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Grief in Adulthood:

Death Education, Intervention and Bereavement Resolution

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Grief in Adulthood:

Death Education, Intervention and Bereavement Resolution

Bereavement and grief will affect all of us. The concern is not if but when (Rogers, 1980). Grief is a universal phenomenon which has as its authority the right to claim its ownership over each of us (Canine, 1999). An estimated eight million Americans will experience the death and ensuing grief of a close family member each year (Osterweis, & Townsend, 1988). Added to this estimate are the extended-family members and friends who will suffer the emotional stress of grief. Clearly, the ability to help those in grief through death education, intervention, and support would be of benefit to those in mourning, or anticipating to be in mourning, if they could better assimilate the complex and phasic process of grief.

To serve as an assumption for this paper, could anyone deter grief resolution for the bereaved spouse the option of a successful readjustment to widowhood and a positive lifestyle as a widow/widower? The question put forth in this paper, prior to a loss or very soon afterward, is whether or not death-related education and intervention is instrumental in grief resolution and assists in a return to a positive and productive continuation of life? This paper gives a sampling of death-related education, grief support-giving concerns, and lastly, examples of intervention to detect if these are beneficial to those who have suffered a loss as they learn to understand the grieving process and helpful as they experience the hardness of grief as they labor toward its final resolution.

Grief Attitudes and Bereavement:

As defined by Kiely (1984), bereavement is the reaction to the loss of a close

relationship. This chaotic stage of life is an all-consuming, emotional experience. Osterweis and Townsend (1988) consider the affect of bereavement to be one of the most powerful events experienced by human beings. These stressful events, and their consequences, are ones that we may experience multiple times during adulthood. Furthermore, experiencing the totally unexpected loss of someone we love, of all the experiences we are dealt in life, the toughest to face is the sudden death, because sudden loss doubles the pain and intensifies the grief (Tatelbaum, 1999). As Trolley (1993) suggested, with the unexpected and suddenness of an unanticipated death occurring, the survivor is confronted with intensified shock and is especially vulnerable to self-destructive behavior. How one copes with such a loss, or any loss of similar importance, is determined by many variables. Some of these factors are easily understood as logical reasons for determining different coping styles, and are factors such as the degree of closeness of the mourner to the deceased, or one's past death experiences, or intellectual level of death education, or the death attitudes of one's culture. These, of course, are no way exclusive or total in number, but they may be predictors of whether or not the bereaved successfully or unsuccessfully recuperates from the trauma caused by the death. While this seems true today, it has not always been so.

Within the history of various cultures most, if not all, have understood the importance of bereavement as a part of life and the need to support the bereft. The American way of death has been changing over the past 100 years and these changes have altered the way Americans are expected to react to their grief and have limited the grieving protocol (Fulton & Owen, 1987). Jessica Mitford put contemporary funeral practices into questions during the 1960's with the

publication of the American Way of Death. Her purpose was to discredit the practices of the funeral industry but seems to have resulted in discouraging funerals, memorial rituals, or other meaningful rites which help the bereaved through the earliest stages of grief (Camp & Bolton, 1984).

According to Oakland (1981), in contemporary Western society there is a breakdown of mourning customs and practices which do cause a greater number of grief responses but, simultaneously, fail to support the bereaved at their critical time. A misconception in today's Western culture is that the death of a spouse, or another deeply-loved and significant other, will not occur until old age. However, between the ages of forty and sixty, more than 50 percent of Americans will experience the death of a parent (Scharlach & Fredriksen, 1993). Rogers (1980) pointed out twenty years ago, that the average age of widowhood, for those living in North American, is 56 years of age. This mean age of widowhood is in stark contrast to one of the death denial attitudes of the American society, i.e., that death only occurs to the very old.

