

# ‘Just live for today’. Living, caring, ageing and dying

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## **ABSTRACT**

There is an assumption in western societies that death in old age is not only ‘natural’ but also ‘easy’. It is often characterised as death which occurs at the end of life with goals complete. By contrast death in youth is a traumatic and untimely end. This paper draws on interviews with people over the age of 75 to explore the nature of attitudes to death in old age. It focuses on the issues raised by elderly people themselves when given the opportunity to talk about death and dying. In so doing, attitudes to death and dying are separated into ‘death of self’ and ‘death of other’. Each of these categories is then divided thematically according to the issues raised by respondents.

**KEY WORDS** – death, dying, attitudes, caring, self, disengagement.

## **Introduction**

And I sit and think that I’m lucky to be here I must make the most of it while I am here. Just live for today, that’s all you’ve got to do. It’s no good thinking of years to come because you don’t know from one day to another. I could go out, get knocked down and be killed. So I don’t think about what is to come, I think about today.

There is an assumption in many western societies that elderly people accept death as an inevitable and natural event in old age – an event which loses its frightening character as the individual becomes older. In 1984 Averil Stedeford in her work, *Facing Death*, wrote of the elderly person that,

He [*sic*] can see old age as a bonus, a time of less responsibility and rush, when he can take each day as it comes. For him, death is not so threatening. He sees it more as a natural event, to mark the completion of his life. ... For such a person, death may come easily, as it should. Mortality is less alien for him, for he has had plenty of time and opportunity to accept its gradual approach as his life has progressed. (1984: 76)

Despite references in The Old Testament which remark on the

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healthy old age of many of its patriarchs (Baily 1979), the notion of old age as the most 'natural' time to die is a relatively recent idea in Europe. In previous centuries, and indeed until the early part of this century, people frequently witnessed death in infancy, youth and middle age (Ariès 1981). Due to a high infant mortality rate, children especially were encouraged to contemplate their own, routinely premature, end (Mitchison 1977; Walvin 1982). By contrast, modern Western society has assumed a modicum of control over the more 'adventitious' aspects of death (Parsons and Lidz 1967; Illich 1976) and now the modern 'bad death' is the 'untimely' or premature end (Bradbury 1996). To die in childhood or youth is death out of time and it brings emotional devastation for survivors (Rando 1986; Riches and Dawson 1996). Discussion of such tragedies often dwells on the 'waste of human life' and the belief that someone must be to blame; with greater care or more sophisticated technology the catastrophe could have been avoided. Conversely, as Stedeford (1984) argues, the 'good death', equated with the 'natural', is one which characteristically occurs in old age with life projects complete. In this representation death adopts a rather benign persona, visiting only those who, aged and frail, welcome its approach as a merciful release from the trials of life.

Disengagement theory offers an understanding of how society prepares its members for death in old age. According to Cummings and Henry (1961) preparation for death is achieved through a process of disengagement. Disengagement occurs as the individual and society prepare for the inevitable, final withdrawal – death. According to this scenario disengagement is gradual, proceeding through a sequence of stages beginning with decreased role engagement, preoccupation with self, social death and, finally, biological death. Disengagement theorists regard this progression as inevitable, universal, and triggered by an awareness of proximity to death. Emotional investment in other people or in the environment is substantially reduced as the individual becomes preoccupied by the self and with thoughts of the past. It is the recognition of a limited future which results in a person's decreased social activities and, as a consequence, in society's withdrawal from the individual.

Disengagement theory tends to go hand in hand with a belief that quality of life in old age is necessarily poor. Bodily restrictions combine with social exclusion to render life intolerable and so to bring greater awareness of the nearness of death and, eventually, resignation. The assumptions implicit in these theories are that decrepitude is inevitable and that it is lack of social contact with younger generations and loss

of role-engagement that precipitate the decline into disengagement. More recently this negative depiction of later life has been challenged and much research now suggests that many older people continue to be socially active, not only among family, but also within the wider community. It is for this reason that disengagement theory has been heavily criticised and there is now a much more positive approach to ageing. There is scant literature, however, which addresses the approach of death in old age. Furthermore, current interest in the sociology of the body has led many to re-examine the possibility of a biological imperative contained within disengagement explanations (Turner 1992).

