

Death in Britain today

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Death is not a single concept. When I've been writing about funeral rituals, the mourning for Princess Diana, roadside shrines, the reporting of death in the news media, afterlife beliefs, or the contemporary interest in reincarnation, friends and acquaintances have been intrigued and have often given me, unasked, their own experiences and opinions. When I've been writing about dying or bereavement the conversation quickly turns to other things. Le Rochefoucauld once wrote, 'Death, like the sun, cannot be looked at directly'. We need a filter. So when I've been writing about the filters – such as rituals, belief systems, or media reports – friends and acquaintances are attracted. But if they fear I'm looking directly at death, without a filter, they turn away. As would have most human beings in history and prehistory.

A lot of rubbish has been written about ours being a 'death denying society'. Conceptually, denial is a tool identified within psychoanalysis as a way in which individuals cope; it is not easy, if at all, possible to apply the concept to entire societies, though there may be certain cases, such as following genocide when it may take decades for a society to acknowledge what happened.

With that caveat, in Britain today, clearly some aspects of death are highly visible, not least in the mass media, while at the same time some bereaved individuals feel shunned and people tend to die out of sight in hospitals and institutions. It's a mixed picture. And it is a mixed picture between individuals, which often causes difficulties in families – long after a death, she still wants to talk, he goes on silent fishing trips; she thinks he

doesn't care, he thinks she should be over it by now. Much of what bereavement counsellors and self-help groups work with are such secondary consequences of loss. The counselling session, the self-help group, provide (at best) a safe place within which feelings can be acknowledged, (at worst) a norm of talking and expressiveness that further alienates those who cope in the more stoical way that served this country well through two world wars (and for whose psychological efficacy there is considerable evidence).

Dying

Dying today shows three main features, all of them historical innovations. First, it is more often than not a slow business. The terminal period of some diseases, notably cancer, can be diagnosed with some degree of certainty, so the person enters not so much a sick role, for much of the time they may feel quite well, but a dying role from which they and others know the end is not recovery, but death. This is also true of those who enter nursing homes; they know they will exit horizontally, though the time frame may be less clear.

For many diseases, as Guy Brown shows in his recent book *The Living End*, though the final end is predictable, the trajectory and time scale are not, and though doctors may know that heart or lung disease is the beginning of the end, this may not be clear to the patient. The end may well take a dozen or more years to materialise, in which one, ultimately futile,

medical treatment after another may be tried. Statistically, this really lengthy, unacknowledged, dying is more likely in the UK to occur in lower income groups characterised by unhealthy working conditions and lifestyles; the healthier affluent classes tend to live in good health a decade longer, and then die a bit quicker from sheer frailty, often following a fall, or (much longer) from dementia. One consequence of these patterns is that many people do not fear being dead; they fear a prolonged frail old age in which they are a burden on others.

Second, dying is medicalised. On getting a terminal diagnosis, we turn in the first instance not to therapists or clergy, but to the doctor: how long have I got? will you be able to control the symptoms? Only when we know the score physically do we wish to address psychological or spiritual or family issues. Lay people are profoundly disturbed if a medical cause for death cannot be found; death is no longer an act of God, a natural end, but a medical dysfunction. And listen to ordinary people talking about how a family member died. The narrative is more often than not medicalised - 'She developed pneumonia. She was taken to hospital and they tried antibiotics, but after a few days it was clear they were not working. The nurses were very good, they let us more or less camp in her room the last 48 hours. The end was quite peaceful.' People are much less likely to talk in terms of the spiritual battle that was taught in the medieval *ars moriendi*, or even the

psychological battle that Elisabeth Kübler-Ross identified in her best selling book *On Death and Dying*.

Third, tied up with medicalisation, is institutionalisation. Though most of the time spent dying is typically spent at home, the actual moment of death is likely to occur in a hospital, a hospice, or a nursing home. We should remember that Kübler-Ross' five stages of dying - denial, anger, bargaining, depression, acceptance - can easily be felt by those becoming an inmate of a total institution, and it is not entirely clear to what extent her interviewees experienced these emotions because they had cancer or because they were hospitalised. Certainly one might expect these five responses by an elderly person reluctantly entering a nursing home.

