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Contents

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Conceived as a vehicle for the publication of scholarly works germane to funeral service, the **Journal** welcomes authors with interests in any facet of funeral service: scientific, psychological, ethical, legal, or managerial.

Ideally, this publication will grow to serve the needs of funeral service education by facilitating the dissemination of original works of research as well as by serving as a forum for commentary, summation, debate, or other forms of academic exchange.

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Death Coping, Work Stress and Empathy: Examining the Interrelationship in the Funeral Director Population

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Introduction

Each of us will someday die. When someone dies in the United States they ordinarily use the services of a funeral director (FD). Someone left behind will usually make funeral arrangements or implement a pre-panned funeral. It would be comforting to know that the professional that assists with the funeral process is unhindered by their fear of death or lack of death coping ability. The purpose of this paper is to understand three of the major variables that could hinder the FD. The relationships between death coping, work stress and empathy in FD's will be examined. Since these variables, especially among FD's, are not reported in current literature, it is necessary to review them in other populations.

FD's encounter death daily. Still, it remains unclear whether this constant exposure to death causes changes in death coping attitudes, or its inverse death anxiety. There is no literature available on this topic in FD's. However, in the medical school population current studies indicate that death coping attitudes are stable and that direct intervention (i.e., medical school) does not change this attitude.

Thornson and Powell (1991, p. 32) found that death anxiety scores did not change for medical students from first to last year of medical school. Using a cross-sequential design, they found that medical school freshmen and seniors had lower death anxiety scores than other graduate students (p. 34). There was no statistical difference between medical school freshmen and seniors.

Using a within subjects pre/post design with medical school being the intervention, Powell, Thornson and Uhl (1990, p.341) found that death anxiety scores were stable across time. They surveyed three consecutive classes of medical school students during their first and senior year comparing death anxiety scores within these groups (p. 340). They found death anxiety scores undifferentiated between groups with no statistical difference.

The work of Thornson, Powell and Uhl indicates that death anxiety and death coping attitudes are stable, at least when the four years of medical school is viewed as the major intervention. That may be true in a population taught to deny death's very existence, but how does prolonged daily exposure and interaction with death effect someone? Can individuals, such as FD's, forced to face death everyday have the same death anxiety attitude stability? In such a population the primary question becomes: does constant exposure to death change anxiety levels?

The published literature indicates that in some populations death anxiety levels are stable but it also tells us that death anxiety correlates to psychological adjustment/maladjustment (White, 1990, p.13). It is these adjustment issues that can cause interaction problems. White found that the high death anxiety group was significantly more distressed and significantly less satisfied with life than the low death anxiety group (p.21). Presumably an individual that is distressed or less satisfied with life would have difficulty empathizing with others facing or suffering from life crisis.

Shultz and Aderman (1979, pp. 327-332) studied the correlation between death anxiety and patient outcomes among physicians. They phone inter-

viewed twenty-four physicians working in a community hospital. During this interview they asked doctors to rate five death anxiety items anchored at -3 as strong disagreement and +3 as strong agreement. A composite death anxiety score was computed for each subject. Unknown to the subjects hospital records were obtained for each of them[1]. These records were individually tabulated for their patients, as follows: 1) total number of patients that died in their care, 2) average length of terminal patient stay in the hospital, and 3) average length of stay for non-dying patients.

Schultz and Aderman (1979, p.331) found that patients of physicians with high death anxiety were in the hospital an average of five days more, before dying, than patients of moderate or low death anxiety. It is possible that high death anxiety doctors admit patients sooner or that they take more heroic measures. In any event their behavior is substantially different from moderate and low death anxiety doctors, without a significantly lower death rate. More currently, a study by Desplender and Lee (1992, p. 138) indicated that when a person is in the terminal stages nurses may spend more time with them [due to the level of care necessary], but display more verbal and non-verbal avoidance.

The change in behavior seen when a medical practitioner encounters death indicates that death is uncomfortable to them. Clearly, death anxiety is correlated with a change in behavior. This behavioral change highlights the importance of examining death coping in FD's. FD's are forced to face death, in a concrete way; it is inescapable for them. Notwithstanding the literature indi-

[1]This study made no mention of informed consent to the doctors regarding access to their patient's medical records. This represents an ethical dilemma as the doctors were not informed that their scores on the death anxiety instrument would be correlated to actual patient morbidity and mortality.

cating that death coping attitudes are stable over time (in the medical student population) it is hypothesized that the direct exposure to death experienced by FD's will yield a change in death coping attitudes. There is no empirical data on death coping vis-à-vis FD's. The above hypothesis is by anecdotal data on FD's and inference from the experience of the author.

Empathy is another variable that was not found the be reported in the FD population. Empathy is defined as the ability to sense another's experience as if it were your own without losing the "as if" [emotional separation] quality (Rodgers, 1975). While empathy research has not been reported in the FD population, it has in many other venues. Empathy has been shown to be statistically associated with burnout (Corcoran, 1989, pp. 141-144) in the social worker population. Yet, when the statistical effect of emotional separation was removed from empathy, there was no association. It was the loss of emotional separation, defined as loosing the "as if" quality of empathy, that was correlated with burnout.

The correlation between burnout and a loss of emotional separation was reported in a study by Corcoran (1989). He mailed surveys to one hundred and fifty social workers from a large southwest urban area. Empathy was scored on a seven-item scale and burnout was defined by scores on an emotional fatigue scale. The findings of this study indicate that empathy, per se, may not facilitate burnout so much as the loss of emotional separation. It is the loss of separation that causes emotional involvement which leads to the loss of objectivity and to exacerbation of burnout.

In funeral service it is necessary to be able to sense the client's experience while staying emotionally separate. This allows the FD to avoid burnout and be more effective. Thus, empathy and its component emotional separation have been included in this study. Their overt correlation to burnout, and its antecedent work stressors leads to the final variable, work stress.

Work stress is a multidimensional construct consisting of the antecedent stressors work load, time pressure, perceived control, role conflict and role ambiguity (Kevin Williams, University at Albany). Work stress, its antecedent stressors and their effect on empathy will be studied. Current literature suggests that burnout among helping professionals can lead to the loss of the "as if" quality of empathy (Corcoran, 1989, p.143). The loss of objectivity can lead to dangerous emotional involvement with clients and ineffectiveness.

The studies reviewed above leads to the following hypotheses: 1) as current literature (Thornson & Powell, 1991, p. 34) states, death coping is stable over the short term (i.e., 4 years of medical school), but is strongly correlated with age (older individuals have better death coping ability); it is hypothesized that death coping and death anxiety will change over time as evidenced by an ANOVA of practicing FD's, control students and mortuary science students (MSS) with FD's having lower death coping scores, 2) due to direct, unavoidable, contact with death and significant work stress, FD's will show lower empathy scores than funeral service students and control subjects, and 3) death coping, work stress, and empathy are strongly related such that as work stress increases death coping and empathy decrease.

The significance of this research is that a strong link between work stress, empathy and death coping could hinder the optimal functioning of a FD in their duties to the bereaved. Upon finding a significant correlation, supportive services such as continuing education or counseling would be indicated to potentially offset the negative effect to empathy and death coping.

Methods

This study utilized a cross-sectional three group design with the measuring instrument being a multi-part survey. The significant difference between groups was the amount of direct exposure to death encountered by individuals within the groups. The groups were: 1)practicing FD's, 2)MSS's, and 3) a control group of English composition students. The following scales were used in this study: (1) Bugen Coping With Death (BCD) scale (Robbins, 1991, 287), see Appendix A, (2) Hoelter Multi-Dimensional Fear of Death (MDFD) scale (Long, 1985, pp. 48-49), see Appendix B, (3) impression management scale (Turrisi, 1993), see Appendix A and (4) work stress (some items selected from Cook, others created) (Cook, 1981, pp. 202-203), see Appendix C. The following scales were created by the author: 1) a demographic data collection sheet, see Appendix D and 2) the balance of the work stress items, see Appendix C.

The demographic information collection sheet was designed specifically for this study. This instrument's purpose is to gather basic demographic information for inter-group comparison. It requests age, sex, education, subjective assessment of exposure to death, and subjective assessment of death coping ability. The subjective assessments allow for correlation to objective measures (BCD, MDFD) and an examination of disparate attitudes. The demographic scale was administered to all subjects.

The BCD and the MDFD were selected due to their face validity and reliability. These scales were judged as the best available measure of the desired attitudes. After reviewing three scales, the Templer Death Anxiety Scale (Templer, 1970) was set aside in favor of the BCD and the MDFD. The selected scales allowed for a multi-dimensional analysis of the fear of death, death coping and empathy. The BCD is internally consistent yielding a Cronbach's Alpha of .89 ($p<.001$) (Robbins, 1991, p. 291), stable over time (p. 296), and has convergent validity with both the Templer and Collett-Lester scales ($r = -.49$ to $r=-.60$) (p. 292). The BCD and MDFD were administered to all subjects.

The work stress scale was included to evaluate the level of stress among FD's. This scale is a combination of role ambiguity and role conflict items from pre-existing stress scales (Cook, 1981, pp. 200-203), and a synthesis of information gathered from experts in the funeral service business. A work sheet was given to the Department Chairperson of a mortuary science college and a former New York State Funeral Home Examiner. Both of these persons collaborated on producing a list of the top stressors in funeral service in the following areas: work load, time pressure, perceived control, role conflict and role ambiguity. The items submitted can be found in Appendix E. These items were then synthesized into an appropriate work stress scale. This scale was only administered to practicing FD's.

An impression management/social desirability scale was included to control for socially desirable responses. On the face, the type of questions asked in the BCD and the MDFD scales could easily lead a practicing or poten-

tial FD to make the socially expected response. This scale was be included at the end of the BCD and was administered to all subjects.

Data was collected in various settings. Data for MSS's was collected in Psychology of Grief and Pathology classes at a mortuary science college. This college is a two year college granting an A.A.S. as the terminal degree for the mortuary science program. All MSS's are required to take these classes and thus, those students sampled are representative of all MSS's at this college. Appendix F contains a listing of which survey materials were administered to these students.

FD's were sampled by mail. FD's were randomly selected from a master list of 2,700 FD's in New York State. The list was provided by the mortuary science college used to sample students. It was a list of FD's in New York State, sorted by the first character of the persons first name. From this list every eighteenth name was selected, yielding 150 names. These 150 FD's were sent a survey packed and a self-addressed return envelope. The return envelope was addressed to the mortuary science college used to sample students. Appendix F contains a listing of which survey materials were send to FD's, the actual return envelope address, and introductory letter sent in the packet.

The control group was built using english composition students from the same college as the MSS's. This college has many programs other than mortuary science and none of the students in the english composition classes sampled were in the mortuary science program. English composition classes were used as it was felt they give a good cross-section of students from many programs. Students from the same college were used to assure the same underly-

ing population in sampling. A listing of survey materials administered to these students can be found in Appendix F.

Results

Demographic Information

The demographic information for subjects reflected population differences. Seventy percent (n=77) of all subjects were male and thirty percent (n=33) were female. Distribution by age was heavily skewed at ages 18 and 19, with the upper range being 67. These findings are unremarkable since funeral service curriculums are composed primarily of males, and draw from virtually all age groups. Also, the majority of subjects came from a community college population (n=82), yielding a largely younger population. The age distribution by group can be seen in Table 1.

