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Death and dying

Main points

- Death is inevitable for human beings and an inescapable element of the life course.
- Death as a definite and incontestable state can be difficult to identify and define, being dependent on social and historical contexts as much as medical classifications.
- Causes of death, and experiences of death and dying, vary considerably across different cultures and throughout history.
- Contemporary society in high-income nations, such as the United Kingdom, displays complex and contradictory attitudes to death and dying, being simultaneously death denying and death aware.
- Sacral or secular ceremonies are important for assisting in social and individual transitions following death.
- Psychological and sociological explanations and interpretations of the processes and experiences of dying offer different but also incompatible insights.
- Health workers and health professionals working with people who are dying can be required to engage in demanding forms of emotional labour.

Key concepts

Death • dying • death denying • death awareness • memorialisation • Kübler-Ross • emotional labour.
Introduction

Quite simply, death is unavoidable and an inevitable feature of human existence. As corporeal biological and embodied beings, humans are locked into an inescapable sequence of birth, life and death: cells wear out, core vital organs shut down, and the biological body ceases to function. Regardless of all humanity’s achievements in altering and controlling for its own benefit many of the challenges posed by nature, death still remains as a place and part of existence beyond our complete control. Humans can definitely alter and condition the cultural practices surrounding dying and the causes of death, but the actuality of death occurring cannot be transcended. A wider study of death and dying, and the rituals and representations that surround death, reveals the impulses and motivations behind many human activities and cultural practices involving death, whether in commemorating the passing of loved ones, or in dealing with the existential anxiety of one’s own demise. In the British Isles, for example, many of the significant structures that mark the rural landscape or punctuate the urban skyline involve, to some extent, death. The oldest surviving structures, megaliths (more commonly referred to as standing stones) and chambered tombs from the Neolithic period, involve some form of engagement with death, dying and the cycles of life; while even in the increasingly busy and high-rise profile of many urban environments it is still spires and steeples that rise above the rooftops, again structures whose rationale was in part to engage with the dramas of life and death.

The main lesson to be found in this chapter is that for all that death may be regarded as the ultimate ‘victory’ of biology and nature over all the abilities of humanity, the process of dying and the moment of death are as profoundly social as they are natural – and it is that theme that is explored in greater depth in the four main sections below. First, as in keeping with practice throughout this book, we scrutinise the actual concept of death, in order to open up and query basic assumptions of what constitutes death and how it can be defined. What is important here is that defining death is far from easy and without dispute, and is strongly bound into social and cultural norms and traditions. Attention then moves to discussing how the causes of death vary between nations and within nations. What becomes evident here is that what leads to one’s death depends on the society in which one lives. Dying of natural causes after a long-lived life, for instance, may be the preserve of a select section of relatively wealthy people living in high-income nations like the United Kingdom, whereas other poorer members of that same society can die much younger. When we open a wider global perspective it becomes obvious that causes of death and the age of dying are once more heavily dependent on the society in which one lives. The third section considers a topic of considerable debate in sociological assessments of death: whether or not contemporary western society has become increasingly death denying, in that

Secularisation refers to the process whereby society becomes increasingly less religious. Secular refers to a non-religious society or non-religious ways of understanding society. Sacral refers to religion and religious understandings of the world.
death as the inevitable end of human life is a taboo topic. The final two sections focus on the parallel experiences of those who are dying, and those health workers and health professionals who work with the dying and the dead.

What is ‘death’? Conceptualising and defining the end of life

One important function of the sociological imagination is not to accept any social phenomena at face or surface value. What people encounter on a daily basis is always open to further question and deeper investigation; that is the purpose and promise of the sociological imagination. As has been explored in relation to class, gender and ethnicity, new insights into what we are studying can be gained by questioning what the concepts of, for instance, class, gender and ethnicity actually mean and how they relate to events and patterns in wider society. So, when discussing death (and we shall return to defining dying later), what do we mean by death? A review of the main debates and arguments reveals that it is more complex than first inspection would indicate.

French poststructuralist philosopher Derrida (1993), in his deconstruction of popular and scholarly ideas, has questioned the existence of a tight and clear delineation and border between life and death. Instead, he draws attention to how mutable and fluid ideas of death are bound into different cultures and are variable and changing across time and history. Death is also, he notes, a state of being that is neither fully social nor fully biological but exists in the fusion and interrelationship of the two. This highlighting of issues relating to defining and conceptualising death and dying is highly useful as it guides us to thinking of death not just as a simple state of ‘non-life’ or the non-functioning of core bodily processes and no brain activity, but rather as a process which exists in the midst of other processes, bound into culture, society, history and biology.