This detrimental attitude about death, in our culture, is further reinforced when those in grief realize they are not resolving their grief as quickly as expected by society's norms, or based upon their own predetermined, internally imposed time-frame, they develop fears that they are not coping adequately when juxtaposed against their own embedded cultural expectation (Kiely, 1984). Another common example is when, in their opinion, some well-intending individuals become upset with those in grief if the griever prolongs the expected readjustment period or if those in mourning do not take their advice to forget the loss and get on with life (Parker, 1995). Parker goes on to infer that this lack of support forces many to grieve alone and reflects a societal

view that a death may be an unworthy reason to grieve. Additionally, in our contemporary society, we find a reduction in the cohesiveness of both the nuclear family and the extended family. As a contextual frame, the mobility and geographic separation of immediate family members cause many to seek non-domestic sources of support to help them cope with their suffering, their isolation, and the lack of family support as they strive to return to normalcy (Trolley, 1993).

As considered by Parkes (1987), bad grief is caused in current Western culture if the inference can be made that we expect those in grief to restrict their overt displays of emotions. Camp and Bolton (1984) claim that this modern decline in acceptable bereavement is responsible for multiple cases of maladaptive grief resolution and is additional confirmation of a death-denying society. Their research into funeral customs in the United States found ambiguous meanings as to what is the proper way to mourn since there are no nationally accepted and appropriate mourning behavior which have consensus approval. A different way of expressing this could mean that since Americans have no traditional patterns or knowledge of the ways of grief, then we may say that if someone doesn't know what to do, deny it, and it will go away. An additional viewpoint could be that social pressures could cause the bereaved to deny the significance of the deceased, to avoid any type of behavior which may signify intense grief, and any overtly displayed mourning in a public setting would be considered by societal norms as inappropriate behavior by the bereaved.

This death denying attitude has highly significant consequences which deter successful grief resolution. In their paper on advice for grieving widows and widowers, Peterson and Warrick (1988) use a quote attributed to Margaret Mead to succinctly state this factor of denial:

when a person is born, we rejoice, and when they're married, we jubilate, but when they die we try to pretend nothing happened.

Oakland's (1981) view of bereavement is essentially that grief is an inevitable yet normal life event that has serious psychological and social results to the individual who has lost a loved one, and knowing this, one can prepare to accept its intrusion into one's personal life. As viewed by Osterweis and Townsend (1988), to be a bereaved individual is like being in a foreign country where all semblance of normalcy is destroyed. To be in bereavement is akin to being unable to behave according to societal expectations because all relationships are disrupted, total disorientation sets in, and everyday routines are upset (Doka, 1999). Therefore, just as each person is multi-dynamic, so is bereavement. Bereavement is a complex multi-issue and each individual will vary in their responses to each issue (Worden, 1991). Worden goes on, by analogy, to say that each loss of a loved one is as traumatic as being severely wounded, with the former being psychological trauma, and the latter one being physiological trauma. In other words, as the physical wound takes time to heal, if properly cared for, so to will the bereaved, if they also are properly tended to and cared for.

Time Frames

As presented, grief is governed by societal expectations and is exhibited as an overt display of emotions exhibited as mourning. An individual's reaction to bereavement and mourning will encompass a wide and confusing range of real and perceived symptoms. Each of these takes time to experience and resolve. From the literature on bereavement, notably from Maglio and Robinson (1994), mourning is a process and not a state which can be definitive in time. An secondary way of looking at this time-frame concept for recovery is that mourning is the

course of adaptation to a loss and mourning takes time before it can be completed (Peterson & Warrick, 1988). They expand this idea stating that the mourning process has no static structure, it is a process of fluid phases and clusters of emotional reactions which continually overlap one another. Since life itself is not unswerving, with many emotional highs and lows, neither does grief progress in a straight and orderly fashion guided by time. Helping to validate the dynamics of grief, Osterweis and Townsend (1988), clarify this fluidity paradigm to mean that just as each bereaved individual will react differently to life stressors (including grief) with unpredictable outcomes, so to is the time-frame for the final outcome of grief resolution to be different than expected.

According to nearly all death related literature of pertinence, each acknowledges the work of Freud's and of Lindemann's early research into bereavement. Contrasting their work, with current grief-related literature, contemporary researchers view bereavement as a lengthy process, but these individuals refrain from putting definite time limits on grief resolution. What has been determined from the literature review is that early research set finite time-lines for uncomplicated grief recovery for intense grief at six months and full recovery at one year, present day grief experts see evidence that the worst part of grieving, for most people is over before one year, for many though, the process may take up to two or more years.

