A SYMBOLIC INTERACTIONIST INTERPRETATION
OF THE DYING PROCESS

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PREFACE

This piece of research is a descriptive study of the observable behavior in a hospice. This includes all of the dynamic interaction patterns that take place between the patient, family and varied staff members. It is also an attempt to demonstrate the applicability of a particular sociological theory known as symbolic interactionism to the field of study commonly known as death and dying. The findings include a series of sensitizing and analytical concepts that the reader can use in his own attempt to understand the unique social phenomena called dying.

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CHAPTER I

INTRODUCTION

This piece of research is a study of the dynamic human behavior that takes place in a hospice. A hospice is a medical institution where a diversified yet coordinated group of medical and health service professionals care for dying patients and their families. Secondly this work is an application of the school of sociological thought known as symbolic interactionism to a specific area of human behavior, specifically that observable in a hospice unit of a hospital.

In the last few years the number of studies in the field of Death and Dying have increased greatly producing many significant insights and findings. However in the midst of these many studies there seems to be very little guidance from any particular sociological theory. Few sociologists have taken a firm grasp on their theoretical training and then used that in the field as a framework for analysis of the area of Death and Dying. The intent of this study is to link symbolic interaction with one area of dying behavior. In so doing, it will be possible to not only expand our knowledge of the dying process but also give a broader phenomono-logical foundation to the school of symbolic interactionism.

With this in mind the review of literature chapter is in two sections. First a discussion of the basic symbolic interactionist principles that go into the development of the self, especially as

those principles may apply to dying behavior. Secondly there is a discussion on the current sociological literature that is relevant to the dying process when viewed through the eyes of a symbolic interactionist.

The methodology chapter discusses those research and field work strategies that are particularly applicable to this theoretical viewpoint. Specifically the methodological principles outlined by Denzin are reviewed for use in this research. Also the work of Glaser and Strauss on the development of grounded theory is discussed as a guideline for field research. Finally the methodology chapter summarizes the field strategies used in order to get this research started in the actual observation process.

The findings are presented in categories that might be expected for symbolic interactionist research. The many observations actually logged in the field are grouped into issues such as the development of a special language and the search for meaning in human interaction. Many other observations and conclusions could be made from the field notes but the ones that were particularly insightful for a symbolic interactionist were given more emphasis. Finally there is a brief discussion of the many limitations of this study and some of the broad results about the dying process and the use of symbolic interactionism as a theoretical perspective.

CHAPTER II

REVIEW OF LITERATURE

Introduction

This review of literature is in two parts. First is a review of symbolic interactionism's understanding of the processes that go into the creating, maintaining and changing of the self. More specifically the Chicagoan branch of symbolic interactionism is the theoretical perspective that will be used throughout this work. The primary reason for the use of the Chicagoan Model is its inclusion of the "I" component of the self, thus allowing for the possibility of novel and self-directed behavior on the part of the individual.

Second is an attempt to demonstrate how the Chicagoan model of self can be used to understand the dying process and how much of the literature on dying can be incorporated into the Chicagoan Model.

The Symbolic Interactionist View of Self

Basic Elements in the Construction of the Self

The most basic feature of the self, as presented by the Chicago school, is that it is developed in the process of interaction with others. For Mead[1] the self emerges as an ongoing process between the two components of the self; the "I" and the "Me". The "I" represents

the spontaneous, unrestrained, and undisciplined response of the self. The "Me" represents the incorporated other into the self. An individual develops a "Me" when he internalizes the "generalized other", or in the words of Mead, when he "takes the attitudes of the organized social group to which he belongs". In any given situation the "Me" constitutes the generalized other and often some particular other. Through the internalization of the "generalized other" an individual develops a self, and interaction is an integral aspect of this process.

Many of the ideas of the other early interactionists were also fundamental in creating the Chicago school's view of the self. Cooley's[2] concept of the "Looking Glass Self" is similar to Mead's "taking the role of the other" to the extent that they both lead to the general proposition, "the self-concept (is) primarily focused on the relationship between other persons' responses to an individual and his conception of himself."[3] Both of these concepts emphasize the process of interaction in the development of self.

James'[4] view of the self is also a fundamental aspect of the current understanding of self. James understood the importance of interaction with others in order to develop a self; however, he went on to emphasize that an individual may have as many different and distinct "social selves" as he has different social groups about whose opinions he cares.

The contribution of Thomas[5] and Sullivan[6] are also relevant to an understanding of the development of self. On the one hand, Thomas' "definition of the situation" which he defines as, "a period of examination and deliberation where the actor defines relevant meaning", accentuates the process an individual goes through in

developing his self. On the other hand, Sullivan's "significant other" demonstrates how an individual chooses particular others to incorporate into his self.

This general emphasis on interaction as being the key to the development of the self, as originally set down by Mead and later supported by Blumer and others, must be more thoroughly elaborated in order to fully understand the self.

Both Mead and more recent Chicagoan interactionists view interaction with others as the way an individual develops a self. For Mead it was only through interaction with others that the self can internalize "the generalized other" through the process of role taking. Likewise, Cooley's concept of "looking glass self" incorporates the importance of interaction with others in the development of self.

Recently Kinch[7] summarized this aspect of the development of the self in his general proposition, "The individual's conception of himself is based on his perception of the way others are responding to him." Lopata[8] details this aspect of the self in four assumptions about "social reality":

1. That identities are formulated in a complicated process of social interaction which involves symbolic definition of the self, the other, and the situation.

2. That repeated interaction with the same other in similar situations . . . results in rather definite and stabilized self and other identities.

3. These identities are modified as the self, the other, or the definition of the situation changes.

4. That the removal of the significant others from interaction with the self will necessitate a reformulation of the identities in which he or she was involved.

Developments in role theory have also connected interaction with others to the development of the self. In a recent article, Turner[9]

stressed the importance of interaction with others in the development of the self, "The more consistently and intensely significant others identify a person on the basis of a certain role, the greater the tendency for the individual to merge that role with his person (self)."[10]

The view of self as a product of interaction with others is a necessary but not sufficient perspective for a complete understanding of the dynamics of self development. It must also be recognized that the self develops as it interacts with itself.

Implicit in the idea of the self interacting with itself is the fact that the individual has a "society in miniature" within himself. For Mead this is "minded" behavior. With this capacity the individual has the ability to take the role of the other within his own self and see himself as others see him. Ultimately this allows the individual to try out his behavior and have it tested before others prior to any overt behavior.

Blumer[11] clearly delineates the need for including this understanding of the self.

> . . . Meanings (symbols) are handled in and modified through an interpretative process used by the person in dealing with the things he encounters . . . while the meaning of things is formed in the context of social interaction (external) and is derived by the person from that interaction, it is a mistake to think that the use of meaning by a person is but an application of the meaning so derived . . . the use of meaning . . . occurs through a process of interpretation . . . First, the actor indicates to himself the things which he is acting . . . The making of such indications is an internalized social process in that the actor is interacting with himself . . .

The implications of having interactions with yourself are crucial for an understanding of the dynamic aspect of the self. Primarily this means that the self is never totally determined by antecedent factors. Therefore, the self, through the use of internal interactions,

is no longer just a passive agent but can direct itself in new and novel behavior. The previous experiences and learning of the individual (socialization) may set the general outline for behavior, but they never absolutely determine it. The individual can construct his act on his own. Thus the individual is allowed considerable freedom in being able to adjust the ongoing activity.

Blumer[12] elaborates on this aspect of the self,

> Second, by virtue of this process of communication with himself, interpretation becomes a matter of handling meanings. The actor selects, checks, suspends, regroups, and transforms the meanings in the light of the situation in which he is placed.

Meltzer, Petras and Reynolds[13] also discuss this aspect of the self,

> With the mechanisms of self interaction the human being ceases to be a responding organism whose behavior is a product of what plays upon him . . . Rather he/she rehearses his/her behavior, summoning up plans of actions, assessing them, changing them, and forming new ones, while indicating to himself/herself what his/her action will be. This tentative exploratory process gives rise . . . to the possibility of novelty of behavior.

Thomas[14] has also spoken of the ability of self to come up with novel behavior in his notion of "power of inhibition": "One of the most important powers gained during the evolution of animal life is the ability to make decisions from within instead of having them imposed from without."

The Death of the Self

The discussion of self thus far presented has dealt with some of the basic processes of interaction, both with others and with one's self, that are necessary for an understanding of the creating and changing of self. However, this view of self is not enough of a

theoretical base for understanding the entire dying process. At this point an additional understanding of self must be incorporated.

In order to understand the self as it goes through the dying process an explanation must be provided that examines what happens to self when it is confronted with the threat of annihilition. It must try to explain those unique processes that only arise in the special case of the self confronting the death of the self.

In order to understand these processes we can use the work of Becker.[15] Becker's treatment of death and the self places an emphasis on the symbolic nature of man and thus can easily be incorporated into the symbolic interactionist's view of the self.

Becker outlines the relationship of the self to the threat of death in the form of a paradox. He believes that each person is made up of two opposing natures. On the one hand, man sees himself as an advanced, abstract and symbolic creature who has the capacity for highly sophisticated philosophical and technological thought. This leads man to view himself as a very powerful creature who is immortal in nature. Yet on the other hand, this abstract symbolic capacity of man also allows for the recognition of his impending and unavoidable death--the mortal side of himself.[16] This creates a great paradox. Each individual wants to emphasize the symbolic immortal aspect of his self and yet he always knows that he is mortal and will soon die.

Becker says people resolve this conflict through a life long process of denial of the fact that they are going to die. All of society is designed to help individuals deny their mortal nature. People's lives and all of society's activities, while they may fulfill

other functions, are also a series of heroic events in which individuals can establish their symbolic and immortal natures and thus deny their mortal nature.

This view of man as primarily symbolic in nature is consistent with the symbolic interactionist perspective and allows for an explanation of what happens when the self is confronted with death. It makes it clear that any such threat cannot be accepted by the self but must be continually denied in order to allow man to go on in his symbolic capacity. Any notion of the total acceptance of death is impossible from this perspective.[17] This understanding of the self becomes critical in trying to explain certain aspects of the dying process.

The Applicability of the Chicago School to the Dying Process

The ideas of the Chicago school of symbolic interactionism have thus far been outlined in this work as a framework for understanding the self as it goes through the dying process. This perspective provides several advantages for understanding the dying process.

First, the situation that arises when a person goes through the dying process is a very dynamic one. Traditional definitions of the situation, well-established relationships, and long standing personal meanings all undergo rapid changes. The Chicago school's view of self, as it has been presented here, is well suited to deal with this dynamic process.