Let us focus a little more on the biological aspects of death briefly mentioned above. In many popular hospital-based dramas the iconic image of a heart monitor flatlining while emitting a high-pitched monotone is used to signal the death of a patient. Such an image informs lay perceptions concerning the finality of death, that death is an unambiguous and definite state: the person alive is now dead, and the two are very clear and distinct separate states. A great many complications exist, however, that question and challenge this straightforward understanding of death. Philosophically, it can be asked: what is death? Such a question raises thorny issues about the relationship between mind, body and self-identity, or more broadly put: what is it to be alive? This question is very difficult to answer succinctly. Is life purely a biological function? Is life the ability to interact with other human beings? Is it a combination of both? And, if so, is one more powerful than the other?

Kellehear (2008) has identified how the criteria used to pronounce death have changed over historical time. In the Middle Ages, the signs that were sought out to establish death were external; the body was examined for stiffness of the muscles, discoloration of the skin,
or putrefaction and decay. In modernity the focus has become increasingly *internal*, with an emphasis on cardiovascular and brain activity. The change as to what constitutes death parallels, in certain regards, the wider historical trend of the increasing rationalisation and advance of technological scientific perspectives, in that designating someone as being dead is made in the context of what a piece of technology (what Latour (1992) would term a ‘non-human actor’ in a wider network of activity and decision making) records as being patterns of a particular electrical or neural activity that are interpreted as being significant of a change in status, in this case, from being alive to being dead. As has been raised in Chapter 2 in a discussion on medical technology and the wider medical model, just because a particular event or interaction between people is mediated by scientific principles does not necessarily entail that scientific medicine provides any definitive answers. There are cases, as Kellehear (2008) notes, where people who may be classifiable as ‘brain dead’ and therefore technically dead, kept going only with the support of technology, are still capable of conceiving or giving birth – two qualities that for many people would signify life not death.

The inverse of the above may also be true, because the body may remain clinically alive in that the heart beats and the various biological organs function perfectly well, but that does not necessarily entail that the person is alive. After all, sociologically speaking, being an active human agent usually implies some form of interaction with others. So the body can be alive, but what makes the individual a particular person is no longer present. Such a state can be evident in cases of dementia and allied conditions that affect the memory of an individual, where what is termed a ‘social death’ can occur. The body is physically present but the person who was known by their friends and family has, to all intents and purposes, passed away. Defining death is made even more complex with current technological developments. Stem-cell technology and the ability of science to operate on a molecular level open up a range of debates as to what is alive and what is dead, given that the lifetime of human cells can be prolonged almost indefinitely, which again raises the question: when is someone truly dead?

**Mortality and the global causes of death**

Seale (2000) has mapped out the main coordinates of death in contemporary global society, and what his work reveals is that death is far from a unitary phenomenon and experience across all societies. Death rates, trajectories of dying, causes of death and age of death (see Figure 17.1) vary markedly from country to country. What passes as being a ‘normal’ way to die in a high-income western nation is notably different from what is normal in a low-income sub-Saharan nation. Comparing deaths due to HIV/AIDS and cancers provides a useful illustration of these differences between global regions (see Figure 17.2 for other selected causes of death). According to the WHO (2011: 74) the Mortality rate for HIV/AIDS in 2009 in the Africa region was 117 per 100,000 in comparison to 19 per 100,000 in the Europe region, a rate that is just over
**Figure 17.1**  Average life expectancy by WHO global region for both sexes, in 2008


**Figure 17.2**  Deaths (000s) in WHO regions, estimates for 2004

sixtimes higher. In comparing cancer (or malignant neoplasms) the differences in mortality between regions are less stark, but they are still quite pronounced. It is the Europe region this time that exhibits the higher number of deaths with a mortality ratio of c.350 per 100,000 in comparison to a mortality ratio of c.160 per 100,000 in the Africa region (WHO 2010: 14). These statistics reveal a number of interesting insights into just how experiences and contexts differ globally. First, the leading causes of death are quite different: HIV/AIDS in Africa and cancer in Europe, with each cause of death accounting for quite high numbers of people. However, one should take care not to lapse into some form of equivalence – into thinking that the two causes of death are essentially similar in that they are both likely to lead to illness with the strong possibility of death. How those causes of death are socially situated, and what the contexts are in which death occurs, are decidedly and critically different.

HIV/AIDS in the Africa region is more likely to kill younger people in their teens and twenties, thus reducing the numbers of economically active people, and also creating a crisis with the number of children who are orphaned after their parents die of AIDS. There may also be a lack of medication and appropriate hospital services, which means that the process of dying (of which more later) is marked by higher levels of discomfort and pain, plus a reduction in the time left available in which to live out an already shorter life. Cancer deaths typically (though not in every instance) generally affect older people who have been economically active, but more importantly the European person dying of cancer will have led a longer life, with the advantages of being able to achieve life goals and engage in the various activities that are important and meaningful to someone across their life course.