Attachment

Grief resolution is solitary work. Stroebe and Stroebe (1987) present a theory that grief and mourning is the result of a bereavement which is caused by a loss of a closely held and emotional attached intangible symbol. Their view is that grief work is something that each individual must do alone, but the ending result is to free, in a psychological sense, the bereaved of

his or hers emotional ties and attachments to the deceased. This resolution is, as stated by Attig (1996), successfully ended when the bond, but not the memories, between the deceased and the bereaved is withdrawn by the bereaved and attached to another individual.

Closely aligned to the outcome of grieving is the nature of this attachment theory between the deceased and the survivors. The attachment theory conceptualizes grief as a disruption of the everyday activities which an individual has established with a significant other, and through death, the bond is broken and the rewards of companionship fail to elicit usual and customary rewards (Krysinski, 1993). Attachment theory considers how influential and important the deceased was to the survivors. The more important the deceased was to the next-of-kin, the greater the attachment and the deeper the grief.

With attachment and bereavement comes the unique meaning of the closeness felt by the survivors to the deceased. Parkes (1987) sees this attachment as unique and the inability to disengage from the deceased and invest in another, with the same degree of intensity, fails to recognize the uniqueness of each relationship. In some losses the reaction is a deep and prolonged grief as that which accompanies the death of a child. Yet in some losses, where the deceased was a colleague, a deep sadness is felt, but not grief since no emotional bonding had occurred (Copeland, Noble, & Fieldstone, 1995). Redmond (1999) believes the real trauma of grief is caused by the breaking of life's continuum. Here the linkage, or attachment between close, intimate individuals, is being shattered with the resulting loss of commonality and the loss of connection resulting in acute trauma and long term grief recovery. This traumatic experience is known as the stages of grief.

Death Education, Anxiety, and Curriculum

One of the goals of education is to help the participants change their attitudes about subject matter (Shoemaker, Burnett, Hosford, & Zimmer (1981). A goal of death education is to show the bereaved how to build back interdependency and reconnect to family, work, and community (Redmond, 1999). Even with these two goals explicitly stated, teaching about bereavement is a controversial topic. Some educators raise questions that address the issue of whether or not the subject should even be taught. Others debate about the optimal age to teach about grief and, if it is to be taught, should it be in a structured classroom setting or in an informal educational setting. Still other teachers feel that it is best to simply leave it up to each individual to experience grief and to learn from each encounter with death without any sort of guidance. Interestingly though, as the debate continues on whether or not death education programs should be taught, there is an ongoing increase in the number of death-related formal education programs being taught across the country, primarily at the college level (Cook, Oltjenbruns, Lagoni, 1984).

Death and grief education has a far-reaching effect. Death education reaches far beyond those who enroll. Educational programs, with death or bereavement as the focus of the class, generally serve to add death-related issues to general conversations outside the classroom. Because those students who are enrolled in these courses discuss the subject matter with their friends, these friends experience some of the ripple effects of those enrolled (Cook, Oltjenbruns, & Lagoni, 1984). Scharlach and Fredriksen (1993) consider this a positive consequence when they write that most students report that after concluding a course in death studies, or for those outsiders who have had some discussions with those enrolled in such coursework, that they have an increased sense of their own mortality and begin to realize the importance of altering their lifestyles in positive ways.

Regretfully, it seems that most educational programs are inadequate in preparing the individual's ability to deal with those affected by a death (Johansson & Lally, 1990). They found in their study that those individuals who are trained to encounter death and dying as part of their professional or volunteer careers, often have difficulty in coping with the stress of dealing with the bereaved. As another example of inadequacy, research by Da Silva and Schork (1984) indicates that there are significant death-related perception issues between sexes. Programs of instruction in death education fail to address differences between such issues as gender, age, experiences, expectations, etc. Their research suggests a distinct need for death education to emphasis these differences during training. As a suggestion, they propose that classes need to address the male inability to express grief and their tendency to repress their death anxiety. Since females are more comfortable in understanding death-related matters, it is also recommend that a curriculum be developed which stresses the manner in which females can accept, share, and provide support to more distressed males.

