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Jillian DeBenedetto
Reaching the End: An exploration of
Attachment and Existential Theory
as a path to assist in the dying
process

ABSTRACT

In this exploration I will utilize the theory of Attachment as well as Existential Theory to assist in expounding upon available paths to assist elderly individuals in their journey at the end of life. I will present an overview of the two selected theories of Attachment as well as Existential Theory and argue that such approaches honor the venerable end stage of life. A discussion pertaining to these two theories will shed light on the question of *how a clinician can seek to improve the quality of life for an individual during the end of life process* and therefore assist in the experience of a good death. The intent of this endeavor is to lend attention to a population that is often neglected as well as forgotten and additionally explore the phenomenon of death, which is also a typically ignored experience, and considered to be taboo within western society.

**REACHING THE END:
AN EXPLORATION OF ATTACHMENT AND EXISTENTIAL THEORY AS A PATH
TO ASSIST IN THE DYING PROCESS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

Jillian DeBenedetto
Smith College School for Social Work
Northampton, Massachusetts 01063
2014

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Thank you to those who have supported me throughout this endeavor. Amber you provided a light when the tunnel got dark and I am truly grateful for your wise words, vibrant spirit and unconditional friendship. Mom, you pushed me to keep going even when I thought there was nothing left. You never doubted me. This journey has revealed how grateful I am to have you in my life. I want you to know that although I do not express this often, I love you.

I am a thousand winds that blow.

I am the diamond glints on snow.

I am the sunlight on ripened grain.

I am the gentle autumn rain.

When you awake in the morning's hush

I am the soft uplifting rush of quiet birds in circling flight.

I am the soft star that shines at night.

Do not stand at my grave and cry

I am not there.

I did not die.

- *Anonymous*

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CHAPTER I

Introduction

Suffering is an ineradicable part of life, even as fate and death. Without suffering and death human life cannot be complete -Victor E. Frankl

Death and dying, these words carry a great weight when spoken. Death is a phenomenon that each of us is guaranteed and an experience that each living creature shares. It is an occurrence that science and medicine cannot cure despite valor attempts to prolong life. Newman in his text *Must we Grow Old?*, startlingly reminds us that “Man’s body and woman’s are of utter necessity sculptured of flesh so exquisitely fragile that even before birth rotting sets in” (Newman, 1941). Death within the medical community is primarily seen as a failure. It was not until the 1970’s, when the philosophy of Hospice care achieved notice in the United Kingdom that facilities addressing the needs of the terminally ill began to be developed in the United States (Connor, 2007). The Hospice care development opened the door within the medical community to see death as a being a part of the life cycle. However, despite the expansion of the Hospice Philosophy, the end of life [EOL] stage of the life cycle is not a readily accepted truth.

If one is fortunate to live a life of longevity then they are destined to see youth fade as they advance through the aging process. It is no secret that we live in a society that values the young over the elderly. Perhaps society chooses to focus on youth because it is a symbol of health and vitality, which distracts us from our fears of death. Yet, despite the knowledge that humans are destined to age, we typically ignore this fact and esteem youth with the greatest

worth. Scientists continually strive to increase the human lifespan through ‘anti-aging’ research that one may find tantamount to the quest for the fountain of youth. In fact emerging within the domain of science is a branch referred to as *biogerontology*. Boleyn-Fitzgerald shares that this branch of science seeks to “delay the biological mechanisms of aging” (Boleyn-Fitzgerald, 2009). It is reported that scientists embarked upon such research ‘between 1940 and 1950’ (Gerhard, 1992). Since then, the quest to delay aging within the U.S. has dramatically grown over the years. Juengst et al., highlights that the 1990’s saw the expansion of the ‘anti-aging movement’ and the development of products marketed to individuals seeking to curtail the aging process (Juengst et al., 2003). Even while walking through one’s local drugstore it is likely that there is a plethora of ‘anti-aging’ remedies available for purchase with the promise of stunting the physical signs of aging and restoring youth. Such products such as skin creams serve to remind us that beauty is held in the smooth skin of youth rather than the wrinkles of aging. Boleyn-Fitzgerald additionally shares that in 1974, congress itself developed what is referred to as the National Institute of Aging (NIA) with the goal “to understand the nature of aging and the aging process and diseases and conditions associated with growing older, in order to extend the healthy active years of life” (NIA website find how to cite). Certainly, the goal of the NIA, which reflects the value of health and quality of life, is laudable, yet this still demonstrates societies desire to escape the aging process. Boleyn-Fitzgerald provides the reader with a quote from Leon Kass’ text titled, *Toward a More Natural Science* that contrastingly expresses another perspective on death and the aging process,

“To know and to feel that one goes around only once, and that the deadline is not out of sight, is for many the necessary spur to the pursuit of something worthwhile . . . Mortality makes life matter” (Boleyn-Fitzgerald, 2009).

As a result of societies emphasis on youth, the elderly population is readily dismissed, discriminated against and labeled with a variety of pejorative terms. The elderly, become the ignored and forgotten population of our society even though they are amongst the most in need and most vulnerable.

With the advent of modern medicine we are living longer than what was ever perceived as being possible in the past. Glancing at recent U.S. history we discover that the year 1900 saw an abundance of deaths caused by infectious diseases such as, “pneumonia, tuberculosis, and diarrhea and enteritis . . . [as well as] cholera, dysentery, tuberculosis, typhoid fever, influenza, yellow fever and malaria” (Cooper et al., 2002). Cooper et al., reports that such infectious diseases were ‘common causes of death’ that “led to the high mortality rate of 1900”(Cooper et al., 2002) However, with the assistance of “improved sanitation and hygiene and the success of aggressive vaccination”, we saw a decrease in the number of deaths caused by the noted diseases and therefore gains in life expectancy as 40% of the individuals who consequently died from infectious diseases in 1900 were children less than 5 years old (Cooper et al., 2002). Additionally, Cooper et al., expands our understanding of medicines contribution to health and longevity by noting impactful developments in the realm of medicine such as the creation of insulin (1922), penicillin (1942), vitamin B12 (1948) all of which serve as examples that improved the health and therefore life expectancy of U.S. citizens (Cooper et al., 2002). Scientists are currently researching and debating the potential future gains in life expectancy, Olshansky et al., (2005) highlights the belief of some scientists, “that life expectancy at birth will rise to 100 years in the United States and other developed nations by the year 2060” (Olshansky et al., 2005). In recent years we are already seeing an increase in individuals who live to the age of 100 and as a result receive the title of a *centenarian*. The Center for Disease Control and Prevention, reports that,

“from 1980 to 2010, the number of deaths among female centenarians increased from 4,668 to 18,222, and the number of deaths among male centenarians increased from 1,552 to 3,607”(Center for Disease Control and Prevention, 2013). Lastly, it is interesting to note that Hallmark has reported selling “about 85,000 100th birthday cards a year . . .” (Cairncross, 2007). With greater life expectancy, comes a great responsibility however, of not simply ensuring existence but *quality* of existence. Bearing this in mind, we must remember to value the elderly and the process of dying that one must undergo to complete the life cycle.

Hospice/Palliative care addresses the necessity to lend focus on the dying individual and their needs rather than neglect the individual when the diagnosis of a terminal illness enters their lives. Stephen R. Connor notes that Hospice care,

. . . provides support and care for persons in the last phase of an incurable disease so that they may live as fully and as comfortably as possible. Hospice recognizes the dying process as a part of the normal process of living and focuses on enhancing the quality of remaining life (Connor, 2009).

Therefore, it is important that we explore this fact of life, *death* and assist rather than ignore the elderly population in ameliorating the end of life process.

Much of the literature that is available on the topic of death and dying focuses on the needs of the dying individuals *family members* and ways for clinicians to assist *them* in the bereavement process. Although there is literature that directly focuses on the dying individuals therapeutic needs, there appears to be a need to lend greater focus on the dying individual their experience of this last stage of life. This focus entail expanding on the ways in which clinicians can assist the dying individual by exploring ways to better understand the dying person as an individual holistically and existentially.

As noted previously, death is an occurrence that none of us are immune from experiencing. It is a fact of life that death will not only reach us directly indirectly as well through the loss of loved ones. The exploration of the end of life process can benefit clinicians who do not directly work within the field of Hospice/Palliative care as well. Death, having no boundaries, is likely to impact the clients of clinicians working outside the field of Hospice/Palliative care as well. Take for example the clinician working within the field of substance abuse. This clinician may encounter a client who recently lost a relative or friend due to an overdose. Let us also consider, the clinician assisting veterans who have returned from war in Iraq and Afghanistan, who may have experienced death through the loss of comrades. We might also include the clinician aiding the child who recently lost a parent in a tragic car accident. Increasing the literature regarding death and dying expands the assortment of tools that clinicians can adapt to their work and utilize to assist their clients regardless of what specific segmented realm of social work they are in. Furthermore, clinicians themselves are likely to experience loss through their lives as well. Expanding the knowledge regarding death and dying not only serves to benefit the clients we work with but also ourselves as individuals who will experience loss as well.

Attachment Theory and Existential Theory are the two approaches that will be examined to expound upon the methods of alleviating suffering during the dying process. Attachment theory prospectively offers the clinician a lens to see beyond the client's current age to the other end of the circle of life, to the time of birth and early attachments. Age often masks the experiences of youth that come to shape us. This theoretical perspective sheds light on the dying person as an individual who has created and lost bonds of friendship and or love.

Considering one's attachments opens the window to assist not only the clinician in developing a relationship with the dying individual but also the Hospice/Palliative care team whom the individual, upon entering the Hospice/Palliative care setting must subsequently become dependent upon.

Existential Theory presents the opportunity to explore the topic of death and dying through a humanistic viewpoint. Taking this approach seems to be particularly important when one considers the medically oriented structure of Hospice/Palliative Care. To explain, although Hospice/Palliative care emphasizes a comfort care approach, the foundation of this philosophy stems from a medical model, which still filters through the cracks. What is sometimes lost within the field of medicine is the individual as a whole, as the disease that is killing the individual typically takes center stage. An existential perspective instills personal worth in the dying individual by valuing them as a unique being. Furthermore, in facing death, questions of one's purpose, self worth and meaning arise; this approach honors the exploration of such pertinent considerations.

This exploration will begin by embarking in a discussion pertaining to the phenomenon of death. While discussing this phenomenon, I will highlight the population whose end of life journeys we will be focusing on. In addition I will call attention to and reflect on the racial/cultural disparities that impact the utilization of Hospice/Palliative care services. In this endeavor I will also venture into an investigation pertaining to the historical attitudes held toward death and the dying process by highlighting prominent early Western society perspectives as well as perspectives held within the contemporary western society time period. Following this historical review, I hope to engage and connect the reader with the phenomenon of death through a reflection on the experience of death. This reflection intends to share with the reader the signs,

symptoms and suffering often experienced at the end of life. I will also introduce the reader to individuals who have journeyed through the dying process and share observations of their death experience. After I have discussed these components of death and dying I will put forth the theory of Attachment as an approach to assisting the dying individual. The Attachment Theory chapter aims to provide the reader with an overview of this theory and its components as well as discuss the role of attachment styles in old age and within a medicalized care setting. Following this discussion, I will review Existential theory, its elements and the role of finding meaning at the end of life. Lastly, we will end this exploration with a final discussion pertaining to significant takeaways and considerations.

Conceptualization and Methodology

How can a clinician improve the quality of life for an individual during the end of life process and therefore assist in the experience of a good death? To assist in answering this question this project will encompass a theoretical approach and utilize the selected Attachment and Existential theories to achieve this endeavor. The previously noted question will frame the lens through which I will explore the application of these theories to the dying process. The rationale for selecting a theoretical approach stems from my own experiences within the realm of Hospice/Palliative care. Such an experience awakened me to reflections of the life cycle and the great value as well as influence that early beginnings have throughout our lifespan, as well as during our final stage of life. Additionally, my experience within the Hospice/Palliative care realm afforded me the opportunity to experience the significance of finding meaning and sharing one's life story at the end of life. The end of life journeys that I have had the privilege to be a part of encouraged me to question how such journeys, that are often defined by physical and psychic pain could be eased through an attachment and existential approach. A theoretical

endeavor offered an opportunity to explore the curiosities and questions that arose regarding the dilemma of easing suffering during the end of life process.

Attachment Theory contends that during the early stages of human development, when we are most vulnerable and entirely dependent on our caregivers, we develop styles of attachments in response to our caregiver's ability to fulfill our innate needs (Berzoff, 2011). It is argued that an individual's style of attachment influences the ability to form relationships throughout adulthood. Attachment style also impacts the relationships and dynamic created between client and clinician within the therapeutic milieu (Berzoff, 2011).

The elderly, much like young children are also vulnerable and dependent upon others to ensure that their needs are met. Considering such, some attachment theorists suggest that the attachment styles we develop during early childhood have an impact in how we respond to and depend on others during the last stage of life. Researchers have explored the influence of attachment style upon individuals facing the end of life and how their style of attachment affects the quality of their experience within a health care setting (Tan et al., 2005). It is argued that although not solely responsible for the positive quality of one's end of life experience, attachment is an important component to consider when addressing the nature of one's end of life experience (Tan et al., 2005).

Psychoanalyst John Bowlby is accredited with the development of the theoretical approach of attachment and with the assistance of Mary Ainsworth developed the concepts of secure and insecure attachment (avoidant/ambivalent) (Berzoff, 2011). The proposed research will examine information related to adult secure attachments as well as insecure attachments (anxious-avoidant, resistant-ambivalent and disorganized) and how such attachment styles contribute to or detract from the dying individuals quality of life.

Existential theory brings light to the individual as a unique being (as previously noted) and places value in the person's ability to develop and realize his or her own meaning (Rice and Greenberg, 1992). This therapeutic approach permits the confrontation of concerns pertaining to death and creates a space for the individual to explore and ascribe meaning to their existence. (Rice and Greenberg, 1992).

Existential authors such as Irvin Yalom, Rollo May and Victor Frankl have contributed to the growth and development of an existential approach to therapy. We will draw on their works as well as the literature that has stemmed from their influential contributions to this theory. What's more, Existential Theory is supported by a strong philosophical background, with such philosophers as Martin Heidegger whose writings have shaped the growth of existential theory and we will highlight concepts from this philosophers works to assist in our understanding.

Each of the theories will be assessed through a lens that bares in mind their degree of applicability to the geriatric population. This is important to keep in mind when considering the individual clients ability to engage in work with the clinician. For example, the prevalence of dementia amongst the geriatric population may create a dilemma or detract from the individuals ability to engage in a therapeutic process that requires the utilization of such brain functions as memory, reasoning, as well as reflection to name a few. If such brain functions are impaired, the utilization of the selected theories with the dying individual would be strained and arguably boarder on cruelty. Secondly, the two theoretical approaches will be assessed to see what is missing from the approach in terms of ways in which the dying individuals needs are not fulfilled and if quality of life is improved. Lastly, case examples and case studies will offer insight regarding the receptivity of these modalities amongst individuals who have entered the final

stages of their life. It is with hope that the use of case studies will allow the reader to feel connected to the individual and their journey toward death.

Biases

In reflecting upon potential biases it seems appropriate to draw on the writings of Continental philosopher Georg Hans Gadamer who explored Hermeneutic philosophy, which is the “art of interpretation” (Taylor and Mootz, 2011). Arguably this entire exploration is an attempt to *interpret* and understand the selected Attachment and Existential theories within the context of death and dying. Gadamer contends that we each operate from our own unique ‘horizon’ or means through which we interpret and understand. Our horizons are influenced and molded by ‘tradition’ or history. By this it is meant that we operate through a ‘historically-effected consciousness’ (Malpas, 2013). Bearing this in mind the proceeding discussion is written through my own horizon. My selection, exploration and subsequent *interpretations* are shaped by and molded by my own contextual, historical positioning within this world. I have written with the assumption and conviction that the selected theories are beneficial to assisting the dying individual as they enter into the final stage of their life. Such a belief and conviction is again influenced by my own ‘horizon’ and therefore it is likely that my own resulting biases have impacted my ability to recognize or *interpret* potential flaws or weaknesses in the application of Attachment as well as Existential Theory within the therapeutic context of death and dying. With that being said, I invite the reader to *interpret* the following discussion through their own unique ‘horizon’ and allow himself or herself to operate through a critical yet open mind. Such a process might allow for the reader to experience what Gadamer referred to as a ‘fusion of horizons’ or, “the formation of a new context of meaning that enables integration of what is otherwise unfamiliar, strange or anomalous” (Malpas, 2013).

Limitations

A great limitation of this endeavor is that it is not possible to exhaust all the available literature on this topic, therefore potentially missing research that could alter conclusions. An additional limitation of this plan lies in the dependence upon the concept of an individual's quality of life as well as the idea of experiencing a good death. To explain, these concepts to some degree incorporate subjective interpretations that can be difficult to accurately measure. Reliance on these concepts to assist in determining the benefit of Attachment and Existential theory may not accurately or universally portray or conclude the potential of the selected theoretical modalities. In addition, this project predominately explored the death and dying process through a westernized societal lens. Therefore, this exploration is limited in the sense that it prospectively provides but one small piece to the vast, and culturally/ethnically complex puzzle of humanities experience of death and dying. Furthermore, I would like to acknowledge a limitation that was briefly noted previously regarding the role of the dying individuals ability to engage in an Attachment and or Existential approach. This work focused on individuals who were predominately cognitively capable of engagement. As a result this project did not address the needs of individuals who are cognitively or physically impaired to such a degree that they are unable to participate or benefit from the selected theoretical approaches. This reflection reveals the limitation of applicability, as not every individual who faces the end of their life will benefit from the utilization of Attachment and/or Existential theory.

Despite the limitations of this exploration, strength rests in the available literature on Attachment theory as well as Existential theory. Existential theory particularly, has a rich background in philosophy that offers a broadened perspective beyond the theoretical realm of social work. What's more, as was noted previously much of the literature available on death and dying focuses on the dying individuals family members. This explorations strength rests in its

attempt to place emphasis on the dying individual and *their* needs, as this is a population that requires greater attention and value. Lastly, I believe an additional strength of this project lies in its earnest attempt to connect the reader with the death and dying process. To explain, part of my goal particularly in writing *The Experience of Death* Chapter was to not solely intellectualize and abstract this sacred stage of life and view it as being a distanced concept explained in words on a page, but rather I ventured to draw the reader closer to death and encouraged the reader to internalize it as a universal *experience* that we must each in our own unique way *endure*.

CHAPTER II

The Phenomenon of Death

The boundaries between life and death are at best shadowy and vague. Who shall say where one ends and where the other begins? -Edgar Allen Poe

The Aged and Racial Disparities

In this chapter I will discuss the phenomenon of death. Though such a topic may present as morbid in nature, I encourage the reader to maintain an open and curious mind.

We may feel fear as well as discomfort in acknowledging the presence of death in our lives, but through exploration, we may find some solace in doing so together rather than in isolation. To achieve this exploration of death, I will first highlight the geriatric population, as it is the elderly and their experience that I will specifically focus on. I also believe that it is important to acknowledge and discuss the racial disparities as well as cultural perspectives that impact minority population's utilization of Hospice/Palliative care services. Following this, we will review the leading causes of death amongst the elderly with racial/ethnic considerations. Lastly, we will take a look at the historical development of death; how we as humans have viewed the event of death throughout time as well as a brief review of what Hospice/Palliative care is.

In 2011, the CDC reported that the average life expectancy for a male residing within the U.S. was 76.3 years and 81.1 years for females (Minino, 2013). If we are so fortunate, we can expect to live on average [inclusion of both females and males] approximately 78.7 years (Minino, 2013). Once we contemplate the time we have to live, especially at the last juncture as we near

death [if of course our paths lead us to live into old age], we may develop a curiosity as to what may unfold. There are many paths that may unfurl along the journey toward death. However, for our purposes we will primarily consider the path experienced by individuals diagnosed with an incurable chronic illness in old age and in turn receive extended medicalized care through services such as Hospice/Palliative Care.

Current research within the United States reports that, “Roughly three-fourths of all deaths occur at age 65 and older” (Sahyoun, 2001). If we compare this to the life expectancy of 47.3 years for individuals born in 1900, it is evident that over the past 114 years we have [within the U.S.] generally seen an increase in the number of years that one can expect to live (Denney et al., 2013). In 2007, deaths of persons 65 years and older accounted for 1.8 million deaths (Health, United States, 2010). Considering the number of deaths that occur at age 65 and beyond, the question arises as to how we define old age and whom are we referring to when we say the *elderly*? If 75% of adult deaths occur at age 65 and older, do we then demarcate old age to begin at 65? These are questions that are difficult to concretely answer. In viewing age as a number that describes the literal number of years we have lived, we can say that age is objective in this sense. However, when utilizing the concept of age as a means to identify an individual as being *elderly*, there lies a difficulty in determining what constitutes an individual as being old or elderly. Age in relation to the term elderly, then is arguably subjective in that one may be 75 years old and live a physically active and healthy life that reflects that of an individual 10-15 years younger. Bearing the subjective nature of how the term elderly may be conceptualized in mind, I would like to caution that the proceeding evaluation of what constitutes as being elderly is not intended to marginalize or discredit the health and vibrancy that persons of such an age may possess. With that being said let us turn to Ian Stuart Hamilton who in his text titled, *An*

Introduction to Gerontology addresses such questions regarding age and concludes that, “old age is defined as the final segment of the lifespan, and for those who must have a number to attach to this, it is further defined as beginning at around 60 years of age” (Hamilton, 2011). Hamilton goes on to stress that this is a number that has largely been accepted by researchers in the study of aging, “for over 200 years”. However, the age of 60 should in no way be seen, as a strict line that once crossed an individual is suddenly *old* (Hamilton, 2011). Before we continue I would like to briefly pause with a quote from Leo Tolstoy that reminds us that age does not make us *old* that it is a but a number and it is in part our perspective that molds our *age*,

Don't complain about old age. How much good it has bought me that was unexpected and beautiful. I concluded from that, that the end of old age and life will be as unexpectedly beautiful -Leo Tolstoy

The aging process is unique to each individual and arguably the quality of how we age and consequently our health in old age is largely influenced by the conditions experienced during our youth and throughout adulthood. To elaborate on this idea, let us draw consideration to the role of one's ability to access resources throughout the life span, resources such as; healthcare, healthy foods [for the provision of a healthy diet]. Additionally, we should also consider situational or environmental factors that impact a person's health such as; the air quality of where an individual resides, safety [in terms of risk of bodily harm due to violence], availability of parks for exercise or physical recreation. [The list of factors that can impact our health throughout our lives goes on and on, my intent is not to exhaust this list but rather invite the reader to contemplate these factors and perhaps conceive of their own risk factors to health.] It is important to note that not all people are dealt a fair and equal hand of playing cards in the game of life. Individuals of color who immigrate to or are born in the United States face the often

subtle yet devastating impact of institutionalized racism and this is one such factor that threatens the health of an individual. As noted previously the average life expectancy for a U.S citizen is 78.7 years, however, if we take a look at life expectancy based on ethnicity, we find that African American males have a life expectancy of 68.2 years compared to 78.4 years for white males. That's an astonishing approximate 10-year difference! Furthermore, African American females life expectancy is 74.9 years compared to 80 years for white females (Smith, 2007).

