EXPERIENCES OF THE PATIENT DURING CARDIAC ARREST AND RESUSCITATION

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DEDICATION

This thesis is dedicated in loving memory to my dad, Oren Richard Wilson, who was a constant source of love, encouragement, and understanding. He, too, caught a glimpse of Heaven in the weeks preceding his death.

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CHAPTER I

INTRODUCTION

Death is an event that every human being faces at least once during his existence; oftentimes one faces death many times during his lifetime, through the deaths of friends, foes, and family. With each confrontation with the "Grim Reaper", one is made more aware of his own mortality (Lepp 1968).

Because of the finality of human mortality, death has been a taboo topic in the American youth-oriented society. It has not been until the last few years that researchers have dared to probe into death's mysteries. Recently, much has been written concerning the experiences and feelings of the terminally ill patient and his family, during a long, drawn-out death process (Kubler-Ross 1969; 1974; 1975). There has been an increase in the amount of research done with the families and friends of those who have died suddenly--often a more difficult situation to deal with, due to circumstances surrounding the sudden death (Surawicz 1973). However, with increased technology, more of the people who would have been included in the mortality rates are being successfully resuscitated and given another chance at life. It has been the

concern of this to evaluate those who have escaped sudden or gradual death at least once and to explore their experiences and feelings.

Many who have been successfully resuscitated are relating dramatic effects on their lives. They are also causing the rest of society to think about death with them, because they are telling about what it is like to die. One minister who was successfully resuscitated in 1973 related his experience of a vision of heaven to the researcher and later to a local newspaper (Taggart 1974). It, therefore, seemed important to explore in more depth the experiences of those who are being given a second chance at life because of the effects these experiences can have on people's lives.

Statement of Problem

The problem of this study was to explore the post cardiac arrest patient's perceptions of his experiences during arrest and resuscitation procedures.

Purposes

The purposes of this study have been to:

1. Determine what the patient who has experienced cardiac arrest was aware of during the arrest and resuscitation procedures.

2. Determine how the patient who has experienced cardiac arrest perceived his near-death.
3. Determine if and how this event has affected the patient's views of life and death.
4. Determine if there is a relationship between the meaning of the patient's near-death and age, sex, religious background, or religious experience.

Background and Significance

It has been said that "death is the supreme enigma" (Bayly 1969, p. 16). Freud said that death was the goal of all life. Socrates thought it might be the greatest of all human blessings (Shneidman 1971). Since Adam and Eve, mankind has troubled over and dealt with death. There have been two recorded cases of a human escaping the death experience--that of Enoch, of whom it is said "God took him" (Genesis 5:24), and Elijah, who was taken into heaven on a whirlwind in a chariot of fire (II Kings 2:11). Therefore, one assumes that every human being with the exception of these two, must be confronted with the death experience at some time during his existence.

Most people readily admit that all men will die, but see their own deaths and the deaths of loved ones as far distant future events. When one is forced to think about his personal death, it is frequently viewed as some

forceful intervention from the outside. Generally, the attitude is one of "it shall happen to thee and to thee but not to me!" (Kubler-Ross 1972, p. 175). This attitude indicates a form of denial of personal death and mortality. Hence, stories of murder and war are heard with distant interest, and thoughts of personal death rarely go beyond financial arrangements "just in case" (Hinton 1968). Because of this distant attitude, most experience with death during one's lifetime is indirect, and only in the presence of another's death is one made aware of his own mortality (Lepp 1968). As a result, death seems to be the exact opposite of life, and only through encounters with death does man become conscious of life (Herzog 1967).

Montaigne said, "It is not death I fear but dying" (Lepp 1968, p. 31). Frances Bacon said during his ministry, "Men fear death as children fear to go into the dark; and as that natural fear in children is increased with tales, so is the other" (Hunt 1971, p. 16). Through the years many studies have shown that the most common emotion associated with death is fear. In one study, this apprehension of death was found to begin about age five--in ages five to nine, the children saw death as a person or some pale, perhaps frightening figure (Hinton 1968). Also embodied in the typical childhood conception of death was an afterlife, involving ideas of heaven and a fear of hell

(Shneidman 1971). Kubler-Ross (1973) says that this death-fear is manifested in personal conceptions of death as a destructive, catastrophic event, one over which the person has no control. It is thought that the denial of personal mortality, as manifested by pushing all thoughts of death into the subconscious, is an overt expression of a death fear. In Hinton's (1968) study of young adult students, ninety percent rarely thought of personal death; in two similar studies of elderly persons, thirty to forty percent kept death from their thoughts. In another study in England, it was found that a belief in an afterlife by no means eliminated an anxiety about death (Hinton 1968).

It is this fear and denial of death that leads to some people's reluctance to speak of death or the possibility of dying. Health professionals are as prone to this as anyone else, and it is because of that characteristic that Kubler-Ross (1969; 1974) has done much of her work with the dying patient, his family, and attending staff. She found that by openly talking about the "inevitable", many person's fears of death and dying were diminished, and people were better prepared to meet their fates of a gradual, drawn-out death. In later years, Kubler-Ross' (1975) research has shown that individuals and families can grow through an acceptance of the death process as a key to the meaning of human existence.

In contrast are the families who fall victim to the trauma of the sudden death of a family member. Because oftentimes there are no warning signs or symptoms, the occurrence of sudden death is frequently related to disturbing emotional distress and sets the stage for an intense shock in the life of the family. Emotional reactions to sudden death are often much more intense than when the family has been prepared over a period of days or months (Surawicz 1973). For these reasons, there have been increased attempts to provide an effective framework for working with the families of patients who have undergone sudden cardiac death (Ryan 1974).

Today, with the increase of medical knowledge and technology, many more people are being "brought back to life." With increasing frequency, many who would otherwise have been included in the mortality rates are being successfully resuscitated and given a second lease on life. In the United States in 1974, about ten percent of the people who experienced clinical death after cardiac arrests walked out of the hospital alive (Cass 1975). Two important mechanical developments have made these successful resuscitations possible. The first was the development of closed-chest methods of cardiac resuscitation, described by Kouwenhoven and associates (1960). And many other arrests have been terminated through the use of external

electric counter-shock, combined with the external cardiac massage. Another important factor in these victims' survival was the development of highly sophisticated intensive-care monitor units for the post-arrest period. These factors have undoubtedly increased the chances of survival for patients undergoing a cardiac arrest (Druss 1967).

These modern day "Lazaruses" have been the subjects of the work of Professor Dlin of Temple University in Philadelphia. He found that most of these "resurrected" vividly recalled the physical sensation of dying, and that at that moment none felt fear--to some death was even intensely pleasurable. He found that some related visions of heaven, whereas none related experiences in hell. Most related intense consciousness of goings-on during resuscitation proceedings, no sensation of pain, and some aesthetic senses (Call 1975). Noyes, of the University of Iowa, has studied this phenomenon of near-fatal encounters with death. In a study of fall victims and near-drowning victims, most of the respondents related a review of life, most often with pleasurable circumstances and vivid flashes of light, color, and music. Some respondents in Noyes' study, however, did report visions of hell and damnation (Newsweek 1974; Cass 1975).

Another study of ten cardiac arrest patients found that not a single patient could face the full implications

of the arrest and called forth various defense mechanisms (primarily denial) to control the anxiety evoked by this experience. Frequently, frightening and violent dreams belied their often tranquil appearances (Druss 1967). Moody's (1975) studies of 150 persons who had close calls with death found similar experiences in three groups: those successfully resuscitated, those with severe injuries or illnesses, and those dying who related their experiences to someone nearby. Recently, Kubler-Ross (1975) has interviewed scores of persons, aged two to ninety-seven, who, after being pronounced clinically dead, "returned from death" and related their experiences. This study prompted Kubler-Ross (People Weekly 1975, p. 66) to make the statement: "Beyond a shadow of doubt, their is life after death." All of these reviewed studies of near-death encounters show that those who have crossed the boundary between life and death have an important message to the living who regard death with fear and anxiety (Cass 1975; Moody 1975).

Definition of Terms

For the purposes of this study, these terms have been defined:

1. Cardiac arrest--the abrupt cessation of effective heart function caused by electrical failure with no impulse formation (cardiac asystole or standstill), or ventricular

fibrillation with ineffective impulse formation and muscle fiber contraction (Aspinall 1973).

2. Clinical death--the moment that a person's heart stops beating and he ceases to breathe (American Heart Association 1973).
3. Biological death--death of vital body tissues due to lack of oxygen--usually occurs four to six minutes after clinical death (American Heart Association 1973).
4. Near-death--a state of being in which cardiac arrest (clinical death) has occurred and would progress to irreversible brain damage and biological death if resuscitation procedures were not immediately administered.
5. Cardiopulmonary resuscitation--a basic life support procedure which includes artificial ventilation and artificial circulation (American Heart Association 1973).
6. Death experience--the actual cessation of earthly existence.

Limitations

For the purposes of this study, the following limitations were identified:

1. There could be no control over the premorbid

personalities of the subjects.

2. There was no control over the subjects' pre-arrest health status.

Delimitations

For the purposes of this study, the following delimitations were identified:

1. All of the subjects had experienced a documented cardiac arrest at some time in the past.
2. The cardiac arrest was documented by a physician.
3. The subjects were to be alert mentally and in control of their thought processes, as manifested by full orientation to time, place, and person.

Assumptions

For the purposes of this study, the following assumptions were identified:

1. Every human is confronted by death directly at least once during his existence.
2. Every human being formulates some thoughts about death at some time during his lifetime.

Summary

This study was an attempt to allow the person who has been unmistakably confronted with his mortality by means of a cardiac arrest and resuscitation to verbalize his experiences with and perceptions of that event. It was hoped that this study has increased the medical and nursing staff's awareness of the cardiac arrest patient's experiences and feelings, and result in more complete care of the patient as a totality--body, mind, and spirit (Dunn 1961).

In the following chapters are a discussion of the methods, tools, and results involved in the study. Chapter II includes a comprehensive review of the literature dealing with death and dying, cardiac arrest, and research involving these. Chapter III describes the methodology utilized in the study. Chapter IV gives a complete analysis of the data obtained in the study and includes an interpretation of the findings. Chapter V gives a brief summary of the study cited and ends with conclusions, implications, and recommendations for further study.

CHAPTER II

REVIEW OF LITERATURE

"What man shall live and not see death?"
Psalms 89:49

Because the certainty of man's death affects his outlook on life, it was the intent of this review to examine the literature and concepts relating to life, death, and dying. The format is as follows: death and dying--philosophical, literary, religious, and American views; research dealing with death--including research with the public, professionals, dying patients and their families, and persons who have had near-fatal encounters; and cardiac arrest and resuscitation.

Death and Dying

Death is as common a human experience as being born. But to most people, death seems to be the exact opposite of life. Man becomes conscious of life as a result of a contrast with death (Herzog 1967), and this experience of death in any form always forces one to ask the meaning of life. As one author said, "Death contains the whole of man's mystery" (Mooney 1975, p. 276).