As we have already pointed out, a person's self is developed as he interacts with others. Schmidt[18] cites Strauss to show that in the case of the dying patient the nature of his interactions and those

people that he interacts with undergo a drastic change. He will increasingly be dealing almost exclusively with the health professionals that are caring for him and the nature of the interactions will be controlled more and more by those professionals. As stated by Shaskolsky[19] the Chicago school is well suited to deal with such a rapidly changing situation, "Intrinsic to the theory is the sense of fluidity and its accent . . . on flexible interpersonal relationships as a basis for an understanding of the working of society." Blumer[20] also speaks of the necessity of a theory that includes the fluidity of interactions,

> . . . the likening of human group life to the operation of a mechanical structure, . . . seems to me to face grave difficulties in view of the formative and explorative character of interactions as the participants judge each other and guide their acts by that judgment.

Second, the Chicago school recognizes the importance of self interaction as a part of an individual's self. In the words of Blumer[21] ". . . Meanings (symbols) are handled in and modified through an interpretative process used by the person in dealing with the things he encounters." For the dying patient a large part of the change in self comes from internal reflections on the many new meanings that he has confronted. No analysis of observable interaction with others would be able to totally account for the new meanings that develop in the dying self. Because the Chicago school of symbolic interactionism recognizes the importance of these self interactions it is a useful tool for understanding dying behavior.

Summary of the Changing Self

It will now be useful to summarize those aspects of the changing

self that will be used in understanding the dying process. As stated earlier, the self is determined through interactions and as a corollary it may be stated that as changes in the nature of that interaction take place there will be related changes in the self.

First, an individual's self will change as there are significant changes in the interaction he has with others. As stated by Kinch[22], "Self concept is a function of subjectively held impressions of public identity." As this "public identity" creates new meanings or new definitions of the situation, the person's self will be directly influenced. This change may be in reference to the general definition of the social setting or it may be in reference to the identity of the individual's self, in either case it is the changing interaction which creates the change. It should also be noted that an individual may change the nature of his interactions by changing the "significant others" or reference groups with which he deals.

There have been many studies that have tried to isolate the main factors of changing interaction that will affect a change in self. Kinch[23] presents a good summary of these factors:

1. The frequency of changing responses in interpersonal contacts.
2. The perceived importance of the contacts.
3. The temporal proximity of the contacts.
4. The consistency of the contacts.

Secondly, changes in self also take place as the individual interacts with himself. An understanding of the self that develops in direct interaction with others is not adequate for explaining all of the changes that take place in the self of the dying patient. The dying patient may in fact spend more and more time interacting with

himself about the dying process as he tries to create meaning for himself out of the unique situation into which he has been thrust. These new meanings vary from individual to individual depending on the issues he is dealing with and his personal history. Lacking the time or room for a detailed case history of several dying patients, it will be sufficient at this point to simply indicate that the processes that take place in a patient's interaction with himself must be considered if an adequate understanding of the changing self is desired.

Current Literature on the Dying Process

The Common Use of Symbolic Interactionism

The view of self presented in the first half of this chapter is a useful model because a great deal of the current literature on the dying process can easily be understood using these guidelines. The remaining half of this chapter will show how many of the current understandings about the changes the dying person goes through can be understood through the Chicago school's view of self.

First, it is useful to note how many of the major researchers on death and dying make use of some basic symbolic interactionist principles both in the structuring of their research and in their general view of the nature of social settings. Perhaps the best example of symbolic interactionism applied to research on the dying process is in the work of Glaser and Strauss.[24] In their first work, Awareness of Dying, they adopted a good symbolic interactionist perspective when they choose to focus on the changes that take place around a dying patient based on the changing patterns of interaction (awareness contexts) rather than focusing on the structural stability of the social setting. Two of the

basic questions that guided their research were, "How do people come to define and redefine other people as significant interactors?" and "What are the recurrent kinds of interaction between dying patients and hospital staff?" These are basic symbolic interactionist issues dealing with the actor's definition of the situation and their significant others.

In their second book, Time for Dying, which is under the general context of the sociology of time, they again deal with the basic concept of defining the situation when they demonstrate that dying trajectories (modes of dying based on temporal qualities) are not determined solely by physiological conditions but are based on each actor's interpretation and definition of the patient's condition.[25]

In another major work concerning the dying process Sudnow[26] documents how dying is an interactional process and makes use of some basic symbolic interactionist concepts. For Sudnow, dying cannot be defined a priori but must be defined in the process of interaction. In Sudnow's words, "I seek to show by examination the phenomena of death and dying . . . cannot be adequately described by any level without consulting the socially organized character of those . . . activities." Also commenting on the importance of interaction in the dying process Baider[27] says that the dying patient, "starts developing new ways of interaction, new modes of dealing with himself and the external world."

Other prominent researchers also make use of basic symbolic interactionist viewpoints. Kubler-Ross,[28] Dempsey,[29] and Kastenbaum[30] all recognize the importance of viewing dying behavior as dynamic, changing, unique and highly influenced by the interaction to which the individual is exposed.

The Importance of Interaction for the Dying Self

The current literature demonstrates nicely how major changes in the self of the dying patient are closely tied to changes in the types of interaction that the patient experiences. Perhaps the best evidence for the relationship of changing interaction and the changing self of the dying patient is the fact that the self cannot even define itself as dying without some kind of interaction with others to confirm the idea. It is clear from the work of Glaser and Strauss[31] and Sudnow[32] that dying is a social phenomena that is created by the on-going definitions of those who have the authority to define one as dying. Sudnow[33] comments on the necessity of such a definition:

> Dying becomes an important, noticeable process insofar as it serves to provide the patient . . . with a way to orient to the future, to organize activities around the expectability of death, to prepare for it.

Once the patient has been defined as dying changes in his self are directly tied to the changing nature of the interaction he experiences. The work of Glaser and Strauss clearly demonstrates the connection between changing interaction patterns and a changing self. Their first work, Awareness of Dying,[34] is centered around the different types of interaction that take place in different "awareness contexts."[35] The self is affected differently in each awareness context (or definition of the situation). When the awareness context changes the nature of the interactions change and there is a related change in the self of the dying patient. The majority of Glaser and Strauss' book is focused on the types of interaction that go into maintaining and changing awareness contexts; however, they do generally discuss some of the specific changes

that take place in the self as the individual shifts from one awareness context to the next. There are four different awareness contexts to be discussed. Each of which is a broad definition of the situation that affects the types of communication patterns that will develop in relationship to the participants knowledge of impending death.

For the patient who is in a closed awareness context, where there are no changes in the make-up of his self because he will continue the same patterns of interaction that he normally uses. If the patient moves into suspicion awareness concerning his impending death he may increasingly try to find out more and more about his illness. If the staff does not want him to know about his illness then he will experience frustration and depression because of his inability to gather enough information to properly determine the true nature of the situation. His self will be in a very frustrated state where it does not have sufficient information to create an accurate definition of the situation. Erickson[36] has also commented that anger, mistrust and helplessness can develop in this suspicion context because of conflicting sources of information concerning the definition of the situation. In the mutual pretense context all concerned parties usually know about the impending death but agree not to talk about it. In this situation the patient maintains normal patterns of interaction in order to use the mutual pretense as a defense so that his self will not have to deal with death.

When the patient moves into open awareness there is no single pattern of change that will take place in the self. Different patients, and the same patient over a period of time, will show a great deal of variation as to how they choose to deal with and structure the

interactions concerning their death. Glaser and Strauss observe that the patient will fluctuate back and forth between denial and acceptance, between anger and calm. Each individual will close out his life trying to combine his own understanding of the correct role to play with the expectations of those around him. Neale[37] comments on the diversity of ways that an individual can deal with open awareness,

> How is the patient going to present his dying self to the world? As the rebel who goes down fighting?; the well behaved, cheerful and composed person he may not have been enduring his life time?; the brave, the silent and stoical individual who is simply doing what is expected? Open awareness asks him to play a difficult role, to find an identity at a time when the self is in a process of dissolution, . . .

Glaser and Strauss' second book, Time for Dying,[38] is also excellent evidence for the relationship between changing external interaction and a changing self. In this work they discuss how the patient will be defined by the doctor and staff as being in one of four possible dying trajectories:

1. Certain death at a known time.
2. Uncertain death at a known time.
3. Certain death at an unknown time.
4. Uncertain death at an unknown time.

The doctor and staff become significant others for the patient when, through the process of interaction, they dictate for him the correct way to behave in each of these trajectories. The patient may, however, experience frustration in defining his self when there is conflict between the doctor and staff concerning the correct definition of his dying trajectory.

Glaser and Strauss also point out other kinds of interaction that will affect the patient's self. The patient will encounter various

patterns of interaction that are already established in the hospital. The patient will be affected by the "sentimental order" of the ward he is on and by the ongoing "careers" of the hospital and staff. It is often the case that these previously established patterns of interaction will come into play when the patient is trying to define his self.

Other researchers have also demonstrated how changing patterns of interaction will influence the self. Mauksch[39] makes use of Goffman's concept of the "stripping process", whereby an individual is totally stripped of all of his previous interaction patterns and significant others in order to create a new self for the individual, to explain how the dying patient in a hospital is exposed to a totally new set of interactions that are centered around his dying and out of these new interactions the individual creates a new self. Dempsey[40] speaks about the "games" that dying patients play in a hospital and how these games are learned through interaction with the doctors and staff.

The work of Kubler-Ross[41] can also be interpreted as an analysis of the changing interaction patterns of the dying patient. Her work discusses the self both as it is in direct face to face interaction with others and as it interacts with itself. According to Kubler-Ross the patient's self experiences five stages, each of which can reoccur from time to time. Briefly listed these are (1) denial, (2) anger, (3) bargaining, (4) depression, (5) acceptance. The first four stages are normal and predictable defenses against the shocking news of death. They serve the function of helping the patient advance toward the stage of acceptance at which point he has finished grieving for himself and his friends and is willing to withdraw himself into a state of benign,

peaceful acceptance of his fate.[42] One other aspect of Kubler-Ross' work that must be included is her recognition that all patients at all times never lose hope for a recovery or some way of defeating death. Kubler-Ross[43] comments, "Even the most accepting, the most realistic patients left the possibility open for hope." Hope is essential for understanding Kubler-Ross' scheme of dying behavior.

Many other researchers[44] have documented the types of concerns that may become important elements in the interactions of the dying patient. A summary list of these concerns is presented here.

1. Pain
2. Loneliness, rejection and avoidance
3. Loss of control (physically and socially)
4. Loss of worldly connections
5. The maintenance of dignity (physically and socially)
6. Being overly dependent on others
7. A concentration on the immediate
8. Guilt
9. Religion
10. Finances
11. Various defense mechanisms

There is no particular order in which these concerns appear, nor is one always more important than the others. At any one time the primary element of interaction may be any one of the above concerns. These concerns may be a vital part of the interactions of the dying patient either as he interacts with others in direct face-to-face contact or as he interacts with himself.

