

Living and Dying: Is There a Difference?  
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#### Abstract

What might seem to be total opposites, living and dying, are alike in more ways than usually thought. The issues and complications related to living and dying are the subtext of the vast majority of therapist-client conversations. These issues are frequently inextricably bound, as life and death do not exist independently.

Each of us is driven to meet the universal need to belong, to be significant, and to be safe in varied and creative ways. Our fear of being unable to meet these needs causes us to create symptoms; the issues and complications that lead us further from our original goals. Despite our training as therapists or counselors, we are not immune to these problems, nor could we be. Whether or not we can help our clients depends on how well we are able to help ourselves.

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## Living and Dying

My childhood was relatively unremarkable, or at least fairly typical. My father went to work each day, and my mother stayed home. I have an older brother and a younger brother. I went to school, did homework as little as possible, and played outside every day. My brothers and I played together and with the neighborhood kids. My grandparents lived close by, and we saw them often. My brother and I took turns spending the night with them. My grandmother was a loving presence and very important in my life.

As a young child, I had a very hard time falling asleep. My mother sent us to bed early, before 8:00 p.m. In the summer, my brothers and I went to bed before the sun went down. Because I could not sleep, I would lie in bed and think. I imagine I thought about my day, though I have no memory of that. What I do remember thinking about is my grandmother. She was always happy to see me; we had fun together, and I loved her so much. Then my thoughts would turn. What would happen when she died? How could I live without her? What would I do? I was so afraid of losing her, I could think of nothing else. These thoughts would spiral around in my little girl head until my fear of losing her overwhelmed me and my tears overflowed. Then panicked and crying as though she really had died, I would get out of bed to find my mother and cry in her lap. My mother gently helped me to redirect my thoughts, to remember that my grandmother was healthy and would be in my life for many years to come. Though my mother was correct, I worried myself to tears about my grandmother's eventual death on more than one occasion. I have to wonder, why was I thinking about death at all? All of the important people in my world were very much alive and well.

The first person I knew who died was a man we called Cousin Red. He was married to my grandmother's cousin and was a lovely man who laughed a lot, and he liked to play and joke with my brothers and me. I was 9 years old when he died, and I wanted to attend his funeral because I loved him. My mother reluctantly agreed to bring me. I began to cry as the service started, I continued crying during the service, and I cried all the way home. My tears embarrassed my mother, and she begged me to stop. I could not. It was a difficult day for us both.

The next death I experienced changed my life. I was 17 and my boyfriend, who was my first love, was killed in a car accident. We had been together almost 6 months. He was a gentle person, and we were deeply in love as only teenagers can be. When I heard he was dead, my disbelief and lack of comprehension was overwhelming. I felt as though I were experiencing the world from inside a bowl of gelatin wrapped in cotton; everything seemed to have slowed down and was muffled. Even so, later that day as my parents drove us to his family's home, I noticed a major shift in my awareness. The world was now spectacularly in color.

I do not mean that I had been colorblind and now was not. I mean I had a realization that my life was previously rendered in shades of gray, and now suddenly it was in Technicolor! Every scene glowed with an aura of light and color in every direction I looked. The world had not ended; indeed no one outside of my circle knew the pain I felt over the loss of this one young man. I felt apart from life at that moment, only hours into the shock of grief, and yet I saw life swirling around and through me, and I knew in my bones it would continue to do so. I also knew that my boyfriend though dead, was not and never would be truly gone.

Though I knew his soul was present, his death hit me like a truck. I did not know what to do, but grief is its own teacher, and my heart and my body took over. I cried often, whenever I needed to and regardless of the surroundings. I needed, asked for, and received many hugs. I retreated from the world when I was tender and raw. I did not, could not, sleep alone. I went to school. I ate. I did the best I could to get through every day. Some days were better than others.

Eventually 1 month, 3 months, 6 months, and then a year had passed. I graduated high school and went on to college.

Time took care of the immediate grief and my life continued, but I was changed by death. In those early years of grief, I felt as though I had been initiated into a secret club. What I learned felt truer than true to me. The pain of my grief was testimony to the connection of our hearts and souls in life, which even death cannot undo.

I did not know it at the time, but this truth was a gift. Despite the pain of his loss, I would not go back in time and forego this lesson. That day of intense and aching pain in my heart was also the first time I felt the spark of divinity in my life, the presence of a deeper consciousness and the unbreakable connectedness of all life. The intensity of the color and light that emanated from everything I saw illuminated the connection of my being to all beings. At that point, I knew. I am as you are. We are the same. Though the circumstances and details of your life are as unique to you as mine are to me, there is no difference between us. We truly are stardust, connected in ways that cannot be explained in words.

His death crystallized for me the beauty inherent in life. It exists equally in joy and sorrow. I learned that the space we connect with others is both inside and in-between joy and sorrow. This is important and needs my full attention. In connecting with other people on this deeper level, life has meaning for me. Our shared humanity is dimensional; it has gravitas, weight, and substance. That is where I am most fully alive. Nothing else matters in the way this does.

Since my first love died, many people I love have died, including the grandmother I cried for so many years ago. Most of these deaths were very much in the normal course of life, even though some died far too early and some too late. I have made peace with death. I know it is present all around me. It is as close as life.

## **Why We Should Care**

There are only two things in this world that all people on the planet have in common. We are all born and we all die, and from a metaphysical perspective we all do it in the same way. One minute we are not here and then we come crashing, or perhaps we slide peacefully, into the world. Until the last minute we are alive, possibly holding on to life by a thread, or perhaps obstinately refusing to let go, and the next moment we are simply gone. These two experiences are universal and hold the potential for having great meaning not just for ourselves, but also for the people around us.

Most people cannot speak of the significance of their own birth for themselves. Our brains are not sufficiently developed for us to understand or express what is happening to us as we are born. Is this a loss? Perhaps, but we have our entire lifetime to understand what it means to be alive and the special and unique gift of the particular life we each receive. Though we may squander the gift.

It is different with death. As people grow and mature, the knowledge that death is a fact of life becomes inescapable. Even young children sense their parents' tension when the family goldfish dies. They may not understand all the nuances, but they know something is different. Even the denial of death suggests knowledge of death. There is no need to deny what does not exist.

As events that are universal for every person on Earth, birth and death are clearly important. Because these experiences are fundamental to being human, there are lessons inherent in the experience. Why does understanding life and death matter? No other sentient creature on Earth asks why. Only human beings question the reason for existence. From the beginning of recorded time, humans have created stories and legends, gods, goddesses, and heroes to give life meaning and explain what happens when we die. For much of humanity's early history, the purpose of life involved killing and eating which we central to securing the food and shelter to sustain life, and thereby give birth to enough children to continue the species. This was hard work and every person was needed to work together toward the health and betterment of the community or the survival of the group was in jeopardy. Early humans understood this as a basic fact of life.

Life is somewhat different today, though it is still very hard work for the many billions of people in under- and undeveloped countries, whose basic need for safety and survival is either uncertain or. Even though life is better today, few communities are so isolated that people must work together simply to survive. While there are people who devote effort and energy to those who have less, there are many more who seek only their own gain to the detriment of others. Obviously, the meaning of existence is not uppermost in the mind of an orphaned child struggling to find food on the streets of Sierra Leone. Nonetheless, this child may look around and see others who have what he does not. Perhaps he then asks why this should be. This child is no less worthy than the one who has a full stomach, a safe place to sleep, and a caring family. The child's natural born desire and need for significance and belonging takes a back seat to striving for survival. What is missing? Connection.

There are many people for whom the basic needs of safety and survival are fairly stable. Many of them have choices and advantages unimaginable to our ancestors. These lucky people, in contrast to the vast numbers living today with few choices, are able to work on meeting their higher order needs of existence. As they do, many of these people become seekers, looking for meaning in various directions. Some people focus on the accumulation of money and things. Other people practically make a religion of buying organic, reducing carbon emissions and up-cycling, sorting and recycling their trash.

Countless numbers try to maintain or recapture their youth through exercise, yoga, and tai chi, taking vitamins and other supplements. They also change their faces and bodies with piercings, tattoos, cosmetics, shape-wear, and cosmetic surgery. Many people find deep meaning more accessible in a commitment to their pets rather than to the people in their lives. Some spend more time online with social media, video games, or movies than with the actual people in their lives. A large number of people rely on their faith community for guidance. Some of these try new religions.

People of the 21<sup>st</sup> century have many options for finding and expressing meaning in their lives, and while many find it, many don't. Those that don't are prone to dealing with serious problems like unfulfilling relationships with family, spouses and partner; ungrateful children, competitive friends and co-workers, job loss, divorce, anxiety, depression, addiction, obesity, anger, bullying, debt... the list goes on and on. What's missing?

Every person at some point will experience disappointment, sadness, illness, fear, and death. No one is immune.

Every person at some point will experience disappointment, sadness, illness, loss, and death. No one is immune to the vicissitudes of life. No one escapes this reality - no matter how it looks from the outside. People everywhere are desperate for connection because we need connection to nourish hope and find healing in the face of the despair that arises from being human.