Tournier (1957) said that sickness and the prospect of death gives rise to questions which the hectic rush of everyday living has kept in the subconscious. Death asks one to identify himself; it makes him ask, "Who am I?" (Fulton 1965, p. 3). To human consciousness, death is a scandalous event. Since men are certain that they will die, but not when or how, they can only reflect on the finality of their own lives through the mediation of the deaths of others (Sobosan 1973). To many individuals death always comes both too early and too late--too early because the ego has rarely realized all its potentialities, and too late because the individual's life has been a detour leading finally to what it had been at the beginning, nothingness (Eissler 1955). Hence, as one author so aptly stated, "...Death is the supreme enigma" (Bayly 1969, p. 16).

Philosophical and Literary Views

Man has troubled over the meaning of death and its relation to life since time immemorial. Death has always been one of the biggest puzzles for the world's philosophers. The ancient Greeks thought death to be the "most terrible of all things" (Choron 1963, p. 42). Sophocles once said, "Of all the wonders, none is greater than man... Only for death can he not find a cure" (Choron 1963, p. 42).

Socrates felt that death was either a dreamless sleep or the migration of the soul to another world (Choron 1963) and thought it might be the greatest of all human blessings (Shneidman 1971). Plato and Aristotle believed death was the release of the soul from the body and argued for immortality in that the soul lived, although the body died. However, to Epicurus death meant an absence of sensation, and his main obstacle to peace of mind was the fear of death (Choron 1963).

Roman and Greek Stoics saw death as as much a part of the order of things as birth--it was "according to nature" to them. Montaigne saw death as the goal of existence (Choron 1963) and said, "It is not death I fear but dying " (Lepp 1968, p. 31). Decades later, Sigmund Freud agreed that death was the goal of all life (Shneidman 1971). Pascal took a dim view of death and thought it to be a meaningless joke. The early existentialists had problems dealing with death and spent much energy trying to determine the significance of death for man. Sartre, a French existentialist, felt that death tells man only about himself (Choron 1963). Teilhard de Chardin, another French philosopher and theologian of the twentieth century, said, "Death is an incurable weakness of corporal beings...the symbol and summation of those diminishings we must struggle

against without...a personal victory" (Commonweal 1974, p. 5).

The theme of death and the mortality (and immortality) of man has always permeated the world's literature. Poets, novelists, writers of all kinds have alluded to and dealt with death throughout the centuries. One of England's greatest Victorian poets, Elizabeth Barrett Browning (1850, p. 94, 110), called death "the patient angel waiting for his place in the new heavens!" One of Tennyson's greatest and most known works is "In Memoriam A.H.H.", which is an eulogy to a beloved deceased friend. Much of his poetry has an underlying theme of death and grief, with doubts about the meaning of life (Abrams 1968). The list of the world's poets who wrote of death is endless. One of the best known American novels dealing with death is Hemingway's (194) For Whom the Bell Tolls. The story is one of a young man's dedication to a cause and his "sacrificial" death for that cause. On the frontispiece, Hemingway (1940, p. 2) quotes John Donne's immortal poem in which he says, "...any man's death diminishes me..." One American writer said of his own impending death, "There is a time to live, but there is also a time to die... It will come for all of us" (Alsop 1973, p. 290). Alsop wrote extensively of his own struggle with leukemia and said that he learned to live with death by "not thinking

about it too much " (1973, p. 21). Literature not only includes memorials to lost loved ones but also personal experiences of the dying individual.

Religious Views

The world's major religions deal very intimately with death; for most, death is seen as a commencement or transition from this earthly life to some other type of existence. Shneidman (1973) says that the content and degree of religious fervor, beliefs, and superstitions, together with generally accepted cultural beliefs, all directly influence man's basic attitudes about death at any given time.

Eastern religions have a general attitude of ambivalence toward death. It takes on the idea of changing old clothes for new and better ones. Physical death is seen as only a moment in the unending process of life. Life is not restricted in meaning to the span of the life of a man between birth and death. Life is generally seen as a process, which cannot be without changes. No changes can occur without "becoming" or the intervening moments of discarding dispensable elements of the life process. Death is viewed as one such moment (Raju 1974).

Chinese religions, especially Taoism and Confucianism, view death as a necessary part of the cosmic process,

a process which is essentially good (Overmeyer 1974). The Chinese view death as one of the true certainties of life, that when there is life as a beginning, there is death as an ending (Kubler-Ross 1975). The individual's ancestors intercede for him with the high god. Chinese religions are basically humanistic and somewhat skeptical, but do not deny some form of an afterlife, whatever it may be. Life and death are believed to depend on "heaven" or fate (Overmeyer 1974).

Indian religions--Hinduism, Buddhism, and Jainism--say that a realization of what one's essential self is takes man beyond the cycle of births and deaths. This shows that man desires not only a conquest of death in his present life but in his future lives, as well. When one realizes what he essentially is, there is no fear of death, and he is freed from the cycle of births and deaths. Death is seen as that necessary step in the continuity of personal life from birth to birth, in whatever form of being. The physical body dies, but not the person's "I-am" or essential self. The "I-am" transcends both space and time and is not within reach of death (Raju 1974). The "I-am" takes up life in a new body--either human (if the individual was good in his lifetime) or animal (if the individual sinned) (Van Zeller 1963). Buddhism and Hinduism go on to define a "heaven" or "nirvana"; it is seen as the exact opposite

of death. Death is seen as a devil counterpart, "Mara" (Amore 1974).

In Japanese Buddhism, the dead ancestors are believed to intercede for the living. In death one is united with the totality of the cosmic and natural processes (LaFleur 1974). To the Japanese Buddhist, the life of man and the cosmos lose their aesthetic appeal and value without death. To the Japanese Samurai, a very devout and select order, death is to be one with the cosmic process, at once spiritual, ethical, and aesthetic (Raju 1974). Another major religion of the Japanese and other Eastern peoples is Shintoism. In this group, death is seen as something impure, as is blood and sickness. Thus, there is more emphasis on the living and life's ceremonialism. However, important long-dead ancestors are worshipped as equal with the gods or "kami". There seems to be little or no distinction between heavenly and earthly worlds, as many things and beings embody the "kami", a sort of reincarnation ideology (Offner 1976).

Judaism is probably the biggest influence on Western and Middle Eastern religions. It is the basis of Christianity and Islam alike (Funk and Wagnalls 1973). Life in Judaism is considered to be a divine gift from the one God, Jehovah, the Creator of everything. Death and other adversities are viewed within the same reference

(Eckardt 1973). Death is viewed as a necessary judgement of God for the sins of man, originating with the fall of Adam (the first man) in the Garden of Eden. Scripture says, "...for dust thou art, and unto dust shalt thou return" (Genesis 3:19). The Jewish attitude toward death is best expressed by a verse of scripture read at Jewish funeral services:

> ...Naked came I out of my mother's womb, and naked shall I return thither: the Lord gave, and the Lord hath taken away; blessed be the name of the Lord.
> Job 1:21

Death is viewed as a necessary end to the individual's earthly life; however in modern Judaism, no exact view of an afterlife is defined or taught (Eckardt 1973). Some of the dead become honored ancestors of the living, for example Abraham, Isaac, Jacob, David, and Solomon (Parsons 1973). The Judaic confessional before the individual's death simply states:

> ...If my death be fully determined by Thee, I will accept it in love from Thy hand. May my death be an atonement for all the sins... of which I have been guilty toward Thee...
> (Eckardt 1973, pp. 129-130)

In Islam, it is believed that death is a necessary part of human existence. Angels play an important role in the Islamic beliefs, and there is one who is the summoner to resurrection and one who is the messenger of death. The individual's body rests in the grave until

the Day of Resurrection. While in the grave, the newly buried corpse is "visited" by two other angels, who "examine it in the faith" and decide if the person has been faithful or not. Then, at the Day of Resurrection, the person will be sent to a paradise, with Allah or God and the prophets, primarily Muhammed, or to the torments of hell, depending on the decisions of the two angels who visited the grave (Anderson 1976). The Islamic paradise is thought to be a place of luxury, pleasure, and rest (Lockyer 1975).

Although Christianity is based on Judaism, the two religions differ greatly on attitudes toward death. And there are a number of differences of opinion on different aspects of death within Christianity itself. Within a basic Christian theological structure, death is viewed as a personal matter between God and man; it is a part of the divine plan and a brother to life (Fulton 1965). Man is composed of mortal (body) and immortal (soul and spirit) components. Life is considered to be a divine gift, as in Judaism (Eckardt 1973; Parsons 1973). The Christian way of death means that there is a perspective which takes the individual beyond the actual death-event into eternity (Hunt 1971). However, Christianity veers from Judaism here. To Christendom, there is a hope of an afterlife, through the life, death, and resurrection of Jesus Christ,

Whom Christians believe to be the Son of God and the long-awaited Jewish Messiah. Jesus and the Apostles spoke of death as "sleep" (I Thessalonians 4:14); as sleep rests the living, death is believed to "rest" the faithful believer (Lockyer 1975). And Jesus' death is seen as a sacrificial one, the supreme sacrifice (Parsons 1973). Scripture says, "For the wages of sin is death; but the gift of God is eternal life through Jesus Christ our Lord" (Romans 6:23). Therefore, to the Christian, death is seen as the consequence of sin, but eternal life of the soul can be obtained through a belief in Jesus Christ as Lord. It is believed that the immortal part of man then spends the rest of eternity in Heaven with God, the Father, the Son, and the Holy Spirit (Gutzke 1974; Brooks 1974; Lockyer 1975). Thus, death is not considered an end but a beginning, to be looked forward to as much as possible (Van Zeller 1963).

However, life is to be prized and not belittled; one is not to make light of God's gifts. In Christianity, there is a concern for the complete individual, body, soul, and spirit. For that reason, Christians pay much attention to the body after death (Van Zeller 1963). Care of the body after death is one area in which different denominations vary in views. The more fundamental groups or denominations (for example Baptist, Assemblies of God, Disciples

of Christ, Nazarenes, Catholics) do not sanction the use of cremation, but bury their dead (Religious Aspects of Medical Care 1975). Catholicism goes further to offer prayers for the dead ones' souls believed to be in Purgatory, in Catholicism, a transition state between Heaven and Hell until the Last Judgement (Eckardt 1973).

To the mainstream of Christianity, the Bible promises that God will raise the dead, with the timing of the Resurrection being another topic for difference of opinion among the denominations (Shinn 1957). After the Resurrection, the Last Judgement is to occur, with the living and dead divided into believers and non-believers. The believers will spend eternity in Heaven, and the non-believers will spend eternity in Hell, a place of eternal punishment and damnation. However, factions of some denominations, even some of the more fundamental ones, are taking more liberal and agnostic views of the Bible, Jesus' life and teachings, and the traditional Christian hope of eternal life after death. There are, also, new denominations and cults thriving and being founded on various differences of opinion with traditional Christianity, including the meanings of life and death (Braden 1949; Marty 1976).