Allan Kellehear has argued that today's medicalisation and institutionalisation form the latest twist in a story of professionalisation that is thousands of years old, dating from the very earliest cities. As soon as humans moved from subsistence farming to cities in which there was a division of labour, certain professionals emerged as experts in dying. The first experts were priests, and now we have doctors, nurses, radiographers, social workers, aromatherapists, counsellors, etc. In each and every case, responsibility is to an extent removed from individuals and families, and handed to professionals. I will return to this issue shortly.

Hospice and palliative care

A major innovation, started in London by Cicely Saunders in the 1960s, is palliative care: the holistic treatment of total pain (physical, emotional, spiritual) so that the dying person may live as fully as possible in their last years or months. This entails a re-orientation of medicine from cure to care, and involvement of a multi-disciplinary team, including social workers, therapists and counsellors. Organisationally, it may mean care within a hospice or hospital palliative care unit, or it may mean hospice or palliative care team members working in the community.

Over the past two decades, hospice and palliative care has faced a number of dilemmas. It is still offered primarily to people with cancer, who have a relatively clear dying trajectory, whose symptoms can more often than not be controlled, who typically retain their mental faculties until a few days before the end and who therefore may act as autonomous persons making informed choices about how they wish to live. It is by no means clear how, or even if, the principles of palliative care can be applied to people with lung and heart disease where the trajectory is not at all clear, or to advanced dementia where informed decision making is compromised. Recent guidelines for end-of-life pathways have also been criticised for being based on an institutional model of care.

In the 1980s, palliative medicine came to be recognised in the UK as medical speciality.

Was the arrival of consultants in palliative medicine a victory, spreading palliative expertise around other medical specialties, or did it lead to domination of medical expertise over other expertises within the palliative care multidisciplinary team? More generally, is hospice and palliative care empowering families and communities to care for their dying members, or giving the message that you need training to deal with dying? Even the nurses have titles on name badges such as 'Palliative Care Advanced Clinical Nurse Specialist'.

A significant challenge to this kind of professionalisation has come from Australia. Starting in the outback, where communities clearly have to look after their own health, calling in a professional from hundreds of miles away only when absolutely necessary, it is now recognised even in cities that – given the increasingly lengthy dying of an ageing population – there is no way that care of the dying can be provided chiefly by professionals. In this new model of what is to me rather obscurely termed health promoting palliative care, the tables are turned. Community care entails not a hospital-based specialist who drives out into the community, but communities taking responsibility for their own health and their own dying, and calling in experts as and when needed. Volunteer teams may make a wholistic assessment of a dying person's needs, which could well be spiritual or familial, calling in a social

worker or chaplain or therapist if needed.

The question of volunteers is pertinent to the UK. All British hospices and a number of hospitals and aged care charities make extensive use of volunteers – to staff their charity shops, to drive service users to day clubs, to help with the accounts, to staff the hospice tea trolley or the hospital shop – almost anything but direct, frontline work with service users! Many of these volunteers are retired professionals, and the waste of expertise is phenomenal. If the British culture of volunteering could be harnessed to the Australian concept of community responsibility, palliative and aged care in our country might find a way to provide care to everyone, not just the select few. Hope is provided by the exceptions, such as the AIDS buddy system developed in the 1980s, and one-to-one commitments by volunteers to one elderly person.

Funerals

Funerals saw considerable change in Britain in the 1990s. A funeral is the ritual disposal of a body. So it has two components – the ritual, and the body. In the UK, the specialists who look after the body (that is, funeral directors) are in the driving seat, and subcontract other specialists such as the crematorium florists, memorial masons and the ritual specialists (that is, ministers of religion and other funeral celebrants). Surveys reveal high levels of satisfaction with

funeral directors, but from the 1980s considerable discontent with the performance of clergy, especially in crematoria funerals, was becoming manifest, not least because of their impersonality. Things could not change overnight, since the funeral directors who had overall control had little or no control over the funeral ritual itself (unlike in the USA, where the main ritual is the wake, held in the funeral parlour). Through the 1990s until now, due to public demand, clergy have had to produce funerals that look backward to celebrate the deceased's life as well as forward to the next life; and a range of other celebrants have emerged to provide purely celebratory funerals.

