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Encountering Death: A Training Proposal for Psychologists Addressing Death Anxiety and End-of-Life Care

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For Caitlin

Abstract

Inward reflection and knowing the self are an essential element to becoming a psychologist and is crucial when encountering themes of death and dying in psychotherapy. There are significant gaps in curriculum and training regarding death anxiety and end-of-life care for psychology trainees and psychologists despite psychologists' growing presence in this type of work. The following paper will explore historical and current day theories of death anxiety and death education. It will also demonstrate the gaps in training for psychologists in the areas of death anxiety and end-of-life care and describe the need for this type of training to be central to graduate and post-graduate studies. Based upon the relevant literature, this paper will propose a training outline focused on facilitating a reflective process for psychologists to understand their own anxieties around death and dying in order to be better equipped to *be* with clients as they examine their own fears, biases, and anxieties.

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"When we finally know we are dying, and all other sentient beings are dying with us, we start to have a burning, almost heartbreaking sense of fragility and preciousness of each moment and each being, and from this can grow a deep, clear, limitless compassion for all beings."

-Sogyal Rinpocke, *The Tibetan Book of Living and Dying*

The field of psychology is a profession of healing, offering sacred spaces to explore and better understand our inner selves in order to relieve suffering and increase meaning. Human suffering cannot be addressed without acknowledging the greatest fear most humans possess: death. As Yalom (2008) emphasizes, most people who come into psychotherapy have some anxieties related to death they wish to explore. Careful attunement on the part of the psychologist is necessary for recognizing the unique symbols and themes of death the client offers, especially given the ingrained defense mechanisms humans employ to avoid encountering their own mortality. In order to improve this attunement and engage in these types of encounters, psychologists must first recognize their own symbols, fears, and defenses associated with death anxiety. This includes a careful examination of how their own cultural background interacts with these themes, given the immense influence culture has on coping with death anxiety. Without this self-exploration, the psychologist's own countertransference may lead to improper conceptualization, treatment, and diagnosis of a client (Straker, 2020).

Self-reflection is a key element for a psychologist and is often interwoven into graduate training, especially in the context of culture and diversity (Collins et al., 2010). There are gaps in this reflective process when it comes to psychologists and trainees examining their own mortality and the variety of existential themes accompanying human existence. For this type of curriculum

to make its way into American Psychological Association (APA) and continuing education standards, the field of psychology needs to acknowledge how equally crucial it is to advocate for the mental health of humans as they live and as they die.

In the context of an aging population and the increased presence of more destructive, widespread illnesses such as COVID-19 and cancer, psychologists need better training to address themes of death and dying with clients as they encounter their own despair and anxiety related to mortality. Education and training in end-of-life care has mainly resided in the curriculum for medical providers, especially those specializing in palliative and hospice care (Committee on Approaching Death, 2015). There is a significant gap in training and research for psychologists and graduate students in clinical psychology programs, despite the overwhelming presence of psychologists in areas where this type of training is necessary.

The diverse groups of people served by psychologists also demand competent training addressing cultural, racial, ethnic, sexual, gender, and disability differences and disparities related to death anxiety and end-of-life care. As will be demonstrated in the literature review, the majority of death anxiety research has been conducted by white males in a western context and many of the foundational philosophical texts regarding death anxiety are also written by individuals of similar demographics. Psychologists have a responsibility to critically examine these dominant narratives and actively seek alternative ones in order to more competently serve groups cross-culturally.

Psychologists have the opportunity to be at the helm of social justice movements and policy initiatives to address inequality and marginalization. Death and dying are key areas where these types of disparities exist and thus should be addressed and reflected upon in the field. This has become especially prevalent during the COVID-19 pandemic as the world witnesses the

wealthy, privileged few get care, vaccines, and personal protective equipment (PPE), while the majority suffers and dies (Juarez et al., 2020).

It is more important than ever that psychologists create a reflective process early in their training to understand their own biases, assumptions, and anxieties related to death and dying. This will allow space to better conceptualize these biases and anxieties with clients and increase efforts for advocating for change in systems where psychologists work. Without understanding our own relationship with death, we cannot assume to be able to competently and empathically make space for a client who is encountering their own. This reflective process will be the key element to the proposed training offered by this paper.

Personal Biases and Assumptions Statement

It was the day after Thanksgiving, 2017. There was an unseasonal rain shower sprinkling Black Friday shoppers. As I drove along the highway, a delicate, light rainbow emerged from the clouds. How mystical, I thought, a winter rainbow. I pulled into my parking lot and sat in the car, finished up a podcast, and then walked into the garage to find my partner working on her car. A few moments later, I looked down at my phone and saw my dad calling. I picked up, but I think I already knew. The words came out that changed everything, “Your sister died.” My legs weakened and I collapsed onto the cold concrete ground.

I often replay that moment in time and find it to be just as vivid as it was three years ago. About two months later, I found myself needing support around the ton of grief now strapped to my back. Being a clinical psychology doctoral student, I reached out to student counseling services hoping to find affordable yet competent support. I filled out the intake form and got a call from the psychology intern through the college counseling center. The conversation quickly disintegrated as this (almost) psychologist tried to diagnose my grief and put me in a prescribed

treatment box of group therapy. I remember telling him I was not ready for group therapy and he responded, “Well, it’s the most effective form of grief treatment.” Grief treatment, what an oxymoron. Why would I want to treat my grief? Was my grief not the normal reaction for the traumatic and devastating loss of my only sister? I hung up with the intern and felt defeated and alone. I also felt disappointed by such a cold, disconnected reaction from my own supposedly empathy grounded field.

Since that phone call, I have had subsequent examples of mis-attuned reactions regarding death and grieving from psychology colleagues, therapists, friends, and family members. One day after a seminar, about three months after my sister’s death, a supervisor cornered me in the hallway to tell me she felt as if I was disconnected and not my usual peppy self in seminar. She wondered what was wrong with me, even though she knew my sister had recently died. I thought to myself, of course I am not my usual self; I have been irrevocably changed.

Existentialists consider this type of event in a human’s life to be a dissonant experience challenging an individual’s sense of self and carefully constructed worldview. As I looked at this supervisor, a psychodynamic psychologist who has been in practice for decades, I was struck at how she was unable to recognize I was in the midst of trying to reconstruct my world. Peppiness was not part of the reconstruction process.

As I made my way through the first year of grief and the death started to settle into my bones, I began to see the connected roots of these interactions. I started to mentally collect the reactions of people when I talked about death and my sister. There were rare cases when someone was able to encounter death with me and be still in the discomfort of recognizing our fleeting existence. The more usual reactions were those of deflection, avoidance, or qualifying. Over time, I saw these reactions for what they were: death anxiety. Hearing about a 33-year-old

woman dying, especially in the way my sister did, presents an uncomfortable mirror reflecting the death anxiety most individuals work tirelessly to keep at bay.

My desire to more intimately understand my own distress around death and dying was born out of this tragedy. My desire to do this type of work as a psychologist was also spurred by the death of my sister and the subsequent reactions to her death. I now hope to become the psychologist I needed three years ago. Even more, I want to understand why death anxiety is so high among professionals in a field grounded in individuals who wish to hold space for the most difficult parts of human existence. Even in oncology and palliative care settings, I have witnessed the tendency toward pathologizing mortality distress and grief. Examples include supervisors requesting I place a diagnosis on a man whose wife of 47 years died after a two-year battle with cancer or labeling a 21-year-old man with leukemia as resistant and shut down because he is not yet ready to contend with the news that he will die in the coming weeks.

I internally shudder as I witness how quickly psychologists fall into the trap of minimizing and diagnosing as a way to cope with their existence. All of these examples sadly reflect this field's obsession with a medical model of diagnosis and treatment. From my experience, this type of model can be hurtful, minimizing, and isolating. It forgets the human in the psychotherapy.

This paper and training proposal are steeped in my own experiences with death, dying, and grief, and ways in which I have seen death anxiety play out in myself and in the field of psychology. My cultural background and unique identities also affect how I approach themes of death and dying and will inevitably influence the structure of this proposed training. These include my privileged identities as a white, educated, middle-class woman, which have afforded me greater access to end-of-life planning and psychological support for grief and loss. These

privileged statuses also contribute to my ability to advocate and communicate my desires for end-of-life care, which is crucial for me to remember as I navigate these discussions with clients from communities who do not hold these same privileges. My cultural background as an American and westerner are key aspects in how I construct ideas around death, dying, and grief. I have had to confront roadblocks and taboos in my own culture in order to better understand and integrate death into my own psyche. Finally, my identity as a bisexual woman intertwines into my own anxieties around end-of-life care. Being a partner in a gay couple in this world and still in many parts of this country, can result in challenges of basic rights, internalized, and externalized biases. I see this part of my identity to be beneficial when advocating for lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities given my ability to intimately relate to some of the experiences this community faces regarding end-of-life care and death anxieties.