The American Way of Death

American attitudes toward life and death are primarily extensions of the traditional Judao-Christian ethic, due to the mixing of nationalities within America's shores. Religion seems to permeate the whole of American society, with the Christian tradition as the main source of unity for Western attitudes (Parsons 1973; May 1973). These attitudes will vary somewhat within individual ethnic groups. Life is seen as a gift of God. It is biologically normal for all individual organisms to die. Death is seen as a major contributor to the evolutionary enhancement of life, a significant part of this "gift of life" (Parsons 1973). Western society tends to dichotomize life and death, and the transition is seen as abrupt, final, and irreversible. The meaning of death is tied to the meaning of life (Knutson 1970). Feifel (1959) does not see death as a purely biological event. He says that the attitudes concerning it and its meaning for the individual can serve as an important organizing principle in determining how man conducts himself in life. However, it is only death--not life--that has sufficient appeal to command the morning headlines and to reduce man to an attentiveness of it, like a priest at his daily devotionals (May 1973).

One author says that there are basically two responses to death in contemporary culture: avoidance, rather than denial, and a preoccupation with death as a destructive, catastrophic event. Death means separation, not only from flesh but from community as well; it threatens all with final abandonment, exclusion, and oblivion. Thus, many die alone, even with people around (May 1973). Other authors say that America is a death-denying society (Sewall 1976; Mitford 1963). Rakoff (1973) projects some theories as to why North American society is death-denying: prosperity, atheism, and a "coming to America" attitude (leaving the old world, people, and ideals behind). She goes further to say that this denial is depicted in the funeral and embalming of the dead "to look natural." Mitford (1963) goes on to sarcastically call the American funeral "grief therapy," and cites examples of outrageous expenses and practices associated with the funeral industry. Gutman(1973) theorizes that because contemporary Americans live in the atomic age, a fear of holocaust contributes to death-denial and tends to make the society narcissistic and hedonistic. He says that aging in America is viewed as a "prelude" to death. Parsons and Lidz (1967) say that Americans respond to death in a manner consistent with their general orientation to life. They do not agree that the reality of death is faced with denial, but rather

that American society distinguishes between a "natural" termination of life and a "premature" or tragic death. Shneidman (1973) defines "premature death" as one before one's time of productivity has ended, before he has achieved his goals or abandoned them with dignity; often any death at a young age is considered premature. However, Parsons and Lidz (1967) disagree with Rakoff. They say that the funeral industry has developed ceremonies of acceptance of death with embalming and cosmetics; these are seen as methods to allow all relatives to gather in a highly mobile society.

The aforementioned "gift of life" ethic comprises a principal premise of American medical ethics. American medicine is oriented to sustaining life; thus, physicians do not want to "play God." Many problems with this ethic are arising due to increased medical technology (Parsons 1973), and medical people are being forced to make decisions that they would rather not make. Because of these problems, much talk of euthanasia, or "the good death," has come into American philosophy and thought (Mannes 1973), and Americans are increasingly discussing the pros and cons of active euthanasia versus death with dignity (Koop 1976). Shneidman (1973) advocates a death with dignity and calls it an "appropriate death," which is one that for the individual is appropriate to the time of his life, his life-style, his

situation and mission in life, and also is appropriate for the significant others in his life.

Attitudes Toward Death and Dying

In recent years, there has been an upsurge of thanatologists--physicians, nurses, clergy, psychologist, psychiatrists, and laymen who work with dying persons and their significant others (Shneidman 1973). Although the word "thanatology" was coined in 1912 by Roswell Park, the scope of this "science of death" has not been fully understood until recent years. It covers the entire range of death-related situations and life-threatening behaviors, for example terminal illness, suicide, bereavement, fatal injury and intoxication, and many others (Weisman 1974). Several studies have been done to determine public attitudes about death and dying. Much work has also been done with the terminally ill patient, his family, and the staff caring for him, as well as with the families, friends, and staff of the victims of sudden death. More recently, work has been done with persons who have had near-death encounters and survived to reflect on and tell about them.

Public Attitudes Toward Death and Dying

Some studies have been done to determine some of the general population's views of death and dying. Shneidman (1971) and Psychology Today found that the magazine's readers seemed to think of death as a more important topic than sex, apparent through the response received. More than 30,000 readers returned the death questionnaire (as opposed to 20,000 replies to the sex questionnaire), with about two thousand personal notés attached. It was found that one third of the respondents could not recall from childhood any discussion of death within the family circle--only in 30 percent of the respondents' families was death discussed openly. It was also found that from late adolescence on, that 35 percent saw death as simply the final process of life--usually in terms of eternal loss of consciousness and the absolute end of one's mental and spiritual existence. The average respondent thought about his own death "occasionally" and tended to make him take pleasure in being alive. In a study of some 375 children in Budapest, Hungary, one author had the children make drawings of death and describe them. They were all ages up to early teens, from different social and religious backgrounds, and about equally distributed as to sex. Three stages of death recognition were found. In Stage I (up to age five), the child did not recognize that

death is final; the dead were in a sense alive, as asleep. In Stage II (ages five to nine), the child personified death in the form of a person who goes around at night; he seemed to understand the finality of death. In Stage III (age nine and above), the child sees death as final and inevitable (Nagy 1959).

In another of Shneidman's (1973) studies, he found that many wished their deaths to be significant, as depicted by sacrifice or ritual suicide ("hara kiri" or "seppuku"), death for a principle, or death at the highest point of their lives. This wish was echoed in Crane's (1952, p. 116) The Red Badge of Courage: "It was perhaps that they dreaded to be killed in insignificant ways after the times for proper military deaths had passed." Shneidman (1970; 1973) also studied attitudes toward death in two hundred of his Harvard students in the years 1969 to 1972. In these studies, he was interested in determining the Vietnam War generation's attitudes toward "megadeath", or mass destruction by means of the atomic bomb, as demonstrated at Hiroshima and Nagasaki in World War II. He found that this constant threat of death caused some of the subjects to put death in their actions, with a heightening of emphasis on the present (the "now" generation). These students also seemed to be waiting for the end with a sense of helplessness and indignation. Only 25 percent

of the women and 35 percent of the men said that this constant threat of death had no influence on their lives. For some, the threat moved them in directions of social reform, civil protest, or political participation. Thus, for most of the students, a threat of death had great influence on attitudes toward death and life.

Other studies have shown that the most common emotion associated with death is fear. One author found three types of death fear: fear of what happens after death, fear of the "event" of dying, and fear of ceasing to be. In some, this death fear becomes a phobia--thanatophobia or unwarranted apprehension of imminent death. The author felt that even some philosophers and psychiatrists manifested this: Freud, Montaigne, Descartes (Choron 1964). In one study, this fear of death was found to begin about age five; in ages five to nine, children tend to see death as a person or some pale, frightening figure (Hinton 1968). Another study found that children became aware of the fact of death between the ages of five and ten, and the discovery of the inevitability of personal death occurred a year or two later. Most subjects responded to this discovery with fear (Greenberg 1965). Another part of the childhood conception of death was an afterlife, including ideas of heaven and a fear of hell. This belief tended to hold over into the young adult years, however, in much smaller percentages

of the sample (Shneidman 1971). This death-fear was manifested in another study of young adult students in which 90 percent rarely thought of personal death (Hinton 1968). In two of Hinton's (1968) studies of elderly persons, 30 to 40 percent of the subjects kept death from their thoughts. Their thoughts of personal death rarely went beyond financial arrangements "just in case." Another study found that 44 percent of its elderly subjects preferred not to think about death, and 10 percent openly admitted fear (Swenson 1965). Still another study of some 270 elderly volunteers from a community in North Carolina found that 10 percent admitted open fear of dying, when asked, "Are you afraid to die?" (Jeffers 1961). Cappon's (1965) study of 75 industrial workers found that 95 percent of them said they wanted to die suddenly rather than slowly, showing that fear of actually dying was much stronger than fear of death when posed as an abstract question. This supports Kubler-Ross' (1973) findings that death-fear is manifested in personal conceptions of death as a destructive, catastrophic event, over which the person has no control.

Still other studies showed some favorable attitudes toward death. In a study of 34 individuals over fifty years of age, it was found that the older the individual, the more positive and accepting his attitude

toward death; the poorer the person's physical health, the more positive was his attitude. It was also found that the more solitary his home situation with less financial security, the more positive was his attitude. About 45 percent of the study's sample held positive attitudes toward death (Swenson 1965). In an English study of 200 people over sixty years of age, 45 percent of the subjects viewed death as a beginning of a new and better life, although a belief in an afterlife by no means totally obliterated an anxiety over death (Hinton 1968).

Attitudes of Professionals Toward Death and Dying

Research has shown that health professionals, some of the so-called thanatologists, have as much difficulty dealing with death as the lay public. It is because of this difficulty that Kubler-Ross (1969; 1974) has done much of her work with the dying patient, his family, and the attending staff. When she began her work of speaking with dying patients and their families, she met most resistance from the staff, many of whom became very angry and hostile. A typical response she received was, "Nobody is dying on our ward" (Kubler-Ross 1969; 1973, p. 8; Wainwright 1969). She later stated that 40 percent of the attendant physicians she dealt with denied the patients' dying to the end (Kubler-Ross 1974). In a study at McMaster

University involving medical, nursing, and divinity students, each was asked to project to the time of his/her own death and fill in a death certificate. It was found that most projected very unrealistic perceptions of their own deaths. They expected to die older and far quicker than would ever be likely to be the case; very few anticipated cancer or suicide, although these are likely causes of death in such a group (Simpson 1975). Because of the difficulty that health professionals, too, have in dealing with death and the dying, two organizations, Ars Moriendi and The Foundation of Thanatology, have been founded to help modern thanatologists (Everett 1975).

In a study of forty physicians' attitudes toward death, it was found that they were more afraid of death than the two control groups of patients and non-professionals. It was also found that 69 to 90 percent of these physicians were in favor of not telling their patients that they were dying, while 77 to 89 percent of the patients wanted to know (Feifel 1965). Kasper (1959) says:

> It is somehow an improbable notion that a doctor should die. The challenge, 'Physician, heal thyself,' is also a hint for what is possible for the physician. Here we glimpse part of the psychological motivation of the doctor: to cure himself, to live forever (p. 260).

Lasagna (1970) found that a number of factors affected the physician's behavior toward the dying patient: the

patient's age, patient response to therapy, the rank or social worth of the patient, patient or family ability to pay for services rendered, the patient's attractiveness, the appeal of the disease, and the physician's own personality (whether or not he was an optimistic person, conservative or radical).

Nurses seem better able to face death than their co-workers. As one nurse so succinctly stated:

> We readily care for those whom we can help cure, and it feels good...knowing a patient is going to die doesn't mean we can't receive just as much reward...
> (Ufema 1976, p. 89)

In a massive study involving some 15,400 nurses, it was found that most of them felt that a dying person needed most to be allowed to die in peace, including the right to refuse treatment. Sixty percent of the nurses thought that the patient should be told as soon as possible that he is dying. It was also found that the nurses' attitudes on many aspects of death and dying reflected their general religious orientation and that the religious nurses were more likely to have come to terms with the idea of their own deaths (Popoff 1975). One nurse-therapist aided the nursing staff in coronary care deal with death by using role-play. Each staff member took on the roles of the dying patient, the family, and the staff to reenact and work through some problems. The therapist found two major

reactions: the majority of the nursing staff wanted to deal more directly with the patient and his problems with dying; some wanted to ignore the problem of death and become involved with technical tasks, relegate responsibility to the physician or minister, and tell the patient that he was alright (Hutchinson 1973).