Table 1 - Age Distribution by Group

	Mean Age	Std Dev	N
Funeral Directors	39.54	11.80	28
MS Students	27.81	9.91	43
Comp Students	19.87	3.84	39
Total	27.98	11.63	110

Table 2 - N subjects per Group

	N	Percent
Funeral Directors	28	25.45
MS Students	43	39.09
Comp Student	39	35.45
Total	110	100.00

Educational attainment was normative for this population with most subjects having an A.A.S. or at least some college. Some subjects had a degree past the associates. Total number of subjects per group can be seen in Figure 2. Educational attainment can be seen in Table 3.

Table 3 - Educational Attainment

	N	Percent
HS	9	8.18%
Some College	66	60.00%
Associates	24	21.82%
Bachelor's	8	7.27%
Graduate	3	2.73%
TOTAL	110	100.00%

Tests of Hypothesis

Descriptive statistics (means, scale reliability and correlations) for the study variables common to all subjects are presented on Table 4. The same statistics for FD's, including work stress variables, are presented in Table 5.

Table 4 - Means, Reliability, Correlations - All Groups

n=110	Mean	SD	1	2		4	5	6	7	8	9	10	11	12	13	14
1. BUGENSC	5.06	.81	(.88)													
2.BUGENEMP	5.02	1.14	.867	(.80)												
3. BUGEN-NFD	5.00	.78	.975	-.869	(.85)											
4. HFPROC	3.79	.80	-.108	-.043	-.147	(.77)										
5. HFDEAD	2.22	.97	-.445	-.342	-.362	.065	(.78)									
6. HFDESTR	3.54	.99	.235	.219	.168	.104	-.297	(.60)								
7. HFSIGO	3.66	.79	-.251	-.183	-.189	.275	.488	-.230	(.80)							
8. HFUNKN	2.57	.89	-.249	-.173	-.257	.356	.133	-.021	.257	(.73)						
9. HFCONS	2.55	1.09	-.477	.377	-.378	.137	.451	-.265	.382	.257	(.82)					
10. HFBODY	2.48	.76	-.335	-.221	-.296	.260	.391	-.028	.297	.399	.542	(.63)				
11. HFPREM	3.24	.97	-.165	-.018	-.157	.285	.225	-.034	.112	.163	.153	.392	(.79)			
12. HTOTAL	3.01	.48	-.427	.272	-.383	.552	.582	.062	.581	.579	.643	.754	.542	(.63)		
13. HOEMOT	3.12	.49	-.429	-.277	-.383	-.581	-.466	-.136	.591	.621	.683	.757	.565	.958	(.58)	
15. SOCDES	2.93	1.21	.192	.119	.152	-.184	-.299	.145	-.410	-.168	-.243	-.204	-.075	-.326	-.331	(.52)

= Significant r
r>.253 = p<.01
r>.194 and < .254 = p<.05

Table 5 - Means, Reliability, Correlations - FDs

n=28	Mean	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1. OVLDFREQ	2.92	.59	(.66)																				
2. OVLDLEVL	2.51	.79	.756	(.61)																			
3. AMBGFREQ	1.96	.79	.295	.425	(.53)																		
4. AMBGLEVL	3.83	.93	.531	.763	.589	(.72)																	
5. CONFFREQ	1.83	.56	.159	.141	.267	-.118	(.41)																
6. CONFLEVL	1.66	.61	.302	.328	.270	.432	.752	(.76)															
7. STRESS	6.07	1.75	.752	.784	.640	.622	.585	.640	(.41)														
8. BUGENSC	5.85	.58	.104	.078	.197	-.221	.100	.209	.159	(.88)													
9. BUGENEMP	5.84	.76	.065	-.098	-.058	.017	.129	.171	.003	.783	(.80)												
10. BUGEN-NFD	5.47	.85	.113	.085	.198	-.233	.110	.229	.168	.998	.775	(.85)											
11. HFPROC	3.91	.77	-.266	-.078	.027	.042	.381	.343	.014	.238	.141	.237	(.77)										
12. HFDEAD	1.61	.52	-.055	.244	.128	-.179	.160	.279	.183	-.164	-.294	-.139	.230	(.76)									
13. HFDESTR	3.96	.94	-.009	-.131	.240	.043	.163	.153	.048	-.012	.093	-.022	-.087	-.291	(.61)								
14. HFSIGO	3.31	.70	.105	.193	-.153	.085	.000	.088	.183	.033	-.090	.037	.178	.252	-.274	(.80)							
15. HFUNKN	2.39	.95	-.326	-.315	-.250	.432	-.122	-.297	-.267	.075	.072	.067	.179	-.280	-.160	.269	(.73)						
16. HFCONS	1.63	.63	.058	.059	-.073	-.127	.028	.202	.096	-.037	-.003	-.013	.089	.024	-.230	.077	.188	(.82)					
17. HFBODY	2.07	.57	.405	-.176	-.006	.145	.137	-.031	-.180	-.080	-.366	-.047	-.107	.270	-.125	.091	.225	.300	(.63)				
18. HFPREM	3.43	.92	.010	.026	-.036	.058	.273	.421	.164	-.156	-.044	-.139	.047	.436	.168	.328	-.064	.023	.421	(.79)			
19. HTOTAL	2.79	.32	-.256	-.101	-.045	.155	.233	.344	.052	-.008	-.005	.007	.440	.348	.122	.535	.457	.354	.526	.680	(.63)		
20. HOEMOT	2.96	.35	-.255	-.107	-.165	.200	.150	.304	-.002	.031	.021	.044	.415	.268	-.192	.618	.601	.458	.545	.581	.934	(.58)	
21. SOCDES	3.66	1.11	.106	.152	-.177	.010	.141	-.207	-.108	-.064	-.091	-.052	-.202	.116	.154	-.036	.028	-.032	-.040	-.014	-.003	-.083	(.52)

= Significant r
r>.462 = p< .01
r >.360 and <.464 = p< 05

There are several significant correlations for all subjects (Table 4). Overall Hoelter death anxiety scores (HTOTAL) for all subjects are significantly correlated with Bugen Coping scores (BUGENSC) (r=-.43, p<.01), Bugen Coping scores with obvious funeral service questions removed (BUGEN-NFD) (r=.27, p<.01) and empathy scores (BUGENEMP), (r=-.38, p<.01). When emotional items are removed from the Hoelter death anxiety instrument (HOEMOT), levels of significance are unaffected. The above correlations do not appear in the FD sample.

Hypothesis 1 stated that there would be a significant change in death coping and death anxiety scores in the cross sectional sample. Scores on these measures are presented in Table 6, along with the analysis of variance (ANOVA) results testing the significance of group differences. ANOVA results indicated that there were significant group differences in death coping scores (BUGENSC), empathy scores (BUGENEMP), and modified Bugen death coping scores (BUGEN-NFD, as described in Appendix G). Contrary to expectations, however, post-hoc pairwise comparisons using the Tukey procedure revealed that the FD's scored significantly higher on each of these scales than MSS's, who in turn scored significantly higher than control subjects. This is the inverse of the hypothesized relationship.

The Hoelter Fear of Death scores reflect the inverse of the Bugen Coping with Death scores. Hoelter overall scores were mean ranked controls, MMSs and FDs. However, certain dimensions of the Hoelter scale, fear of the dying process (HFPROC), and fear of being body being destroyed (HFDESTR) have inverse mean rankings of controls, MMSs, and FD's. Hypothesis 1 is disconfirmed by overall death coping (BUGENSC) and overall death anxiety

Table 6 - Means of Scales by Group - ANOVA Results

	FUNERAL DIRECTORS	MORT SCI STUDENTS	CONTROL STUDENTS	F(2,107)
1. BUGENSC	5.649 a	5.222 b	4.452 c	29.640 **
2. BUGENEMP	5.843 a	5.154 b	4.282 c	21.657 **
3. BUGEN-NFD	5.471 a	5.140 b	4.505 c	18.101 **
4. HFPROC	3.911	3.783	3.701	.553
5. HFDEAD	1.613 a	1.930 a	2.979 b	29.795 **
6. HFDESTR	3.964 a	3.593 a	3.173 b	5.796 **
7. HFSIGO	3.310 a	3.547 a	4.039 b	8.731 **
8. HFUNKN	2.393	2.544	2.718	1.126
9. HFCONS	1.629 a	2.433 b	3.354 c	32.782 **
10. HFBODY	2.066 a	2.519 b	2.744 b	6.627 **
11. HFPREM	3.429	3.111	3.244	.902
12. HTOTAL	2.789 a	2.932 a	3.244 b	9.238 **
13. HOEMOT	2.957 a	3.076	3.282 b	1.141 *
14. SOCDES	3.679 a	2.868 b	2.470 b	9.539 **

* = p < .05 DIFFERENT SUBSCRIPTS ARE SIGNIFICANTLY DIFFERENT

(HTOTAL) scores, but certain dimensions of death anxiety (HFPROC, and HFDESTR) are in the hypothesized direction.

For some measures, FDs and MSSs did not differ from one another, but were both significantly different from control subjects. Three of the Hoelter subscales were significant. The fear of the dead (HFDEAD), the fear of being destroyed (HFDESTR) and the fear for significant others (HFSIGO) were atypical from the rest of the death coping and death anxiety scores. On these scales, FD's and MSS's were homogeneous, differing significantly from controls. There was also a significant group effect for social desirability scores. Post hoc Tukey tests revealed that FDs scores higher than MMSs, who scored higher then controls.

Hypothesis 2 states that due to direct and unavoidable contact with death and work stress, that FD's would show lower empathy scores than MSS's

and control subjects. As noted above, on most sub-scales, except the fear of being destroyed (HFDESTR) and the fear for significant others (HFSIGO), the FD scored better then the other two groups. All of these scores combine to indicate that the FD has higher death coping ability, even with obvious FD responses are controlled (BUGEN-NFD and HOEMOT). The same result, more positive scores, can be seen in empathy (BUGENEMP). This hypothesis was largely disconfirmed

Hypothesis 3 predicted that a strong correlation between death coping, work stress and empathy existed, and that as work stress increased, death coping and empathy would be decreased. Data from Table 5 partially disconfirms this hypothesis. There were no significant correlation's between the overall stress score, death coping and its inverse death anxiety or empathy, and any other major variables. However, some individual stress sub-scales, ambiguity, conflict, and overload significantly correlated with Hoelter sub-scales: fear of the dying process (HFPROC), fear for the body (HFBODY), fear of the unknown when dead (HFUNKN) and fear of a premature death (HFPREM). These sub-scale correlations indicate that, although a negative relationship between job stress and general death coping does not exist, some dimensions of death anxiety are significantly related to certain dimensions of job stress.

The significant correlation's between the Hoelter sub-scales and work stress indicate that certain dimensions of death fear are related to stress. Fear of the dying process (HFPROC) and the frequency of conflict (CONFREQ) are significant ($r=.381, p<.05$); as the level of job conflict increases so does the fear of the dying process. Fear for the body (HFBODY) and the frequency of being overloaded on the job (OVLDFREQ) are significant ($r=.405, p<.05$); as overload

frequency increases so does fear for the body. Fear of the unknown (HFUNKN) and the level of ambiguous tasks on the job (AMBGLEVL) are related ($r=-.432, p<.05$); as ambiguity frequency increases fear of the unknown decreases. Fear of a premature death (HFPREM) and the level of conflict on the job (CONFLEVL) are significant ($r=.421$, $P<.05$); as conflict increases so does the fear of a premature death.

Analysis of Covariance Results

Several nuisance variables -- particularly age and social desirable responding -- varied across group and were thought to be significantly related to the major variables of interest in this study. The significant differences identified above were re-analyzed using analysis of covariance (ANCOVA) procedures. In separate analysis, age and social desirability were treated as covariates and group differences in adjusted means were examined for significance.

