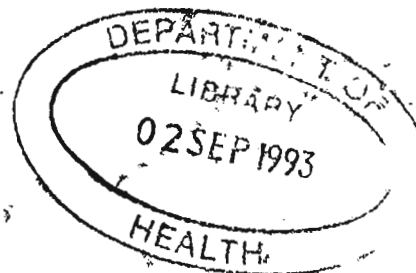


*Centre for Adult and Community Education
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**DEATH, BEREAVEMENT AND
HEALTH EDUCATION**

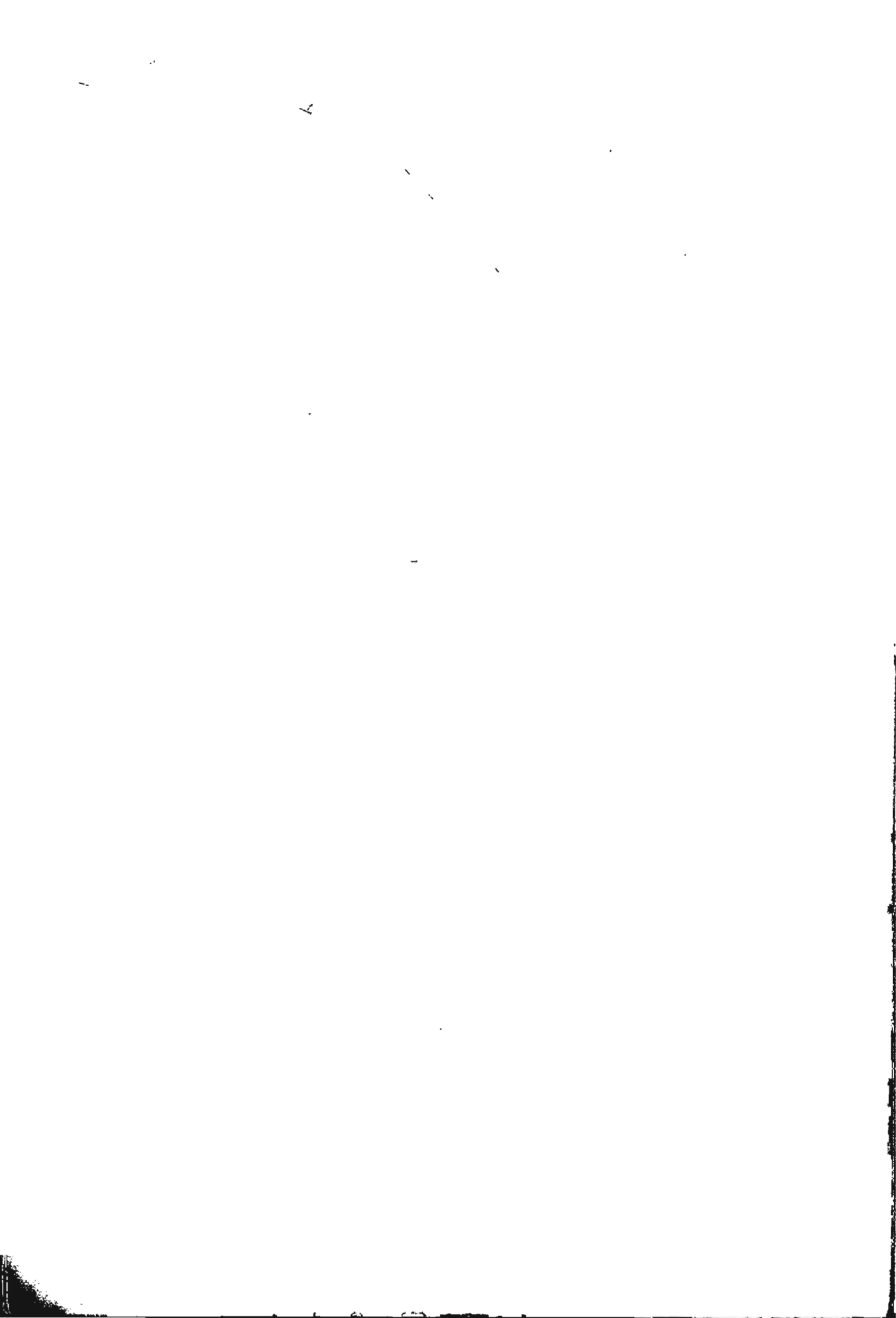
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INTRODUCTION