We need connection with others to experience all the emotions of life and take full advantage of the gifts that arise from being human. First, we need to connect with ourselves, respecting, loving, and encouraging our own growth. Only then can we develop healthy relationships with other people. We simply do better when we share our lives with other people.

## **Attitudes About Death**

Archeologists know how people lived and died in early centuries based on the evidence of their daily activities, which remain long after life ends. The placement of bodies and other items in the graves suggest that death, and the transition from life to death, was important to early humans. The true meaning of these actions is unclear, though there are many assumptions and hypotheses proposed based on the physical evidence collected.

When the Sumerians developed a form of writing in 3200 B.C., ancient people began to document what was known about the world around them, and the unseen world as well. Documentation of attitudes and practices surrounding life and death continued with ancient Egyptian, Chinese and Meso-American societies. Though life was challenging for the ancients, it was fairly understandable for most people living at that time. Ancient society was usually organized in a hierarchical fashion, and men, women, and children all had their place. Children, if they lived, grew up quickly and began working towards the goals of their community alongside other adults. There was no question that finding food and shelter from the elements was a major focus of life. Death and the afterlife however, were important too and required explanations and rituals so as to manage fear of the unknown and maintain the business of life. Every society developed rituals and legends to provide answers. Normally the dead were buried quickly, with mummification usually reserved for the ruling classes, though it sometimes occurred accidentally.

In the Middle Ages, most people were born and grew to adulthood living much of their lives in the same small village or town. Travel was difficult and infrequent. Everyone, including children, worked to support the family. Women gave birth to their children at home, sometimes with the help of a midwife. If a person became ill, they were taken care of at home by a family member or a healer in the community. If that person died, that too occurred at home, where family members surrounded them. Though there were some experimental attempts at embalming, most people were buried or cremated quickly, unless the ground was frozen.

There were few, if any, hospitals during this period, though with the rise of Christianity and monasteries in the ancient world, some charitable and religious orders began to fill a similar role. This was a major change from the ancient Greek concept of a civil society, where classes were stratified with emperors and nobles at the top, citizens of the state in the middle with the poor, soldiers, and slaves at the bottom. In fourth century Europe, the Christian hospital was an innovation not seen even in the Mediterranean or Middle East.

Record keeping in the early Middle Ages was quite different than today, so it is difficult to know with certainty what occurred within those ancient buildings. What seems clear from available research is that despite being few and far between, these early hospitals made a difference in the lives of the people served by them, as well as the lives of those doing the serving. Very much like today, hospitals even then provided employment for many people - priests, nurses, attendants, gravediggers, builders, and maintenance staff of all kind. These were incredibly valuable economic opportunities, and very welcome for the people living nearby.

Until the scientific advances of the late 19th century became widespread, the practice of medicine was based mostly on supposition and superstition. Caring for the sick meant providing the only relief possible: perhaps some food, clean clothes, and a place to sleep out of the cold. Physicians did not receive training; it was simply not available, nor were they much concerned with prognosis, as the outcome was fairly certain. Death was the cure for most sickness. The hospital was not a place where the sick went to be cured, but a place where the sick went to die.

**Western attitudes.** Toward the end of the Renaissance era as scientific methods gained ground, people began to recover from disease. Over time medical and even surgical treatments were developed, eventually transforming hospitals from religious places to medical ones. Cities and larger towns in the United States and England began setting up hospitals, which isolated patients, and almshouses for the sick, the infirm, and the poor. In the early 18th century, Florence Nightingale's nursing school began teaching clinical skills in London in 1859. The increasing numbers of medical institutions were used more by the lower classes, while people from the middle and upper classes were cared for at home

by family.

Ancient ways of living and dying in the world began to change in the mid 19th century. After the World War I, the hard won but unintended benefits of warfare included greater knowledge of the body, which sped up modern health care considerably. No longer almshouses, hospitals became places for those with severe illness, not just for quarantine or asylum, and were used by rich and poor alike. Scientific inquiry increased along with the pace of life, much of it due to the electrical and mechanical innovations introduced at the end of the second industrial revolution. Health care practices became more professional and eventually a new market place for medical services was born.

As science and medical technologies continued to improve, access to clean water, better nutrition, and sanitation prevented diseases once thought incurable. Life expectancy changed profoundly in the early 20th century with more babies surviving infancy, and middle-aged people living longer, too. By 1925, the American hospital had become an institution whose goals were *recovery and cure* to be achieved by the efforts of professional personnel and increasing medical technology.

According to the National Institute on Aging, a baby born in 1900 could expect to live to age 50. If born today that baby could live to be 81 years old. People all over the world are living longer than ever thought possible, even in undeveloped countries. Finally, after centuries of always being the loser in the fight against death, modern men and women in the early 20th century were able to cure many diseases. The moment of death was pushed back for untold numbers of people. It is an amazing accomplishment, and something for which everyone benefitting from modern health care can be truly grateful.

But are we grateful for the accomplishments of modern medicine? Or do we expect still more? A more recent history of health care in America shows that feelings and attitudes toward health, illness, and death are a bit more complicated. In 1869, Bellevue hospital in New York City launched the first ambulance service in the city. This was a major innovation in transporting patients, allowing the sick and injured to get to the hospital much more quickly. Private hospitals soon began to provide the same services for their patients. At the same time, financial management was becoming more visible to hospital administrators, and profitability was especially important to the private institutions. An ambulance service delivering sick people directly to the hospital seems to be a great way to add new patients, and new profit. It was very successful in that regard, so why should this be a problem?

Remember the early days of hospitals, when nothing much could be done for the sick except to make them comfortable until they died? In this new age of modern health care, people are recovering from illnesses that used to kill them. The old image of the hospital as a place to die is bad for business, which is also bad for profits. Unfortunately, not every patient brought in by ambulance could be helped. Hospitals had a very strong desire to hide this fact and promote inflated cure rates and low mortality rates in order to present their institutions as places for the production of health - rather than a place to a place to die.

The ambulance did bring more patients to the hospital, and administrators liked that very much; however, many of these patients had been in accidents and were sent to hospital by the police. More often than not they were poor, and their families could not pay the bill. Charity cases ate into the profits at private hospitals. Patients who were hopelessly injured or sick with no hope of cure were bad for business. Then, as now, an ambulance was required to bring a patient to the closest hospital where care could be safely provided. Hospital administrators at the private pay institutions not so subtly encouraged their ambulance drivers to take "the most undesirable patients directly to the public hospitals instead.

Now known as patient dumping, a term first used in the 1960s, it began almost in conjunction with the modern convenience of the ambulance. This unsavory practice contributed to the deaths of many people and has been documented even as recently as 2010. The idea that severe illness and injury, disability, or death renders one literally worthless—has continued unabated not only in our health care policies and institutions, but has extended into our larger society. This idea is widely reflected in our culture and is a defining characteristic of American attitudes toward not just death, but life too.

How exactly are these attitudes expressed? One omnipresent method is the media: television, radio, magazines, the Internet, Facebook, YouTube, Twitter, and more. Common expressions of societal attitudes toward aging. Advertisers of questionable products and pharmaceutical companies encourage the latest quick fix for sagging jowls, thinning hair, low libidos, and a myriad of drugs to manage these. These products also claim to salve the associated difficult and confusing emotions caused by the aforementioned problems, and any miscellaneous other problems generated by life and aging. The actors portraying real people on TV and in magazine ads would have the public believe that any problem representing the breakdown of our bodies or minds, from depression and dry eyes to leaky bladders and losing hair, is unacceptable and must be treated through medication, surgical alteration, or permanent removal.

While some products and drugs do actually have the potential to change and improve lives, the overall effect of many ads can be insidious, too. For many people, modern advertising seems to suggest two things: (a) if you are depressed, anxious, hyperactive, or otherwise mentally ill, have a chronic or terminal physical illness, disability, or experiences the natural consequences of aging, you are a problem, or have one, and should fix it right away; and (b) you do not have the right stuff, enough stuff, and you had better hurry and buy this miracle cure or you will miss this one time golden opportunity to be fixed. This message is destructive on many levels and is loud and clear: those with broken, smelly, ailing bodies, grey hair, wrinkles, hairy underarms, and tiny, sad, little lives are not good enough. It is true unfortunately; disappointment, illness, fear, and death create uncomfortable feelings that are difficult to manage, but there are unintended consequences to focusing only on the cure.

It is also true that not everything can be fixed, nor should it be. No one feels well or is happy all the time. No one gets his or her way all the time. This is an unpopular message and difficult to share, whether delivering or receiving the message. Being unable to say no, or to have a difficult conversation when it is required, has negative consequences for individuals, families, and society at large. The word no is a particularly polarizing message with regard to managing health care delivery and cost, caring for people with physical and emotional disabilities, and for the dying.