Maglio and Robinson (1990) associate programs of death education with two types of learning approaches: didactic and experimental. In the didactic method, which is the traditional classroom setting with instructors lecturing from prepared curriculum material, the aim is to acquaint the student with the terminologies and professions whose vocation is working with the antemortem or postmortem aspects of death. Whereas, in the experiential education method, the emphasis is on interaction, role-playing, and open discussions of what they have learned or how they will apply it in the future (Hutchison & Scherman, 1986). Both didactic and experiential training is to give death-related information, assist the trainees in the self-exploration of their own anxieties of death, and to help these individuals to come to a greater sense of resolution of their

ability to aid the bereaved in providing information about community support for the bereft.

The nature and content of most death education programs have, as an expressed objective, the aspiration of reducing students perceived level of death-related anxiety (Hayslop, Galt, & Pinder, 1993). However, both death and anxiety are considered subjective, personal issues which cause researchers much difficulty when summarizing their results as to which method is better. The problem of not reducing self-reported death-anxiety was found by Maglio & Robinson (1994) as they report that in both styles of education, immediately following the term, there is a higher self-reported awareness of death anxieties by students. As found in studies following their literature review, Shoemaker et. al., (1981), report significant increases in self-reported death anxiety among participants after attending grief seminars. Contrasting these are results from other research studies on the effects of death-related education which state that anxiety is definitely reduced following the course (Maglio & Robinson, 1994).

Hayslop, Galt, and Pindar (1993) view these opposing research findings as logical since immediately following instruction, and being closely attuned to death and its related issues, the students are more cognizant of death's implications, are thinking a lot about the subject, and are discussing the topics daily and therefore are more concerned with the effects death will have on them. This fact is confirmed by Shoemaker, et al, from a study which followed a six-week course on death-related issues and found that immediately after the session that their subjects reported higher anxiety after the course than before. However, after a period, the urgency of study has abated, the daily reminders are less, and other more important daily topics present themselves to the students. The students have learned to assimilate the information, have learned what they want and will use, and have reached a level of acceptance to the consequences of death. In a study by

Johansson and Lilly (1990) they report that the mean score of self-reported death anxiety was much higher following only a didactic presentation of death education. They suggest that all death education programs should incorporate both audio/visual materials with supervised clinical experiences, which they infer is the most important and relevant part of any death education program.

The viewpoint here is that using only the didactic instruction method is not very effective when related to the confrontational, experiential method where students share their feelings and can see the reactions of fellow students when faced with emotional charged issues. Amplifying this last suggestion, Hutchison and Scherman (1986), recommend that training for death education care givers should include both the didactic and experiential instruction. Within the didactic curriculum should be lecture presentation on the phasic process of grief and discussion of these stages to the bereaved and their family and the tasks which mourners need to experience. Further, training which provides role-playing opportunities under the experiential method should be designed to allow students to explore their own attitudes toward death and encourage them to anticipate their own deaths. Experiential grief training aids the helper-to-be to become aware of the pain of grief and gives meaning to the person's ability to be an empathetic listener during their counseling sessions.

Before someone can help another, they must have accepted their own mortality, become aware of their attitudes toward death, and have resolved successfully any lingering grief issues. These exercises seem to enable the grief support individual to work through any of their own unresolved grief and learn listening skills and helping skills which they will use when counseling the bereaved. Hutchison and Scherman (1986) view these self-awareness role-playing exercises as

essential for grief support intervenors.

Intervention

For those in grief, very few need professional help. Usually, they resolve their anguish without the expertise of grief counselors (Folta, 1981). As stated by Sanders (1989), although everyone needs some sort of assistance to recovery from grief, most are fortunate to have family, friends, or social contacts to rely on. This reliance on social contact is supported by research which found that the healthier the interaction between family members and community, the greater is the likelihood they will have more resources and support systems available when needed. These nonexclusive social contacts can include ministers of faith, funeral directors, or self-help groups. Conversely, a maladjusted unsocial family tends to deny the reality of death, block any emotional reaction to a death, and is isolated and less likely to use available support systems (Williams, Polak, & Vollman, 1970).