In conclusion it can be observed that the self of the dying patient is created in the process of interacting with others and himself. The patient's self is his interaction and the patterns of this interaction change as he interacts with others who have defined him as dying and as he interacts with himself about the new issues that he is confronting.

The General Decrease in Interaction and the Self

In reviewing the literature on the dying process one of the most obvious conclusions is the general decrease in the number of interactions that the dying patient experiences. Dempsey[45] and Baider[46] both observe that the most notable thing that happens to the dying patient is his physical and social isolation. In listing the qualities that hospital personnel include in the "good" death, Kastenbaum[47] includes the following elements that relate to decreasing interaction:

1. The good or successful death is quiet, uneventful; the death slips by with as little notice as possible,

2. Not too many people are around,

3. The physician does not have to involve himself intimately,

4. Emphasis is on the body, not the personality.

There is considerable evidence to indicate that doctors, nurses, relatives and friends all try to avoid contact with dying patients. Schulz and Adurma[48] have the best general review of the literature concerning doctors inability to deal with the dying and their general tendency to avoid the patient. Glaser and Strauss[49] and Sudnow[50] also demonstrate that once a patient has been defined as dying he is no longer "medically interesting" and the doctor tends to fade out of the scene.

There is just as much evidence to indicate that nurses tend to avoid dying patients and are slow to respond to their call. Mauksch[51] coins the term "bank account" to refer to the number of interactions nurses are willing to have with patients and he notes that the "bank account" level for dying patients is far below average. Glaser and Strauss[52] observe the stage of "nothing more to do" in which nurses define the patient as medically "over the hill" and then tend to avoid the patient whenever possible. Kubler-Ross[53] and Sudnow[54] also document how family and friends often either avoid the dying patient or else the dying patient is isolated from them.

When interaction does take place it has been observed by Dempsey,[55] Sudnow,[56] and Erickson[57] that this interaction tends to avoid the topics of death and dying, rather it is focused on "safe" topics of little consequence for either party.

What affect does this general decrease in interaction have on the self of the dying patient? If the self is created through the process of interaction, then when there is a major quantitative and qualitative decrease in the interaction that a person experiences we can expect a deterioration of the self. It is in this light that Kubler-Ross' stage of acceptance can be reinterpreted as a deterioration or fading away of the self.

Kubler-Ross describes the stage of acceptance as not really a happy stage but rather as one where there is virtually a void of feeling. The patient's circle of interest and number of communications dwindle to practically nothing as the patient approaches death. Abrahms[58] has verified how a patient's communications dwindle as he reaches the "terminal" stage. The last stage of acceptance is

decathexis is which Kubler-Ross says the patient cuts off as many ties as possible and even seems to resent any interaction from the outside world. Feifel[59] has also spoken about the stage of decathexis as one where there is simply total withdrawal from interaction. Koenig[60] has observed that because of a total loss of interaction with others the patient tends to become withdrawn and seems to lose interest in both himself and others.

As stated earlier, Becker[61] has nicely made the argument that no symbolic creature could ever agree to accept his death. A more feasable argument for what happens in the stage of acceptance is a gradual deterioration of self as the self's level of interaction decreases. When the dying patient is unable to find any validation through interaction for whatever meaning he is struggling to create then there is no longer any grounds for the self to be based upon. Symbolic interactionism explains the self as developing through interaction and when interaction ceases it is reasonable to expect that the self will cease.

Summary

This review of literature has been in two parts: the first being a review of the Chicago school's view of how the self is constructed, maintained and changed and how the Chicago school is particularly useful for understanding dying behavior; the second being an attempt to fit some of the literature on the dying process into the Chicagoan model of the self.

The Chicago school provides a useful tool for understanding the dynamic and rapidly changing meanings that are created for the dying

patient who knows there is very little time left and for recognizing the fact that the changes the self goes through are directly tied to the process of interaction. Symbolic interactionism also provides a theoretical explanation for understanding how symbolic human beings deal with death and for a reinterpretation of "acceptance" in an interactionist framework.

ENDNOTES

[1]Meltzer, Bernard N., "Mead's Social Psychology," *The Social Psychology of George Herbert Mead* (Western Michigan University, 1964), pp. 10-31.

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[52]Glaser and Strauss, Time for Dying, p. 172.

[53]Kubler-Ross, p. 119.

[54]Sudnow, p. 83.

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[56]Sudnow, p. 70.

[57]Erickson, p. 290.

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[61]Becker, p. 26.

CHAPTER III

METHODOLOGY

Introduction--Statement of Purpose

It is the purpose of this research to tie the theoretical and methodological perspectives of symbolic interactionism to an understanding of the dying process thereby broadening our understanding of dying behavior. This particular style puts a heavy emphasis on the insepar-ability of theory and method as will be demonstrated throughout this research. This line of investigation will lead to an examination of questions like: How is the self of the dying patient created? What are the changing patterns of interaction of a person once he has been defined as dying? How do the various patterns of interaction interrelate? How does the dying patient find meaning?

The rest of this methodology chapter will be in four parts. The first part will review the basic methodological principles that the theoretical perspective of symbolic interactionism requires. The second part will discuss the use of Glaser and Strauss' grounded theory for generating theory on the dying process. Then a discussion will follow of the validity in symbolic interactionist research and the actual methodology and field strategies used in this research.

Methodological Principles of Symbolic Interactionism

The use of symbolic interactionism as a theoretical perspective requires the use of several specific methodological principles in the research process. Denzin[1] provides a list of these requirements which have been used as a guide throughout this study. A brief outline of these principles is discussed here.

1. Symbols and interaction must be combined before an investigation is complete.

Social behavior is observable at two interrelated levels, interactional and symbolic, and an analysis of any social process must incorporate both levels of behavior. On the symbolic level the investigator must take the time to learn the language and symbol structure, both verbal and non-verbal, of the subjects. Every sub-group within society has its own language that expresses meaning for its members in its own specialized way. Learning the language of the subjects also allows the investigator to capture the reflexive nature of selfhood which is constantly evolving and creating new symbols and meanings.

2. The investigator must take the perspective of his subjects and view the world from their point of view, but in so doing he must maintain his own sociological perspective.

Adopting the perspective of the subjects allows the investigator to see the world as they see it and discover their world of meanings. This also prevents the investigator from being guilty of creating a logico-deductive theory where the patterns of interaction of the subjects are forced into pre-conceived categories of meaning by the researcher.

At the same time, enough objectivity must be maintained to keep the sociological perspective and make the kind of analysis that the subject is not equipped to do. (A more detailed discussion of the balance between intimate participation and objective observation is included in the section on field strategies.)

> 3. The investigator must link his subjects' symbols and definitions with the social relationships and groups that provide those conceptions.

A methodology that examines the link between symbols and social relationships emphasizes the social and interactional nature of the self and how the self evolves in the interaction process.

> 4. The behavior settings of interaction and observation must be recorded.

The settings that interactions take place in play an enormous role in the development of the self. The normative structure governing conduct, the physical structure of the location, traffic patterns, the degree of privacy, the type of participants typically at the site all play a crucial role in the flavor of the interaction.

> 5. Research methods must be capable of reflecting process or change as well as static behavioral forms.

Since human interaction is highly dynamic and meanings are constantly being changed and reinterpreted the research methods must be capable of capturing these dynamic processss. Rather than focusing on stagnant states and typologies of behavior the research must be able to identify the processes that create meanings.

> 6. Conducting research and being a sociologist are also acts of symbolic interaction and the researcher must recognize how his own values and definitions affect his research.

A researcher that puts a heavy emphasis on participant observation and seeing the world from the subjects' point of view must be careful

to recognize how his own values and definitions are altering the degree of objectivity that he is hoping to maintain in his reporting.

7. The researcher must use sensitizing concepts in his research before he adopts rigid operational definitions.

Before the researcher goes into the field with rigidly defined concepts or scales or questionnaires he must do whatever groundwork is necessary to sensitize himself to the symbols, interactional patterns and values of the subject. This sensitivity must be maintained throughout the research in order to prevent the creation of theory that is disjointed from the real world.

Grounded Theory as a Theoretical-Methodological Framework

The Advantages of Grounded Theory

Using the methodological techniques outlined by Glaser and Strauss in *The Discovery of Grounded Theory*[2] provides several advantages in research on the dying process. The most general advantage is the ability to close the gap between theory and methods. For Glaser and Strauss the research process is a constant combining of theory and research for the simultaneous generation and verification of theory. An original theory may be used when the field work begins but the methods of research may end up altering the theory, or again the theory may end up altering the methodology. There is a constant interplay between the two and it often is not known how the theory will develop until well into the research. As discussed in the introduction of this chapter it is the purpose of this research to demonstrate how both the theory and methodology of symbolic interactionism are

applicable to an understanding of the dying process. Adopting the framework of grounded theory is very useful for this purpose.

Second, the methodology of grounded theory is not primarily designed for the verification of previously existing theory but rather is used for the creating of new theory to explain previously unexamined social phenomena. This is precisely what is needed in research on the dying process because of the lack of theoretical explanations for the changes a dying patient experiences.

A third advantage is that grounded theory is very closely tied to the substantive area of study and the researcher can feel confident that his theory will accurately reflect the social milieu that it was created from; the theory is automatically grounded. This is in contrast to the use of intellectually constructed logico-deductive theory which the researcher may have to force onto the data and subjects.

The fourth advantage is that the theory will tend to "work well" and will create relevant explanations, interpretations and applications. Having been simultaneously created and verified directly out of field experience the final product can be taken back into the field and used with confidence.

The final advantage is for the layman. Theory that is generated from the ground up and is closely tied to its subjects has the advantage of being understandable enough to layman to be useful and applicable in the real world.

The Methodology of Grounded Theory

Grounded theory is based on the comparative method. Through the

comparison of theoretically relevant groups the researcher is able to observe relationships between groups and within groups. The researcher then integrates these direct relationships together into a comprehensive theoretical whole.

The first step in this process is to adopt a theoretical perspective with which to view the empirical world, in this case symbolic interactionism. You must then begin to ask guided questions about that world based on your perspective and the groundwork research you have done to sensitize yourself to the symbols, meanings and interaction patterns of that world.

Through the process of "theoretical sampling" you begin to select relevant groups to study and compare. At the early stages of research you must be careful to start with a minimum of categories and not over structure them in order to prevent forcing a predetermined theory onto your data. Symbolic interactionist research principles tell us that you cannot get too specific until you get into the symbols, meanings and interaction patterns of the subjects.