Physicians and other medical care providers frequently have a hard time saying no and because many patients and their families are afraid, they are unable to process the message even when it is delivered. When a cure is not possible, or the patient dies, the physician is considered to have failed. An example of how this feeling of failure develops can be seen in the results of a study of third-year medical students seeking to understand how students experience the death of a patient who dies under their direct care, or that of their care team. For many medical students, the third year is the first time caring for and interacting with live patients and families in the hospital, and the first time experiencing a patient death. Student's emotional reaction to death, and the reactions—or lack of them—by supervisors and team members is very impactful for them. Two-thirds of the students interviewed rated the deaths they experienced moderately or highly emotionally powerful, and unsettling to some degree for a variety of reasons. Most of the students attempted to cope with their feelings by talking with others despite feeling isolated from members of their care team. Only the medical aspects of death were discussed, if at all, and not the emotional reactions surrounding death. The rare conversations in which students discussed their emotional reactions to a patient death with the attending physician were appreciated and helpful for the team. Most students in this study felt “their educational needs were not being met” and were left feeling frustrated and angry.

The students understood two messages from their training. First, the lack of discussion and emotional reaction to patient deaths taught them physicians should not react to death; better to avoid the issue and get back to work as if nothing happened. The second message was more troubling: “We have failed if patients die”. The research team summarized their understanding of the study participants' comments in this way:

*The physicians' focus was keeping patients alive. There was little discussion regarding whether it was appropriate to keep a patient alive; living was viewed as a medical goal in and of itself. When the patient was dying, physicians felt that they had nothing more to offer. Rounds on dying patients were often skipped. Students received the message that little could be learned from these dying patients*

As noted in the study above, the simple fact that physicians and patients have the option to use artificial means to slow the symptoms of chronic illness, disability, the signs of aging, or even to postpone death, it seems as though we are obligated to do so. Through our individual actions, we are responsible for our health and how we age. Community and government leaders are responsible as well, and those decisions inform what behaviors are valued in society. Regardless of how well or poorly we manage this process, everyone should have the opportunity to be cared for in an atmosphere of dignity and respect for life, and especially when the outcome is death.

Clearly, death and dying is not just uncomfortable and difficult to face for the individual and his and her family, for whom it is a decisively personal and personally relevant event. It is also very uncomfortable and difficult for people who see it, and come to expect it, on a very regular basis. What can this mean for the rest of us? How can we possibly deal with our discomfort when even our physicians cannot manage it?

This feeling is more acute today than a century ago, as evidenced by higher levels of physician burnout, because physicians have many more tools in their medical bags. The medical advances that save lives so routinely in many cases have become golden handcuffs in others. Because more is possible, more must be attempted; and more is expected. It is no wonder physicians feel they must make every attempt to maintain life, even for those at death's door. We expect to be cured. What good is technology and medical advancement, if not to save lives? The fact is people continue to die because death is the natural end of life. Life does not, and never will, exist without death.

Despite tremendous progress, there are still great differences in treatment and care opportunities available to patients of different ethnicities and care preferences. Minority groups, the poor, and persons with disabilities frequently have few options and opportunities for excellent care. Though many disabilities are life limiting, many people live for years with their disabilities before requiring end of life care. They, too, are negatively affected by our society's denial of imperfection, and the fiction that life must be happy, or it is worthless.

**Multicultural attitudes.** A strong characteristic of people in Western societies is a reliance on the self; to be independent and autonomous is highly valued (Sue & Sue, 2013). What is best for the individual frequently influences decisions not only for the individual, but in family life, too. American and other Western attitudes are quite prevalent in the United States and Europe, but there are many culturally distinct ideas and viewpoints with validity. Other societies instead value the wisdom of parents and the elderly to guide decision making for the good of the entire family. Cultural attitudes influence values, decisions, and concepts surrounding death and dying as well as how individuals live and interact with other people every day (Sue & Sue, 2013).

Cultural competency for mental health counselors and other health care providers is an important factor in providing sensitive and appropriate care for people from diverse backgrounds (Sue & Sue, 2013). This is increasingly important, as the U.S. Census Bureau (2012) predicts that the United States will become a more pluralistic society, where no one ethnic group will have a majority. In addition, the population of people aged 65 and over is also predicted to more than double the numbers counted in the 2010 census (U.S. Census Bureau, 2012). For these reasons, it is wise to consider multicultural perspectives as they relate to living, dying, mental health, and well-being.

Discussing and understanding specific issues of concern held by people of different backgrounds may allow barriers to appropriate care to be addressed. This is important even in the United States where, in 2010, the National Hospice and Palliative Care Organization noted a less than 20% utilization rate of hospice care by Blacks and Latinos, despite overall growth in the use of hospice care services (National Hospice and Palliative Care Organization, 2013). Bullock sought to understand why this might be so. Collecting data from questionnaires, focus group discussions, and interviews, Bullock found Blacks to have attitudes and beliefs in stark contrast to those held by Whites (Bullock, 2011).

Specific to end of life care, Blacks were less comfortable with an autonomous style of decision-making and felt that advanced planning would not make a difference in their dying experience (Bullock, 2011). Blacks had fewer trusting and positive relationships with physicians than did Whites. Blacks also were more comfortable with family members advocating for them with care providers than were Whites. Blacks stated additional concerns that written advance care plans could serve instead to cause care to be withheld, or denied against their wishes (Bullock, 2011). Religious beliefs influenced decisions about end of life care as well, in that Blacks more commonly spoke of a belief in a "higher power" and "believing in miracles" to manage end of life concerns (Bullock, 2011, p. 92).

In the summary of findings, Bullock confirms opposing worldviews for Blacks and Whites. "Blacks . . . tended to value collectivism, interdependence, interconnectedness, and present orientation", where Whites "value individualism, independence, self-reliance, and future orientation" (Bullock, 2011, p. 94). The researcher points out that for people who value collectivism and interdependence, family members should be drawn in to discussions related to the patient's plan of care. Patients can be consulted regarding whether they would like a spiritual or community leader involved in their care plan (Bullock, 2011).

Moss and Williams (2014) found similar results in their study of the end of life preferences of Afro-Caribbean adults living in the United States. They confirmed the cultural values of family interdependence, the importance of extended family, and the reliance on the wisdom and guidance of grandparents. It was noted that Afro-Caribbean adults suffering from illness are frequently cared for in their own homes by family, friends, or church members. The importance of religion and spirituality for Afro-Caribbean adults is paramount with regard to issues at the end of life. As in Bullock's (2011) findings with Black older adults, Afro-Caribbean older adults expressed past experiences of mistrust and racism in their communications with health care professionals (Moss & Williams, 2014).

People of Asian and Asian-Indian descent share a collectivist orientation as well, and are especially deferent to the elderly. Family relationships are typically hierarchical and patriarchal, with communication patterns that flow from fathers and mothers down to children. More support is expected from sons than daughters, but all are obligated to family relationships and maintaining traditions (Sue & Sue, 2013).

This sense of commitment children have toward their parents is rooted in Confucian teachings regarding five types of relationships, including that between parent and child (Ko & Berkman, 2010). To meet the duties of filial piety, a child must obey parents' wishes, and behave in pleasing ways. When the child becomes an adult, he or she is responsible for supporting the parent with regard to food, shelter, and health care. The adult

child may also be responsible to make decisions regarding health care. In many cases the eldest child, especially the son, acts as proxy for his parents, and siblings defer to his judgment (Ko & Berkman, 2010).

Some evidence supports that filial piety plays a role in the advance planning decisions made by people of Asian descent. Ko and Berkman (2010) refer to studies in which older adults of ethnic minorities are shown to be less likely to complete advanced directives, or to discuss end of life care planning with their physicians or families. In general, attitudes about end of life planning in this population were found to be mostly negative, but decision making for some Korean older adults is not necessarily consistent with typical cultural beliefs. Ko and Berkman (2010) spoke with 23 Korean older adults about the role of their children in making end-of-life decisions. Participant responses ranged from no role at all, to a willingness to listen to adult children but make an independent decision, to complete confidence in and deference to the decisions of their adult children. The reasoning behind these variations is as unique as the individual, his or her stage of life, and acculturation to American attitudes (Ko & Berkman, 2010).

Many Asian people are Buddhist, Hindi, Jain, or Muslim. Religion, spirituality, and faith are important in the Asian culture regardless of specific belief, including for those who subscribe to Shamanism and Animism (Le, 2014). These religions influence cultural attitudes about death and dying in different ways. Deshpande, Reid, and Rao (2005) found Asian-Indian Hindu attitudes about end of life care to be very different from typical American attitudes. Hinduism, more a philosophy than a religion, includes a belief in a “unitary life force” that “connects all existence” (Deshpande, Reid, & Rao, 2005, p. 132). A Hindu’s main goal is to attain enlightenment through recognition of the immortal soul “by following one’s *dharmā*, or personal righteous conduct” (Deshpande et al., 2005, p. 132). A “belief in *karma*, which essentially dictates that one’s actions leave an imprint on one’s mind and soul” is fundamental to this belief (Deshpande et al., 2005, p. 132). Actions adding to one’s good karma bring the person closer to enlightenment. Also key to this belief system is that enlightenment may take many lifetimes. The body is temporary, the soul immortal (Deshpande et al., 2005).