Concern with death, dying and bereavement as problems with educational and social science significance has expanded dramatically in the last ten to fifteen years, especially in the United States. The new field of "death education," which deals with counselling and support for the dying and the bereaved and with general social reactions to death and bereavement, has rapidly accumulated a large body of research and expert literature (there are now at least three academic journals dealing with death education and related topics, *Thanatology*, *Omega*, and *Death Education*). This paper presents a brief overview of the thinking underlying death education and makes particular reference to its current and possible future applications in Ireland, especially as a branch of general health education. The paper contains three parts: first, a review of literature on death and bereavement from the social, psychological and educational viewpoints, drawing especially on the literature in Britain and the United States; second, an assessment of the social and educational reactions to death and bereavement in Ireland; and third, an indication of possible areas where health education in Ireland might be developed to deal with some of the problems that now seem to be emerging in public reactions to death and bereavement.

The paper is intended as an introduction to the topics it discusses rather than as a comprehensive or systematic treatment. The second part of the paper, the review of social and educational reactions to death and bereavement in Ireland, is based on interviews with a number of people professionally involved with the dying and the bereaved (see Acknowledgements). To my knowledge, there have been no systematic analyses of developments or patterns in approaches to death and bereavement in modern Ireland and the present treatment is not intended to fill that gap. The ideas on these topics contained in the present paper are impressions drawn from the limited number of interviews carried out rather than conclusions drawn from hard data, and any implications drawn from these ideas must be treated with appropriate caution.

REVIEW OF LITERATURE

The literature on death and bereavement can be reviewed in connection with three themes: popular attitudes and reactions to death and bereavement; attitudes and reactions to death and bereavement among those professionally involved in dealing with the dying and the bereaved (such as doctors, nurses and pastors); and health education responses to problems now being identified in modern approaches to death and bereavement. The distinction between these three themes is not one commonly made in the literature itself. However, in dealing with the Irish situation,

one possibility that will have to be considered is that popular reactions, professional reactions and educational reactions to death are disjointed from each other, possibly in a way not common to the countries where much of the discussion of these topics to date has taken place. Consequently, from the start it is worth distinguishing between these different areas and isolating the ideas in current thinking that are associated with each.

Popular attitudes

Much of the concern for death as a social and educational problem that has emerged in recent years derives from a pessimistic judgement on the social and psychological wisdom of the approach to death that is now seen to prevail in many modern societies. One of the earliest and most influential exponents of this pessimistic judgement is the British sociologist Geoffrey Gorer, whose 1955 article, "The Pornography of Death," sounded the keynote for much of the subsequent discussion of this topic (this much-quoted article is reproduced as an appendix to Gorer (1965)). Gorer's central assertion is that death has become a taboo topic in much of western society in the twentieth century, replacing sex as a subject to be elided from acceptable discourse. In Gorer's view, just as the Victorian lady was felt to have no sexual impulses and the Victorian gentleman was expected to control his sexual urges by strength of character, so twentieth century men and women are expected to suppress their fears of death and control their mourning by sheer will. "Giving way to grief is stigmatized as morbid, unhealthy, demoralizing...; and the proper action of a friend and well-wisher is felt to be distraction of a mourner from his or her grief.... Mourning is treated as if it were a weakness, a self-indulgence, a reprehensible bad habit instead of as a psychological necessity" (Gorer, 1965: 113).

The outward consequences of this taboo, according to Gorer, have been a weakening of the social recognition of mourning and a decline of the traditional customs for dealing with death and bereavement. Traditional customs defined the appropriate behaviour of mourners and those who came into contact with them and usually set time bounds to various stages and levels of mourning. In Gorer's view, such structured and "time-limited" mourning was "the most appropriate technique for mourners to make the complicated social and psychological adjustments involved in the loss of a primary relative." Consequently, the decline of customs of mourning (which Gorer documented for Britain in his 1965 study) can only have harmful effects: "the outcome is liable to be either the permanent despair of depression or melancholia, an impairment of the capacity to love in the future, or various irrational attitudes towards death and destruction" (Gorer 1965: 111-112).