No significant differences were found in the ANCOVA analysis. This probably points to a methodological problem in administering surveys or an uncontrolled confound of this subject matter with FDs and MSSs. Current literature states that age usually covaries with death coping, this phenomenon was seen in these data. Perhaps the types of instruments used are inappropriate for accessing death coping, death anxiety or work stress in the funeral service group. Another, more deceptive manipulation is presumably more likely to tap the desired constructs in this population.

Discussion

The data shows that the funeral director appears to have better death coping and empathy scores, and less death anxiety than controls or MSSs. This may be due to actual results or may be an error in manipulation. Both of these explanations for the results of this study need to be further researched.

It was hypothesized that FDs, MSSs and controls would have significance differences in death coping scores and death anxiety scores, and that work stress would be strongly correlated to those differences. Work stress was significantly related to burnout as reported in the social worker population. This significant relationship was not seen in the funeral service population. This is probably because the types of measurement (survey instruments) were too simplistic a manipulation for this population when you attempt to tap the constructs of death coping, death anxiety and work stress.

Death coping and death anxiety are two constructs that reflect emotional states in many peoples mind. These emotional states are assumed to be under control in the FD. The obvious content of these survey instruments may have elicited several unwanted these control demand characteristics. FDs are trained to "be there" for the bereaved, and to attain an "acceptable" level of emotional involvement. These demand characteristics may have caused the FD to respond to survey materials in the same way they would deal with a client, with "acceptable" levels of emotional involvement. The manipulation would need to be stronger in any replication of this study.

Literature states that work stress is an antecedent of burnout and that burnout can been in seen as the loss of emotional separation in empathy. There is an overt correlation between work stress and empathy in the social work population. It was hypothesized that this same correlation wound be seen in FD's. It was not. It may be that the instrument was not sensitive enough to detect this correlation or that subject matter confounded the manipulation.

Overall work stress scores were not significantly correlated to overall death coping (BUGENSC) or death anxiety (HOTOTAL). However, individual dimensions of work stress did significantly correlate with individual dimensions of death anxiety. Although this hypothesis was largely disconfirmed, a significant correlation does exists between certain work stress dimensions and death anxiety dimensions. These dimensions may be resistant to confound by subject matter.

Job stress scale individual dimensions significantly correlated with the fear of the dying process (HFPROC), fear for the body (HFBODY), fear of the unknown (HFUNKN), and fear of a premature death. This indicates a potential link between work stress and some dimensions of death anxiety. The fear of the dying process and fear for the body scores were significantly different and higher for FDs than MSSs and controls. This is most likely related to the FDs constant exposure to death and the ravages that death takes on a persons body. These significant findings could indicate that other dimensions of death coping/anxiety are actually affected, but masked.

The fear of the unknown and fear of a premature death are sub-scales which significantly correlate to job stress and on which FDs are also significantly higher than MSSs and controls. These are probably further indications that death coping/anxiety is being affected by job stress, but effectively masked by the funeral director.

Appendix A - Bugen Death Coping Death Scale

1. Strongly agree (SA); 2. Moderately agree; 3. Slightly agree; 4. Uncertain
5. Slightly disagree; 6. Moderately disagree; 7. Strongly disagree (SD)

1. Thinking about death is a waste of time.
2. I have a good perspective on death and dying.
3. Death is an area which can be dealt with safely.
4. I am aware of the full array of services from funeral homes.
5. I am aware of the variety of options for disposing of bodies.
6. I am aware of the full array of emotions which characterize human grief.
7. Knowing that I will surely die does not in any way effect the conduct of my life.
8. I feel prepared to face my death.
9. I feel prepared to face my dying process.
10. I understand my death-related fears.
11. I am familiar with funeral pre-arrangement.
12. Lately I find it O.K. to think about death.
13. My attitude about living has recently changed.
14. I can express my fears about dying.
15. I can put words to my gut level feelings about death and dying.
16. I am making the best of my present life.
17. The quality of my life matters more than the length of it.
18. I can talk about my death with family and friends.
19. I know who to contact when death occurs.
20. I will be able to cope with future losses.
21. I feel able to handle the death of others close to me.
22. I know how to listen to others including the terminally ill.
23. I know how to speak to children about death.
24. I may say the wrong thing when I am with someone mourning.
25. I am able to spend time with the dying if I need to.
26. I can help someone with their thoughts and feelings about death and dying.
27. I would be able to talk to a friend or family member about their death.
28. I can lessen the anxiety of those around me when the topic is death and dying.
29. I can communicate with the dying.
30. I can tell someone, before I or they die, how much I love them.

ITEMS 1,7,AND 24 ARE RECODED AS FOLLOWS: (5=1) (4=2) (3=3) (2=4) (1=5)
A COMPOSITE SCORE IS COMPUTED BY RECODING THE ABOVE ITEMS, COMPUTING A MEAN OF ALL ITEMS (1-30), AND THEN SUBTRACTING THE MEAN FROM 8 TO REVERSE THE OVERALL CODING. THIS YIELDS AN OVERALL SCORE WITH HIGHER SCORES INDICATING HIGHER (BETTER) COPING ABILITY

Impression Management Scale

31. I sometimes argue with my friends.
32. I sometimes do things that are not honest.
33. I get sad and blue every once in a while.
34. It makes me sad to see a lonely stranger in a group.
35. I tend to get emotionally involved with a friends problems.
36. Sometimes words of a love song move me deeply.

Impression Management Scale (added to the end of the Bugen Scale); items 31-33 actually used in scoring.

Appendix B - Hoelter Multi-dimensional Fear of Death Scale

1. Strongly Disagree (SD); 2. Disagree; 3. Neutral; 4. Agree 5. Strongly Agree (SD)

1. I am afraid of dying very slowly.
2. I am afraid of dying in a fire.
3. I am afraid of experiencing a great deal of pain when I die.
4. I am afraid of dying of cancer.
5. I have a fear of suffocating (or drowning).
6. I have a fear of dying violently.

FEAR OF THE DYING PROCESS SUB SCALE

7. I dread visiting a funeral home.
8. Touching a corpse would not bother me.
9. Discovering a dead body would be a horrifying experience.
10. I would be afraid to walk through a graveyard, alone, at night.
11. It would bother me to remove a dead animal from the road.
12. I am afraid of things which have died.

FEAR OF THE DEAD SUB SCALE

13. I would like to donate my body to science.
14. I do not want medical students using my body for practice after I die.
15. I do not like the thought of being cremated.
16. I do not want to donate my eyes after I die.

FEAR OF BEING DESTROYED SUB SCALE

17. I have a fear of people in my family dying.
18. If the people I am very close to were to suddenly die, I would suffer for a long time.
19. If I were to die tomorrow, my family would be upset for a long time.
20. Since everyone dies, I won't be too upset when my friends die.
21. I sometimes get upset when acquaintances dies
22. If I die, my friends would be upset for a long time.

FEAR FOR SIGNIFICANT OTHERS SUB SCALE

23. I am afraid that there is no afterlife.
24. I am not afraid of meeting my creator.
25. I am afraid that death is the end of one's existence.
26. I am afraid that there may not be a supreme being.
27. No one can say, for sure, what will happen after death.

FEAR OF THE UNKNOWN SUB SCALE

28. There are probably many people pronounced dead that are really alive.
29. I am afraid of being buried alive.
30. People should have autopsies to insure that they are dead.
31. It scares me to think I may be conscious while lying in a morgue.
32. I hope more than one doctor examines me before I am pronounced dead.

FEAR OF CONSCIOUSNESS WHEN DEAD

33. I am afraid of my body being disfigured when I die.
34. I dread the thought of my body of being embalmed some day.
35. The thought of my body never being found after I die scares me.
36. It does not matter whether I am buried in a wooden box or a steel vault.
37. The thought of my body being locked in a coffin after I die scares me.
38. The thought of my body decaying after I die scares me.

FEAR FOR THE BODY AFTER DEATH SUB SCALE

39. I have a fear of not accomplishing my goals in life before dying.
40. I am afraid I will not live long enough to enjoy my retirement.
41. I am afraid I will not have time to experience everything I want to.
42. I am afraid I will never see my children grow up.

FEAR OF PREMATURE DEATH SUB SCALE

ITEMS 8,13, 20, 24 AND 36 ARE RECODED AS FOLLOWS: (7=1) (6=2) (5=3) (4=4) (3=5) (2=6) 7=1)

Appendix C
Work Stress Inventory

Please indicate your responses to the following questions. Please circle the frequency and stress level for each item. The following questions relate to perceptions of your work (job).

	FREQUENCY					STRESS LEVEL				
	NEVER	VERY RARELY	SOME OF THE TIME	MOST OF THE TIME	ALWAYS	NOT AT ALL STRESSFUL	MIDLY STRESSFUL	MODERATELY STRESSFUL	VERY STRESSFUL	EXTREMELY STRESSFUL
1. I have too many things to do in a work day.	1	2	3	4	5	1	2	3	4	5
2. I perform embalming on children.	1	2	3	4	5	1	2	3	4	5
3. I must rent/borrow vehicles for funerals.	1	2	3	4	5	1	2	3	4	5
4. I spend a lot of time maintaining vehicles.	1	2	3	4	5	1	2	3	4	5
4. There are not enough clients to support this funeral home.	1	2	3	4	5	1	2	3	4	5
5. I feel pressed for time during the work day.	1	2	3	4	5	1	2	3	4	5
6. I get late night/early morning removal calls.	1	2	3	4	5	1	2	3	4	5
7. The death certificate is always signed on time.	1	2	3	4	5	1	2	3	4	5
8. I often have multiple funerals on the same day.	1	2	3	4	5	1	2	3	4	5
9. The cemeteries I deal with always cooperate.	1	2	3	4	5	1	2	3	4	5
10 I receive an assignment without the manpower to complete it.	1	2	3	4	5	1	2	3	4	5
11.I receive incompatible requests from two or more people at work.	1	2	3	4	5	1	2	3	4	5
12.I do things apt to be accepted by one person and not accepted by another.	1	2	3	4	5	1	2	3	4	5
13.I have to do things that should be done differently.	1	2	3	4	5	1	2	3	4	5
14.I feel certain about how much authority I have.	1	2	3	4	5	1	2	3	4	5
15.Clear planned goals exist for my job.	1	2	3	4	5	1	2	3	4	5
16.I know exactly what is expected of me.	1	2	3	4	5	1	2	3	4	5

Appendix D - Demographic Data Collection Sheet

Please complete this page before proceeding to the next section. In order for this research to be completed it is necessary that you answer all the questions on this and all other pages.