Buddhism, Jainism, and Sikhism have similar philosophies of birth, death, and rebirth. For people adhering to these philosophies, the concept of the immortal soul could in some way negate concerns about end of life care (Deshpande et al., 2005). A Hindu may well believe that the pain and suffering experienced today is due to actions of the soul in a previous life, and therefore accepted as essential for his or her spiritual growth. For members of these faiths, many important beliefs do not seem to be in conflict with the goals of hospice and palliative care. The lack of knowledge about advanced care directives or hospice care may be a barrier to Asian-Indian use of these services, and more research is warranted. In the meantime, health care professionals can verbally acknowledge, and actively include, family members and cultural traditions in the plan of care for patients at the end of life (Deshpande et al., 2005).

Another example of both the similarity and variation in distant populations is seen in a qualitative study by Johnston Taylor, Simmonds, Earp, and Tibble (2014), which focused on Māori views of death and hospice care. Their review of previously published literature established that although Māori patients are less frequent users of hospice care, they are more likely to die in their homes and at younger ages than other hospice users. Māori people may prefer to die at home due to a belief that “it is spiritually important to die and be buried at one’s ancestral home” (Johnston Taylor, Simmonds, Earp, & Tibble, 2014, p. 62). If a Māori does not die at home, the body is brought to a meeting house where family and friends gather for a handful of days. Mourners remain at the meeting house, talking, singing, even joking with the deceased as a way to bring closure to the relationship. The person is then buried (Johnson Taylor et al., 2014).

Barriers to receiving culturally appropriate care were identified and similar to those of indigenous populations in Canada, Australia, and the United States. Johnston Taylor et al. (2014) struggled to find willing participants despite the presence of a Māori researcher, who speculated that a fear of discussing death was the likely cause. Eventually, 12 of the 35 people approached agreed to participate (Johnson Taylor et al., 2014).

Participants stated a desire for hospice providers to psychologically and physically make room for family and community involvement in patient care, as they would if the patient were in their own home. Certain cultural practices were also seen as vitally important for patients and families. Speaking the Māori language to patients was comforting for them and their families, as was being able to respond to sacred moments appropriately and with adequate privacy (Johnson Taylor et al., 2014).

The Māori desire to die in their own home, and the obligation to spiritually cleanse the body of the deceased and their belongings is reminiscent of an aspect of the traditional practices of the Pitjantjatjara, one group of Anangu people in Australia (Edwards, 2013). The Anangu people believe

The spirit-beings gave birth to all the animal and plant species, including humans . . . spirit continues to exist in the earth and its physical features, as well as in all the animate species which inhabit it . . .

There is a close relationship between all elements of the universe. (Edwards, 2013, p. 32)

Landscapes. plants. animals. and people are imbued with the spirits of the beings from which they are created.

This understanding of life's origins creates deep attachments and responsibilities to particular locations. Origin stories impact the rituals and behaviors associated with relationships with the living and the dead as well (Edwards, 2013).

Owing to the inability to preserve dead bodies, many aboriginal cultures buried their dead quickly. Other traditional practices, which may be related to the belief in spirit-beings, include burying the dead in a round grave fairly close to where the person lived, leaving an opening at the north to allow the spirit to roam. The deceased's belongings, campsite, and even footprints would be destroyed, so the spirit would not return to them and harm the living. This was the case for the Pitjantjatjara in Australia until the 1960s. Their traditional burial practices have since changed over time due to modern conveniences, like electricity and automobiles, as well as from the incorporation of selected Christian religious beliefs (Edwards, 2013).

There are hundreds of fascinating studies about death attitudes, practices, and beliefs for many of the world's cultures. As populations grow and migrate, beliefs and practices change, too. In the United States, it has become more important to understand the cultural framework for the death attitudes and beliefs of people with Hispanic and Latino backgrounds because their population is expected to double from one in six people to one in three over the next 50 years (U.S. Census Bureau, 2012). Hispanic and Latino peoples originate from countries around the world and though these countries have much in common, their cultures are not exactly the same (U.S. Census Bureau, 2011-2013).

The Latino worldview by and large centers more on the needs of the family than those of the individual. Traditional Latino families are conservative, hierarchical, and patriarchal, with clear gender roles. The family unit is extended and includes grandparents, aunts and uncles, and cousins, as well as important non-family members such as godparents and close family friends. Religion and spirituality also factor significantly in family life (Del Río, 2010). Maintaining good interpersonal relationships is key, and these are often deeply respectful and affectionate. While there are parallels to other non-Western cultures, for Latinos the meaning of family is summed up in the word *familismo* (Sue & Sue, 2013).

According to Del Río (2010), *familismo* consists of three elements: (a) a felt obligation to support one's extended family both materially and emotionally; (b) an expectation that one's family can be counted on to provide the same in return; and (c) the belief that one's family members are the appropriate role models for accepted behaviors and attitudes. Encompassed within these concepts is an attitude of respect for the patriarch of the family, parents, grandparents, other older adults, and various other forms of authority, such as physicians. With regard to health care professionals, Del Río (2010) found that reciprocal respect, "by including family members in decision making" was a factor in the quality of the doctor-patient relationship, and could affect patient satisfaction and compliance with medical advice (p. 140). The concept of reciprocal respect illustrates *personalismo*, which "refers to the development of a warm, personal relationship", in which trust is built over time and respect is received as well as given (Del Río, 2010, p. 140). Frankly, *personalismo* sounds like an excellent way to develop a warm relationship with anyone whether physician, friend, or family member.

**Final thoughts on death attitudes (no pun intended).** What is critical to understand in this review of cultural worldviews is that people differ in how they understand the world. Cultural and ethnic background needs to be considered so that people and families are treated respectfully and in a congruent manner for their circumstances. It is equally essential to recognize that there is no right or wrong way to understand the world. The autonomy paradigm, which has been primary in the United States, is likely to become a minority position within the next 50 years (U.S. Census Bureau, 2012). A more pluralistic attitude will create ripples of change in American society, the health care arena, care of the elderly, and people with disabilities, chronic, and terminal illnesses. End-of-life planning is becoming more important globally, just as it is in the United States (National Institute on Aging, 2011). Many non-Western attitudes are consistent with advanced planning for end-of-life. The problem is that the bio-ethical and legal foundation of advanced planning is based on the principles of autonomy, a particularly Western idea (Del Río, 2010). These principles need to be reexamined if culturally sensitive and appropriate care is to be provided to an increasingly diverse American society.

Support for this viewpoint can be found in a study conducted by Colon (2012) to ascertain whether acculturation and attitude are factors influencing why Latinos are under-represented in hospice programs. In a literature review of the subject, Colon (2012) noted that previous researchers studying this dilemma were reliant on a "one dimensional scale to measure acculturation", which limited the conclusions drawn (p. 231). To counter this, Colon designed a self-administered questionnaire for use with a convenience sample. Three hundred and sixty-seven people, representing a "cross section of socioeconomic groups and various nationalities of Latinos", responded "at a Latino cultural event" (Colon, 2012, p. 231). The study measured participants' knowledge of, and attitudes toward, hospice, collected socio-demographic information, and assessed

acculturation along both Hispanic and non-Hispanic dimensions. Colon was testing two hypotheses: “participants who have a lower level of acculturation will show more negative attitudes toward hospice” and “participants . . . who were bicultural, would show more positive attitudes toward hospice” (Colon, 2012, p. 239).

Ultimately, neither of Colon’s hypotheses was confirmed. What was found to be important in attitudes toward hospice were that participants had higher income and education levels, a “familiarity with the word ‘hospice’ . . . and were older” (Colon, 2012, p. 242). These results were similar to those found in a 1988 study of hospice knowledge in which the “means of dissemination” was quite important (Colon, 2012, p. 243).

Colon (2012) suggests that older people with higher income and education have more robust social networks and better methods of seeking information than those who are younger with less income and education. The discussion concludes by noting that the larger barrier to hospice for Latinos is not a negative attitude, but a “lack of information about hospice” (Colon, 2012, p. 243). Colon (2012) recommends paying close attention to socio-economic factors when providing educational opportunities about hospice to the Latino population.

Many studies have previously documented racial and ethnic disparities in health care. Could it be possible that, as is the case for Latinos, an important barrier to care for members of other ethnic groups is a lack of knowledge? It would be interesting, and potentially advantageous to other underserved ethnic groups, to replicate a similar process of investigation to discover the answer.

This section has been a long—and occasionally tedious—discussion about how various cultures and people think about death, and something of the environments that influence individual attitudes. It is also good background information for students in the mental health field seeking to improve cultural competence. We may now be able to guess why so many people in American culture are anxious, or depressed; infatuated with things, wanting more yet never satisfied, not really knowing what is missing in their lives. We now begin the discussion of how individuals move from the unspoken fears that drive a feeling of discontentment with life to one of greater satisfaction and healing.

### **From Death to Life**

The previous discussions acknowledge that death is a scary topic. Though there is no way to combat any one specific fear, there are methods of addressing some critical concerns. For many people, those who are diagnosed with a chronic or terminal illness, their concerns are related quite naturally to the weeks, months, or years prior to death. For some people, concerns about death are hidden from conscious awareness and instead manifest in symptoms that interfere with a full participation in life. For other people, those who are aging in what might be considered a normal fashion, fears or unresolved regrets arise with the awareness that their time on Earth is growing short. Regardless of the situation, people can improve their lives and continue to grow despite the challenges life presents. The question is how best to do that.