In contrast to disengagement which is based on the idea of a mutual withdrawing of society and older people from one another, the notion of social death (Mulkay 1993) stresses society's disengagement from its older members. After retirement, as health deteriorates and elderly people are increasingly less able actively to interact with family and peers they are forced to reduce social contacts and to rely on private care in the home or public care in the hospital or other residential institution. Where once people died at all ages, now the majority die in old age. No longer wishing to be surrounded by death, the youthful avoid public reminders of mortality and restrict those reaching the end of their lives to the privatisation of the home or the confines of institutions. Dying elderly people are marginalised from society at large and, if the process of dying is lengthy and requires long-term hospital treatment, they may see less and less of family members for whom 'life has to continue': who, although capable of gathering considerable resources in times of crisis or sudden or short terminal illness, are unable to offer long-term care and consideration for their ageing relatives. For Norbert Elias this rather sinister fate, is characteristic of modern society:

Never before have people died as noiselessly and hygienically as today in these societies, and never in social conditions so much fostering solitude.

(Elias 1985: 85)

Yet, it is not necessary either to accept or reject disengagement theory wholesale. There is a further approach which suggests that once an elderly person has completed a life review and concluded that life has been satisfactory, they are then freed to live in the present (Evers 1981), to *re-engage* in a manner which activity-driven middle-aged researchers may confuse for disengagement. Without having to worry about such things as career prospects or the children's upbringing, elderly people may effectively have released themselves from younger

adult mechanisms of engagement. This form of engagement *with the present* is radically different from the goal-oriented engagement of youth or middle age.

In the following discussion, based on research with elderly people, it is clear that the majority of people interviewed had certainly not disengaged – on the contrary, most remained firmly ‘attached’ to life and spent little time contemplating their own death.

### **Methodological note**

The data on which this paper is based derive from a study concerned with quality of life for people over the age of 75 years who continued to live in their own homes. The study was undertaken between 1991 and 1993 and was longitudinal, involving three rounds of in-depth, tape-recorded interviews with people from a sample of 100 households in two districts of a North London borough, one primarily working class and the other middle class<sup>1</sup>. This research was concerned with the maintenance of independence and autonomy among people over the age of 75. It did not primarily focus on attitudes to death and dying. However, whilst conducting semi-structured, in-depth interviews in the homes of interviewees, respondents frequently raised issues and talked of concerns which were not directly related to the primary purpose of the study. Death was one such issue. Respondents’ comments were prompted by various stimuli: scheduled interview questions relating to family and social relationships, activities, financial circumstances or support networks; or respondents may have been bereaved since the previous visit or have become ill themselves. Thus the discussion here is based on information volunteered by respondents. The nature in which this data was gathered is significant as it reflects the views and concerns of people who, for one reason or another, were particularly interested in talking about the subject. The dialogue between researcher and respondent was, therefore, founded on issues which the latter deemed important rather than those which might have conformed to the researcher’s agenda. Although the opinions of these respondents are not representative of people over 75 as a whole, in presenting their concerns this paper gives voice to the sort of views which may well be reproduced in similar intimate conversations.

Between 1991 and 1993 I conducted two rounds of interviews with 72 people in 55 households. Of the respondents, 42 (58 per cent) made some mention of death. The forms it took range from a brief observation on the nature of a neighbour’s death through to a lengthy

exposition of the death of a spouse, or reflection on the way in which they themselves would like to die or to have their funeral conducted.

### **Themes**

So, what features emerged from these elderly people's thoughts on mortality? First, their diversity was striking. At one extreme were those who spoke of their readiness for a welcome death. By contrast, others clearly preferred to think only of the present or expressed feelings which suggested they clung fiercely to life. One explanation for this great diversity is that attitudes were influenced by quality of life – the more able-bodied and socially active respondents generally reported extensive social contact and had little time for thoughts of death. Moreover, although there appeared to be considerable consistency in opinions about death in general, there was nevertheless incongruity between the conceptual understanding of their own death, and the death of others for whom they cared. For example in discussing their own end, concepts of the 'good' and 'bad' death were frequently used. When describing the death of another, most usually that of a spouse, the same terms took on different meanings. For this reason, in the following discussion, respondents' attitudes to death and dying are considered through two frameworks: *the death of self* and *the deaths of others*.