AGE: _____ SEX: _____

EDUCATION: (Please Circle)

High School Degree or Equivalent
Some College
Associates Degree
Bachelors Degree
Graduate Degree

ARE YOU A: (Please Circle)

Mortuary Science Student
Funeral Intern
Practicing Funeral Director
Other

PLEASE FILL-IN THE MOST APPROPRIATE RESPONSE:
[The following questions deal with your general perceptions of death and death exposure]

1) My personal exposure to death is: (Please Circle)
Extreme Very Much Moderate Some None

2) How many deaths have you experienced from:
A) A close family member or friend dying: ____
B) A distant family member or friend dying: ____
C) Other (i.e., volunteer work, co-workers, etc.): _____
DUE TO THE EXTREME VARIABILITY AND UNPREDICTABILITY OF RESPONSES THESE ITEMS (2A-2C) ARE NOT USED IN ANY ANALYSIS

3) I feel I handle death: (Please Circle)
Very Well Pretty Good OK Fair Not Well At All

Appendix E - Work Stress Scale Data Items

WORK LOAD

death certificates- very time consuming
embalming esp. children, and trade (for other funeral homes)
removals - accident, children, home vs. hospital
disaster training
collect money, business dealings of funeral home
vehicles - overhead - caskets, rent vs. own - esp. for small funeral homes
lack of clientele
normal dealing with clergy & cemetery

TIME PRESSURE

death call at 2:00 am
death certificate not signed and need for burial permit
getting time at church
family members not showing up on time
other funerals going on during the same day
cremains not returned to funeral home on time for memorial service
grave openings & closings - making dates

LACK OF CONTROL

weather, employees, family members not agreeing
doctors, cemetery, vault people not doing things when said they would
casket not there when promised by manufacturer

ROLE CONFLICT

should be doing counseling, support groups, continuing education; do not have time
do not want to accept AIDS cases/gypsy cases - but should

ROLE AMBIGUITY

if you do not do things that present role conflict (above), are you a bad funeral directory because? Are you a bad funeral director because you do not do the contagious cases (AIDS, hepatitis)? Is it ok to do this selective embalming

Appendix F - Survey Packet Contents

Mortuary Science Students and English Composition Students:

Demographic Information Collection Sheet

Bugen's Coping with Death Scale

Impression Management Scale

Hoelter Multi-dimensional Fear of Death Scale

Funeral Directors:

Introductory Letter (Sample on next page)

Demographic Information Collection Sheet

Bugen's Coping with Death Scale

Impression Management Scale

Hoelter Multi-dimensional Fear of Death Scale

Work Stress Inventory

Return address of envelope enclosed in funeral director packet:

Project 93MSG

Mortuary Science Department

Hudson Valley Community College

80 Vandenburgh Avenue

Troy, New York 12189

Sample Funeral Director Introductory Letter

Project 93MSG
Michael S. Gendron
Mortuary Science Department
Hudson Valley Community College
80 Vandenburgh Avenue
Troy, New York 12189
(518) 270-7113

January 17, 1993

Dear Funeral Home Manager:

I am a graduate of the Hudson Valley Community College (HVCC) Mortuary Science Department and am now a student at the State University of New York at Albany (SUNYA). I am currently working on my honors thesis. As part of that thesis I am performing research, in collaboration with HVCC.

The purpose of this letter is to request your participation in this research. I am asking that you complete the enclosed survey. Upon completion, please return this survey in the enclosed self-addressed envelope. Please return these by January 31, 1994 so that your data can be included in this study.

Upon the completion of this research, articles will be submitted to the NFDA's journal *THE DIRECTOR*. Thank you for your assistance with this research.

Sincerely,

Michael S. Gendron
Primary Researcher

enclosure:survey

Kevin Williams, Ph.D.
SUNYA Honors Committee Chairman
(518) 442-4849

Elaine Reinhard
HVCC Mortuary Science Chair
(518) 270-7113

Appendix G - Data Dictionary for Major Variables

Below you will find the major variables, their shorthand name and a full definition. In the tables the major variables are referred to by their shorthand name.

SHORTHAND NAME	DESCRIPTION OF VARIABLE
BUGENSC	BUGEN COPING WITH DEATH SCALE COMPOSITE SCORE - HIGHER SCORE INDICATES BETTER DEATH COPING
BUGENEMP	EMPATHY SCORE (EXTRACTED FROM BUGEN SCALE) - HIGHER SCORE INDICATES MORE EMPATHY
BUGEN-NFD	BUGEN COPING WITH DEATH SCALE COMPOSITE SCORE - REMOVING ITEMS 4,5,11 AND 19 TO REMOVE OBVIOUS FUNERAL SERVICE BIASED REPONSES
HFPROC	HOELTER FEAR OF THE DYING PROCESS
HFDEAD	HOELTER FEAR OF THE DEAD
HFDESTR	HOELTER FEAR OF BEING DESTROYED
HFSIGO	HOELTER FEAR FOR SIGNIFICANT OTHERS
HFUNKN	HOELTER FEAR OF THE UNKNOWN
HFCONS	HOELTER FEAR OF CONSCIOUSNESS WHEN DEAD
HFBODY	HOELTER FEAR FOR THE BODY
HFPREM	HOELTER FEAR OF PREMATURE DEATH
HTOTAL	HOELTER COMPOSITE SCORE
HOEMOT	HOELTER COMPOSITE SCORE WITHOUT HFDEAD AND HFDESTR, LEAVING ONLY EMOTIONALLY BASED ITEMS
SOCDES	SOCIAL DESIRABILITY SCALE
OVLDFREQ	WORK STRESS - OVERLOAD FREQUENCY
OVLDLEVL	WORK STRESS - OVERLOAD LEVEL
AMBGFREQ	WORK STRESS - AMBIGUITY FREQUENCY
AMBGLEVL	WORK STRESS - AMBIGUITY LEVEL
CONFFREQ	WORK STRESS - CONFLICT FREQUENCY
CONFLEVL	WORK STRESS - CONFLICT LEVEL
STRESS	COMPOSITE WORK STRESS SCORE USING A MULTIPLICATIVE METHOD OF OVERALL STRESS COMPUTATION

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Visual Detection of Systemic Disease Embalming Diagnosis and Treatment

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Wayne State University
College of Pharmacy and Allied Health
Department of Mortuary Science

Introduction

The embalmer/funeral director is faced with a myriad of embalming complications caused by systemic disease. Visual detection of the presence of various conditions in the remains can lead to better embalming results and treatment. Certain pathological conditions can affect pH, water content, oxidation-reduction potentials, temperature, and other physical and chemical changes in the remains. There are many very important cutaneous signs of systemic disease that may give the embalmer insight into preparation of arterial treatment and fluid concentration. Infectious diseases such as impetigo, typhus, erysipelas, and syphilis may be detected by simple visual examination.[1]

Many systemic diseases such as diabetes, renal disease, and liver disease give cutaneous clues to their presence. These cutaneous signs are important clues to the embalmer to treat with proper embalming fluid dilutions and topical treatment. Medical devices such as Tenckoff catheters, feeding tubes, radiation markings, and topical patches may give Some indication of conditions and disease progression

Pathology of Disease and the Funeral Director: Importance

Physiological changes caused by chemotherapy and/or drugs may also be detected by visual examination. These physiological changes may also seriously affect the fixation of properties of formaldehyde and/or glutaraldehyde on the proteins of the human remains. Adriamycin, a cytoxic agent administered for treatment of neoplastic disease, can cause heart failure which leads to multi-system organ failure which eventually leads to buildup of nitrogenous by-products, edema, and discoloration of the remains. Single drugs or combinations thereof will cause an embalming nightmare unless good observation and technical skills are practiced in embalming treatment. Awareness of possible biochemical and physical changes may be the responsibility of the embalmer if he/she is to successfully retard decomposition of the remains.

Hemodynamic Disorders: Diagnosis and Treatment

Of all other physiological conditions, the presence of hemodynamic disorders present the most difficult for embalming treatment. Most fatal hemodynamic disorders originate from shock. Shock simply is a severe pathophysiologic condition associated with abnormal cellular metabolism. Shock may be caused by loss of fluid, heart failure, sepsis, trauma, or drug overdose. In any event, the end stage of shock causes vasoconstriction, acid-base imbalance and other biochemical changes.

The presence of edema greater than ten percent of total body weight is considered excessive by embalmer's standards.[2] Edema may be localized or generalized. Local edema may also be associated with deep venous obstruction, and obstruction of the lymphatic system via a tumor. (Table 1) Generalized edema may be caused by kidney disease, hepatorenal syndrome, congestive heart failure, and other pathological conditions.

The etiologic mechanism for these causes of edema must be discovered before embalming treatment is done. If there is dependent edema of the extremities, embalming treatment should be localized to that specific site. A two percent hypertonic compensatory fluid should be used for site specific injection e.g., if there is massive edema of the hand use the radial or ulnar arteries for restricted circulation to that area. The affected area should be raised above the body to facilitate movement of fluid and remove excess cell water. Use caution in local injection if the affected area may signal presence of an emboli or thrombus in the area. Edemic areas must also be examined to determine if the edema is accessible to embalming fluid flow. Many areas of edema may not be treated by hypertonic fluid injection. The term third spacing refers to edema that is not in the normal circulation. Third-spacing is very common in shock patients; one example of nonfunctional edema is ascities. Ascities should be removed prior to injection as ascities is an extravascular obstruction to flow. Removal of ascities should be done with a blunt tip trocar inserted at the lowest part of the abdomen. The trocar should be pointed
anteriorly to avoid disruption and accidental puncture of the abdominal aorta.

A method for ascertaining whether fluid is present is by tapping one side of the abdomen and placing your other hand on the other side. Gently tapping one side will exhibit a wave pattern if fluid is present; however, if there is simply air , a hyperesonant sound will occur.

There are many signs of hemodynamic disorders that may be detected on examination of the remains. If there is blood in the ascitic fluid, you should suspect a vascular rupture and you should proceed with a multi-point injection. If there is an excessive amount of turbid fluid and a foul smell, suspect massive microbial translocation and increase your formaldehyde content in the fluid. The embalming treatment should always be at least two percent (table 2) and you should refrain from pre and co-injections of fluids. Ancillary solutions will only hinder the reaction of formaldehyde with the proteins of the remains.

Treatment of Neoplasia and Chemotherapeutic Problems

Disturbances in circulation may also occur in remains with neoplasia, cancer or cancer treated with chemotherapy. Neoplasia is the formation of benign or, more particularly, malignant tumors or cancer. These growths often present with

extravascular obstructions to flow. These new growths will often cause the remains to appear cachetic or exhibit an emaciated appearance. This appearance is due to the excessive metabolism of the neoplastic cells and relative poor nutrition of these patients. Embalmers should be cognizant of these changes in the remains. Some chemotherapeutic agents cause physiological problems such as heart failure, renal toxicity, and retention of fluids. There are visual indicators for the relative presence of cancer. (Table 3). The embalmer should also be aware that the remains may also have signs of protein depletion and should inject a high index formaldehyde fluid. This treatment will insure that all available protein is fixed and unavailable for microbial decomposition; also an addition of a co-injection of humectant and or glycerol will guard against excessive dehydration and leathering of tissue. Further investigation should be done to insure proper fixation of protein depleted tissue. The remains may contain a large amount of nitrogenous wastes due to multi-system failure secondary to the effects of neoplasia and side effects of appropriate chemotherapeutic drugs. (Table 4).

The embalming treatment of neoplasia and chemotherapeutic cases should depend upon the initial pre-embalming diagnosis. One should assume with the presence of wasting and cachexia, that the remains lacks sufficient protein. The embalmer must balance cosmetic and preservative considerations carefully. Of course the embalmer must always use at ***least two percent formaldehyde solution.*** If intense rigor is present a combination glutaraldehyde/formaldehyde may be used to counteract the delirious effects of an acidic pH. The primary injection should diffuse slowly and thoroughly using good massage techniques. Aspiration should be delayed at least twenty-four hours if possible. A good quality high potency cavity chemical should be used with an ample drying agent. (i.e. phenol, Table 5)

Liver and Renal Disease Complication Treatment

The presence of liver complications cannot be overstated. Alcoholic liver disease (ALD) is a major sociomedical problem in the United States and may directly affect more than 10,000,000 Americans, with an annual economic loss exceeding 43 billion dollars.[3] Liver disease complications will result in one of the embalmer's chief troublesome condition, jaundice. Jaundice results from an overproduction of unconjugated bilirubin, and may present a varying picture of coloration ranging from a deep-green yellow in chronic jaundice, and in some cases, may result in a dark brown to black discoloration, due to the presence of melanin. This complication is best treated with patience and embalming treatment is based on the individual condition.