There are a myriad of factors that potentially contribute to such discrepancies in life expectancy [we previously noted examples of such factors related to accessibility of health care or nutritional foods]. If we consider, the reality of “white privilege” which refers to the material advantages secured by whites from being positioned as a dominant race in the U.S. (Smith, 2007), we find examples that greatly threaten the well-being of individuals considered to be of the minority population. For example, white individuals are more likely; to be in good health 92% versus 86% for African Americans and 83% for Latinos, have a regular doctor 80% for white, 67% for African Americans and little over 50% for Latinos (Smith, 2007). Also, reflecting upon doctor's visits, whites are less likely to have trouble communicating with [their] doctors whereas 23% of African Americans and 33% of Latinos report experiencing communication difficulties (Smith, 2007). Additionally, for consideration, Smith (2007) notes that whites are more likely to, bring home more income in a year, and highlights the differences in salaries. Whites earn on average \$55,768 versus \$34,369 for African Americans and \$34,272 for Latinos (Smith, 2007). Olshansky et al., (2012), notes, “social conditions [such as income] can be a fundamental cause of health inequalities” (Olshansky, 2012). Furthermore, Olshansky et al. discuss the correlation between an individuals level of education with one's socioeconomic status and argues that the more education an individual acquires the greater socioeconomic status one will experience.

What's more, "In 2008 white US men and women with 16 years or more of schooling had life expectancies far greater than black Americans with fewer than 12 years of education-14.2 years more [of life] for white men than black men, and 10.3 years [of life] more for white women than black women" (Olshansky et al., 2012). Here we find that the level of education an individual obtains may also serve as a factor that impacts health, well-being and subsequent life expectancy. Olshansky et al., add, "Education exerts its direct beneficial effects on health through the adoption of healthier life styles, better ability to cope with stress, and more effective management of chronic diseases"(Olshansky et al., 2012). It is also interesting to note in a study conducted by Olshansky et al., they discovered that, "Blacks and Hispanics with sixteen or more years of education lived 7.5 years and 13.6 years longer, respectively, than whites with less than twelve years of education "(Olshansky et al., 2012). It is startling to reflect upon the prominent role that education obtainment seems to play in our life expectancy, and serves to highlight an additional grasp that racial oppression has upon the well-being of individuals of color. The previously noted factors related to education, socioeconomic status are just a few of the many disparities that exist within society that have an impact on an individual's health and well-being as they age.

Utilization of Medicalized Care

We have given consideration to the aging process and the disparities that exist as we age, so baring such factors in mind let us now reflect on the question, *who utilizes Hospice/Palliative care at the end of their life?* According to the National Hospice and Palliative Care Organization (NHPCO), " In 2012, an estimated 1.5 to 1.6million patients received services from hospice care" (NHPCO, 2013). Looking at the ethnic/racial makeup of these individuals reveals that such services are disproportionately utilized, as whites used 81.5% of these services. This is in

comparison to only 8.6 % of African Americans, and 6.9% of Hispanics or persons of Latin American origin (NHPCO, 2013).

Why are there such great disparities in terms of the utilization of Hospice/Palliative care services between white individuals and individuals of color? Let us once again consider what was previously highlighted, regarding the reality that we live in a society that oppresses and discriminates, therefore resulting in the unequal hand of playing cards dealt within the game of life. Crawley et al., shares the following to assist in our understanding of the occurrence of such disparities,

The legacy of slavery, abuses in medical experimentation, economic injustices, racial-profiling practices and the disproportionate numbers of incarceration to name a few, reflect societal and ethical misconduct that has led to a general loss of credibility of many institutions, including the health care system (Crawley et al., 2000).

One such factor that potentially deters African Americans from utilizing Hospice/Palliative care services is the stark reality that the health care system is simply not a trusted source of care and support (Carrion et al., 2012; Jenkin et al., 2005). This struggle to trust the health care system is not exclusively experienced by just African American, other Minority groups have also endured a history of discrimination. Therefore, distrust of the healthcare system is found amongst other minority groups as well such as Latin Americans and Asians.

Another factor that influences the number of minority groups who receive Hospice/Palliative care is the reality that there is little knowledge about this end of life option. Kreling et al conducted a qualitative study about hospice experiences amongst Latinos and

findings revealed that, “Most had misconceptions about hospice or no knowledge before the patient was enrolled. For instance, most thought hospice was a place for poor, old people or a place for paralytic people (Kreling et al., 2010). In addition, Jang et al., focused attention on the willingness of older Korean-American adults to utilize Hospice/Palliative care services and notes that Asians are far less likely to select Hospice/Palliative care at the end of life even when accounting for ‘socioeconomic status’ (Jang et al., 2010). In a study conducted within the state of California comparing the end of care planning knowledge of 4 selected ethnicities it was revealed that Korean Americans ‘had the lowest level of knowledge about advance directives and that a majority of those participants exhibited negative attitudes toward EOL [end of life] care planning’ (Jang et al., 2010). Jang et al. goes on to highlight findings that indicate that older Korean Americans have a lower willingness to pursue Hospice/Palliative care and argues that this low degree of willingness is related to the amount of knowledge and education older Korean Americans have regarding the philosophy of Hospice/Palliative care. What’s more Jang et al., adds that acculturation to American society plays a role as “a greater level of adaption to the host culture seems to be linked to greater knowledge about the acceptance of available resources and services” (Jang et al., 2010). Lastly, Jang et al., shares that in general, there is a need to increase cultural sensitivity within the realm of Hospice/Palliative care by acknowledging that individuals of minority populations may not have exposure to Hospice/Palliative care options and furthermore, language may serve as a barrier to gaining such knowledge and as a result there is a need to offer Hospice/Palliative care education in languages other than just English (Jang et al., 2010).

In addition, we might also consider the demographic context of many Hospice/Palliative care facilities. Spruill et al., (2013) highlight a study amongst African Americans that explored

the barriers to Hospice care use revealing that, “77% of the participants would be more willing to use hospice if hospice teams were more racially diverse” (Spruill et al., 2013). What’s more Spruill et al., highlight that the Hospice and Palliative Nurses Association reported ‘only 5% of its members [identifying as] African American (Spruill et al., 2013) An absence of diversity also contributes to the discrepancy in hospice utilization amongst minority populations. This piece seems to be especially important if we connect this with the previously noted reality that the health care system is not a trusted source of care. It is not surprising that individuals of color would feel discouraged from entering a health care facility composed of individuals who resemble a race/ethnicity that has enacted racially charged injustices throughout time. Might we highlight the use of enslaved black individuals who were medically experimented on for the benefit of ‘white health’. For example, Thomas Jefferson had 200 of his ‘slaves’ experimentally vaccinated for smallpox (Randall, 2006). Might we recall more recent medical injustices such as the Tuskegee syphilis experiment (1932-1972) or “In 1963 [when] the United States Public Health Service, the American Cancer Society, and the Jewish Chronic Disease Hospital of Brooklyn, New York conducted experiments on 22 chronically ill and debilitated Black patients. Without the Blacks’ consent or awareness, the patients were injected with live cancer cells” (Randall, 2006). In a text titled *Dying While Black*, Vernellia Randall poignantly outlines additional examples of ‘post slavery experimentation[s]’ that have taken place that lends a startling background to the development of distrust of the health care system amongst Black Americans. I encourage the reader to explore this text for additional information regarding the racial disparities that exist within the health care system from the past to the present.

Cultural factors play a prominent role in accounting for why such small percentages of minority groups enter into Hospice/Palliative Care services. Crawley discusses the religious and

spiritual traditions held by many African Americans and notes, “. . . Religious and spiritual beliefs and practices reflect a view of death as a *welcomed friend*, there to assist the decedent in the transition from an earthly to a heavenly existence”(Crawley, 2000). To elaborate further Crawley states,

This spiritual view of death, however, is not necessarily compatible with the goals of palliative care, which are to relieve physical, psychological, and spiritual suffering. On the contrary, some traditional Christian religious views regarding death held among many African Americans depict pain and suffering as not to be avoided but rather to be endured as part of a spiritual commitment (Crawley, 2000.)

Furthermore, Kreling’s study among the Latino population presents a contrast in how white caregivers and Latino caregivers approach and cope with a loved one’s end of life. In this study white caregivers tended to appreciate and request direct, detailed information including; prognostication and education regarding the dying process. Whereas, Latino caregivers saw such an approach as unnecessary and preferred to gain limited knowledge about their loved one’s prognosis and chose to maintain hope of recovery through denial (Kreling, 2010). Within the Latino culture families seem to prefer to have minimal discussion regarding diagnosis, and this conflicts with typical Hospice/Palliative care approaches that generally prioritize education of families on the illness, as well as the death and dying process. Further, Ngo-Metzger et al., (2008), highlight that informing the dying individual of their terminal prognosis and providing detailed education regarding this prognosis is a ‘western value’ that is not typically upheld by individuals of other cultures. Metzger et al., go on to explain that minority groups [particularly noting Asian cultures], often hold a ‘family-centered model of decision making’ as well as ‘filial

piety', which refers to the "moral obligation of children to care for elderly parents" (Ngo-Metzger et al., 2008). As a result of these two cultural components, Metzger et al, argue that caregivers are less inclined to agree to a Hospice/Palliative approach because there is the conviction of 'protecting' the parent from learning the truth of their prognosis and therefore are less inclined to agree to the path of Hospice/Palliative care which is aimed at comfort, calmative measures rather than curing measures (Ngo-Metzger et al., 2008).

Moreover, Ngo-Metzger et al., (2008), call attention to the 'systematic barriers' that serve to deter minority groups from selecting Hospice/Palliative care as an approach to end of life. Ngo-Metzger et al., explain that many individuals of the minority population who have immigrated from their country of origin, do not always have family or close relatives to serve as a caregiver which Metzger et al., notes regarding Medicare Hospice Benefit legislation, "Medicare requires that a full time caregiver be present to care for the patient" (Ngo-Metzger et al., 2008). Minorities may not be able to utilize the Hospice/Palliative route through Medicare because they do not have an individual who can serve as the required caregiver. In addition, if we recall the previously noted conviction of some cultures to protect their loved one from the terminal truth of their illness, we find an additional roadblock to accessing Medicare Hospice Benefit. To elaborate, the terminally ill individual is required to provide 'informed consent' in order to receive services. Hence, the family must inform the dying individual of their condition, which as we have learned contradicts cultural values (Ngo-Metzger et al., 2008).

Leading Causes of Death

We have just reviewed some of the racial/ethnic/cultural factors that serve to deter or create a barrier from individuals of minority populations from utilizing Hospice/Palliative care services. I would like to briefly draw consideration to the leading causes of death amongst individuals residing within the U.S. Surprisingly, deaths caused by cancer is reported by NHPCO (2013), to ‘account for less than half of all Hospice admissions (36.9%) (NHPCO, 2013). Since the 1970’s the U.S. has seen a decrease in individuals being admitted to Hospice facilities due to cancer, research has revealed that as of 2012, ‘debility unspecified (14.2%), dementia (12.8%), heart disease (11.2%) and lung disease (8.2%)’ account for the primary reasons for admission into a hospice facility (NHPCO, 2013). Yet, chronic illnesses of the elderly consists of, ‘stroke (cerebrovascular disease), chronic obstructive pulmonary diseases, diabetes, pneumonia and influenza’ (Sahyoun, 2001). I would like to acknowledge the influence that racial/ethnic disparities have upon the maturation of chronic illnesses amongst elderly of color and generally speaking, individuals of color regardless of age. Spruill et al., (2013) highlight, “African Americans are disproportionately affected by cancer when compared with other racial groups. The incident rate of cancer in African Americans is 504.1 per 100 000 people compared with 470.1 per 100 000 people in the general population (Spruill et al., 2013). Spruill et al., provide additionally distressing statistics regarding the prevalence of cancer reported amongst African Americans, “African American men experience a 33% higher cancer death rate than do white men, and African American women have a 16% higher death rate than do white women” (Spruill, 2013). From these statistics we are informed of the importance in recognizing that the phenomenon of death is not a separate construct from the institutional racism, ethnic/racial

oppression and other forms of unjust treatment. Rather the phenomenon of death [within the United States] is woven with the threads of inequality.

Historical Perspectives on Death

Tho' much is taken, much abides; and tho' We are not now that strength which in
old days Moved earth and heaven, that which we are, we are, -Alfred, Lord
Tennyson

In the following section I would like to reflect upon the attitudes toward death and dying that are held currently as well as attitudes held throughout history. To accomplish this we will first discuss contemporary 'medicalized' attitudinal trends toward death and then we will take a look at historical viewpoints prior to the 19th century, and finally we will review the concept of a good death as it ties with the newly evolving Hospice/Palliative movement of today.

Humans are curious creatures by nature and the phenomenon of death is an experience that has been questioned by humans for thousands of years. None of us truly know the experience of death, as it is an event that scientifically speaking one cannot return from and reflect upon with others. Death is a mysterious phenomenon that arguably causes one, at least to some extent, to reflect upon one's own death and therefore question what it is to die, to question *what is death?* Some seek answers to death related question through the practice of religion, and we can see the formation of religion as a culturally universal attempt to find answers to the mystery of death (Koppelman, 2010). Unlike a mathematical equation, there are no concrete and definitive answers to our metaphysical questions of death. In our attempt to find answers we seek meaning and purpose with the question of *why* and the resolution of *because*. The perspectives we develop towards death become social constructions that mold the way we interact with death.

Our rituals, funerary, practices, and portrayals of death in the media are arguably all shaped by our beliefs and these beliefs of course vary from culture to culture.

The passing of time and death seem to be cousins that walk toward each other on the same path, as time steps forward, death too steps closer and closer. We cannot prevent either from occurring, but throughout history we have managed to change our experience of death.

Much of the research available on death and dying reflects on the contemporary trend of the “medicalization of death” within the western society. This term arose in the 1970’s by, Ivan Illich who critiqued the growth of the medical institution and its domineering control over the dying process. (Clark, 2002) In Illich’s own words he states, “I coined the term [medicalisation of death/dying] in reference to a medical establishment that had assumed the functions of a dominant church and whose symbolic effects included the shaping of people’s beliefs and perceptions, needs and claims”(Illich, 1995). Ruth Davies highlights Illich’s argument that a reliance on the health care system creates a dependency that strips individuals of their sense of power and control. Furthermore, death, a natural phenomenon and once viewed as being such became a ‘mechanical’ process that resists nature (Davies, 2012).

Within contemporary western societies we have struggled with the unknown quality of death and the reality of our impermanence. During the past 100 years western society has changed its view of death from being a ‘natural’ process to one that we fight against. We have attempted to battle death through the utilization of medical interventions. In the process of resisting death we have developed a distanced relationship with it. Jenny Hockey draws on this idea of western societies distance from death and argues for Illich’s theme of medicalized death by utilizing the term the ‘professionalization of death’. Hockey argues,

Western societies who lack any professional involvement in this area [death and dying] have somehow been deprived of agency, the result of social changes since the beginning of the twentieth century; for example secularization and the loss of religious meta-narratives, modernization and the breakdown of local communities, the professionalization of care of people who are dying, dead or bereaved, the increasing longevity brought about by improvements in public health and medicine . . . (Hockey, 2007).

Essentially throughout the 20th century [1901-2000] and the 21st century [2001-2100], western societies perception of death and dying has been molded by the growth of medical technology and the health care institution. The perception developed encompasses one in which death and dying is seen as a process that requires a ‘professionals’ intervention and authority. Therefore we have relinquished direct responsibility or agency to health care professionals who in a removed designated care setting manage death.

Let us now rewind time to gain understanding of the attitudes held toward death from the past. Granda-Cameron and Houldin reflect on death during the Stone Age [Prehistorical time , 2 500 000-4000 Before Common Era [BCE]. During this time period death arrived abruptly through ‘accident’ or attacks by ‘human/animal predators’, often times with little warning. The sudden nature of death did not allow for individuals to prepare or plan for their death. “In this context a time of social transition for the dying person did not happen as a pre-death experience. Instead, they dying experience was viewed as a post-death activity depending on how the survivors behaved on behalf of the dead” (Granda-Cameron and Houdin, 2012). Granda-Cameron and Houldin go on to highlight the view of death held during the Pastoral age [3500 BC-15th Century] as a period when the nature of death shifted from it lack of predictability

towards an oncoming phenomena as individuals typically died from diseases that, “. . . led to a gradual dying process that allowed the person to actually participate in his or her own dying” (Granda-Cameron and Houldin, 2012). During the eras of the middle age [approximately 500-1500 Common Era [CE]] and the Renaissance periods [14th-17th centuries approximately 1150-1600[date varies based on scholar]] individuals also held a very different relationship with death than the medicalized, professionalized view of death this held today in western societies. Lewis R. Aiken notes,

Publically viewed executions, mortal skirmishes involving ordinary people, and mass epidemics that claimed the lives of thousands were common occurrences before the 19th Century. No one knew when death might strike or even if it might happen before the day was over (Aiken, 2000).

Death and dying prior to the 19th century [1801-1900], was not hidden or tucked away within health care facilities as it is today. Death was a common occurrence that was not held at a distance, but rather frequently and closely witness as well as endured. When death was known to be approaching, dying individuals typically orchestrated ‘rituals’ bedside within their home and this allowed for family and friends to openly express grief, for priests to perform religious duties and to finalize wishes and business (Aiken, 2000). The dying individual typically suspected that death was near and acknowledged this, thus such acknowledgment allowed for the dying individual to plan and prepare. Death was met with a degree of acceptance and composure (Morris, 1989). It is through this opportunity to prepare for death and the composed nature of the dying individual that such a death experience was termed the ‘Tame Death’ (Wood & Williamson, 2004).

As noted previously the human perspective on death and dying has changed throughout the passing of time. O’Gorman outlines a 5 stage model developed by Illich that illustrates the historical development of dominant attitudes towards death from the 15th Century to the present and adds a 6th stage that is currently developing. Stage 1 [15th century, 1401-1500] is characterized by the ‘Dance of the Dead’. At this point in time there was a shift in individuals viewing death from a “deliberate personal intervention of God” (O’Gorman, 1998) to holding a personal awareness of self that saw death as a process of life rather than solely an act of God (O’Gorman, 1998). “Death became personal, and destruction of self was associated with a newly conceived fear of dying” (Tucker, 2009). Prior to this shift, in viewing death as a personal event, individuals held a community centered group mentality that emphasized contribution to the whole rather than a focus on the self as an individual (Tucker, 2009). This is unlike the individualistic mentality that is held today particularly in the United States. The awareness of self in relation to death came to be termed the “Death of self” (Morris, 1989). However, as Morris highlights, this was an attitude toward death that was predominately afforded to and developed amongst the wealthy who in their endeavors pursued personal advancement and power through for example education. Such a lifestyle permitted for the growth of self-reflective attitudes and a concentration on one’s individual being. Individuals of a ‘lower social class’, who were not privileged to explore such personal expansion, maintained a ‘tame death’ attitude (Morris, 1989).

Stage 2 encompasses the ‘Dance of Death’, in which the rise of institutions birthed the view that this dance represented a shift from focusing on the after-life to focusing on the meaning and purpose of self in the mortal realm (O’Gorman, 1998). During this time period artists depicted a theme in artwork typically displaying the living of all ranks; from peasants to

the pope interacting with skeletons. This representation revealed the ‘universality’ of death; the reality that all, despite social rank or wealth will one day meet death (Rosenfield, 1991).

Stage 3 the ‘Bourgeois Death’, arose amidst the 17th century [1601-1700] and continued through the Industrial revolution which resulted in a growth of wealth and the formation of the bourgeois family. The bourgeois family or class, were defined by their wealth, and it was with this wealth that allowed them to seek good health and a long life. Death amongst this class came to be viewed as an inconvenience that was staved off through payment towards good health. Furthermore, good health came to be valued and considered within the political and economic realm of society as efforts began to be put in place to politically and economically improve health. It was during the 18th century [1700-1800] when medical care for illnesses through the doctor began to grow. Good health of the self expanded beyond the wealthy class and came to be held as an ethical obligation amongst families of the middle class as well (O’Gorman, 1998).

Stage 4 is titled the ‘Clinical Death’. It was during the 19th century [1801-1900] when western society began to see the growth and perception of the ‘doctor against death’. Doctors began to ascribe illnesses to the causes of death, and began to develop a reputation that they could ‘control the outcome of diseases’. A new hope of defeating death was placed in the hands of the doctor and this perceived ability, granted the doctor power and status (O’Gorman, 1998).

Stage 5, reflects the growth of a mindset in the middle of the 20th century [1901-2000] that individuals had the right to be treated for illnesses. Furthermore, health “has become a commodity undermining the unique spiritual and intellectual strength of the human race which enables them to rise to the challenges of dying and death” (O’Gorman, 1998).

The most recent and currently evolving Stage 6 returns us to our discussion of the previously noted medicalized and professionalized attitudes toward death, which define this

stage. O’Gorman argues that death is seen as an event to be controlled and managed by the doctor as well as medical team. Furthermore, the death of a patient is seen as a failure of the medical system rather than a natural occurrence in the cycle of life (O’Gorman, 1998).

Considering the medicalized perspective held today toward death in western society, there is irony to be found in the distance created between death and ourselves through the medicalization of the death journey. The witnessing of and being in the presence of death’s occurrence is no longer experienced today as it once was prior to the 19th century. However, Gibson contends that we are frequently exposed to death through ‘simulated death via media technologies’ (Gibson, 2007). We may not witness or experience death while walking through a town’s center where 200 years ago a public execution might have taken place, or exist in an age where the visibility of mass epidemics exists right under our noses, yet, we now are exposed to others ways that heighten our awareness and give us new methods of viewing death.