The death of my sister and the grief that has followed has irrevocably altered my perception of the field of psychology and clarified my calling in this profession. This has resulted in major theoretical shifts for me in the field of psychology, which will also color this proposed training. I have moved away from medical and cognitive behavioral models of psychology and moved toward phenomenological, existential, and depth psychology models. I believe these theoretical models are more humanistic, less pathologizing, and offer more flexibility in exploring human existence. Thus, these theories will be dominant throughout this paper and in the proposed training.

Literature Review

The following literature review will provide context and background information regarding the historical, philosophical, and psychological aspects of death anxiety, death education, and end-of-life care. It will begin with a brief overview of historical and spiritual practices related to death in order to demonstrate how themes of death anxiety, and ways to contend with it, have existed since ancient human civilizations. Next, a description of key philosophical and psychological theories related to death and dying will be presented. The literature review will then address cultural differences and disparities associated with death anxiety and end-of-life care to emphasize the importance of psychologists understanding their own roots and the unique cultural backgrounds of their clients. The review will also offer brief commentary on death anxiety during the COVID-19 pandemic and special considerations for psychologists regarding this current crisis. The review of literature will then offer a definition of death anxiety, outline contexts in which psychologists are currently caring for those who are dying, provider experience working with themes of death anxiety, current trainings, and gaps in training. Finally, given the information provided by the literature review, a clear argument for why this type of training is important will be outlined.

Historical and Spiritual Aspects of Death

The Greek philosophers Epicurious and Plato are two notable ancient thinkers who addressed the mysteries of death and dying. Plato wrote about the importance of a dialogue between the self and death in order to facilitate a greater understanding of existence. He believed dying to be a common fear among all people but emphasized the importance of focusing on the actual process of dying. Through the dying process, there may be transformation and

transferable wisdom. He also acknowledged the mystical elements of dying and the potential for death to be a portal into an afterlife (Gavin, 1974).

In contrast to Plato, Epicurus was not as concerned with the mystical properties surrounding life and death. He believed humans' ability to sense creates concepts of fear, good, and evil. When a human dies, according to Epicurus, these senses are lost, and thus, there is no reason to fear death given death will lead to a state of nothingness. Epicurus would argue, if humans are able to accept the inevitable nothingness accompanied by death, they will be freer to live a fuller life and reduce their own misery (Epicurus, translated by Robert Drew Hicks, 2016*).* Both of these perspectives continue to be key philosophical elements in death and dying literature today and are echoed in modern day philosophical and psychological texts.

Cultural traditions have long been dictated by death, dying, and what happens to the spirit or soul once it has left the earthly plane. The ancient Egyptians were one of the most notable civilizations whose culture was consumed with death rituals and planning for the afterlife. They viewed death as an initiation into the next phase of living. The modern Arabic word for death, *al mawt,* is equivalent to the ancient Egyptian word for mother, linking the death process to rebirth (Mark, 2017).

The creation of organized religion over the centuries is also connected to fears of dying and desires for immortality through the creation of an afterlife. It is beyond the scope of this paper to outline the belief structures of all religions, but a few key ones will be noted for the purposes of highlighting how religious institutions have created structures that facilitate meaning around death and dying for their followers. The following are broad generalizations about these faith traditions. It is important to consider that within each tradition there are significant individual and community differences.

Christians believe a life well lived in Christ leads to the promise of eternal life in heaven, while a life of unrepented sin can lead to eternal damnation in hell (Life After Death, 2021). Through confession and reconciliation, Christians are able to ascend to heaven where they will reconnect with their loved ones. As is similar in Christianity, Judaism emphasizes the preciousness of life. This value of life admonishes any attempt to end life early whether through homicide, suicide, or any other means that would quicken the dying process. Jewish people also believe in an afterlife where those who have lived a faithful and good life will be rewarded, where those who have led a life of sin and evil will be punished. Judaism and Christianity both have traditions around the dying process including being surrounded by loved ones, sacramental rituals, and prayer (Life After Death, 2021).

Buddhism is rooted in teachings of impermanence. The teachings of the Buddha provide distinctions between the impermanent human body and the reincarnated human soul. “Believing in reincarnation, he or she sees the biological shell as a guest-house in which the travelling consciousness sojourns but briefly, soon to go to another, quite different, place” (Holmes, 2017 para. 3). Buddhists believe through meditation, detachment from earthly attachments, and acceptance of suffering as part of humanity, that enlightenment can be reached, and reincarnation can end.

Hindus also believe in reincarnation or *samsara*. Similar to Buddhism, the goal of this reincarnation process is to achieve *moksha* or the final release from rebirth. In order to reincarnate to a more favorable life or to eventually achieve *moksha*, Hindu’s believe in the currency of karma. The concept of karma suggests the actions of this life will influence the quality of the next (Verghesese, 2017).

In the religion of Islam, death is followed by entrance into a utopian afterlife dictated by the actions of this life. Muslims do not believe death should be feared or resisted. In Muslim traditions, death is not a topic to be skirted around, instead death is often a central point of discussion and understanding of life (Sheikh, 1998).

Creation of religious institutions are linked to current death anxiety theories. As will be discussed later in the literature review, Terror Management Theory (TMT) suggests that affinity toward religiosity is predominantly based in fears around death and what will happen to the self once the body dies. These fears give rise to humanity's desire to adopt religious dogma and cultural norms (Kokosalakis, 2020).

Philosophical Theories of Death Anxiety

Schools of philosophy and psychology broke from religious conceptualizations of death and dying in order to address alternative contexts of how humans experience and cope with their existence and mortality. Philosophers and psychologists in the field of death studies argue for the significance of recognizing fears of death as a unifying human experience which is at the root for the development of cultural beliefs, defenses, complexes, and psychopathology.

Existential philosophers are some of the most notable thinkers in studies of death anxiety and givens of existence. "The existential reality of death is something different. It raises philosophical questions about what death really means in a human existential context. How do humans cope with it? What light do religious explanations of death shed on the existential experience of death and what do philosophical traditions have to say on this matter?" (Kokosalakis, 2020, p. 402). Addressing death anxiety from a philosophical perspective is key to grasping the complexities associated with existence. Philosophical theories address the

intersections of self, culture, mysticism, religiosity, psychology, and biology as a means of understanding a human's experience with existence.

Meaning of life and death cannot solely be explained by biological measures of what it is to be alive and what it is to be dead. It does not address the existential elements arising as humans attempt to reason with existence and non-existence. Heidegger, an existential philosopher, reflects that humans are the only [known] species in our world with the ability to perceive that one day we will no longer exist (Heidegger, 1967). In order to understand this dialect between life and death, existentialists speak about frameworks of transcendence. Transcendence comes from the Latin *trans* meaning "beyond" and *scandere* meaning "to climb". For philosophers, this signifies a human being's unique ability to try to transcend, or climb beyond, the confines of the biological givens of life to find meaning and purpose in life and perhaps in death (Kokosalakis 2020).

Søren Kierkegaard is notable for his writings on existence, anxiety, and death. His work has inspired modern day existential philosophers and schools of psychology. Kierkegaard describes death as connected to existence. Death is the only certainty in life, "an uncertain certainty" (Watkin, 1990, p. 65). Human time on earth is precious and finite. Because of this, Kierkegaard believed the greatest human task and responsibility is to reconcile with the impermanence of life and decipher its meaning. Confronting death can allow for life itself to come to light (Watkin, 1990).

Martin Heidegger presents influential existential thoughts on death and its accompanying anxiety. Heidegger's theory of 'being-towards-death', "captures the relational nature of our human stance in living as mortal beings, that we face the possibility of death - *our death* – in the immediacy of every moment we are alive" (Mandić, 2008, p. 254). Mandić's (2008) examination

of Heidegger's philosophy, especially as it shows up in psychotherapy, outlines the importance of helping a client be more authentically close to death in order to have more freedom in life. This represents Heidegger's more positivistic attitude toward mortality and meaning. Heidegger wrote about the power of dismantling the carefully constructed systems of avoidance and protection humans create for themselves in order to avoid thoughts or feelings surrounding death. While these defenses are important in human development, they inevitably imprison humans and keep them from living freely and moving toward meaning.