Cassem and Hackett (1975) described their work with the staff of the critical-care units of a large metropolitan hospital. They used group sessions called "group-crisis meetings" to help the staff deal with stresses, including the high rate of death in their areas. Another study involving 426 members of nursing service staff showed that most of the personnel viewed death as a "peaceful, controlled, predictable, and common phenomenon" (Folta, p. 235). It was perceived with a high degree of anxiety, although it was more frequently seen as a natural end of the life process (Folta 1965). Daniel Cappon (1961) summarized most health professionals' attitudes toward death when he said:

> Men of medicine have eschewed public utterances on the dying patient. The surgeon is superstitious. He needs to be optimistic and shut out twinges of professional guilt and worry. He turns away. The physician feels impotent. Though sympathetic, he turns away. The psychiatrist faces often the threat of man turned against himself; but if suicide is carried through, the psychiatrist also looks away, covered in guilt and shame. Even the priest absorbs his keenest feelings in ritual. The relatives and friends are immersed and blinded by grief; the nurses are busy; only

> the poet and the philosopher take a look from afar (Cappon 1961, p. 35).

Attitudes of Dying Patients and Their Families

Much research has been done in an attempt to understand the actual process of death and dying and the feelings and perceptions of the person who is dying, the person who is terminal. A patient is considered terminal when all measures to sustain life have failed, for example surgery, irradiation therapy, and chemotherapy (Bouchard and Owens 1972). As early as 1904, a study of 500 dying patients was done. Only eleven showed mental apprehension at the prospect of dying, two showed positive terror, and ninety suffered bodily pain of some kind. The great majority gave no sign one way or the other; each death was a sleep and a forgetting experience (Osler 1904).

Many authors describe the emotional turmoil and loneliness of the dying patient. Kneisl (1967) says that dying patients experience loneliness as a result of exposure to abandonment and isolation. The longer one is in the state of dying, the greater the abandonment and isolation. Williams (1976) describes this phenomenon further and says that it is manifested by the patient in three basic levels of fear: fear of pain, fear of loneliness, and fear of meaninglessness. Weisman and Hackett (1961) call

this interaction between the dying patient and his family or staff "premortem dying." The isolation is potentiated and characterized by nonverbal gestures of dimming the lights and drawing the blinds, and the verbal gestures of whispering and giving stereotyped answers to the patients' questions. Thus, despite increasing public and professional interest in death and dying, dying remains a lonely and isolated event and the patients often feel "dehumanized, impersonalized, and mechanized" (Kubler-Ross 1971, p. 55).

One of the most prominent thanatologists is Kubler-Ross, who has done much of her work in the last ten to fifteen years with terminally ill patients and their families and attending staff. She has said, "My best teachers were my dying patients" (Kubler-Ross 1973, p. 13). In a study of 500 dying patients, five stages of grief and dying have been identified. The stages do not always follow one another; they overlap sometimes or vascillate back and forth. The patient and his family both apparently go through the stages, although not necessarily at the same pace and time.

The first stage is one of denial, in which the patient cannot believe that the diagnosis is true. Denial is a healthy protective mechanism, and the patient should be allowed to work through it. This denial lasts from a few seconds to a few months; less than one percent of those interviewed maintained it to the end.

The next stage is one of anger, in which the patient becomes critical of those about him, demanding, and often difficult to deal with. He is angry with himself, with God, and with the "living" who he feels have many more years ahead of them. Anger is often manifested by the question, "Why me?"

The patient may then begin the third stage of bargaining, most frequently with God. He may pray for more time to reach his goals, to see his children grown, to see his new grandbaby born. The patient may promise to change his lifestyle, to go to church every Sunday, or to donate his kidneys; he will usually promise something in exchange for extension of life.

The next stage is one of depression, when the full impact of the diagnosis hits home. Two kinds of depression have been identified: a reactive depression, in which the patient cries when he speaks of his illness and mourns the losses which he has experienced or is about to experience; later, the patient may become quiet and depressed.

Finally, the patient may begin to accept his impending death and separate himself from the people that he must leave in the near future. Kubler-Ross (1969) calls this a period of decathexis, when the patient no longer feels like talking; when he has finished all unfinished business; when he wants the closeness of one person with

whom he is comfortable, who can just sit quietly with him and hold his hand. The patient seems to be saying, "My time is near, and it is all right" (Kubler-Ross and Wessler 1972, p. 177).

Shneidman (1973) does not see his dying patients going through stages of dying as Kubler-Ross describes. He sees her described stages as emotional stages that interplay and vascillate; the dying person goes through an alternation between denial and acceptance. He goes further to say that no one "knows" that he is about to die and that there is always the presence of some degree of denial. Shneidman does, however, describe what he calls a "hive affect" of isolation, envy, bargaining, depression, and acceptance. These are not necessarily stages in any order, but all are against a backdrop of the person's total personality and philosophy of life.

Death work is described as two-fold: intrapsychic, or preparing oneself for death, and interpersonal, or preparing oneself in relation to loved ones and at the same time, preparing the loved ones to be survivors. This "death work" is further compounded by the "hive affect" of emotional states. Shneidman (1973) goes on to describe how the patients will make "postself" projections, or projections after their deaths. These projections are seen as a type of "holding on" and an attempt to obtain immortality, a post

mortem life, in the memories of loved ones, in the arts, in the bodies of others through organ transplants, through the genes of their children, and philosophically in the cosmos.

A recent television documentary attempted to demonstrate to the American public what it is like to be dying. Several dying persons were interviewed in an attempt to improve understanding. The television crew found themselves profoundly affected by what was seen and heard, much the same way that health professionals and patients' families are affected (PBS 6 May 1976; Time 1976). As one study stated, "To probe into the private world of the dying person evokes anxiety in the researcher" (Elmore and Verwoerdt 1967, p. 35). The authors further said that in their study of thirty patients, the type of reaction the patient exhibited to impending death apparently depended on several factors: the acuteness of the organic process, the psychological maturity of the individual, the extent of denial used in the basic personality, and the attitude of the physician and staff. Another study showed that the dying patients were less disturbed by talk of death than the staff attending them, and that most of the patients, 67 percent, wanted to know about their diagnoses (Cappon 1965).

Glaser and Strauss (1965) described different types of "death-awareness" or means of facing death, from six years work in several hospitals in the San Francisco

area. A "closed awareness" occurs when the patient is not aware of his diagnosis, although the family and staff know. They consequently try to "keep the secret" from the patient. A modification of this is a "suspicion awareness," when the patient does not know but suspects his diagnosis and tries to catch someone unaware with questions about his disease. There is also a "mutual-pretense awareness," in which both family, staff, and patient know the prognosis, but all act as if nothing is to happen. The authors found that the most satisfying method of facing death was an "open awareness", when all involved admit the diagnosis and prognosis and plans are openly shared.

Harrington (1969) described four life-styles of death-facing: a way of standing out against the laws of creation and decay by posing one's will on the world, dominating others, and commanding life and somehow death by talent, force, drive, or magnetism; a way of retracting the self, giving up one's being to the management of others or sharing it with others, thus settling for a collective mortality; a way of deliberately dulling one's awareness of events, drawing away from experience, and seeking safety in the familiar; and a way of trying to by-pass death through "gentle diffusion" or a violent disjointing of the self. One can easily see that some dying patients might exhibit some very undesirable behaviors--behaviors that might be

dangerous for himself, his loved ones, and the attending staff. The oncology unit at the University of Wisconsin utilizes behavior modification to help some of their terminal patients adapt to the idea of dying and channel undesirable behavior in more productive manners (Whitman and Lukes 1975). This was another attempt to aid the dying person in living as fully as he can for the time that is left.

Other attempts have been made to help the dying person and his family, to make the most of his remaining life, in the form of hospices. Institutions for this purpose have come about due to the isolation of the dying in hospitals. Reasons for this are that the hospital is an organizationally based medical order, and the dying must fit into this order; the comatose patient no longer exists socially; and the hospital is committed to restoring health and life, not death (Sudnow 1967). Another author supports the idea that dying patients become more isolated in the hospital due to the staff's inability to deal with death and give supportive care (Mervyn 1971). Glaser and Strauss (1968) say that the dying often stay in the hospital, supporting a loss of control over their living as best they can, while trying to learn how to be acceptable dying patients.

In contrast, the hospice is a place where the dying go to die peacefully. Hospice is a medeival term, signifying that the doors are open to the traveler on a journey from one life to the next. Hospice care emphasizes spiritual and emotional care, as well as medical care (Craven and Wald 1975). The staffs are well trained in every aspect of the patients' and families' care: psychological, emotional, and spiritual counseling, as well as the broad spectrum of physical care required by the terminal patients. The first hospices began in Europe; one of the best known is St. John's Hospice, London, England (Saunders 1965). Many hospices are now being founded all over the United States: Santa Barbara, California; Marin County, California; Branford, Connecticut; and Paoli, Pennsylvania, to name a few (Craven and Wald 1975).

There has also been much work done with the survivors of the victims of sudden death, due to the nature of the event. Sudden death is frequently related to much more disturbing emotional distress and shock in the lives of the survivors. In contrast to a slow, gradual death from some terminal illness such as cancer, the family of the victim of sudden death has no time to adjust before the death; and often there are no warning signs or symptoms to alert the family. Some authors say that probably the most disturbing feature of sudden death is the element of unexpectedness.

Due to circumstances just prior to the death such as a period of great emotional stress, anger, or hurt for the victim, there frequently are manifested severe guilt feelings in the survivors. Their immediate reactions are usually severe and include such emotions as grief, anger, remorse, disbelief, fear, and despair (Surawicz 1973; Goldstein and Heideman 1976). One author says that there is a high incidence of suicide in the surviving mate after sudden death of the spouse (Rinear 1975).

Shneidman (1973) says that the sudden death of a loved one is seen as a disaster, similar to the news of catastrophic events. Friedman and Lum (1958) described this as a "disaster syndrome" several years ago after the "Andrea Doria" shipwreck: an initial psychic shock, followed by motor retardation, flattened affect, somnolence, amnesia, and suggestibility. In a study done after the Cocoanut Grove fire, Lindemann (1944) found that the survivors suffered effects even weeks later, manifested by insomnia, panic attacks, guilt feelings, exhaustion, and numerous bodily disturbances. There was an attitude of "What right do I have to go on living?" Wolfenstein (1957) also described this syndrome as a combination of emotional dullness, unresponsiveness to outer stimuli, and inhibition of activity. She said that the person who has just undergone a "disaster" is apt to suffer from at least a transitory sense

of worthlessness; his usual capacity for "self-love" becomes impaired.