It is important to consider the age that we live in, which is dominated by technological advancements that allow us to communicate through texts and tweets in seconds. Also, the capturing of images is not reserved for the photographer but is available to many who own a cell phone with a built in camera. The advancement of social media has impacted our communication patterns dramatically and the experience of death and dying is not immune from such technological growth. Gibson shares that such technologies have impacted the way we preserve the memory of lost loved ones by for example preserving old voicemails, emails or text messages that were previously sent. Gibson argues, “. . . The Internet has been one of the main archival sources of documenting our new digital age of memory and memorialisation”(Gibson, 2007). Furthermore, if we consider the content of televisions shows, movies and news broadcasts we

find that our experiences with death are also impacted through this virtual dimension as well.

Gibson further contends,

Through genre [of fictional death] death and dying become domesticated for consumption. Recent television programs such as *Crime Scene Investigation (CSI)* with their gory, anatomical scrutiny of the dead body, have pushed previous limits of representation in televised programs. Their gory, anatomical scrutiny of the dead body, have pushed previous limits of representation in televised programs (Gibson, 2007).

Gibson's exemplification of the CSI television shows, is just one example of programs that are viewed and themed with the concept of death. What we can pull from this form of exposure to death and the 'dead body' reveals, that although we live in an era where the dying and death are tucked behind a curtain, we are experiencing death in other ways through movies, television shows, and streamed videos. This holds true for what is depicted in news programs, as Hanusch notes, ". . . Undoubtedly, we are now exposed to a multitude of mediated representations of death through newspapers news broadcasts and, especially the Internet (Hanusch, 2010). With this daily exposure to themes of death and dying, questions arise as to why (although slowly shifting) the current trend is to hide death within hospitals and institutions? Gibson argues

The viewer knows they are experiencing proximity at a distance. And depending on the politics or ethics of a representation, this proximity at a distance can also produce modes of emotional connection or disconnection from the image and narrative (Gibson, 2007).

There is safety in viewing death on a screen that can be turned off with the tap of a power button, it is not 'real' it is fiction. Exposure to death through television even if it is brief may

direct one's thinking to his or her own mortality and cause feelings of anxiety or fear to surface. However, there is luxury in exposure to death through television in that we can shut ourselves off from the reality of death, again with the swift tap of a power button.

This distancing is not possible when we are standing before a loved one facing death, or when we ourselves are. This experience of death is 'real' and we no longer have the safety of 'proximity at a distance'. Gibson highlights, "When death is faced 'in a real life context' particularly in relation to significant others, all the narratives and images which have shaped and informed an individual consciousness do not necessarily prepare for witnessing death and experiencing grief" (Gibson, 2007). When death is 'real', Gibson argues that we are not prepared to face this reality because exposure to death through the media creates a false distance that allows for us to disconnect from the truth of our own mortality.

Conceptualization of the medicalization of death, as a result of technology has allowed for developed nations to transform the experience and in-turn perspective and attitudes on death. Developed nations live in an era that has seen advancements in medical technology that was not otherwise believed to be possible prior to the 20th century. Cynthia Goh highlights the medical advancements we have seen such as growth in drug therapy, the management of metabolic conditions, decrease in infections, and the ability to reverse organ failure (Goh, 2012). However, despite the improvements in healthcare and health benefits of the growth of medical technology, there has been an emergence of questioning the 'medicalized' and 'professionalized' approach to death (O'Gorman, 1998). O'Gorman notes that in 'the second half of this century' we are seeing an increase in 'holistic views' toward death. Such views encompass the care and comfort approach of Hospice/Palliative care. The question in play asks whether this approach truly

provides *quality of life* at the *end of life*. A cry for a humane and ‘good death’ has increased over the years and this cry is being addressed by the growth of Hospice/Palliative care.

Within the United States of America (USA), if we consider the concepts of collectivism versus individualism the USA is a poster child of individualism and is at the forefront of promoting a central component of Hospice/Palliative care with its emphasis on “individual autonomy and agency”(Walter, 2012). O’Gorman (1998) speaks on Illich’s concept of the medical death and terms it as a ‘clinical death’ sharing that a holistic approach is what is needed to address not only the physical component of the dying individual but also the emotional and psychic pain that is experienced when facing death. Despite an increase in deaths occurring at home, half of all deaths from a chronic illness have been reported to still be occurring within acute care facilities This is in spite of, surveys of U.S. citizens, which have indicated that most individuals prefer to die in the comfort of their own home (Gruneir et. al, 2007). Those wishing to die at home seem to indicate a longing for a more naturalized less ‘medicalized’ approach to dying and achieving a good death.

The Good Death?

Here we draw on the idea of experiencing a ‘good death’. This may sound like an oxymoron, how can death be good? When we dare to think of our own deaths, arguably do we not all hope for a death that is pain free, peaceful and well, good? The desire for a death that is good is not a newly formed notion. It is a universally held desire and can be traced back thousands of years to the ancient Greeks.

The ancient Greeks held the belief and standard of a good death with this concept coming to be defined in two ways. The first was *Eu Thanatos* that literally translates to *good death*. Under this definition death was viewed as being “. . . a gentle, painless, death a ‘dying well’

(Floriani and Schramm, 2010). This is where today's controversial term of euthanasia is derived and is considered to be a merciful, assisted death (Mystakidou et. al, 2005).

The second term *kalos thanatos*, was defined as *kalos* meaning good or beautiful and *thanatos*, again meaning death. Floriani and Schramm (2010) explain that this type of good death holds value for the beautiful and heroic death. In ancient Greece war was a common occurrence and soldiers were frequently called to battle. Van Hooff notes, “. . . Shame was a major concern for Greeks and Romans” (Van Hooff, 2004). Hiding from or avoiding participation in battle was seen as being a form of cowardice. Therefore Greek soldiers took great pride in fighting for their homeland. If we consider Homer's Iliad and the Odyssey we find the characterization of the soldiers of this time period as well as a perspective held toward death. Here is highlighted, “the Homeric hero as concerned with his own glory” and furthermore, . . . “the hero accepts death as an unavoidable evil from which even the supreme God cannot save his mortal child” (Hooff, 2004). This holds historical relevance because we find with this definition of death, a perspective that is unique in that death in battle was seen as being heroic and beautiful. Floriani and Schramm (2010), wonderfully summarize the essence of a death in battle, “There is, in this conception of death a deep aesthetic sense, a beautiful feeling, which gives this kind of death a noble connotation, a beautiful death, an ideal or exemplary death. With this attitude we find an approach to death that is characterized by acceptance and not avoidance. The ‘heroic death’ in contrast to the ‘tame death’ as previously discussed is highlighted, “. . . because death is inevitable; death in war brings fame and admiration from the whole people. Death at home in peace, is less rewarding” (Morris, 1989). Here we find two contrasting ideals of the good death, one dying at home in peace versus dying as a soldier in battle.

We have briefly highlighted two concepts of a good death in history, but what about contemporary trends regarding a good death? Vig et al. (2002), helps us to explore this question through a descriptive study that examined views of a good death versus a bad death amongst individuals of the geriatric population. Participants were asked open-ended questions that painted a picture of what they believe a good death consisted of. Results of the study revealed responses such as, 'to die without pain, in one's sleep, quickly, without suffering, and without knowledge of impending death' (Vig et al., 2002). Such responses seem to mesh with the previously noted concept of *eu thanatos* which emphasizes a quick painless death was also illuminated in the shared participants responses. The following example of a participant's response verbatim reveals a preference to be aware of impending death,

[A good death] would be one you'd be in control of, you'd know it's coming and that you could, as best you can, put things in order and then- and then die. I mean, you could say, well, die in my sleep, but I'd prefer not to die in my sleep.

This particular individual's response seems to echo the concept of a 'tame death' that emphasizes the ability of the dying individual to prepare for and take care of tasks prior to their death. The study also asked participants to reflect on their views of what constitutes a bad death.

Participants revealed multiple beliefs regarding a bad death that consisted of "pain, prolonged course of dying, accidental death, and dependency" Another participant conveyed their hope for a painless death,

Oh, I think it's horrible if a man's in pain-he's dying of cancer, you know, and he's in terrible pain-and they keep him alive.

In such a response a sense of fear is conveyed regarding the experience of pain and the idea of being 'kept alive' to endure such pain. This statement illuminates a possible role for medical

technology during the end of life experience positing that the well- intended effort to preserve life may in fact detract from one's quality of life.

Our experience of death seems to be ever evolving especially as technology continues to develop and in turn mold and remold the world in which we live. Although our experience of death has changed over time there remains a desire for a peaceful death whether that consists of a pain free, swift, or planned death. The achievement of a 'good death' seems to be a persistent and resolute desire throughout time. Considering the concept of a 'good death', the question arises as to how we can help those facing the end of their lives achieve the 'good death' that they desire? This question seems to be especially important within western society, as we live in an era in which death is predominately controlled by medical technology and health care institutions. Despite well- intended efforts, a high percentage of individuals are dying in institutions when they would prefer to die at home. In the proceeding chapters we will reflect on two theories [attachment theory and existential theory] that may possibly assist in individuals experiencing deaths that are considered to be 'good'.

Hospice/Palliative Care

Before we proceed further, I thought it appropriate for us to take a moment and discuss some of the facts about Hospice/Palliative care so that we have a clearer understanding of what this particular path to the end of life journey encompasses. We will turn to the National Hospice and Palliative Care Organizations' (NHPCO) *Facts and Figures* guide to primarily assist in learning more about this end of life approach.

It was noted previously in the introduction to this project that Hospice/Palliative care is a means to “. . . provide support and care for person in the last phase of an incurable disease so that they may live as fully and as comfortably as possible” (Connor, 2009). I would like to

reiterate that Hospice/Palliative care is an approach that places emphasis on caring for the dying individual not curing. What's more the Hospice/Palliative approach is not isolated to just the dying individual, Hospice programs integrate the needs of the family as well as they are also coping with the eventual loss of a loved one. Hospice care teams focus on alleviating distress from pain through pain management regimens, as well as emotional or spiritual needs they may require the assistance of a social worker or religious/spiritual figure (NHPCO, 2013). There are a variety of approaches to receiving Hospice/Palliative care such as through 'freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities' (NHPCO, 2013). The provision of Hospice care continues to grow as there are currently Hospice Services in each of the 50 states and 5,500 Hospice programs spread throughout the United States (NHPCO, 2013). Hospice care [as outlined by NHPCO (2013)] is grouped in one of three 'tax status categories' consisting of;

1. Not-for-profit [charitable organization subject to 501(c) 3 tax provisions]
2. For-profit (privately owned or publicly held entities)
3. Government (owned and operated by federal, state, or local municipality).

The majority of Hospice Care agencies within the U.S. falls under the category of 'For-profit' encompassing 63% of the agencies as compared to only 5% of government owned Hospice agencies (NHPCO, 2013). Any form of medical care particularly within the United States is expensive and Hospice care is no exception to this as Aldridge et al., (2012) reports that in 2010 there were 1.1 million Medicare beneficiaries at a cost of \$13billion (Aldridge et al., 2012). However, Hospice care is typically "covered under Medicare, Medicaid, and most private insurance plans and patients receive hospice care regardless of ability to pay" (NHPCO, 2013). To shed more light on the role of Medicare within the realm of Hospice care we turn to

Kinzbrunner (1998), who shares that in 1982 the *Medicare Hospice Benefit* was initiated and became the “first legitimate funding source specifically designed to provide comprehensive care to patients with a life-limiting illness and to their families”(Kinzbrunner, 1998). What’s more the formation of the Medicare Hospice Benefit served to further establish Hospice care as a viable and respected course to end of life care and “had a major influence on the shape of hospice care in the United States. Its passage established a working definition of a terminal prognosis and created conditions of participation that defined where and how hospice care would be provided and who would deliver the care” (Kinbrunner, 1998).

In order to qualify for Hospice care under Medicare the individual must be ‘Entitled to Part A of Medicare; and certified as being terminally ill in accordance with [‘Certification policies of terminal illness’] (Code of Federal Regulations, 2014). Two physicians must determine that the individual is terminally ill and is expected to live no more than 6 months, additionally; the individual must ‘forgo curative care’ (Aldridge et al., 2012). Once an individual has selected Hospice as an approach to their end of life care and is admitted into a Hospice care facility the dying individual can expect to receive the following care practices [some of which were noted previously] from an interdisciplinary team within the facility. The following is a list of services outlined within the NHCPO Guide of 2013,

1. Manage the patients pain and symptoms
2. Assist the patient with the emotional, psychosocial and spiritual aspects of dying
3. Provides needed drugs, medical supplies, and equipment
4. Instructs the family on how to care for the patient
5. Delivers special services like speech and physical therapy

6. Makes short-term inpatient care available when pain or symptoms become too difficult to treat at home, or the caregiver needs respite

7. Provides bereavement care and counseling to surviving family and friends

It is with hope that this brief review of the components of Hospice/Palliative care lends itself to provide the reader with a greater understanding of the Hospice/Palliative care approach to the end of life. In the next chapter we will discuss the *End of Life Experience*.

CHAPTER III

The End of Life Experience

Nothing, they say is more certain than death, and nothing more uncertain than the time of dying. –Thomas Paine

Before we enter into a discussion pertaining to the chosen Attachment and Existential Theories, I thought it would be appropriate for us to first discuss the end of life experience. I would like to touch on the signs and symptoms of the dying process, and acknowledge the suffering or distress that often times accompanies the dying experience. Also in the process, I will highlight cases of individuals and their unique end of life journey. It is my hope that this discussion will help to paint a picture of the journey of death and in the process lend itself to conceptualizing the chosen theories. Furthermore, I want to acknowledge that the discussion of death may be a distanced and abstract topic, or conversely, this discussion may strike very close to home. Bearing this in mind, the intention of the following discussion is to bring us closer to the experience of the dying individual. If we are too far distanced from this experience this discussion will quickly lose relevance.

I would like to share with the reader my own observations and experiences from being a part of a Hospice and Palliative Care Team. In my experience individuals who enter a Hospice Care setting [barring that the individual is cognitively competent] typically know that they have entered the facility to receive assistance with their dying experience. Individuals who are placed under hospice are given 6 months or less to live. However, this prognostication is not definite as some individuals die within days of entering Hospice Care or live well beyond 6 months. Plonk

and Arnold note that that “Approximately 37% of hospice patients die within a week of enrollment, and only 7% survive more than 6 months” (Plonk and Arnold, 2005).

After admittance many individuals tend to go through a “honey moon phase”, during which they transition to living within an inpatient care facility. For some individuals who experience this “honey-moon” phase, terminal illness symptoms have not yet critically advanced and are well-managed by round the clock nursing staff and many thrive under the care they are provided with. Despite circumstances, this period can be a pleasant time when friends and family members visit and if cognitively capable the dying individual will engage in dialogue of reminiscence or for example, speak of how grandchildren or nieces and nephews are doing. Something that I have witnessed with some individuals facing the end of their lives is that often there is an awareness of death, yet the weight of this reality, during the ‘honey-moon’ phase, is not fully expressed.

Signs and Symptoms of Death

As the illness progresses and symptoms begin to manifest to a greater extent, I have seen the “honey moon phase” fade, as the dying individual tends to experience the progression and extent of their illness to a greater degree. Literature that has examined the dying process has revealed that there are multiple signs and symptoms that an individual experiences as this person enters into the ‘actively’ dying or ‘terminal’ stage of death which one typically enters during the last 2-weeks of life (Kehl and Kowalkowski, 2012).

Not every individual experiences the same trajectory of symptoms, for example, terminal illnesses such as renal disease, metastatic small cell lung cancer, or metastatic mesothelioma, each present with distinct symptoms. Yet, research has revealed common symptoms that typically manifest at the end of life. We will utilize a caregiver’s guide titled ‘When Death is

Near,' to assist in exploring such symptoms. During the dying process one may witness the withdrawal of the dying individual. In this process the individual may no longer get out of bed or partake in activities, sleep is more frequent, there is a decrease in socializing with family and friends, and they become less alert and oriented. This withdrawal is viewed as a means for the dying individual to prepare themselves for their death (Hospice of Santa Cruz County, 2008). Another symptom consists of a decrease in appetite and difficulty in solid or liquid intake. As the body prepares itself for death, it no longer needs the nutrition once required to keep it functioning, as a result the dying individual sometimes experiences weight loss. Incontinence is also a symptom of the dying process. There is a tendency for individuals to lose control of their bowel movements and this is largely due to decreases in muscle strength. There are also changes in respiration in which breaths may increase dramatically or decrease to the point in which it appears the individual is not breathing (Hospice of Santa Cruz County, 2008). Plonk and Arnold note that respiratory changes, “. . . are thought to indicate significant neurologic compromise near death” (Plonk and Arnold, 2005). This draws on the last symptom we will note which consists of the disorientation and confusion that often occurs, and is referred to as ‘Terminal Delirium’. It is not uncommon for individuals to lose their sense of time and date, reach out hands and grasp for something only seen by the individual, claim to see deceased loved ones or hold conversations with person’s who are not present within the room (Hospice of Santa Cruz County, 2008). Terminal Delirium, “. . . occurs in 28% to 83% of patients near the end of life”(Plonk and Arnold, 2005). This terminal symptom can manifest itself with a ‘hyperactive’ characterization in which the individual experiences *restlessness, agitation or hallucinations* or can take on a ‘hypoactive’ state consisting of *somnolence* (Plonk, and Arnold, 2005).

Suffering and Death

What I would like to capture now is the suffering that often accompanies the dying process. First I would like to be cautious and note that not all deaths are defined by or contain suffering that requires extensive therapeutic and medical interventions. I can recall one individual named Mr. O who was a 95- year old male who came to the Hospice facility with the preemptive expression that “he was ready to die”. Mr. O did not express or convey suffering or distress. He was an individual who had “taken care of all his business” and seemed to accept that he was in the final stage of his life. It was a short time after his admittance that he quietly died.

Suffering at the end of life is not a light topic to discuss, however, it is important to not ignore the reality of suffering that often times accompanies the process of dying from a terminal illness. Death as noted previously is a unique experience and unfolds differently for each individual especially when considering one’s culture. Although it is beautiful when individuals are able to die peacefully, the course of death is not always one free of suffering. I have utilized the word *suffering* in this section multiple times and so it is important to clarify what is meant by the use of this term. Krikorian et al., define suffering as,

. . . A negative emotional response . . . a complex negative affective and cognitive state, characterized by a perceived threat to the integrity of the self, the perceived helplessness in the face of that threat and exhaustion of psychosocial and personal resources for coping (Krikorian et al., 2012).

Krikorian goes on to highlight that suffering is not necessarily one- dimensional and is often a complex composition of both psychological and physiological pain and notes, “. . . Others recognize the multidimensional nature of suffering and believe a mind/body distinction is no longer valid” (Krikorian et al., 2012).

The suffering experienced by the dying individual is not simple nor the origin readily defined. The realization that death is near can cause an individual to react and cope in unique and varying ways. Along the psychological spectrum it is crucial that we highlight the anxiety that many person's experience at the end of life. Krikorian notes regarding research amongst individuals diagnosed with cancer, "More than half of advanced cancer patients who experience suffering also meet the criteria for anxiety or depressive disorders"(Krikorian et al., 2012). Such anxiety can greatly detract from the quality of life experienced at the end of life. "Death anxiety may grow out of uncertainty when the patient becomes aware of the seriousness of his illness. It relates to many other fears: pain, punishment, loneliness, loss of control, the unknown, death or agony" (Krikorian et al., 2012). Neimeyer et al., also note that death anxiety may stem from a low-degree of 'self-worth' and highlights Erikson's life span developmental theory. Although we will not venture into great detail regarding this theory, it lends itself to support the chosen theories [Attachment and Existential] in that it contends that ". . . fuller attainment of ego integrity (a sense of generativity, satisfaction, and purpose in life) is associated with lower fear [anxiety] about death" (Neimeyer et. al, 2011). We will expand upon the occurrence of *review* or *appraisal* of one's own life while facing mortality when we enter a discussion pertaining to Existential Theory. For now it is enough for us to acknowledge the evaluation of self-worth as a psychosocial example that contributes to the suffering encountered at the end of life.

Case of Mr. D

At this point I would like to introduce the reader to an individual I met while I was apart of a Hospice/Palliative Care Team. I will refer to him as Mr. D. He was an individual who lived the life of a nomad. He traveled throughout the United States as well as Europe and quickly adapted to wherever he chose to reside. Mr. D. was a Vietnam War veteran and suffered from the

effects of exposure to Agent Orange, [herbicide used to remove foliage during Vietnam War]. Mr. D. was diagnosed with metastatic cancer at the age of 65 and chose to not pursue invasive procedures. He was a friendly, polite individual who readily welcomed visitors into his private room on the hospital unit. I began meeting with Mr. D on a weekly basis and we embarked in discussions regarding his perceptions held toward his terminal illness. In the process, Mr. D revealed that he was not a religious man and did not turn to a God for support. His approach and composure regarding his prognosis was astounding, as Mr. D. commented, "I'm not afraid of dying, I'm actually kind of curious about what happens." Mr. D. also highlighted "I'm at peace with dying" and emphasized that he did not want to live a life in which he was bedbound. It was unclear whether Mr. D's expressions of peace and composure were a façade to hide his inner anxieties or that he was truly at peace. Regardless, this was Mr. D's way of facing his mortality and tearing down his potentially protective cloak would have been cruel.

It was early January shortly after we had started meeting that Mr. D began to experience a dramatic decline in his health. Nurses reported nights composed of episodes in which he would remove his clothes and climb out of his bed. He no longer registered who I was and seemed to have difficulty in recalling our earlier meetings with each other. Mr. D presented with a great degree of restlessness and agitation that required continued 1:1 support to prevent him from physically harming himself and to assist in calming him.

I present to the reader the case of Mr. D, because he is an individual who displayed a great deal of anxiety while entering into the actively dying phase of death. Although prior to this phase, Mr. D presented with composure and a sense of acceptance this was perhaps a means to cope and once the threat of death actively presented itself, stirred up Mr. D's anxieties. One can never fully predict an individual's reaction to threats when they are actively occurring. Mr. D's

last days on earth were marked with a great degree of anxiousness, and restlessness that seemed to cause him suffering that could temporarily be alleviated with medication and as previously mentioned 1:1 support. Mr. D's end of life experience contrasts considerably with that of Mr. O whose end of life journey was quiet and apparently calm. This exemplifies the point that one's experience of death can manifest itself quite differently for each individual.

Death and Pain

We have highlighted examples of the physical symptoms one may experience at the end of life however I would like to further expand upon the pain experienced during the dying process. We once again turn to Krikorian who notes multiple physical aspects that can contribute to the experience of pain and in turn suffering during one's end of life journey. An individual who is diagnosed with a terminal illness typically experiences a series of physical symptoms [some of which noted previously] such as, 'pain, fatigue, dyspnea, anxiety, depression, anorexia, insomnia, mental confusion and constipation'. These are just a few of the symptoms that may arise at the end of life and contribute to one's experience of pain and if we are to discuss the end of life journey it is important to highlight the role of pain that accompanies this passage.