Ernest Becker, another dominant figure in the study of death and dying, discusses the many ways humans have come to understand, avoid, and fear death in his book, *The Denial of Death* (1973). He outlines how death is at the root of mental illness, from the more benign to the most severe. For example, he discusses how schizophrenia can be conceptualized as a failure of a human, from early on in development, to build the defenses that guard against the gruesome and gritty realities of human existence. These defenses are similar to the avoidance strategies conceptualized in Heidegger's theories. Overall, Becker provides two arguments for the roots of death anxiety: the healthy minded argument and the morbidly minded argument. The healthy minded argument proposes death anxiety to be something that is learned in comparison to the morbidly minded theory which argues death anxiety is inherent in every human (Becker, 1973).

Becker postulates human nature is tightly intertwined with the hero complex. "It is still the hero-system in which people serve in order to earn a feeling of primary value, of cosmic specialness, of ultimate usefulness to creation, of unshakable meaning" (Becker, 1973, p. 5). Becker explains how humans construct systems placing them and others in hero complexes as a means of trying to defy death and decay. This creation of heroism begins in the early development of the child. Children are taught to adopt these defenses in order for formation of

ego strength. Becker believed humans create complex systems around heroics including communities, societies, religions, countries, myths, and gods. Becker discusses how confronting the hero complex can cause significant dissonance in the self but in a supported setting such as in psychotherapy, it can also lead to transformation (Becker, 1973).

Psychological Theories of Death Anxiety

Many psychologists have offered theories of death anxiety and how humans either deny or learn to integrate it into their lives. These range from early psychoanalytic theories to modern day existential and meaning centered theories. Freud did not believe death to be an underlying source of anxiety. Although he did provide theory on the death instinct, which he believed to be at the root of internal and external aggressiveness and destruction, he did not equate the death instinct to death anxiety. He also did not support the idea that death anxiety serves as a primary psychological concern for humans, due to the lack of experiences of death in early development. Melanie Klein departed from Freud's conceptualization of death fears. She theorized that fear of death is at the root of all anxieties and is developed early in childhood. She believed even infants begin to develop these anxieties unconsciously prior to direct experience or knowledge of death (Blass, 2014). Similar to Klein, Carl Jung conceptualized death anxiety to be a key unconscious element with which humans contend. He theorized that integrating death into the conscious psyche is paramount to the individualization process. He theorized that the individuation process is helped by exploring death and shadow leading to a more authentic and whole life. Jungian and depth psychology theories rely on dreams and active imagination to explore these themes within the self (Sinoff, 2017).

Erik Erikson included death anxiety into his theories of human development, which is accounted for in the final stages of development. He titled this stage: wisdom: ego integrity

versus despair. In his view, humans who are able to attain ego integrity will find more meaning and purpose as they enter later stages of life, ultimately helping to mediate fears around death and dissipating feelings of regret. Conversely, holding onto denial and avoidance tactics associated with death and dying will result in despair and an increase in death anxiety (Pandya & Kuthuria, 2021).

Kastenbaum's edge theory proposes that death anxiety is a survival mechanism when human's feel they are in life threatening circumstances. His theory espouses a strengths-based theory of death anxiety. According to Kastenbaum, death anxiety allows a human to prepare for these crisis situations and thus should not necessarily be squashed. Kastenbaum describes how death anxiety is constructed from both biological and advanced cognitive processes (Kastenbaum, 2000).

Viktor Frankl's logotherapy has also made significant psychological contributions to the death anxiety literature and psychotherapy. The creation of logotherapy was in response to the gaps Frankl perceived in psychoanalytic treatment as well as in response to his imprisonment at multiple Nazi concentration camps during World War II. At its roots, logotherapy or meaning therapy, suggests that the ultimate human task is to make meaning. This discovery of meaning is grounded in Frankl's theory that humans are not just physical and psychological beings but also spiritual beings. Recognition and exploration of the spiritual aspects of humanity are closely tied to meaning centered work. Through meaning making, Frankl believed humans are able to mediate the effects of existential distress, which is key when working with individuals at end of life (Frankl, 1959/2006). Breitbart's meaning centered psychotherapy (MCP) and Chochinov's dignity therapy have their roots in Frankl's theories and are being more widely used for individuals at end of life (Rosenfeld et al., 2017).

Irvin Yalom has provided some of the most robust psychological theories on death anxiety and how to address themes of existence in psychotherapy. In his seminal book *Existential Psychotherapy* (1980), Yalom details the four existential givens of human life: death, isolation, meaning in life, and freedom. While all of these givens intertwine, especially in psychotherapy, death or the inevitability of non-existence is prominent in each of the other givens. Yalom refers to existentialism as anything that pertains to existence and the fact that human existence is shadowed by the knowledge that just as unexpectedly as we were born to this earth, we will leave it (Yalom, 1980).

Yalom emphasizes the crucial role death anxiety and denial of death play in conscious and unconscious aspects of human life. Consciously, these exist in defense mechanisms beginning in childhood. Unconsciously, they arise in instinctual reactions, through fantasy, and in dreams. It is Yalom's position that humans spend an inordinate amount of time trying to manage their death anxiety, which can result in difficult internal and external experiences affecting our interpersonal and intrapersonal relationships. Yalom, like Heidegger, believes death and life are intimately connected: one cannot exist without the other. Both reflect on the benefit of encountering the realities of death in order to set us free enough to find meaning and purpose in life (Yalom, 1980).

Yalom describes two main complexes that emerge from death denial: the ultimate rescuer complex and the specialness complex. Like Becker, Yalom believes both of these are tied to the hero complex and desire to cheat death through either being or being close to a heroic figure. The formation of the ultimate rescuer is aligned with a human's tendency to create beliefs in gods, powerful people, or powerful idea structures. By being close to these, the human believes they may be able to avert death. The concept of specialness is a more internalized model representing

something in the human (i.e., a gift or mystical quality) elevating them to a heroic level. These complexes are ingrained in humans starting in childhood through the inundation of fantasies, myths, fairy tales, and parental defense strategies (Yalom, 1980).

Elisabeth Kübler Ross, a prominent Swiss and American psychiatrist who is famous for her stage theory of grief, also provided important contributions to death and dying literature. Her interviews with individuals at end of life promoted the therapeutic quality of openly discussing death. Her work also exposed how providers tend to skirt away from these conversations due to fear and discomfort. She examined how death has become a taboo in modern day life resulting in the dying process becoming more isolating and dehumanizing (Corr, 2019).

For psychologists, Kübler-Ross offers three key lessons regarding work with individuals at end of life. The first lesson reminds providers that people who are actively dying are also still living. They are still beings with needs for processing, meaning, and connection. The second lesson underscores the power of active listening and attunement to the person who is dying. The third lesson encourages reciprocal learning between the psychologist and their dying patients in order to counteract power differentials. Through these encounters, Kübler-Ross believed psychologists could access their own psychology of the impermanence of life resulting in greater meaning and connection to self and others. Kübler-Ross' work should serve as a reminder to psychologists that we cannot solely rely on the mechanistic aspects of therapy when encountering themes of death and dying. Instead, psychologists must learn to *be* with another human as they explore the depths of their existence without shying away or tuning out (Corr, 2019).

Paul Wong, a modern-day existential psychologist's meaning management theory and death acceptance theory focus more heavily on measuring death acceptance and levels of

meaning making. Wong's theory postulates that finding meaning in death will directly correlate with finding meaning in life. Finding meaning in death does not erase death anxiety but allows for a human to be in better relationship with death. In sum, Wong's theory suggests two key psychological tasks: "to protect ourselves against the terrors of loss and death (e.g., managing death anxiety) and to pursue the good life of living meaningfully and abundantly (e.g., managing death acceptance). These twin tasks of living well and dying well are interconnected in important ways because of the intimate relationships between the meanings of life and the meanings of death" (Wong, 2007, p. 3).

Meaning management theory (MMT) has its foundations in humanistic-existential psychology and Niemeyer and Kelly's constructivist theories. Constructivist theory posits that humans create worldviews that include hierarchical constructs that help them to order the events of their lives. Dissonant experiences challenge these worldviews. Usually, these experiences can be incorporated into the self without altering affects, but some experiences are too dissonant and can result in fragmentation of the self. Death, whether fear of your own or grief over the death of another, are examples of dissonant events that are difficult for humans to integrate into their constructed worldviews. When there is space made for integration of these types of events (e.g., psychotherapy), humans have the potential to move toward greater self-actualization and meaning and move away from avoidance and terror (Neimeyer, 1994).