Lifton (1967) later described this "disaster syndrome" in relation to the survivors of the Hiroshima bombing. The survivors, "hibakusha"--explosion-affected persons, suffered from a psychic closing off and a "psychic numbing"; they had a clear sense of what was happening around them, but their emotional reactions were unconsciously turned off. Shneidman (1973) further expanded his work with this "disaster syndrome" with parents of adolescent suicides and identified basic phases in the survivors' grief process: resuscitation, from the initial shock through the first twenty-four hours; rehabilitation, one to six months after the death; and renewal, a healthy tapering of the mourning, lasting six months or more. Shneidman (1973) and Weisman (1974) dubbed this work with the survivors as a "psychological autopsy," which they developed at the Los Angeles Suicide Prevention Center, originally for the purpose of investigating the circumstances in which the suicide victims sought and found death. Ryan (1974) goes further to suggest methods of helping families cope with sudden cardiac death. Her goals of survivor-care were: to prevent the family from distorting the reality of the event, to identify regular support people for the family, and to enhance the family members' coping mechanisms.

Attitudes of Resuscitated Patients

More frequently today than ever before, many persons who would otherwise have been included in the mortality rates are being successfully resuscitated. Because of increased knowledge and medical technology, about ten percent of the people who experienced cardiac arrest and clinical death in the United States in 1974, walked out of the hospitals alive (Cass 1975). Public and professional interest has been sparked about these people who are being "reborn" and talking about it. Abraham Maslow (1970, p.3), world-renowned psychologist, said after his "heart attack": "My attitude toward life changed...Everything seems to look more beautiful rather than less." He referred to his life after his near-fatal encounter as his "bonus life" and said that he felt a wonder and appreciation at life after his near-death. Many people who come close to death (without actually being clinically dead), by way of motor vehicle accidents, falls, near-drownings, illness, or electrocution are relating similar experiences to those of the "resurrected" ones.

However, many who are skeptical of the idea of "resurrection" refer to the experience as one of thanatomimesis--a state of the appearance of death or a sort of suspended animation (Kastenbaum and Aisenberg 1972).

Dempsey (1975) cites examples of premature burials of those who were thought to be dead but were found to be "death-feigning." Another author refers to this experience as "the Romeo error" and cites examples of what was thought to be thanatomimesis (Watson 1974).

Reports of near-fatal encounters date as early as 1892, when a Swiss geologist, Albert Heim, reported the near-fatal experiences of thirty victims of Alpine falls, including an experience of his own (Heim 1892). One of the first recently reported cases of a person telling of what it was like to be dying and clinically dead for a period of time was that of a young registered nurse, who had a near-fatal allergic drug reaction. She related being very aware of the life-saving maneuvers about her and reacted at first with a "frantic fear" of dying. This fear passed quickly and was replaced by thoughts of her husband and their relationship. Then after a brief violent struggle for life, she felt a release of fear and wanted death to come. She then related a quick review of her life with many vivid colors and a feeling of ecstatic happiness; this was followed by a state of bliss and a vivid mental picture of the Taj Mahal. Upon her successful revival, she stated that she would never again fear death (Hunter 1967).

Since 1967, other researchers have reported many more cases of close-calls with death. In a study of 323

such persons who experienced near-fatal injuries or illnesses, Kalish (1969) found that only 23 percent were fearful or panicky. He also found that 77 percent experienced no fear, and 25 percent of these were unafraid, happy, and anxious to get the death process over with. Twelve percent of his study reported a flashback of their lives.

Noyes (1972), of the University of Iowa, in a study of approximately 80 persons who had near-fatal encounters, found many similarities in their experiences and the ones described by Heim (1892) and others (Crosby 1953; Jung 1961). Noyes (1972) found that the experience of almost dying, and presumably of actually dying, frequently includes three distinctive phases: resistance, life review, and transcendence. In the first phase, resistance, a person faced with the apparent certainty of sudden death struggles frantically against the physical danger and a longing to surrender himself to the danger and die. The second stage is marked by a rapid succession life-review of more important events in the victim's life, with very vivid colors, sounds, and emotions. In this review, the subject may be impressed with his good and bad characteristics. He then enters a period of transcendence, where the victim frequently surrenders himself to the idea of death, with an intensely pleasurable and tranquil feeling. Many subjects later related that they were sorry to "come back" because every

experience became so peaceful (Noyes 1972). Jung (1961) called his period of transcendence a "nontemporal state" in which he became aware of a change in his orientation to time.

Dlin, of Temple University in Philadelphia, found in a study of some thirty post-cardiac arrest victims that they found death to be intensely pleasurable and calm. However, he found that they usually awoke with a mental jumble of fear, fact, and fantasy, and often with a sense of disappointment at being brought back. Several of Dlin's subjects insisted that they were in heaven, but none related experiences in hell. Dlin went on to generalize, saying that religious people tended to have visions which could be described as heavenly, while those with agnostic views tended to view death as some sort of nothingness (Cass 1975). Another psychologist, Karlis Osis of the American Society for Psychical Research, found that virtually all of his subjects related meeting with long dead loved ones, scenes of "other-worldly beauty," or out-of-body experiences (Panati 1976). Not all subjects in Noyes' study reported only pleasurable experiences; a few related visions of hell and damnation (Newsweek 1974). Another study of ten post-cardiac arrest patients found that none of them could face the full implications of their near-deaths. They tended to utilize various defense mechanisms,

primarily denial, to control the anxieties provoked by the experience. Then afterwards, the subjects frequently experienced frightening and violent dreams (Druss and Kornfeld 1967).

These "out-of-body", near-fatal experiences are causing much difference of opinion as to the existence of a life after death. Charles Dahlberg, a psychiatrist from New York University, says that life after death is a question of faith. Pastor R.M. Herhold, San Bruno, California, says that life after death is, by definition, beyond scientific research. Noyes said that he does not believe that these experiences are clear-cut evidence of life after death (Panati 1976). However, Moody (1975) in his book, Life After Life, takes a somewhat different view and calls the experiences "life after life" due to the uncertainty of definitions of death today. Moody said of his study:

> Whether the dying person is Catholic, Protestant or an atheist; rich or poor; black or white; man, woman, or child, the similarities in their stories are too striking to be mere coincidence.
>
> (Panati 1976, p. 84)

In his study of 150 persons who had close-calls with death, he found three distinct groups: those successfully resuscitated after clinical death, those with severe injuries or illness, and those dying who related their experiences to someone nearby. Although no two of the experiences were

exactly alike, Moody (1975) did find a number of common elements that occurred:

1. Peace and contentment: most subjects described intensely pleasant, peaceful sensations during their brushes with death
2. Ineffability: the subjects found their experiences ineffable, or extremely difficult to put into words; many sights were indescribable
3. Noise: most who had a near-death experience heard some kind of a repetitive sound: bells, horns, humming, buzzing
4. The dark tunnel: many subjects described falling or floating through a darkness, like a tunnel
5. Meeting others: many of the subjects were met or greeted by a significant person or being, such as a religious figure or saint or a deceased loved one
6. The light: one of the more common elements was the appearance of a light, described as "brilliant", "dazzling", or "blinding"; this light tended to have great religious meaning to most of Moody's subjects who saw it; many interpreted the light to be God or Jesus Christ

Kubler-Ross takes a much more adamant view of these near-death encounters. While addressing a college audience in 1975, she said, "It's not a matter of belief or opinion;

I know beyond a shadow of a doubt that there is a life after death" (Woodward 1976, p. 97). It has taken her over ten years to collect data on about 200 cases involving patients aged two to ninety-six, from all over the world with all kinds of social and cultural backgrounds. She found that they "all experienced the same thing." The experience of dying was described as a detachment from the physical body, like a butterfly sheds the cocoon. They all felt a great peace and a sense of "wholeness," despite cancerous bodies or severed limbs. Most subjects also reported meeting a previously departed loved one, who was assumed to be an aide in the transition from life to death. For many, the loved one was a religious figure, such as Jesus Christ or a church saint. Those who reported "seeing" Jesus or God, described them as a "brilliant" or "blinding" light with form. There was also a common sense of contentment, so much in fact, that the subjects often resented, even bitterly, the attempts to bring them back to life. Kubler-Ross also found that none of the subjects was afraid to die again (People Weekly 1975; McCall's 1976; Woodward 1976; Reed and Lindeman 1975; Chandler 1976).

Cardiac Arrest and Resuscitation

Cardiac arrest can best be defined as the abrupt failure of the heart to pump sufficient blood to keep the

brain alive (Gilston and Resnekov 1971). Cardiac death is further defined as when the person's heart has stopped beating, and he has ceased to breathe (Glaser 1970). Clinical signs of cardiac arrest and death are: loss of consciousness, seizure, gasping or no respirations, dilated pupils, ashen grey skin and mucosa, and absent pulses (Gilston and Resnekov 1971).

Cardiac arrest and sudden death can result from a number of pathologic processes. In Western society, 75 percent of all sudden and nontraumatic deaths are due to coronary heart disease or acute myocardial infarction (Goldstein and Heideman 1976). Further, some 92 percent of all deaths post-myocardial infarction occur from ventricular fibrillation (Pantridge and Adgey 1975). Other causes of sudden death include ventricular standstill (for whatever reason), myocardial rupture, or massive pulmonary embolism. Besides acute myocardial infarction, ventricular fibrillation and standstill can result from electrocution, choking, electrolyte disturbances, and surgery (Mazzoleni 1973; Castagna 1973).

The frequency with which resuscitative measures are performed has increased in recent years in part because of prompt recognition, training of increased numbers of people to perform basic cardiopulmonary resuscitation, and the mechanical ability to sustain critical patients for

longer periods of time. Hospitals are better equipped and staffs are better trained than ever before. Consequently, once the arrest victim reaches the hospital, survival rates range from 10 to 25 percent. Resuscitation procedures include external cardiac massage, mechanical ventilation, administration of pharmacologic agents, and electrical counter-shock (Castagna 1973). Electrical countershock was first used successfully to defibrillate a human in 1947 (Resnekov 1975), although the methods were first described in usage on dogs in 1932 by Kouwenhoven and his co-workers (1932). Direct current shock causes momentary depolarization of the majority of heart fibers, thus terminating ectopic activity and allowing the heart's pacemaker to reestablish itself as the pacemaker (Resnekov 1975).

Signs of effective resuscitation are: spontaneous respirations, carotid and femoral pulses, eyelash reflex, large pupils that decrease in size, improved skin color, clenched jaw, and struggling (Gilston and Resnekov 1971).

Summary

The review of literature presented in this chapter focused on the following areas: Death and Dying, Research Dealing with Death, and Cardiac Arrest and Resuscitation.

Concepts and beliefs of death and dying were explored from all aspects. Philosophical and literary views were briefly discussed. Major world religions were explored, and their views of death, dying, and afterlife were discussed. American views of death and dying were also examined in relation to earlier explorations.

Research concerning death-dealing was thoroughly explored. General public attitudes were described, including development of death attitudes in children. Health professionals' attitudes and methods of coping with death and dying were explained. Certainly the attitudes and coping mechanisms of the dying themselves are important, so theirs and their significant others' attitudes were explored. A more recent topic of discussion, research with persons who have had near-fatal encounters with death was described.