There are socially interested approaches and techniques for providing healing to individuals and families in pain. Regardless of the method chosen, individual worldviews and cultural beliefs affect the course of care, the extent to which healing can be received, what success means to the person(s) involved, and whether a successful outcome is achieved. Attitudes and approaches to death inform how we live. Equally, attitudes and approaches to life inform how we die. Healthy ways to approach the fears of living, illness, aging, and death are examined in more detail below.

**Spirituality.** For many people, one of the most challenging life situations is caring for a sick family member. For many non-Western cultures caring for aging or ill family members is expected, and though a big responsibility it is also seen as a privilege (Sue & Sue, 2013). Family care giving is likely to become a more common scenario for many people as the population ages, so finding ways to support care givers is important for all involved. Tapping into spirituality may be one means of accessing the strength needed to meet this challenge (Hodge & Sun, 2012).

While there is an overlap between religion and spirituality, there is some agreement that spirituality can exist without a belief in a particular religion, or any expressions of religiosity. Seeking the transcendent may provide a means of accessing a more positive attitude for people as they age, or when facing an uncertain future, as in the case of chronic or incurable illness (Collin, 2012). Being religious and expressing spirituality, together or separately, has been shown to provide many benefits including better physical and emotional health, improved quality of life, and better cognitive performance (Vahia et al., 2011). These benefits occur in the normal course of life, and also for those people who are encountering more difficult circumstances.

Research by Hodge and Sun (2012) supports this conclusion for Latino caregivers. In their literature review, Hodge and Sun found studies that recognized caregivers of Latino descent found more positive aspects in providing care to ill and aging family members than did caregivers of European American descent. One of the reasons for this seems to be that spirituality was a source of strength for Latino caregivers, which may be a

reflection of high rates of religious affiliation and the use of prayer in this population. Hodge and Sun (2012) show a positive correlation between using spirituality as a source of strength, and the ability to find meaning and other positive rewards in the difficult act of care giving. The main point here is that caregivers are more likely to provide better care when the experience itself is seen as rewarding and satisfying. Understanding and supporting personal spirituality, and religious observance, of family caregivers can bring about better health and well-being for all family members (Hodge & Sun, 2012).

**Hospice and palliative care.** Dame Cicely Saunders, who was inspired by her experiences as a nursing student during World War II, founded the hospice movement and established the first hospice organization in England in 1967 (St. Christopher's, n.d.). Her goal was to meet what she believed to be the needs people have related to the end of life, including the relief of pain and other symptoms, maintenance of dignity, and appropriate mental health and spiritual care. Palliative care, which grew out of the hospice care movement in the 1960s, is generally applied to medical patients with serious, chronic, or life-limiting illness (National Hospice and Palliative Care Organization, n.d.). The model provides team-based caring, support and treatment for patients and their families as they live with disease and approach the end of life (National Hospice and Palliative Care Organization, n.d.). According to the National Hospice and Palliative Care Organization, the definition of palliative care is

. . . Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice. (National Hospice and Palliative Care Organization, n.d.)

The definition of palliative care applies to the needs of living people whose needs are remarkably similar to the needs of dying people. The concept of patient and family-centered care is one of the foundations of Adlerian theory, and a common goal for many mental health professionals providing service to the public. Mental health providers are ethically obligated to the patients they serve. Marriage and family therapists are also ethically obligated to individual patients, both individuals in a couple, to an entire family system and its members, and other people in relational systems that are seeking help.

While therapists and counselors may not be able to anticipate suffering, psycho education and therapeutic treatment can empower people to understand their own individual goals and values, thereby making better decisions for themselves and their families. Through these treatments, suffering in many spheres of life may be prevented, reduced, or eliminated. Mental health care is palliative in its focus on the physical, intellectual, emotional, social, and spiritual needs of living patients.

Patients receiving hospice and palliative care, and the families who care for them, are often focused on coping. Investigations on this topic include perspectives from multiple angles and from varied points in the process. The patient, family, medical professionals, and personal caregivers all have differing points of view. Each person involved has different tasks to accomplish and different needs, which change over time. These needs are different at diagnosis, over the course of living with a disability, chronic, or terminal illness through the last days or weeks of life, and after the death of the patient.

A sense of relief from pain and symptoms, whether emotional or physical, is needed to function well in all phases of life. Preservation of dignity may be considered a basic human right for all people, regardless of the stage of life. The last need identified by Dame Cicely, providing appropriate mental health and spiritual care, might seem to be more difficult to apply to a persons needs in life. However, the existentially-oriented therapist Irvin Yalom suggests that by helping clients to confront the deep issues of existence, which include recognition of one's own death in the search for meaning, the therapist and client can reveal unconscious forces that may be the root of problems in life (Yalom, 2002).

**Good medicine and communication.** Palliative care, as noted above, is focused on the patient and the needs of his or her family. This type of patient centered care is recognized as integral to providing high quality care for all patients, and not only those who cannot be cured. Caring for patients in a way that addresses individual needs and preferences requires certain behaviors of physicians. These include basic respect for, a genuine interest in, and personal involvement with the patient in addition to high quality communication skills (Levinson, Lesser, & Epstein, 2010).

A patient's health outcome and their satisfaction with their health care provider are influenced by the relationship with the physician (Stensrud, Mjaaland, & Finset, 2012). Most relationships develop organically as people meet and connect personally or emotionally. Though the physician-patient relationship is normal, it is not necessarily a relaxed and comfortable environment for patients. In this situation, it is "the physician's role and responsibility" to take on the "emotional labor" of setting the tone for their relationship (Levinson et al, 2010, p. 1311).

Teaching physicians to attend to their own emotional reactions as they interact with patients is important in terms of how they are perceived by the patient, which in turn affects the developing relationship with the patient (Levinson et al, 2010). Zambrano and Barton (2011) confirm this finding, and that of previous research, that suggests physicians often disregard their emotional reactions and responses to patient illness and subsequent death partially because they lack time between patients to adequately process their emotions. Doing so can have a lasting impact on medical professionals, influence their interactions with patients, and affect their own lives too (Zambrano & Barton, 2011).

There are still more good reasons for physicians and mental health professionals to practice good communication skills and patient centered care. One of these is the somewhat self-serving reason of avoiding lawsuits. Gladwell (2005) notes in the book *Blink: The Power of Thinking Without Thinking*, the reason people sue their physician, or choose not to sue, involves more than negligence. There are also many competent physicians, who make no mistakes and yet are sued anyway. What is similar in lawsuits against physicians is how the patient is treated “on a personal level” by their physician (Gladwell, 2005, p. 40).

The deciding factor is the relationship between two people and how the patient feels in the presence of the physician. Those physicians who explain what they are doing, look directly in the patient’s eyes as they speak, who listen carefully, and ask questions of the patient are almost never sued. Gladwell (2005) references studies conducted by a medical researcher and a psychologist to support these statements. Although knowledge and competence are essential for physicians, it appears that good communication and the ability to establish personal connections are the more critical skills allowing a physician to become a valued and trusted partner to their patients (Gladwell, 2005).

Another important reason for health professionals to communicate well, and sensitively, is the frequent task of breaking bad news. News of illness, injury, or death may signal the loss of a dream, changing a person’s life in untold ways. Breaking bad news is never an easy task regardless of the context, and it can be as stressful for the bearer as for the recipient. Adding to the difficulty is that the emotional and cognitive experience of the stress for the bearer and receiver of bad news are not aligned. For the bearer, stress rises prior to delivering the message and is reduced once delivered. For the receiver, stress rises as the message is delivered and continues to rise (Keefe-Cooperman & Brady-Amoon, 2013).

Understanding how individuals cope in these moments can help health professionals manage the delivery of bad news so as to minimize the trauma of the moment for patients and their families, or themselves. Despite this need, many people in helping professions have few natural skills in this regard and receive little or no preparation during their training (Barnett, Fisher, Cooke, James, & Dale, 2007; Keefe-Cooperman & Brady-Amoon, 2013). For medical professionals, the main focus of the difficult conversation is to help the patient adjust enough so as to begin critical physical treatments as quickly as possible.

It is different for mental health professionals, for whom “breaking bad news is a process, not a singular event” in which adjusting to the bad news does not necessarily precede moving forward into treatment (Keefe-Cooperman & Brady-Amoon, 2013, p. 267). For patients or clients seeking help with emotional, mental health, educational, or developmental concerns for themselves or their children, receiving bad news is only the beginning of the process. Moving toward treatment begins as the individual is assisted, in a culturally sensitive manner, to accept the distressing news, and then given hope they will be able to manage the new future just presented (Keefe-Cooperman & Brady-Amoon, 2013).

No matter the goal when interacting with other people, good communication skills are essential to build trusting relationships and create meaningful connections with other people. Additionally, it is important to have trusting and meaningful relationships with many people, not just with family and close friends. Clearly there is no substitute for having familiar and trusted healthcare providers who will listen as we share concerns about the intensely personal changes to our bodies and minds as we age, experience illness, and approach death. We can look to our health professionals to provide impartial, relevant, and accurate advice for many situations, if only we ask for help. A deep and satisfying source of connection may arise from a random encounter as well as from a person already known. The stranger sitting next to you on the train one moment may perhaps be the person who saves your life the next moment.