Embalming treatment is based upon a good pre-embalming analysis. Primary treatment is based upon the remain's condition. For instance if the remains has ascities with concomitant wasting and cachexia, the treatment should consist of restoration of volume via large amounts of fluid i.e. at least one gallon per 25 pounds of body weight. Secondly, fluid amounts should be sufficient to overcome the lack of protein that accompanies

acute and chronic liver disease. Lastly , the embalmer may use co-injections to restore volume to the remains and prevent dehydration and over embalming . One must remember that the liver is the center of protein metabolism and many varying factors may affect the embalming process.

The renal system causes many embalming problems, first and most common is chronic renal failure. Chronic renal failure may be caused by many diseases and causes a retention of nitrogenous wastes in the remains. This syndrome may cause a collection of fluid in non vascular areas, a condition known as third spacing. This renal syndrome may also occur in conjunction with liver disease and is known as hepatorenal syndrome.

The embalming treatment for renal dysfunction is again based upon individual examination. If the remains has extravascular fluid (i.e. ascities, pleural fluid), this must be removed first with a trocar and or a flexible catheter. The reason being that extravascular fluid may dilute the primary dilution of formaldehyde injected in the remains. Secondly, a hypertonic fluid must be used to overcome fluid dilution in the remains. One must also be cognizant of the complications of overtreatment resulting in excessive dehydration and presenting a mummified appearance. Secondary injections of fluid can contain glycerol or some humectant to prevent dehydration.

Discussion

One of the most important tools an effective embalmer must have is an analytical approach to treatment of systemic disease. This must include a comprehensive knowledge of embalming and biological chemistry. Only then can the embalmer know the interactions and achieve proper fixation of the human remains can take place. Visual clues of systemic disease may be ascertained and treated with relative ease by knowledgeable embalmers. The embalmer must also be aware of the drug and physiological conditions that may take place and its effect on the embalming process.

Edema , one of the most challenging complications in the death process can be treated effectively if the embalmer knows the underlying condition and can ascertain if edema can be treated by hypertonic dilutions of embalming fluids. The in-vitro germicidal activity of formaldehyde compounds has been established and documented.[4] However much work needs to be done. Future trends in embalming should be focused upon proper fluid dilution on an individual basis as determined by the condition of both the remains and environment. A uniform protocol for shipping remains and the effectiveness or utility of pre and co injections. (Table 6)

The future of embalming science is in dire need of large blinded multi-centered statistical studies to prove the efficacy of varying embalming treatments. The continuing education of embalming science can only be enhanced by the continuing research and studies in the efficacy of our techniques and procedures.

Table 1

PATHOLOGY OF EDEMA FORMATION

DEPENDENT EDEMA

- **Limbs, Hands, Arms, Feet**
- **Diseases**
  - **Arteriosclerotic Heart Disease**
  - **Congestive Heart Failure**
  - **Tumor Obstruction**
  - **Lymphatic Obstruction**

Table 2

EMBALMING TREATMENT

Hemodynamic Disorders (Edema)

- **Low Pressure (less than or equal to 5lbs/2.27kg)**
- **High Volume (greater than or equal to 2.5 gal./9.5 liter)**
- **Hypertonic primary injection of fluid (high index greater than 30)**
- **Two percent or greater concentration of formaldehyde**
- **Addition of salts , ammonium sulfate, calcium acetate, or astringents**
- **Delay aspiration to allow salts to imbibe edema**

Table 3

VISUAL INDICATORS OF NEOPLASIA/ CANCER

- **Grayish discoloration of skin secondary to administration of antimetabolites and cytoxic agents**
- **Cachetic, Emaciated appearance due to excessive metabolism of neoplastic cells**
- **Implant of infusion Pumps**
- **Presence of analgesic Patches**
- **Evidence of Radiation burns and target markings**

Table 4

CHEMOTHERAPEUTIC COMPLICATIONS IN EMBALMING

- Increased edema formation due to altered metabolism
- Increase in loss of protein in body
- Retention of nitrogenous wastes due to physiological conditions or direct presence of chemotherapeutic agents
- Alteration of circulation secondary to tumor or scar formation

Table 5

EMBALMING TREATMENT OF CHEMOTHERAPY PATIENTS

- Take each individual case and consider body condition
- Always use at least two percent concentration of formaldehyde solution
- NO ASPIRATION FOR AT LEAST 24 HOURS
- High potency cavity chemical treatment with ample drying agent (i.e. phenol)

Table 6

FUTURE TRENDS IN EMBALMING SCIENCE

- **Research for effective amounts of formaldehyde complications**
- **Addition of co-injection, pre-injection fluid effectiveness and utility**
- **Ultrafiltration techniques for excess edema**
- **Uniform protocol for shipping cases to prevent liability**

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DONEEN NIKAS

PSYCHOLOGY OF GRIEF

"DEATH EDUCATION,
A PRACTICAL APPLICATION"

Why should death education be taught in schools? Because, it is part of life. Every day, from the moment of birth, we as individuals are getting closer to death. Children are exposed to death when their pets die, when someone they love dies, by watching T.V., and even by experiencing the seasons. Leaves turn colors, die and fall off trees.

Even though children are exposed to death, many times they have little experience in learning how to express their feelings and coping with their thoughts surrounding this matter. Death in our society is a taboo subject. Not talked about and definitely not a shared experience with little children. So again, why teach death education? The more exposure children have with death, the better they will be able to express their thoughts and feelings and the more comfortable they will become when it affects their life. In the absence of education about death, loss, grief and mourning we cannot teach an appreciation of life or develop the art of living to its fullest.

"He that has thought most deeply loves that which is alive" (Sneler, 1962, p. 87). If we do not teach about feelings, we are ignoring an important part of human experience. Educate the whole child. Teach them to give expression to their feelings of joy and of pain.

For purposes of this unit, I will give specific lesson plans to be presented in the classroom. The lessons will be divided into three age groups. First, kindergarten level, 5-6 year olds. Second, primary ages 6-9; and last, elementary grades 9-12 year olds.

LEVEL I: The Five-Six Year Olds

Very young children usually have no fear of death, although they have two innate fears of sudden loud noises and of falling from high places (Kubler-Ross, 1983, p. 64). As children get older, they become afraid of separation. Aware that they are dependent on those around them, these children feel panic, pain, anxiety and anger if they are abandoned. During this period, an awareness of death begins to emerge. A child of this age is naturally self-centered and has not yet developed an understanding of cause-effect relationships. Because of this, a five-six year old may believe that he/she is responsible for the death of a loved one.

The goals of this unit for the five-six year olds will be to explore feelings, their physical bodies, spiritual self, changes, what makes people die, and grief.

Happy, Sad Feeling Lesson

Objectives

- To explore the many types of feelings—happiness, sadness, anger and fear.
- To express feelings through movement, art, music, writing.
- To recognize that both happy and sad feelings are a normal part of living.

Activities

Have the children tell the class the different types of feelings they have had. List them on the board. Ex.: scared, happy, angry, sad, lonely.

Play music. I have selected Paul Winter's "Winter Song, Tomorrow Is My Dancing Day".

Next, guide the children around the room expressing the feelings listed on the board. For example, have the children move as though they are happy, sad, etc. Go through all the expressions listed.

After this activity is finished, seat the children with paper and crayons and have them draw, with the music playing, the different emotions they felt.

Next, talk with the children about how sad you feel when you lose something you really love. Read I'll Always Love You by Hans Wilhelm. This is a wonderful book about the close relationship between a boy and his dog. Both the boy and the dog, Elfie, grow older. Then, one night Elfie dies in her sleep. Grief-stricken, the boy takes comfort in the fact that every night, he told Elfie, "I'll always love you."

Discuss how many times we have both happy and sad feelings in our lives. Also, point out how the little boy had nothing to do with the cause of Elfie's death. An important philosophy of this story is that the children should realize how necessary it is to tell loved ones how you feel, while you can.

The Who Are We Lesson

Objectives

° To identify body parts and their function.

° To identify physical body changes after death occurs.

Activities

Play games where children identify their bodies. Examples: ears, eyes, nose, arms, heart, lungs, bones, muscles. Discuss the function of each body part. By using grocery bags, have the children cut out a place for head and arms. Then have the children draw the body parts on their grocery bag.

Next, have the children wear them as you read Lifetimes by Bryan Mellonie and Robert Ingpen. Lifetimes is a beautiful book that explains that nothing that is alive, goes on forever. Lifetimes have beginnings and endings—for plants, people, birds, fish and animals.

After reading this book, discuss how people stop working. E.g., the eyes do not see, the heart stops beating, and the breathing stops.

The Where Is The Really Me?

Objective

° To explore the relationship between the spirit of a person and the physical body.

Activity

Where Is The Really Me Game (Reed, Helping Children With the Mystery of Death, 1970, p. 33).

Teach the following poem to the class:

Where is the really, really me?
I'm somehwere, I know, but where can that be?
I'm not my nose, nor my mouth, nor my eye.
I'm not my feet, nor my leg, nor my thigh.
I'm not my hand, nor my arm, nor my lip.
I'm sure I'm not my elbow or knee.
Oh, where am I? Oh where can I be?

After teaching the poem, discuss where a person really me is. Point out that the body just houses "the really me".

The Life Changes Lesson

Objective

° To learn that every living thing grows and changes in nature.

Activities

Plant seeds, nurture them and watch them grow. Discuss how plants grow and change and how people change and grow.

Read and discuss The Dead Tree by Alvin Tresselt. This unusual book depicts poetically and through illustration the life cycle of an oak tree. Death is portrayed as a natural and necessary part of this life cycle. It is shown that in nature nothing is ever wasted and nothing completely dies.

Have the children write stories and draw about the loss of someone or something in their lives. After the children are

finished, have sharing time so that each child can express verbally his/her experiences.

What Makes People Die?

Objectives

- To acknowledge that not only animals and plants die, but people do also.
- To understand the physical reasons for death.
- To discuss that self-blame is not a cause of death.

Activities

Read Badger's Parting Gifts by Susan Varley. This is a lovely book about a very special friend named Badger. Badger, who was very old, died. At first, Badger's animal friends were overwhelmed by their loss. However, as time went by, all the animals began to realize all the special times they had together. Finally, Badger was a happy part of their lives again.

Discuss that, just like animals, people die also. Some people, just like Badger, grow old and die. Explain that we do not yet know how to cure some diseases or fix some accidents.

Read from Talking About Death by Earl A. Grollman, p. 5.

"What is dead?
Remember when you saw a dog that was hit by a car?
He was lying on the road still . . .
not breathing . . .
not moving . . .
His heart was not beating
He would never breathe or move again.
HE WAS DEAD.

It is the same for people.
The body does not move.
It does not breathe.
The heart does not beat.
The body is still . . .
quiet and peaceful.
There is no hurt, no pain, no life.

The teacher when discussing why people die, should be very concerned that the students realize they can neither make someone die, nor stop someone from dying.

Death and Grieving

Objectives

- To realize that feeling sad is normal after someone you love dies.
- To understand that eventually someone who is grieving will feel better.

