoughts of death. People with high self-esteem are less sensitive to signals about death. High self-esteem is seen even as a substitute for immortality.

Interpreters of TMT also show other mechanisms to mitigate the fear of death (Mikulincer, Florian, and Hirschberger 2003). In the case of older people, social contact is of particular importance. The consequence of exposing death is the motivation for closer ties with individuals who have the same worldview. Thanks to this motivation, one has a sense of belonging and an increased sense of security. Relationships with loved ones can be an important mechanism for protection against existential anxiety.

The diverse concepts and theories described here do not exhaust the many ways that scholars in different disciplines study death and dying. They only briefly introduce the range of interests and perspectives. Future research may focus on the integration of these diverse perspectives, attitudes to death and dying in the life-course perspective, and social and cultural diversity in end-of-life care.

SEE ALSO: Abortion; Bioethics; Body, Sociology of; Durkheim, Emile; Eugenics; Freud, Sigmund; Gerontology; Sartre, Jean-Paul; Social Psychology and Health

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