**People like us.** What if the issue does not require a physician? One possibility might be turning to others who share a similar problem, sometimes called a support group. This type of support can be used by people of all ages and for concerns ranging from addiction, depression, and eating disorders, to cardiac health, cancer, and grief support. Clergy, a trained professional counselor, therapist, or even a member of the group may facilitate group support. One of the many benefits group participants come to understand is the universality of their experience; that they are not alone in their suffering (Malone, 2012).

This one simple fact can prove very helpful when faced with complicated problems, and particularly so for adolescent girls who have experienced the death of a friend through suicide accident or other violence

for adolescent girls who have experienced the death of a friend through suicide, accident, or other violence.

Young girls in this situation sometimes find well-meaning family, friends, or teachers minimize their grief, which causes a variety of problems in other areas of their lives. Malone (2012), a counselor in private practice, determined there was a need to better serve this population and established an adolescent girls' group in three school districts in Texas to find methods to help the girls cope more effectively with their grief.

Of the four treatment groups established, the 20 girls had experienced a total of 28 peer deaths over the previous 2 year period. Many of the girls participating suffered physical symptoms such as stomachaches, headaches, and difficulty sleeping. Participants also struggled with their emotional reactions, feeling confused, angry, guilty, frustrated, and sad. Many were uncertain how to act. Various interventions and exercises, along with the knowledge that many girls shared similar physical and emotional responses helped them learn to alleviate tension and also validated and normalized their experiences (Malone, 2012).

Many of the girls were feeling socially isolated and were inhibited in talking about their grief with their friends. The group was a safe space for the girls to talk about their loss and connect with others who were able to relate. Conversations with one another helped them gain new perspectives, and empathize with each other as they learned to share difficult thoughts, listen and provide feedback in healthy ways. Malone (2012) concluded that adolescent girls groups could provide valuable assistance to teen girls who experience a peer death and should be considered as a viable intervention.

Supportive groups and group therapy can be an important means of connecting with people one might not usually turn to for help. For people with terminal illness though, a typical support group may not be enough to improve spiritual well being and a sense of purpose and meaning in life. Breitbart et al. (2010) referenced a 1997 report by the Institute of Medicine noting that spiritual well being is "one of the most important influences on patient quality of life at the end of life" and developed an intervention for advanced cancer patients to address this need (p. 21). Based on the work of Viktor Frankl, they created what is now called meaning-centered group psychotherapy (MCGP) "to help patients with advanced cancer sustain or enhance a sense of meaning, peace and purpose in their lives even as they approach the end of life" (Breitbart et al., 2010, p. 23). The focus of MCGP is to help patients explore concepts and sources of meaning in his or her life, the impact of cancer on his or her identity, and to understand his or her personal and historical sense of legacy (Breitbart et al., 2010).

Patients were randomly placed into either MCGP or supportive group psychotherapy (SGP), another established intervention that focuses on allowing patients to share cancer concerns, emotions, and experiences, discuss problems, and methods of coping. Patients' opinions and perceptions were assessed before treatment began and twice after completion of the 8-week group sessions. Based on the results of the assessments, Breitbart and colleagues discovered significant improvements in spiritual well being and a sense of meaning for those patients in the MCGP, as compared with the SGP. Improvements for those patients in MCGP persisted and continued to grow even 2 months after the end of the group sessions. In addition, the level of psychological distress appeared to be reduced for this group as well (Breitbart et al, 2010).

Imagine what might happen if people who are not terminally ill were to explore concepts and sources of meaning in their lives, or the impact challenging life experiences have on a sense of self. People might find peace, a source of contentment, and a sense of purpose in life, even as they are living it. This could be a promising topic for further research.

Connecting with other people, even those who are not family or friends, has unforeseen benefits for those willing to be vulnerable and authentically share their thoughts and feelings. Seeking the meaning and purpose of one's existence also provides value, certainly at the end of life, and in all likelihood at anytime of life. People who engage in these activities improve their ability to cope with the challenges they encounter.

### **From Life to Living**

The concept of death is so frightening for many people that it simply cannot be acknowledged. Instead it is transformed from a fear of death into a fear of life. This unacknowledged fear of death is a driving force causing people to creatively mismanage the tasks of life. In so doing, they distance themselves from others, thereby greatly reducing opportunities to find meaningful ways of connecting with other people. This lack of connection with other people reduces an individual's ability to be fully engaged in life, which ironically solves the original problem. If one does not contribute to or engage with life, then one cannot be hurt by life. If one does not live, then one cannot die.

This is a beautifully symmetrical solution. Unfortunately this perfect solution creates other problems. Of course it could always be different, and there are many ways to live a satisfying life. Various techniques for approaching and coping with a fear of death can also be used to help people live more fully. The opposite holds true as well; tactics for more effectively dealing with a fear of life will ultimately help manage death anxiety. Symmetry is present here as well. Instead of continually resisting life and denying death, learning to

effectively solve the problems of living helps individuals connect with one another, bringing greater meaning and satisfaction to all of life, including the very end of it.

**A metaphor for living.** What is it about connection that is of such vital importance? The simple answer is that human beings cannot live in isolation from other people. Reality is tested, and confirmed or denied, in relationship to others. A more personal interpretation explaining where the need for connection comes from may be found in a discussion of the universe. It must be understood that these ideas are a personal fiction to explain how the world works. The only proof of these ideas is to be found in the life experience from a sample of one person.

According to astronomers, physicists, and other scientists, the universe exploded into existence with a very loud bang. What existed prior to that is unknowable. The universe began growing immediately and has been in constant motion for more than 13 billion years. The number of ways energy comes together to create the heavenly bodies that populate the skies, and the human bodies that populate the planet is seemingly infinite. While many human and heavenly formations are similar, many are vastly different from one another. Planets are created and they grow by incorporating the energy of other heavenly bodies as they collide (collision = connection = growth). Stars are born; they shine brightly and explode, their expended energy rearranging into new patterns. Galaxies are created through accretion and collision, and are reborn over time. Every iota of the universe that is present today was also present at its very beginning. Everything needed already exists. Nothing is wasted, and nothing is ever lost.

Life is the universe for each human being who was ever created. Each person's awareness of life begins in the instant he or she is born. Whether existence occurred prior to birth for that person is unknowable. The healthy infant begins growing from the moment of birth; learning and changing through interactions with others, and continues until the moment of death. We are recreated through the energy received from our connections with other people.

People continue to grow and change throughout life, from young to old, from ignorance to wisdom. We are constantly moving from one state of being to another, preferably from lower to higher and more evolved states of being. We move to become more perfectly who we are, and who we continually strive to be—the highest and truest version of the self. To accomplish this we must be paying attention, observing, listening, learning, experimenting, and changing, all the time. If we stop moving, growing, and changing, life ends—literally or figuratively, and sometimes both. Moving backward or being stuck indicates that we have not mastered some facet of a life task, and another opportunity to learn and grow is presented so we may try again.

The universe began from a single point in space, where all that exists today was one. Even if only for a moment, everything was intimately connected for that eternity of time before the universe exploded. All people share this genesis, and during our lives we strive continuously to recreate the intimacy of that moment. Humanity is a single creation in this universe and though each person is unique and separate, the absolute and unchangeable value of all individuals is exactly the same.

This fact of life (though unproven here) is highly suggestive (to this sample of one) that whatever governs the universe must apply equally to each separate individual, as it does to humanity as a whole. We began as one and though we are now separate, we do not and cannot exist on an individual basis. We seek connection with friends, family, and others as the means to recapture our very essence. Everything needed already exists. Nothing is wasted, and nothing is ever lost. How can it not be so when each of us is created of the same pure stardust resulting from the primordial big bang?

The grandeur and design of the universe generates a sense of wonder and awe that sentient life exists. Whether by design or accident, that we live at all suggests that each life, all lives, are inherently worthy. We have much in common with each other. This is why the commandment to love thy neighbor as thyself makes sense. It is social interest, a clear lens from which to perceive the experiences of life. If one has the faith to operate under this belief, then it is no great leap to understand the Adlerian theory that suggests the meaning of life is to contribute to the whole (Powers & Griffin, 2007). Doing so is of great benefit to other people, to oneself, and additionally it just plain feels good to be helpful and useful to other people.

**Cooperation.** In order to live fully and well, in concert with other individuals, one must be able to cooperate. This means contributing to the well-being of the self and that of other people, too. Individuals moving toward a similar and useful purpose “for the benefit of the community”, whether separately or together, will meet the challenges of living on this earth (Slavik, 1999a, p. 212). It is through cooperation with others that individuals thrive as they attempt to manage the tasks of life. Adlerian therapists help their clients learn the benefits of cooperation by modeling that behavior as they work together in service of the client's goals (Slavik, 1999b). “Psychology means establishing a cooperative contact; it is a dialogue-based relationship between two equal human beings” (Jääskeläinen, 2000, p. 149).