Activities

Read The Tenth Good Thing About Barney by Judith Viorst. This is an excellent story about a little boy's cat, Barney, that dies, and his mother helps him prepare for the funeral and offers comfort by asking the boy to think of 10 good things about Barney. He can only think of nine. But with the help of his father, he is able to add the tenth good thing: "Barney is in the ground and helping grow flowers." The story is gentle and hopeful and portrays parents who are deeply sensitive to children's needs and capable of giving them comfort.

Discuss how the little boy dealt with Barney's death and why he felt better after thinking of ten good things about Barney.

Have the children write and publish a book on The Ten Good Things About [person or animal who has died in their life].

Complete the lesson with the story It Must Have Hurt A Lot, by Doris Sanford. This is a book about death and learning and growing. Joshua's puppy, Muffin, was hit by a car and She Died! The loss of Muffin caused Joshua to hurt for weeks and many nights he cried himself to sleep. Through his grieving, Joshua learned secrets about life . . . which warmed him.

In summary, at this age level as in every developmental stage, the following information may be helpful:

1. Talk about loss whenever the child asks questions.
2. Answer honestly and only what's asked.
3. Speak in plain English.
4. Remember, until they are about nine years old, most children do not understand that death is permanent.
5. Tell the child he did not cause a death by his anger. (Children confuse the wish with the deed.)
6. Talk about your own feelings of sadness when you have experienced a loss. Don't shut the child out.
7. Don't wait for the one grand "tell it all" session.
8. If you are comfortable with death, the children in your classroom will be also. (It Must Hurt a Lot, Sanford, 1986.)

LEVEL II: 7-9 Year Olds

Children at this stage, understand death as an irreversible event. Anxieties and fears are centered on bodily mutilation, on being buried alive, and on the physiological process of death, decomposition, and decay (Wass and Cerr, 1984, p. 87).

Another source of anxiety is the belief that death can happen if you are unlucky. Children up to age ten visualize death in different forms, such as a ghost, a skeleton and the bogey man.

Television has a great influence on children of this age. With its explicit scenes depicting death, children watch people being killed not only on weekly drama shows and movies, but also on nightly news shows. Their exposure to death is greater than it was to their parents and grandparents.

Still, children at this stage feel that death happens mostly to the old, still sensing that it could occur to their parents and even themselves.

Life and Death In Nature

Objectives

- To reason why all living things need to die.
- To understand that all living things are born so therefore they die.

Activities

Introduce the lesson by asking the question, "What would happen if nothing died?" Discuss their responses. Read, The Beaver Who Wouldn't Die. This book is about Cyrus, a beaver, who lives in the north woods. He is granted his wish to never die. As he keeps on growing and becomes larger and larger, and particularly as he sees his peers and even his children and grandchildren die, he feels out of place and out of time. Cyrus gets very lonely and depressed, wishing he could die. Fortunately, his wish to die is granted and he happily joins his loved ones. This story is important in showing the naturalness of the life cycle.

What Happens After Death

Objectives

- To explain to children what happens to the physical body after death.
- To explain to children what social customs we carry out when death occurs.

Activities

Show the film The Dead Bird. This 13-minute color film

with cartoon pictures tells Margaret Wise Brown's story of a group of children who discover, bury, and mourn a dead bird. (Indiana University, Audio-Visual Center, Bloomington, IN 47401.)

Discuss experiences the children might have had with dead animals. Talk about what happens when a person dies. If children press for concrete details about life after death, we should tell children that we do not know what it is like. Dr. Grollman believes that the introduction of the traditional idea of heaven may create far more problems than it solves, and that it is healthier for children to share the quest for understanding than for the immediate curiosity to be appeased by fictions. (Grollman, Explaining Death to Children, p. 12.)

Attached is a Scrapbook of Memories by Dr. Earl A. Grollman for the children to keep or complete, if they desire. It would be wonderful for children to make their own scrapbook on memories of someone or some animal they have loved and lost.

Death Brings Sadness

Objectives

- To understand the many feelings people have when they lose someone close.
- To realize it is natural and necessary to express these feelings.
- To understand that life goes on in spite of the grief caused by death.

Activities

Have the children tell you the feelings people have when they lose someone. List them. Read A Taste of Blackberries by D. B. Smith. This is a story of a little boy who is confronted with loss, grief, and guilt when his best friend, Jamie, dies from being stung by a bee while the two are picking blackberries. The feeling of guilt is natural enough. Jamie had a way of kidding around, so that, when he rolled on the ground after the bee sting, his friend thought he was only joking. After a time, the boy comes to accept his friend's death.

After reading the story, have the children add to the list of feelings. Play Paul Winter's music and have the children move around the room expressing the different emotions felt by Jamie's friend.

Still playing the music, give the children paper and crayons, paint, or colored pencils and have them draw their feelings. Discuss the paintings.

LEVEL III: 10-12 Year Olds

At this stage, children begin to believe that everyone dies, including themselves (Formanek, R., "When Children Ask About Death", Elementary School Journal, November, pp. 92-97.) They think of death as being part of life. (Reed, E. L., 1970, Helping Children with the Mystery of Death, Nashville: Abingdon Press.)

Children at this stage are less egocentric than in previous stages. They can generalize enough to be able to view death as happening to everyone at some time.

Grief

Objectives

- To express individual feelings about death.
- To understand that people deal with death in many ways.
- To realize it is O.K. to grieve in any way you feel necessary.

Activities

Role Playing - Scene I. Your favorite pet has just DIED. Let two or three children act out a scene where their favorite pet died. Discuss their reactions and how others might have acted differently.

Scene II. Someone you love has just DIED. Select two children to act out this event. One child is grieving and the other child is reacting. Discuss the events. Video the scenes —kids love to see themselves on film.

Story. Read I Had A Friend Named Peter by Janice Cohn. In this sensitive story, Betsy learns of the tragic death of her friend Peter. Her parents help her cope with the death. This book has a wonderful introduction covering children and death.

Next, read How It Feels When A Parent Dies by Jill Krements. This story tells of the thoughts and feelings of 18 children, ages 7-16, who lost a parent. Emotions range from confusion, anger and guilt. Many different reactions are explained to show that a wide range of feelings are normal and appropriate. Discuss the reactions of the 18 children and make comparisons between these children and Betsy. How are they different and how are they the same?

Let the children write their own stories or poems on death and grieving. The children should share their stories to vent their feelings and promote sharing.

Dr. Earl Grollman in Talking About Death has set forth the following guide for parents in explaining death for children. These points should also be adopted by teachers in dealing with death in the classroom.

1. Mental Health. The mental health of us all, child and parent, is not the denial of tragedy but the frank acknowledgment of it. Help children see that death is an inevitable part of human experience. He/she must give up the illusion that death is an unfortunate accident that need not occur.
2. Do not tell the youngsters what they will need to later unlearn. Avoid fairy tales and half-truths.

3. Children, like adults, experience grief. Each child experiences three phases in the natural grieving process. The first is protest when the child does not believe a person is dead. The next is pain, despair, and disorganization when a child begins to accept the person is gone. Finally, hope, when a child believes that his life will go on.
4. Allow the child to vent his grief. Emotion is natural, inevitable and highly desirable. Grief is a normal reaction necessary for health.
5. Suffering and death should not be linked with sin and punishment.
6. Do not close the door to doubt, questioning and difference of opinion. This guide is necessary for death education to work in the classroom.
7. Do not teach the child as if you have the final answers which he must accept.
8. A child from approximately the age of seven should be allowed, if he chooses, to attend the funeral. At the very least, he should be aware of its procedure. Children need to feel a sense of belonging, not abandonment.
9. Assist the child to unburden his feelings through remembrance and release. Children need to express their thoughts and feelings.

10. Avoid focusing on the morbid details of death. It is important to emphasize the beauty of the deceased's life and love.

11. Help your child not only by the tone of your voice but by the nonverbal response of the warmth of your body.

Summary

Death education is a necessary part of the school curriculum because it is an important part of a child's life and his/her development. This paper has attempted to briefly discuss children's development as it applies to death. Developmental psychologist Jean Piaget has provided the most comprehensive and widely recognized description of cognitive development from infancy to adulthood. Therefore, as death educators it is reasonable to believe that children's concepts of death develop in the same manner. According to H. Wass, in Concepts of Death: A Developmental Perspective (1984, pp. 3-23), this is confirmed. Children's perceptions of death occur in four stages, although individual differences affect the rate of development.

I have attempted to take these developmental stages and applied them into specific lesson plans. One important recommendation in talking to children about death is to be honest. Dr. Grollman in Talking About Death agrees emphatically for telling the truth. In talking to the very young, he uses the following example.

" * * * When you die, you're dead * * *
Dead is dead * * * The body does not move.
It does not breathe. The heart does not beat.

The body is still * * * There is no hurt, no pain, no life" (pp. 9-11).

" * * * For flowers and for all of us * * * there is a season * * * There is a time for every living thing to grow and to flourish and then to die" (p. 13).

~~Attached to this paper is a list of~~ There are excellent books on the topic of death and children. These books offer a wealth of information on many different situations that can be a wonderful asset to any classroom; use them. Discussion of the books is an essential and integral part of any school curriculum that is concerned with significant life issues. The subject of death cannot and should not be avoided at any age level. Anyone involved in the school system knows that death knocks at its door and can catch everyone involved totally unprepared. These lesson plans are an attempt at that not being the case. As teachers we should be at least somewhat prepared for all life situations as they walk through the classroom door.

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OJIBWAY SPIRITUALITY

LAURA ECKELBECKER

(Draft no. 6)

Forward

My ancestral background is four-fold. I am French, Native American (I will use the term Indian for simplicity, even though I do not like the term.), Finnish, and Irish.

I did not know of my Indian heritage until I was eight and my grandfather told me. My father apparently did not want me to know of my heritage because, he was visibly upset when he learned I knew of it.

I was baptized, made my holy communion, and was confirmed in the Catholic faith. I had always had questions about certain aspects of the Catholic religion, questions that still have not been answered to my satisfaction, by anyone in the Catholic church. It was these unanswered questions, that influenced my decision to break all ties to the Catholic church.

I began investigating my Indian heritage and the Ojibway Indian culture, about ten tears ago. I discovered that my grandmother, on my fathers side, was Indian. I never knew my grandmother because she died two years before I was born, at the age of forty six. During my investigation, I found that I am most probably Lakota or Ojibway or both.

When I began college, at Ferris State University, I noticed a lack of support for the Indian students on campus, so I and two of my Indian friends founded an organization called " Circle of Tribal Nations", dedicated to bringing our Indian culture to the attention of the university and the

surrounding community. As a result of this endeavor, I and my husband Cliff, became respected artists, elders, and pipe carriers (aperson authorized to perform ceremonies with his/her pipe.) in the Indian communities throughout Northern Michigan.

The point of this forward, is to help the reader understand why I have a vested interest in Indian culture, spirituality, and religion (all three, are inseparable.), also, to know how I have gained my knowledge in these areas.

Since the Indian community considers me an elder, it is my duty to educate people about our culture; this I will do to the best of my ability.

Laura Eckelbecker

Oct. 24, 1993

PREFACE

There are some universal concepts in all Indian cultures but, there are also many differences among nations, tribes, bands, clans, and even families. These differences should be kept in mind when studying Indian cultures. If we only dwell on the universal concepts, we run the danger of stereotyping.