Much of the care for the bereaved is overseen by family and friends which they offer to comfort and give consolation (Raphael, 1983). This comforting gesture, e. g., simply hugging the bereaved or listening, is usually best given in the early, acute stages of grief. In spite of such simple human kindness, Copeland, Noble, and Feldstein, (1995), suggests that those closest to the bereaved, i.e., family and friends, may at times hinder the grieving process or even harm the griever when they intervene in their attempt at easing the pain. These situations may be were those trying to comfort themselves have high death-anxiety, lack of bereavement education and training, or simply fear saying something wrong and are not successful in their attempts at intervention. Here is found the blunder of adding additional stress and increased feelings of isolation to the one they are trying to help. This compounds the anguish since both know they are being unsuccessful, they

both become upset with the failed attempts at console, and lastly, the griever becomes even more distant and distressed as they try to hide from these disastrous intrusions. These types of incidents accelerate the mourner's need to seek outside, professional intervention.

With society's rapid changes and mobility, personal crises are more difficult for those in mourning because these individuals are less likely to know where to get help. They may be living in strange new towns, far from relatives and have not become situated into business or social ties. Therefore, there are fewer known sources of interpersonal and social support that they can turn to for help. Knowing where to turn for grief intervention is the key to resolving complicated grief according to Greeson, Hollingsworth, and Washburn (1990). Support is the greatest asset the griever has but too many times those in grief don't want to lay their burden on friends, let alone strangers, or they believe their mourning needs to be done alone; therefore, they do not ask for help and they feel further isolated from obtaining help. Even though most come through the turmoil of grief and become wiser, some experience unresolved grief and suffer long-lasting, detrimental psychological damage. Sometimes these unresolved issues lead to crutches which are abused as they try to work through their sorrow. Parkes' (1987) extensive research on post-bereavement counseling suggests that for most cases of negative grief recovery, the bereaved individual seeks help because of depression and alcoholism resulting from atypical grief resolution.

There is not one specific type of bereavement intervention method that will nicely fit into the needs of all people. As stated by Parkes' (1987), it is completely naive to think that one, and only one, intervention treatment will work for all. Depending on the phase of grief in which one is in when intervention is begun, as well as a vast array of other variables (age, health, personality, facts of the death, strength of attachment), will determine the method and duration of counseling

(Sanders, 1989). To be effective, intervention should be commenced as near as is feasible to the onset of grief. It must always be remembered that even with intervention, those in bereavement will still feel the sorrow of the loss. Feeling of pain, anger, hopelessness can be reduced dramatically during mourning, if prompt and appropriate intervention starts at the time of anticipatory grief and continues through the period of acute grief (Greeson, Hollingsworth, and Washburn, 1990). With grief counseling it is hoped that it will be less overwhelming and have possibly shorter duration until one can return to a productive lifestyle.

A professional grief counselor must be trained in, and have a clear understanding of bereavement; plus have the ability to establish a trusting and client-centered relationship (Copeland, Noble, & Feldstein, 1995). Professional counselors need to understand the pain the patient is going through. An environment between the client and counselor should be established where the bereaved are encouraged to express their feelings, to demolish defense mechanisms, and to realize the practicality and benefits of working through grief to reach the resolution phase. Schwartz and Borden (1992) properly see a major obstacle to effective grief work is the mourner's avoidance of both pain and intense expression of grief. If the counseling session can be nonjudgmental, this framework will help the bereaved cope with the crisis of death by lowering resistance, fostering mutual trust, and easing the universality of grief. What is difficult for many professionals to show is the basic comforting gesture of an embrace because it shows the human side of the individual and some therapists feel they need to stay detached and though empathetic, must remain professional (Raphael, 1983). Paraphrasing the work of Raphael and Nunn (1988), which forms a basis for bereavement counseling, the following should be the counselor's task: a) ask of the circumstances which caused the death to learn how the bereaved feel about it; b) learn of

the relationship between the deceased and bereaved to find positive and negative feelings; c) inquire how and from whom they are receiving support to learn of the support network and how they are reacting; d) investigate the client's bereavement experiences to see how they have coped with loss in the past; e) familiarize yourself with the client's cultural and religious background for a perspective on their upbringing.