Krikorian notes that pain is often defined as, “. . . an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Krikorian et al., 2011). Yet, the definition of pain much like suffering is not black and white. Pain may have multiple origins stemming from symptoms of the terminal illness, but may also stem from existential pain as well as psychological pain (Prommer and Ficek, 2012). The assessment and treatment of pain can be a difficult process to achieve. This is largely due to the fact that clinicians must tease out what *type* of pain the dying individual is actually experiencing. Pain management is typically gauged by Pain Assessment Scales such as the Edmonton

Symptom Assessment Scale or a Numeric rating scale of 0-10, [0 no pain, 10 ‘worst pain you can imagine’] (Prommer and Ficek, 2012). Such assessments of pain can become particularly challenging when individuals are cognitively impaired and unable to verbalize their own accounts of pain. Under these circumstances, Prommer and Ficek share that “. . . behavioral and verbal cues are relied upon for clinical assessment” (Prommer and Ficek, 2012).

However, even with admirable, best-made efforts and assessments, there are individuals facing the end of their lives who will still endure the suffering of pain. Startlingly Wilkie et al, note, “unfortunately, pain management and symptom management are often inadequate, even for people facing the end-of-life transition with palliative and hospice care” (Wilkie et. al, 2012). When considering individuals facing terminal cancer, Black et al. note, “pain continues to be one of the most common symptoms associated with cancer, with up to 90% of patients experiencing pain during the course of their illness and 50-80% having poorly managed pain” (Black et. al., 2011).

Case of Mr. V

This truth is highlighted because although one of the missions of Hospice/Palliative Care is to manage and alleviate pain to promote quality of life, there are instances where this mission is not achieved. I would like to take a moment and reflect upon a case shared by Doctor Rebecca Sudore et al., of a 63-year old male named Mr. V who was diagnosed with anal squamous cell carcinoma. Mr. V was a Vietnam War veteran who worked as a bartender and had little contact with his family. Mr. V was admitted to a hospice care facility with the knowledge that he was dying. This individual’s expressed wish was that he remain alert. For four months Mr. V lived a life of quality as measured by himself. However, after reaching a 4- month benchmark, Mr. V began to experience a progressive decline. During Mr. V’s decline a communication error

occurred in which one of Mr. V's pain medications was ordered through the organizations computer system. However, unbeknownst to the Hospice care team, this integral pain medication of IV methadone, was not stocked within the hospital. Subsequently, Mr. V endured 20 hours without this pain medication and experienced immense pain. The Hospice Care team worked to alleviate Mr. V's pain by adjusting his medication regiment but again despite efforts to titrate his analgesic medication, efforts continued in vain as Mr. V struggled with intense pain. As a result of restrictions placed on the Hospice care team regarding Mr. V's need for increases in IV fentanyl and IV morphine, Mr. V, against his original wish to die in the Hospice Unit, was transferred to the hospital's ICU, which could provide the increased doses of pain medication he required.

Despite pharmacological interventions to assist in alleviating Mr. V's pain, he continued to grimace in pain. Non-pharmacological approaches were also utilized as Dr. Sudroe writes to Mr. V in an article after his death,

At this point our goal was to manage your symptoms, whether your suffering was physical, emotional, or existential. Both the palliative care nurse practitioner and chaplain were with you for a good portion of each day talking with you, playing your favorite classical music, and sitting at your bedside. Yet, nothing we tried appeared to console you (Sudore et. al., 2010).

After 8 days of remaining on the ICU, clinical staff noted that Mr. V had developed opiate-induced neurotoxicity [‘a multifactorial syndrome that causes a spectrum of symptoms from mild confusion or drowsiness to hallucinations, delirium and seizures’ (Gallagher, 2007)]. Dr. Sudore writes, “a palliative care nurse practitioner apologized for having to move you to the ICU, acknowledged how hard you had fought to hold on, and told you that now was the time to let go.

You then relaxed, your breathing slowed, and you died quietly 20 minutes later while we held your hand” (Sudore et al., 2010).

I bring the case of Mr. V to this discussion, because his end of life [EOL] journey exemplifies the reality that the wish and desire to be pain free, may not be something capable of being fulfilled by the clinical team despite admirable efforts. Mr. V’s story also lends the reader insight into the experience of Hospice care as well as what a dying individual might endure.

If we again consider previous reflections on the hope for a ‘good death’, a pain free death for many dying individuals is part of what composes their definition of a *good death*. To highlight this point further, Munn et al. report that one of the prominent themes of the literature exploring a ‘good’ end of life, consists of the management of symptoms and pain so that one may be ‘comfortable’ (Munn et al., 2008). The difficulty of managing symptoms and pain at the EOL is a particularly critical piece to consider especially when we discuss the role of Attachment Theory during the EOL, which will be discussed in the theory section of this paper.

Death and the Physical Body

Lastly, I would like to acknowledge the vessel in which we live our lives within, the physical body. Often times there are series of losses that an individual goes through as their bodies begin to shutdown, for example; the loss in the ability to walk, the loss of hand functioning, the loss of sight, or the loss of physical strength. Bearing witness to such decline and loss is not an easy feat, but imagine how difficult this experience must be if it were your body shutting down. It is with hope that this discussion will promote a greater understanding and appreciation for the EOL process and cause the reader to connect with and contemplate this human experience.

While a part of the Hospice/Palliative Care Team, I have met individuals who were admitted to the program and witnessed the deterioration of their physical bodies. While witnessing the often times slow decline of clients, I could not help but wonder how they appeared when they were younger before the aging process and their illness consumed their health and physical abilities. With this thought came the question of, who were they before their health began to decline? Lawton explains that within the context of western society the body plays a significant role in shaping our conceptions of 'self'. Lupton (2012) refers to the works of Deleuze and Guattari who proposed 'a philosophical model of a body-without organs.' This 'body without organs', consists of our concept of self as Lupton argues, the body is 'intrinsically bound up with our sense of identity'. Lawton as well comments that that the human body is a vehicle for achieving 'individual self-determination'. In addition, the body permits the movement of oneself throughout the social realm and serves as a physical representation of one's *emotional, moral and spiritual* condition (Lawton, 2000).

Lupton goes on to note Foucault's review of the human body in which it is argued that the individual under medicalized care, loses autonomy of their body. For our purposes concerning terminal illnesses, Foucault contends that the body, in order for medical staff to palliate symptoms of the illness becomes an 'object'. Furthermore, the body is 'owned by the medical system' (Lupton, 2012). As part of our review of the experience of death, we find in this discussion of the physical body the acknowledgement that the dying individual endures a great deal of transitions throughout the dying process. One such transition as Lupton assisted in highlighting, is that of the potential shift or view of self, as well as the loss of autonomy over one's own body as a result of symptoms of illness as well as the nature of being under medicalized care.

Finally to close our discussion of the physical body, I would like mention a noteworthy point of Lawton's that seems particularly relevant for the closing of our reflections on the dying experience and the physical body. That is, the recognition that if we are in good health, than the ability that our bodies possess to function in day-to-day life is typically taken for granted.

“persons for whom the body functions unproblematically, the body tends to disappear from conscious awareness, it becomes as it were, a form of *experiential absence*” (Lawton, 2000). We are not residing in the position of the dying individuals of whom we are referring to, therefore in a sense we are ‘outsiders’ to this experience of physical deterioration in this form. It is because of this position of being an outsider looking in, that we acknowledge the distance that we hold from the dying individuals experience. I would like to further emphasize this point by noting a piece that Lawton discusses in her text,

People in good health take their lot, and their bodies for granted; they can see, hear, eat, make love and breathe because they have working organ that can do all of those things . . . Each person simply accepts the fact that he [*sic*] has two legs and can walk; he does not think about it or marvel at it anymore than he would feel gratitude for the oxygen content of air. These are among the simple existential conditions of life . . . illness [however] negates this lack of awareness of the body in guiding our thought and actions. The body can no longer be taken for granted, implicit and axiomatic, for it has become a problem (Lawton, 2000).

We have just discussed the experience of death and the various pieces that assist in composing this process. It is true that one can never fully ‘stand in another’s shoes’, and therefore we can never fully comprehend the experience of another. Although we can educate ourselves on the end of life, we can never fully understand death until we ourselves are no longer

outside looking in, but inside looking out. Therefore, as we venture into the discussion of attachment and existential theory, let us bear in mind this discussion of the experience of death and allow it to guide us in our attempt to connect with the dying individual and *their* experience. Let us remain mindful of all that the dying individual must endure physically, as well as psychically as we apply these two theories to the process of death and dying.

CHAPTER IV

Attachment Theory

Kindness and intelligence don't always deliver us from the pitfalls and traps: there are always failures of love, of will, of imagination. There is no way to take the danger out of human relationships-Barbara Grizzuti Harrison

Defining Attachment

Prior to us entering into the defining and exploration of the concept of Attachment, it should be noted that the Theory of Attachment is ever evolving as we continue to learn more and more about infants and the role that caregivers play in their growth and development. With that being said the definition of Attachment should in no way be viewed as something set in stone, but rather a concept that is continually being developed and edited as more knowledge is gained.

The concept of Attachment Theory is largely accredited to John Bowlby (1907-1990), a British psychoanalyst who was very much interested in the impact of the parent-child bond upon the child (Berzoff, 2011). To assist in answering the question of what is attachment, we must for the moment steer our thinking away from the end of life and death toward birth, and the beginning of life.

A review of the literature reveals that there are multiple ways in which one can define the concept of Attachment, the trouble is teasing out what is most relevant to our discussion of Attachment and the end of life [EOL] process. Mooney (2010), in a text exploring the theories of attachment notes that there are several words that are typically associated with the term of attachment. These consist of: *bonding*, *relationships*, as well as *affection*. Mooney argues that

each of these terms can be considered a ‘component of attachment’ and goes on to provide the reader with a variety of ‘textbook definitions’. I will first highlight one such definition attributed to Berger, 2001:

An enduring emotional connection between people that produces a desire for continual contact as well as feeling of distress during separation.

As well as a second definition from John Bowlby (1982),

The dimension of the infant-caregiver relationship involving the protection and security regulation. Within this theoretic framework, attachment is conceptualized as an intense and enduring affectional bond that the infant develops with the mother figure, a bond that is biologically rooted in the function of protection from danger.

Mooney goes onto highlight that the *enduring* characterization of Attachment is a term that it frequently utilized to define and explain this theory. It is noted that the relationships we develop during infancy and childhood are in fact *enduring* as they impact our development and the effects of which remain with us throughout our lives. (Mooney, 2010) For our purpose, viewing attachment as having an enduring quality is particularly relevant, as we will discuss attachment in older adult-hood at a later point.

Attachment Development

We have just reflected on the ways in which attachment can be defined and now have a sense of what is meant by the term Attachment. Next, it is important that we explore the central functions of Attachment. Davies (2011), contends that, *providing a sense of security, regulating affect and arousal, promoting the expression of feelings and communication and serving as a*

base for exploration are the ‘four main functions’ of attachment (Davies, 2011). Let us enter into a discussion that will allow us to highlight and expand on these essential functions.

Attachment theory originally stems from Bowlby’s development of an ‘attachment system’ that is biologically rooted (Agishtein and Brumbaugh, 2013). This ‘attachment system’ is formulated during the early years of our development as infants. During this age we are dependent upon our caregivers for the fulfillment of a variety ‘physiological needs’ and this process of fulfillment as Hardy (2007) notes, “. . . requires close and frequent physical contact throughout infancy” (Hardy, 2007). It is this physical contact that helps the infant to become familiarized with his or her caretaker and also assists in the bonding process that we will highlight momentarily. The infant at a young age, within the 0-6 month time range, (Holmes, 2013) is able to distinguish whom their primary caretaker is, as the child perceptively learns ‘what her face looks like, what she smells like, what her touch feels like, and how her voice sounds’ (Davies, 2011). Connected with the experience of recognizing the primary caregivers face, is the significance of the mirroring process that occurs within these moments. During intimate face to face interactions between child and caregiver, such as when the child smiles, Holmes notes that, “the child’s smile evokes a mirroring response in the mother; the more she smiles back the more the baby responds . . . this contingent and marked mirroring . . . feeds back to the child a picture of their internal affective stage and forms the nucleus of internal models of one’s emotions” (Holmes, 2013).

Security and Safety

As infants continue to grow they develop the ability to crawl as well as other movements such as *jumping, climbing* etc. (Thelen, 1996). Hardy highlights that the child’s ‘intentional movement’ permits him or her the ability to physically attempt the achievement of close

proximity with their caretaker (Hardy, 2007). Berzoff adds that during this time period we seek out our primary caretaker for the provision of protection. This *seeking* is referred to as ‘proximity seeking’ (Berzoff, 2011). Holmes (2013), shares that, this action of seeking out the caregiver is referred to as ‘Attachment behavior’, and is exhibited when the child senses the threat or action of separation from the caregiver. Separation from the caregiver or even just the threat of separation, can present to the child as a frightening and distressful experience (Davies, 2011). Additionally, the child [not yet having developed the ability to vocalize distress] non-verbally communicates to the caregiver, his or her need for comfort through for example crying or whimpering. These examples are what Davies refers to as ‘distress signals’ that alert the caregiver to the child’s need for soothing support (Davies, 2011). Here in lies one of the functions of Attachment theory; the function of ‘providing a sense of security’. The child as Holmes (2013) further notes, then requires a response from the caretaker that serves to remove or ‘assuage’ the threat of separation and reestablish a sense of *safety* or *security*. Such a response from the caregiver may consist of a glance to the child of reassurance, “physical closeness and soothing words without touching to being tightly held and cuddled” (Holmes, 2013). The nature or degree of the response provided by the parent to child depends upon the level of separation or threat of separation. The bond or lack there of that is developed between child and caregiver depends a great deal on the caregivers ability to respond to the child in a manner that provides the child with the previously mentioned sense of security and safety. When speaking about the caregiver’s abilities in part, these is referring to their ability to sense when their child is in distress and sequentially, provide the child with soothing mechanisms. Davies notes that the child’s expression of for example, distress during separation ‘activates the mother’s side of the attachment system, and the mother takes steps to calm the baby’s distress’ (Davies, 2011). [It

should also be noted; that although the term mother is utilized the primary caretaker may also consist of a male who as well can provide soothing mechanisms to relieve the child's distress.] The distress of separation from the parent tends to diminish if the child has developed a healthy and secure sense of attachment to their caregiver. When this occurs this sense of security [provided by the caregiver] instills within the child the courage and confidence to investigate the curious world around them. The child becomes brave in their exploration because they have the security in knowing that they can return to the caregiver for support and soothing should they experience distress (Davies, 2011). This reflects one of the four main functions of attachment theory, 'serving as a base for exploration'.

The 'transactional patterns' of the caregiver responding to the child [soothing words or cuddling], does take time to develop, as the caregiver and child learn to relate to and interact with each other. However, once these patterns are established Davies writes, "Repeated successful mutual regulation of arousal helps the infant begin to develop the ability to regulate arousal through his [or her] own efforts." Davies further notes that, "Through the experience of being soothed, the infant internalizes strategies for self-soothing"(Davies, 2011). This ability to self-soothe draws in a second function of attachment concerning the 'regulation of affect and arousal. To expand further, the ability to self-soothe, assists in the child developing the realization that the experience of distress is not in itself catastrophic as the child learns that they have the capacity within themselves to self-regulate and allows for the child to feel 'competent in controlling distress and negative emotions' (Davies, 2011).

Internal Working Models

Here we arrive at an additional piece to the puzzle of Attachment Theory, regarding the concept of *internal working models*. It was discussed that during the interactions between

caregiver and child, 'transactional patterns' are developed. It is these 'transactional patterns' that as Holmes highlights, Bowlby applied to the concept of 'internal working models', which Bowlby derived from the works of Kenneth Craik, particularly *The Nature of Explanation* (Holmes, 2013). Internal working models develop from the interactions had with caregivers. The purpose of such models as Bretherton (1990) notes, ". . . is to interpret and anticipate a partner's behavior as well as to plan or guide one's own behavior in the relationship" (Bretherton, 1990). Based on the interactions had with others particularly the primary caregiver, the child then "builds representations of interactions that have been generalized or self-other schemata" (Holmes, 2013). It is further noted by Holmes that, ". . . the developing child forms relatively fixed representational models, used to predict and relate to the world of intimate relationships in which he [or she] finds [him or herself] (Holmes, 2013).

It is important to highlight the impact of these interactions upon the development of subsequent 'self-others schemata'. Bretherton helps to explain the impact of these interactions by highlighting that if for example a child experiences negative or ". . . a rejecting relationship with a primary caregiver, the working model of the rejecting parent is likely to be complemented by a working model of self as unlovable" (Bretherton, 1990). The child essentially internalizes the rejection experienced by the caregiver and develops and carries with them a view of self as someone who is 'unlovable'. This schemata of self as unlovable, as one can imagine, then impacts the way in which he or she interacts not only the caregiver but also other relationships. Conversely, Bretherton writes ". . . if an individual has experienced a supportive parent-child relationship, the working model of the loving parent is likely to be complemented by a working model of self as worthy of support and love" (Bretherton, 1990).

Pietromonaco and Barrett (2000), highlight research regarding memories from an individual's childhood that supports the assertion that the internal working models developed during childhood maintain a degree of longevity into adulthood. Pietromonaco and Barrett reveal that the structure of these models, tend to 'evolve' over time. This is due to the fact that as children our cognitive abilities are not yet sophisticated, therefore, we tend to internalize information in simplistic terms (Pietromonaco and Barrett, 2000). For example, "dad ignores me when I ask him to play with me, he doesn't love me." However, as cognitive abilities expand, the information that we internalize increases in complexity and therefore augments the intricacy of the internal working model (Pietromonaco and Barrett, 2000). To utilize the example of the child's relationship with Dad, "dad ignores me when I ask him to play basketball, Dad is concerned and stressed about a deadline at work. I see that Dad is preoccupied and did not intend to ignore me because he loves me." Here we find greater complexity and an expanded cognitive ability and awareness that augment the individuals internal working model.

Lastly, Pietromonaco and Barrett (2000) contend that although the internal working model concept is 'theoretically rich' and has served a prominent role regarding research in the social sciences, there is still a need for additional empirical research and evidence to lend additional support to this concept (Pietromonaco and Barrett, 2000).

Maternal Sensitivity

At this juncture, I would like to briefly discuss the requirement placed upon the primary caregiver to sooth the child and note that this is not necessarily as simple as for example simply picking up the child and holding him or her. It is important to note that the parent may not always be attuned to the child's distress and as Davies states, ". . . even in the most secure attachment, synchrony is not always present. Parents are not always optimally responsive and

attuned, nor do they need to be” (Davies, 2011). Parents/caregivers, although in the eyes of children appear to be superhuman and invincible are, as is well known, human and prone to tiredness, irritability, anger, depression, fatigue etc. Such experiences of human nature may interfere with the parent’s ability to respond to their child’s cries of distress. However, these moments of non-attunement or lack of ‘synchrony’ do not necessarily mean that the child’s attachment to the parent is permanently damaged. Actually, Davies (2011) highlights that such ‘interactional mismatches’ are repairable. Furthermore, “an indicator of secure attachment is the ability of the parent and infant to use interactive coping skills to repair such mismatches when they occur, thus restoring equilibrium for the infant and for the attachment relationship (Davies, 2011). This also reflects an additional function of attachment theory of ‘promoting the expression of feelings and communication’.

What we have just discussed regarding the caregivers ability to respond to and alleviate the child’s anguish encompasses the essence of the concept of *maternal sensitivity*. To further clarify, Drury defines this as, “the understanding of and responding to a child’s needs” (Drury, 2012). Maternal sensitivity is a central component of attachment theory; it is the piece that greatly assists in creating the bond between child and caregiver and as Whipple et al. note that this piece significantly contributes to the attachment style that is subsequently developed by the child. It is further noted that, “sensitivity is currently one of the most robust precursors of infant security of attachment (Whipple et al., 2011).

Attachment Style

Let us now review the four attachment styles, *secure*, *avoidant*, *resistant* or *ambivalent* as well as *disorganized*, which have been identified in infants. Attachment styles as defined by Holmes “ [is] the state and quality of an individual’s attachments” (Holmes, 2013) Broadly there

are two overarching types of attachment styles, secure as well as insecure. The key difference between these two branches of attachment remains in the care that the individual is provided with during early development. Securely attached individuals have typically received sensitively responsive care while insecurely attached individuals have received ‘suboptimal care’ that was not predictable/reliable or rejecting (Puig et al., 2013). The attachment styles of avoidant, resistant-ambivalent and disorganized are held under overarching branch of insecure attachment (Holmes, 2013). The first attachment style to be discussed consists of the secure attachment.

Secure Attachment. Secure attachments develop from caregiving that provides the child with a sense that they will be provided with support and subsequent relief during moments of distress (Mikulincer & Shaver, 2009). Based on repeated attentive responses from the caregiver the child develops confidence that they will continue to provide support whenever they may need it. For example if a child awakes in the middle of the night from a nightmare they can accept their caregiver to pick them up and rock them back into a sound sleep. Children, as Popper and Amit (2009), explain who experience this assured confidence will be more apt to explore their environments knowing that should they experience fearfulness they have the security of their caregiver to return to (Popper and Amit, 2009). Observational studies of infants have revealed that upon separation, infants of secure attachment have a tendency to display objection and challenge the departure of caregiver, this is revealed through cries from the child. However, upon return of the caregiver the child welcomes him or her back and seeks out the caregiver’s affection (Hardy, 2007).

Holmes notes that attachment style is connected with the previously noted ‘internal working model of attachment’ which “serves as a blueprint of the world in which the self and significant others, and their interrelationships are represented . . .” (Holmes, 2013). Drawing on

the internal working model concept, Mikulincer and Shaver note that the development of healthy internal working models which promote a secure attachment style, assist in the individual recognizing that during times of distress they can in fact turn to others, particularly significant others. Internal working models create ‘scripts that become activated during times of distress. Mikulincer & Shaver provide the following script to help in understanding this internal process, “If I encounter an obstacle and/or become distressed, I can approach a relationship partner for help; he or she is likely to be available and supportive; I will experience relief and comfort as a result of proximity to this person; I can return to other activities” (Mikulincer & Shaver, 2009). Possessing such a script is a powerful and positive component that contributes to one’s well-being, at this script can be utilized continually as moments of distress arise. Mikulincer & Shaver (2009), note the benefits of this scrip such as the ability to turn to others and trust that they will provide support. This instills ‘positive belief in others’ and assists the individual in developing intimate and emotionally rich relationships with others. In addition, “reliance on the secure-base script thus makes it less necessary to rely on psychological defenses that distort perception, limit coping flexibility, and generate interpersonal conflicts”(Mikulincer and Shaver, 2009).