### **Death of self**

People's thoughts about their own death can be categorised into four major preoccupations: (i) 'good' and 'bad' death; (ii) the extent of control which they might be able to exert over this final status passage; (iii) the way in which death could be legitimated or made meaningful; and (iv) the question of funeral rituals and the desire to be remembered. Although divided here it is important to recognise that these concerns were interlinked. For example, whether a death was perceived as 'good' or 'bad' partly depended on the extent of control over its timing and location. Similarly, satisfactory funeral rituals could add value and meaning to the death and so assist in defining it according to the good/bad dichotomy. For the purpose of this paper, however, each category will be explored in turn.

#### *'Good' and 'bad' death*

'Good' death came in many forms but, for those who spoke of it, the overriding desire (71 per cent) was for speed and ease. Death which was

quick and took the person whilst asleep, and so unaware, was especially favoured.

I hope mine's quick and easy. ... A neighbour down the road her husband died suddenly without warning, he had a heart attack and died. ... If he had to go that's the best way and I hope it happens to me.

By contrast the 'bad' death was a lingering, painful one where the victim suffered loss of physical or mental abilities, effectively becoming a 'non-person'.

If it comes to the time someone's got to wipe my nose, which means waiting on me and everything, I might as well go. ... I'm a very independent person. There's no point in living if I can't do anything for myself.

Concern not to become 'a burden', as many other studies have shown, is a particular worry. This was specifically mentioned by 62 per cent of respondents. In relation to their thoughts on death and dying, the lingering bad death was made worse if their care fell upon a son or daughter.

I don't want to live until I'm a lot of trouble to people. All the time I'm able to look after myself and do for myself I'm quite happy but I should hate to have to tie my daughter down looking after me.

### *Controlling death*

Control refers to the individual's ability to influence the mode, method and timing of the dying process and of death. It is the extent of control which is commonly seen as significant in conceiving of death as good or otherwise (Bradbury 1996; Elias 1985). For example, the hospice movement, geared primarily to offering palliative care for cancer sufferers, is premised on the idea that the distress of people with terminal illnesses can be greatly alleviated if they are aware of their condition as terminal and so able to prepare themselves and their families for death (Saunders *et al.* 1981). For the people in this study, control was characterised in a number of ways. Although on the one hand there was a desire for a quick death, on the other, knowledge of the approach of death was seen as enabling people to make important preparations. Pre-warning, it was thought, afforded the opportunity to 'say goodbye' to friends and family and to ensure that 'affairs were in order'.

The actual timing of death was repeatedly remarked upon in an almost fatalistic manner, suggesting that ultimately there was little anyone could do to 'tame' death. A 78-year-old woman, who had just survived an operation for a blood clot in her arm, remarked with some gratitude that:

It wasn't my time to go was it? When it's my time to go I suppose I'll go... If God wants you he'll take you.

A further aspect of controlling the death was the extent to which the bad death could be avoided. Some respondents talked positively of euthanasia as a solution to the potential trauma involved in suffering a lingering demise.

I'm hoping I'm gonna die at the end of this year, that's what I should love... Well I've seen my garden and I'm getting more helpless so I don't want to live on. There's nobody to help you. I think doctors ought to be able to give you a sleeping draught. Then you put it there. Then you think, 'now shall I or shan't I?' You leave it for a little while, and maybe, might just as well, and then, finish. I mean you're a drag on your children, somebody's gotta come and look after you and if you're incontinent – I'm a little bit incontinent but not too bad. I don't think people should live when they're fed up... I mean really and truly once you're past it... I mean they keep people alive for years when they just go to bed and get up.

It was not so much death that this woman feared but the transformation from being a person to being 'just a body'. Like others, she dreaded a long drawn out death, believing that she might not only lose control over her body but over her entire life. Whether by euthanasia or natural means, death which ended long-term suffering was legitimated, by all who spoke of it, as a 'merciful release' – an end to pain and indignity.

#### *Legitimizing death*

As we have seen the concept of the 'good death' is linked to its appropriate timing along the life course. It is also constructed according to its legitimacy. Marshall lucidly illustrates the manner in which these two criteria are combined to legitimate both *dying* and *living*.