Considerable and substantial differences are also present within countries just as much as between countries. Section 2 of this book focuses on health inequalities that emerge out of wider social inequalities, and these wider social inequalities also apply to death. What is evident is that death is not due to random chance, an unlucky roll of destiny’s dice, but is found in one’s class, ethnic and gender location. So, a person from a working-class background will live on average seven years less than someone from a middle-class background; and in some cases, as was discussed in relation to areas in Glasgow, the mortality difference can be up to 30 years. In terms of gender, even though the gap is closing, women still outlive men by five or so years; and in regard to ethnicity, people from ethnic minority backgrounds will on average die earlier than those from ethnic majority backgrounds. Remember that these inequalities often run together, and people who are at the intersection of inequalities will experience increased chances of early mortality. Death, as with so much in life, is therefore to do with social structures rather than chance, biology or individual agency.

War as a cause of death is included in Figure 17.2 among the more expected ‘medical’ conditions. It is included to highlight that when seeking to understand death it is important to situate death in its fullest context, and that considerable numbers of people die of
a cause that is purely the outcome of human intervention in the form of particular (and failed) social and political processes. Medical sociology as a subdiscipline has, as Williams (2004) notes, been silent on the issue of war and health, which is surprising given that war is fundamentally concerned with the negation of human life and bringing harm to embodied human beings. The actual numbers of people killed in the recent wars in the Middle East, for example, are hard to identify; estimates of deaths attributable to war-related violence in Iraq have ranged from 151,000 in a survey for the World Health Organisation (Alkhuzai et al. 2008) to 607,207 in a survey published by The Lancet journal (Burnham et al. 2006). Regardless of the exact numbers of civilians who have died lately as a direct and indirect consequence of conflict, the point here is that death for many is the result not of ill health but of violent human action.

Modern society: ‘death denying’ or ‘death aware’?

Since the publication in English of the highly influential and stimulating work of Philippe Ariès on death in The Hour of our Death (1982) and Western Attitudes toward Death: From the Middle Ages to the Present (1974), modern European society has been characterised as being death denying. This particular concept implies that modern society silences discussion of death, forbids the topic of death and dying in everyday conversation, and excludes and isolates the dead and dying to the physical and symbolic outer regions and limits of society. In effect a taboo surrounds death and modern society denies its existence, to a similar degree that sex was a taboo in Victorian society. Ariès’ thesis is based upon his empirical study of cultural, literary and artistic representations of death and dying. From his study he contends that practices and rituals surrounding death have changed and altered over time in parallel with how society understands and creates death. He offers a periodisation (Small 1997) of death in which it moves from being seen as an inevitable experience towards being an experience that can be tamed, where the dying person can focus on sorting out their affairs with the full involvement of their family and friends so as to lead to a good death. In the eighteenth century, death was romanticised as being almost a beautiful experience but one bathed in pathos and ideas of personal tragedy. The one main arc of historical change he notes is the move away from public recognition – if not very public display – of the dead and the dying to a privatised and hidden death, where death becomes dirty and an event to be shunned and relegated to the margins of conversation.

Death denying implies that a society and individuals who are part of that society attempt to ignore the subject of death in conversation and generally behave as if death did not exist. Death aware is the reverse of death denying, where death is acknowledged and accepted but not necessarily in a way that is consistent and without contradictions.
It is useful to briefly consult the historical record here again in order to indicate just how much has changed in terms of our relationships with both death and the dead. At other points in history death was all-pervasive, experienced by having dead family members in the household, seeing the dead in the streets and observing the dead represented in art forms. The Black Death that raged across Europe in the middle 1300s claimed the lives of somewhere in the region of 375 million people, one of the most devastating pandemics in human history. The sheer scale of the disease challenged and reshaped society on a myriad of levels. The power and social role of the Church for one was questioned, but one of the more visual manifestations of death in this period was the frequent use of death images in art. This tradition was most evident in the various Danse Macabre images of the medieval period (Figure 17.3), where skeletons engaged in a wild dance with each other, or mischievously taunted the living that their own death could happen without warning at any moment.

The possible reasons for the movement from an open and accepting culture of death to a denial of death can be traced to distinct social developments within the twentieth century. Walter (1994: Chapter 1) advances the following reasons for why contemporary society can be perceived to be death denying, a state in which the often interrelated processes inherent in modernity lead to the depersonalisation of death and the repression of emotion and grief. The end result of all these processes acting on and shaping societal and individual beliefs...
is that death becomes a taboo subject, an off-limits area of conversation, blanked out as an issue in personal reflection on one’s life and its future:

- **Rationalisation.** Like so much of modern life, death has become the object of the various forces and processes of rationalisation, where the very intimate moments of death become subject to timetables, bureaucracy and categorisation. Death is not just the ending of someone’s life, but an element of the great paper trail of modernity, where every aspect of life is recorded and filed. The end result is that death becomes disconnected from private emotional reference points, grief in particular, and attached to the cold emotionless framework of the public office and public official. The death certificate is an example. As a document the death certificate records very objective information such as date of birth, the cause of death and the name of the recording officer. Subjective and affective information, such as the emotions of the surviving relatives, go unrecorded. This is all very useful for the running of a large bureaucratic state, which requires information on its citizens but is not very effective at dealing with the issues of loss and grieving.