Terror Management Theory (TMT) has become a central psychological theory in modern day death anxiety literature. It was originally developed by Jeff Greenberg, Sheldon Solomon, and Tom Pyszczynski and is rooted in Ernest Becker's theories of death anxiety (Pyszczynski et al., 1999). According to Arndt and Vess (2008), TMT is a, "social psychological theory that draws from existential, psychodynamic, and evolutionary perspectives to understand the often

potent influence that deeply rooted concerns about mortality can have on our sense of self and social behaviour" (p. 909). TMT builds off of Becker's existential paradox (i.e., human's desire for immortality juxtaposed with the awareness of certain death), which can result in crippling anxiety and fear for humans. This paradox can also be a key element in conceptualizing psychopathology. TMT suggests self-esteem, cultural worldviews, and affiliations act as safeguards against death anxiety. Cultural worldviews promote belonging, purpose, and belief structures enabling humans to believe they can defy death through things such as an afterlife or legacy (Iverach et al., 2014). TMT suggests strong self-esteem is developed when an individual feels they are aligned with the values of their particular worldview and culture. According to TMT, a strong affinity with one's worldview as well as a well-developed sense of self can offset the fears associated with eventual non-existence (Portelinha, 2012).

TMT also offers a broader theory on human conflict, behavior, socialization, art, spirituality, and language. According to TMT, these aspects of human civilizations are created in response to a human's awareness of their own death or, "mortality salience or death-thought accessibility" (Ivereach et al., 2014, p. 582). Conflict between groups of humans is a product of one group feeling as if their worldview is being threatened by another group. This type of threat, according to TMT, uproots the worldviews used to off-set fears surrounding death (Portelinha, 2012).

There is a plethora of current examples where humans feel their worldviews are being challenged. This can be seen through responses to the COVID-19 pandemic, presidential transitions of power, racial tension and discrimination, environmental crises, and increasing socioeconomic division. At the root of this divisiveness, there is the simple yet profound fear of

non-existence. TMT is a useful framework for not only conceptualizing the individual's internalized conflict with non-existence but also the collective's struggle.

Psychological Interventions for Death Anxiety

There are many psychological interventions and assessments born out of death anxiety theories. The most prominent interventions come from existential-humanistic models of psychotherapy, but more cognitive and behavioral (CBT) models have also adopted interventions to address death anxiety and end-of-life concerns. While more experiential, existential, and humanistic interventions will be focused on in the proposed training, examination of thoughts, feelings, and behaviors around death anxiety through CBT interventions may be useful for some clients (Arndt & Vess, 2008). It is useful for psychologists to know how to flexibly adapt these interventions to serve diverse communities and to step outside of the box and employ more creative and experiential interventions such as art, music, and nature.

Emphasis on existential themes such as meaning making, spirituality, and suffering are highlighted as important factors to be addressed in psychotherapy with individuals at the end of life (Vos et al., 2015). When existential themes are addressed in psychotherapy, clients express better treatment outcomes overall (Henoch & Danielson, 2008). Meaning centered psychotherapy (MCP), rooted in existentialism and logotherapy, has become an efficacious therapeutic model for individuals at end of life, especially those in the cancer community. In its most structured form, MCP is designed as a seven-session model with the goal of supporting an individual (or a group) in processing meaning in their life. For example, sources of meaning, how meaning has shifted in their life, historical sources of meaning, attitudinal sources of meaning, creative sources of meaning, and hopes and reflections for the future are incorporated into the process. The ultimate goal is to complete an individual legacy project by the conclusion

of the psychotherapy process. MCP is often accompanied by discussions around spiritual aspects of an individual's life and how spirituality contributes to meaning (Breitbart, 2001). These types of interventions can be used for individuals, groups, and have also been expanded for caregivers (Applebaum et al., 2015).

Chochinov's dignity therapy interventions focus on addressing existential and psychosocial difficulties among individuals at end of life. Dignity therapy places emphasis on increasing dignity and overall well-being for individuals at end of life given the high percentage of individual who feel demeaned, depressed, and isolated during the dying process. Dignity therapy is a two session, brief therapy design where clients share their life story and hope for their loved ones. The sessions are recorded, transcribed, and then given back to the patient to modify at will. The questions focus on important life events, moments where the client felt most alive, legacy, accomplishments, imparted wisdom, and instructions for family and friends post-mortem (Chochinov, et al., 2005).

In western cultures, there have been a push toward cognitive and behavioral conceptualizations of death. While these can be useful interventions for helping people to understand their fears around death, it is equally important to understand the somatic or embodied experiences of death and grief. Accessing the wisdom of the body can be a powerful intervention in death and dying work, as it can help the client move out of an intellectualizing space and toward a space where they can be more present with their mortality. In therapy, psychologists can help the client learn to attune to somatic reactions and sensations to better access embodied meaning and knowledge (Brinkmann, 2017).

Creative interventions such as music, art, and nature-based therapies have been demonstrated as effective and meaningful interventions for death and dying work. These types of

interventions can be especially important given how difficult it can be to verbalize feelings, sensations, and thoughts around death. Music therapy can include receptive forms of interventions (i.e., listening to music), performing music, creating or composing music, and utilizing music with other interventions such as dance or art (Bradt & Dileo, 2014). Art therapy has also been shown to be an effective intervention for individuals experiencing death anxiety. This can be an especially beneficial for children and adolescents (Mortazavi, 2018). Finally, nature-based therapy techniques can be useful for improving quality or life and connection for individuals at end of life. Horticultural therapy techniques such as work in a therapeutic garden, tending to plants, or being around plants have been indicated as efficacious for improving spiritual, social, emotional, and physical well-being. For those at end of life, there have been promising research outcomes indicating that these types of interventions help individuals feel more connected to others and increases a sense of purpose and meaning (Lai et al., 2017).

The use of dream work can also be a powerful intervention in death and dying work. Yalom (2008) encourages attunement and attention to dreams in psychotherapy given the rich material dreams can provide regarding existential themes in an individual's life. Dream work has been incorporated into meaning centered psychotherapy techniques, especially for those with terminal illnesses (Wright et al., 2014). Dream work allows for deep self-exploration and reflection. Dream exploration at end of life has been shown to help individuals explore themes of loss, control, fears of dying, and relationships (Goelitz, 2007).

Cultural Considerations for End-of-Life Care

There are significant gaps in end-of-life care for racial and ethnic minorities living in western contexts in comparison to white community members. The largest identified barriers to equitable end of life care have been identified as: 1) cultural differences between healthcare

providers and persons approaching end of life care, 2) under-utilization of culturally-sensitive models designed for improved end of life care, 3) language barriers; 4) lack of awareness of cultural and spiritual diversity issues, 5) exclusion of families in the decision making process, 6) personal racial and religious discrimination, and 7) lack of culturally-tailored end of life information to facilitate decision making and uptake of care for culturally and spiritually diverse communities (Fang et al., 2016 pp. 2-3).

Fang et al., (2016) provide recommendations for improving end-of-life care for culturally diverse communities. These include improving needs assessments for specific cultural and spiritual groups to bolster competencies, along with encouraging increased reflective processes for providers to gain insight into how their own values and culture influences end-of-life care. Fang et al. (2016) offer suggestions for policy changes in care facilities that prioritizes cultural differences in end-of-life care and conceptualizations of need. This may include using alternative pain models, using non-traditional communication strategies, honoring hierarchical family systems, and incorporating sacred texts and native healers into care and treatment planning. Finally, they encourage providers to avoid classifying cultures as homogeneous in order to recognize the individual and family differences within the same culture.

As seen throughout this paper, literature and research on the forefront of death anxiety and death studies are dominated by western, colonial thought. While these contributions should not be negated, it is also crucial to include the voices of those who are promoting a decolonization of death studies and end-of-life practices, especially as it pertains to psychological care. Decolonization in its broadest terms is, “The removal or undoing of colonial elements” (Attaas, n.d.). Decolonization of health and mental health systems are efforts to understand how our current systems continue to be rooted in colonial practices which aim at

marginalizing indigenous, racial, ethnic, gender, and sexual minorities. Decolonization efforts surrounding death and dying are crucial for addressing gaps in care cross culturally and examining how our systems of caring for individuals at end of life are predominantly rooted in colonialism. Colonial death practices can result in trauma, pathologizing, medicalizing, and isolating individuals at end of life. It can also lead to a disconnect between spiritual practices, native healers, family and community practices, and natural remedies for healing (Fletcher, 2019).