The symbolic construction of a 'good death' – one that is seen as appropriate and legitimate – reflects then a delicate counterpoise between legitimation of one's life and legitimation of death itself... Legitimation for death can thus co-exist with legitimations for continued living, held in reserve, so to speak, for when they will be needed.

(Marshall 1974: 32)

For some, having seen children and grandchildren grow to maturity was an expression of the completion of life goals. For these people, death was legitimated and deemed appropriate because it was 'time to step aside and make way for younger generations'. Indeed, some perceived death as meaningful through a belief in an after-life, and the prospect of reunion with those 'gone before' was often warmly anticipated.

As Marshall suggests, however, legitimisation for dying can co-exist with legitimisation for living – a legitimisation which frequently took the form of being needed to care for a family member. In this context, although much of the discussion here is based on the thoughts of widowed people as we shall later see, this rationale was often used to describe the period of care for a sick or dying spouse. Indeed, one recently widowed woman who had raised a granddaughter and tended her sick husband for a number of years, voiced this opinion quite clearly. After explaining that 20 years earlier she herself had almost died, she now believed that she had survived in order to care for her family.

[At the time] I said it'd be better if I die; they'll be sad but they'll have to get on with their life and it'd be better if I die... And when my daughter died and the question was going all round the family, what's gonna become of her baby? I said, well that's why I've survived. And I knew, and I still feel now, that's what I got better for – to do something useful. Otherwise I didn't deserve to have that return to life.

#### *Ritual and remembrance*

Most of those who stated a preference, elected for cremation as the mode of disposal of their remains. Despite having grown up during a period when burial was the norm in Britain, respondents tended to refer to cremation as 'cleaner', 'more hygienic' and 'safer'.

My mother and father were buried 'cos they never had cremation in those times. And I used to lay in bed and think, there must be nothing left of 'em – just skeletons. Why didn't they have cremation years ago? I think it's cleaner. I mean a lot of people now die of cancer... but I mean when they bury 'em and they've got that in their body it's still in the air, it can't be all in that box all the time. So I do believe in cremation.

This attitude to disposal was unexpected. It suggests a distinct departure from strongly held beliefs in the 19th and early 20th centuries in the appropriateness of burial and the sanctity of preserving the body, whole, to the grave (Richardson 1987). If, however, ideas about disposal have changed, these respondents' views on funeral ritual remained in close accord with those of an earlier period. One particularly notable practice among those living in the working class area was their continued contribution to burial insurance schemes. Born in the days when burial insurance meant the difference between a pauper's burial and a 'decent' funeral (Howarth 1996), most of those interviewed in the working class district continued to pay their weekly or monthly premiums. Often the pay-out from these policies, which most had held since birth, was not expected to cover the cost of the



funeral. In this case money had usually been set aside to ensure that they would not be 'a burden' on the family or suffer the ignominy of being buried 'on the parish'.

A further interpretation of the desire for a 'decent' funeral is its utility as a means of regaining some of the status formerly lost through social marginalisation. Elderly people may have little or no control over the process of dying but they are still able to exert influence over the ceremonial farewell. Assuring themselves of a reasonably conspicuous funeral may restore a social standing lost in life (Matthews 1975). Apart from ensuring that there were sufficient funds – a cause for which some said they deprived themselves of holidays, clothing and 'luxuries' – people told their relatives of special requests, such as a specific type of flowers or the inclusion of a particular piece of music at the funeral service. They were thus able to exert preferences which would influence others' perceptions of the funeral and of the deceased.

### **The deaths of others**

Regarding others, respondents primarily talked of the death of a spouse, a sibling, or a son or daughter. Many of the people who had experienced the death of a child expressed their distress about the untimely nature and inappropriateness of a death which they felt should not have preceded their own. When discussing the death of a spouse, however, premature timing was not usually a feature of their grief. Given that the majority of respondents were widowed this discussion will concentrate on the death most frequently mentioned, that of a spouse. Their concerns are organised into four primary themes: (i) the dying process; (ii) caring for the spouse; (iii) the death itself; (iv) after death.

Differential mortality rates meant that, of the 35 widowed people interviewed, 29 were women. For that reason discussion of the death of spouse is, for the most part, based on the experiences of widows.

#### *The dying process*

Losing a partner in old age can be an especially traumatic event. Many respondents had been married for over 40 years. Some said that when their spouse had died they felt as though they had lost a part of themselves.