- **Medicalisation.** Discussed earlier in this book, medicalisation involves the colonisation (the ‘taking over’) of an increasing number of areas of life that were once regarded as existing outside the medical gaze. The same applies to death and dying. Death for most of human history was explicable in religious terms; it was God’s Will that people should die, and therefore religion was the only source of insights into and understandings of death. As medical technology has developed, however, death has become framed less as a moment defined by the divine and increasingly as a medical event, with death resulting out of a distinct sequence of biological stages. Walter also notes one further way in which death has become medicalised: the change in the location of dying. In western high-income countries the place of death is now more likely to be in the hospital under the auspices of the medical profession than in the home supported by friends and family.

- **Secularisation.** Allied to the above, one other development within modernity is the decline of sacral or religious belief. Modern society has become increasingly secular, which means that people do not interpret their lives within the symbolic framework of religion. Previously, in a Judeo-Christian context at least, images of death, resurrection and redemption informed the minds and actions of people. Without the presence of such imagery, death becomes less a feature of life. Walter (1994) points to the First World War as a turning point in religious belief in Western Europe, where the idea of a loving God became increasingly untenable given the mass death and suffering of the conflict. However, as both Hunt (2005) and Bruce and Glendinning (2010) maintain, secularisation begins much earlier in the eighteenth century, when the new urbanisation brought
about by the Industrial Revolution removed ordinary people from the control and teachings of the church.

- **Individualisation.** One debated trend within contemporary society is the move away from community to a life based more on individualism. Such a trend may sound appealing in that we now possess the potential to make more of our lives as and how we wish, unbidden by pressures from the wider community. Walter notes, however, that one rather demanding cost of being individual is that one lacks the ties to other people who could provide emotional support in times of crisis, such as when facing death. The upshot is that it is better to ignore rather than embrace death.

Walter does not include *consumerism* in his summary of why today's society might be death denying, but the various characteristics of consumer culture could also contribute to a death denying culture, extolling as it does the perfect, young but crucially *living* body. The number of facial cosmetics and the ease of access to cosmetic surgery could be cited as further evidence of death denial, since the purpose of such products (and here surgery is as much a product as an anti-ageing cream) is to deny the passing of time and ageing, let alone the very real finality of death.

This perception of modern society being death denying has been challenged by a number of sociologists (such as Seale 2000), and the work of Ariès and others who have advanced the death-denying thesis has been critiqued. One of the main objections to Ariès' analysis of death, for example, parallels that of critiques of his work on childhood: that by drawing ostensibly on artistic and literary sources for his empirical data, he does not allow for those...
sources to be contextualised as idealised versions of death and dying at a particular point in history rather than as how death and dying was actually experienced and understood at that time. What Ariès presents in effect is an overly romanticised view of death and dying that is nostalgic for a past that never was, as opposed to an accurate recreation of the place of death and dying in the past and over time.

The main thrust of the counter-argument is that contemporary society is not death denying but is just as death aware as in previous times, only in a way that is more fluid, complex and contradictory. On the one hand, unlike Victorian society, contemporary society denies death; it is a topic shunned in conversation, and issues of dying, such as the ageing process, have become almost a taboo subject. On the other hand, death is frequently depicted in many mainstream cultural products, where the subject of death and what it is to be dead form the basis of plotlines in films and television serials. Death and what the dead are like are very distinct and idiosyncratic in such media. In many contemporary films and TV shows, such as the Twilight trilogy or Buffy the Vampire Slayer, to be dead is to be reborn in the afterlife as an emotionally complex but still very sexy American teenager, where death is not about bodily decay or the end of self but instead is a continuation of self at the peak of one's young powers. One could claim, as Gorer (1965) did back in the 1960s, that this form of death awareness is 'pornography' and does not really deal with death; yet these depictions of the dead and death are often more nuanced and subtle than the traditional blood-'n’-gore movies of that period.

Throughout popular culture there is other ample evidence of engagement with death. In addition to the new wave of vampire movies, one could point to The Time Traveller’s Wife (both the novel and the film), which focuses on memory of a loved one and dealing with loss, as does The Finkler Question, and to the various geographic variations of the American crime series CSI, where death and the dead are treated and portrayed in computer-generated high detail. In popular music there is the subgenre of death metal, where fast and furious bass-heavy songs in doom-laden minor keys celebrate motifs of death and dying, and where bands refer to death in their names, such as Korpse, Entombed and (the not so subtle) Death. There is also, of course, the Goth subculture (Hodkinson 2002) in which adherents also, albeit probably more playfully and elegantly than in death metal, adopt imagery and symbols associated with death.