In line with decolonization practices, Rattner (2018), offers discourse on un-disciplining dying, especially in the context of addressing gaps in care for cross-cultural populations. This includes the recognition of tendencies toward pathologizing reactions to death anxiety and grief. For example, diagnosing an individual with complicated grief or an adjustment disorder if they have not returned to "normal" following the death of a loved one. Un-disciplining end of life care makes space for multiple truths surrounding death and dying. This includes multiple definitions of pain; increases in transparency between provider and patient; explorations of a variety of sources of suffering, including physical and non-physical suffering; multiple realms of healing; and importantly, equal space for an individual to discover and *not* discover meaning associated with death and dying.

Historically, end of life decisions and themes of death and dying were constrained to a family or community. With advances in medicine and technology, these cultural considerations around death and dying have become more delegitimized. Native healers, elders, and family wisdom are superseded by the powerful expert and almost god like role of the physician (Blank, 2011). In order to reduce gaps in care and promote the importance of culture in death and dying,

there needs to be advocacy and policy change on larger system levels and room for diverse voices and narratives.

Special Considerations Regarding COVID-19

The COVID-19 pandemic has put death and dying at the forefront of the collective psyche. For many people, thoughts of death are not central on a daily basis. For those who are usually able to employ defenses against death anxiety, COVID-19 has introduced major disruptions in how we normally keep death anxiety at bay. Constant updates on the news regarding death tolls and the fear of an infectious, invisible virus have made it difficult for humans to escape from thoughts of their own mortality. Other reminders of threats to existence such as masks, signs for social distancing, closures of public spaces, and testing sites have also induced higher levels of death anxiety. As individuals contend with their own death anxiety in the face of the pandemic, there has also been a surge in othering and conflict among communities. This echoes TMT theory and humans' tendencies to place blame on other groups to bolster their own sense of safety and security (Menzies et al., 2020).

The COVID-19 pandemic has also disproportionally infected and killed marginalized racial groups in the United States including: Black, Hispanic, Native, and Asian Americans (Lopez, Hart, & Katz, 2021). It has also disproportionately affected individuals in lower- and middle-income counties (LMICs) across the world. These affects range from an increase in disease transmission, disruption in foreign aid, food insecurity, decreased access to medical and mental health providers, and disruption in migration and refugee relocation (Bong et al., 2020). LMICs also continue to face inequality in regard to the distribution of the COVID-19 vaccine, resulting in higher death tolls and infection rates (Lenhardt, 2020).

COVID-19 it has resulted in disruptions to how families and communities say goodbye to a loved one who is dying and how they memorialize them after death. Specifically, due to the contagious nature of COVID-19, many families have been forced to say goodbye to a loved one over a screen. Doctors have had the horrific job of watching patients die alone and have been burdened with the responsibility of telling family members they cannot come into a room to hold the hand of their loved one in their last moments of life. These types of death notifications are weighing heavily on our essential workers who are also combatting their own fears around contagion and death from COVID-19. The psychological fall out from COVID will not be entirely understood until there is more control over the virus, but psychologists are already feelings the immense weight of need from clients as they attempt to help them navigate their fears while attempting to manage their own (Wallace et al., 2020).

Definition of Death Anxiety

Death anxiety is subsumed in the larger study of death, thanatology. Thanatology is defined as, "The study of death and dying, including the medical, psychological, and sociologic aspects of it" (Shiel, 2018). While there are several definitions of death anxiety, the majority of them share common elements. In the field of psychology, death anxiety has been defined as, "The anxiety experienced from the anticipation of personal death… a pervasive human condition" (Belviso & Gaubatz, 2013, p. 144). Thus, psychology's role in understanding death surrounds the experience, behaviors, thoughts, and meaning humans make out of mortality.

How Psychologists Currently Support Death and Dying

Psychologists contribute to end of life care in a variety of settings and through direct and indirect care. Many psychologists are embedded members of palliative or hospice care teams providing support to clients and their families as they manage life threatening and life limiting

illnesses or injuries (Haley et al., 2003). Palliative care specializes in, "Providing patients relief from pain and other symptoms of a serious illness, no matter the diagnosis or stage of disease. Palliative care teams aim to improve the quality of life for both patients and their families. This form of care is offered alongside curative or other treatments you may be receiving" (The Mayo Clinic, 2017). Hospice care is a special kind of care that focuses on, "The quality of life for people and their caregivers who are experiencing an advanced, life-limiting illness. Hospice care provides compassionate care for people in the last phases of incurable disease so that they may live as fully and comfortably as possible" (American Cancer Society Medical and Editorial Content Team, 2019).

In general, psychologists have four main roles in end-of-life care including: clinical roles, education and training roles, research roles, and policy roles (American Psychological Association, 2005). Within clinical roles, psychologists can provide wrap around care before illness strikes; after illness is diagnosed and treatments begins; during advanced illness and dying processes; and after the death of a patient, with bereaved survivors (Haley et al., 2003, p. 627). These services can be offered in a variety of settings including, private practices, hospitals (on integrative teams), community mental health, nursing homes, outpatient medical clinics, and in the home (Haley et al., 2003). Psychologists also take on important assessment roles around end-of-life care. For example, capacity and competency evaluations have become a crucial role for psychologists, especially in the realm of physician assisted dying (Allen & Carpenter, 2017).

Regarding education and training, psychologists are in positions to help educate other providers and community members on grief, loss, and psychological impacts of death and dying. Psychological research regarding effective assessment and interventions around death anxiety is another area of involvement for psychologists interested in death and dying work. Regarding

policy initiatives, psychologists have opportunities to work at the federal, state, and local levels to advocate for more comprehensive and ethical end of life care. Psychologists also have the ability and responsibility to advocate for better care and policies in health care systems. This is an especially important role given the discomfort many have when discussing death and dying (Lyon, 2017). These roles and guiding initiatives for psychologists involved in end-of-life care are supported by the APA's working group on end-of-life issues and care. Since its formation in 1998, this APA group has worked to define psychologists' tasks in this area of psychology and promote policies and procedures for dignified end-of-life care that accounts for culture and diversity (Werth, 2017).

Provider Experience Working with Death and Dying

A 2015 comprehensive literature review on existential distress among professional caregivers highlighted five key existential themes that providers working in end-of-life care experience. These included: 1) opportunity for introspection; 2) death anxiety and potential to compromise patient care; 3) risk factors and negative impact of existential distress; 4) positive effects such as enhanced meaning and personal growth; and 5) the importance of interventions and self-care. The types of providers covered in this literature review included medical providers as well as psychologists (Pessin et al., 2015).

This review emphasizes the importance of an ongoing reflective process for providers working in end-of-life care. This type of process helps to counteract risk factors such as burn out, poor patient care, feelings of increased responsibility for the patient's life and death, depersonalization, poor self-care, and disengagement from the meaningful nature of the work. When these risk factors are dominant, there is an increase in existential distress. Conversely, the benefit of this type of work can lead to feelings of meaning and fulfillment, greater appreciation

for life, increased ability to be in the present moment, and aids in the deepening of interpersonal relationships and connections to spirituality and the mysticism of life (Pessin et al., 2015).

This array of experiences supports the need for better training, especially around reflective processes for psychologists working in the realms of death and dying. The review emphasizes the use of meaning centered interventions for providers to help in this reflective process, which will be a key component to the reflective work offered in the proposed training.

Current Trainings for Psychologists

Studies and training in death anxiety in the United States can be traced back to the 1950's. Psychodynamic schools of thought proposed the difficulty of studying death anxiety attitudes given the potential for unconscious beliefs around death. In order to access unconscious death anxieties, researchers used measures such as skin tests to measure biologic responses to death stimuli, projective measures such as the Thematic Apperception Test (TAT), word completion tasks, and sentence completion tasks (Neimeyer et al., 2003, p. 48). In the 1970's, research shifted to more quantifiable self-report measures that could be more easily administered and scored. While these are easier in nature, those steeped in death anxiety research argue that these only get at a basic level of understanding of death anxiety and have the potential to miss deeper levels of understanding. This is not to say that these should all be discounted but the use of self-report measures alongside experiential techniques are encouraged in training and education (Neimeyer et al., 2003).

Herman Feifel, a notable modern day death educator, argued death education should be present for a wide variety of professionals as well as incorporated into education starting in childhood. Feifel supported a humanistic model of death education focused on acquiring knowledge while also reflecting on personal meaning and values associated with life and death.