From the viewpoint of psychological health, questions have long been asked about some religious funerals. Do funerals that single-mindedly rejoice in the deceased's arrival in heaven represent a denial of grief, or provide meaning in grief? We may ask the same question now. Do today's singlemindedly celebratory funerals deny grief, or provide a public narrative of how the deceased can continue as part of the ongoing lives of individuals, families and communities? This brings us to the question of theories of grief.

Grief theories

Through the second half of the twentieth century, the theoretical base underlying grief counselling derived primarily from the Freudian notion of grief work and from Bowlby's attachment theory. Put simply,

the mourner has to work through the pain of grief in order to detach emotionally from the deceased and engage in new relationships. By the 1980s, various groups of mourners were voicing their unhappiness with this view, or at least with bowdlerised versions of it. The dead baby would always be a part of the family, even as it rejoiced in the birth of new children; widows resented any suggestion that a failure to remarry implied they had not worked through grief. Evidence showed that many people lived psychological healthy lives by moving on with, not without, the deceased. (Which is perhaps what the celebratory funeral ritually kickstarts.) From the mid 1990s, new theories became influential on therapeutic practice, such as Klass et al's idea of continuing bonds and Stroebe & Schut's dual process theory, along with increasing empirical evidence (presented, for example, by George Bonanno) that distraction and activity lead to greater psychological health than attempts to work through the pain of loss.

Bereavement care and psychology

This raises the question of the relation of bereavement care to various schools of thought in psychology. Most trained bereavement care in the UK is provided by volunteer counsellors working for Cruse, which has over two hundred branches around the country. Cruse training has been based on a mixture of psychoanalysis and attachment theory. This is

in marked contrast to freelance therapy where humanistic approaches are more common, and therapy paid by the NHS or employers, which is more likely to employ cognitive and behavioural therapy. Paymasters want results quickly, and CBT promises this, certainly compared to the lengthy time that psychoanalysis requires. One might therefore argue that it would be ethical to use CBT in preference to other therapies when time (as with the dying) or resources (as with the heavy demand for Cruse) are severely limited. This debate, however, has yet to emerge. There would be benefit in more dialogue between volunteer bereavement counselling and professional therapy.

Let me give some related examples of unjoined up practice and thinking. Social work often has to deal with the consequences of bereavement, yet bereavement plays a remarkably small role in professional social work training. Likewise in the world of addiction. De Quincey, distraught at the death of his friend Wordsworth's daughter, was by no means the only person whose opiate addiction has begun with a bereavement. And there is some evidence that criminality can have some roots in childhood bereavement. The world of bereavement care scarcely engages with these other professional worlds, and they in turn need to relate to the expertise found in bereavement care.

Private grief, public mourning

In small scale rural societies, where everyone knows everyone else, the death of a member leads to a loss by the community as well as by the family. The community mourns, so the grieving family knows its pain is shared, though in lesser measure, by the community at large. Though we sometimes see this today, as when the grief of parents is shared by an entire secondary school, more typically grief in modern, mobile, long-lived, urban society is private. My elderly mother dies, but my neighbours and workmates never met her, because she lived a hundred miles away. The separation of home and work means that when a spouse dies, my workmates may never have met her; or when a workmate dies, my wife had never met him. Grief becomes an experience of the individual. I may be supported by others, but it is support from others who are not themselves in mourning.

This is modern grief. It is in this context that people may choose to speak to a counsellor. Or they may join a mutual help group whose members never met my child, but they too have lost a child. And in the group, as I speak about my child, they get to know him, and he begins to have a posthumous life within the group, as Dennis Klass has documented.