It is, overall, difficult to sustain a perspective that claims that modern society is exclusively death denying. A quick survey of popular culture, as revealed above, finds plenty of evidence to the contrary. Seymour (2001), though, cautions against such a simplistic ‘either/or’ dichotomy of society being either death denying or death aware; the actuality, she argues, is much more complex, but then again so is the phase of modernity. As Kellehear (2007) maintains, the practices and understandings of death and dying parallel the norms and cultures of a given society; so as society becomes much more complex, an equally complex approach to death and dying develops. Walter (1994) characterises this complexity towards death and dying as being consistent with postmodern trends in society. As with other postmodern
trends there is a rejection of a simple ‘one-size-fits-all’ approach, with its implication of
everyone acting uniformly, and instead an acceptance that everyone follows a path that is
much more of their own making, drawing on whichever elements of social culture and social
symbols they choose. Seale (2000) notes something similar: that in late modernity a greater
reflexivity exists in how people approach various aspects of their life course, in that they are
frequently engaged in working out how they make their lives meaningful, in a context that is
most appropriate to them. So, what we can see today is not one mass society-wide approach
to death but a myriad of individual approaches. However, one must be careful to acknowl-
edge that these choices are not open to all. As Kellehear (2004) reminds us, not everyone
possesses the power to choose exactly how they live and how they die, depending on class,
gender and ethnic differences.

Rites, rituals and ceremonies: dealing with death

Regardless of how a society defines death, when it does occur it can lead to a traumatic and
significantly upsetting period both in the lives of friends and relatives and also in wider
society. The various bonds that link a person to others and to wider society are, for a time at
least, broken and damaged; a phase of uncertainty and change follows, where people need
time to make adjustments and hopefully re-establish their own personal and social narra-
tives. That is why so many rites and rituals surround death, the purpose of which is to repair
and heal those social and individual bonds so as to allow for the return of some form of
‘normal’ functioning.

Religious narratives and symbols were the traditional discourse that people deployed to
deal with and assist in either their own dying or the death of a loved one. All religions,
whether historic or contemporary, offer a core set of symbolic beliefs concerning death
and dying. Historically, for example, in Neolithic (Stone Age) and Iron Age Britain the
dead were not separate from the living. As archaeologist Francis Prior (2004) has discerned
about Neolithic society and its religious affirmations, death and life were firmly enmeshed
together both physically and symbolically. It was common in that period for burials, for
example, to be close to human habitation. In some instances, the dead were buried beneath
the floors of roundhouses to indicate a connection with their ancestors and the great cycles
of life and death, the moon and the sun; while the landscape itself would be altered to
symbolically record the dead with burial mounds and standing stone circles marking the
horizon (see Figure 17.4). Neolithic social ceremonies also involved a close physical and
symbolic relationship with the dead. The placement of human remains found in chambered
tombs, such as the West Kennet Long Barrow near Silbury Hill in Wiltshire, strongly sug-
gests that the disarticulated bones of deceased relatives of ancestors were regularly moved
around, taken out from the tomb and used in ceremonies that were important and signifi-
cant for the people of that time.
In western Judeo-Christianity the central symbolic narrative and mythology concern resurrection: that by believing in God, not committing sin and acting in a compassionate and caring manner, your soul will be saved and you will be granted eternal life in paradise. Other religious faiths and belief systems offer different interpretations as to what happens after death. Hinduism and Sikhism, for instance, have reincarnation as their understanding, while Buddhism reveals rebirth, in some respects similar to reincarnation. There may be some quite different ideas as to what happens after death throughout the world’s religions, but the fact that they all deal with issues of death is what is important. The world’s religions also provide various ceremonies and rituals to structure and provide focus for those who have lost someone. As Durkheim highlighted in his functionalist sociology, humans require and develop rituals and ceremonies to mark all the important transitions in their lives, and death is no exception. The traditional Christian funeral in western high-income nations involves either a burial or a cremation, preceded by a ceremony that focuses on how the departed individual is now in a better place, involving prayers and hymns and reference to God and an afterlife. The ceremony also allows relatives and friends an acceptable place and appropriate occasion in which to grieve; though as Elias has argued, grieving is not always a spontaneous outburst of emotion, and the various civilising processes present set parameters, especially for men, as to what is appropriate or dignified.
One current social trend, however, is the increasing secularisation of society, principally within the UK and other European states, where belief in organised Christian religion is in considerable decline. This development does pose a question: how do non-religious societies deal with death? If Durkheim is correct in claiming that humans require ritual to mark and make sense of important stages in the life course, then what ceremonies do secular societies provide to endure the challenges posed by death? In fact, there has been a proliferation of different forms of funerary practice. Humanist funerals have become increasingly popular. As a ceremony they may resemble conventional Christian funerals in so far as there will be a burial or a cremation, with the ceremony led by a specially designated individual, accompanied by songs and readings. There are crucial differences, however. The focus of the ceremony is not on an afterlife or a supernatural being (or God) but entirely on the deceased, celebrating their life and recording their favourite experiences and music. One of the more colourful practices that can be used in secular funerals is the balloon release. Here mourners gather together each holding a balloon; once they have reflected on the life of the deceased and they feel at some form of peace, they release the balloons, symbolising a letting go of grief.