Because cardiac arrest is the means by which many persons confront near-death, the actual clinical cardiac arrest syndrome was described. Resuscitative procedures were also described briefly.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The study undertaken was of an exploratory design as defined by Fellin (1969). He described it as those studies that are empirical research investigations having as their purpose the formulation of a problem or a set of questions, developing hypotheses, or increasing the investigator's familiarity with a phenomenon or a setting to lay the basis for more precise future research. Included in this chapter was the setting of the study, the population sampled, a description of the tool developed, methods of data collection, and treatment of the data obtained.

Setting

It has been found in other studies that initial, short-term reactions to arrest and resuscitation included a mental jumble of fear, fact, and fantasy (Cass 1975). Therefore, to minimize the possibilities of interviewing a patient during this period of confusion, a time period of one month between the resuscitation and interview was allowed. This would also allow more time for the patients

to recover physically and return home.

All interviews were conducted within the state of Texas, nineteen in the Dallas area and one in Madisonville. An attempt was made to conduct the interviews in an environment in which the subject could be most comfortable. With the exception of one subject who chose to be interviewed at his place of employment, the interviews took place in the homes of the subjects.

Population

The population consisted of twenty patients who had experienced cardiac arrest and resuscitation. Three other patients were approached for interview but refused to be interviewed. All patients had experienced a cardiac arrest documented by a physician.

Tool

An original interview guide was developed, based on current literature and with the assistance of several experts (see Appendix D). This group included a hospital chaplain, a clinical psychologist, a nurse who works with dying patients and their families on a neurological unit in a metropolitan hospital, a cardiologist, and a psychiatrist

whose primary work is with terminally ill patients in a large medical center.

Basic demographic data included: present age, sex, race, religious affiliation, and date of interview. A question eliciting the subject's conception of his religious orientation was also include, as in Shneidman's (1971, p. 45) study in Psychology Today (see Appendix E). Kubler-Ross suggested the use of Moody's (1975) book, Life After Life, as an appropriate source of questions for the body of the interview guide (see Appendix F). Thus, suggestions for appropriate questions were obtained from Moody's and Kubler-Ross' many works. Appropriate questions were asked to determine what each patient experienced physically, mentally, emotionally, and aesthetically during the cardiac arrest and resuscitation (see Appendix E). Important to the study were questions to determine what the subjects' perceptions of life and death were prior to cardiac arrest, and how his experience had affected these perceptions. Much of the literature supported the fact that many patients were aware of events, people, and conversations during their cardiac arrests (Moody 1975; Love 1976; Woodward 1976; Panati 1976; Cass 1975). It, therefore, seemed important to include a question attempting to elicit any comments the patients might have about the

behavior of those participating in the cardiac arrest (see Appendix E).

A pilot study of five subjects was then conducted to test the content validity of the tool, to insure that the tool actually measured what it was designed to measure (Abdellah and Levine 1965). After the pilot study was conducted, it was decided that the age at the time of the arrest and the date of arrest were to be added to the final tool, to determine the time interval between the arrest and the interview. It also seemed important to add a question to determine what changes in the patients' life-styles occurred following the arrest, as some of the literature indicated that numerous changes in the patients' life-styles occurred (Druss and Kornfeld 1976). Another panel of three experts was consulted for assurance of face validity of the changed tool (see Appendix G). These included a cardiologist, a clinical psychologist, and a hospital chaplain. Based on their responses the tool remained unchanged.

Data Collection

Data collection took place over approximately two months time, from mid-January to mid-March, 1977. As previously stated, sequential, convenience sampling was

utilized in obtaining the sample population, upon referral from private physicians. Of the initial group of twenty-three patients, three persons refused to be interviewed, leaving a sample of twenty patients. Two said that they had not been feeling well and did not want to participate; one person refused, saying he "would rather not talk about it." Nineteen interviews were conducted in the patients' homes and one in a patient's business. It took approximately one to two hours for each interview. Sixteen interviews were conducted in the evening and four were conducted in the afternoon.

Treatment of Data

Because the study was exploratory in nature, no attempt was made to quantify data. Demographic data and the questions in reference to religious orientation are presented in appendices and table. Simple percentages and a mean of the total sample were determined for age groups. Simple percentages of the total sample were determined for sex of the subjects. Percentages of the sample population were determined to note changes in their life-styles and attitudes toward life and death. Primarily, the results of the study were compiled and presented by item analysis in narrative form, with the aid of tables.

Summary

In this chapter, the procedures for collecting data were discussed. This included a description of the setting, the population, and sampling technique. The development of an original interview guide was described. The procedures used for collection and treatment of data were also discussed. A complete discussion of the results of the study follows in Chapter IV.

CHAPTER IV

ANALYSIS OF DATA

The purposes of this study were to determine: what the patient who has experienced cardiac arrest is aware of during the arrest and resuscitation procedures; how he perceives his near-death; if and how his views of life and death have been affected; and if there is a relationship between the meaning of the person's near-death and age, sex, religious background, or religious experience. The results of this exploratory study are thus presented in the following discussion.

Presentation and Analysis of Data

The sample population of this study consisted of a total of twenty subjects. Three patients were approached but refused to be interviewed. Two patients refused interview by saying that they had not been feeling well and did not want to participate. However, one patient refused interview by saying that he "would rather not talk about it." Perhaps these patients who refused interview were using defense mechanisms, as described by Druss and Kornfeld (1967). It was found in their study that not a

single patient could face all the implications of the cardiac arrest, and all called forth defense mechanisms, the most common being denial and isolation, to relieve the emotional impact of the experience.

Patients ranged in age, at the time of the cardiac arrest, from 35 to 67 years, with their current ages ranging from 39 to 68 years (see Tables 1 and 2 and Appendix H). The mean age at the time of cardiac arrest was 50.8 years. At the time of arrest, four patients were in the 30 to 39 years of age range, 20 percent of the total sample population. Six patients were in the 40 to 49 years of age range, 30 percent of the total sample population. Five patients were in the 50 to 59 years of age range, 25 percent of the total sample population. Five patients were in the 60 to 69 years of age range, 25 percent of the total sample population. There were no patients in the 70 or above years of age range at the time of arrest.

The sample population consisted of 17 males and three females (see Table 1 and Appandix H). The males composed 85 percent and the females composed 15 percent of the total population. All patients in the sample were Caucasian, with two subjects from Jewish ancestry.

The length of time between cardiac arrest and interview varied from two months to forty years (see Table 3 and Appendix H). Four patients were interviewed within

twelve months of their cardiac arrests. Eight patients were interviewed within twelve to twenty-four months of their cardiac arrests. One patient had experienced cardiac arrest between 24 to 36 months prior to interview; another four patients had had cardiac arrest between 36 to 48 months earlier. One patient's cardiac arrest took place approximately 68 months prior to interview, and one approximately 91 months prior to interview. One patient's cardiac arrest took place approximately forty years earlier.

Table 3

Length of Time Between Cardiac Arrest and Interview

Time in Months	Male	Female	Totals	
			Number	% of Total
0-6	2	0	2	10%
6-12	2	0	2	10%
12-24	6	2	8	40%
24-36	1	0	1	5%
36-48	4	0	4	20%
48-60	0	0	0	0
60-72	1	0	1	5%
72-84	0	0	0	0
84-96	1	0	1	5%
96-108	0	0	0	0
108+	0	1	1	5%

There were two major world religions represented in this study (see Table 4 and Appendix I). Eighteen of the subjects professed religious views compatible with Christianity, whereas two professed Judaism. Of the subjects who professed Christianity, two were Catholic, three were Church of Christ, six were Baptist, one was Presbyterian, two were Lutheran, and one was Assembly of God. Three subjects who professed Christian beliefs had no preference of denomination, although one was reared Lutheran and one was reared Baptist. Two ministers were included in the sample population, one Presbyterian and one Baptist.

When asked how they religiously perceived themselves, no one claimed to be "not religious" (see Appendix E). Only one person considered himself "somewhat religious," whereas eleven considered themselves "moderately religious," and eight considered themselves "very religious." Table 4 shows patient perceptions of the degree of religiousness according to the religious denomination.

When questioned what they were told about their cardiac arrests, two patients replied that they were told nothing, but knew that they "had died." They later questioned family members and physicians about it; no one denied that an arrest had occurred. However, the patients were told no more. Two patients were told of their arrests by family members before the medical personnel said anything;

Table 4

Patient Perception of Degree of Religiousness According to Religious Denomination

Religious Denomination	Degree of Religiousness				
	Not	Somewhat	Moderately	Very	Total
Jewish		1		1	2
Catholic			1	1	2
Baptist			3	3	6
Presbyterian				1	1
Lutheran			1	1	2
Church of Christ			3		3
Assembly of God				1	1
No preference			3		3

N = 20

one patient's wife told him that his monitor "was in a straight line", and that she had called the nurses. In contrast, sixteen of the patients interviewed were told either that their "heart stopped beating" or that they had "had a cardiac arrest", with some details, by someone on the medical team. The physician informed fourteen of the patients; a nurse informed one patient; and a physical therapist, who had taken part in the resuscitation, informed one patient.

In response to the question, "What do you remember about your cardiac arrest?", ten patients remembered nothing about the actual cardiac arrest and could only describe events leading up to and following the arrest (see Table 5 and Appendix I). One patient who remembered nothing of the cardiac arrest itself said that he awoke afterward "freezing to death" and thought it was "six degrees." Of the patients who remembered nothing, two were Jewish; two were Catholic; two were Church of Christ; one was Presbyterian; one was Lutheran; and two were of Baptist background, although one claimed no denominational preference.

Ten patients experienced some type of "out-of-body" or "otherworldly" experience, in which they saw, heard, and experienced things in another dimension, often as a spectator. Eight of these "out-of-body" experiences were described as some type of religious experience. Five of the patients who had a "religious out-of-body" experience were Baptist, one was Church of Christ, one was Lutheran, one was Assembly of God, and two claimed no denominational preference.

The experiences of the patients were described in a variety of ways. Three persons related a feeling of falling or spinning, as in a darkness or tunnel. A description by one subject was that of feeling as if he were "swimming in

Table 5

Experience During Cardiac Arrest
According to Religious Denomination

Religious Denomination	Type of Experience		
	Nothing	Out-of-Body	Religious Out-of-Body
Jewish	2		
Catholic	2		
Baptist	1		5
Presbyterian	1		
Lutheran	1	1	
Church of Christ	2	1	
Assembly of God			1
No preference	1		2
Totals	10	2	8

N = 20

a sea of B-B bullets"; another described the darkness as "like falling into the Grand Canyon."

Two patients had the experience of walking on a road. One patient described arriving at a fork in the road. He was about to take the left fork, when a voice told him to go back to the crossing and go the other way. He said that he realized later that the left fork "was the road to Hell." He returned to the crossing and was about

to go onto the right fork, when a voice again spoke to him and said that he had a purpose in "this world" and that it was not his time to die. Another patient described walking up a road to two large open gates. As he reached them, the gates swung closed, and a voice said, "Go back--we're not ready for you yet." Both patients said that at the point where they were told to go back, they awakened to see and hear nurses and doctors working over them.

