

article argued that a policy of simply making contraception available to women will not be successful because fertility will decline substantially only if there are fundamental changes in features of social organization that determine the motivation to bear children. The article was lauded by conservatives and berated by liberals, despite the explicitly stated corollary, and essentially feminist argument, that achieving the goal of sharply reduced fertility would better be achieved by policies making educational, occupational, and income opportunities for women equal to those of men. Davis continued to contribute to understanding changes in the family, economy, and women's roles at the University of Southern California (1977–92), most notably in “Wives and Work: The Sex Role Revolution and its Consequences” (1984).

Davis's early interest in cities and urbanization also was abiding. Prominent among his contributions were “The Origin and Growth of Urbanization in the World” (1955), “Colonial Expansion and Urban Diffusion in the Americas” (1960), “World Urbanization 1950–1970” (V. 1, 1969; V. 2, 1972), *Cities: Their Origin, Growth, and Human Impact* (1973), and “Asia's Cities: Problems and Options” (1975). In the final years of his career at the Hoover Institution (from 1981 until his death on February 27, 1997), Davis organized conferences and edited books addressing causes, consequences, and policies for below-replacement fertility in industrial societies (1987) and the connections linking resources, environment, and population change (1991).

Davis's creativity and the breadth of his influence in academia, in the Washington policy community, and the discourse of the general public are reflected in the terms *demographic transition*, *population explosion*, and *zero population growth* which he coined, and in the honor bestowed upon him as the first sociologist to be elected to the US National Academy of Sciences. As one of the giants among twentieth-century social scientists, Kingsley Davis's legacy to scholarly and public discourse will endure for generations to come.

SEE ALSO: Demographic Transition Theory; Economic Development; Family Planning, Abortion, and Reproductive Health; Fertility

and Public Policy; Function; Industrial Revolution; Malthus, Thomas Robert; Stratification and Inequality, Theories of; Structural Functional Theory; Urbanization

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death and dying

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Sociology of death and dying is the study of the ways that values, beliefs, behavior, and institutional arrangements concerning death are structured by social environments and contexts. Although death is a universal human experience, societal responses to death vary according to cultural attitudes toward death, as well as contextual factors including the primary causes of death, and normative age at which death occurs.

Conceptualizations of and practices surrounding death in the United States have come full circle over the past two centuries. In the eighteenth century, death was public and visible. Death tended to occur at a relatively young age, at home, and due to infectious diseases that could not be “cured.” The loss of a loved one was expressed by dramatic displays of grief among survivors, and elaborate efforts to memorialize the deceased (Ariès 1981). Throughout the late nineteenth and most of the twentieth

centuries, death became “invisible” (Ariès 1981) and “bureaucratized” (Blauner 1966). Physicians and hospitals assumed control over dying, death and mourning became private, the handling of dead bodies and funeral rites were transferred from private homes to funeral parlors, and people were encouraged to deny death and believe in medical technologies (Blauner 1966). Treating dying persons in isolation was believed to help smooth the transition beyond death; reducing the social status of those who were about to die would minimize disruption of ongoing social and economic relationships.

The epidemiology of death also changed dramatically (Omran 1971). In the nineteenth and early twentieth centuries deaths occurred primarily due to infectious diseases, which were not stratified by social class or gender. Men and women, rich and poor, were equally likely to become ill and die, and death often occurred relatively quickly after the initial onset of symptoms. Death during the latter half of the twentieth and early twenty-first centuries, in contrast, occurs overwhelmingly due to chronic diseases, including cancer and heart disease. These diseases tend to strike older rather than younger adults, men more so than women, and persons with fewer rather than richer economic resources. Death typically occurs at the end of a long, often debilitating, and painful illness where the dying patients’ final days are spent in a hospital or nursing home, and where life-sustaining technologies are used.

In the late twentieth and early twenty-first centuries, death is again becoming visible and managed by the dying and their families. Patients’ and care providers’ recognition that dying is often a socially isolated, physician-controlled experience has triggered a number of political and social movements with the explicit goal of placing control of the dying process in the hands of patients and their families. The Patient Self-Determination Act, passed by Congress in 1990, requires all government-funded health providers to give patients the opportunity to complete an advance directive (or living will) when they are admitted to a hospital. The hospice movement, which began in the United States in the early 1970s to promote palliative care at the end of life, also has grown in popularity. Hospice care, whether in hospital or at home, provides an alternative

to the medical, scientific model of dying. Pain management, open communication among family, patient, and care providers, and a peaceful accepted death are core goals.

As the context of death and dying has changed, research foci also have shifted. In the 1950s and early 1960s, research and theory were guided by the assumption that the United States was a death-denying society (Gorer 1955). Influential works included an examination of the problems associated with transferring death and funeral rites from private homes to professional funeral homes, and explorations of the ways that health care providers, dying patients, and their family members mutually ignore and shield one another from their knowledge that the patient is dying (Glaser & Straus 1965).

In the late 1960s and 1970s, the “death awareness” movement guided research and theory. Key scholarly works of this era offered important advancements in conceptualizing the dying process. Barney Glaser and Anselm Straus (1968) proposed that dying tends to follow one of three trajectories: lingering, expected quick, and unexpected quick. The latter was considered most distressing for both health care providers and surviving family members. Elizabeth Kubler-Ross (1969) delineated the emotional and cognitive stages that dying persons pass through, before reaching the final stage of “acceptance.” The interdisciplinary field of death studies and the two leading scholarly journals of death and dying also were launched in the 1970s: *Omega: The Journal of Death and Dying* debuted in 1970, while *Death Studies* has been published since 1977.