In addition to the secular ceremonies and belief structures discussed above, Lee (2008) notes that various developments concerning New Age religion and beliefs offer a re-enchantment of society. He makes this point in reference to Weber’s key criticism of capitalist society: that it robs the world of enchantment and the ‘magic’ of life and replaces all that is special and unique, in a process of disenchantment that leads to modern life being similar to living in an ‘iron cage’. Finally, one other recent trend in memorialisation of those who have died is evident in the increase in roadside memorials, usually in the form of flowers, but also including poems, stuffed toys, football shirts, or other objects that were meaningful for the deceased. So, even if the traditional forms of funeral and memorialisation are on the wane, new forms are beginning to appear that could become how future societies celebrate the life of a deceased friend or family member.

**Dying and the anticipation of death**

It is useful once more to highlight that death and dying are not solely biological events, but are crucially bound and interwoven into social relationships and the culture of a particular society. What counts as being dead, and the experience and process of dying, are defined and set by the context and society in which someone lives (and of course dies!). In this section on dying, about the anticipation of death and how both the individual and society make adjustments to the end of life, it is vital to bear in mind that dying here is not limited exclusively to the biological experience of dying. What is under discussion is how that biological
(or embodied) element of the process is prefigured and contextualised into an array of social relationships that vary by society and by historical period.

Before any further discussion it would be helpful to tie down what is meant by dying, as was carried out earlier in this chapter when defining death. As Kellehear (2008) notes, death is a very particular biological point when nerves and tissue irreversibly cease to function; but as humans are emotional beings, their experience of dying is not just limited to the biological horizon but is, instead, tied into existential reflection, social norms and personal relationships. Kellehear also usefully defines the process and anticipation of dying in the following more sociologically nuanced manner, where emphasis is placed on wider social relationships, and dying is seen as a social process but one which is also animated by individual desire and agency:

I speak here of dying as a self-conscious anticipation of impending death and the social alterations in one's lifestyle prompted by ourselves and others that are based upon that awareness. This is the conscious living part of dying rather than the dying we observe as the final collapsing of a failing biological machine. (2008: 2)

For people living in contemporary high-income nations the idea of dying, or the anticipation of dying and their own death, exists in the distance of time, a process to be encountered and endured towards the end of up to eight or more decades of life, probably following a lengthy debilitating illness or the slow natural demise of the body. During the intervening years the focus is on life and living rather than on dying. This distancing of dying is a comparatively recent development in experiencing the life course brought about by the extension of life expectancy through the twentieth century. In previous epochs, the distinction between life, dying and death would not have been so marked. There would have been greater awareness of the inescapable fact that life is short and death could happen much sooner than one would wish. Indeed, given how rapid death could be in other historical times (due to an accident or aggressive infectious disease), dying as both a social activity and a social relationship may have been quite different from how dying is thought of today. In the Neolithic era death was, for example, a very sudden event, and there simply would not have been an extended period for the dying person to reflect on their life and the big change that was happening to them. Instead, the process of dying would begin well within life, but essentially as a symbolic activity, with people making preparations for their death by making sure that their journey through the afterlife was well stocked with appropriate weapons for a man, or food supplies for a woman. These preparations could have involved planting a certain type of tree that was symbolically rich for the tribe, for example, or by storing an axe to be collected in the afterlife. Once someone had died, let us say, of an accident whilst out hunting or gathering food, it was the surrounding members of the tribe who would ‘do’ the dying, engaging in ceremonies that would ease the journey from this world into the other world for the recently deceased member of their tribe and community (Kellehear 2004).
As human society develops and changes over time so does the process of dying and how people go about the business of dying. One advantage that humans gained from establishing settled farming communities is that they could begin to develop the basics (steady food supply, shelter and safety) that would allow them to live longer. By living longer, time for dying and a space for personal reflection was created, as death would become less of a random, swift and unexpected event. Again, how people approach dying alters across time as society develops.