For those people who are uncooperative, giving in or giving up may be perceived as leading to a worsening of their situation (i.e., needs will not be met). Without help in learning other ways of interpreting life experiences, this mistaken idea of reality will color all of life with the same brush. Eventually this leads to neurotic behavior, thereby limiting success in meeting life tasks. Oddly enough, an excessively cooperative attitude could also be a neurotic response to life. Cooperating by striving always to please others in the belief this is the only way to meet one's needs can be as damaging to the individual, and equally limits success in meeting life tasks as much as having the opposite orientation does. Living at either end of the spectrum, being wholly uncooperative or cooperating in the extreme creates problems. This illustrates well the creativity human beings bring to solving life problems.

One's "lifestyle convictions are fictions" as Alfred Adler described it (Slavik, 1999b, p. 460). Yet regardless of their outward appearance, our mental fictions are necessary to understand and interpret life. They help "define and create current situations as if they were like . . . the past", allowing one to determine how to act in the present (Slavik, 1999b, p. 460). This psychological framework allows people to orient themselves in the world, while reducing the ambiguity of interacting with unknowable others (Slavik, 1999b).

The difficulty is to create a balance between the neurotic behaviors generated to manage the fear of exposing an authentic self (needs) to the scrutiny of the world and more importantly to oneself, and possibly be condemned to separation from others; and the recognition that our fear is only an emotion. The cure for fear is not to eliminate or run from it, but to recognize it as a precursor to growth and learn about oneself in the process of moving through it.

**Courage.** Action, a movement in one direction or another, is necessary to get beyond fear. One must make a choice to make progress in life. Choosing involves evaluating options, determining which fits best with personal goals, and then making a decision. Unfortunately the 5 year old waiting for the big, yellow bus on the first day of school only knows he feels like crying and does not want to go. He wants to stay home, safe and secure with mommy. Clearly, he needs courage to get on the bus. Unfortunately, every phase and stage of life will bring challenges like this that require courage to resolve.

Why is this so hard? To some extent, it is hard because that 5 year old is still very much alive inside each of us. That young child has precious little self-awareness, much less knowledge, and even less experience in the world. To him (and to us) it appears everyone else knows exactly what to do, how to act, what to say, and when to say it. As we get older we do actually learn from our experiences. We also learn how big the world is, and how little we truly know. We will always have to make decisions without full and complete information, and this alone is frightening enough.

It is also complicated because our choices represent who we are, who we think we are and want to be, and what we want for ourselves. Our decisions symbolize our thoughts, made visible to the world. We become exposed and vulnerable, no longer alone in a private world where consequences do not exist. There are people whose opinions do matter, our friends, family, and co-workers. Even the opinions of acquaintances through social media matter to us. Someone is sure to express judgment about my choice, about me, of what I just did, of who I think I am, of how that reflects on him or her, and what he or she wanted me to do, or thought I should do, or should not have done.

It takes courage to open oneself up to that kind of scrutiny from our family and friends. Unfortunately there is more than the judgment of others. Assume I accept the censure of my peers, convince the naysayers (my parents, spouse, best friend) that I really do know what I am doing. And then, it all goes to hell in a hand basket. I screwed up, made the wrong choice, forgot my lines, fell flat on my face, bought a lemon, got a bad haircut, failed out of school, drank too much, got a ticket, hurt your feelings, wasted all the money. I know what they think of me. I look dumb, worse than dumb, stupid. I am not even close to perfect, and now everyone knows. They probably hate me; I can never show my face in this town again.

Well, maybe that is a bit dramatic. But really, who wants to go through all that? Perhaps it is best not to even try. I can just sit quietly here, in the closet, in the dark, and then everything will be fine. No more mistakes. No more pain. No sadness. No disappointment. No change. No growth. No fear. No courage, and oh yeah, absolutely no fun.

The prospect of failure is so discouraging for some people it stifles movement. Failing, doing poorly, or being wrong about something feels irreversible. Failure though is only a word, just like fear is only an emotion. Failure is not a judgment regarding one's value or worth, but a consequence of movement and believe it or not, evidence of courage. When heeded appropriately, it is usually a temporary condition that slows movement towards a useful goal. Failure is feedback, a signal to step back, reevaluate, and get more information. Maybe a change of direction is needed, a detour. Perhaps doing something completely different is warranted. Failing creates an opportunity to try again, and perhaps make a new mistake. There is no question courage is essential

creates an opportunity to try again, and perhaps make a new mistake. There is no question courage is essential.

Without a doubt, we need courage to fuel the energy required to try again. We also need courage to apologize or make other amends, if another is hurt through our actions. Even with courage however, the glaring proof of imperfection is still a bitter pill to swallow. There is good news though. Perfection is not required to successfully meet life's tasks.

Only movement is necessary. In fact, seeking perfection can hinder movement. This can be a relief to people who cannot acknowledge their imperfection. Human beings have always been, and will always be, perfectly imperfect. This is the human condition—no other option is available. Human beings are wired for discovery, which implies there is much for us to learn. From the moment of birth, we make mistakes as we grow less imperfect, not by seeking perfection. The only way out of this paradox is to face one's own imperfection and practice becoming "less and less" perfect (Lazarsfeld, 1991, p. 94). Human beings must accept with humility and humor that imperfection drives growth. Perfection does not.

We are habitual creatures. Actions that accomplish our goals are repeated with the expectation they will continue to do so. When these same actions are no longer effective, we do not always notice and instead, work more diligently to reach our goals. In this way we perfect our mistake, defeating the point of making the mistake in the first place, which is to help us learn. This is the definition of a failed mistake, one in which the lesson remains unlearned. A discouraging and demoralizing state of affairs at best, recycling old mistakes leads to great success at finding new ways to fail. The truly successful mistake is one where the lesson is learned relatively quickly. We can then courageously move toward making new mistakes and continue solving the problems of living.

All people struggle with the same issues regardless of who they are, where they live, or any other difference that separates one from another. The questions are the same. How do I get along with my family? How do I make and keep friends? How much love can I give and receive in my life? What am I passionate about and how can I use it to bring value to others and myself?

The answers change over time, as do the circumstances and problems of living. What works brilliantly for the teenager will not work for the adult in mid-life, nor is it meant to do so. Nonetheless, each person begins the search for his or her specific answers in a similar fashion. It starts by looking inside oneself with an open mind, and a heart opened wider, to accept graciously the singular and exclusive combination of stardust that creates each one of us. Everything needed already exists. Nothing is wasted, and nothing is ever lost.

**Compassion for the self.** Assume for a moment it is true that the universe, the heavenly bodies, and all the people living today were created in the same instant. Every form of life, whether animate or inanimate, is comprised of the same basic elements of energy. So even though human beings are individually distinct, the experience of living on this planet is common to all. We share our humanity through the five basic senses that allow us to perceive the world and the emotions that are recognizable regardless of culture or language. We share our humanity in our experiences of wonder, love, happiness, joy, and delight, as well as confusion, sadness, pain, and despair.

Many people also share the belief that compassion is an appropriate response to those who are suffering. Many of these same people judge themselves to a higher standard, berating themselves relentlessly for their failures and imperfections. They believe themselves so uniquely bad there is no possibility of excusing or explaining their special awfulness. This increases a sense of isolation, causing a further downward spiral into discouragement, depression, or despair. This makes little sense, for if others are worthy of our compassion, are we not worthy of our own (Neff, 2003)?

The concept of self-compassion affirms that we are not separate from others, but a member of the same imperfect human species, and connected to others by means of our common humanity. Our suffering is, and we are, worthy of receiving the kindness and compassion shown to anyone in pain. Through self-compassion we forgive ourselves for our imperfect humanness, speak kindly to ourselves and so refresh our courage and gain the strength to persevere (Neff, 2003).

Though the details of one's life are unique, we share similar circumstances we must each contend with and master. For the vast majority of people, it is not a question of whether something inconvenient or unpleasant will happen, but when. Self-compassion allows us to mindfully attend to these moments, secure in the knowledge that all human beings feel similar emotions as a condition of being alive. We can instead reflect on painful moments with greater perspective, express kindness toward ourselves, and let go of harmful self-judgments. One is not above the other, nor is he or she below. We are the same, and the experiences of living happen equally to each of us (Neff, 2003). This must be too good to be true. How can we act on this advice when we are still so afraid of disappointment, sadness, illness, fear, and death?

### **Therapeutic Considerations**

What have we learned so far? First, embodying a cooperative attitude is a likelier route to building

loving relationships, finding success at work, and developing meaningful friendships than is a competitive attitude. Second, a courageous approach to living is necessary to cope with the natural disappointments and difficulties of existence. Third, a self-compassionate attitude engenders kindness, increases a sense of connection with others, and allows us to maintain healthy self-awareness without creating drama and chaos for ourselves. Self-compassion also builds resilience, and has been shown to positively impact mental and physical health (Hall, Row, Wuensch, & Godley, 2013). Each of these concepts can help individuals develop a stable foundation for managing the challenges and fears of living well and dying peacefully.