We were childhood sweethearts. We'd been together for over 60 years. When I think of what we've been through together! When he died I felt as though a part of *me* had gone.

For many widows the death of their husband had been a lengthy and painful experience. In keeping with the pressure on medical science to extend life (Illich 1976; Elias 1985), there was often substantial medical intervention and periods of hospitalisation prior to death. Some of the women reported occasions when they had expected their husbands to die but the hospital had 'pulled him through'. Although all realised that death must come eventually, for most, their impulsive response to acute illness was to contact the doctor or hospital. Relying on medical intervention in this way meant that they and their husbands often had little control over the dying process, as the patient was shuttled between home and hospital for months or even years.

This period was remembered by some as one in which they had 'trusted' the medical profession to 'do what was best' and to 'make the right decisions' on their behalf. One clearly significant issue, frequently mentioned by respondents, was the disclosure of a terminal diagnosis to the dying person. Only one widow said that the doctors had told her husband that he was shortly to die.

... when the doctor came in he said, 'Well Mr M, I'll come round to see you but I can't do anything more for you. You've had everything and we can't do any more for you' ... So he (husband) said, 'Oh well, that's it'. He just shook his hand and said, 'Thank you very much for telling me. Now I know' ... And when [the doctor] went out, when he got to the street door, he said, 'Isn't he marvellous'! And I said, 'Yes'.

In all other cases the surviving wife or husband had been told by the doctor but the patient had been kept in the dark (see also Young and Cullen 1996; Seale 1991).

And a doctor took me into his office and he said, 'Your husband's got three months to live, make the most of it, he's riddled with cancer'. He told him he had a chest infection. He never knew.

Most of those interviewed did not regret withholding the information from their partners, even though they felt that this had placed additional strain on their relationship. The period of care at home had been particularly traumatic for one woman and had caused her deep distress as she had 'tried hard to live the lie':

Well it was knowing, knowing he was dying. Oh I don't know how I got through that.... They said that when he got too much for me I was to phone and they'd admit him. So I said to him on the Easter Monday night it was, I think you'd better go into hospital I think they can do more for you.... But I knew when he went he wouldn't come back.

One man, however, did regret not sharing the awareness of impending death with his wife. Reflecting some of the respondents of Glaser and

Strauss (1965), he described an occasion when his wife, conscious that death was near, had clearly wished to talk about her fears and sadness. His response had been to rebuke her for being morbid. He subsequently felt that it had been his own fears that made him so reluctant to allow her to share her thoughts with him.

I knew my wife was going to die but I didn't know she knew. She knew she was gonna die but she didn't let me know. But there's things they say at times and then after you think, did they want to talk about these things? She said to me one day, she'd had the hump all day long and when we went to bed I'd been lying there about ten minutes and she said, 'Are you still awake?' I said, 'Why what's the matter?' She said, 'If I died tomorrow I've had a good life.' 'What the hell do you mean! If you talk like that,' I said, 'I'll push you out of bed!' But now I wish I'd stopped and spoke to her. She might have wanted to talk about it. But that happened and that was it. I mean it was difficult.

And when the doctor told me he said, 'Do you want me to tell her?' And I said, 'No, please don't'. But then, I didn't know that she already knew herself. Course, we found that out the day after she died. Some of the patients told us. They said she knew she was gonna die.

#### *Caring for the spouse*

Unless death was diagnosed as imminent it was usual for hospitals to send the dying person home. In more than one case it appeared that the hospital had persuaded a reluctant spouse to take on the full-time care of a sick or disabled partner.

And they put it to me, they had me in the office and talked to me for hours and said could I manage him at home. They talked to me so much that in the end they badgered me.... And I wasn't very well myself at the time and I thought how can I, how can I possibly do it?

Most of the carers in this study were women who were themselves old and often frail. The caring role was highly demanding requiring both physical and mental stamina, day and night. Some of the women described how their husbands had slowly deteriorated over a number of years, and how their own lives had been increasingly filled with the tasks of caring.

Well I just looked after him myself, and they didn't send him to hospital. I looked after him, did everything for him because he couldn't do much himself: washed him, dressed him, and everything, and I looked after him as best I could.... I used to get up in the night, he'd fall out of bed, I'd get him back into bed.