The best-known interpretation of what a dying person undergoes is provided by Elisabeth Kübler-Ross. Her work emerges out of her reaction against what she perceived to be the increasingly inhuman and cold treatment of dying people in modern society. In her landmark and highly influential work *On Death and Dying* (1969) she presents a stage model consisting of what Walter (1994: 70) terms the ‘famous five’ stages that dying people pass through as they die and move from denying to accepting that they are dying:

- **Denial**. This is a phase of the person not believing what they have been told by the doctor or specialist, that the terrible news they have been given must be the result of an incorrect test, that someone has made a mistake in the lab, and that if the results were to be rechecked then all would be well and they would not be dying. The related reaction of isolation can also occur here, where the dying person withdraws from the world about them, seeking their own company and avoiding the company of others.

- **Anger**. Denial may be impossible to maintain and the initial feelings of rejecting what they have been told transmute into anger and rage. The target of this anger can range from people they know who have engaged in much less healthy lifestyles than they have, but more likely the anger will be funnelled towards the medical staff and health professionals around them.

- **Bargaining**. Here the dying person attempts to gain more time in which to live. Bargaining can be with God or the medical staff, running on the lines of, 'If you give me more time, then I'll do something for you in return.'

- **Depression**. As the realisation sinks in that bargaining leads nowhere, due to ongoing and increasingly debilitating medical and surgical procedures, for example, the dying patient can experience loss of role and an awareness that the end is near, though they can remain in this stage for quite some time.

- **Acceptance**. This is the last stop on the journey of dying and accepting that death is now inevitable.

This five-stage model may read quite neatly and provide a nice and ordered approach to the no doubt highly traumatic and difficult experience of dying, but it is not without its shortcomings, which throw into question the actual usefulness and accuracy of its basic
precepts. Walter (1994) provides a useful summary of the problems that have been identified with the Kübler-Ross model of dying, and the key ones are as follows:

- Doctors and health professionals may misinterpret the patient’s actions and behaviours, incorrectly assigning them to the denial or anger stage. Doing so can give rise to miscommunication and misunderstandings, resulting in negative impact on the patient’s health and care in the ward.
- Very little empirical research has been carried out on the five-stage approach in order to assess how accurate it is. This lack of rigour has potentially allowed the stage model of dying to gain a credibility that is perhaps questionable.
- It is too neat and tidy. The concept of such a linear approach to death is not necessarily reflective of reality; approaches, adjustments and interpretations of death and dying (as discussed in the previous section) are more fluid.
- The whole model is very American in its orientation, reflecting American cultural values of individualism, with the emphasis being on the person and not the wider social context in which they live.
- Finally, Kübler-Ross’ work is perhaps less an academic thesis and more a personal vision of how dying could and should be.

Questions
Assess the disadvantages and advantages of the Kübler-Ross approach to dying. Do you agree or disagree with the criticisms listed above? Provide reasons for your answers.

The emotional labour of working with the dead and dying

As indicated earlier in this chapter, the majority of people in contemporary high-income nations such as Britain die in a hospital. In such locations a whole array of health professionals and health workers will obviously be found, and part of their daily labour and practice will involve working with people who are dying and with those who have died. One subtheme of this chapter has been that death involves a certain emotional cost for those who are connected in some way with the dying and the dead. If that is the case – that emotions, and here the more ‘negative’ and troubling emotions of grief, are the focus – how are those workers and professionals affected?
The theory of *emotional labour* as developed by Arlie Hochschild (1983) provides a useful starting point in exploring and answering the question just set. Her theory centres on one particular development in the field of work in late modernity: the shift away from work requiring a set of skills to do with the physical movement of the body (such as being able to turn a lathe or operate machinery) to work involving the emotions of the body, where as part of the working day (or night) enacting and performing appropriate emotional displays are the core requirement of the job (hence *emotional* labour). Emotional labour can therefore require the suppression of how one is really feeling and the simultaneous performance of emotions that one is not really experiencing. So, for example, when working with a client, the health professional may have to hide and not display feelings of boredom and frustration with that client and instead perform or enact an outward display of care and interest.

The original focus of Hochschild’s research fell on female airline stewardesses, who as part of their job were obliged by the organisation they worked for to create a certain emotional environment for the airline passengers, involving making the passengers feel welcome. The creation of a relaxed and welcoming ambience relied on the ability of the stewardesses to act enthusiastically in response to the passengers’ needs and demands. On first inspection, having a job that involves only flashing a few smiles and being ‘nice’ to people may appear to be relatively undemanding and perhaps even enjoyable. Hochschild’s (1983) findings pointed, however, to a quite different reality. The stewardesses reported that they were alienated from their emotions, they felt that their smiles were no longer their own, their emotional display and feeling were somehow ‘false’ and synthetic, and they had an overall feeling of being ‘burnt out’. The reason for the stewardesses reporting emotional exhaustion and damage to their emotional self was that the surface acting of emotions (that is, smiling to welcome a passenger) can require the manufacture of emotion and also a drawing upon real, deep and core emotions, which were not an infinite resource and whose reserves could be depleted over time – in effect, using up all their emotions.