As you begin to gather data and observations your research is guided by three interrelated strategies: collection, coding, and analysis. First there must be collection of data and observations. Simultaneously you must begin coding these observations into relevant groups and categories for the purposes of comparison. Finally analysis of these patterns and relationships will begin to lead you to hypothesis and theories.

As the research process progresses two kinds of concepts emerge. Analytic concepts will help in the analysis of the data and the creation of patterns, explanations and theories. There will also be

sensitizing concepts. These are concepts that evolve throughout the process of the research that will help you "get into the heads" of your subjects. They will help you ask the right questions and prevent you from asking the wrong ones.

It is important to note the interrelatedness of all elements of this research, referred to as the "constant comparative method". The collection, coding, analysis and creation of concepts all take place simultaneously and a change in any one can alter all the others. The development of insightful sensitizing concepts might alter the type of collection and coding you are doing or the coding you are doing might alter the type of sensitizing concepts that emerge.

Validity

In symbolic interactionist research validity checks and measures come during the theory generation process. Principles for examining both internal and external validation are applied as part of the constant comparative method when developing grounded theory.

When developing categories and the relationships between them there are many things to consider when checking the internal validity of the insights that emerge. Generally these can be grouped into four categories: (1) changes in subjects, (2) effects of observer, (3) changes in the setting, and (4) historical developments. In the theory generation process any collection, coding or analysis that is done is subject to checks for internal validity in these four categories.

For example after several weeks of observation the researcher may have divided the subjects into various groups with several principles explaining the types of relationships between the groups. If he wants

to check the internal validity of his findings he must look to the four categories above. Specifically he must look for any changes in his subjects. If the subjects have matured or altered their behavior then the report must change. A frequent problem here is subject bias and mood. The subjects behavior or relationship may have changed due to an altering bias or mood and this should be reflected in the findings.

Another problem area for internal validity are the many potential effects of the observer on the interaction he is observing. The participant observer role requires that the investigator not interject his values or beliefs into the setting under study. However, because it is impossible to remain absolutely objective and neutral the observer must honestly report what his role was in the interaction and how this changed the results.

Changes or peculiar developments in the interactional setting will also affect the accuracy of the findings. If there is a change in the participants or a change in the physical setting these must be taken into consideration in order to make sure the reporting is still accurately reflecting the true setting.

Finally, historical development or the consideration of time and its passage must be considered for the validity of a study. Interactional settings can be very volatile and undergo wide changes in a short period of time. The researcher must constantly be gauging his conclusion against the changing setting to insure the internal validity and good fit of his report.

External validity tests for the participant observation mode are generally done by asking the subjects if the conclusions reached seem

to ring true and accurately reflect the social setting. This is often the ultimate test of the researchers ability to observe the setting.

In summary, there are many ways to constantly check the validity of the conclusions generated when using the methods of grounded theory. Good theory must constantly use the internal validation procedures outlined here. The final validity test of good theory is its ability to illuminate a previously vague or unexplained phenomena. If the theory can explain and make sense out of a social phenomena for both the layman and the professional then the theory has both internal and external validity.

Field Strategies

Preparation

Before going into the field and making contact with patients or families who are going through a terminal illness, the researcher doing symbolic interactionist research must first prepare by developing certain sensitizing concepts. These concepts will sensitize the researcher to the types of meaning and the types of interaction patterns that are relevant to the subjects. Developing these background ideas will help familiarize him with the technical vocabulary and jargon of his subjects. It will also all him to ask questions that will lead to significant insights and it will hopefully prevent him from asking embarrassing questions that could do harm.

In order to develop appropriate sensitizing concepts four areas of background preparation were reviewed: (1) read the research for the review of literature chapter of this work, (2) subscribed to and read the Bay Area Hospice Association[3] and the National Hospice Organization[4]

newsletters, (3) regularly attented the monthly Bay Area Hospice Association luncheons, (4) attended the National Hospice Organization annual convention in Los Angeles, California. These activities allowed the researcher to develop a basic understanding of hospice and the types of interaction that take place there.

Making Contact

Through the Bay Area Hospice Association a nearby Hospice was located. Contact with Mr. Richard Brett, director of Haiser Hospice in Hayward, California, was made and an interview was scheduled. Mr. Brett wanted to know what role the Kaiser Hospice would have in research on death and dying. Roughly paraphrased the following explanation was given:

> I am a student at Oklahoma State University and am doing a thesis on the type of interaction and communication patterns that dying patients experience. I will be using the theoretical perspective of a branch of sociology called symbolic interactionism. I would like to become involved in a hospice organization and use my observations as the basis of my thesis.

Mr. Brett saw no problem with this and thought the best avenue of involvement would be to become active as a volunteer. After signing the volunteer list and completion of a brief orientation program the participation began with the assignment of every Tuesday evening from 5:00 to 9:00 p.m. as hours of service.

Object of Study

The object of study was the eight bed Hospice unit of the fourth floor of the Kaiser Hospital and the dynamic interaction patterns found there. The participants in these interaction patterns were

doctors, nurses, volunteers, patients, families, clergy, administrators, family pets and this researcher. Altogether this researcher came to know approximately 25 patient-family units over a six month period.

The setting for interaction was a small eight bed, four room wing of a hospital. The area has been partially made over in order to give a warm homelike setting. There was a family room with fresh flowers, bookshelves, television, stereo and easy chairs. The patient rooms were basically like any double occupancy hospital room except for the lack of equipment and technical devices. Patient rooms would sometimes have recliner chairs in them if a relative desired to sleep in the room. Rooms were also spiced up as much as possible with personal items that belonged to the patient such as pictures and nicknacks.

The interaction patterns that emerged from this conglomerate of settings and subjects were the objects of study in this research.

Data Collection

The primary method of data collection was participant observation with the subjects and the setting. Denzin describes at least four levels of participant observation along a continuum ranging from the separate, neutral and objective researcher playing the role of "observer" to the totally involved researcher seeing the setting only from the viewpoint of the subjects and playing the role of complete "participant". Between these two extremes are the "observer-participant" and the "participant-observer" with the emphasis in research on one or the other but still including both.

This research attempted to adopt the viewpoint of the participant-observer. That is to say that there was emphasis given to becoming

involved in the day-to-day activities of the subjects and trying to see the world, its symbol structure and meanings from their perspective. In the midst of this participation hopefully enough sociological training and objectivity remained to be able to report findings and observations that would not be apparent to the untrained eye.

Occasionally the mood of a setting would lend itself to a more formal interview type of format. Interviews would never be pre-structured or use pre-structured questions. In order to prevent forcing something on a patient that would make him/her feel uncomfortable interviews only developed when the patient seemed to be in an information sharing mood. This also had the advantage of adding a sense of reliability to the information gathered. Patients or staff would often ask this researcher why he was so interested in death and dying and why volunteer time at such a place. An answer similar to the following was usually given:

> I have been doing quite a bit of reading on the experiences that patients with serious illnesses go through. Also about how important that is to the family of the patient and the medical people he is working with. I decided it was time to stop reading and actually go get a job where I can learn more about it first hand.

Finally certain factual information could be gathered from publications, pamphlets and newsletters put out by the Hospice. These were helpful in gathering statistics, dates, medical definitions and history.

Whenever possible these different modes of data collection were combined in a form of triangulation to confirm information and facts. If an unusual bit of information or an atypical interaction was observed in a patient, an interview with a staff member or an examination or written documents could be used to confirm the phenomena.

Ethical Considerations

Research that is intimately involved in the very personal experience of dying must give consideration to the ethical problem of prying into peoples private lives and using them as guinea pigs. These problems did not seem to arise at the Kaiser hospice unit for at least three reasons. First the entire program had an air of training for everyone concerned. It was expected for people to be asking questions as they learned the ropes of the new program. It was not uncommon to frequently be training a new nurse or doctor as to the goals and objectives of the program. As a volunteer trying to understand how the program worked it did not seem unethical at all for this observer to step right in and ask questions and receive training just like regular staff professionals.

Secondly, it was not uncommon to see various community, state and federal employees coming in to study the new program. Also various media and health care people would stop in to learn what a hospice program was about. The program coordinator was fully aware of this type of research and raised no objections. To quote from the Hospice Report,[5] "A steady flow of representatives from the media, government and health care providers have come to visit our hospice program." The idea for this piece of research was presented to the hospice coordinator before the field work began and he saw no problem with the work.

Finally, as an ethical justification an analogy from Dr. Raymond G. Carey[6] can be borrowed. The subjects used in this research were not used for the purposes of study alone. The researcher acted as a active volunteer on the unit and as such provided a wide range of help

and services to the patients. According to Dr. Carey this is like a doctor who gives the best service he can while at the same time keeping good records and reporting the results.

ENDNOTES

[1]Denzin, Norman K., "The Research Act," Symbolic Interaction, 3rd ed., eds. Jerome G. Manis and Bernard N. Meltzer (Boston, 1978), pp. 58-67.

[2]Glaser, Barney G. and Anselm Strauss, The Discovery of Grounded Theory (Chicago, 1965).

[3]Glaser, Barney G. and Anselm Strauss, Hospice Report (San Francisco: Bay Area Hospice Association).

[4]Glaser, Barney G. and Anselm Strauss, NHO Newsletter (McClean, Virginia: National Hospice Organization).

[5]Walter, Norman, Hospice Pilot Project Report (Hayward, CA, 1979), p. 12.

[6]Carey, Raymond G., "Living Until Death: A Program of Service and Research for the Terminally Ill," Hospital Progress (February, 1974), p. 64.

CHAPTER IV

FINDINGS

Introduction

The findings in a study of the dying process through the eyes of a symbolic interactionist are many. However, a proper understanding of the findings of this research should begin with a basic understanding of the hospice and its philosophy. The setting of the Kaiser hospice was described in the previous chapter under field strategies. The philosophy of the project is stated in their own publication, Hospice Report,[1]

> The hospice program appears to provide for the needs of the terminally ill via skillful symptom management, comprehensive planned care, active patient-family participation in the caring process, and a supportive, communicative milieu integrated in an effort to maximize assistance to families and patients in coping with the crisis of impending death.

The principles of hospice work are also outlined by the National Hospice Organization[2] in which the Kaiser hospice is very active.

> Hospice is a coordinated program of palliative and supportive care (physical, psychological, social and spiritual) for dying persons and their families which is provided by an interdisciplinary team of professionals and volunteers under a central administration. This care is available 24 hours a day seven days a week. Admission is on the basis of patient and family need. Hospice care continues into bereavement.