Anxious-Avoidant Attachment. Silverman (2011), writes that the development of this particular style of attachment stems from the caregivers repeated ‘distant’, ‘dismissive’ or ‘unreliable’ care (Hunter & Maunder, 2001) ‘maladaptive interactions’ and ‘misattunements’ which then cause the child to develop the outlook that they must be self- reliant and autonomous. (Hunter & Maunder, 2001; Silverman, 2011). Unlike children of secure attachments, children of anxious-avoidant attachment have no confidence in their caregiver’s ability to provide them with support and comfort during times of distress. As a result of this lack of confidence the child then

believes that they cannot rely on or trust others to fulfill their need for comfort and instead rely on themselves. Such children come to expect rejection from their caregiver rather than nurturance (Popper & Amit, 2009). The child no longer sees purpose in signaling to their caregiver that they are experiencing distress as Mooney notes, “these children come to believe that communication of their needs makes no difference at all” and therefore present with minimal affect (Mooney, 2010).

Research has revealed that children display little regard for caregivers or other adult figures while in their presence. Mooney notes that the child “tends to ignore both parent and primary caregivers, whether there are strangers nearby or not” (Mooney, 2010). As a result of the child’s lack of recognition of those around the child can present as ‘unemotional’ and tightly controlled’ (Hunter & Maunder, 2001). Although the child neither expresses emotional reaction to the parents presence or departure, studies of avoidant children in the ‘strange situation’ have revealed ‘physiological recordings indicating that children in avoidant relationships are aroused and distressed by their mothers’ [caregivers] departure . . .” (Madigan et al., 2013).

Resistant-Ambivalent. This style of attachment develops out of the caregiver’s unpredictability as to whether or not the child’s needs will be fulfilled. The child does not experience security in knowing that his or her needs will be met each time that they exhibit distress signals (Popper & Amit, 2009) although the caregiver may occasionally offer relief from distress. Leerkes et al., also offer that the mother’s display of anxiety may actually contribute to the anxiety experienced by the infant and lend further “uncertainty about their mother’s ability or willingness to keep them safe . . .”(Leerkes et al., 2011). However, the child does not feel confident that the next time the caregiver is needed that this relief will occur. Furthermore, Luijk et al. purport that when signaling for the parent the child tends to “maximize their distress signals

in order to get their parents attention”(Luijk et al, 2010). This maximization in expression as Leerkes (2011), elaborates occurs because of the inconsistent care that the child receives, and this is the child’s way of desperately attaining the attention of the caregiver (Leerkes et. al., 2011). During times of separation the child of resistant-ambivalent preoccupation, will experience and display ‘extreme anxiety and distress’ (Mooney, 2010). However, when the caregiver returns, despite the distress experienced in their absence, the child typically displays an anxious quality. Such children display a longing to be comforted and nurtured but also conversely resist and push against the parents embrace. The distress and anxiety of the child is quite evident and reunion with parent takes on ‘an angry quality’ (Luijk et. al, 2010; Mooney, 2010)

Disorganized Attachment. The final style of attachment to be discussed consists of Disorganized Attachment. This is perhaps the most devastating style of attachment to be developed amongst infants. Research reveals that children who develop this attachment style ‘when children find themselves emotionally and physically dependent on someone who is also a source of fear, due to parental maltreatment, mental illness, and/or disruptive forms of parental behavior”(Madigan et al., 2013). The child experiences conflict regarding their attachment figure as their caregiver, who should be a source of security, safety, and nurturance is the source of the child’s distress and suffering. Due to this conflict the child may be seen ‘reaching for and turning away from the caregiver’ (Hardy, 2007).

The child comes to learn that their caregiver is not a secure base to be relied upon as a result Madigan et al., (2013) note “[this prevents the child] from developing appropriate attentional and behavioral strategies to cope with distress, which may ultimately result in vulnerability to internalizing psychopathology” (Madigan et al., 2013). Furthermore, the child

develops an intense sense of fear with the realization that their caregiver does not protect them from distress and suffering but rather is the source of their pain and suffering, as such the child does not develop appropriate self-soothing mechanisms that would allow them to cope with distress on their own (Madigan et al., 2013).

Periods of separation and reunion with the caregiver cause the child to experience 'distress' as well as 'avoidance' (Luijk et. al, 2010). When the caregiver returns to the child after separation the child, "greet[s] their caregiver in a punitive or hostile manner or alternately . . . [is] excessively concerned with the caregivers' physical and psychological well-being" (Madigan et al., 2013). Furthermore, this concern regarding the caregivers well-being require a high degree of energy on the behalf of the child. Therefore, Madigan et al., highlight that because the child is preoccupied with ensuring the caregivers well-being the child then has little or no energy remaining to explore their environment. This suppression of exploration then leads to a loss in development and places the child at great risk for walking down 'a pathway leading to internalizing problems' (Madigan et al., 2013).

Attachments History and Development

Let us take the time to discuss the history of attachment so that we can gain a greater understanding of the theory and in the process reflect on the influences that have assisted in shaping the theory of attachment. In order to embark on our discussion we must begin with John Bowlby. As previously noted, Attachment Theory's developmental roots which stem from the British Psychoanalyst John Bowlby and it is contended that his own childhood beginnings sparked his interest and motivation to study the significance of the bond between child and caretaker. Horst (2011), writes that as a child John experienced examples of separation at a young age. As previously discussed such experiences of separation can cause distress for the

child. Horst also shares a candid reflection from Bowlby on his own childhood, “he stated that it had a great effect on him and that he had been *sufficiently hurt but not sufficiently damaged*”(Horst, 2011).

Horst (2011) lends further insight into Bowlby’s early beginnings and highlights that in accordance with Bowlby’s upper-middle class upbringings and standards, children were primarily raised by nannies and John was no exception to this. As a child Bowlby and his five other siblings spent approximately 1 hour with his mother a day and only saw his father on Sundays. At a young age he developed what one could term an attachment to his nanny Minnie. However, at the age of 4 years old Minnie left the Bowlby residence. It was reported that Bowlby was deeply impacted by this separation. An additional experience of separation occurred during the opening of WWI while residing in London. Due to the threat of bomb raids, Bowlby at the age of 11 and his brother were sent away to boarding school (Horst, 2011). Horst and Veer note Bowlby’s reflections regarding this experience as expressed in the following sentiment, “he would not send a dog to boarding school at that age” (Horst and Veer, 2010). Lastly Horst shares with the reader, that, “These early experiences in Bowlby’s personal life arguably influenced his subsequent thinking and research” (Horst, 2011).

Let us now fast forward several years and discuss some of the experiences or influences that helped to guide Bowlby on his journey toward the development of Attachment. To assist with this endeavor we first turn to the writings of Bretherton (1992). It was during Bowlby’s time volunteering at a school for maladjusted children, where he met two unique children. Bretherton describes the first child as a teenager who was “. . . very isolated, remote, [and] affectionless . . . who had been expelled from his previous school for theft and had had no stable mother”(Bretherton, 1992). Bretherton then describes a second child, who was an “anxious boy

of 7 or 8 who trailed Bowlby around and who was known as his shadow” (Bretherton, 1992). Bretherton highlights that it was these children who propelled Bowlby to pursue child psychiatry. Bowlby then studied at the British Psychoanalytic Institute. While studying here, Bowlby received supervision from Object Relations developer, Melanie Klein. Bretherton notes Klein’s position that “emotional problems are almost entirely due to fantasies generated from internal conflict between aggressive libidinal drives rather than to events in the external world (Bretherton, 1992). Bowlby however, disagreed with Klein’s approach, which adamantly restricted the involvement of the child’s parent in the process of analysis. Bowlby believed that the bond between child and caregiver as well as childhood experiences held significance in the process of assisting a child (Mikulincer and Shaver, 2007). Out of Bowlby’s opposing view to Klein’s, grew his perspective on the ‘intergenerational transmission of attachment relations’, which attempted to involve parents rather than exclude them while assisting the child (Bretherton, 1992). Although it is clear that Bowlby did not agree with Klein’s perspective, it can be argued that his work with Klein influenced the development of his own view on attachment. Bowlby was also greatly influenced by the studies of Ethologist Konrad Lorenz. Berzoff (2011), shares that Bowlby was interested in Lorenz’s’ work which noted the imprinting that occurs between ducklings and their mothers after they have hatched. In a study Lorenz tested this ‘imprinting’ and discovered that ducklings would imprint upon him, if he were the first figure observed by the ducklings. This resulted in the new hatchlings following Lorenz around his laboratory. Bowlby drew from this the conviction that “. . . all complex organisms, including humans, have an attachment system, one that is highly adaptive in that it keeps the young in close proximity to a critical older animal to whom the young seek to return at times of danger” (Berzoff, 2011).

The advent of WWII also impacted Bowlby's development of attachment theory. It was during this time period that Berzoff notes, Bowlby had to pause his career as a child psychiatrist and work with a research group 'studying officer selection criteria. This time period taught Bowlby 'research procedures' and also revealed to him additional evidence regarding the significance of childhood bonds with caregivers. Interestingly, Berzoff shares that the British Secret Service selected men from orphanages when seeking individuals who would be qualified to 'work behind enemy lines and engage in very violent behaviors such as cold-blooded murder of an enemy'. Children who were raised in orphanages were sought out by the British Secret Service, because they were deemed to 'have few feelings for others and little guilt or concern about the tasks they would be asked to do' (Berzoff, 2011).

At the closing of WWII Bowlby joined the Tavistock Clinic which Berzoff describes as, 'an early psychoanalytically oriented London Center' (Berzoff, 2011). It was during this time period that Bowlby posted an ad requesting a research assistant. Here arrives Mary Ainsworth, who responded to Bowlby's ad and came to be known as a co-founder of attachment theory (Mooney, 2010). Amongst Ainsworth's studies at the University of Toronto consisted of security theory. This theory as Bretherton highlights, contends, 'that infants and young children need to develop a secure dependence on parents before launching out into unfamiliar situations' (Bretherton, 1992). Ainsworth and Bowlby both held similar perspectives regarding the development of children and the significant role that attachment plays with the child's caregiver. Mooney shares with us Bowlby's bright perspective on his partnership with Ainsworth, "Bowlby recognized at once that Ainsworth had a brilliant mind and a passion for research. He was excited that her education, interests, and early research were much like his own" (Mooney, 2010).

The two worked together for 3 and ½ years and as Mooney highlights, “. . . their interest fed each other’s work for the rest of their lives” (Mooney, 2010).

Ainsworth contributed greatly to the development of Attachment Theory, and we will highlight some of these contributions in the following discussion. We have utilized the term secure base throughout our discussion thus far, and it was in fact Mary Ainsworth who as Holmes (2013) shares, ‘coined the term’. One of Ainsworth’s influential contributions to Attachment Theory consists of research conducted in Uganda. Over the course of a month, Ainsworth closely observed the interactions of Ugandan children with their primary caretakers. Ainsworth’s approach to achieving such observations was unique in that she did not separate herself with a ‘white laboratory coat’ so to speak but rather, entered the homes of the individuals she observed. Ainsworth immersed herself with the individuals she was observing and helped the mother’s with whatever tasks or duties she could assist with. This method of observation resulted in a number of key observations (Mooney, 2011). Mooney provides us with a list of what some of these noted observations were:

- crying when the mother leaves
- following the mother
- showing concern for the mother’s whereabouts
- scrambling over the mother
- burying the face in the mother’s lap
- using the mother as a safe haven when in a strange situation
- flying to the mother when frightened
- greeting her through smiling, crowing, clapping, lifting the arms, and general excitement

Bretherton (1992) adds that Ainsworth's collection of data regarding the 'individual differences' observed during the Uganda Study, provided information that Bowlby himself, 'had earlier left aside as too difficult to study' (Bretherton, 1992). However, Ainsworth clearly proved that such tedious data could in fact be collected. Here we also find Ainsworth's addition of evidence of the effect of the previously discussed *maternal sensitivity*. It was the Uganda Study that assisted in understanding the great influence that the mother's responsive nature or maternal sensitivity plays in the child's developed attachment. Bretherton (1992) notes regarding findings of this study, "it turned out that secure attachment was significantly correlated with maternal sensitivity. Babies of sensitive mothers tended to be securely attached, whereas babies of less sensitive mothers were more likely to be classified as insecure" (Bretherton, 1992).

Holmes (2013) argued that one of Ainsworth's greatest contributions to the Theory of Attachment consists of her development of what is termed the 'Strange Situation'. Holmes explains that in the 1960's Ainsworth created '20 minute sessions' in which a mother and a 1-year old child were brought into a playroom and were introduced to the selected stranger. Once child and 'friendly stranger' were introduced, the mother was asked to leave the room for approximately 3 minutes and the child was left with the newly introduced stranger. Focus was placed on the child's reaction during his or her separation from their mother as well as during their reunion. Holmes (2013), goes on to explain that the goal or intent of this experiment was to record the ways in which the child coped with the distress created by the separation from the mother. What repeated experiments of this design revealed, was that the children responded to the separation from and reunion with their mother in four distinct 'patterns'. These patterns came to form and add evidence as well as support regarding the previously discussed four primary

styles of attachment; *secure, insecure-avoidant, insecure-ambivalent* and *insecure-disorganized* (Holmes, 2013).

Lastly, I would like to acknowledge the significant contribution that Attachment Theory has provided to the realm of social science. To do so we turn to Gold who highlights that although Bowlby never claimed to be an ‘integrationist’, the theory of Attachment proved to be inclusive of studies outside of the world of child psychiatry and in fact as Gold notes “combined elements of psychoanalysis, developmental psychology, social psychology ethology and biology” (Gold, 2011). Bowlby and Ainsworth’s development of Attachment theory revealed the relevance and contribution that observational analysis could provide to enhance and develop theory. Gold also highlights that it was Attachment Theory that assisted in steering the zeitgeist amongst the psychoanalytic community from drive theory to seeing the significance in evaluating interpersonal relationships as well as the environment (Gold, 2011). However, although it is evident that Attachment Theory has had a significant impact on the way in which we view the effect and impact of early interpersonal interactions the introduction of Attachment Theory received a cold reception within the realms of psychotherapy as well as psychoanalysis. Gold writes that during the time of Attachment Theories development and introduction, communities of psychology were very much immersed in ‘conventional analytic thinking . . . [that] was dominated by Freudian drive theory and it’s tamed step child, ego psychology, both of which reduced the reality of interpersonal relationships . . .” (Gold, 2011). However, Attachment Theory over time came to be recognized as come to be “. . . One of the most heavily research conceptual frameworks in modern psychology” (Mikulincer, 2007).

Attachment and Biological Function

Here we will discuss the biological function of attachment theory in greater detail, as it is important to acknowledge the biological mechanisms behind the attachment process.

Mikulincer, writes that for Bowlby a child's proximity seeking behavior serves the purpose of protecting the 'dependent' and 'helpless' infant from danger. Here we can find a Darwinian influence in Bowlby's line of thinking in that he purported that evolutionarily, "infants who maintained proximity to a supportive caregiver were more likely to survive and eventually reproduce, causing genes that fostered proximity seeking and other attachment behaviors in times of danger to be selected for and passed on to subsequent generations" (Mikulincer and Shaver, 2007).

Since the initial development of Bowlby's theory of Attachment additional research has revealed the behind the scenes functioning of the attachment process. Mikulincer shares that,

We now know that the action of these genes is mediated by the neuroendocrine hormones and physiological "axes" or systems, such as the neuropeptides oxytocin and vasopressin, the stress hormones adrenaline and cortisol, the amygdala, and the hypothalamic-pituitary-adrenal (HPA) axis that respond to threats and stress (Mikulincer and Shaver, 2007).

First, I would like to provide the reader with a greater understanding regarding the hypothalamic-pituitary-adrenal axis or HPA. However I would like to note, for our purposes we will not go into the mechanizations of this process, as the details are beyond the scope of this discussion. Nader and Weems (2011), explain that stressors or threats activate the HPA axis. In response to such stressors/threats the HPA axis releases a series of hormones one such hormone being cortisol which then serves to "convert fats to glucose, inhibits the immune response, suppresses

inflammation and assists the body in returning to a calm state after threat” (Nader and Weems, 2011).

Regarding the role of vasopressin and oxytocin, Carter (2014), writes that these neuropeptides interact with and impact the functioning of the other. Additionally Carter comments that vasopressin unlike oxytocin “has been associated with mobilization, anxiety, and defensive behaviors but [like oxytocin] also the formation of selective social bonds”(Carter, 2014). Mikulincer goes on to note that the hormone oxytocin assists in developing the critical bond between caregiver and child and is also the same hormone that is released in adulthood during ‘romantic/sexual *pair-bond* attachments’ (Mikulincer and Shaver, 2007). In fact Carter adds insight regarding function of oxytocin in the attachment process. Previously it was noted that the familiarization process that occurs between baby and mother such as learning the mothers face, scent, voice etc serves in facilitating the bonding process, Carter notes that oxytocin is linked with ‘social attention and ‘eye gaze’ which as Carter notes, ‘are critical in early stages of relationship formation’ (Carter, 2014.) Here we again find the potential role of oxytocin in chemically creating the bond between mother and baby. When reflecting upon the early stages of an infant’s interactions with his or her mother, it is intriguing to highlight the process of breastfeeding. Breastfeeding is an intimate interaction between mother and child that also arguably assists in the bonding process which, Carter refers to as ‘hormonal communication’. This intimate act of bonding, Carter argues is likely to be assisted by the oxytocin, which is found in the mother’s breast milk (Carter, 2014).

Previously, it was noted that during WWII the British Secret Service sought out males from orphanages to participate in gruesome military tasks. To reiterate, such males were pursued because of the assumed lack of expressed emotions and remorse for the brutal acts committed.

Mikulincer lends scientific evidence to support this frightening phenomenon, and writes that oxytocin levels are reported to be lower in children who are raised in orphanages, particularly those where the children ‘were neglected or poorly treated before being adopted’ (Mikulincer and Shaver, 2007). In addition, drawing on the role of cortisol it is further noted that this stress hormone is typically shown to be higher in children as well as in adults who experienced separation from their primary caregivers (Mikulincer and Shaver, 2007).

Literature regarding the biological functions of attachment seems to indicate, that early development during infancy into childhood is an extremely vulnerable point in a human beings life. The treatment of an individual during childhood can greatly impact the hormonal balance of the individual. Kocvoska et al., (2013) note, “maltreatment in early life can be associated with long-term changes in regulation of the stress hormone cortisol . . .” (Kocvoska et al., 2013). Conversely, we have previously highlighted the pertinent role that *maternal sensitivity* plays in a child developing healthy and secure attachments; interestingly, Kocvoska et al. highlight the association between children raised in institutions and the ‘general suppression of the hypothalamic pituitary axis, as it is argued that such suppression is connected with the inadequate maternal sensitivity that these children experienced (Kocvoska et al., 2013). Research has also revealed that children with an insecure or disorganized attachment are reported to have higher cortisol levels (Nader and Weems, 2011). Furthermore, Carter (2014), conversely highlights the beneficial impact of positive social interactions noted in a study conducted by Koh and Fredrickson in which it was discovered that the experience of ‘higher parasympathetic activity revealed rapid increases in self-described positive emotions and a sense of connectedness (Carter, 2014).

We will end our discussion of the biological functions of Attachment Theory on a bright note. Promisingly, research has revealed that although you cannot remove negative experiences from childhood, such as verbal, emotional abuse, or neglectful caregiving, research has shown that it appears that such caregiving does have a biological impact on the developing child. However, Drury (2012), shares that attachment based therapies have been shown to improve ‘dyadic function’ as well as reduce or ‘normalize cortisol reactivity’. Drury (2012), notes that there is hope for the reparation of early damaging attachments, and explains further that in the process of ‘repairing’ caregiving relationships there is speculation that the HPA axis ‘may be reset as well as ‘other biological processes’ (Drury, 2012).

Attachment in Adulthood and Old Age

In this next section, I would like to transition to a discussion pertaining to Attachment in adulthood particularly in old age as we face the end of life. What I would like to remind the reader of is the enduring quality of attachment that was mentioned at the start of our discussion of this theory and reiterate the significant impact of our early attachments throughout our lives. Moreover, before we proceed with this discussion, let us recall the content from the previously discussed chapter on ‘The Experience of Death’. I once again, encourage the reader to keep this experience of death in mind as we apply the theory of attachment to the process of death and dying.

Changes in Attachment. It is no secret that growing old is a natural process of life. However, the process of aging and the changes that one endures as we begin to age, seems to be a rarely discussed topic. To start off our discussion I would like to highlight one of the changes we must endure throughout our lives as we age and this concerns the changes of one’s attachments. Cicirelli, (2010) points out that the process of aging poses a number of challenges

regarding one's attachments and highlights that such challenges can reduce the number of attachments maintained during the older adult years of one's life. As we age, loss of partners, family member's as well as friends due to death; naturally result in a decrease in the number of attachments an individual has. Declining health, as Cicirelli notes likely serves as a limitation in terms of one's ability to form new relationships or attachments (Cicirelli, 2010). Another potentially contributing factor to the experience of decrease in attachments consists of what is referred to as the *socio-emotional selectivity theory*. For our purposes, we will not go into great detail regarding this theory, however it is important to note the central tenant of this concept. This theory purports that as we age and gain a greater awareness of our own mortality we become more selective in terms of to whom we decide to establish and maintain within our inner relational circle. There is less concern regarding the quantity of relationships and greater value placed upon the quality and intimacy of the relationship. As a result of this selectivity, there is a tendency for the number of individuals in this inner relational circle to decrease (Assache et al., 2013).