Intervention from self-help groups, is considered best when those from the support groups have similar experiences and can share their own grief with the newly bereaved (Sanders, 1989). Intervention by group sessions, instead of one-on-one counseling, offers the bereaved individual multiple opportunities to share their personal feelings with individuals who have experienced similar losses (Copeland, et al., 1995). In scenarios involving group counseling, there is a group facilitator who informs, educates, and encourages the members to reach out to each other to understand the pain, confusion and sadness they all feel. Group membership allows the griever to support and be supported by other members. Topics for sessions can range from discussion of the phases of grief, to coping strategies, finances, spirituality, home management, and self-identity issues. Self-help groups are very effective in uncomplicated grieving situations according to Copeland and others. They also imply that nonprofessional self-support groups are not particularly effective for complicated grief or grief reactions that are the result of alcoholism, those with suicidal thoughts, or long-term and chronic psychiatric problems.

Vollman, et al. (1970) undertook a study to see if intervention at the time of a sudden death reduced the morbidity and mortality rates in surviving family members. She, with her other researchers wanted to see if the interaction between family and society determines whether or not the family is open to intervention. Among some of the important findings of their research where:

that families accustomed to professions and experts were more willing to accept their advice; those who are more social, or outgoing, were also more willing to participate in professional intervention. On the other hand, they found that families that are asocial, belong to few if any clubs, have few friends or neighbors, and live with minimal social contact are families which need more aid and support during times of tragedy. However, this group is more resistant to help, even though their needs are great. Their conclusion states that the more interaction between the family and the larger social system, the better will they seek and accept intervention at the time of a death.

To deal with grief effectively, the helper must be aware of how the bereavement process is perceived by the family and be sensitive to the individual differences of mourning. During the grief intervention, the helper is encouraged to express the need for the bereaved to release their emotions, to listen and show genuine empathy, and help the bereaved see that they are not alone and abandoned during each session. For the bereaved, family and friends can offer only short-term emotional support. Since each family member must return to their normal routines, specific helping groups such as Compassionate Friends are there for the long run and can assist the bereaved through their troubling times all the while releasing the strain of family care-givers and personal doubts about their ability to help the bereaved cope (Sanders, 1989).

Conclusion

Bereavement and therefore grief is an emotional charged and extremely painful part of the passage of life. If the fear of losing someone dear would normally result in anxiety, then death education programs stressing intervention, with curricula that encompasses death awareness, would seem appropriate to relieve death anxiety and promote grief recovery in a timely fashion. This seems to be what Da Silva and Schork (1984) meant when they suggested that the acceptance

of one's own mortality would help alleviate stress by realizing a new perspective of life and greater balance of priorities.

It is important to realize that not all those in grief will react the same, nor will each griever proceed through each distinct phase of grief. Past experiences will play a critical part in future episodes as one learns which tactics helped and which one's where hurtful. Some will seem to fit the model perfectly while others will seem to progress rapidly to resolution.

The societal culture expectations along with the individual's personality traits will dictate how one resolves their grief. Social roles dictate the emotional response in terms that a person must attempt to conform to in the overt behavioral display of mourning. Society expectations guide or determine the rules which prescribe those behaviors which are negatively sanctioned by community norms and the grieving individual is expected not to only confirm but also to control their internal desires to cònform least they offend those around them. This, of course, is an example of detrimental grieving.

Educational approaches encourage students to talk about bereavement and the nature of grieving so that their self-reported level of death-anxiety is reduced. Both attempt to attain this goal using different methodologies. Regardless of the teaching style selected, anxiety about death is so varied and with so few consistent patterns that results from most studies are not reliable enough to generalize to the general population.

Where support is inadequate, the risk of ill health will be highest unless a planned support system is organized to fill the gap. A planned support system is most often provided by those who have suffered and want to help. For most people, primary support sources are their family, friends, and neighbors, but when faced with particularly stressful situations, they are likely to seek out

professional services and self-help/support groups. The reason for not joining a self-help/support group could be that they have enough social support in their natural environment including the support of friends who had lost someone like them. On the other hand, a major reason for joining a support group is to become connected with other parents in a similar predicament and because their family and friends encouraged them. Through support group participation, participants cannot only increase the quantity of support on which to depend but also find the type and reciprocity of support they seek. Organizations have developed support groups for specific types of bereavement and in these groups the empathy between members can be quite strong.