Two other subjects related the experience of seeing open gates or doors. One patient described the doors as "gigantic white cathedral doors." Past these were faceless people in hooded white robes. She was not able to go through the doors, which she stated was "perturbing," because everything was so peaceful and calm. She described the colors there "as the most vivid she had ever seen." She then awoke with a sensation of pain to a bright light in her face. Another subject, who experienced standing in front of gates, "saw Jesus, with a face like pictures in the Bible," and with His hands outstretched. His arms went down, and the gates closed in her face. She said that as she begged to get in, He replied, "It's not time." She stated that she then awoke fighting and in pain.

In much of the literature concerning "out-of-body" experiences, many people are met by someone: a deceased family member, a church saint, or Jesus Christ. Two other

patients in this study described seeing someone that they believed to be Jesus. One patient described feeling himself "floating upward like a balloon," with his feet hanging down; he could see the buildings below him. He stated that as he went up to and above a brilliant light, he looked down and saw Jesus. The patient described His hair as "light red, between wheat and gold"; He was also wearing a crown. A face was not discernible; there was a "void" where His face should have been. Colors were described as radiating from a light in a "soft glow" and as the "most beautiful" that the patient had ever seen. He then described floating back downward and remembered thinking, "I don't want to go back; why are they sending me back?" He then awoke feeling very nauseated. Another subject described seeing himself on a table, covered in a "white, clean, pure sheet all except my face," and could not feel the weight of the sheet. He described seeing a "figure likeness of a Man in a long white cascading robe," Who put His arms under the patient and lifted him straight up. He stated that at about that time he saw his wife and several other family members with peaceful expressions on their faces; the Man holding him said, "Here he is." At that point the patient said he awoke and knew that he had "come through OK" because he "had been in the hands of the Lord."

One subject experienced a cardiac arrest in her home. She described a sensation of feeling her "spirit" leave her body through the right side of her chest and float through the celing and through the top of the house. She stated that she could see where "everyone was in the room" and felt "so free, happy, and overjoyed." She stated that she then heard two distinct, separate voices, the first saying, "You needn't be so happy. You may not get in when you get there." To which she answered, "I'll go in by the blood of Christ," and kept floating upward. Another voice then answered, "You can't come on; you have to go back. You can't come on; you have to go back." She stated that her spirit then went back through the top of the hose, the ceiling, and back through the right side of her chest, and she awoke.

Another patient, a minister, described seeing the "glorious beauty of heaven." He described standing on a cliff overlooking a beautiful river. On the other side of the river was the "heavenly city," with only one street that was lined with "beautiful, stately mansions." He described the street as of the "purest gold--it was transparent." The colors of everything were described as "unlike anything he had ever seen on earth." He added that many weeks later he found a verse of scripture that described what he had seen:

> And the twelve gates were twelve pearls; every several gate was of one pearl: and the street of the city was pure gold, as it were transparent glass.
> Revelation 21:21

He stated that as he looked down the street, he saw a "heavenly being" walking, almost floating, toward him with outstretched arms. Coming from above and behind the being was a brilliant ray of light; he said that he knew the light to be the "Light of God Himself." He stated that as he looked to see where the light was coming from, he awoke with pain in his chest and doctors working over him.

When asked about their views of life and death, some of the patients interviewed had to stop and formulate their thoughts about the topics before they could answer. Five patients, 25 percent of the total sample, said that the cardiac arrest experience had not caused them to change their views of life and death, that their beliefs were basically the same after as before. However, fifteen patients, 75 percent of the sample, stated that their cardiac arrests had altered their views of life and death in some manner. Six patients admitted that prior to their cardiac arrests they had never given death much thought. One patient stated that he had only thought about death "during the war years." Another stated that he did not think about death and "did not like sadness." Of these six patients, one said that the cardiac arrest had not changed his views; one said that

he has since worried about death and wonders when he has chest pain "if this is it." Two patients who had not thought of death prior to the arrest stated that they were now ready to die, although they did not want to. They added that they were not afraid of death, but enjoyed living more and took life "day by day." Three patients' faith in God was conformed since the cardiac arrest. One stated that he now knew that he "was going to Hell before" but "can face death now--I know where my place is."

Of the four others who said that the cardiac arrest had had no effect on their views, three patients expressed traditional Christian beliefs about life and death. One patient summarized this view by saying, "Death is like a sleep until the end of time--then heaven or hell." One patient, however, was somewhat unsure about the idea of a hereafter, although he expressed a strong belief in "a Supreme Being" and "His interventions in men's lives."

One patient stated that before her cardiac arrest she had such a fear of death that when the word was even mentioned, she would get physically ill; and her life was useless and "dim." Since the arrest, her views have been completely reversed; she stated that her life has taken on meaning, and that she had decided that death is nothing to be afraid of--"It's all peaceful and calm." Nine other patients related

changes in their views of life and death since their cardiac arrests. All nine expressed traditional Christian views of life and death. All nine said that their faith in God was confirmed and that their beliefs were much stronger. They all stated that they enjoyed life more and care more about their fellow man. Three patients stated that they had since found specific reasons for being "sent back." One patient believed he was to take care of his sick wife; another was to rear her two-year-old child. The other patient, a minister, felt that he was sent back to confirm his belief in healing and miracles to his congregation. Two more patients, a husband and wife, stated that since their cardiac arrests they have had "an inner perception of things to come" and have been able to predict the future as much as three to four weeks in advance.

Table 6 shows that three persons reported no changes in their life-styles, 15 percent of the sample population (see Appendix E). One of the three said that his rheumatic heart disease had debilitated him so badly that the cardiac arrest made no difference. However, he had since had surgery and was able to do more than before his cardiac arrest. Seventeen patients, 85 percent of the sample population, reported some changes in their life-styles since cardiac arrest. Thirteen of these, 65 percent of the sample, reported that they had changed their life-styles for the

better and participated in healthful activities, such as quit smoking, diet, weight loss, and exercise. Two patients, 10 percent of the sample, reported some memory loss. Five patients, 25 percent of the sample, reported that they had since been forced to quit work or retire.

Table 6

Change in Life-Style Following Near-Death Experience by Sex

Change	Male		Female		Totals	
	Number	% of Total	Number	% of Total	Number	% of Total
Yes	15	75%	2	10%	17	85%
No	2	10%	1	5%	3	15%

N = 20

When questioned to elicit comments about behavior of the staff involved in the resuscitation, none of the patients interviewed gave negative comments. Nineteen of the sample simply expressed their thanks for the abilities and kindness of the staff. One patient was resuscitated by a family member and thus had no comments about the staff; she only said that her physician "had given up on her." One patient added that the staff should, and did, "Care--give a damn." Another patient added that he wondered if the physicians and nurses realized "Who was working beside them all the time."

Two questions were asked to see what these people would say to other patients or nonmedical people about their experiences (see Appendix E). Answers to both questions were basically the same. Eighteen of the group stated that they would describe their experience readily, although one patient said that it took him three years to be able to tell anyone about it. One patient, an electrician, dwelt on the experience of the electrical shock. He stated, "That electrical shock is one helluva jolt--it was the worst I've ever felt." One patient stated that he really did not know what he would say, so he probably would not say anything if the opportunity arose. Another patient stated that he probably would not say anything because he would not be sure how a person might react, since "people react differently to situations." Seven patients said that they would speak to others about prevention, proper care of the body, and slowing the pace of one's life. One patient added, "Don't just stop and smell the roses, but learn to plant a few." Five patients stated that they would attempt to alleviate the lay person's fears of death by describing their experiences with near-death. Three patients said that they felt their experiences to be "a gift from God." One patient even added that he wished "more could experience what he did." One patient added a note of warning to be prepared to die. She stated, "We have an appointment (to die)

with God; a foolish person doesn't prepare for that appointment."

Summary

In this chapter, the results of the study were described. Demographic data and data relating to religious orientation and changes in life-style were presented in six tables. The majority of the interviews were presented by item analysis in narrative form, with quotes from patients and paraphrasing of their comments.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Summary

This was an exploratory study to determine the awareness during resuscitation of the patient experiencing cardiac arrest; the patient's perception of his near-death; the effect of the experience on the patient's views of life and death; and the relationship between the meaning of the patient's near-death and age, sex, religious background, and religious experience.

The setting for this study was primarily the Dallas area, with one interview taking place outside Dallas county. Interviews took place at a place chosen to meet the patient's convenience, and all interviews were at least one month post arrest.

There was a total of twenty patients in the sample population. Three other persons were approached but refused interview. Each patient's cardiac arrest was documented by a physician, and signed permissions were obtained from the physicians and patients. No limits were placed on age, sex, or race of the patients. Patients for interview were selected by sequential, convenience sampling.

It was found that the cardiac arrest experience is one that affects people's lives in a number of ways. Many related changes in their views of death, changes in their outlooks on life, and changes in their life-styles. Half of the sample related an "out-of-body" experience of some kind; whereas others could recall nothing of the near-death experience.

Conclusions

Based on the findings of the interviews and the review of the literature, several conclusions were made. Cardiac arrest is an event that has significant effects on patients' lives. This near-death event also influences the patients' perceptions of life and death. There apparently is no relationship between the age of the individual and the near-death experience of cardiac arrest. All the females in the study had very dramatic experiences, as opposed to seven of the seventeen males.

All patients who had an "out-of-body" experience could recall precise details, regardless of the length of time since cardiac arrest. There were a number of common elements occurring in the "out-of-body" experiences, although not in all. They included a dark tunnel, a bright light, vivid colors, a meeting with a significant person, a voice, and a feeling of peace and calm. Patients were also aware

of people, conversations, and events leading up to and immediately following the cardiac arrest. The moment of the actual clinical death was apparently not an unpleasant experience for the majority of subjects. However, defense mechanisms may have been utilized by some in attempting to cope with the emotional impact of the cardiac arrest.

Implications

Because death is a reality of life and an integral part of human existence, nurses must deal with this aspect of the health-illness continuum, as well as any other. Every nurse must at some time in his or her career care for a dying patient. Thus, it is important for every nursing staff person to be able to confront and cope with the mortality of self and mankind.

Because of the prevailing attitude of denial of death in American society, nursing schools need to embody more death and dying theory within their curricula. Also, hospitals should include this in topics for continuing education of employees. This should include the discussion of persons who have been "resurrected" after cardiac arrest because cardiac arrest is equated with death, clinically and publicly. Because more people are being successfully resuscitated, emphasis should be placed on dealing with these

"resurrected ones," as well as aiding them in coping with their experiences.

The full effects of these experiences on individual lives are not known. It therefore seems important to explore further the near-death event and the person who has experienced it. It is every nurse's responsibility to herself, her clients, and her profession, to be the very best that she can be. To do so, she must continually expand her knowledge through study, education, practice, and research.

Recommendations

A number of recommendations were made from this study. Another larger, exploratory study should be conducted to encompass a larger population with a broader background of cultures and religions. A larger scale survey of the psychological effects of cardiac arrest should be conducted, again encompassing a larger geographical area, with a broad background of cultures.

Because all three of the females in this study had a very dramatic experience as opposed to forty-one percent of the males in the study, a comparison of the experiences of males and females should be made. An additional survey of the patients' specific remembered staff behaviors during resuscitation procedures should be explored. It would also be interesting to compare changes in life-style after

acute myocardial infarction, without cardiac arrest, to the changes in life-style after acute myocardial infarction, with cardiac arrest, to determine if there would be any differences.