The specific findings of this research will be presented under two categories: first, a brief discussion of the interrelatedness of all the findings reported on here and second, a presentation of what kind of

theory can be generated by this research with the use of the principles of grounded theory. This will include a review of grounded theory and a discussion of some basic sensitizing and analytical concepts that can be created to understand dying behavior.

Interrelatedness of the Findings

In the process of drawing conclusions about the types of interaction that were taking place one of the most overwhelming observations made was how tied together and interwoven all of the various elements were. An analysis of the two statements of philosophy given in the introduction will reveal how all levels and types of care are interwoven and treated as a whole. The use of the words "integrated" and "coordinated" in the two definitions, respectively, give the reader a clue as to how no single interaction can be viewed as an isolated event, but rather must be understood as a part of the whole.

Observing the different actors and their various roles indicates how intertwined the roles are and how the behavior of each individual affects the rest. The staff of the unit would frequently comment on the blurring of the role boundaries between the various professionals. The family-patient unit was another good example of the tie between the relevant interactions. A proper understanding of the attitudes of a patient could not be reached without knowing the family and their values. Frequently if a nurse or doctor wanted to change the attitude or alter the behavior of either a patient or a family member the patient-family unit as a whole would receive the treatment or counseling. The attitude taken toward medical treatment also shows how all the different elements of the life process are to be taken

into consideration. The Hospice Report[3] quotes Rosin as stating that medical treatment should not depend solely on treatment and diagnosis of a pathological disease. Rather it should also give consideration to the emotional and psychological response of the patient.

The findings discussed throughout the rest of this chapter are also examples of the interwoven and interrelated nature of any observation of the dying process. For example,there is a single section on the discussion of a specialized language. However when reading about the other findings,the reader must keep in mind the effect of a special language. Or again there is a brief discussion of growth in the face of death. In order to properly understand how this growth occurs the reader must relate it to every other finding reached in this study.

It has proven remarkably appropriate that symbolic interactionism was used as the theoretical framework for this research. The methodological techniques of grounded theory and the principles of research outlined by Denzin frequently speak of how each observation is tied to all the elements of the setting and how all symbols, interaction, definitions and settings must be interrelated before a full understanding can be reached. Adopting this perspective was very helpful in understanding the dying process as a whole.

Generation of Grounded Theory

The generation of grounded theory according to the principles outlined by Glaser and Strauss[4] has tremendous applicability and usefulness in understanding behavior in a hopsice. The details for following this process were discussed in the methodology chapter. This section will present a listing of the sensitizing and analytical

concepts that were generated as a result of the collection, coding and analysis process that went on in the field observation. After those concepts are presented a final discussion will review and test the theory generated for its usefulness and ability to meet the criteria for grounded theory as discussed by Glaser and Strauss.

Sensitizing Concepts

In this section four concepts are presented that serve to sensitize the researcher to the basic issues in a hospice. These concepts are a part of the overall piece of grounded theory generated by this research.

Language of the Dying. A good place to begin an understanding of the interaction patterns in a hospice is with a review of the special language that develops not only for the patient but also for the family and the entire staff. Kubler-Ross[5] discusses three levels of communication that go on among dying patients; all of which are observable in a hospice unit. Most obviously, but not necessarily most significantly, are the straight forward plain English conservations about age, aging, death, grief and afterlife. This observer occasionally participated in conversations about how an individual had aged, how life had changed, about concerns for the rest of the family, about the Bible and about the after life. However, it was not very often that these conversations were started just for the sake of conversation. When they did occur they were often academic in nature and third party oriented. They were emotionally safe in nature and not too revealing about an individual's personal search for meaning.

A more subtle and more specialized language of the dying is apparent in symbolic non-verbal communication. It is at this point

that the researcher and indeed the regular staff (doctors, nurses, and volunteers) have to take the time to learn this specialized language if they are to appreciate the deeper levels of interaction and meaning that are taking place. The power of this language of silence has been expressed poetically by Rosenthal[6] "I never knew what fear was until I saw it in the eyes of the people taking care of me."

This researcher spent a lot of time as a volunteer just sitting by the bedside. This allowed observing and participating in such behavior as silent hand holding and staring out the window by one participant while everyone else is busy talking. At times it also seemed important for one individual to simply be in the room without saying anything. The power of silence at these times was quite often apparent. In The Hospice Movement[7] Stoddard uses the phrase, " . . . pregnant with her own death" to describe the kind of power and serious meaning that can come about during these moments of silence.

Sometimes the disease of the patient may be such that verbal communication is impossible. One particular patient had a cancer that attacked the skin on the face which made talking nearly impossible. It was common in this case to observe silent hand holding, communicating with sign language and many silent stares. This patient had quite a history of sailing. A picture of a windjammer was placed on the wall at the end of the bed. It would be common to see silent stares or pointing and gesturing at this windjammer.

Other non-verbal interaction observed that showed significance beyond their direct effect included holding and fondling of a Bible, being angry (either the patient with the family or vice versa),

pushing away medication, and leaving the room in the middle of a conversation. To analyze the deeper significance of these symbolic acts of interaction is difficult and subject to many types of bias. This research will go no further than to note that these types of interaction do occur and a good researcher must be prepared to take note of them.

A third type of observable language is verbal and symbolic. It was quite possible to observe verbal interaction that began on one particular topic but which was a signal that the participant was ready to or would soon be moving on to another more serious or frightening topic. One such occasion was when this observer was asked to pick a Bible passage and read to a patient. No particular passage was requested and the patient soon turned the conversation to what life after death might be like. The interaction then consisted mostly of sharing ideas of the religious image of afterlife with the observer playing the role of a silent hand holder.

Another example of a specialized symbolic vocabulary was a discussion that started out about sleep. In a very short while the conversation turned into a mutual recognition of the impending death of this gentleman and how that might very well be nothing much different than sleep.

All patients, families and staff of the hospice unit knew, on one level or another, that death was impending for any given patient. However, no one forced such information on anyone in the form of a speech, sermon or discussion. By having open lines of communication and being sensitive to the special language that was being used by each patient, conversations about serious matters would naturally arise at

the proper times. The importance of knowing this specialized language is nicely summarized by Sister Teresa McIntier[8]:

> Generally, interpersonal relationships are built on the foundation of human communication. A common ground is identified and a distinctive vocabulary is laid down. The degree of fulfillment one derives from the relationship is in direct proportion to the time and effort expended in learning to communicate on different levels.

Individuality of Each Interaction. In the course of observing hospice interactions for the purpose of social research there is always the urge to begin grouping, categorizing and typing observations and interactions. However to do so seems to run against the grain of the very structure of the program. To create a firm typology of hospice interactions would be a mistake since each interaction, each moment, each case and each setting is so fluid and subject to change. At best the researcher can only hope to become sensitized to the possibility of certain types of interactions and ways of finding meaning. As expressed in the Hospice Report[9] by Dr. Richard Lamerton,

> There is only one place where I could learn about this particular patient's needs in this particular moment. It could not be from his case notes, my college training, or among the rag-bag of self-centered ideas in my head . . . If, at this moment, someone is trying to classify the patients questions, to categorize it according to some textbooks on psychology, to make it fit some diagnosis, then the infinite variety of subtlety and nuance will be missed.

In the American Journal of Nursing[10] Fox also notes that, "The act of death is singular and final, but the act of dying is variable in form and subject to human interaction."

The uniqueness of each case and interaction is built right into the structure of the daily routine on the unit where flexibility is

the rule of the day. With a small program (only eight beds) each setting can remain intimate enough so as to allow the staff time to get to know the patient-family units' values, conflicts and individual language patterns. All medical and support programs are also tailored to meet individual needs.

Examples of the patients' needs determining the plan of case are abundant. Visiting hours and visiting restrictions are very flexible and have been known to be bent for one individual. It was not uncommon to see children visiting after 10:00 p.m. Also pets were brought in if the patient had requested them. Diet was another example of flexibility. People ate the standard hospital food or hamburgers from across the street or champagne brought in by the family. A microwave oven allowed for warming of food whenever the patient was ready to eat. Medications, including the all important hospice mix, followed no rigid regimen. In fact changing the time on the medication according to the patients' needs rather than the nurses schedule was crucial to the medical plan. Slightly altering the nature of the mix to meet the tastes of the patient was also common.

Individuality in patients' roles in interaction was also the rule. Nothing was out of the realm of possibility including a religious service with many participants to reaffirm the wedding vows of a couple before the death of the wife. A comment can be made here about the volatility of interaction involving patients. A mood or a state or a pattern that exists now may disappear or radically be altered when one more actor walks in the room, or a single door is shut or some insight suddenly emerges. A researcher must be prepared to recognize the rapid and fluid nature of these interactions.

The sources for creating unique interactions are endless. This brief discussion can only list a few examples and a few causes of such diversity. Suffice it to say that the creation of patterns and typologies can certainly be as dangerous as they are helpful. Saunders[11] nicely summarizes the possibilities, " We have the endless fascination of watching each individual come to terms with his illness in his own way and come along his own path to life's ending."

Medical Issues. In the midst of the many interactions occuring on a busy hospice unit, the most predominant issues are around medical concerns, for a hospice is a medical institution first. As stated in the Hospice Report,[12]

> The needs of the dying are bodily first. (emphasis theirs) If you are so constipated that you are vomiting, if the least movement produces showers of pain, if talking is almost impossible because of thrust coating your tongue and palate, how on earth can the mind be free to contemplate death, and how could any reassurance sound anything but hollow . . .

Or as expressed by the director of the program Brett,[13]

> . . . primarily important to treat the physical symptoms. The patient must be made to feel as comfortable as possible before anything else can happen . . . Staff members were shocked to discover that it was more important to play the role of Florence Nightingale than Kubler-Ross.

The medical philosophy of the hospice is palliative rather than curative, care rather than cure. It is a new type of medical treatment that is not equated with recovery and recuperation. Case has a much broader scope than cure of a particular disease. The medical treatment that comes with care is aimed at controlling pain, nausea, obstipation and whatever correlates of cancer that arise which interrupt a comfortable and meaningful life style. There is no complicated and

intimidating medical apparatus in the room, no code blues, no heroic resucitation, and a minimum of tubes, wires and artificial support systems. As expressed by Stoddard,[14]

> People in hospices are not attached to machines, nor are they manipulated by drips or tubes, or by the administration of drugs that cloud the mind without relieving pain. Instead, they are given comfort by methods sometimes rather sophisticated but often amazingly simple and obvious and they are helped to live fully in an atmosphere of loving kindness and grace until the time has come for them to die a natural death. It is a basic difference in attitudes about the meaning and value of one human life, and about the significance of death itself. . .