All the women who spoke of caring were proud of the role they had performed. Mrs A, for example, reported receiving praise for the high quality of care she had given her dying husband.

And I think that's why I feel reasonably contented now – because nobody could have possibly done more for a man than I did for him. And as the sister said this morning, 'Mr A only lived a long life like he did because of the way you looked after him'.

In terms of the 'good death', the criteria discussed earlier, which were utilised when referring to the death of self, appeared to be inappropriate when associated with the death of an other for whom one was caring. In the widows' reflections on the last months of their husbands' lives, there was a clear contradiction between their own desire not to 'burden' relatives and the selflessness with which they reported caring for their partners.

Looking back on my life there's not one member of my family that I haven't put up at some time or other, they've all come to me with troubles... I apparently was entitled to receive attendance allowance and the nurses were absolutely pushing me to do it. They got me the papers for it and I just couldn't bring myself to apply for it. I just couldn't. I thought what I do for my husband I do 'cos I love him.

This is reminiscent of findings from other studies which show that many women subscribe to a culture which promotes care as a labour of love rather than duty (Graham 1983; Qureshi and Walker 1989; Twigg and Atkin 1994).

The attitudes of these women demonstrate a weakness in disengagement theory. In concentrating on the loss of roles, the theory fails to appreciate cultural and gender differences. Old age is a gendered experience, widowhood more markedly so. And yet, disengagement – regarding elderly people as role-limited – derives from a western male encounter which privileges roles in the labour market. For women, old age is only rarely accompanied by loss of role-engagements. For most of the women in this study, born before the 1930s, paid employment was not a primary source of social or personal identity; retirement, therefore, did not inevitably result in role-disengagement. Their work as 'domestic carers' – a significant feature of the lives of women – continued past official retirement age, into pensionerhood, and sometimes well into widowhood. This role is modified throughout their lives by stages in the lifecourse and the demands of kin – children are often substituted by grandchildren and husbands by siblings or sometimes neighbours (Howarth 1993). For many of these women the full-time care of a dying spouse had revived a role from an earlier stage in the lifecourse, albeit one for which their energy was waning.

I had to have him down here – the bed – because then I was just on the flat instead of going up and down (stairs). That nearly killed me, all that going up

and down all the time. And then in the finish, I had to do the bathing. I had to bath him 'cos he couldn't get in the bath and there was all that weight. And I said well perhaps one of the boys would come up. And he said, no, no, leave them. I don't want them, he'd say.

Similarly, Hockey (1990) notes of the old persons' home she studied, that most women found it hard to be cared *for*; men and upper class women found it easier.

### *The death*

In almost all cases the surviving spouse reported dissatisfaction with the circumstances or manner in which their partner had died. If the dying person was at home when they were near death, survivors felt it necessary to immediately call for medical assistance; almost instinctively the doctor was contacted without first considering whether the person should die at home. Their recourse to medical assistance was perceived by respondents as the attempt to save life even though, as one woman remarked, it could only have been achieved with medical technology, and then only in the short term. A further explanation given by some was that they did not know how to deal with death; their lack of experience left them afraid that they might be alone and 'helpless' when it occurred.

And the doctor said, 'I think he'll have to go away'. And I think my husband was trying to tell us that he doesn't want to go 'cos he kept saying, 'No, no...'. So I thought to myself perhaps it's just as well because I thought, well, what if he just died and I'm on my own here?

One woman whose husband had died before the ambulance arrived, had clearly been traumatised by the experience.

He died there while I watched him, I had no other choice, I just watched my husband die!

Another respondent blamed hospital staff for not asking her if she had wanted to stay with her husband on the night he died. She was convinced that they – and he – had known that death was imminent. Indeed, he had 'said goodbye' to her at the end of the visiting hour.

And I said, 'I think I'll go now. I'll see you tomorrow'. So he said, 'You've been a very good wife to me. I don't know what I would have done without you'. Now the nurses could have said, 'You can stop with him a bit longer'. But that is what upsets me. I still think about it now. See him sitting there on the bed. Why didn't they tell me?

Their own lack of knowledge of the process of dying and of the signs that death was near was contrasted by a perception of the professionals

as all-knowing. Yet, despite the expertise available in the hospital, with hindsight many women regretted the manner of their husband's death, and some actually said they were sorry it had been in impersonal circumstances, surrounded by medical technology, rather than at home in a familiar environment.