Subsequent analyses of the modern approach to death have to a great extent simply repeated or elaborated on the main themes in Gorer's work. Aries (1974), for example, traced changes in popular attitudes to death in the West from the Middle Ages to the present. While his research has given historical background to contemporary analyses, it concludes with a picture of twentieth century approaches to death that echoes Gorer: in Aries' view, the twentieth century, in Britain, Northern Europe and America especially, "forbids" death, pushing the dread of mortality to the margins of consciousness and the old, the ill and the bereaved to margins of social recognition (see also Aries 1977). Choron (1963) suggests that the avoidance of death in recent times is characteristic not only of popular attitudes but has also permeated Western philosophy. In his view, since the second half of the nineteenth century, when look for the thinking of philosophy on death "we find a conspiracy of silence on the literal and figurative 'skeleton in the closet'" (Choron 1963: 268). Even in Christian theology, according to Smart (1968), in the attempt to make the language of faith more acceptable and credible to modern ears, concern with the after-life, and consequently with death and mortality in this life, has tended to be pushed to one side, with the result that death is approached only obliquely in modern theology, rather than as the massive and unavoidable fate of human existence that stood at the centre of much of traditional Christian thought.

Recent analyses of modern attitudes to death, in short, have consistently arrived at one central conclusion: that wherever one looks one finds silence, evasion, furtive embarrassment, inarticulateness, or some other sign of an inability to come to terms with death or even to interact openly with those who are dying or those who are in the emotional throes of bereavement. This conclusion has implied a decline in traditional mechanisms for dealing with death and bereavement and has also implied an increase in the emotional stress and sense of isolation of those in confrontation with death. In other words, death and the disruption caused by death, in this view, has become socially tabooed, but it continues to wreak its havoc underground, increasing the misery it brings to individuals and making ever more necessary a radical redirection in prevailing social reactions to mortality and mourning.

Professional attitudes

The concern that modern society adopts an evasive, fearful approach to the subject of death is at its most intense when it is applied to those whose professional duty it is to deal with death and the dying - medical professionals especially, but also clergy, social workers and others involved in the caring professions. For those who advocate a new educational ap-

proach to death and mourning, it is quite often precisely these professionals who are judged to have the greatest need for what that education has to offer. Indeed, for some commentators, the central symbol of the coldness and inhumanity of the modern way of death is the high-technology, remote and impersonal hospital. In this view, the hospital not only serves to remove the ill or dying person from public view, thus contributing to the public evasion of death. It also converts the dying person from a suffering subject into a dehumanised collection of symptoms and physical disorders. In the hospital, according to Kübler-Ross, the patient "may cry out for rest, peace, dignity, but he will get infusions, transfusions, a heart machine, or a tracheostomy. He may want one single person to stop for one single minute so that he can ask one single question—but he will get a dozen people around the clock, all busily preoccupied with his heart rate, pulse, electrocardiogram or pulmonary functions, his excretions or secretions, but not with him as a human being" (1968: 8).

The gloomy view of the gruesome and dehumanized treatment of the patient in the modern hospital acts for many as the summation of the professional approach to death that has emerged as the counterpart of popular fear and denial of death. For some critics of the modern medical system, professional callousness towards the terminally ill and the bereaved is but one symptom of the now general inhumanity of "industrialized medicine," where technological prowess and the pursuit of professional awards have replaced concern for the patient as the motive force for care (Illich 1975: 139-44, Ehrenreich and Ehrenreich 1970, Ehrenreich 1978). A somewhat more charitable view is that the very devotion of the medical ethic to life and the preservation of life makes it difficult for doctors and nurses to accept the inevitability of death in terminal cases and consequently makes them inept at facilitating the social and emotional support needed by the ill and their families when facing death (Strauss and Glaser 1970, Mauksch 1975). In addition, the very success of modern medicine has resulted in the decline in the prevalence of acute illnesses as causes of death, with a corresponding increase in the prevalence of chronic illnesses requiring long-term medical care. In this sense, it might well be said, the problem with the hospital is partly a result of the success of the hospital: the effectiveness of modern medicine in prolonging life throws a greater burden of chronic illness on the hospital and leads to expectations of social and emotional support for patients enduring long term illness that doctors and nurses have not been trained to give. The failure of the hospital, therefore, in so far as it is inadequate in the more social-psychological aspects of therapy, might at least partly be excused as a "failure of success," an area left unattended, and indeed partly created, because of rapid and impressive strides forward in the purely medical side of hospital services (Gruenberg

1977).