The whole wellness of the patient is of primary concern. Therefore many types of care and treatment are used. For example, conversing and listening are part of the medicine and nursing as well as the technical medical acts. Also the patient is brought into the treatment plan as much as possible. This allows the patient to have a say in his own destiny and not suffer from a sense of loss of control. This involvement also prevents fear of medical abandonment which can be a problem on the hospice unit. Exercise and nutrition plans are also skills that can be taught to the patient-family unit which broadens the care oriented treatment plan.

The primary symptom that must be treated is pain. Lamers[15] has said that the cornerstone of successful care of the chronically ill patient is good pain control. Pain and the anticipation and fear of pain play an overwhelming part in many of the interactions that take place. One of the primary reasons patients come to the hospital for a stay in the hospice unit is when the pain level gets out of control. Interactions around pain are unique from person to person and moment to moment and evolve from a myriad of sources.

The experience of pain is a very complicated personal and social experience and a special set of interactions revolve around it. Pain does not come only from physical dysfunction or injury in a simple unilinear cause and effect chain. Saunders[16] uses the term "total pain" to denote all of the elements that can go into pain including physical, mental, social, spiritual, and financial. Other factors to be considered are anxiety, expectations, individual history of pain, fear and family problems. Good pain control comes from frequent analysis of all these sources and their various contributions. Careful assessment requires a close reading of physical signs, verbal statements, body language, gestures, voice tone and interaction patterns in general.

The goal of all treatment is to keep the patient out of pain and out of a drugged stupor. The patient should remain as integrated, lucid and alert as is normal for that person. To accomplish this the process of symptom control must be based on a multi-faceted comprehensive approach including drug use, massage, exercise, positioning, heat and counseling.

A final and very important element of pain is anticipation. The fear of pain intensifies all forms of pain. A state of anticipation causes fear and then tends to have a negative effect on all other interactions. It is often the goal of the treatment to alleviate the anticipation and fear of pain rather than an actual physical pain with a direct physiological cause.

Anticipation is one stage of a cycle patients know all too well and come to dread. Patients are frequently used to a cycle that goes from anticipation and fear to pain and suffering to relief associated with side effects and then back to anticipation (Figure 1).

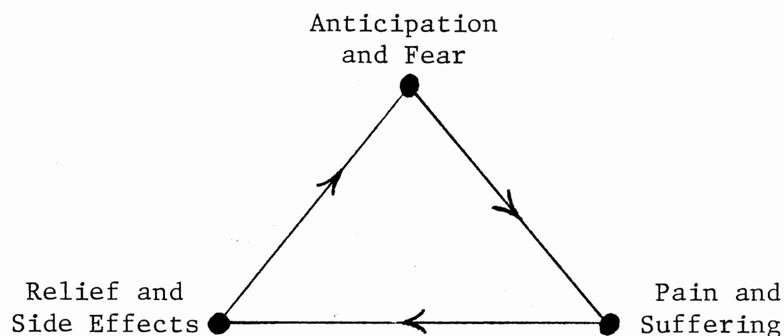

Figure 1. Pain Cycle

Traditionally, following the PRN[17] schedule medication is inserted into this cycle only after the pain and suffering has gotten to an unbearable level. This means each patient knows he will be experiencing pain and the horrible cycle of anticipation, suffering and relief continues (Figure 2).

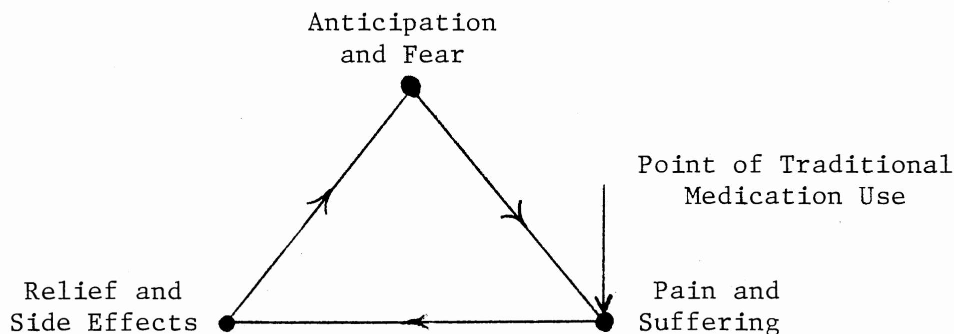

Figure 2. Pain Cycle--Traditional Medication

In a hospice a patient is watched closely to find the beginnings of the anticipation stage of the cycle and the medication is

administered at that time in doses plenty strong enough to control the pain. This prevents the pain stage from ever arising. Once the patient has confidence that the pain will not return the anticipation part of the cycle will fade away and he can return to a normal life (Figure 3).

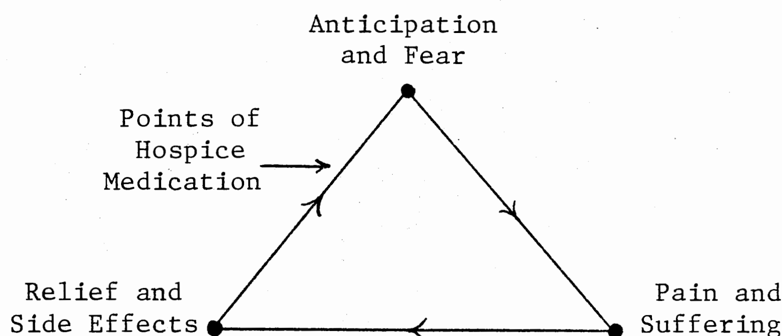

Figure 3. Pain Cycle--Hospice Medication

Once the anticipation is gone all types of pain levels seem to decrease. Then the dosage of medication can be titrated down to prevent being over medicated with the haze and various other side effects that go with heavy drug use. It was often amazing, according to the nurses, how low the medication level could be at this point which speaks significantly of the tremendous contribution anticipation makes to interaction evolving around pain. Edgely has discussed the ideas presented in Figures 4 and 5 demonstrating how the level of pain can be greatly reduced by altering the timing of the medication.[18]

Emily Dickenson[19] has a poem that gives a sense of the intense personal nature of pain and the contribution anticipation and fear make.

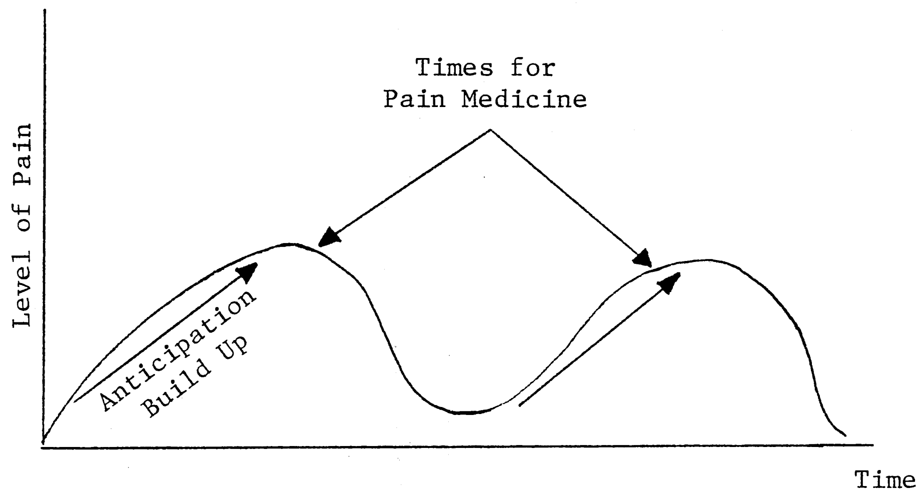

Figure 4. Traditional Medication Timing

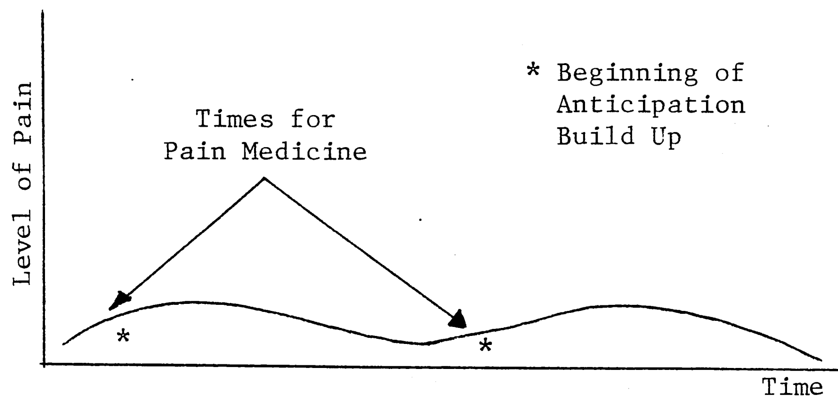

Figure 5. Hospice Medication Timing

Pain--has an Element of Blank--
It cannot recollect
When it began--or if there were
A time--when it was not--

It has no future--but itself--
Its Infinite contains
Its past--enlightened to perceive
New Periods of Pain.

Accomplishing a sense of confidence of being permanently free of pain allows for a feeling of safety, security, independence and trust building. When pain control is accomplished and the cycle of anticipation is broken the patient and family are free to move on to other issues around chronic illness and impending death.

A Sense of Immediacy. Invading all interactions on the hospice unit was a sense of immediacy. The processes of life seem to be boiled down, distilled and condensed leading to a sense of concentration and intensity visible in many different ways. Along these lines author Muggeridge[20] writes,

> The prospect of death wonderfully concentrates the mind . . . I find it (death) . . . a distillation as it were of everything most loving and beautiful that has gone before.

This trend was visible among patients, one of whom once commented that, "The patients on this ward have a marvelous ability to cut through the bull." At another time a patient said, "When you're out of the hospital then dying doesn't take up as much of your time." This comment came in a conversation about how being on the hospice unit forced you to remember your death and when you were there you had to put aside trivialities and give thought to what you were going to do with the rest of your life.

A sense of immediacy was also visible in the patient-family relationships. Conversations were often present oriented even with a tendency to avoid future oriented or long term plans. It was also possible to see family members putting aside their needs for the moment in order to fulfill some immediate need or interest of the patient in the hospice unit. Families also had a sense of urgency about the various practical matters that had to be taken care of including insurance, wills, taxes and funeral plans.

The nurses who were working on the unit also seemed sensitive to the importance of quick response and the importance of immediate need. A nurse pointed out how each request may have a sense of urgency to it and you must not respond with, "I'll do it in a minute" or "I'll take care of it in the morning."

On another occasion a nurse explained how patients on the unit have a special definition of time. The very present moment is very important but the concept of time of day lost meaning. At four or five o'clock when the shift changed and some of the staff went home the patient did not stop dying. He still had his very important present needs. Schedules could not be based on the clock but rather on the patient's immediate need.