How can a new therapist incorporate these concepts into a therapeutic practice? As with many skills, one must be able to practice what one preaches. Examine the heart and the mind to evaluate whether one's actions are congruent with the values of cooperation, courage, and self-compassion. Be mindful that living these values constitute a practice in name and in deed. As such, we will likely have many occasions to practice self-compassion as we grow in self-knowledge and competence.

While it is important to be a positive role model for clients, we must also be willing to present our imperfect and good enough self to them. The client needs to know we journey with them, striving to become our best selves just as they do. We need each other for support as we learn together to walk the talk on our separate paths.

### **Gratitude**

What is one of the first things many of us are taught to say as children? Thank you. It is good training to express appreciation for the gifts we are given, whether or not we asked for it, like it, or even want it. There is always something to be grateful for and for some of us, finding it may be key to healing and recovery. If one's normal outlook on the world is one of cynicism, do not jump in with both feet, but start small instead. Focus on the simple miracle of waking up to a new day, the pleasant smell of coffee, or the love of a faithful pet. There are many small miracles that occur each day for which we can be grateful. We can learn to gradually increase our recognition of the many blessings of living in each moment—in this place, at this time, with the people surrounding us. Concentrating on gratitude brings up even more to be grateful for, more positive feelings and fewer negative emotions. Even the simple awareness of positive emotions can be a blessing (Emmons & McCullough, 2003).

McCullough, Emmons and Tsang (2002) found that grateful people are more socially interested in others, “providing favors, as well as emotional and tangible support” for the people in their lives (p. 118). These behaviors support and enhance connections between people and are consistent with Adlerian theories espousing social interest as one measure of mental health. This same study found those with a grateful disposition to be more inclined towards religion and spirituality, which in other research has shown to be beneficial to mental and physical health as well (McCullough, Emmons, & Tsang, 2002; Hodge & Sun, 2012).

In later research, Emmons and McCullough (2003) confirmed that “the experience of gratitude” could stimulate and “strengthen social bonds and friendships” further reinforcing attachments between people (p. 388). They reference as well the “broaden and build model of positive emotions” by Fredrickson (as cited in Emmons & McCullough, 2003) as the means in which gratitude increases well-being by building “psychological, social, and spiritual resources” (p. 388). Cultivating a grateful outlook on life is associated positively with “life satisfaction, vitality, subjective happiness, optimism, hope, and . . . negatively with . . . anxiety and depression” (McCullough et al, 2002, p. 118). An attitude of gratitude “makes people feel good in the present” without the cost or negative side effects of prescription drugs (Emmons & McCullough, 2003, p. 388).

### **Connection**

The need to connect with other people is a repeating theme in this document. Whether acknowledged or not, connection is also a fact of life for human beings. We are social creatures and have a strong need to belong somewhere, and to be significant to someone, in order to function at our best. Connecting with people, even with those we do not know well, enhances our sense of belonging and makes us happier than being isolated (Sandstrom & Dunn, 2014). While it is certainly possible to live in mental or physical isolation from others, doing so is a severe punishment to the person and has lasting negative effects on the psyche. John Donne captured this reality perfectly with his words, “no man is an island, entire of itself; every man is a piece of the continent, a part of the main” (Donne, n.d.). We live only in relationship with the people we choose to have around us, and we create our world every day through our connections.

Our society encourages independence and autonomy. These are wonderful goals, but striving for and attaining them does not create a full and happy life. Without the presence of, and meaningful interaction with, other people in our lives we cannot realize our full human potential. Seeking and finding connections with people is as necessary to mental and physical health for adults as it is for infants and children. Maintaining close ties with family and friends are very important, but surprisingly even weakly held ties with acquaintances

close ties with family and friends are very important, but surprisingly even weakly held ties with acquaintances and near strangers can add immeasurably to one's sense of belonging in community. Go ahead and say hello to everyone you pass, maybe strike up a conversation with the local barista, neighbors out walking the dog, that guy in spin class, even the librarian. These peripherally connected people are part of your "diverse social portfolio" and they increase your social resilience and boost your happiness at the same time (Sandstrom & Dunn, 2014, p. 11).

Have you ever noticed that when you make the effort to really talk with someone and learn who they are, you find many things in common with him or her? Perhaps you are both family caregivers; you help your aging parents while they have an autistic child. Maybe you both are adult children of divorce with stepparents. Perhaps you attended the same college and have many of the same friends. These commonalities are affirming, and can be found even among people of vastly different ideologies and cultures. Our differences are more accidents of birth and the specific circumstances of our individual lives. Regardless of these, we all share certain inborn desires: to love and be loved, to have a meaningful purpose, and to be safe from harm. These are worthy goals and they drive all behavior. Knowing we all share this truth can help us to be more open and hospitable towards the people in our lives, and to ourselves, and everyone we meet.

### **Self-Compassion**

Practicing compassion for the self begins a cycle of kindness, understanding, and forgiveness that starts with the self and spreads to other people, while at the same time increasing interpersonal well-being and happiness. Self-compassionate people are better partners, more accepting and supportive, less controlling and aggressive than those who are not self-compassionate. Caring and supporting the self is a way to recharge the emotional batteries needed to manage our life issues, and support those we love as they manage theirs (Neff & Costigan, 2014).

Feeling and behaving compassionately towards other people comes easier when we practice self-compassion. Because we are kind to ourselves when feeling fearful or anxious, we can respond similarly to others when evidence of their fear or anxiety becomes obvious. Knowing intimately how difficult life is for everyone, we can let go of negative self-judgments. We no longer need to judge others either, as we know that family and friends are doing the best they can in their difficult lives, too (Neff, 2003).

One of life's harshest realities is that the control we so desperately seek to maintain over our lives is an illusion. This is not an easy concept to accept. From the moment of birth, we each seek to control the environment to meet our needs. Because we usually have some degree of success, we continue using these same methods, maintaining our fiction of control, as we grow to adulthood. Once we are out in the world however, we may find that our methods do not work as reliably as they used to do. The typical reaction is to attempt to reestablish control, setting us up for further frustration and stress. Mindfulness, the third element of self-compassion, can help us be present to our suffering in moments of hardship and stress without denying our pain or getting stuck in it (Neff & Costigan, 2014).

Traditional Buddhist teachings on compassion include loving-kindness (*metta*) and mind-training (*lojong*) meditations (Pace et al., 2009). These can be used alone, or in conjunction with transcendental meditation, which aims to calm the mind and improve mindfulness, a state of focused attention. Studies examining compassion meditation practices found them to be useful in reducing stress and enhancing immune functions. In addition, *metta* meditation practices have been found to increase self-compassion, which is also associated with reduced stress, anxiety, and depression, and more life satisfaction (Pace et al., 2009).

### **Conclusion**

We who enter the mental health profession do so because we care when we see someone hurting, and we want to help alleviate his or her pain. It is important to us to make a difference in other people's lives. Unless we are able to see our pain clearly, and work towards our own healing, we will not be able to truly see, or help heal the pain of others. We cannot ethically advise our clients if we are not able to do this work in our own lives.

As a mental health professional, it is essential that we model a healthy and encouraging relationship with ourselves as the foundation for learning how to be in relationship with others. We need to share our practice of integrating the imperfect aspects of ourselves as we work toward becoming less imperfect. Every day we move toward becoming the person we hope to be. Expressing and fostering gratitude, nurturing healthy connections within and with other people, and practicing self-compassion helps us maintain balance and continue growing into ourselves. We must live in congruence with these values as we guide our clients to discover their own path of healing. The point is that this effort does not end for us until we take our last breath. This is the gift of life; if we are willing to learn the lessons life offers, we grow. If we refuse life's lessons, we become stuck. It is our choice and we can begin, or begin again, at any time. Recognizing and appreciating our many blessings, family and friends, and acting kindly and respectfully to everyone, especially to ourselves, gives us the strength to be

fully engaged, consciously living every day of our lives.

Nothing is too difficult for people who share hearts and minds to overcome their problems. We are made of incredibly strong stuff, after all even the youngest of us is more than 13 billion years old. Everything we need already exists inside us. No one can waste the energy of the universe, though we must work to find and develop our purpose. No one is lost if she or he reaches out to help, or accept help from, another.

### **P.S. Final, Final Thoughts**

The process of writing this document was a positive learning experience, though exasperating in two specific ways. Initially I had a plan regarding the topic, an outline, and a timeline, to guide the writing. The paper you just read is not that paper. This paper required continuous research even into the final sections, uncovered ideas I was hesitant to share, and refused to follow my schedule. This was uncomfortable, messy, and unpredictable. My plans were irrelevant. Writing a thesis is just like life, a wise (chair) person suggested to me... So just as I must in my actual life, I remembered to get comfortable with being uncomfortable. My progress was easier after that.

My second concern regarded managing the pronouns to meet APA guidelines. This was a struggle, as APA requires the writer to remain aloof and impartial in tone and words. But I could not maintain the objective and separate voice APA requires. The topic covered applies to everyone—including me, and I do not wish to, nor could I, disconnect myself from the rest of humanity. I, you, she, he, we, they, them. We are together in this life. It is important to remember that. It is equally important to remember that in this messy and unpredictable life, sometimes it's okay to break the rules. (Yes, I did just use a contraction!)