In the late twentieth and early twenty-first centuries, research on death and dying has flourished (for an excellent and comprehensive compendium, see Bryant 2003). Scholarly and public concern about death reflects two broad social patterns. First, increasingly large numbers of older adults are living longer than ever before, with most suffering from at least one chronic and terminal disease at the end of life. Second, technological innovations to extend life, including life-support systems, organ transplants, and advances in cancer treatment, extend the life span, but also raise important questions about the meaning of life and death.

Despite dramatic growth in death-related research, the claim by William Faunce and Robert Fulton (1958) that the sociology of death is “a neglected area” remains at least partially true. The development of broad and unifying theoretical perspectives on the sociology of death and dying has not occurred alongside the explosion of empirical work (Marshall 1980; George 2002). Rather, subdisciplines of sociology have each claimed distinct – and seldom overlapping – topics of study pertaining to death and dying.

For example, demographers study the timing and social patterning of mortality. Social gerontologists investigate a broad array of issues pertaining to death, dying, and end of life, but their analyses focus nearly exclusively on persons age 65 and older. Sociologists of culture examine the ways that death is depicted in humor, art, literature, and other forms of media, cross-cultural differences in death rites and rituals, and public discourses about controversial issues related to death and dying, including euthanasia and the death penalty. Medical sociologists investigate interactions between patients, family members, and their physicians at the end of life, as well as ethical, social, and financial issues pertaining to life-extending technologies and practices. Sociologists of law focus on legal definitions of death, and the implications and problems created by such definitions for heroic medical efforts, transplantation, inheritance, and insurance. Sociologists of religion focus on rites and rituals at the end of life, the impact of religion and spirituality on beliefs about life and death, and changes in religious attitudes and practices as individuals manage their own dying process and the deaths of family members. Sociologists of deviance investigate deaths that violate traditional norms, such as murder and suicide, as well as reactions to death that are considered deviant, such as anniversary suicides.

Despite the absence of an overarching theoretical framework, one broad theme that underlies much current research is the importance of personal control and agency, among both dying persons and their survivors. Two specific lines of inquiry which have developed over the past ten years are personal control over practical aspects of the dying process, and active

“meaning-making” among the dying and bereaved.

Mounting research explores how dying persons and their families make decisions about the type, site, and duration of care they want to receive at the end of life. Sociologists’ key contributions have included identifying the cognitive, emotional, and structural factors that may enable or prevent individuals from receiving the type of care they hope to receive. Recent research reveals that patients and their family members seldom have sufficient information about their illness trajectory and future life span so that they can make informed decisions. Nicholas Christakis (1999) argues persuasively that physicians are extremely poor at prognosis, or projecting how much longer a dying patient has to live, and they often convey an unrealistically optimistic picture of their patient’s future.

A second area of inquiry that has attracted renewed scholarly attention is meaning-making among both the dying and their loved ones following loss. This concept was first set forth in *Death and Identity*, where Fulton (1965) argued that “preserving rather than losing . . . personal identity” was a critical aspect of the dying process. Victor Marshall (1980) proposed that heightened awareness of one’s impending death triggers increased self-reflection, reminiscence, and the conscious construction of a coherent personal history. More recently, Edwin Schneidman (1995) proposed that dying persons actively construct a “post-self” or a lasting image of the self that will persist after their death.

The ways that bereaved survivors actively find meaning in death was articulated early on by Herman Feifel (1977: 9), who observed that the mourning period following loss provides a time for the bereaved to “redefine and integrate oneself into life.” Current research explores the ways that active meaning-making among the newly bereaved helps to reestablish predictability and one’s sense of security. Other goals for the bereaved include personal growth, an adaptive broadening of philosophical perspectives, and an increased appreciation of other interpersonal relations.

Scholars of death and dying face several important methodological challenges. First, bereavement research focuses nearly exclusively

on the loss of a spouse, children, and parents; few studies investigate personal responses to the deaths of friends, siblings, or unmarried romantic partners, including gay and lesbian partners. A further limitation is that studies vary widely in their operationalization of "dying." Common measures include one's current illness diagnosis, combinations of diagnoses, symptom expression, and functional capacity (see George 2002 for a review). Although rich conceptual models of dying trajectories have been developed, formal operationalizations need further refinement. Finally, although most conceptual models of the dying process and bereavement are dynamic, such as the stage theory of dying (Kubler-Ross 1969), most empirical studies still rely on single point-in-time evaluations that retrospectively recall the dying and bereavement process.

In the future, the research agenda may focus increasingly on positive aspects of dying, including psychological resilience in the face of loss, and the characteristics of and pathways to a "good death." Important research goals include pinpointing modifiable factors of social contexts and relationships that may help ensure a smooth transition to death and bereavement. Early theories of loss proposed that persons who were not depressed following the loss of a loved one were "pathological." Researchers now are documenting that the non-depressed bereaved may experience "resilience" rather than pathological "absent grief" (Bonanno 2004).

Research on the "good death" also is accumulating. A good death is characterized as one where medical treatments minimize avoidable pain and match patients' and family members' preferences. A "good death" also encompasses important social, psychological, and philosophical elements, such as accepting one's impending death and not feeling like a burden to loved ones. However, as norms for the "good death" are solidified, a fruitful line of inquiry may be the consequences for bereaved family members and health care providers when a death occurs under conditions that fail to meet the widely accepted ideal. Failure to achieve the "good death" may reflect enduring social and structural obstacles. For example, family member (or caregiver) involvement is essential to a patient's participation in hospice; few studies have explored the extent to which unmarried or

childless people rely on hospice. Such inquiries may further reveal the ways that the experience of death reflects persistent social inequalities.

SEE ALSO: Aging, Sociology of; Disease, Social Causation; Euthanasia; Gender, Health, and Mortality; Healthy Life Expectancy; Medicine, Sociology of; Mortality: Transitions and Measures; Social Epidemiology; Suicide; Widowhood

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