He also theorized death anxiety and death education are a product of a particular time in history (Wass, 2004). "We are embedded in our time and culture . . . each generation contends with the presence of death raging against it, embracing it, attempting to domesticate it…and, at the same time, his further observation that although we are more knowledgeable and realistic about death, there is a persisting avoidance" (Feifel, 1982, as cited in Wass, 2004). This echoes the necessity for training in these areas to emphasize cultural awareness, as well as taking an ecological perspective which promotes conceptualizing death and dying in the multiple contexts surrounding a human.

When experiential elements are incorporated into death educational courses, students report more meaningful internal understanding around death and an overall reduction in death anxiety in comparison to solely didactic driven courses. Reflective and experiential processes in death and dying courses can also help reduce the stigma associated with discussing themes of death and dying. Students who engage in these types of courses report exposure to these topics and their internal models of death and dying decrease the taboo nature of *being* with mortality. In general, students report an increased comfort in having discussions around existence and believe this type of course and training would aid them in future career pursuits (Buckle, 2013). The practice of interjecting actual experience into the learning process has its roots in the early 20th century writings of John Dewey when he introduced the idea and significance of experiential learning in education. The goal was to link the process of understanding with doing. He later expanded his thinking by suggesting that this experiential learning was critically important to later community participation and involvement (Davis-Berman, 2014).

Davis-Berman (2014) explored the use of experiential death education alongside didactic learning with undergraduate psychology students. In line with Dewey's theories, this research

hypothesized that students would report greater learning and meaning through experiential exercises versus solely didactic illustrations of what it is like to be with someone who is dying. To illustrate this, students did a narrative project (memory book project) with patients in hospice care using dignity therapy techniques. The results of this qualitative study indicated that students increased their comfort with discussions surrounding death and dying. The students also had a greater appreciation for meaning in their own life after engaging in this experiential activity. Although this study focused on educational materials for undergraduate students, it is a useful template for graduate studies in death education. While it can feel safer to engage with death through more intellectual models, the experiential elements are paramount for internal reflection and transformation.

In recent years, the APA's Committee for End-of-Life Issues and Care has started to expand access to training and education for psychologists in areas of death and dying. These educational opportunities are most commonly offered through continuing education efforts and organizations such as the Association for Death Education and Counseling and Education in Palliative and End of Life Care (EPEC Project). Both of these organizations provide opportunities for membership, conferences, and courses (American Psychological Association, 2017).

Gaps in Training

As noted above, psychologists' presence in end-of-life care is increasing but there continues to be a lag in graduate level curriculum addressing death, dying, and end of life care. The literature suggests that there is more access to death and dying courses, in general, at the undergraduate level. Specialty training in end-of-life care, death anxiety, palliative care, and hospice care for psychologists is rarer in graduate education (Haley, et al. 2003). Some programs

offer courses in grief and loss, but these are usually electives, given this type of curriculum is not mandated by APA accreditation standards. There are also few fellowships providing specific training in palliative and hospice work. This is increasing in certain Veteran's Affairs hospitals and with the influx of psychosocial oncology but there is still a significant amount of work to be done to increase this type of training for psychologists (Allen & Carpenter, 2017).

According to the APA committee, of those psychologists who do receive specialized training in end-of-life care, most receive that training during internship or fellowship. This underlines the lack of curriculum and didactic training for graduate students during their doctoral studies, despite personal implications and it being an area where psychologists are having a greater presence (American Psychological Association, 2017). There appears to be limited data specifying the exact number of psychology departments offering courses on death, dying, and end-of-life care. Eckerd (2009) surveyed psychology departments in nine Midwestern states regarding death education courses. Of the departments she surveyed, only 20% of the programs offered a course in the last five years. Programs identified gaps in course offerings being due to lack of faculty expertise, curriculum, and assumptions that topics of death and dying would be covered in other areas of study.

Why Psychologists Should Receive Death Education Training

Yalom (2008), provides a poignant reminder of the power of encountering another in the therapeutic space in an authentic and human way. He deems connection to be the ultimate agent of change for humans, especially as it pertains to discussions around death anxiety. "In my work with clients, I strive for connectedness above all else. To that end, I am resolved to act in good faith… no pretense of knowledge I do not possess; no denying that existential dilemmas strike home for me as well; no refusal to answer questions; no hiding behind my role; and finally, no

concealing my own humanness and my own vulnerabilities" (p. 206). Here Yalom shares how deeply important it is for every psychologist to understand their own anxieties as it relates to existential givens of life, especially death anxiety. Without this, the process of psychotherapy has the potential to miss deep, transformational themes of human existence.

It is my hope that the previous pages have adequately outlined the need for psychologists to be more competent stewards of the process of dying just as much as we are stewards of the process of living. As discussed in the literature review, mortality is a driving force for how humans develop psychopathology, religious beliefs, spiritual beliefs, culture, and sense of self. Given this is a human experience each of us will encounter, the need for death education in psychology is imperative. This education should encourage the psychologist to do deep, reflective work on their own systems of fear and anxiety around mortality. This type of training will promote the power of vulnerability and disclosure in the therapeutic space in order to co-create an experience where both the client and the therapist can feel encouraged to explore all facets of this human life, including the most inevitable one: death. As two existential psychologists, Groth and DuBose (2020) have emphasized, the therapeutic encounter requires both the client and the psychotherapist coming together, in a shared place for an authentic human encounter. This relationship is, after all, the consistent change agent among all psychological theoretical orientations (Wampold, 2015).

Statement of Purpose

In order to *be* with a client who wishes to explore their own death anxiety, the psychologist must first explore their own relationship to death and dying. The following is an outline for a proposed training geared toward psychologists and psychology trainees. The training aims to facilitate a space where psychologists can examine their relationship with death

anxiety through a variety of reflective exercises, self-report measures, case studies, readings, films, podcasts, and role plays. The training will also provide an overview of current and historical understandings of death anxiety. This will include a required reading list for participants of the training as well as didactics covering key components of the literature review. This approach will allow participants to have a contextual grounding as they do self-exploration, as well as a variety of strategies to take with them post training to continue this reflective process throughout their career. The training will have a strong emphasis on culture and diversity in order to increase awareness, knowledge, and skills for working with individuals from diverse backgrounds.

Death Anxiety Training Outline

I. Training Facilitation

A. This training is designed to be facilitated by licensed mental health providers from master's level to doctoral level therapists.

B. Within a doctoral program, the curriculum should be presented within the first year of training.

C. The training can be adapted to a quarter or semester long course as well as a three day intensive workshop.

II. Participant Informed Consent (see Appendix A)

A. Given the personal and potentially emotional nature of this training, each participant will be provided with an informed consent sheet to read and sign prior to participating in the training.

1. Resources for further processing, including referrals for psychotherapists, will be provided.
2. The instructor will be available after the training for debriefing.

III. Pre-Course Preparation

A. A pre-course reading list, movie, and podcast will be provided to each participant (see Appendix B).

B. Each participant will be required to finish reviewing these materials prior to the training. In the event of a multiple week course, these materials will be assigned on a weekly basis.

C. Each participant will be asked to write a brief reflection on their reactions to the assigned materials.

IV. Death Anxiety and Acceptance Rating Scales

A. Give Multidimensional Fear of Death Scale (found in Neimeyer, 1994) and the Death Attitude Profile- Revised (found in Neimeyer, 1994).

1. Research and utility surrounding these types of measures will be provided.
2. Discussion on the limitations of these measures.
3. A description of alternative death anxiety self-report measures will also be reviewed (all found in Neimeyer, 1994):

V. Narrative Reflection: Personal meaning of death paragraph (adapted from Harrawood et al., 2015)

A. In contrast to standardized, self-report measures, each participant will spend 10-20 minutes writing about the following questions:

1. What is death?
2. What does death mean to you?
3. How do you feel when you work with someone who is dying or brings up themes of mortality? If you have not worked with someone directly, how can you imagine feeling?
4. What aspects of working with dying clients are most difficult for you?
5. What emotions or personal responses arise for you?
6. What are your somatic reactions to thinking and talking about death?
7. What pieces of your cultural, racial, ethnic, gender, and sexual identity influence your ideas around death and dying?

B. Given the current climate of the pandemic, participants will spend about 10 more minutes writing on their experiences with death anxiety as it pertains to COVID-19.

    1. What themes of death and dying have you noticed during the pandemic?
    2. If you have addressed these themes with clients, what has that experience been like for you?
    3. What challenges to your sense of self and worldview have you noticed during the pandemic?
    4. What symbols of death have you noticed during the pandemic?
    5. Reflect on any avoidance or defense strategies you have tried to utilize.