The following are some universal concepts of Indian culture: 1.) The universe and all things in it, is considered to be a circular web. Anything that affects one strand of the web, will ultimately affect all the other strands. 2.) There is only one Creator. The Creator made everything in the universe, which makes everything and everyone relatives to each other. Relatives are to be respected at all times. Relatives always help each other. 3.) It is a good and honorable thing to give all that you can to help others in need. It is shameful to be greedy. 4.) There are many mysteries in the universe that only the Creator knows the answers to. Only through visions and/or dreams will the Creator reveal the answers to some of these mysteries, if he/she so chooses. 5.) Elders, holy men/women, medicine men/women, are to be treated with the utmost respect at all times. 6.) a decision of any kind, should be fully considered (no matter how long it takes.) before action is taken. 7.) The journey to the spirit world begins at the moment of conception and may end any time thereafter (Henry).

With the help of other elders and scarce reference materials, I will attempt to explain some aspects of Ojibway culture from a traditional perspective. Traditional being, the incorporation of the old (praying with a pipe) with the new European culture.

Oral history

Ojibway knowledge (as well as other Indian cultures,), until recent times, has been passed on from generation to generation by an oral history. In other words, knowledge was relayed by word of mouth, not by written words, because we had no written language.

Morals and ethics were taught to children through stories that they could relate to.

Male and female duties were taught by story telling and example, as were ceremonies and medicinal instruction.

The end result of this oral history, was many cultures with individuals who were expert orators, who had superb memories (some had almost total recall.).

Since each Indian tribe usually spoke a different language, sign language helped communication. Whether this sign language was universal or varied regionally, is unknown to me.

When the Europeans came to the America's, they misinterpreted the Indians lack of written language as ignorance. Since they could not understand the Indians, they labeled Indian cultures as savage, barbaric, and

un-Godly, hence the attempt to wipe out Indian cultures (after all, they (Europeans.) knew what was best for the world and themselves.).

The Traditional Ojibway in European Culture

In recent years, the Ojibway have begun to re-educate themselves in the traditional ways, with the help of all elders (this is one of the main purposes of elders today.). They have re-learned the stories, ceremonies, and how to incorporate traditional ways into their everyday lives.

To the traditional Ojibway, every new day is a gift from the Creator. The following is an example of how "White Cloud Woman", a traditional Ojibway might spend one of her days: White Cloud Woman rises with the sun (her bed always faces the east.), to prepare for a new day. She gets her prayer pipe and tobacco from her dresser and begins to fill her pipe. To fill her pipe properly, she must take a small pinch of tobacco hold it up to the Creator and say a prayer. She will repeat this ritual five more times (for east, south, west, and north, earthward.), saying a prayer at each of the directions. When she is done filling her pipe (which represents the universe.), she will smoke it, until all the tobacco in the pipe is used.

When White Cloud Woman is through preparing her breakfast,before she eats, she will set aside a small portion of each item she has cooked and set it outside. This ritual is done in thanks for the food the Creator has provided for her, also, it is to give back to Mother Earth some of what she has given.

Throughout the day, White Cloud Woman will carry with her several small bundles of tobacco. The tobacco will be given to any person (animals, birds, insects and plants are relatives therefore, treated with respect by also, giving them an offering of tobacco.) she must ask a favor of. The tobacco is to show respect and give thanks for the favor that is done and for the Creator, who put the person on earth to do the favor.

White Cloud Woman may also wear a medicine bag and/or a feather. The medicine bag may contain something of significance to her. The bag may also contain plants with purifying or medicinal properties. The feather, may be of an eagle, a blue heron, or a personal guardian (seen in a vision.) of White Cloud Woman's.

Lunch and dinner will be accompanied by the same "separate plate" ritual as breakfast.

The same pipe ritual will be conducted at sunset, as was conducted at sunrise. The purpose of the sunset pipe ritual, is to thank the Creator for the day that has just passed into night and to pray that the creator will let her wake to see another day.

As you can see, a traditional Ojibway does not merely go to church one day a week to thank the Creator, but does so in everything she/he does everyday, throughout life. To thank the Creator only one day a week, would be greatly disrespectful. The Creator never stops providing for us at any time, therefore, we should show respect and pray thanks always.

***OJIBWAY CEREMONIES*/RITUALS**

Naming Ceremony

In Ojibway culture, a name is not merely a term of address, it is an identity, which later becomes a reputation therefore, much thought must be given before giving an individual a name. Sometimes it is years before a person receives a name.

When a person is to be given a name, the services of an elder are required. The elder will pray to the Creator through his/her pipe, meditate, and dream, sometimes for many days, in seeking a name for an individual. Seeking a name is never easy, it requires a journey beyond memory, into the realm of enlightenment and revelation. When an individual receives a name, the elder who gives the name becomes as a grandfather to the individual, and is addressed in this manner by the individual given the name.

The naming ceremony: Before the elder sings in prayer a pipe will be filled, as described earlier and passed around sun-wise, while being smoked among the men (if the name giver is a woman, the pipe will be smoked among the women.). The person who is to receive a name will stand facing the east holding a small tobacco bundle. The elder who is to give the name will sing in prayer to the six directions (skyward, east, south, west, north and earthward.), turning sun-wise as he/she does so. When the elder is finished, he/she will announce the name that will be given. All participants congratulate the person who was given the name, and a feast with celebration follows the congratulations. Depending on the financial stability of the family of the person who receives the name, a give-a-way may follow the feast. If there is no give-a-way, then the feast signals the end of the ceremony, otherwise the ceremony ends after the give-a-way.

The Vision Quest

In most Indian cultures, the quest for vision plays an important role in self-discovery, self-direction, and individual spirituality.

The success of this ritual depends on the faith and integrity of all involved with the quest.

A person may quest for vision at any time in his life (usually after the age of fourteen.), and may choose to quest more than once in his life.

When an Ojibway wants to quest for a vision, he/she will seek the advice and/or help of an elder who is knowledgeable in questing (many are.) and vision interpretation. In questing for a vision, the person is asking the Creator for some guidance and revelation in his/her life.

The vision quest: The person wanting to quest, will first have gone to his/her selected, secluded, spot and properly prepared it for questing in the following way; the area will be smudged (burning an herb and wafting the smoke on an object, to purify it.) and a bed of cedar put down on a six by six foot square. At the east, south, west, and north sides of the square, a flag will be placed. The flags colors will be yellow for the east, white for the south, blue for the west, and red for the north (these colors represent the four directions and the four races of man. These colors remind us to serve all people, not just Indian people (Mails-Pg. 175)).

Just before the quest, the elder that the person questing has chosen and all other assistants, will participate in a sweat (a purifying ceremony.).

After the sweat, the questor will go to the questing site he has prepared. At the questing site, he will stay (never leaving the boundaries of the four flags.) for as many days as he has pledged to stay. While he is at the site, he will not eat or drink anything and always moving sun-wise, he will pray with his pipe.

When the time he has pledged is up, the elder will come for him and take him home. The questor may or may not have had a vision. In any case, the elder will know , because he will have had the same vision as the questor and will interpret the vision for the questor. A person should never ask a questor of his vision, because it is a very personal communication between the questor and the Creator.

The Sun Dance

This ceremony and ritual is the biggest religious event of the year for many Indian cultures. I have participated and danced in sun dance ceremonies, so, what I describe will be from personal experience.

Each year, about the time of the summer solstice, my husband and I leave for the Turtle Mountain, Chippewa/Ojibway Reservation in N. Dakota, to sun dance.

Upon arriving and after camp is set up, all the persons who have come to participate, begin building a large arbor of trees and branches with leaves. When the arbor is finished, the men go pick a tree to be used for the sun dance pole. The pole is put in the ground, in the middle of the arbor. That night we have an all night sing in a large tipi. When morning

comes, everyone who is to dance (and all visitors.) eats and drinks (no alcohol.) their fill; this is their last meal until they are done dancing as many days as they pledged. Around noon, on that same day, the dancers enter the sun dance arbor, where they will dance and sleep for as many days as they pledged (1 to 4 days.). When the drums sound and the men beating the drum sing, the dancers must dance. The dancing usually lasts from sun-up to sun-down. All the while the dancers are dancing, they are also blowing on bird bone whistles. Once a day, all the visitors are fed. The visitors are there to support the dancers. When the visitors eat, they are eating for the dancers. As the dancers dance, they pray for all the people and for vision (in general.).

On the second or third day, dancers and visitors give flesh offerings (this is optional.). During flesh offerings, people line up to give tiny pieces of skin (as many as they wish.), as a sacrifice to help the people and show our faith and love for the Creator.

On the fourth and fifth day of the sun dance, piercing takes place (also optional.). To pierce, two small, thin sticks, which have been shaved smooth and are pointed on each end and a clothes line, are brought to the center of the arbor by each dancer who wishes to pierce (one person at a time.) The dancer who wishes to pierce, is fanned with eagle feathers, while an appointed person makes cuts in each side of his/her upper chest, for insertion of the sticks. The sticks are inserted through the skin and the clothes line is attached to each stick. The free end of the clothes line is then tied to the top of the sun dance pole. As the drum sounds and the singers sing, the person tied to the pole begins to dance, always looking at the top of the pole and pulling back on his/her tethers, as hard as he/she

can. When the person attached to the pole is done dancing, the sticks and clothes line are removed and tobacco rubbed into his/her wounds (to promote healing.). The sticks are pushed into the ground, at the base of the sun dance pole and the dancer hugs the pole, crying tears of love (for the Creator and all the people of the world.). The clothes line, is usually given to a person who is significant in the dancer's life.

When the four days of sun dancing is through, there are many, many give-a-ways for the poor people at the reservation and the elders (these give-a-ways are also, a sacrifice.), followed by an enormous feast (enormous, if money permits. Small if money is scarce, but it matters not to anyone.). The sun dance is ended and everyone returns home, some from as far away as Norway.

Rites of the Dead

When a traditional Ojibway dies, his/her body is washed, clothed in the best regalia (ceremonial clothes.), and hair braided. The family of the deceased send for a holy man. The holy man instructs the persons preparing the body to place the body on a pallet, gather all of the deceased belongings, and paint his/her face, the way it was always painted in life.

The holy man will then summon the family of the deceased and begin to pray, addressing the soul/spirit of the deceased (The soul and spirit are separate, but united. The soul helps to hold the spirit to it's body, until it is ready to go on the journey back to the spirit world, where it was born. (Poulin)) These prayers are directions to the soul/spirit of the deceased, on

how to safely travel the pathway of souls (the Milky Way.) and reach the spirit world. The holy man will do this for four days. The family will also sing the deceased death song if he/she did not have the chance to sing it himself before he/she died.

It is believed that the soul/spirit lingers near it's body for four days, awaiting complete transformation from soul/spirit to spirit and soul, when it is fit to enter it's new life.

On the third day after death, a grave is dug. The holy man wishes the soul/spirit of the deceased a safe journey. On the morning of the fourth day, the funeral procession, carrying the deceased, set out for the grave, with them they bring all the deceased possessions.

A lock of hair from the deceased is put in a birch bark bundle. The deceased is lain in the grave, with his/her possessions and his/her body is covered with cloth or animal hide. As the the men fill in the grave, the women rise, one by one, to sing songs of lament and dance the burial dance.

When the funeral is over, a spirit house is built and put on the grave. Food is placed in front of the spirit house door. A four day vigil with a fire and prayers will take place at the grave site.When funeral and vigil are over, the spouse of the deceased unbraids his/her hair, removes his/her funeral attire and replaces it with old worn clothes, which he/she will wear for one year (standard mourning period.). His/her funeral attire is put into a large birch bark container and in this he/she also puts the container which holds his/her spouses lock of hair (which represents the spouses soul.). He/she

will carry this large bundle with his/her always during the year of mourning and add to it any gifts he/she may receive during that year.