It is recommended that further study be conducted on issues brought forth in this paper. A long-term study on those students who enrolled in death education classes related to how they managed their grief at some later date is one possibility and consideration could be given to investigate death education courses given over the Internet in the framework of online distance learning versus in-class instruction and related the degree of anxiety reduction or anxiety increase.

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Student Articulations*: An Exercise in Peer Teaching and Learning

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* *ar·tic·u·la·tion (är-"ti-ky&-'lA-sh&n)*

1. *The action or manner of connecting two parts*
2. *A joint or juncture between bones in the skeleton*

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Introduction

Four years ago, I (LB) began teaching a one semester Human Anatomy course that serves about 40 Funeral Service (FS) majors a year. Unlike the science and allied health students in other courses I teach, FS students are not pursuing a career in science - they are business majors. My objective for FS students is not only to provide a comprehensive foray into human anatomy, but also to prepare students to succeed in state and national Mortuary Science exams. In order to better engage students and thereby increase their chances for success, I have explored a number of non-traditional methods to teach this terminology - rich and conceptually challenging course. One successful activity has been to allot 30 minutes per class for small group exercises consisting of labeling figures, responding to prompts, and answering questions that require critical thinking. Although this is a sacrifice of direct teaching time, it works. Groups consist of three to four students each with rotating membership. In a peer group, students with a better grasp of the material have the opportunity to help others gain a clearer understanding of the material. In this way students not only learn, but also get to know each other, apply their knowledge, participate (when in the traditional chalk and talk sessions they are less engaged), and argue and defend selected answers. One person in the group usually gravitates towards the role of guide. Mixing students in interactive exercises not only provides a layered learning experience for students but also fascinating data for the instructor to use for further refinement of teaching methodologies.

Funeral Service Students Unite With Physical Therapist Assistant Students

This article focuses on a peer-teaching arrangement between students in very different career tracks: Human Anatomy students in the Funeral Science (FS) program and Physical Therapist Assistant (PTAs) students. Initial discussions between faculty (LB and BJB) centered on the idea of providing the opportunity for PTA students to instruct FS students in an area of PTA specialty -articulations (joint anatomy) and kinesiology (joint movement) (Blinderman and Behrens, 1999). The two-fold objective was to facilitate learning of articulations and kinesiology by the FS Anatomy students and also provide a format for PTA students to develop teaching skills upon which they rely in interactions with patients or clients. We were also interested in connecting students from disciplines otherwise disparate. Arthrology, the study of joints, lends itself particularly well to experimentation in teaching methodology and active participation by students because a major focus of the curriculum is on movement and because PTA students have developed expertise in this area. The FS/PTA teaching model we developed is described in this report.

Each semester, two PTA students are given a flexible template to use as a springboard to develop an hour long presentation. Guidelines include the following:

1. Funeral Service students have a general knowledge of the skeletal system.
2. Include all synovial joint types, such as ball and socket (hip) and hinge (elbow) joints.
3. Utilize handouts, overheads, and models (artificial and especially live).
4. Include an exercise in which students participate actively.

The FS students meet in the PTA laboratory, which in addition to typical classroom supplies has a large space for movement exercises, models, and physical therapy equipment. Faculty (LB and BJB) are present but do not participate.

Analysis and Discussion

Evaluations by FS students of PTA student instruction are consistently high. FS students enjoy doing something "different" and appreciate the time the PTA student instructors put into developing their presentations. Originally, we were unsure of how the FS students would view peers as teachers and were concerned about a lack of attention. However, we observed the FS students to be supportive and respectful during the presentation. FS students are comfortable in asking questions and the PTA students always receive questions or comments concerning personal joint injuries or anomalies. Funeral Service students have contributed anecdotes and/or demonstrations including hyperextended joints, knee movement limitation due to an injured meniscus (a cartilage pad within the knee joint), an inability to invert a foot due to surgical fusion of tarsal bones, ligamentous laxity ("double-jointedness"), and the effects hip replacement surgery. Such discussion provides a means by which students can later recall joint information by association. Hearing of the soccer game that led to the student's torn meniscus may later help students recall that the tibiofemoral joint is one that contains a cartilage pad.