If one was sensitive to it this notion of immediacy was present in all kinds of interaction between all kinds of actors. On many occasions it gave a sense of condensing life and packing more meaning into a short period of time.

Analytical Concepts

Along with the various sensitizing concepts that evolve in the

generation of grounded theory there are also certain analytical concepts that can be developed which prove useful in understanding how certain meanings are found by the participants. Toward this end we can return to the work of Lopata[21] and the four assumptions about social reality which she proposes for how the self forms its social reality. Briefly stated they are:

1. That identities are formulated in a complicated process of social interaction which involves symbolic definitions of the self, the other and the situation.

2. That repeated interaction with the same others in similar situation, . . . results in rather definite and stablized self and other identities.

3. These identities are modified as the self, the other, or the definition of the situation changes.

4. That removal of the significant others from interaction with the self will necessitate a reformulation of the identities in which he or she was involved.

Using these four principles we can now turn back to the findings and begin to develop some analytical concepts. The primary subject matter for these concepts comes from the participants continual search for meaning in the midst of their rapidly changing lives. An analysis of this search produces analytical concepts in the three areas discussed throughout the rest of this chapter.

<u>Familiarity and Meaning</u>. When patients, families, staff and volunteers come to the hospice they frequently have no experience with the dying process. The first step toward finding meaning is familiarity with all the new types of interaction patterns encountered. Many elements are purposefully combined to create meaningful encounters and to gain experience in this unknown area. The family is encouraged to participate in medication routines, medical conversations, bathing,

and meals. Also open communication patterns are the standard for talks. There is little tendency to withdraw or lose eye contact when the conversation turns to something intimate or fearful. After the death the family is allowed, to the extent of their desire, to see the body rather than rushing it away and hiding it.

The staff also participates in the journey toward familiarity. The staff is trained to avoid euphamisms when discussing death and the dying process in order to help themselves and the families and patients develop direct experience with the impending issues.

Looking at these processes with a sociological eye one can see how the self of the dying patient and family members is changing according to the guidelines set down by Lopata. There are new and specific norms and symbolic definitions being laid down for the self, others and the definition of the situation. These definitions get reinforced regularly and the self learns to adopt them. Most people learn the new physical and symbolic definitions and begin to follow the new interaction patterns. However a few do not and cannot fit in with the new definitions. A nurse once reported that young nurses who are still in a very idealistic medical model often do not do very well with the open communication patterns and burnout quickly.

Role modeling is an important type of interaction that fits in with the re-definition of the self. It is used by all participants for gaining relevant experiences, learning the appropriate language, developing values and reducing anxiety. On an eight bed unit where there is open awareness that all patients are in some stage of a terminal illness, it is quite possible to see patients learning from one another different ways of handling death. Patients become a support network for one

another and do a lot of their own counseling informally among themselves. Peer group work leads toward both dying and grief practice for the patient and the family.

At this stage in the observation and theory building one can again step back and look at this role modeling behavior with the perspective of a symbolic interactionist. The notion of awareness contexts as introduced by Glaser and Strauss[22] can be used as a theoretical framework. All hospice patients are in a state of open awareness about their terminal state. However, there are varying degrees of openness or knowledge about the nature of cancer or how one is expected to act in a hospice unit. It is at this point that role modeling becomes the observable behavior for moving the self into greater degrees of open awareness. These rehearsals bring everyone a step further toward the familiarity desired by the staff of the hospice unit. To the sociologist this is seen as a process of recreating the self and the definitions of the situation with the help of role modeling and the creation of new degrees of open awareness.

Examples of this process are many. A nine-year-old girl once explained that she was not too nervous or scared about the death of her grandmother because she had another relative die in this unit before. Role modeling has provided her with the definitions and familiarity she needed to cope with the situation. On a different evening a gentleman was telling about the type of visits he usually had with his doctor. He was complaining that the doctor never stayed more than five minutes and used mostly big words that he did not understand. This seems to be an example of a breakdown of the system and its' goals of moving toward familiarity. There was no extra open awareness gained

and no role modeling that would lead toward a new definition of the dying self.

Returning to the observational side of theory building, another element that can be observed, which is a by product of familiarity, is trust building. A lot of time is spent earning the trust of the patient and developing close relationships with the nurses and staff. Patients and family quickly come to trust the medical professionals to tell them the truth about their condition and their hopes. They also trust the doctors to take care of them medically and prevent any pain or suffering. Volunteers are also included in this trust circle because they can often be confided in when the patient does not want to impose upon one of the health professionals on the unit. A volunteer may be called upon to make a special phone call or run an errand because they have extra time not available to a paid staff member.

When this trust level is established many positive friendships and bonds can be created. Nurse patient relationships are often strong, helpful, hopeful and supportive. This prevents the loneliness, sense of isolation, loss of control, depression and general negative attitude of dying patients towards nurses frequently reported in other dying research.

It is now possible to propose an analytical concept that is useful for understanding the behavior observable in a hopsice unit. When an individual becomes a patient in a hospice there will be a lot of new experiences that provide consistent reinforcement for the creation of a new self and definition of the situation. Role modeling will also play a part in the creation of a new sense of familiarity with these new behaviors and values. The by-product of this process is trust

between the relevant parties. However, the degree of trust developed will depend on the amount of role modeling exposed to and the strength and consistency of the new definitions experienced. Some individuals will develop high levels of trust and others will not be able to depending on the degree of exposure the self experiences to this new complex social milieu. This process and concept will fit into a broader whole as it is related to other analytical concepts developed throughout the rest of this chapter.

Dying As You Live. In observing hospice interaction there is a tendency to look for the notable and honorable ways that people try to find meaning in the face of death. If one is to be honest though, it must be reported that most of the interactions that take place seem rather common and day to day in nature. The researcher looking for the magnamonious noble death where every word uttered is full of wisdom and each relationship built is intimate and beautiful is likely to be disappointed.

The philosophy of hospice is neither to hasten death nor to postpone death. Instead the philosophy is to create a social and medical atmosphere whereby the patient can remain in control and continue to live as normal a life as possible. To a large extent, life goes on as it normally would for the patient and family. In fact one of the goals of the unit is to keep the patient at home living a normal life. Patients only come into the hospital when pain or emotions get out of control.

When allowed to continue a normal life patients end up doing their dying much as they did their living. In the Bay Area Hospice Report, McIntosh expressed this when she stated,[23] ". . . to a large extent,

people die as they live." To go one step further, Wall in Dealing With Death says, "One does not die a Socratic death if one hasn't lived a Socratic life . . . One needs to learn how patients have dealt with past crisis." Nouwen[24] referred to this type of death as "death with dignity" meaning not that a person suddenly becomes filled with dignity and is frequently uttering pearls of wisdom for everybody to gather up. Rather a person is simply allowed to carry his life style under the power of his own free will into dying instead of being intimidated by machines, beauracrats and medical experts.

When patients are allowed to die in their own style it is not uncommon to see activity based on the persons' day to day interest. Conversations about football, politics and the weather are present like in any other setting. One gentleman enjoyed talking about his responsibilities in a recreational vehicle club and their previous and future excursions. Also conversations that may seem atypical and perhaps filled with meaning or symbolism may stem from a simple direct cause. For example, it was not uncommon for patients to loose track of time when they had been on the unit for several days. This was not caused by their terminal disease but simply an effect that happens to anybody who is institutionalized for long periods of time.

From time to time bits of wisdom that could be cherished for a life time would arise and beautiful relationships would develop but the reader should note that a great deal of the meaning that is experienced on a hospice unit stems from the same and regular life style that a person has developed over a life time. The ideal and romantic death is not observable around every corner.

In observing this element in the development of self in the dying situation the sociologist recognizes that a persons' past and previously established self, values and definitions play a major role in the development of the self. This factor works in concert with the concept of self development postulated in the previous section and provides a balance between the forces of social development and those of the self and its ability to affect its' own development.

A second analytical concept then can be developed out of the basic tenants of symbolic interactionism as discussed in the review of literature chapter. Specifically, the observer must recognize a person's past values and symbolic definitions and his or her ability to incorporate these into the development of self. These forces will have to be weighed against the social pressures that come from role modeling and the new definitions presented by significant others and the social setting.

Growth in Dying. After several months of observing and participating in all types of interaction on the hospice unit it became obvious that one of the by-products of hospice care was change, development and growth in relationships and levels of meaning. Defining the nature and direction of this growth however is a very difficult task.

The foundation for the definition of growth in the hospice setting is available to the observing sociologist from the social processes already defined in this chapter. First the patient, family and staff are all encouraged to develop a heightened sense of familiarity with the dying process. Through an atmosphere of openness and trust everyone is encouraged to begin to accept new definitions and new

meanings. Through role modeling they learn about the nature of their disease and see new ways of handling the dying process.

Another element that defines the direction of growth taken for any individual patient is the fact that to a large extent people die as they live. If a person has a history of being cooperative and open to new areas of familiarity they may readily participate in the learning about their disease and the ways that others handle it. However if a person has a history of being stoic and stubborn then they may show no interest in learning new areas and they will not experience the same growth and change. The staff is trained to be non-judgmental in regards to these varying styles of dying and accept the various ways that people try to make sense out of their impending death. However even in a non-judgmental atmosphere there is always a slight social pressure towards accomplishing new areas of familiarity. The ideal form of growth is described nicely by Stoddard[25] "At its' (dying) finest, it elicits from us the frankly and fully offered human companionships that bring benefits, and a kind of joy, to any shared adventure."

With these two factors to use as a definition of growth we can now look for some specific areas of growth experienced in the hospice unit. One such area is the patient's ability to move into varying levels of open awareness about the nature of the disease. While the staff is always encouraging more familiarity and openness, the patient may or may not be willing to ask questions or receive information about the diagnosis or prognosis. For example, the gentleman with the severe skin cancer always wanted to understand every step of his treatment and be informed on what to expect next from the disease. This patient

would be said to have experienced growth according to the subtle social criteria seen in the hospice. However, the gentleman who wished to remain very active in his recreational vehicle club and came into the unit only to have severe pain alleviated and did not want to know any details did not experience any new levels of familiarity or growth. This is an example of an individual's personal style overriding the new social experiences and definitions in the hospice unit.

Growth or the lack of it can also be observed in relationships particularly through the use of selective role modeling. One patient in particular took on the role of teacher of social behavior for other patients. He would take his glucose drip bottle on its' rolling stand and walk around the unit visiting other patients rooms. He would then participate in all kinds of discussions including the nature of illness and how sad this could be but how everyone would make it through all right if they would just "hang in there". Other patients would take him as a role model and try to adopt his positive attitude and cheeriness in the face of death. The acceptance of this definition of the situation and these new forms of behavior would be looked upon as growth. These patients had moved into new levels of open awareness about the socially prescribed ways to behave.