However, whether the tone used in discussing this topic is anti-doctor or not, there is a widespread judgement that the medical model of care, which focusses on physical problems and the quest for scientifically based cures to all ills, is inadequate and sometimes harmful if used as a guide for a response to dying and bereavement. Since in the face of death, the problem is no longer simply physical and the ill is beyond cure in the narrow medical sense, any attempt to confine interactions between medical professional and the dying or bereaved into a strict medical frame does violence to human feelings and increases rather than eases the stress and anxiety of those involved.

The response of education

The bleak view of the modern way of death that is suggested by analyses of both popular and medical approaches to death and mourning in modern society is the principal rationale for the growth of "death education." In the seminal and widely popular work of Elisabeth Kübler-Ross (1968) the rehumanization of death and grieving in the face of social evasion and medical mechanization is taken as given as a valuable, indeed urgent, therapeutic goal. For Kübler-Ross, as for most of those who take up the cause of death education, two principles are fundamental. First, in the face of death, there is always a healthy way to grieve or to prepare for death, no matter how distressing or disruptive death may be. That healthy way enables the dying person to achieve some peace and resignation in the face of death and it enables the bereaved to come to terms with their loss and emerge from grief with a renewed capacity for normal social existence. Second, in societies such as those of the modern west where there is no widespread sense of what the healthy way of death is, that sense can be rediscovered and recreated through sympathetic self-exploration and exploration of others in confrontation with death. That rediscovery and recreation is the task of death education.

Working from these two basic ideas, death education has been concerned first to define precisely what constitutes a healthy approach to death. Gorer (1965), as a sociologist, was concerned mainly with the "health" of external social and cultural patterns associated with death. In looking at the British situation, he emphasized the importance of ritual and mourning customs as means to healthy grieving and suggested the development of new secular rituals of mourning as a possible solution to the inadequacy of modern approaches to death. Kübler-Ross, by contrast, as a psychiatrist, has been more concerned with the internal emotional states associated with healthy grieving, and to a great extent it has been

this focus on the emotional states and processes of grief and mourning that has dominated in subsequent writing. In her highly influential analysis of the coping mechanisms employed by dying patients in an American hospital, Kübler-Ross suggested that coming to terms with death is a process involving five emotional stages. First is denial and isolation, where the patient when confronted with the prospect of imminent death, and having recovered from an initial state of shock, simply refuses to accept that it can happen to him or her. Second is anger, rage or resentment, quite often based on a "why me?" mentality and equally often displaced outwards in an aggressiveness towards family, doctors, nurses or even God. Following that comes a short period of bargaining, where the patient hopes against hope that some extraordinary acts of good behaviour can gain a postponement or respite from the inevitable. The fourth stage is depression, where anxiety, fear, a sense of loss or isolation combine to overwhelm all capacity for positive emotion. The fifth and final stage is acceptance, which involves not a sense of happiness but a sense of relief and silence, of struggle over and rest achieved.

In Kübler-Ross's approach, these stages are more-or-less natural reactions to the prospect of death and the principal means to a healthy management of them is simply to let them happen. This means that the recovery of a healthy approach to death involves a renewed openness to "natural" feelings of denial, anger, depression, etc., and a refusal to allow reticence or the desire to preserve a stoic appearance interfere with the expression of those feelings. Such a healthy approach benefits not only the dying, allowing them to achieve a measure of equanimity and comfort in their approach to death. It equally benefits the living, enabling them to work through the throes of grief and loss and emerge from mourning with the capacity to pick up the strands of normal life again. Given this openness, the living can give genuine support to the dying, not by evading the fear and pain of death but by giving it space for open expression. The living can also support each other, and indeed help themselves, by a similar openness, thus avoiding a destructive bottling up of powerful emotions and a demoralising loneliness in the face of loss.