C. After participants are finished, there will be a brief discussion of what people wrote in small groups and then in the larger group.

VI. Brief overview of key philosophers and psychological thinkers associated with death anxiety and death education.

A. This section will reflect the major components of the literature review and will be presented in lecture format. It will include:

    1. Religious and cultural associations with death anxiety
    2. Philosophical theories associated with death anxiety
    3. Psychological theories associated with death anxiety
    4. Definitions of death anxiety and death education
    5. Definitions of death anxiety and death education
    6. How psychologists currently engage in this type of work

B. A group discussion will take place regarding assigned readings.

C. A group discussion on the assigned film and podcasts will also take place.

**In the case of a full quarter or semester course, this section would be broken down into weekly chunks in order to provide a more robust description of each theory and assigned reading.*

VII. Culture, Diversity and Death

A. Discuss how western cultures approach themes of mortality.

B. Provide and discuss examples of how other cultures approach themes of mortality.

C. Discuss how to clinically incorporate and assess for differing cultural aspects of death and dying.

D. LGBTQ Considerations

E. Disability Identities (Not Dead Yet, 2021)

F. Racial and ethnic considerations

G. Discuss decolonization strategies around death and dying.

H. Provide information on disparities and gaps in care for marginalized populations at end of life.

I. Discuss ways in which psychologists can advocate for marginalized communities at end of life in systems and in the therapeutic space.

J. Discuss how to incorporate native healers, rituals, and texts into death and dying work.

K. Participants will spend time reflecting on how their conceptualization of death and dying will influence work with individuals from other cultural, racial, or ethnic backgrounds.

VIII. Implications of COVID-19 Pandemic

A. Discuss death anxiety in the context of COVID-19.

B. Disparities in care.

C. Death notifications and its effect on providers.

IX. Psychotherapeutic Interventions:

A. Paperwork and Planning (see Miller & Berger 2019) and (see Kleespies, 2004).

1. Practice filling out a 5 Wishes Document (hard copy will be provided)
2. Process what it would be like to discuss this with a client
3. Advanced Directives
4. Wills and Ethical Wills
5. Durable Power of Attorney
6. Death and finances
7. Discussing quality versus quantity of life
8. Child and Adolescent Considerations
9. Right to Die Laws and Practices
    a. Review the APA's guidelines for psychologists' involvement in assisted suicide otherwise called physician assisted suicide or dying with dignity.

B. Psychoeducation:

1. Palliative Care
2. Hospice Care
3. Death anxiety and psychopathology
4. Describing the dying process and dispelling myths

C. Existential Interventions

1. Taking a phenomenological approach to the work

2. Recognizing and discussing death anxiety and existential themes
3. *Being* versus *doing* in the therapeutic space
4. Goal of having authentic encounters with a client

D. Meaning Centered Approaches

1. How to access your own meaning through this work
2. Co-creating meaning with clients
3. Legacy Projects
4. Examining "rippling" effects of life (Yalom, 2008)
5. Meaning centered work with caregivers

E. Psycho-spiritual Approaches

1. Collaborating with chaplains or other spiritual leaders
2. Collaborating with native healers
3. Creating ritual with clients around end of life

F. Expressive Interventions

1. Narratives (legacy projects)
2. Music Therapy
3. Art Therapy
4. Ecotherapy Approaches
5. Using myth, symbols, and fairy tales
    a. The Phoenix (Exploring Your Mind, 2020)
        a. Preparation for death
        b. Resilience
        c. Transformation

b. Fairy Tales (Violetta-Irene & Anastasia, 2015)

c. Mythology (Young, 2002)

6. Incorporating Dream Work

a. Pilot study with hospice patients.

b. Utilizing dreams as a way of communicating fears, hopes, and meaning at end-of-life.

c. Looked at improved existential well-being and quality of life through dream exploration.

G. Language and Death (adapted from Dying Matters, 2018)

1. What language is used to talk about death?
2. What language did you use growing up when discussing death and dying?
3. What language do you use now when talking about death and dying?
4. What feelings arise for you when you use certain language to talk about death and dying?
5. Cross cultural considerations in language around death.

X. Case Examples (see Appendix C)

A. Provide case examples

B. Discussion

1. What themes of death anxiety were present in the case example?
2. What went well in the interaction?
3. What would you have changed?
4. What anxieties of your own can you imagine showing up in this case?

XI. Participant Case Examples

A. The space will be opened up for participants to offer any case examples they may have.

B. Discuss the case as a group.

XII. Role Plays using Sociodrama and Psychodrama Teaching Techniques (Baile et al., 2012)

XIII. Other processing questions that will be used throughout the training.

A. Participants will break up into small groups throughout the training or course and discuss the following questions. The facilitator will walk around and talk with group members as they explore these questions.

1. What systems have you put in place to defend against your own fears around mortality? How have these been challenged?
2. What are your personal experiences with death separate from your clinical work?
3. What is your earliest memory of death?
4. What have your experiences been with attending funerals?
5. What are discussions of death like with your friends and family?
6. How did your family talk about death when you were growing up?
7. Have you ever had a close encounter with your own mortality?
8. Have any of these experiences influenced the direction of your career or psychological interest in death and dying?
9. What does dying with dignity look like for you?
10. Does everyone deserve a dignified death?

11. What are some of your symbols, dreams, and that arise for you in regard to death and dying?

B. Next steps-how can you continue this process?

C. Closing reflections

1. Post-test will be given (see Neimeyer, 1994)
2. Final 10 minute free write reflection.
    a. Participants will reflect on their training experience and reactions to the content.
    b. Brief discussion on final reflections

Conclusion

There is no manualized way to encounter death. Some may find meaning and peace at the end, while others will be unable to confront death until it has already come to pass. There is no right or wrong way of navigating our existence. It lives entirely in a murky, messy, grey area that we each must stumble through. Psychologists have the rare opportunity to step into this space with people and gently peel back the thick overgrowths of avoidance to perhaps, together uncover meaning and connection. The ability to exist in a space without defined parameters or road maps is essential to this type of work. It is not the job of the psychologist to tell someone how to understand death or how to die. It is our job to *be* another human, open and willing to ask the questions and sit with the shared fear that these lives will one day come to an end. This can be what psychotherapy is all about: a profound, transformational, powerful, yet terrifying experience of coming to know oneself and our place in an existence without predefined meaning.

Shortly after my sister died, I had a brief yet influential encounter with a psychologist. She spoke to me about the crystalizing effect of death. After someone dies or is in the midst of dying, all our defenses are pushed away to reveal the self and this existence as it is. She encouraged me to stay in this crystalized space for as long as I could, even though it meant sitting with immense despair, pain, and grief. For it is within the shadow where we find transformation of self. She spoke to me about the specialness of this type of moment. Not special in the joyous sense, but special in the way of an initiation. Initiation into the parts of ourselves we try to lock away and avoid until it may be too late.

I did stay in that crystalized space for a time but as all humans do, my defenses eventually started to creep back in, but never to the extent that they had prior to my sister's death. I often talk to people experiencing grief or facing death about the shattering effect death

has on one's sense of self. I share the feeling of life being irrevocably changed and acknowledge the powerlessness to fix any of it. For me, this change illuminated a very clear professional and personal path. I now find myself being drawn to the shadow, to the people who wish to look death in the eyes, and to promoting the importance of this type of practice and work with my psychology colleagues and future students. My parents recently referred to me as a soon to be 'death psychologist'. While in jest, I cannot think of any other type of psychologist I would rather be.

Limitations and Future Directions

Psychologists, as members of a healing profession, will encounter the most intimate and feared parts of other humans, including fears of non-existence. To be with someone as they explore and learn to integrate these anxieties into their psyche is a privilege. To do this work authentically and empathetically, psychologists must first do their own exploration about their death anxieties. From a space of self-reflection and self-examination, psychologists will be better positioned to recognize their own avoidance, biases, and assumptions regarding death anxiety and themes around end of life in order to better serve their clients, colleagues, and communities.

This proposed training is a first step in enhancing psychologists' comfort with their own death anxiety in order to better serve clients who are examining their own or who are at end of life. As seen throughout this paper, psychologists are becoming more integrated into settings such as oncology, palliative care, and hospice where themes of death and dying are central to the psychological care. Psychologists are also central figures in work with an increasingly aging population and will continue to be key figures in the psychological recovery of the COVID-19 pandemic. From this training, my hope is that psychologists will continue a reflective process around their own death anxiety and feel more versed in theories of death anxiety.