APPENDICES

APPENDIX A

TEXAS WOMAN'S UNIVERSITY
RESEARCH INSTITUTE
DENTON, TEXAS 76204

BONE METABOLISM LABORATORY
BOX 23546, TWU STATION
PHONE (817) 387-5305

November 14, 1976

Ms. Thena E. Wilson
Texas Woman's University
Dallas Campus
Dallas, Texas

Dear Ms. Wilson:

The Human Research Review Committee has reviewed and approved your program plan, "Experiences of the patient during cardiac arrest and resuscitation"

Sincerely yours,

George P. Vose, Chairman
Human Research Review Committee

cc Dr. Bridges
Ms. Goosen

APPENDIX B

13406 Noel Rd.--#253
Dallas, Texas 75240
October 13, 1976

Dr.

Dallas, Texas

Dear Dr.

Some months ago I discussed with you my projected study for thesis--"Experiences of the Patient During Cardiac Arrest and Resuscitation." As you recall, I am very much interested in exploring the patients' perceptions of the happenings and experiences during a cardiac arrest situation.

Though you gave me verbal permission to interview some of your patients, I must have your written consent to use some of your patients in my study. Please complete the enclosed form letter and return it to me, in the enclosed envelope, at your earliest convenience.

Let me remind you that each patient will be assured of anonymity. Safeguards will be taken to structure the interview guide so that no person should feel threatened by the questions asked. A written consent for interview will also be obtained from each patient. A copy of the interview guide will be sent to you as soon as it is tested for validity.

If you have any further questions regarding the study, I can be contacted at 661-0727 or 946-8181 (ext. 327).

Thank you again for your help.

Sincerely,

Thena E. Wilson, R.N.

Thena E. Wilson, R.N.

CONSENT FOR USE OF PATIENTS AS RESEARCH SUBJECTS

I hereby authorize Thena E. Wilson to interview certain patients under my care. Names of subjects (patients) have been supplied to Miss Wilson previously. I understand the purposes of her study entitled "Experiences of the Patient During Cardiac Arrest and Resuscitation," and know that safeguards are being taken to protect the rights and well-being of my patients.

SIGNATURE_____

DATE_____

APPENDIX C

To Whom It May Concern:

I am a graduate student at Texas Woman's University, working toward a Master of Science in Nursing. As part of the fulfillments for that degree I am conducting a research project with persons who have experienced a cardiac arrest. Your confidential, anonymous participation would be greatly appreciated. Your physician has given me permission to speak with you.

Let me also ask that you give me your written permission for this interview. I would like to thank you for spending this time with me. If you have any questions, please ask.

Thank you.

Thena E. Wilson, RN

Thena E. Wilson, R.N.
TWU Graduate Student

TEXAS WOMAN'S UNIVERSITY

(Form A -- Written presentation to subject)

Consent to Act as a Subject for Research and Investigation:

(The following information is to be read to or read by the subject):

1. I hereby authorize _____
(Name of person(s) who will perform procedure(s) or investigation(s)

to perform the following procedure(s) or investigation(s):
(Describe in detail)

2. The procedure or investigation listed in Paragraph 1 has been explained to me by _____.
(Name)

3. I understand that the procedures or investigations described in Paragraph 1 involve the following possible risks or discomforts: (Describe in detail).

TEXAS WOMAN'S UNIVERSITY

(Form A - continuation)

3. I understand that the procedures and investigations described in Paragraph 1 have the following potential benefits to myself and/or others:

4. An offer to answer all of my questions regarding the study has been made. If alternative procedures are more advantageous to me, they have been explained. I understand that I may terminate my participation in the study at any time.

_____ _____
Subject's signature Date

(If the subject is a minor, or otherwise unable to sign, complete the following):

Subject is a minor (age_____), or is unable to sign because:

Signatures (one required)

_____ _____
Father Date

_____ _____
Mother Date

_____ _____
Guardian Date

APPENDIX D

INTERVIEW GUIDE

AGE_____ SEX_____ RACE_____ DATE_____

RELIGIOUS AFFILIATION_____

DO YOU CONSIDER YOURSELF TO BE:

___Not religious
___Somewhat religious
___Moderately religious
___Very religious

WHAT WERE YOU TOLD ABOUT YOUR CARDIAC ARREST?

WHO TOLD YOU ABOUT IT?

WHAT DO YOU REMEMBER ABOUT YOUR CARDIAC ARREST?

WHAT WERE YOUR VIEWS OF LIFE & DEATH BEFORE YOUR CARDIAC ARREST?

WHAT ARE YOUR VIEWS NOW?

DO YOU SEE THIS EVENT AFFECTING THESE VIEWS?

HOW?

WHAT WOULD YOU SAY TO THE MEDICAL & NURSING PERSONNEL WHO PARTICIPATED IN YOUR RESUSCITATION PROCEDURE?

WHAT WOULD YOU SAY TO OTHER PATIENTS ABOUT THIS EVENT?

WHAT WOULD YOU SAY TO OTHER NONMEDICAL PEOPLE ABOUT THIS EVENT?

APPENDIX E

INTERVIEW GUIDE

Date of Interview_____ Sex_____ Race_____

Date of Cardiac Arrest Occurrance_____

Present Age_____ Age at time of Cardiac Arrest_____

Religious Affiliation_____

Do you consider yourself to be:
_____Not religious
_____Somewhat religious
_____Moderately religious
_____Very religious

What were you told about your cardiac arrest?

Who told you about it?

What do you remember about your cardiac arrest?

What did you believe about the meaning of life and death before your cardiac arrest?

What do you believe now?

Do you see your beliefs being affected by your cardiac arrest? If so, how?

Do you see your life-style being affected in any way by your cardiac arrest?
If so, how?

If given the opportunity, what would you say to the medical and nursing personnel who participated in your resuscitation procedure?

If given the opportunity, what would you say to other patients who might undergo a similar experience?

If given the opportunity, what would you say to other non-medical people about your experience?

Let me thank you again for giving me some of your time and talking with me about your experience.

APPENDIX F

(312) 798-2559

Ross Medical Associates, S.C.
Emanuel R. Ross, M.D.
Elisabeth K. Ross, M.D.
1825 Sylvan Court
Flossmoor, Illinois 60422

April 8, 1976

Ms. Thena Wilson, R.N.
13406 Noel Road #253
Dallas, Texas 75240

Dear Ms. Wilson:

Thank you for your recent letter and your interesting proposal in studying those patients. I am sure that after reading, Dr. Raymond Moody's book, you will get some ideas as to what directions to take in questioning your patients who have had an incident like this. I would be most interested in reading your findings when you have completed your study. In the meantime, I wish you a Happy Easter - and much success in your important work.

Cordially,

Elisabeth K. Ross

Elisabeth K. Ross, M. D.

EKR/vz

APPENDIX G

13406 Noel Rd.--#253
Dallas, Texas 75240
November 21, 1976

Dear Panel Judge:

Thank you again for agreeing to help me with my thesis: "Experiences of the Patient During Cardiac Arrest and Resuscitation". As a member of the panel of judges, would you please read the enclosed interview guide. This interview guide will be the tool I will utilize to gather data concerning the patients' perceptions of the near-death experience of cardiac arrest and resuscitation.

Please examine each item for clarity and conciseness. Also, determine if you see each item as being pertinent to the study. Indicate your decision by placing a check (✓) in the yes or no space. Space has also been provided for additional comments about each question.

I would like to have your decisions about the interview guide on December 6, 1976, if this date will be convenient for you. If it should prove to be impossible to meet this date or should you need further clarification, please contact me at one of the following numbers: 214-661-0727 (home) or 214-946-8181, ext. 327 (work).

Thank you for being a member of the panel of judges for this study and for taking the time to examine my interview guide.

Sincerely,

Thena E. Wilson

Thena E. Wilson, R.N.
T.W.U. Graduate Student

INTERVIEW GUIDE FOR CARDIAC ARREST PATIENTS

Demographic Data:	Evaluation:	Comments:
Date of Interview	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
Date of Cardiac Arrest Occurrance	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
Present Age	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
Age at time of Cardiac Arrest	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
Religious Affiliation	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
Do you consider yourself to be: ____Not religious ____Somewhat religious ____Moderately religious ____Very religious	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	

Questions:	Evaluation:	Comments:
What were you told about your cardiac arrest?	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
Who told you about it?	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
What do you remember about your cardiac arrest?	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
What did you believe about the meaning of life and death before your cardiac arrest?	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
What do you believe now? (refer to above question)	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
Do you see your beliefs being affected by your cardiac arrest? If so, how?	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
Do you see your life-style being affected in any way by your cardiac arrest? If so, how?	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	

Questions:	Evaluation:	Comments:
If given the opportunity, what would you say to the medical and nursing personnel who participated in your resuscitation procedure?	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
If given the opportunity, what would you say to other patients who might undergo a similar experience?	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	
If given the opportunity, what would you say to other nonmedical people about your experience?	Clear and concise? Yes____No____ Pertinent to study? Yes____No____	

Signature:

_____

APPENDIX H

DEMOGRAPHIC DATA

Patient	Sex	Race	Age at Interview	Age at Cardiac Arrest	Months Since Cardiac Arrest
01	M	C	58	54	46
02	M	C	68	64	41
03	M	C	59	58	17
04	M	C	56	55	17
05	M	C	42	39	34
06	M	C	63	61	19
07	F	C	39	37	23
08	M	C	39	38	11
09	M	C	53	49	39
10	M	C	55	54	02
11	M	C	68	67	08
12	M	C	62	61	13
13	M	C	43	42	17
14	M	C	50	47	44
15	M	C	59	53	68
16	F	C	48	47	12
17	M	C	53	45	91
18	M	C	56	56	05
19	F	C	75	35	480
20	M	C	61	60	12

M = Male
F = Female
C = Caucasian

APPENDIX I

RELIGIOUS DENOMINATION AND EXPERIENCE

Patient	Religion	Denomination	Degree of Religiousness	Arrest Experience
01	Christian	Church of Christ	Moderate	Out-of-Body
02	Christian	Baptist	Very	Religious Out-of-Body
03	Christian	Presbyterian	Very	Nothing
04	Christian	Lutheran	Very	Nothing
05	Christian	Catholic	Very	Nothing
06	Jewish		Somewhat	Nothing
07	Christian	No preference	Moderate	Religious Out-of-Body
08	Jewish		Very	Nothing
09	Christian	Lutheran	Moderate	Out-of-Body
10	Christian	Catholic	Moderate	Nothing
11	Christian	Church of Christ	Moderate	Nothing
12	Christian	Church of Christ	Moderate	Nothing
13	Christian	No preference	Moderate	Nothing
14	Christian	Baptist	Very	Religious Out-of-Body
15	Christian	Baptist	Moderate	Religious Out-of-Body

16	Christian	Baptist	Very	Religious Out-of-Body
17	Christian	Baptist	Moderate	Religious Out-of-Body
18	Christian	Baptist	Moderate	Nothing
19	Christian	Assembly of God	Very	Religious Out-of-Body
20	Christian	No preference	Moderate	Religious Out-of-Body

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