The educational task, then, from this point of view, is to point up the cultural barriers and psychological resistances to openness that pervade modern approaches to death. Such a task is not simply a cognitive one, to be mastered intellectually, but an emotional one to be achieved in direct contact with the dying and the bereaved. The techniques employed in education of this kind can vary. Typically they require as a central element some real closeness to the reality of death, either by casting back into the bereavement experiences of those involved or by coming into contact with people experiencing grief or terminal illness. The seminars with

the terminally ill reported by Kübler-Ross (1968) represent for many the ideal way for both the dying and living to come into such an educational confrontation with the reality of death. Subsequently, the full panoply of educational techniques has been applied to this field, though with an emphasis on the more informal methods such as the small group seminar (Wass et al. 1980).

In more recent years, however, the practical difficulties in realising the ideals of death education have begun to emerge. Death education, particularly in the United States, has become an academic growth industry, with a proliferation of textbooks and readers, conferences and under-graduate courses, audio-visual aids and professional terminologies. It is doubtful if this growth has been achieved without some attenuation of original purpose. It is also questionable to what extent death education in any kind of intense form can effectively be proliferated through university courses, given the original emphasis of that education on genuine encounters with grief and loss. Already, some doubt has been expressed about the tendency towards professionalization in death education, especially as far as the benefits to be had from a new breed of professionally trained "grief experts" are concerned, since these too might become just another set of basically self-serving beneficiaries from the death industry (see, e.g., Taylor 1977). Kübler-Ross, the early champion of death education, has also been accused of turning her cause into a vulgar, ego-boosting cult centred on herself (O'Connell 1981). On a more technical level, many commentators have questioned in one way or another the widespread validity of the five stages of grief identified by Kübler-Ross or of the alternatives proposed by others: the emotions and the sequences of those emotions, they would argue, are far more variable and unpredictable than any single analysis might suggest. Consequently, even at this level, there have been fears that scientific analysis might not just be wrong, as inevitably happens, but that it might also give rise to new orthodoxies which might ultimately be as oppressive as those they aimed to replace (Kimmel 1980, Chap 10).

However, these difficulties may be accepted as the imperfections of a basically sound movement. The remarkable upsurge of interest in the field does seem to suggest that death education is responding to widely felt need and perhaps does hold the promise of genuine benefit to at least some of those struck by grief and loss. Presented as an option to be selected by those who feel the need for it, rather than as a new dogma to be imposed indiscriminately, the teachings of death education and the support and counselling services of "grief experts" are at the very minimum an unobjectionable addition to the sparse social resources typically allocated (either formally or informally) to the emotional needs of the dying and the bereaved. More generally, although commentators working in these areas

might argue about the precise content of healthy grieving, or about how such content might be realised in individuals' lives, they would agree at the same time that an educational drive towards a more open and accepting context for that grieving, if properly managed, is a desirable and attainable social goal. Whether or to what extent that drive as it is now underway in places such as the United States will achieve its goal is a matter that will be very difficult to judge.

DEATH AND BEREAVEMENT IN IRELAND

There is much in the literature on death and bereavement just examined that does not seem to ring true when applied to Ireland. While there is no doubt that traditional Irish rituals of mourning, such as described by O'Sullivan (1987), have lost much of their prominence and power, it is hardly yet true that the Irish approach to death has tabooed death and silenced mourning. The strongly attended funeral is still a regular feature of Irish life and the widely practised customs of condolence and remembrance are still lively, if perhaps weakening, parts of normal social behaviour. Indeed, some commentators have suggested that the "death avoidance syndrome" which is present in Britain and America is by no means universal even in the modern west. Aries (1974) suggests that there may be a great divide on this issue between, roughly, northern Europe and America (the generally Protestant areas of the west), on the one hand, and Latin Europe, on the other. Gorer (1985) likewise suggests a difference between the Protestant and Catholic heritages in these areas and points out, for example, that Irish Catholic immigrants in Britain stand out as one of the few minority communities in that country that still generally practise traditional customs surrounding death. However, we have no systematic studies of attitudes or behaviour in this particular area of Irish life. While the general impression would be that Irish practice is more accepting of death and the public accomodation of mourning than British or American practice, the reality behind this impression has not yet been tested.