If we reflect on the relationships held within our own lives we would likely come to find that there are those person's whom we choose to confide in or turn to for support over others. Cicirelli draws on this truth by highlighting a study conducted, which examined the hierarchy of attachments or relationships, that we possess in our lives. A discussion of the results highlights the experienced shift in our attachments as we enter the final stage of our lives. Cicirelli notes that the predominant attachments of the persons examined in the study consisted of 'adult children, deceased spouse, and God, with living spouses, siblings and friends' (Cicirelli, 2010). To explain further, Cicirelli notes that typically living spouses serve as a primary attachment however, if a spouse dies the individual may experience a shift in their primary attachment as

adult children may now serve and come to fulfill this role. However, a unique quality of attachment which recent research has revealed is that older adults may develop what is termed ‘non-living attachments’ (Assache et al., 2013). Assache et al. explain that although a loved one such as a spouse may no longer be living, one may still hold onto their memory and preserve the lost loved one as a primary attachment. I can recall providing bereavement support to an elderly woman, we will refer to as Mrs. R., whose husband was admitted to the Hospice/Palliative Care Team and remained with the Team for approximately 6 months. Mrs. R. and her husband's attachment was evident in the dedication she displayed in caring for her husband and the time she spent visiting him as the two could be seen sitting with each other daily in the units’ family room. After the death of her husband, Mrs. R. shared that she believed her husband was still with her and that she spoke with him everyday and further that this brought her comfort. I would like to note that Mrs. R. did not display indications of complicated grief or symptoms that would cause concern regarding her mental health. Instead, Mrs. R. exemplifies that although a loved one may no longer be with us, our attachment to them does not necessarily terminate and in fact such ‘non-living’ attachments can fulfill our needs of comfort and support. Research has also indicated that older adults not only utilized deceased spouses as attachment figures but also turn to God as a primary attachment figure. As a part of the aging process and entering into the final stage of one’s life there is a tendency to observe losses pertaining to the self for example, the loss of our physical bodies functioning, or memory impairments. These observations along with experiences of loss of loved ones cause individuals to contemplate their own mortality to a greater extent. The contemplation of our own mortality and realization that we are entering into the final stages of life can cause a number of distressful reactions; anxiety, fear etc. To assist in coping with our feelings of distress at the end of life Cicirelli notes that, “Many people become

more religious in old age, believing that prayer is a way of communicating with an all-knowing, all-caring, and all-powerful God when help is needed” (Cicirelli, 2010). In addition, Granqvist et al., (2012), highlights the role that attachment style may play in one’s utilization of God as an attachment figure. In a study conducted by Granqvist et al., (2012), it was revealed that individuals who identified as having an avoidant attachment style were more likely to avoid seeking God as an attachment figure and what’s more typically held an ‘unloving conception of God.” The figure of God appears to also serve as a ‘non-living’ attachment figure, which would seem to be reliable as well as supportive.

Assache et al. go on to note that the needs of attachment may also be achieved through ‘places’, such as an individual’s location of residence. Assache et al. write, “an overwhelmingly majority of older adults reported to be strongly attached to their place of residence, both their homes and their neighborhood” (Assache et al., 2013). If we think about the place in which we call home, home often times hold valuable and meaningful memories. For example home may be the first place where one moved into with their partner who may now be deceased. Home may be where one raised their children, watched their grandchildren play and grow in, as well as where momentous occasions were held such as birthdays or holiday celebrations. Considering such it becomes difficult to dismiss the meaning and value which one’s home may contain for someone and furthermore, the comfort, sense of security or safety and subsequent attachment that may be attributed to the ‘place’ of home. Assache et al. also note the significance of an additional non-human attachment concerning pets. Netting (1987), also highlights the strong bond that often exists between pet owner and pet and further explains that in old age one may experience the loss of roles such as daughter, wife, sister, as it was previously noted that as one ages individuals may undergo losses of loved one’s through death. However, pet ownership offers the opportunity for

an individual to maintain the role of caregiver and serve as a significant attachment (Netting, 1987). I would like to again share with the reader the case of Mrs. R., who after the death of her husband resided in her home with her pet dog. Although family member's frequently visited Mrs. R., it was her pet dog that Mrs. R. offered, "is a very good companion" and was at her side arguably serving as a valuable and supportive attachment after the death of her husband.

It should be acknowledged as Assache et al. apprise that the 'attachments to place' as well as 'attachments to pets' do not necessarily fit the original mold of attachment figures developed by Bowlby and further warns the reader to keep in mind, "even if the same behavioral system is activated, there may be important differences in the nature of attachment to place and to real attachment figures as current finding show that the latter seem to fulfill a broader set of attachment functions" (Assache et al., 2013).

Attachment and Medicalized Care

We have spoken of attachment changes that occur in old age, now I would like to discuss the role of an individual's attachment style and its impact upon an individual's reception of care within a medicalized setting. The diagnosis of a terminal illness at any age is not an easily accepted fate. There are a number of emotions that may accompany the realization that one's life is to come to a close. Tan et al., (2005) share that when an individual learns of such a distressful prognosis, attachment behaviors are called upon to help the individual in coping with such news. What's more, as the individual's illness begins to progress and symptoms present to a greater extent, he or she may require greater care and support. As a result, often times this increased need for care requires the individual to seek long-term care, or Hospice/Palliative Care. Once admitted to a Hospice/Care Facility the individual goes through a period of adjustment as they acclimate themselves to a new environment. They must become acclimated to a new routine

consisting of required procedures [e.g. blood pressure tests, skin integrity assessments ECT]. The individual must also adjust to new persons in their life such as doctors, nurses, social workers as well as a potentially new set of peers.

In recognizing the distress associated with the prognosis of a terminal illness, in combination with the transitional experience of having to move from one's home [especially considering the previously noted 'non- living' attachment role that homes serve for many elderly persons] into a Hospice/Palliative care facility, it seems natural that during such a time of distress and transition that an individual's 'attachment behaviors' would be activated. Such behaviors might result in inviting or seeking out supports from significant others or conversely, reserve seeking support from others and instead turning to the self to fulfill attachment needs. If we recall from our previous discussion regarding the activation of proximity seeking behaviors in infancy, when a child experiences distress [during which he/she seeks out the primary caregiver] such attachment behaviors are activated in adulthood as well. However, the primary caregiver may no longer be the parent but rather a spouse, adult child and within a medical care facility doctors/nurses/social workers etc. Tan et al., share that an individual's attachment style impacts whether positively or negatively, the individuals "capacity to be soothed by or accept help from health care professionals"(Tan et al., 2005). In acknowledging this, once entering a Hospice/Palliative care facility [despite the extent of the illness's progression], an individual loses a degree of independence and in turn experiences an increase in dependence on others. This increased need to rely on or depend on others can greatly impact the individual's quality of life. What's more Hunter and Maunder, (2001) explain that hospitalization can trigger 'attachment stresses' such as "separation from significant others, the obligation such as, having to trust strangers [for example medical personal], and the need to negotiate a new *sick role*" (Hunter &

Maunder, 2001). I would also like to emphasize the significance of *trust* during this particularly vulnerable time of transition. The terminally ill individual is required to enter into a new environment with new individuals of whom he or she must now rely on to meet their needs. The development of trust between patient and treatment team is of great importance, especially if we consider the relationship between physician and patient as Hooper et al. (2012) note, “the criticality of the physician-patient relationship cannot be overstated. In some ways without a warm and trusting physician-patient relationship, effective medical treatments cannot take place”(Hooper et al., 2012). Furthermore Hooper et al., (2012) argue that considering the patient’s attachment style assists in facilitating the development of a relationship between patient and physician so as to provide care in accordance with the individual’s attachment style. (Hooper et al. 2012). Also, considering the fact that for many individuals entering a Hospice/Palliative Care facility, they have lost the majority of their family members and friends, additionally the team of nurses doctors, social workers ect. are the one’s spending a significant amount of time with the dying individual. As a result of this, there is a tendency for the Hospice/Palliative Care Team to become the individuals surrogate family. Therefore, the nature of the relationships developed between staff and the dying individual, greatly impacts their end of life experience. These relationships also come into play when we consider the individuals style of attachment.

Attachments in Adulthood. Here we draw on the question of how the earlier defined attachment styles; *secure, anxious-avoidant, resistant-ambivalent* as well as, *disorganized* developed at the beginning of life then impacts the individual at the end of life. First, let us note that there are different models to refer to regarding adult attachment style and determining which model to follow can be rather conflicting as each model contains valuable insight. Hunter et al. explain two such models; the first is referred to as a ‘three-group typology’ consisting of the

following styles, *secure*, *anxious-ambivalent*, and *avoidant*. The second is a ‘four-group typology’ containing the styles of *secure*, *preoccupied*, *dismissing-avoidant* or *fearful-avoidant* (Hunter et al., 2005). For our purposes we will not exclusively adhere to one typology of attachment, instead we will incorporate components of these attachment styles as they arise, so as not to limit the discussion.

Furthermore, despite the varying models or typologies of adult attachment style, the general consensus of research contends that although attachment styles developed in early childhood possess an enduring quality and impacts us throughout our lives, attachment styles developed in childhood are not necessarily set in stone (Hooper et al., 2012). In fact, as was previously noted, attachment styles endure changes as we age and mature. Our discussion on ‘Internal Working Models’ highlights an example of such changes. To reiterate, as we mature cognitively, our internalized schemas grow in complexity and sophistication resulting in alterations to our attachment styles. Let us bare these changes in mind as we enter into a discussion regarding the impact adult attachment styles within a medicalized setting.

To assist in connecting the reader to the terminally ill individual and their experience, allow me to draw the reader into a Hospice/Palliative Care setting; imagine the medicinal scent in the air, glossy linoleum floors, passing visiting family members in the hall, nurses in scrubs pushing medicine carts, cumbersome white linen hospital beds, and lastly, the dying individual resting in their bed; perhaps peering out the window while listening to classical music or catching a favorite western from childhood on TV.

Secure Attachment. Now that we have an image developed regarding an example of a Hospice/Palliative Care setting, let us discuss the experience of a *securely* attached individual within the medicalized setting. The securely attached individual having developed early on, a

trust that others can and will support them in times of distress or need, believes that the medical team is trustworthy as well and will support him or her as their illness progresses. (Hunter & Maunder, 2001). Let us briefly turn to McWilliams (2004), who creatively provides us with a ‘first person’ description of the secure attachment style.

It is easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don’t worry about being alone or having others not accept me. I can take risks.

The secure individual recognizes themselves as someone who is ‘worthy of attention’ (Assache et al., 2013) and does not minimize nor exaggerate the experienced distress but rather responds to it with a sense of confidence by “acknowledging it [and] enacting instrumental constructive actions and turning to others for emotional and instrumental support” (Simpson & Rholes, 1998). This individual learned early on that experiences of distress can be tolerated and managed. Therefore, although this person experiences natural reactions to their condition, they are not consumed by nor engrossed in their natural emotional responses. Instead they present with a degree of ‘adequate resiliency’ (Simpson & Rholes, 1998; Hunter & Maunder, 2001). Furthermore, the secure individual possess the capacity to express the emotional reactions they experience throughout their end of life journey in a way that does not push away caregivers nor isolate themselves from said caregivers. In connection with ability to express themselves the individual is comprised with a “strong reflective ability, i.e., an ability to think and feel about not only their illness, but also the effect it has on significant others and staff”(Hunter & Maunder, 2001). All in all the secure individual is typically a client or patient within the medicalized setting who the Hospice Team can effectively communicate with regarding their needs and wishes to fulfill the Hospice philosophy of quality of life at the end of life. Hunter & Maunder

(2001), highlight that this individual ‘may be in difficult straits but they are not difficult to help, even when one feels for their misfortune.’ While working with secure individuals at the end of their life, their ability to openly express their emotions assists in developing a positive relationship with supports such as social workers. Such support as Loetz et al., (2013), explains typically does not entail increased psychosocial support, secure individuals are generally adequately supported with ‘basic support for example, by helping them in structuring their remaining time or by giving them spiritual support’ (Loetz et al., 2013).

Next, let us open a discussion regarding insecure attachment styles. In general, persons designated as having an insecure style of attachment have not experienced caregiving and support that reliably and regularly fulfilled their attachment needs (Tan et al., 2005). As a result of inconsistent caregiver support such individuals in adulthood, tend to suffer as a result in a number of ways. Hooper et al., 2012 point out that insecure individuals are more likely to be “ill equipped to regulate emotions, tend to have limited coping strategies and may resist treatment recommendations put forward by health care providers and physicians.” Additionally, insecure attachments amongst older adults are associated with the utilization of defensive coping mechanisms as well as consisting of ‘an external locus of control’ (Van Assache et al., 2013). We will touch upon the impact of such limited as wells as defensive coping mechanisms as we transition to a discussion pertaining specific insecure attachments.

Insecure-Dismissing Style. Under the insecure branch of attachment lies the *insecure-dismissing style* [which is also labeled as avoidant attachment]. Individuals, who have developed this attachment, have experienced caregiving that was ‘consistently unresponsive’ (Hooper et al., 2012). Therefore, dismissively attached individuals have developed a deeply rooted mistrust of others and as a result do not generally seek support within interpersonal relationships, because it

is not believed that others can relieve their distress. McWilliams (2004), provides the reader with an internal narrative of this attachment style,

I am comfortable without close emotional relationships. It is very important for me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Instead of relying on others, dismissive attachment emphasizes a strong reliance on the self. As a result, this attachment can be characterized by its autonomous outlook in which the self is seen positively and as holding worth because it is the self that serves to relieve distress rather than relying on others to do so (Tan et al., 2005; Hooper et al., 2012). However, as Tan et al., (2005), explains there is a cost to this reliance on the self, as such individuals typically do not develop close intimate relationships as the prospect of relying on others stirs a terrifying sense, because others cannot be trusted. Furthermore, individuals with a dismissive attachment typically do their best in refraining from exhibiting emotional expressions such as fear, sadness or anger regarding their internal distress. Dismissive individuals see no function or purpose in emotional expression of distress, as they hold no expectations that others will respond to such expressions (Tan et al., 2005). What's more the dismissive individual will typically "downplay their symptoms and the severity of their illness or do not report symptoms at all as a way to reinforce their self-sufficiency and avoid a relationship with a caregiver or health care provider" (Hooper et al., 2012). Additionally, dismissive individuals may also exhibit confusing attachment patterns as the individual may call for nurses to provide assistance but may conversely assert their independence and ability to care for themselves (Loetz et al., 2013). This can present as confusing and frustrating for nursing staff as it may not be clear what remedy the individual requires especially since expression of dialogue and symptoms are not readily expressed.

Case of Ms. B and Dismissive Attachment.

Let us briefly highlight the case of Ms. B as shared by Tan et al. (2005), who was designated as having a dismissive attachment style. Ms. B was a 47-year-old female diagnosed with ovarian cancer and was admitted into a palliative care ward with a small bowel obstruction. I would like to acknowledge that our focus has predominately been on elderly adults, however, despite Ms. B's relatively young age the case of Ms. B illustrates the impact of attachment behaviors within a Hospice/Palliative Care setting. Ms. B presented as an independent, self-reliant woman. She was described as an individual who predominately focused on her career, which was prioritized over relationships with others. Ms. B despite the noted non-significance of interpersonal relationships remained in a relationship with a male for approximately 10 years. However, Ms. B ended this interaction stating she, *no longer had a need for such things*. Tan et al., (2005), highlight that Ms. B conveyed a reluctance to depend on the palliative care team for assistance with for example pain medication by an expressed refusal to accept an increase in pain medication. Tan et al., share that Ms. B expression that *no technology existed to control her pain* exemplifies her distrust in the team to alleviate her distress. It is also noted that such refusal of reception of pain medication also appeared to communicate 'contradictory signals to staff' as such refusal also seemed to indicate her desire to remain "alert and vigilant in relationship to others." Ms. B received individual therapy, which allowed for her to acknowledge, "she valued human relationships more than she had recognized, although she had been very fearful of disappointment". The counseling process, which acknowledged Ms. B's dismissive attachment style, brought about positive changes in her medicalized care experience. For example Ms. B was able to communicate her needs and wishes to the clinical staff and even agreed to increases

in her pain medication to alleviate escalating symptoms of pain. The Palliative care team also acknowledged Ms. B's dismissive attachment styles during team meetings that strategized methods to improve her care. By recognizing Ms. B's need for autonomy and control, the team worked to allow Ms. B to feel more involved in her own care. After several months, Ms. B died "without distress and with her mother and friends at her side"(Tan et al., 2005).

When working with individuals who present with a dismissive attachment style Loetz et al., (2013), further recommend that, "A therapeutic intervention should focus on suppressed feelings, for example, by mirroring latent emotions." This arguably, allows the dismissive individual to explore their hidden, unexpressed emotions. Furthermore, by allowing the individual to participate in medical decisions regarding their care, this grants the individual a sense of autonomy, and validates the autonomous mode of being that they have utilized to cope with distress and soothe themselves.

Insecure pre-occupied. Much like the childhood experiences of dismissive children individuals who develop a *pre-occupied* attachment style did not receive consistent support from their caregivers and additionally they often endured repeated rejection. [This attachment style also corresponds with the label of insecure-anxious attachment.] Let us once again turn to McWilliams for the internal narrative of this attachment style,

I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like to. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

Pre-occupied attachment is defined by an individual who has a 'negative view' of themselves resulting in low self-esteem (Hooper et. al. 2012; Tan et al., 2005) They have little

confidence in themselves and their ability to alleviate or soothe themselves during times of distress. Despite their negative perception of self they have a positive view of others. Hunter and Maunder (2001) explain that the pre-occupied internal working model fosters the belief that by continuously signaling distress the individual will receive attention and support from others. The pre-occupied individual then as Hunter and Maunder (2001), highlight does feel some degree of comfort when a clinical team member such as the doctor is present at the bedside; however, this feeling of security is not maintained when the doctor has physically left the individual. As a result of the individuals need to constantly signal for assistance the pre-occupied individual develops the reputation amongst the clinical staff as being the 'dependent' as well as 'clingy' patient (Tan et al., 2005; Hunter & Maunder, 2001). However, once it becomes apparent to the Hospice/Palliative staff that the individuals distress signals are not eminent the staff recognizes such patterns and distress signals must be modified to prevent the caregiver from leaving the individual. Hunter & Maunder (2001) note that, "to keep the caregiver at the bedside, new strategies are employed, ranging from flattery, through seductive behaviors, to a more frank and desperate plea for proximity"(Hunter & Maunder, 2001). However, despite the pre-occupied individuals attempts to achieve proximity to for example nursing staff they are never adequately soothed therefore, they persist in a state of heightened anxiety. The vicious cycle of signaling distress to caregivers, receiving assistance, and not being adequately soothed continuously persists. The 'clingy' nature of the pre-occupied individual can be exhausting and off-putting to staff, as keeping up with the continual need to be soothed can be a draining process. Hooper et al., give notice to the requirement of the physician to be aware of the nature of this individuals' attachment style so that the physician can prevent themselves from expressing or conveying their exhausted or fatigued reactions to the patient (Hooper et al., 2013). This sentiment can be further

extended to therapists working with the pre-occupied individual as well, as the needy and clingy nature of the individual is likely to contribute to negative countertransference. Furthermore, to help ensure quality of life within the medical setting Hunter & Maunder (2001), argue that, “clear limits are required with the delivery of good, empathic attention within those limits.” Hunter & Maunder go on to expand on this idea of setting ‘clear limits’ by explaining that an appointment schedule should be created for the individual that would designate times for the Hospice/Palliative care team members, such as nurses to regularly meet with the individual. This approach is designed to offer the patient predictable and reliant support from the team before the individual feels the need to send out distress signals (Hunter & Maunder, 2001) Lastly, Hunter & Maunder recommend that pre-occupied individuals would benefit from having what is referred to as an “external regulator”. The role of the “external regulator” would be to abide by a reliably consistent appointment schedule, as well as ‘accepting rather than confronting the individuals dependence’ (Hunter & Maunder, 2001). What’s more, the therapist assists the individual with the intense anxiety that is experienced by “reframing anxiety about procedures and events as understandable and manageable” (Hunter & Maunder, 2001)

Insecure fearful attachment. Individuals who develop a *fearful* style of attachment have typically endured caregiving that is characterized with a cruel, ‘harsh’ and ‘rejecting’ nature (Hooper et al., 2013). McWilliams (2004), once more provides the internal narrative that characterizes a fearful attachment,

I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to others

Fearfully attached individuals have a desire or longing to engage with and become close with others. However, they are fearful of doing so due to a fear that others will reject them as a result of earlier negative interactions with caregivers (Van Assche et al., 2013; Hooper et al., 2012). Individuals with a fearful attachment may desire assistance from staff of the Hospice/Palliative care team however; they may experience anxiety in seeking such support. As a result such individuals may present with a degree of ‘avoidance’ and ‘self-sufficiency’ (Tan et al., 2005). Furthermore, Tan et al., (2004), adds that individuals of a fearful attachment may develop a sense of trust with the clinical team if they experience reliable and consistent care.

Case of Mr. C, Fearful Attachment. To help expand our understanding of how this attachment style is exhibited within a palliative care setting, let us turn our discussion to a case review of an individual named Mr. C. First I would like to note that this is a case of a younger individual however, during my experience in the Hospice Care Facility I did not encounter an individual characterized with a fearful attachment. Tan et al., 2005, share that Mr. C was a 55-year-old male diagnosed with metastatic lung cancer. Mr. C began to receive assistance from the palliative care team due to a referral of a marital assessment to assist his wife in coping with the progression of his illness. Mr. C asserted that he did not need support from others and instead contended that it was his wife who was in need of assistance, Mr. C adamantly portrayed himself as a strong and independent individual and stated regarding his perception of his prognosis, “as for me, I don’t need help. I’m just dying” (Tan et al., 2005). It is further shared, that Mr. C ‘relied enormously on his wife’, and that when she left the house and asked her adult children to assist their father, Mr. C became aggravated by this asserting that “he didn’t need a babysitter”. However, as Mr. C’s needs increased his wife began to ‘resent his neediness’ and took to gambling as a means to separate herself and cope with her internal struggle. Therapeutic work

with Mr. C involved assistance in expressing his emotions regarding his prognosis. This was difficult for Mr. C as with a fearful attachment style expressing his internal emotions to others was not a familiar process. However, as work with his therapist progressed he displayed an ability to share his emotions regarding his terminal illness rather than deflecting the need for assistance onto his wife. Tan et al., 2005 highlight that individuals with a fearful attachment style generally down play their internal emotions as Mr. C did at the expense of their own emotional well-being. Furthermore, the therapist must proceed with the awareness that bringing insight and acknowledgment regarding the needs of a fearfully attached individual 'may reactivate concerns about loss or rejection' as a result the individual is likely to respond by utilizing defensive coping strategies such as 'reject[ing] help despite evident need and desire for support' (Tan et al., 2005). To counteract this 'rejection of help' the therapist must be willing to continue to provide support, acknowledging that although the individual rejects help he or she internally desires the support (Tan et al., 2005).