Some of the more interesting questions posed to the PTA students include queries about Christopher Reeve's spinal cord injury, whiplash, ligament pulls, and the joint anatomy of contortionists. In a discussion about Reeve's injury, students learned that the phrenic nerve, which innervates the muscular diaphragm to allow breathing,

exits the spinal cord below the second cervical vertebrae, the site of the injury. Had the injury been above the second cervical vertebrae, Reeve would have died. This type of dialogue between students is exactly what we had hoped for.

A significant benefit to the PTA students is the realization that they have acquired a substantial knowledge base. The peer teaching exercise affords PTA students the opportunity to access and communicate that knowledge to a lay audience. This has utility in terms of career preparation for the training physical therapist assistant. Studying hip joint structure and function, for example, prepares one to understand the relationship between articular cartilage and ball and socket movement, but only direct teaching experience informs one of his/her ability to effectively communicate that information.

One of the movement exercises developed by Physical Therapist Assistant students involves arranging the Funeral Service students in a large circle. Each student is given a slip of paper with a phrase such as "eversion of the foot", "flexion of the tibiofemoral joint" (knee), "circumduction of the humeroscapular joint" (shoulder), "inversion" or "pronation". The specified joint movement is demonstrated while the rest of the class, often after some discussion, identifies the motion. This is a fun exercise that provides an atmosphere of camaraderie. Those students who incorrectly demonstrate a movement are guided in the right direction by the PTA student facilitators. Variations on this exercise have been presented in other semesters.

Part of the success of this student-centered learning activity stems from the rich diversity of students at Mercer County Community College. MCCC serves Trenton and surrounding communities and the college's student body represents a wide range of academic, ethnic, regional, cultural, and experiential backgrounds. The age of students

in the Human Anatomy course ranges from 17 to over 60. A summary of our observations is provided below (Table 1).

Table 1. Summary of Benefits of FS/PTA Student Exercise

Funeral Service Students	PTA Students
1. Interaction with students from a different discipline	1. Interaction with students from a different discipline
2. Peer-centered environment in which to ask questions	2. On-site team-teaching experience
3. Active participation in the classroom	3. Development of presentation planning and delivery skills
4. Appreciation of the PTA profession, lab, and equipment	4. Coordination of classroom activities
5. Recall by association	5. Opportunity to be creative in the design of interactive exercises
6. Respect for peers	6. Respect for peers

The exercise was evaluated using both academic and non-academic criteria. The exercise satisfied our academic expectations in that almost all students performed very well on the arthrology portion of the exam (A or B grade). In that respect, the interactive classroom of the peer teachers was at least as effective as traditional lecture room instruction.

Although the exam is the measure of subject matter learned, it is also important to provide students with opportunities for individual growth, team work, confidence building, and other somewhat intangible and difficult to measure aspects of a liberal arts

education. In an attempt to gauge the value of the exercise to the FS students, we provide an evaluation form with specific questions as well as space for commentary. Students overwhelmingly and consistently give high ratings to the exercise in general. Responses indicate that the FS/PTA "articulation" is both informative AND enjoyable. Most (>95%) students respond that they would like to experience this type of learning in other classes. In addition, almost all students are comfortable being "on stage" in the movement exercises, enjoy getting to know students within their own classroom, and find interacting with students in another discipline to be of value.

In the article Saying Good-bye to Couch Potato Classrooms, (Taylor, 1998) the author observes that "calling forth students out of the comfortable position of passive receiver into literal and involved action spills over into other areas of their learning and gives them a vested interest in and a very real sense of propriety over their own education." The student-centered interactive classroom described here fosters this sense of ownership. Students get out of their seats, interact with students from a different discipline, and by their participation, influence the nature of the exercise itself. They also have fun.

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