More particularly, we have no studies of the approach to the dying and the bereaved among Irish medical professionals and consequently we cannot judge if the "death avoidance" syndrome has permeated that particular group. One might argue that the medical profession inevitably reflects the larger social environment that surrounds it and that consequently it will reflect the general social acceptance of death and mourning that seems to prevail in Ireland. A further link between popular approaches and the medical approach, it might be said, is provided by the strong presence of the Catholic church in the hospital system through the religious congregations involved in health care. These congregations (such as the Sisters of

Mercy and the Sisters of Charity) not only run some of the country's biggest hospitals, in which a significant proportion of the administrative and nursing staff is provided from their own memberships. They also exercise a strong influence over the secular nursing profession through their schools of nursing and through the strong links between nursing and the religious life which have existed in Ireland since the nineteenth century. The influence of the religious congregations, like that of the Catholic church as a whole, does not extend in such a formal way to the medical schools nor to the working medical profession. Nevertheless it could be argued that the Irish medical system in general, both because of the general cultural environment and the strong church presence in hospitals and nursing, retains a stronger sense of religious values than is common in the modern west and that consequently the worse extremes of dehumanization in the medical approach to death and mourning have been avoided.

In the face of arguments such as these one could conclude that, in Ireland, since we do not display the general social evasiveness towards death that has perturbed commentators in other countries, we have no need for death education. The traditional beliefs and customs whose passing is seen to be the root of the problem in those countries are still widespread in Ireland and, it might be said, do more to relieve the stress and anxiety of grief and mourning than any deliberately contrived modern replacements. Indeed, from this point of view, the efforts of modern psychiatry and psychology to devise a substitute for the folk and Christian traditions of grief and mourning, however well intentioned, may seem limp and shallow and pathetically inadequate to the task. In addition, a scepticism towards contrived solutions, especially if such solutions are to be part of the stock in trade of professional courses, could lead to a dismay at the prospect of "grief experts" emerging from professional courses, therapeutic routines in hand, to confront us at every turn when we ourselves are about to die or to bear a personal loss.

However, this conclusion might seem too casually dismissive of an alternative approach to death that may be desperately needed by many. Indeed, we could take a much less sanguine view of the Irish approach to death: although we may have relatively elaborate death and mourning customs, that is no guarantee that those customs are broadly effective in maximising the social support and emotional release needed by those hit by death. It might be argued, in fact, that those in Britain and America who regret the passing of traditional customs of mourning may be ascribing to those customs an efficacy they never fully possessed and that cultures such as ours that still give those customs a strong place may yet be far from a "healthy" approach to death and bereavement. Indeed, it might well be argued that traditional customs, however supportive they may appear in

public, might not necessarily always be benign in their personal impact. In some cases they can be used as empty formulae, or as conventions behind which people can hide or under which they can suppress disruptive emotion. External participation in customary rituals can become a substitute for true openness to grief, and blanket-injunctions to mourning in traditionally defined ways can violate the needs of those whose circumstances or feelings do not fuse with the dominant pattern. Even the Catholic influence, for all its ritual richness, can seem less impressive when viewed in the light of the Catholic Church's traditional distrust of personal expressiveness and its traditional emphasis on sin, guilt and the need for redemptive suffering in humanity's relations with God. In addition, there may be groups—such as children or the victims of particularly tragic loss—for whom traditional recourses can be wholly inadequate. In circumstances such as these, then, the strength of traditional custom may be of little avail and might even in some unpredictable way be an additional stress as much as a source of support to those stricken by grief.

In the Irish medical system also the treatment of death can hardly avoid all of the bad features usually associated with the increased emphasis on technology in medical care. Whatever the nature of the general cultural environment in which the Irish medical system is located, the medical model of care still dominates in Irish hospitals and other medical institutions. It is scarcely to be expected that the Irish version of that model, which shares most of what people normally think of as the good elements common to its international counterparts, could avoid its bad elements. With the continuing tendency for medicine in Ireland to mechanise and for illness—terminal or otherwise—to be hospitalised, it would seem foolhardy, and indeed insensitive to the interests of patients and their families, to discount the lessons on ways to humanize medical care that have been drawn from similar experiences elsewhere.