However, other patients did not experience the type of growth subtly encouraged by the program. Through the use of selective role modeling one patient picked out all the others he could see who never cried or showed any emotion about their disease. He admired this behavior and refused to participate in emotional displays and encouraged his family not to do so either. The staff often encouraged a little

bit of crying and said it was healthy but this individual had too long a history of stoicism to participate in this type of growth.

The staff can also experience growth as defined here by further adopting the values and goals of the program. This is frequently done by the staff using the patients as teachers of good and noble forms of social behavior. After some time spent on the unit nurses reported changing their medical attitudes from curative in nature to caring in nature. This is an example of a further acceptance of the new definitions and values espoused by the official program.

Personal relationships are another area where growth within the given social definitions can be expected. A side affect of the open awareness and communication patterns that are encouraged is a possibility for new levels of openness in personal relations. Fitting right into this pattern is the example of a young girl in braces who reported how she had never talked very much to her mother or been very close but during the last few weeks in the hospice unit they had managed to do a lot of communicating and had grown much closer. This is an example of growth as defined by open awareness. Or again the dying woman who had her wedding vows reinacted with her husband did so as a sign of their renewed love and improved communication.

On the other hand there is the case of the male patient who refused to accept the social pressures towards open communication and discouraged his family from coming to see him in the unit and talk about his prognosis. This gentleman did not experience the type of growth encouraged by the hospice program.

As a final analytical concept we can conclude that growth in the face of death is quite possible but within the constraints of certain

social definitions. The amount of growth a patient experiences in a hospice unit depends on the degree to which he or she is willing to accept the goals of increased familiarity with the dying process and open awareness about the social behaviors expected of the self. This growth will be tempered or fostered depending on the individual's previous history and experiences in similar situation.

ENDNOTES

[1]Walter, Norman, Hospice Pilot Project Report (Hayward, CA, 1979), p. 63.

[2]Koff, Theodore H., Hospice: A Caring Community (Cambridge, MA, 1980), p. 14.

[3]Rosin, J. Assael WL., "The Influence of Emotional Reactions on the Course of Fatal Illness," Geriatrics, Vol. 31 (1976), p. 87.

[4]Glaser, Barney G. and Anselm Strauss, The Discovery of Grounded Theory (Chicago, 1965).

[5]Elisabeth Kubler-Ross in Dempsey, David, The Way We Die (New York, 1975), p. 143.

[6]Ted Rosenthal quoted in Stoddard, Sandol, The Hospice Movement (New York, 1980), p. 23.

[7]Ibid., p. 90.

[8]Sister Teresa McIntier quoted in Koff, p. 72.

[9]Dr. Richard Lamerton quoted in Walter, p. 10.

[10]Fox, J. E., "Reflections on Cancer Nursing," American Journal of Nursing (June, 1966), p. 1317.

[11]Koff, p. 21.

[12]Walter, p. 11.

[13]Brett, Richard, Hospice Report (San Francisco: Bay Area Hospice Association, May, 1980), p. 6.

[14]Stoddard, p. 11.

[15]Dr. William Lamers in Koff, p. 42.

[16]Cicely Saunders in Walter, p. 60.

[17]PRN Schedules are those which allow treatment or medication to be given as needed.

[18]Credit is given to Dr. Charles Edgley of Oklahoma State University for this concept.

[19]Emily Dickenson's poem from Johnson, T. H., ed. Final Harvest: ED's Poems (Boston, 1961), p. 34.

[20]Muggeridge, Malcolm, A Twentieth Century Testimony (New York, 1978), p. 73.

[21]Lopata, Helena Znaniecki, "Self-Identity in Marriage and Widow-hoos," The Sociological Quarterly, Vol. 14 (1973), pp. 407-418.

[22]The Concept of Open Awareness was discussed in Chapter II and is a term borrowed from Glaser, Barney and Anselm L. Strauss, Awareness of Dying (Chicago, 1965).

[23]McIntosh, Kate, Hospice Report (San Francisco: Bay Area Hospice Association, March, 1981), p. 7.

[24]Nouwen, Henri, Reaching Out (New York, 1975), p. 147.

[25]Stoddard, p. 7.

CHAPTER V

CONCLUSIONS

Summary of Findings

This piece of research has used symbolic interactionism as a theoretical framework for understanding dying behavior in a hospice setting. As discussed in detail in the review of literature chapter this has many advantages because the major tenents of symbolic interactionism are so appropriate for the type of behavior seen in a hospice. Some of the basic points include the following:

1. The self develops in interaction.
2. The importance of others in developing meaning and self.
3. Emphasis on dynamic, fluid and flexible relationships.
4. Emphasis on both the symbolic and interactional nature of human behavior.
5. The research principles outlined by Denzin were also very effective.

In discussing specific areas where this theoretical framework can be applied Huber[1] said, "Mead provides a way to formulate important aspects of social psychological problems but suggests few actual problems for investigation." The field of death and dying would seem to be one good area for the application of Mead's principles.

In fact these principles are so appropriate for hospice behavior that a careful reading of many of the quotes taken from the staff sound like statements by trained symbolic interactionists.

Through the use of these tenents and the work of Glaser and Strauss' principles of grounded theory,this research was able to generate a small amount of theory to be used in the description of dying behavior. First of all,four sensitizing concepts were identified. These were:

1. The language of the dying.
2. The individuality of each interaction.
3. The medical issues.
4. The sense of immediacy.

After reviewing the four concepts the researcher is better prepared to be sensitive to the relevant issues and concerns of the setting. Taken in conjunction with other findings they help produce a well-rounded description of the observable behavior.

Secondly, analytical concepts were generated in three areas as they relate to the continual search for meaning. These are:

1. In regard to familiarity, open awareness and trust:

    a. An individual who becomes a patient in a hospice will be exposed to a new and regularly reinforced set of norms, for the self, others and the definition of the situation.

    b. Role modeling becomes an important avenue for passing along cues as to what new definitions of self, the situation and meanings are the standard in the hospice unit.

    c. The self will change as it moves into new levels of open awareness as learned through new experiences, role modeling and social cueing processes.

    d. The amount of trust developed in relationships will be related to the ability of the self to accept all the new definitions and role modeling and levels of open awareness that are encouraged in the new social milieu.

2. In regard to a selfs' individuality and history:

    a. A person's previously established self, values and definitions affect the extent to which the self can adopt the new values and norms being presented. This factor provides a balance against the social forces experienced.

3. Regarding growth in dying:

   a. Growth is seen as a positive and worthwhile goal in a hospice. The amount of growth accomplished in the process of dying will depend on the extent to which a patient can move into new levels of open awareness regarding his disease, the correct forms of social behavior and in personal relationships.

   b. The ability to move into new levels of open awareness will be tempered by an individual history of accepting open awareness in similar situations.

This group of analytical concepts will provide the researcher with a more critical sociological eye for describing some of the major social forces at work in the development of the self. Again it must be emphasized that all of the concepts summarized here must be taken as a whole and interpreted through the guidelines of symbolic interactionism. No single concept can be properly understood without relating it to all the other issues.

In summarizing about these descriptive concepts we can say that the human being is still a social animal even in the midst of dying, that human interaction and the social setting still play a vital role in the development of meaning and self. Stoddard[2] nicely summarizes the importance of human interaction in a hospice, "Dying is hard work, . . . in most cases, like birthing, it is a process requiring assistance."

After generating a small piece of grounded theory we can return to the criteria laid down by Glaser and Strauss for what makes grounded theory. First of all, grounded theory is intended to close the gap between theory and method. Hopefully this was accomplished in the field observations by the gradual development of the relevant groups of study. By constantly maintaining an interplay between what was being observed and the theoretical principles that were guiding the research the gap between theory and field methods could be kept to a minimum.

Secondly, grounded theory is intended to generate new areas of theoretical application. This was accomplished by the generation of certain sensitizing concepts for describing hospice behavior and by tieing certain previously existing theory into new areas through new analytical concepts. The ideas of Lopata[3] on the development of self and Glaser and Strauss[4] on open awareness were related to some of the important areas of human behavior in a hospice. This also served to meet the third goal of keeping the new theory closely tied to the substantive area of study.

The final goal of grounded theory is that is will work well for the layman who wishes to have a more critical understanding of human behavior. Toward that end it is the belief of this researcher that a review of the findings of this study would act as both a sensitizing and analytical tool for the layman reader wishing to understand dying behavior.

Limitations

The first limitation of this research is both a limit and a strength. That is the fact that the number and type of observations reported on is only a small fraction of the number of events occurring in the field. For example, these findings tend to have a focus on the patient with very little emphasis given to the family, nurses or staff. In reality all of the participants including doctors, social workers, volunteers, chaplains and the program coordinator were each active in the development of a special language, the medical issues and the broad search for meaning. Also the hospice program has many other elements to it that this report does not even begin to cover like a

home support program and a grief follow up program. Regrettably due to a limited amount of time in the field and a limited amount of reporting space only certain interactions were given adequate description. However this can also be seen as an advantage because it allowed for enough focusing to allow the selection of only certain relevant groups and behaviors for more analytical analysis.

A second limitation has to do with the population under study. Patients in the Kaiser hospice unit were predominantly white middle class with a Judeo-Christian background. Any reader of these findings should not apply them to minority populations or any cross cultural situations. A much broader study done with a wider socio-economic population would be needed to see if symbolic interactionism is a good theoretical framework for all hospice situations and if there are any types of interaction that are cross cultural. Also, the Kaiser hospice was a free standing hospice unit as opposed to the more common home visitation type of program. The reader should take note that the interaction patterns can be expected to be considerably different between the two types.

Finally there is always the criticism that more work can be done in the development of analytical concepts and their relationships to dying behavior. However, it should be noted that this is a never ending process and that this entire piece of research can be seen as one giant sensitizing tool that a researcher could use to prepare to go into the field to make observations. Perhaps someday this can be done and more theory will be generated in this particular area.

ENDNOTES

[1]Huber, J., "Symbolic Interaction as a Pragmatic Perspective: The Bias of Emergent Theory," American Sociological Review, Vol. 38 (1973), p. 278.

[2]Stoddard, Sandol, The Hospice Movement (New York, 1980), p. 7.

[3]Lopata, Helena Znaniecki, "Self-Identity in Marriage and Widowhood," The Sociological Quarterly, Vol. 14 (1973), pp. 407-418.

[4]Glaser, Barney G. and Anselm Strauss, The Discovery of Grounded Theory (Chicago, 1965).

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