I could have been with him couldn't I? It's just the thought of being on his own when he... My daughter in Ireland, she lost her husband two years ago. She was with him when he died in her arms. When she told me that it brought it all back again...

#### *Dead but not gone*

It was not uncommon for respondents to say that they still enjoyed some form of communion with their late spouse.

...I sit here often and I can see my husband sitting there. I know he's there, he's here. And your eyes just automatically go. When you've sat in front of anybody like that you can sort of visualise them and you know what they're doing, you know.

Husbands appeared in dreams, during waking hours, they remarked on daily events, gave advice and talked of things past, present and future.

And sometimes I say to my husband 'Why can't you help me?' I used to dream about him a lot... But he used to say to me 'Stop pulling the covers off me Doll'. And I used to say 'I'm not'. I'd answer him back and when I put my arm out he wasn't there. Another thing he'd say is 'Where are the boys?' And I'm dreaming it. And I'd still answer him. I'd say 'Well they've gone out together'. When I used to look round I thought 'Where is he?'

In explaining this extension of social life beyond biological death, the work of Mulkay and Ernst (1991) is useful here. They contend that continued interaction with a dead spouse is not a form of hallucination. Rather, these women were participating in meaningful relationships – possibly one of the few close relationships which remained to them.

#### **Conclusions**

It appears from these findings that the notion of old age as the 'right time to die' is not as straightforward as is generally assumed. Modern society has witnessed increased longevity and this has raised expectations that the life-span will continue to be stretched. As people age they may no longer think of death as appropriate at 65, 75 or even 85 years. The contemplation of death is discouraged throughout life and, in later

life, reflections on mortality may well be introspective and isolated; elderly people left to deal with their fears and anxieties in private. Characterising death in old age as the 'natural' conclusion to the process of disengagement implies acceptance or resignation on the part of elderly people. Yet, for the people in this study at least, death was not always the easy and welcome experience that many among the younger generations would like to believe it is. Philip Larkin aptly captures this disposition.

Waking at four to soundless dark, I stare.  
In time the curtain-edges will grow light.  
Till then I see what's really always there:  
Unresting death, a whole day nearer now,  
Making all thought impossible but how  
And where and when I shall myself die.  
Avid interrogation: yet the dread  
Of dying, and being dead,  
Flashes afresh to hold and horrify....

(Larkin 1977)

Ageing does not necessarily release people from a fear of their own death or that of others – only from the anger of a premature end (and not always even this). The assumption that in old age people have had time to resign themselves to their own mortality and so satisfactorily complete life projects seems somewhat misplaced as the pace and culture of modern communities discourage members from dwelling on what is considered – in old age and youth alike – to be morbid or unhealthy thoughts. Indeed, it may be that the natural and easy death in old age is a construction of younger adults. In relative youth, many assume that they will most likely live until old age. Alongside the expectation of a deferred death comes an illusion that, being so distant, it is probably not unpleasant. Hockey (1990) has referred to this as a temporal boundary which complements the spatial boundaries (of, for example, the old persons' home or the hospital) between life and death.

Glaser and Strauss (1965) interpret death as a 'non-scheduled' rite of passage, and argue for greater control and increased awareness for the dying person and their family. This has been significant in the creation of hospices for dying people where they are enabled, rather than disabled, on the journey into the unknown. For elderly people, however, because the modern 'good' death is thought to belong to old age, this final rite of passage becomes a scheduled rather than a non-scheduled one. That being the case, hospice care is largely viewed as superfluous to their needs as they slip into an awareness and acceptance of mortality. The fact that most people generally spend a lifetime

avoiding thoughts of death and dying means that they do not know 'how to die'. In old age, and facing their own death and the loss of those they love, they are unlikely to be in a position to control the process of dying and to think of death in an 'accepting' and 'enlightened' fashion as the completion of the journey of life. People of all ages need to be helped out of life as they should be helped into it – with sensitivity, care and support.

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### NOTE

- <sup>1</sup> Interviews were transcribed and analysed using \*NUDIST, a qualitative data analysis package. The data used here are drawn from first and second round interviews. For further details of the research methodology see Howarth (1993).

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