Recent developments

In the long run, however, discussion in general terms of the adequacy or otherwise of the Irish approach to death, whether in popular behaviour or in behaviour of medical professionals, is less likely to give shape to future developments than the force of experience in concrete circumstances. In other words, those developments will emerge, not from general principle nor from an abstract conviction that international innovations should be replicated in Ireland, but from a pressure from those who face the grief and fear of death or who have to provide support to those who do. It is not clear where that pressure will push towards. But already there are signs that, where the opportunity for a new and more emotionally supportive

approach to death has been presented, it has drawn a grateful response from those able to avail of it.

That opportunity, on any formal or organised basis, is rare in Ireland but the few instances where it does exist cover a range of situations, from the primarily medical to the more generally educational. At the medical end, the most notable innovations have occurred in the hospices for the dying, one example of which is Our Lady's Hospice in Harold's Cross, Dublin. In narrowly medical terms, this particular hospice concentrates its service on the relief of physical pain among those with terminal illness (especially cancer). It does so in the belief that, since all efforts to provide emotional support are futile where physical pain is present, the suppression of physical pain is the primary and essential service which medical technology can offer the terminally ill. However, deliberate attempts have been made to extend a social and emotional supportiveness to patients and their families so that the strictly medical service is embedded in a broadly humane approach to the total needs of the dying patient.

These efforts have not been self-consciously linked to international developments in death education, but they nevertheless reflect some of the themes that are common in that movement. First is a policy of complete honesty and of readiness to talk openly with patients about their physical condition, although this policy sometimes runs into opposition from family members who would prefer to have the truth concealed. Second is an attempt to deal with the patient as much as possible in conjunction with the patient's family, so that the hospice staff, instead of becoming a barrier between the patient and the patient's normal social world, help the patient's social and family relationships to continue in as normal and supportive a way as possible through to the patient's death. Third is the provision of a support staff of social workers and counsellors, as well as the medical staff, who are available to provide help and counselling to patients and their families. This provision extends to former patients (many of whom will eventually return to die) as well as to the families of former patients who are free to return to the hospice staff for counselling if they wish to do so. Finally is the operation of a team approach among the staff, geared not only to the needs of patients, but also to the support of individual staff members through the personal emotional strain which the work, by its traumatic nature, places on them.

Institutions for the treatment of incurable terminal illness represent the principle instance in Ireland of a formal medical response to the non-medical as well as the medical needs of patients. In the general medical system outside of institutions for the terminally ill, such responses are rare and where they occur are *ad hoc* and dependent on the initiative of in-

dividuals rather than a formal element of the system. As a general rule, no provision is made in the formal training of doctors or nurses for a grounding in the non-medical aspects of care and support for patients and their families, whether in situations involving death or otherwise. In some training institutions various informal efforts—such as the provision of occasional lectures or short courses—have occurred in this area. In general, however, it is not clear that medical professionals in Ireland accept to any great extent that there is a need for such a provision as a formal element in professional medical training. Nor is it clear that even those medical professionals who would favour the extension of non-medical support services in the medical system would accept that medical people, as opposed to non-medical counsellors or social workers, should have a direct hand in those services or should have any responsibility for adjusting their own traditional style of operation to bring such services closer to the heart of the medical system. In sum, there is little sign that medical professionals in Ireland have seriously regarded the claims that the general medical system, outside of institutions for the treatment of incurable terminal illness, ought to make a general adjustment towards a more socially and emotionally supportive role towards patients and their families.

The medical system in Ireland, as elsewhere, has always had attached to it a traditional non-medical element in the form of chaplaincy services for hospitals and it is in this area that a further instance of a movement with echoes of death education has occurred in Ireland in recent years. In spite of the traditional strong Catholic involvement in hospitals the Catholic church has given little attention to training for pastoral work in this field. Indeed it was not uncommon in the recent past to reserve chaplaincy work in hospitals for priests whose age or ill-health made them unfit for the rigours of ordinary parish work. More recently, however, the special demands of this type of work have been recognised and Clinical Pastoral Education has emerged as a specialist field in pastoral training (Ashley and O'Rourke 1978: 396-98). In the Irish Catholic Church, this specialism has not yet been incorporated into seminary training. However, the chaplaincy services of individual hospitals have begun to take cognisance of it and since 1980, under the auspices of the Conference of Major Religious Superiors, the chaplaincy services in two major Irish hospitals (St Vincent's in Dublin and the Regional Hospital in Cork) have run training courses for pastoral workers (mainly priests) in this field. The courses run for three months full-time and emphasise practical work in the wards along with flexible class work and supervision as training methods. They are geared to work with all kinds of hospital patients, so that although they pay considerable attention to the processes of bereavement and grief, they are not confined to the issues dealt with in death education. The impetus for the courses came from the