In the past couple of decades, however, some people have become more public in their mourning, either for those intimately mourned, or for those

known only at a distance. In the global media village, celebrities are known by all and mourned by many; football pitches and palaces become adorned with mountains of flowers after a tragic death. This requires no special explanation, as it simply transfers into the global village what for millennia has occurred in traditional villages: everyone turns out to mourn the death of the chief. Premature, especially violent death, of more ordinary people is also now marked publicly, especially if the death propelled them into the local or national news; roadside shrines to motor fatalities may be seen in town and country. This entails a certain democratisation: the young and victims now receive as much mourning as chiefs and celebrities. And mourning these public deaths is now voluntary; nobody is required to mourn, unlike in feudal times.

Voluntary and democratic modern public mourning may be, but it is not uncontentious. Signs of mourning are no longer restricted to the cemetery or crematorium, and not everyone approves. 'Floral fascism', 'grief lite', were two terms of abuse journalists hurled at Diana's mourners. The Mountaineering Council of Scotland has a policy of removing commemorative cairns and plaques from the top of Ben Nevis, while some local authorities have removed teddy bears and wilting flowers from memorial benches in urban parks. Not all members of the public, whether climbing the Ben or going to kick a ball around the park, want these reminders of mortality, anywhere and everywhere, and especially not

in places devoted to rest, recreation and pleasure.

Finally

Historians such as Philippe Ariès and Clare Gittings have argued that the Renaissance, with its celebration of the individual, turned the death of each individual into a personal disaster. But maybe in the twenty first century a more comforting view is emerging. In his book *The Living End*, scientist Guy Brown argues from sociology, psychology and biology that we do not have a unitary, unchanging self. We are more like a wave that moves through life than an atomic particle. We are the sum of our experiences, of our behaviour, of our self concepts, and these change over time; there is no 'self' that is experiencing the experiences (in this, Buddhism is right). And many of our experiences are shared with others, so there is a fluid boundary between self and other – we therefore have in part a shared self. 'If the self is not a single, unified entity, but a wave constituted of genes and memes, then the dissolution of the self at death does not necessarily mean the end, because the genes and memes may continue in other selves.' (p.137)

How we die, how we work with people who are dying or mourning, even how we think about death, all depend in part on the society and the historical period we inhabit. Postmodern views such as Guy Brown's may prompt new kinds of therapy with those who are dying or grieving or otherwise troubled by mortality.

References

Ariès, P. (1974) *Western Attitudes toward Death: from the Middle Ages to the present*, Baltimore: Johns Hopkins University Press.

Bonanno, G. (1998) 'The Concept of "Working Through" Loss: a critical evaluation of the cultural, historical and empirical evidence', pp. 221-247 in A. Maercker et al, eds *Posttraumatic Stress Disorder*, Göttingen: Hogrefe & Huber.

Brown, G. (2007) *The Living End*, London: Macmillan.

Gettings, C. (1984) *Death, Burial and the Individual in Early Modern England*. London: Croom Helm.

Kellehear, A. (1983) 'Are We a 'Death-Denying' Society?' *Social Science and Medicine*, 18(9): 713-23.

Kellehear, A. (2007) *A Social History of Dying*, Cambridge: Cambridge University Press.

Klass, D. (1997) 'The Deceased Child in the Psychic and Social Worlds of Bereaved Parents During the Resolution of Grief', *Death Studies*, 21(2): 147-75.

Klass, D., Silverman, P.R. & Nickman, S.L. eds (1996) *Continuing Bonds: new understandings of grief*. London: Taylor & Francis.

Kübler-Ross, E. (1970) *On Death and Dying*. London: Tavistock.

Stroebe, M. & Schut, H. (1999) The Dual Process Model of Coping with Bereavement, *Death Studies*, 23: 197-224.

Walter, T. (1999) *On Bereavement: the culture of grief*, Buckingham: Open University Press.

Walter, T. (2008) 'The New Public Mourning', in M. Stroebe et al, eds *Handbook of Bereavement Research and Practice*, Washington, DC: American Psychological Association.

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