If he/she has any children still living at home, they will be required to paint black circles around their eyes for the year of mourning.

At the end of the year of mourning, the spouse of the deceased may once again braid his/her hair, put on new clothes and go on with his/ her life, with his/her in-laws approval. Four days after coming out of mourning, a huge feast is given and the mourner has official permission to resume a normal life and look for another spouse.

Although, these are considered the proper funeral and mourning rituals for traditional Ojibway, more modern standards are employed now , which incorporate some of the old ways with some of the new.

The above rites, would also be know in some Indian cultures, as the keeping of the soul. Keeping a soul purifies it, so, it and it's spirit may return to the spirit world (and pathway of souls.) and need not wander about the earth, like the souls of bad people. By keeping a soul, we are reminded of death and also, of the Creator, who is above death. (Brown-Pg. 11).

SUMMARY

Although, the ceremonies I have talked about are only a few of the many practiced by traditional Ojibway people, they exemplify the extent of Ojibway spirituality. Through dream or vision they elicited revelation - knowledge that they then commemorated and perpetuated in story and re-enacted in ritual. This is why culture, religion, and spirituality, for the

Ojibway (and all Indian cultures.), cannot be separated. The Creator is in all of their thoughts and actions, everyday (Johnston- Pg. 7).

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Toubuls... Elder, Medicine Man, Holy Man and Pipe Carrier- Pine Ridge, S. Dakota

Edwin Poulin... Native American Deacon of the Catholic Church- Detroit, Mi.

Laura Eckelbecker... Elder, Pipe Carrier and Student at Wayne State University- Detroit, Mi.

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Fools Crow--- Thomas E. Mails

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MULTIPLE CHOICE QUESTION

One of the universal concepts of Indian cultures is : (a.) Indians believe in scalping. (b.) Indians pray to animals and inanimate objects, as if they were Gods. (c.) Indians believe there is only one God. (d.) Indians believe that rocks have souls. e.) All of the above.

ANSWER

C.) Indians believe there is only one God.

SHARED EXPERIENCES:

SEMINARS IN MORTUARY SCIENCE

One of the Departmental requirements for the degree in mortuary science at Wayne State is participation in a two credit hour seminar. This course, offered every semester to accommodate enrollees, is designed to encourage undergraduate research via investigation of multidisciplinary topics.

The format for seminars has remained fairly constant over the years. We open with discussion-presentations led by departmental and extra-departmental faculty designed to provide background information on the topic for the semester. Once the research parameters have been defined, class is adjourned for approximately one month as students gather their portions of the data. During the final four weeks of the term class is re-convened, data presented, complied and discussed and conclusions drawn.

Initially, seminars focused on cultural and ethical perspectives on death and dying but as these topics became incorporated into the psychology and management components of the curriculum emphasis shifted to exploration of death and the arts (including at various times, literature, the graphic arts, and music). As an example, early classes compiled film images of funeral directors and/or collected

photographs depicting death in different decades of the 20th century. Both exercises provided ample opportunity for students to explore society's changing views of their profession in particular and death in general.

For the last two summers we have examined music and death. Working from the premise that art can only be understood in light of the general intellectual and moral climate of the time, seminar for Summer,1993 chose four historical periods and investigated the milieu, philosophy, and music of each age. As part of that seminar, the work of the French philosopher, Hippolyte Taine, was discovered. Briefly, Taine viewed the development of art from an evolutionary perspective and wrote that " the moral temperature of society affects the selection of talented individuals. A certain moral temperature is required in order for certain talents to develop." (Taine. vol.1 p.55 in Blankopf. p.29.)

As a result of discussion of Taine's perspective, seminar for Summer, 1994 focused on the sociology of modern music and sought to hypothesize future trends in funeral service that could emerge in response to changing popular views of death as defined by contemporary music.

As a departmental offering, seminars have been most interesting and profitable. They have provided opportunities for students to explore beyond their prescribed curriculum, to interact with diverse departments and personnel, and to integrate their profession into a perspective of society as a whole.

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Final Exit - An Open Letter to the Author

John N. Alloway, BS; Karen Lerner, BA, Camden County Prosecutors Office, Scientific Investigation Unit; and Robert J. Segal, M.D., Camden County Medical Examiner's Office, 43rd & Madison Avenue, Pennsauken, N. J. 08110

REFERENCE: Final Exit - The practicalities of self deliverance and assisted suicide for the dying. The Hemlock Society, P.O. Box 11830, Eugene, Oregon.

In todays age of do-it-yourself books, it is not surprising to find one on self-deliverance and assisted suicide. Derek Humphry, Director of the Hemlock Society, has put forth, exacting ways for one to commit suicide either alone or with assistance. His principle criteria is that an individual be diagnosed as terminally ill by at least two physicians, and that he/she has lost the desire to live because of unbearable conditions of the disease. This book is aimed at educating the public on how to achieve a dignified death. Routine methods of suicide (shooting, hanging, etc.) are described as bizarre and are emphatically discouraged.

The number of people who want to avoid long, painful deaths, at the hands of modern medicine is growing. The cost of quality health care is becoming prohibitive. This leads many terminally ill patients to actively seek an end to their sufferings. It is for these people that Derek Humphry has written his book. However, what about the multitude of depressed individuals who are looking for a fail safe method to end their lives? What about the stressed, confused, and pressured teenager who reads this book in order to finally succeed at something? Just as disturbing, is the unusual case of the not so kind and caring son who used this book in an attempt to cover-up a murder?

In three New Jersey counties, over a four month period, following the publication of "Final Exit" there have been six suicides, one homicide, and one attempted suicide where the book "Final Exit" has been utilized for purposes other than it was intended. Five of these cases are presented.

CASE 1 MURDER

This case took place in October, 1991 with police officers responding to a death scene. A man called police requesting an ambulance for his mother. Upon arrival, the officers found the residence locked. After repeated knocks, the officers were met at the door by a white male who was curiously wet.

The victim, a white female, fifty years of age, was on a bed in the living room. She was in a supine position with a large amount of blood surrounding her head. Her right arm was up and her right thumb and index finger were on top of a four inch Smith and Wesson revolver. The barrel of the weapon was pointed toward the right side of her head, which displayed obvious trauma. Inspection of the weapon revealed that there was only one cartridge in the cylinder and that it was located in the one o'clock position. The serial number of the weapon had been drilled off.

In the same room, a typed unsigned suicide note was located on a lamp table, laying on top of the book "Final Exit". Other books, covering the topics of chemotherapy, prescription drugs and home remedies was also found in the living room. The patient had ovarian cancer.

Blood was located in several rooms of the house as well as on a pole in the basement. Men's clothing, located in the basement washer were clinging to the side of the drum, as if the final spin cycle had just recently finished.

In a statement, the victim's son told the police he didn't own a gun. He also stated that the only thing that gave him any indication that she might have suicidal tendencies was his observance of her reading the "Final Exit". He describes it as a book about people who are terminally ill or in terrible pain and advises ways to end one's live. It should be noted that the book found at the scene had never been opened.

Statements from other persons indicated that the victim's son had threatened to kill his mother on several occasions so he could inherit her money. These same statements revealed that the son had purchased a weapon for the purpose of killing his mother and had drilled off the serial number to make the weapon untraceable.

The son was charged with murder.

CASE 2

In December of 1991, a local police department received a phone call from a female requesting that they dispatch police officers to her home immediately. She refused to disclose the reason they were needed.

Upon arrival the officers observed a white female, 73 years old, in a first floor bedroom lying across the single bed. She had a gunshot wound of the mouth. A .38 caliber Smith and Wesson, five shot, was observed in her lap. Gun shot residue was noted on her left thumb, index and middle fingers.

Inspection of the weapon revealed one spent casing located in the 12 o'clock position. A cordless phone was on the bed to her right. The woman suffered from advanced emphysema and had an oxygen tube in her nose that was still functioning when police arrived. A note near the front door instructed them to turn off the oxygen.

In the kitchen, the book "Final Exit", and a section of newspaper containing an article on euthanasia were located on the table. A closer inspection of the book revealed several highlighted sections. One highlighted section was "Shooting". It indicate that the preferred method is to put the gun into the mouth and shoot upwards towards the brain. Handwritten in the margin next to this sentence was "It works with no pain".

In the living room, under a rocker, was a cardboard box addressed to the victim. It contained handwritten instructions, with diagrams, on how to load and fire the weapon. Later investigation revealed that the weapon had been used in the suicidal death of the woman's niece and had been sent to her through the mail by her nephew.

CASE 3

This case was a 34 year old single white male who was staying at a casino in Atlantic City. He was found lying on the floor of his hotel room. Earlier in the evening, he was escorted from the casino to his room by security officers because he had become unruly and intoxicated. When he was found, a bottle of 80% proof vodka was observed in the room along with a copy of the book "Final Exit" which was in his overnight bag. The decedent had a medical history of a malignant melanoma which was removed surgically four weeks prior. Family members described the man as a loner and denied any knowledge of his desire for suicide. Autopsy showed that this man died from a suicidal overdose of Meperidine and ethanol poisoning. Interestingly, a $5 bill was found clenched in the decedent's hand. In Chapter 17 of "Final Exit", Humphry suggests that if one is to end their life in a hospital or motel, they may want to leave a note apologizing to the staff for any inconvenience or shock. He also states that he heard of someone who left a tip to the motel staff.

CASE 4

This case involved a 60 year old white female who was found in a motel room. In the room the book "Final Exit" was found along with empty prescription bottles of Darvon, Restoril and Halcion. A plastic bag with a tie was observed over the decedent's head. The decedent had a medical history of depression. She had told her husband the day before that she was going to commit suicide. Autopsy findings showed that the decedent died from mechanical asphyxia and an overdose of medications. No chronic or terminal illness was identified.

CASE 5

This case involved a 29 year old stockbroker who was found lying on the floor of his apartment. In the residence, the book "Final Exit" was found in the decedent's trenchcoat. The decedent was despondent over the breakup of his marriage and discouraged with his high pressure occupation. He told family members of his depression, and did leave a suicide note which was found in his residence. Approximately four days prior to his death, the decedent had discussed his feelings about the Hemlock Society and the book "Final Exit" with a psychiatric counselor. The counselor was most emphatic in stating that if the decedent had not been reading this book, he probably would be alive today.

SUMMARY

Five cases occuring over a period of four months in three New Jersey counties are reported. In each, the book "Final Exit" was found at the scene. In one case the book was part of an elaborate although poorly executed murder plot. In another it represented part of a set of detailed instructions for suicide using a hand gun. Four of the victims appear to have been reviewing their lives and were unable to resolve certain conflicts leaving them, in their mind, with only one solution - suicide. "Final Exit" became their assistant. It assured them that they would not fail at this last task. In only two cases was the victim terminally ill and one of these was the murder victim. Only one of these cases even begins to resemble the deep thinking, soul searching intellectual who after careful consideration chooses a dignified alternative to a prolonged agonizing terminal illness. Even in this case "Final Exit" failed as the victim used a gun which is specifically rejected by Mr. Humphry.

COMMENT

It is not the purpose of this paper to pass judgment on the concept of suicide by the incurably ill for whom the book "Final Exit" was written. We do wish to point out that the book has profoundly effected the lives and parenthetically the deaths of people for whom it specifically was not intended, although made readily available.

The authors wish to thank the administration and staff of the Camden County Medical Examiner's Office, the Camden County Prosecutor's Office, the Atlantic County Medical Examiner's Office and Cape May County Medical Examiner's Office for their assistance in preparing this presentation.