pastoral workers themselves, who felt the lack of any organised training or preparation for their work. The response to these courses suggests the inadequacy of the traditional reliance on general spiritual formation both as a method of training pastors for this area and as a central element in the service to patients and their families.

There are a number of other attempts in Ireland to develop new responses to the needs of the bereaved and the dying, ranging from public lecture courses on the nature of "healthy grieving" to moves to alter religious liturgies for the dying. Although these are generally small scale and as yet have made little impression on general behaviour, they produce a useful and gradually increasing store of experience in this field in Ireland. In any larger study of the area these efforts should be examined and the lessons they produce drawn together, but the present paper does not have the scope to do so here.

THE ROLE OF HEALTH EDUCATION

In attempting to conclude from the discussion so far on the need for a health education service in this field, the following points can be made.

1. It is not clear to what extent the social and psychological analyses that have underlain the development of educational services in these areas in other countries—particularly Britain and the United States—can be applied to Ireland. There is particular doubt about the existence of a death avoidance syndrome of the kind that has been described in those countries. Since this syndrome has been presented as one of the principal rationales for the need to educate both the public and the medical system towards a more open and accepting approach to death and bereavement, the apparent absence of the syndrome in Ireland suggests, at the very least, that the precise form of the educational task in this area in Ireland is different from elsewhere.

2. However, if the educational task is different, that is not to say that it does not exist. We may not have a British or American form of death avoidance syndrome but we may well have one of our own. It is quite possible that underneath our relatively elaborate public rituals of burial, condolence and remembrance, we have an extensive private repression of grief and fear, with all the consequences of stress and loneliness which such repression brings. However, since we cannot say in general terms what the extent or nature of that repression is, we may suspect the existence of educational needs in this area without being able to define a well founded set of goals for a broad-ranging response to those needs.

3. It is on the level of particular experiences, some of them institutional, that we have accumulated in Ireland some scattered impressions of the kinds of needs and kinds of appropriate responses that are present in dealing with death and bereavement. These impressions are not systematic enough to derive any general conclusions about the Irish approach to death. But they are valuable for their closeness to concrete experiences and they suggest that there is room for further development along the same lines. In devising additional educational responses to death and bereavement, these experiences and the insights of those involved in them represent a useful source of guidance and they need to be brought together in a more systematic way than has been done to date.

4. Given the absence of general analyses of the problems associated with death and bereavement in Ireland, one way forward for health education is to begin to make good the absence of general research in the area by carrying out a study on the extent and nature of death-related social problems in Ireland. Such research is needed to establish the inadequacies in existing social practice towards which an educational drive might be directed.

5. However, in the shorter term, there exists a sufficient sense of what some of those deficiencies might be to examine ways in which they might be resolved. Ultimately we may find, in this area as in so many others, that it is easier to identify the problem than it is to do anything about it. Consequently, there is scope for health education to conduct educational pilot projects based on existing experience and expertise in this field. These projects could aim to explore and develop techniques for use in education relating to death and bereavement in Irish circumstances. One possible location for such pilot projects is the hospital system, since a frequently identified area where education of this kind might produce useful results is the modern hospital's treatment of patients and their families in the approach to death. In Ireland, the hospices for the dying have developed useful experience in this area and an obvious challenge at the present time is to see if this experience can be generalised in any way to the hospital system as a whole. As a task that is relatively limited and subject to organisational intervention (compared, say, to the task of informing or altering public attitudes as a whole), the challenge of the hospital approach to death would seem to offer a practical starting point for the development of a broad educational approach to Irish way of death.

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