We have just reviewed four attachment styles identified in adulthood. In this discussion we find the relevance in considering the dying individuals style of attachment. If we bring into consideration the way an individual copes with and responds to their end of life prognosis, we can work to improve their end of life experience by catering to their attachment style. We can gain insight into the exhibited behaviors at the end of life by applying the theory of attachment. Take for example the individual who continuously calls for nursing staff. Rather than allowing ourselves to become annoyed or exhausted by this patient and feed into a negative countertransference, we can assess their attachment style. In this scenario we would respect their pre-occupied classification and strategize to alleviate the expressed distress according to this attachment style.

At the end of life the individual becomes vulnerable due to the sheer experience of pain, physical deterioration as well as the emotional underpinnings of the end of life experience. Much like at the beginning of our lives, during infancy when we are dependent upon the caregiver, at the completion of the circle of life we once again return to this dependent state. It is through the acknowledgement of one's attachment style that we can strive to fulfill the psychosocial, as well as medical needs of the individual at the end of life.

Attachment and Culture

At this point I would like to briefly discuss the role of culture and ethnicity with regards to the theory of attachment. This section is not meant to be an exhaustive review regarding the literature on culture and ethnicity in terms of attachment. Instead my goal in the following discussion is to acknowledge the cultural and ethnic diversity that exists between human beings and furthermore recognize, that we cannot simply assume that the proposed theory is a 'one size fits all' account. It is important to account for the cultural and ethnic implications that play a role in shaping and defining one's development of attachment.

With that being said let us turn to the discourse that currently pervades the topic of Attachment and its 'universal validity'. Agishtein & Brumbaugh (2013), poignantly highlight that the theory of Attachment was predominately developed and researched through a white 'middle-class' and westernized lens (Agishtein & Brumbaugh 2013). This of course raises the concern of this theories applicability to individuals of color or individuals raised in non-western cultures and traditions. Furthermore, Agishtein and Brumbaugh (2013), argue that culture including 'environmental and social factors' plays a significant role in the ways in which caregivers raise their children and this subsequently impacts what the child internalizes and therefore the style of attachment developed.

An additional argument pertains to the previously discussed concept of maternal sensitivity. Huang et al., discuss the ‘cultural validity’ of this concept and note that there is no conclusive agreement however, there is evidence to support the argument of maternal sensitivities effect across cultures. It is further noted that studies amongst Colombian as well as the Dogon of Mali reveal that maternal sensitivity does impact the child’s developed attachment style. However, it is also highlighted that research also purports the argument that maternal sensitivity is ‘culturally constructed’ (Huang et. al., 2010).

It is also interesting to note that research studying attachment on a global scale claims that the attachment styles of, secure, avoidant and anxious have been observed worldwide. It is further elaborated that cultures favoring a collectivist perspective have an increased prevalence of anxious attachment style. The rationale behind the increase in anxious attachment theorizes that collectivistic cultures emphasize ‘psychological dependence’ which increases the need sensed need to depend on attachments therefore increasing the characteristic of anxiety (Agishtein & Brumbaugh 2013). Lastly, although there is considerable debate regarding the universal validity of attachment is it generally proposed that although culture and ethnicity may result in culturally specific internalizations and therefore differing ‘attachment behaviors’ Huang et. al., 2010 argue that ‘basic patterns of attachment and the predominance of secure attachment are found in disparate cultures.’

CHAPTER V

Existential Theory

Life has to be given meaning because of the obvious fact that it has no meaning

Henry Miller

In the following chapter we will open a discussion pertaining to Existential Theory. Why might we venture to explore and take this approach in assisting persons who are facing their death? To assist in justifying this approach, I shall respond with the argument; that we spend our lives trying to make meaning of the events, tragedies, coincidences etc. in our lives. We live with the hope that our existence is valuable that our existence is worth something. We constantly search for purpose and meaning. Who among us can say that they have not pondered the meaning of their own existence or questioned the purpose of their being? I set forth this theory as an approach to aiding the dying individual in their experience of a dignified and good death, because the presence and occurrence of death threatens our very existence. Therefore, it seems a natural fit that as one enters into the last stage of their life, that there is a heightened awareness of one's own existence as well as conversely, impermanence. Such an approach aims to alleviate the distress or suffering that accompanies the realization that one is reaching the end of their life, with a theory that upholds the value of our existence and the search for life's meaning.

Also it seems appropriate that I should forewarn the reader that the contemplation of this theory is likely to stir up one's own existential ponderings and in the process, may lead to varying reactions such as fear, or even anxiety. I bring this forward with the reader as I have attempted to emphasize throughout the discussion of death, that this is a process that none of us are immune from; a universal truth of life that we all share. Although there may be a degree of

distance between death and the words written on these pages, as the author, I have found this distance to at times diminish. As a result I have realized my own reluctance in traveling down this exploration of the end of life process due to my own fears and experience of ‘death anxiety’. Therefore, I encourage the reader to recognize that they too may have such an experience. Lastly, although we may have this experience, Zafirides et al., reminds us that the exploration of our ‘human condition’ “need not be an exercise filled with dread”, and furthermore adds a quote from Irvin Yalom [existential contributor to be discussed], “ the confrontation with the givens of existence is painful but ultimately healing” (Zafirides et al., 2013).

In the following discussion, we will start with a review of what Existential Theory is in the process I will illustrate the various components that encompass Existential Theory. Then we will enter into a discussion pertaining to the history of this theory with the hope that this will provide the reader with a greater understanding of the theory. Afterwards, a discussion pertaining to the theme of finding meaning will be ventured into. Lastly, we will discuss Existential Theory within the therapeutic context.

Defining Existential Theory

If we were to categorize the theory of existentialism it would fall under the umbrella of *humanistic psychology*. This branch of psychology upholds four principles as Greenberg & Rice (1997), highlight. The first consisting of the ‘commitment to a phenomenological approach’ which contends that the human with her unique quality of consciousness, is capable of self-reflection that is honored as valuable in understanding exhibited behaviors. The second principle consists of the conviction that humans ‘strive toward growth and development rather than merely toward maintenance of stability’. The third principle affirms that we are ‘self-determining’ individuals, by that it is meant that we are capable of choice and not bound by occurrences from

our 'past' or 'environment'. Fourth, contains the concept of 'personcenterdness' in which it is viewed that each individual and their unique being should be respected and held with value (Greenberg & Rice, 1997). As a result of residing under the branch of humanistic psychology, Existential Theory, too, encompasses these held values.

Dasein. To help in understanding this theory let us break down what is meant by the term existential. Truscott (2010) explains that the concept of existential was birthed from the "Latin root *existere*, meaning to stand forth, become or exist" (Truscott, 2010). Here we draw on one of the important pieces to include when discussing the components of existential theory and this consists of the concept of Dasein. This is a term that refers to our human way of 'being', our very way of 'existing' (Wheeler, 2013). Dasein is a term that was conceptualized by the European or Continental philosopher Martin Heidegger (works focused on 'phenomenology and existentialism') and is a concept one will see utilized predominately amongst Continental philosophers. What is important for us to take from the concept of Dasein is that it refers to the unique way of human *being*. Wheeler (2013), warns the reader that Dasein should not be interpreted as the human or the 'biological being'. Rather, Dasein is the act of *being* that is capable of contemplating and questioning what it means to exist. Furthermore, because we have the capacity to contemplate our *being* in this world we have a sense of choice in how to actually *be* in this world (Wheeler, 2013).

The concept of Dasein assists in our understanding of Existential theory as a 'philosophical approach' to therapy, that encompasses the potent questions we ask ourselves regarding existence, as well as the meaning found in life and death (Jacobsen, 2007). As the philosopher Georg Hans Gadamer argued in his studies of Hermeneutics, "the very being of the human being, . . . is in fact an *understanding* being and an *interpreting* being"(Vilhauer, 2010).

Jacobson (2007) further explains that as a result of our composition as sentient humans with the capacity to ‘reflect’ upon and contemplate our *being* in this world, we all [regardless of gender, ethnicity ECT] share in this contemplative experience.

‘Existentials’. What’s more, there are central themes or as Jacobson refers to as ‘life conditions’ or ‘existentials’ that are universally pondered amongst humans (Jacobson, 2007). Irvin Yalom is a well-known existential philosopher who amongst his many contributions to this theory, wrote on ‘four basic existential conditions’. It is these four conditions that set the context or ‘frame’ for which an individual lives their life (Jacobsen, 2007). The first of these conditions entails (1) *the reality that ‘we are going to die’*. As humans we have the ability to think about this universal truth and the contemplation of this truth may result in fear and/or anxiety of dying, as we are beings who strive to maintain our existence (2) *‘in decisive moments we are alone’*, [Zafirdes et al. also refers to this as ‘existential isolation’], although we desire to achieve closeness and companionship with others we are each separate beings who are alone during birth and death. Furthermore, our concerns of being alone stem from our need to be seen by others and therefore feel reaffirmed in our existence (3) *‘we have the freedom to choose our life’*, we possess the ability of choice and as a result it is argued that we are free beings. What’s more the freedom we hold obliges us to be responsible for our chosen actions and therefore the lives we lead. I would like to acknowledge a contention held regarding this particular existential. As was previously highlighted within the ‘Phenomenon of Death’ chapter, we are not all dealt equal playing cards in the game of life. As a result, arguably the choices that we make are in part influenced by institutionalized racism, ethnic/racial oppression, social class/economic status as well as poverty. (4) *‘we struggle to create meaning in a world which our life meaning is not given in advance’*. As a result of not having a script to follow that grants one meaning and

purpose, we must seek and discover meaning within and for ourselves. However, the search to find meaning can create anxiety and fear in not discovering one's meaning in this world.

(Jacobson, 2007; Truscott, 2010; Zafirdess et al., 2013).

Authenticity. We have just noted that according to existential theory we have the capacity to make choices in our lives and connected with this 'existential condition' is an additional component of Existential Theory that we must address concerning the notion of *authenticity*.

What does it mean to live with *authenticity*? Jacobsen (2007), explains that to live an authentic life the individual must live in accordance with their own set of morals, values and convictions. This does not mean that each of us lives according to the same guiding set of principles. Rather as unique individualistic beings we embrace our own guiding set of principles to live by. What's more, Jacobsen (2007) shares the thoughts of theologian and philosopher John Macquarrie who supported the idea that we must each "mould the self into his or her own image"(Jacobson, 2007). This 'moulding' of self is also referred to by Miars (2002) as 'autonomous self-creation' and is achieved by 'exercis[ing] our freedom' as well as 'self-determination', meaning we choose what resonates with our own guiding principles or 'deep convictions'. Otherwise if we allow ourselves to be guided by or 'moulded' into the 'prevailing tastes and standards' that do not fit with what resonates with our unique individual self, than we are living an inauthentic life. We can view living an authentic life as possessing a profound self-awareness. This is an awareness in which we live our lives "appreciating that we are finite and time is limited . . ." (Truscott, 2010). Irvin Yalom provides a profound perspective on the reality of possessing self-awareness with the following quote from his text titled, *Starring at the Sun overcoming the terror of death*;

Self-awareness is a supreme gift, a treasure as precious as life. This is what makes us human. But it comes with a costly price: the wound of mortality. Our existence is forever shadowed by the knowledge that we will grow, blossom, and inevitably, diminish and die (Yalom, 2009).

Furthermore it is our *responsibility* to exercise our freedom and choose to live an authentic life (Jacobsen, 2007). In addition, Truscott reminds us that by accepting and embracing this responsibility, “we are free to choose how we live and that we are not the product of victimization, impulses, patterns of reinforcement, or poor parenting”(Truscott, 2010). Miars adds that in becoming more authentic we “can achieve a healthier relationship with the world” (Miars, 2002). I would also like to highlight an additional perspective on the concept of authenticity that Jacobson, (2007) shares with the reader from moral philosopher Mary Warnock. Mary Warnock reasons that to live authentically we must each “fulfill . . . [our] own potential and possibilities” (Jacobson, 2007). The endeavor of fulfilling one’s potential, is a concept that dates back to ancient Greece and was written upon by the philosopher Aristotle. Aristotle put forth the idea that humans must live up to their potential and fulfill their final end or ‘telos’. The example of an acorn is used to illustrate this assertion as the seed is planted into the ground and is set to fulfill its ‘telos’ of growing into an acorn tree. Interestingly, Aristotles’ writings within the *Metaphysicas* as well as *Nicomachean Ethics* reflect our earlier discussions pertaining to us as contemplative beings. Aristotle too asserts that we humans have the choice to seek and fulfill our potential and this is exercised through our contemplative ability. It is interesting to consider that this existential theme has been contemplated by humanity for thousands of years and asserts its universal quality (Johnson, 2005; Aristotle, and McKeon, 1941).

We are not perfect beings, therefore upholding and living by our guiding principles is not always an easily achieved feat or one that we always live by. Jacobsen (2007), shares that we may not always live authentically but rather that there may be moments or even periods in our lives when ‘we live in a slightly superficial way for years’ (Jacobsen, 2007). However, this does not mean that we should feel shame or be viewed as *bad* for not always living authentically. We sometimes get caught up in the daily currents of life and our awareness of authenticity fades to the background and we in the process end up “forgetting the meaning of it all” (Jacobsen, 2007). However, there is always the potential and opportunity for us to ‘awaken’ from a state of ‘superficial’ living and exist authentically. Jacobsen writes that this *awakening* typically occurs after a ‘difficult life experience’. This brings the individual to develop a sense of ‘resoluteness’ in which the individual experiences “decisiveness, firmness and determination” (Jacobsen, 2007).

Being-Thrown. An additional component of existential theory that we will briefly highlight consists of the concept of *being-thrown*. This concept has a very strange title to it however; let us explore the significance of this concept. Stolorow (2007) explains that Dasien, our existence or being “exists as thrown, Being *toward* its end, death” (Stolorow, 2007). Here the works of Heidegger are greatly drawn upon as under the existential approach, death is not seen as an abstract or *othered* phenomenon, but rather discerned as a reality of our *being*. Due to the nature of our *being*, death “is a distinctive possibility into which we have been thrown” (Stolorow, 2007). The experience of *being-thrown* as Bauman explains occurs when we are forced to contemplate and realize the finite, mortal nature of our being. For example, “this is the case when an unexpected event (a tragedy, an accident, a crisis, or even a sudden insight) occurs, and we may wish to deny its reality or flee” (Bauman, 1998). Certainly, as the reader can

imagine this experience of *being-thrown* as Bauman (1998), highlights causes the individual to experience ‘distress’, ‘anxiety’ or even ‘guilt’

History of Existential Theory

At this point I would like to discuss with the reader the history of Existential Theory as this review will help in further understanding this theory. Literature frequently reports Soren Kierkegaard (1813-1855) as being the father of existential philosophy (Truscott, 2010). Kierkegaard was known to be ‘a religious rebel against systems of speculative thought’. (Glendinning, 1999). His works were developed in an era during which religious dogma reigned, therefore his works presented as being controversial. Kierkegaard emphasized the significance of not conforming to ‘convention’ but rather embracing the individualistic ‘human experience’, which is composed of our incessant quest to find meaning (Truscott, 2010).

Switching gears from the realm of philosophy to that of psychology we find that existential theory began to develop in Europe during the tumultuous and uncertain period of WWII and onward into the 1950’s (Truscott, 2010). Expanding on the era in which this theory was developed Bauman (1998) highlighted that this was a time period when a) the trend in scientific development was to ‘deny subjective human experience’ b) the growth in ‘industrialization and urbanization of society separated people from those activities that had provided direction and meaning in life’. Further to this, Karl Marx wrote [see Karl Marx’ and Friedrich Engels Economic and Philosophic Manuscripts of 1844] in response to the growing class separation [bourgeoisie and proletariat] of the laborer who must work to survive; such an existence resulted in the alienation of the individual from their world c) the occurrence of two tragic world wars all of which greatly contributed to “a pervasive sense of alienation and meaninglessness (Bauman, 1998). In addition, Existential Theory developed in a time period

when Freud's drive theory dominantly reigned, however there were a growing number of individuals within the field who were becoming 'dissatisfied' with this path to therapy. Ludwig Binswanger and Medard Boss were two such therapists who saw Freud's theoretical position as well as their peers' approaches as "not seeing patients for who they really were and instead were seeing a projection of their theories about them" (Truscott, 2010). As a result of this dissatisfaction Binswanger and Boss worked to emphasize the significance and requirement of the therapist to acknowledge and hold the 'individual's experience' as possessing value and worth, rather than the therapist dismissing this by placing their own 'presuppositions' upon the client. Greenberg and Rice (1997) explain that Binswanger and Boss broke their thinking away from Freud's drive theory and turned to Heidegger and his concept of Dasein [as previously noted as our *being*]. In utilizing the concept of Dasein they established what is termed Daseinanalyse, which was an approach to therapy that 'emphasized the human capacity for giving meaning to existence,' (Greenberg and Rice, 1997). It was their support of existential theory that helped it to gain recognition amongst other therapists of the time (Truscott, 2010).

Literature reveals that within the realm of psychology there is no one particular author who is credited with the development of Existential Theory. Rather there are a number of individuals that are noted as contributing to Existential Theories development. Moreover, it is evident that each contributor's piece to the growth of this theory stems from a philosophical root. As noted prior, Binswanger and Boss played their role in acknowledging the significance of the 'individual's experience' in therapy. A review of the literature reveals additional contributors such as Irvin Yalom, Rollo May and Victor Frankl whose names are prominently found within the writings of Existential Theory. Let us briefly expand on the contributions of each of these authors. We will start with Rollo May (1909-1994) who is typically credited with bringing

Existential therapy to the United States. Truscott (2010) explains that it was May who introduced America to the previously noted existential authors Binswanger and Boss. May also experienced his own existential crises while working as an English teacher. During this time period he suffered from a 'nervous breakdown'. This experience put him on the path to studying psychotherapy and later moved to the U.S. where he found himself to be disenchanted with psychology's behavioral approach and instead chose to study with philosopher-Theologian Paul Tillich. While working towards his doctorate May was diagnosed with tuberculosis and faced his own personal existential crisis as he was faced with his own mortality. It is noted that the experience of this illness contributed to May's understanding of existential theory he 'found meaning in his suffering' (Truscott, 2010). Irvin Yalom (1931-present) [who was briefly noted earlier in the discussion] is well known for his writings such as *Existential Psychotherapy* (1980) (Truscott, 2010) as well as additional works on death, which as Hoffman (2012) notes, "has [allowed Yalom to] become one of the most influential voices on death". Yalom has emphasized a critical piece to working with individuals and the phenomenon of death and that is that in order for the therapist to effectively assist the client in their death concerns, the therapist must themselves explore and face their own mortality. This also leads us to note another aspect of Yalom's existential approach, which consists of his upholding the client and therapist relationship as the heart of effective therapy (Hoffman, 2012). However, for therapists who strictly enforce the role of boundaries within a therapeutic context may find within Yalom's existential approach a struggle to maintain and emphasize boundaries between client and therapist. For example, one can find this struggle of boundaries regarding case examples within Yalom's influential text, *Staring at the Sun overcoming the terror of death*. Lastly, we will briefly note Viktor Frankl (1905-1997), who as well has greatly added to the existential approach

to therapy. Frankl expanded on this approach by adding what is termed Logotherapy. Frankl explains that this is a method to therapy that emphasizes “the meaning of human existence as well as on man’s [as well as woman’s] search for such a meaning . . . this striving to find a meaning in one’s life is the primary motivational force in man [and woman]” (Frankl, 1984) Much of Frankl’s work was influenced by his own experience within a concentration camp and his journey of survival. Frankl’s grappling’s with existential concerns are tragically and remarkably captured in his well-known text titled *Man’s Search for Meaning*.

Finding Meaning

We have just noted the historical background regarding Existential Theory and the contributors to this theory. At this point I would like to transition from the past to a reflection upon Terror Management Theory. We previously discussed what it means to live an authentic life, and this requires that we hold an awareness of our finite existence. Part of the process of honoring our responsibility to live authentically entails the process of finding meaning for ourselves. However, here again we find the role of one of the four ‘existentials’ or ‘existential conditions’ which, to reiterate consists of our struggle to find meaning in a world in which we were not assigned or given such meaning.

Terror Management Theory. *Being-thrown* is a concept mentioned earlier, if we hold this concept in mind and consider the realization that occurs when one is diagnosed with a terminal illness and facing the end of their life, this is certainly an example of *being-thrown*. From this experience of *being-thrown*, we search for alleviation from the distress caused by this impactful event. Here is where we draw on an additional theory of *Terror Management*. Although we will not go into great detail regarding this theory, it is important for us to highlight

its role as this theory assists in understanding the process of finding alleviation from the distress caused by the confrontation of one's own mortality through the act of finding personal meaning.

Orit and Adi (2011), note that two mechanisms are activated when an individual experiences the distress of facing one's mortality. The first consists of;

- 1) Cognitive and behavioral efforts aimed at validating one's cultural worldview enabling people to understand and give meaning to the world in which they live and

This allows for the individual to collect 'a sense of value' as well as 'the promise of symbolic immortality' (Orit & Adi, 2011).

The second mechanism that is activated concerns;

- 2) Cognitive and behavioral efforts to live up to the standards and values set by one's society and culture, thus increasing the sense of self-esteem

When an individual experiences events that activate the previously noted 'terror management mechanisms' the individual requires two hypothesized needs [referred to as mortality salience] consisting, of 'cultural worldview validation' as well as 'self-esteem enhancement' (Orit & Adi, 2010; Mikulincer et al., 2003; Greenberg, 1997). The former of these two needs serves as a means to protect the individual from anxiety or distress that results from thoughts of one's own mortality by allowing the person to 'transcend thoughts of one's own death' by investing their contemplations in the 'cultural worldview' (Mikulincer et al., 2003). The need for 'self-esteem enhancement' also serves to protect the individual from death distress through the belief that one is living up to the values standards set in place by their culture. If one is in fact living up to cultural values and standards, then they are said to have a high self-esteem and therefore experience protection from distress and anxiety (Orit & Adi, 2010; Mikulincer et

al., 2003). However, studies have revealed that individual's who are identified as having a low self-esteem experience higher rates of anxiety and display greater physiological responses (Orit and Adi, 2010). What we can take from our brief review of Terror Management Theory is that when we endure the experience of *being-thrown*, and for the purpose of this discussion, when *being-thrown* consists of the experience of facing one's end of life, we cope with such distress by terror management mechanisms in the hope of finding meaning and purpose for our existence.

Life Review. With this brief review of the components of Terror Managements, we take with us what Orit and Adi argue, "human meaning is explained in terms of the ultimate threat of death", baring this assertion in mind I would like to proceed to a discussion pertaining to a process that is utilized to help find and discover meaning. The process I am referring to is termed *life review*.