The proposed training also emphasizes the importance of culture and diversity when working with themes of death and dying. In order to encounter others from differing cultural, racial, ethnic, political, economic, and social backgrounds, psychologists must understand the intersections of their own culture with conceptualizations of death and dying. This is a beginning step for acknowledging unavoidable biases and assumptions in order to encounter someone from a space of humility, openness, and eagerness to learn and grow. This is a central tenet to all psychological work but is even more crucial when sitting with someone as they process existence. Navigating death is a daunting and vulnerable process, especially when dying in a culture different than yours or in a culture which has abused and marginalized you. Psychologists can be at the helm of advocating for more competent care and for decolonizing death practices.

This paper provided broad strokes of death anxiety, death education, and end of life care. The scope of this paper was narrowed due to it being primarily focused on the field of psychology. Thanatology is an area of study spanning multiple disciplines and thus there were theories and practices unaccounted for in this paper from other fields of study. While this paper touched upon cultural considerations, it was beyond the scope to provide in depth examinations of specific cultural beliefs and practices around end of life. Finally, this training is meant to be an introduction to death studies and end-of -life care for psychologists. From this training, psychologists have a responsibility to further study and explore death and dying whether through reading, self-reflection, or their own psychotherapy.

Future directions for increasing psychologists' comfort with death, dying, and working with those at end of life should include more access to death education trainings. The field of psychology as a whole should encourage death education curriculum to be a core competency for APA accredited programs. This will allow for psychology trainees to have access to this type of

training and reflective process from the beginning of their training. This would be a monumental shift from the current standards for accessing this type of training. As indicated in this paper, the majority of psychologists do not get this type of training until they are on internship or during their fellowship. Improving one's ability to be with someone as they contend with existence should be at the forefront of all psychologists' training from the start.

I Am Standing Upon The Seashore

-*Victor Hugo*

I am standing upon the seashore.
A ship at my side spreads her white
sails to the morning breeze and starts for the blue ocean.

She is an object of beauty and strength.
I stand and watch her until at length
she hangs like a speck of white cloud
just where the sea and sky come
to mingle with each other.

Then, someone at my side says;
"There, she is gone!"
"Gone where?"

Gone from my sight. That is all.
She is just as large in mast and hull
and spar as she was when she left my side
and she is just as able to bear her
load of living freight to her destined port.
Her diminished size is in me, not in her.

And just at the moment when someone
at my side says, "There, she is gone!"
There are other eyes watching her coming,
and other voices ready to take up the glad shout;
"Here she comes!"
And that is dying.

Appendix A: (adapted from Cox & Fundis, 1992)

INFORMED CONSENT TO PARTICIPATE IN TRAINING

Training Title: Encountering Death: A Training Proposal for Psychologists Addressing Death Anxiety and End of Life Care
Trainer's. Name and Credentials: Bridget Kromrey, MA (doctoral candidate)
Trainer Contact Information:
Email: bridget.kromrey@du.edu
Phone: 720-338-7169

A. **PURPOSE OF TRAINING:**
The purpose of this study is to increase psychologists' comfort with their own death anxiety in order to better serve clients presenting for care around themes of death and dying. This training aims to facilitate a space where psychologists can examine their relationship with death anxiety through a variety of reflective exercises, self-report measures, case studies, and role plays. The training will also provide an overview of current and historical understandings of death anxiety.

B. **RISKS:**
Exploring themes of mortality has the potential to activate strong emotional reactions and memories for participants. Conceptualizations of death and dying are highly personal and rooted in an individual's unique contextual make up. There is a potential risk that participants will experience dysregulation, stress, anxiety, overwhelm, sadness, etc. by participating in this training.

C. **BENEFITS**
Exploring your own relationship to death and dying, while gaining knowledge of the pertinent literature, will potentially provide a deeper connection to your own meaning of life as well as enable you to have an experience where you can examine how your own relationship to mortality may be impacting your work with clients who want to explore similar themes or who are currently at end of life.

D. **CULTURAL CONSIDERATIONS:**
This training strives to incorporate diverse and culturally rooted conceptualizations of death and dying. While it is not possible to fully grasp the intricacies of another's culture or account for the beliefs of every group or community, this training strongly promotes diverse voices. This training also strives to recognize the specific context from which the creator comes in order to facilitate transparency around potential biases and assumptions. Each participant's cultural identity will be valued throughout this training. Discriminatory actions or speech will not be tolerated in the training space and will result in immediate removal from the training experience.

E. **CONFIDENTIALITY:**
This training has an emphasis on reflection and self-disclosure in order to facilitate an opportunity for transformational growth in this area of human existence and clinical practice. Each participant agrees to upholding the confidentiality of each group member and agrees to not disclosing the personal content of the training to anyone outside of the training space.

F. VOLUNTARY PARTICIPATION:
This training is completely voluntary. The participant acknowledges they can discontinue participation at any time during the training experience without consequence.

G. EVALUATION:
This training is non-evaluative. Each participant will receive a certificate of completion, but no grades or other evaluative marks will be given to the participant.

H. QUESTIONS/SUPPORT NEEDS:
The trainer is available throughout this process for questions, concerns, and feedback. The trainer will also have a list of resources if any participant needs support during or after the training. The participant acknowledges that this training is not individual or group psychotherapy. The participant understands that resources for psychotherapy will be provided if they require more in-depth support around this material.

I. CONSENT
YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN A TRAINING. YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE DECIDED TO PARTICIPATE IN THIS TRAINING AFTER READING ALL OF THE PROVIDED INFORMATION. YOU AGREE THAT YOU UNDERSTAND THE INFORMATION IN THIS FORM, HAVE HAD ANY QUESTIONS ANSWERED AND HAVE RECEIVED A COPY OF THIS FORM FOR YOUR RECORDS.

Signature_____ Date_____
Participant

Signature_____ Date_____
Trainer

Appendix B:

Required Reading and Film List:

1.) Books:
    a. Staring at the Sun: Overcoming the Terror of Death (Irvin Yalom)
    b. The Denial of Death (Ernest Becker)
    c. A Beginner's Guide to the End: Practical Advice for Living Life and Facing Death (BJ Miller & Shoshana Berger)
2.) Articles (selected from reference list, below)
3.) *Nomadland (2020)*
4.) Podcast (selected episodes will be provided):
    a. Death in the Afternoon (http://www.orderofthegooddeath.com/podcast)
    b. Dying for Sex Season 1(https://wondery.com/shows/dying-for-sex/)

Appendix C:

Case Examples

Case #1: Case of Ava

i.) 21-year-old female, white diagnosed at 17 with stage IV Hodgkin's Lymphoma

ii.) Themes of death anxiety prior to second bone marrow transplant

iii.) Navigating end of life desires in psychotherapy

iv.) Discussions of quality versus quantity of life

v.) Navigating fears around leaving loved ones behind after death

vi.) Themes of grief and loss due to illness

vii.) Countertransferential reaction

Case #2: Case of Brian

i.) 61-year-old, white male with a diagnosis of acute myeloid leukemia

ii.) Diagnosed one month prior to his death in the hospital

iii.) History of alcohol abuse resulting in guilt and shame around lost time with his family

iv.) Navigating his end of life wishes versus those of his three children

v.) Navigating Do Not Resuscitate (DNR) versus Comfort Care Do Not Resuscitate (DNRCC) and other legal pieces of end of life

vi.) My experience working with the patient and his son on his last day of life

Case #3: Case of Laina

i.) 12-year-old, Latina, female with a history of leukemia in remission

ii.) From a religious family- Christian identifying

iii.) Ongoing fears she will die

iv.) Ongoing nightmares around treatment and death

v.) Family encouraging prayer, which did not feel useful to the patient

vi.) Themes regarding loss of childhood

vii.) Parents shying away from discussions around death and dying

viii.) Cultural components to psychotherapy

ix.) Navigating family dynamics

x.) How death anxiety can manifest in children

Case #4: Case of Alana

i.) 30-year-old, African American, female with a diagnosis of Crones Disease

ii.) Presented to psychotherapy with increased anxiety in the context of COVID-19

iii.) Strong Christian affiliation

iv.) Increased fear that a disease will kill her

v.) Fears of falling asleep at night due to death anxiety

vi.) Family member died from COVID due to improper access to care

vii.) Fears around COVID vaccine- navigating historical trauma associated with vaccines and medical interventions for African American populations

viii.) Recognizing racial and cultural differences between therapist and client

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