A parallel situation can be seen to exist for health workers and health professionals in working with the dying and the dead. Contemporary health care requires a combination of professional, instrumental skills and, just as importantly, the emotional skills necessary to engage with the emotional aspects of care and the patient experience. There are distinct occasions in health care where emotional skills play an important role in assuring both patient dignity and the success of care and treatment. Nurses working in intensive care, for example, may engage in emotion work in order to provide a more
human environment for patients who are dying in a place that is cold and filled with
cold technology, and to assist in the development of good relations between the patient,
clinical staff and family members (Seymour 2001). Emotional labour, as Hochschild
strongly suggests, often comes with a cost, as indicated in the discussion above concerning
airline stewardesses. A variety of research has identified that the emotional labour costs
associated with the care of dying people are multiple, and include burnout, feelings of
aggression, alcohol or substance (mis)use, and suicidal ideation. As Sorensen and Iedema
(2009) argue, the problem with the stresses and anxieties that emerge from emotional
labour in a hospital or health care setting is that they are less well understood than the
normal stresses and anxieties (such as the number of hours worked and the amount
of task-centred labour) associated with organisational and institutional demands. They
are less obvious and therefore harder to identify and quantify, which makes taking any
ameliorative action quite problematic; the negative consequences of emotional labour
therefore remain unchallenged, creating further and deeper issues of well-being for
health workers and health professionals.

Questions

Reflect on the concept of emotional labour in relation to your own experiences of
work (this does not necessarily have to be in the health field). Identify how important
certain emotional performances are in the modern working environment and what
effect they could have on the person doing the performing.

Conclusion

Death will unfortunately come to us all; that is an inescapable part of being human.
However, our experiences of dying and our understandings of death will differ greatly by
social class, gender and ethnicity on the one hand, and by wider social, global and historical
developments on the other. So, we all may die but that final stage of existence is also cut
across by the various inequalities that structured and conditioned the life we had before our
death. By also discussing those social differences, another point is made about death and
dying: as moments in our life they are not solely explicable in biological terms. Biology is a
very important element in relation to the terminal changes that occur in the body, but these
biological events are woven into the wider social and cultural contexts that can be both the
cause of death and the provider of the symbols and rituals that help to make sense of death
and dying.
So, once again, we can see how sociology and the sociological imagination provide insights into a very intimate and difficult part of our life and our health, and how essential an appreciation of social processes is in order to gain a fuller and deeper understanding of death and dying.

Summary points

- Human beings have always sought to deal and cope with death and dying.
- Death is not necessarily an unambiguous state, and what counts as being dead changes across time and across cultures.
- The reasons why people die are again highly variable and depend on which part of the world you live in.
- There is a debate as to how much contemporary western societies deny death. There may not be the same direct openness about the existence of death that existed in Victorian times, for example, but perhaps a more subtle and nuanced acceptance of death has developed which does not necessarily rely upon public display.
- New forms of funerary rites are beginning to emerge that are replacing older and traditional religious approaches as society becomes increasingly secular.
- Health professionals require a certain level of emotional labour when working with people who are dying.

Case study

What some people noticed at Jamie’s funeral, especially the older people who had a little more acquaintance with death and what must be done when someone passes away, was that even though it was in the city crematorium it wasn’t a minister or a priest that conducted the service. Instead, there was a man who in very dignified tones informed the packed room that he was a humanist celebrant and would be leading not a funeral service but instead a celebration of Jamie’s life. Jamie was nineteen when he died, a silly and pointless accident where a second’s inattention had made the difference. Out camping with friends he had walked to some nearby cliffs. The long coastal grass had over grown the cliff top giving a false impression that the edge was a little further away than it actually was. He had stepped forward not realising where the true edge was. Both he and his family were not religious and it just seemed inappropriate to involve someone from the church – plus the last thing Jamie would have wanted was for his farewell to be anything but a big joyous party! So, no one was to wear anything associated with mourning, and the music that was played between the various speeches made by friends and family was his favourite songs and some of the demo tracks he had recorded with his band.
Questions

The above case study may seem to portray a very modern way of managing death and conducting a ritual for someone who has died, but try to detect and identify any themes that could be found in any other historical time or even in any other society.

Jamie’s funeral was a humanist service – how does this choice of ceremony reflect wider changes in society in relation to organised religion?

Why do you think humans need to mark key moments across the life course (think of other events as well as death) – try to relate you discussion to sociological theories and concepts.

Taking your studies further

This chapter will have helped you understand many of the key terms, concepts, theories and debates relating to death and dying. Listed below are books that will provide deeper and more detailed discussions of the points raised in this chapter. You will also find what is available on the companion website. This offers downloads of relevant material, plus links to useful websites in addition to podcasts and other features.

Recommended reading


On the companion website