Victor Frankl notes that the primary driving force of a human being is the individual's search for meaning" (Jacobsen, 2007). The end of one's life [although not necessarily true for all individuals] can be a time period of distress in which one may experience the pressing drive to discover meaning in their life. Life review is a guided process in which the individual is assisted in 'evaluating' their life (Jenko et al., 2010). They further explain that there are two processes that are utilized to achieve the goal of life review. The first is titled, *integrative reminiscence* in which there is, "the integration of both positive and negative memories within the life story" and the second process consists of *instrumental reminiscence* that "concerns the use of past memories to cope with present problems and challenges" (Jenko et al., 2010). Life review entails 3 distinct components; *recontextualizing forgiving* and *reclaiming an unlived life* (Jennko et al., 2010). Recontextualizing entails the review of previous occurrences in the individuals life that one may have a negative view regarding or see as being a mistake. The facilitator in the life

review process then ‘reframes’ this event or occurrence in a positive light. This is not necessarily an easy process as Jenko et al., warns, the individual ‘must be willing to view the past differently’ and furthermore, revisiting memories from the past, particularly those of a negative nature is not an easy feat. Recontextualizing also endorses the existential value of taking responsibility for one’s own life by giving the individual the opportunity to realize this responsibility that they are in fact in control of their lives rather than the ‘victim’ as Jenko et al, explains.

The second component *forgiving*, is an act that may be to forgive a loved one or it may be to forgive oneself. It is explained that the forgiving utilized in the life review process is not a means in which the wrongs and pain of the past are forgotten. Rather, forgiving in life review is about acknowledging the ugliness of the event and allowing oneself to no longer harbor the toxic emotions that prevent one from loving the offender (Jenko et al, 2012). Jenko shares with the reader a case example of an elderly man who exhibited distress that could not be accounted for medically. A life review process was started and in the course of this review, it was revealed that this elderly gentleman held onto a traumatic memory from WWII that deeply affected him. The man recounted a memory from the war in which enemy soldiers were approaching him, out of fear he shot each of them with his machine gun. However, the men he had killed were holding a white flag to surrender. Jenko et al., goes on to share that his family, who were also engaged in the life review process, ‘offered forgiveness on behalf of the murdered men’s families’. As a result of the forgiveness he received, the elderly man experienced a release from the emotional distress of this event.

Lastly, the component of *reclaiming an unlived life* entails working with the regrets that one harbors. Regret is an experience that has a tendency to prevail for many at the end of life. Jenko et al., provides some examples of what regrets may arise at the end of life; “how

misgivings about attending school affected other life decisions, lack of success or choice of career, long-lost loves and unsuccessful relationships, or disappointments in abilities attitudes, and behaviors”(Jenko et al., 2012). Under the umbrella of Existential Theory, one of the experiences of regret is referred to as ‘existential guilt’. This is important for us to note as the experience of regret or ‘existential guilt’ can cause an individual great distress at the end of life. Existential guilt reveals to the person, “you have not as yet lived up to the possibility there were given to you (including possibilities to treat others and nature with care and respect)” (Jacobsen, 2007). For the dying individual, whose time is limited on this earth, this does not mean that the existential guilt experienced is irreparable, in fact, Jacobsen argues that this experience of guilt affords the individual the opportunity to “redirect the rest of your life and to reach some sort of reconciliation with that which cannot be changed” (Jacobsen, 2007).

Suri (2010), shares the case of John, a 78-year-old African American male who greatly valued finding meaning as he neared the closing of his life. Suri notes that many of her sessions with John focused on life review in which John had shared that ‘although he had been faced with various hardships, he felt that he had lived his life in a dignified and respectable manner’ (Suri, 2010). John found joy in having the opportunity to reflect upon memorable events in his life and the chance to have these stories heard and valued by another individual. Suri lastly shares with us that John, “. . . was eager to eager to describe his joys and struggles and saw this as a way to support others who were facing similar situations” (Suri, 2010).

The life review process supports the existential tenant of holding the individual as a unique and valuable being by regarding the dying individual’s life story as meaningful and intrinsically valuable. The process of engaging the dying individual in the life review process can be an emotionally challenging as well as rewarding experience particularly for the dying

individual. Jenko et al., argues that the life review process assists in facilitating the experience of a good death. Furthermore, it allows for the individual to feel heard and seen and as Jenko et al., notes, “Profound listening work offers the chance to recapture a patient’s personhood.” (Jenk, et al., 2011). On a last note regarding the life review process, Jenko et al., reminds us with a quote from Curtis and Eldidge, the power of life review,

The deepest convictions of our heart are formed in stories and reside there in the images and emotions of story. . . Life is not a list of propositions; it is a series of dramatic scenes . . . if we’re going to find the answer to the riddle of the earth-and of our own existence-we’ll find it in a story (Jenko et al., 2011).

Existential Theory in action; Case Application

Much of what we have discussed thus far has focused on *what* Existential Theory is without lending much focus on what the utilization of this theory looks like in therapy. At this point I would like to discuss with the reader Existential Theory in action. First I would like to note that Existential Theory is not well-known within the field of therapy and is not a popularly taught [or if so not taught in great depth] within schools of psychology or social work. Miars, (2002), provides the reader with multiple rationales as to why Existential Theory is not necessarily readily accepted or utilized to a greater extent amongst therapists;

- 1) An existential perspective in counseling is often viewed as a luxury that is generally relevant to the few *worried well* clients who have the time and money to engage in personal growth work
- 2) Existential psychology is frequently viewed as esoteric and too abstract to have practical application to common client concerns

3) Many believe that an existential perspective is based primarily on a negative view of human beings and their existence and therefore, is not psychologically useful to most clients

However, despite the opposition and reservations held toward the utilization of Existential Theory within the context of therapy, Miars (2002) argues that an existential approach can positively affect the client therapist relationship and serve to ‘deepen’ the therapeutic process. Additionally in an interview with well-respected existential counselor Dr. Clemmont E. Vontress, a question is posed regarding the nature of the therapeutic relationship in existential counseling/therapy. Vontress responds, “Death is the common leveler. When a counselor recognizes that he or she is as mortal as the client, all the facades of superficiality, superiority, and inequality that may enter the counseling relationship dissolve and the counselor and client interact with equality and genuineness” (Epp, 1998).

In the confines of counseling, Existential Theory is concerned with what Miars (2002), refers to as the ‘self-and-world construct system’ that the individuals has developed in their lifetime. Although critics of the theory contend that this approach is for the *worried- well*, Miars argues that we all possess existence and therefore are concerned with the question “How shall I live?” (Miars, 2002). We can view this construct as consisting of how we view ourselves our *being* and how we view ourselves our *being* within the context of the world that we live in. This is how we operate in our everyday living. Furthermore, it is argued that this construct is often ‘unrecognized’ although many of the ‘problems’ and ‘emotional distress’ that we experience in life stems from disruptions in this individualized construct. Additionally, within existential counseling there is concern regarding the clients, “life-enabling and the ‘life-disabling effect of their self-and-world construct system” (Miars, 2002). This concern in existential counseling is

one that can be generalized to clients across the board who suffer from a spectrum of mental health issues, because this is a “broad and inclusive concept” (Miars, 2002). Tackling the criticism that an existential approach is too ‘abstract’ Miars notes that existential concerns unfold on an ‘experiential level’ and are often expressed through anxiety that is universally experienced as a part of the human condition. Lastly, the critique that existential theory is negatively focused and therefore not beneficial to clients is contrasted with the perspective that rather than focusing on meaninglessness, existentialism strives to explore meaning and purpose in an individual’s life. This search for meaning Miars argues, “attempts to force each individual to transcend personal emptiness and to discover how he or she can and must freely choose the values that are life’s building blocks” (Miars, 2002). To expand upon this, we once again turn to an interview with Dr. Vontress, during which he was asked the question, “Wouldn’t discussing existential concerns of suffering and death only depress the client?” Vontress replies, “Perhaps initially. But there is a paradoxical principle of human behavior I have observed over the years: when you can confront the painful realities of life, you can transcend them and find greater happiness than when you deny them” (Epp, 1998).

In addition, Existential Therapy views the individual as a unique ‘self-reflective being, therefore, during the therapeutic process, the therapist does not assume or project ‘hypotheses’ upon the client. Rather, the therapist acknowledges the self-reflective component of the individual and allows them to reflect upon their own experiences without the influence of the therapist (Greenberg & Rice, 1997). However, this approach is often critiqued for relying on the client’s ability to engage in honest self-reflection, as many critiques argue that much of the rationale for our exhibited behaviors occurs on an unconscious level (Greenberg & Rice, 1997).

The therapist strives to, “use a combination of discovery, interpretation and confrontation” (Greenberg & Rice, 1997). Truscott adds that this combination of therapeutic actions requires that the therapist pay “careful attention to and focus on the client’s experience” (Truscott, 2010). When the client is sharing their experience, it is the therapists’ task to remain ‘present’ with the client and absorb what they are sharing. To remain present, the therapist does not ‘search for hidden meanings’ but rather ‘stays right with the client, and accepts everything at face value’ (McDougall, 1995). Also the existential approach aims to achieve the goal of allowing the individual to experience ‘self-discovery’ so that they can see their potential and ability to make choices that serve to enhance their quality of life and alleviate distress or suffering (Truscott, 2010; Epp, 1998).

I would like to now share with the reader the case of George provided to us by Liat (2003). George was an 89-year-old white male of protestant faith who was married and had two children. George was admitted to the hospital and was noted to have ‘suffered from a complex medical condition including past history of cardiomyopathy, prostate cancer, and COPD (Liat, 2003). Interactions with George revealed that he was afraid of death and that this was a primary concern of his. Liat notes that George’s admittance to the hospital brought about a loss of independence and the hospital environment instilled a constant reminder of his own mortality. It was previously discussed that when one is faced with the experience of *being-thrown* one seeks meaning in life as a mean to alleviate the distress of realizing one’s own mortality. Liat explains that at the end of George’s life he sought to find meaning and purpose in his life and he found such meaning in God. George found meaning by “Praying to God, talking about God, talking with God and experiencing God” (Liat, 2003).

We have reviewed Existential Theories components, history, as well as the role of finding meaning and lastly, Existential Theory within the therapeutic context. Although there are a number of criticisms that accompany this approach to therapy, it is an approach that addresses the fundamental and profound ponderings that occur when one is faced with the end of their life. This method of therapy may not be an appropriate approach for each individual who has reached the end of their life, however it is one that honors the individual as a human being rather than simply as a biological composition of a terminal illness.

CHAPTER VI

Discussion

We have now reached the end of our exploration of death and dying. As our journey comes to an end, in this final chapter I would like to discuss the main points that I hope the reader has gathered particularly from the chapters on Attachment Theory, Existential Theory as well as the Phenomenon of Death Chapter. First we will engage in a review of the essential ‘takeaways’ from the expedition of Attachment Theory and we will do the same regarding Existential Theory. Following this review of ‘takeaways’, we will devote a final visitation with the phenomenon of death and reflect upon the significance of this phenomenon and lend further attention to an often neglected, dismissed and taboo topic within western society. We will also consider the strengths and weaknesses of the methodology, and consider implications for social work practice. Lastly, to close our journey I will provide a final reflection of my own experience working with individuals at the end of their life.

Attachment Theory ‘Takeaways’

In our discussion pertaining to Attachment Theory we reviewed its components, developmental history as well as attachment in adulthood with a particular focus on attachments role amongst the elderly within a medicalized care facility. First, it seems appropriate while considering death and dying that we also consider the beginning of the life cycle; birth and early childhood. This exploration of Attachment Theory has prominently communicated the significant role that our caregivers play during the vulnerable stage of our lives in infancy and early childhood. The primary founders of Attachment Theory, John Bowlby and Mary Ainsworth have paved the way for us to recognize that we as human beings, particularly during our most

vulnerable stages of life [one stage being infancy/early childhood] require affectional support [caring attempts to fulfill emotional and physical needs] from others. Without said affectional support, we attempt to compensate by developing attachment styles that serve as a means to cope with for example neglect, rejection, or physical/emotional abuse. The subsequently developed attachment styles may to some extent serve to protect us but may also serve as barriers to experiencing quality of life. For example, let us consider the individual who in early childhood experienced neglect as well as rejection and subsequently developed an internal working model that informs the individual that others are not to be trusted. As a result this individual may struggle to develop meaningful reliable bonds with others. Therefore, due to the lacking of trusting reliable bonds this individual may experience a sense of isolation or loneliness that detracts from their well-being and quality of life. As was discussed earlier, there is an enduring quality to the internal working models that we develop in childhood. I reiterate this example of a developed working model with the reader because I would like to emphasize how the construction of our early attachments serve to shape the way we exist within the world. Particularly regarding our interpersonal interactions with others and thus impact the quality of life experienced throughout adulthood and especially during the end of life stage, when we once again return to a state of dependence and reliance on others for the fulfillment of our physical and emotional needs.

Another piece that we must takeaway relates to the enduring quality of the attachment styles we develop early on in our lives. Although there is some fluidity and opportunity to ‘repair’ the impact of negative childhood experiences and therefore attachment style, the attachment styles developed early on impact our lives through adulthood as well as during the final stage of the life cycle. What I have attempted to illustrate is that attachment is a piece that we cannot

ignore especially when an individual is facing perhaps one of the most vulnerable points in their life, death. When an individual reaches the end of their life, it is the individual who must proceed through the dying journey and will alone experience their own death as no one else can make this journey for them. However, although the journey of death is uniquely experienced by the individual, this does not mean that one must suffer through the dying process, whether that suffering be physical pain emotional pain or both. Arguably, one's style of attachment is especially tested once an individual a) enters into the final stage of life and b) is admitted to a facility such as Hospice in which they must become reliant on others to fulfill their needs as basic as they might be. Therefore, it is important to assess for and consider the dying individual's style of attachment as this may impact their reception of the care provided and therefore the quality of life experienced at the end of life.

Existential Theory 'Takeaways'

Let us now enter a review of the essential 'takeaways' from the chapter on Existential Theory. In our discussion on this theory I have attempted to define what Existential Theory is by highlighting its key components such as Dasein, existentials, authenticity, as well as being-thrown, what's more we have reviewed its history, and reflected upon the role of finding meaning at the end of life as well as a process to achieve this such as life review.

One of the essential ingredients that encompass our *being* consists of contemplation. We are beings that possess the capacity to reflect on our existence. This ability may be interpreted as a gift or a curse as we are able to reflect upon the beauty of life while at the same time we struggle with the universal truth that we are destined to die. Despite this knowledge of the ever-present threat to our existence, we have a choice to live an *authentic* or *in-authentic* life. If we choose to live in-authentically we become consumed by superficial pieces of life. Periodically living in-authentically is a common occurrence and one can always be roused from this existence.

However, by choosing to live authentically we therefore exist with a self-awareness that grants us the power to acknowledge our finite nature and honor as well as value this reality. In honoring this reality we choose to live a life that is guided by our own morals and principles. The significance of living authentically lies in the resulting opportunity to live up to our potential.

A ‘takeaway’ for consideration that I would like to highlight concerns the significant value of *finding meaning*. To assist in connecting the reader to this ‘takeaway’ of finding meaning, I encourage the reader to think of a time in their life when they had the opportunity to reflect upon and share a story that impacted them. I invite the reader to recall the value in having that story heard by another. It is a very precious, supportive, and priceless experience to have one’s story heard. Existential Theory sustains the individual worth of a human being and when applied to the end of life experience assists in guiding the dying individual in a journey of sharing one’s life story and finding meaning and worth in this story.

The Phenomenon of Death Revisited

In our discussion pertaining to the phenomenon of death attention was lent to the selected population, in addition a special focus was applied to the racial/cultural disparities that exist in terms of the utilization of Hospice/Palliative care, also highlighted were the leading causes of death amongst individuals admitted to Hospice care and importantly the inequality that contributes to the development of terminal illness’. What’s more, we discussed the history of death lending attention to perspectives on what a good death is. Lastly, the reader was provided a brief overview of what Hospice/Palliative care is.

Although the discussion of death is not a light topic to pursue, it is with hope that despite the potentially perceived weight of thinking about death, that the reader was able to ‘takeaway’ some of the crucial pieces from this discussion.

I would like to highlight the significance in acknowledging the cultural differences that contribute to an individual's experience of death as well as an individual's utilization of Hospice care. The final stage of life can unfold in various ways depending on the individual's cultural context and beliefs. Yet, regardless of one's cultural context, the approach of death is a time period that deserves to be respected and what's more each individual deserves the opportunity to die with dignity and quality. As we have learned however, Hospice care, an approach to the end of life that upholds the philosophy of providing comfort, peace, and quality of life as death approaches, is not an accessible approach to all individuals. It should be noted that Hospice care may not be an approach accepted by all cultures and individuals who are faced with the end of their life. The assertion is that elderly individuals diagnosed with a terminal illness should equally be provided the opportunity to receive Hospice care in a culturally respectful and responsive manner. It is important for us to maintain recognition of the implications of inequality, racial/cultural discrimination and how these truths seep into the various aspects of an individual's life and impact the quality of living experienced and threaten the experience of a 'good death' [whatever the cultural construction of this might be].

Strengths and Weaknesses

Weaknesses. The reader is likely to have noticed that the majority of individuals who were introduced were primarily, white males. The individuals, whom I have shared with the reader from my own experience working with a Hospice Palliative care team, demographically reflect the majority of individuals who utilized Hospice care at the facility that I teamed with. Also, the case studies found in available literature, predominately noted cases of white individuals as well. This arguably demonstrates the racial disparities that exist regarding the previously noted utilization of Hospice services amongst individuals of color. Furthermore,

lending consideration to gender, males also composed the majority of cases shared, as a result there is an under representation of females in this exploration. Therefore, a weakness rests in the lack of diversity [regarding ethnicity/culture/gender] amongst the cases highlighted to exemplify the end of life experience and an absence in voices that were not heard. Future research, might lend greater consideration to a more diverse case presentation.

An additional weakness consists in the reality that this was not an exhaustive exploration. Due to the inability to exhaust all of the literature available on death, dying, Attachment Theory, as well as Existential Theory, there is very likely to be pieces that were left out of this discussion. What's more in reviewing the completed discussion, a weakness that becomes apparent is the lack of critical analysis of the selected theories. This minimal attention to critique likely stems from my own bias pertaining to my own perceived significance of these two theories to assisting the dying individual. Future research might reframe the discussion with a more critically oriented eye.

Strengths. In recognizing the universal quality of death, I have attempted to ease the reader into the discussion of death and dying and remain empathically mindful of the central theme of death. Therefore, strength rests in the empathic approach taken to writing on a topic that can be potentially triggering for the reader. Although the shared cases of this project predominately focus on white males, another strength consists in the attempt to provide the reader with multiple cases throughout the discussion so that the reader can feel connected to the experiences of the dying individual.

Implications for Social Work Practice

If we as social workers are to share in the end of life journey with an elderly individual it is important to holistically honor the individual and strive to assist the individual in experiencing a ‘good death’. Attachment Theory as well as Existential Theory are tools that the social worker can keep within their *belt of tools* when working with individuals at the end of their life.

Let us consider the application of Attachment Theory. A social worker for example, may work on a Hospice Unit and recognize that a newly admitted individual is experiencing greater than expected difficulty in transitioning to residing within a Hospice care facility. The Hospice Team may be at a loss as to why the individual is perhaps presenting with agitation and or rejecting behaviors toward nursing staff. In recognizing this difficulty in adjusting, the social worker might pull from their tool set the Theory of Attachment to assess the individual's potential style of attachment. Recognizing an individual's style of attachment may lend answers as to why the individual is rejecting of nursing staff's care, or is extraordinarily requesting assistance despite their ability to assist oneself.

If we consider Existential Theory, the social worker may work with an individual who is diagnosed with a terminal illness and present with distress regarding this difficult reality. The social worker might attempt to engage the individual in a process of finding meaning through life review. This might serve to alleviate the individual's distress by allowing them to feel seen and recognized as more than a *cancer patient* or *dying person*.

Final Reflection

We have reached the conclusion of our discussion and to practice an Existential component of finding meaning I would like to close with a reflection upon my own experience working with individuals during their end of life journey. The intent of this reflection is to be

transparent with the reader and to furthermore, provide additional insight regarding end of life experiences, as well as potentially incite additional considerations within the reader.

In my experience while working with a Hospice/Palliative care team, I found that the last stage of life is a very unique experience to be a part of. Each individual I met coped with and internalized the truth of their diagnosis in various ways, and although someone may at the beginning stage of their end of life journey present with expressions of acceptance and 'be at peace', this presentation may shift to one composed of anxiety and distress as the individual recognizes that death is closing in.

Within the therapeutic context, the knowledge of deaths approach appeared to create an intimate quality to the atmosphere. To be with someone as they reach the end of their life is somewhat of a sublime experience. I can recall working with one individual in particular, Mr. G. I met with him weekly over the course of several months and had developed a strong relationship with him. He welcomed me into his inner circle and together, sometimes along with his friends spent time reflecting on memories from his younger days. Mr. G's ability to share stories from his past began to fade as he reached his final days. There were times when I simply sat at his bedside with him as he rested. Our last meeting with each other occurred about a day before he died as he had passed over the weekend when I was not on the hospital's unit. I had seen how much Mr. G had declined and sensed that this was the last time I would see him. I offered my support and sat with him as he expressed his fear. I shared with Mr. G the value he held, I cannot recall my exact words but Mr. G shed a tear and I placed my hand on his shoulder. In our own way, we whispered goodbye to each other and I left his room on the unit feeling that sublime sense.

My time working with the Hospice/Palliative care team has since ended, but I still think of the individuals such as Mr. G whose end of life journey's I had the privilege of being a part of. They shared with me their stories. Stories of happy memories such as traveling throughout the U.S, memories of courage such as bravely serving their country in war, sad memories such as the loss of loved ones, as well as regret such as a missed opportunity for love. In being a recipient of such memories and stories, I have witnessed the impact in honoring an individuals shared story and providing a space for an individual to reflect upon their life and its meaning to be heard to be seen and to be valued.

This endeavor has created a personal reaction within myself. I have found that a veil has been lifted that had previously shadowed the reality of death from my eyes. I live with a greater fear of the loss of my own existence and the loss of those that I love. However, despite this fear I also hold a greater appreciation for the loved ones in my life whether I am able to reveal this love or not and a greater passion to live vibrantly and authentically. With that being said, if the reader too has experienced greater reflection regarding their own existence and the existence of those they love; I encourage the reader to reflect upon what meaning life holds for them. Ask how to the best of your ability, you can live authentically and honor your personal meaning of life.

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