Death and dying

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Key points

- Document the social patterning of contemporary death and dying.
- Identify the components and patterning of grief among bereaved persons.
- Describe theoretical perspectives on mental health among bereaved and dying persons
- Suggest policies and practices that can mitigate against the mental health consequences of bereavement and dying.
- Convey that the mental health consequences of death vary dramatically on the individual, relational, and contextual factors.

Abstract

Death is a normal part of the life cycle, yet its impacts can be emotionally devastating. Bereaved persons may experience mental health symptoms including grief and loneliness, while dying patients also may experience symptoms including depression and death anxiety. This entry describes: (1) the social patterning of contemporary death and dying; (2) the components and patterning of grief among bereaved persons; (3) theoretical perspectives on mental health among bereaved and dying persons; and (4) policies and practices that can mitigate against the mental health consequences of bereavement and dying. We conclude by underscoring that the mental health consequences of death vary dramatically on the individual, relational, and contextual factors.

Introduction

Death and dying are natural and inevitable parts of life (Carr and Luth, 2019). The COVID-19 pandemic, which took nearly one million lives in the United States and more than six million lives worldwide as of April 2022, is a stark reminder of the pervasiveness of death and loss (Centers for Disease Control and Prevention, 2022). The pandemic also affected the mental health of family members, friends, coworkers, and health care providers of those who succumbed to the virus. Experts estimate that each COVID decedent was survived by an average of nine significant others (Verdery et al., 2020). The deaths of close family members, especially a spouse or child, are among the most distressing of all life events (Holmes and Rahe, 1967). However, contemporary research underscores that the mental health consequences of loss and the psychological symptoms experienced by dying persons vary widely on the basis of individual characteristics, relational factors, and contexts of the death (Stroebe et al., 2008). In this article, we first describe the social patterning of contemporary death, and provide an overview of grief and its components. We then review theoretical perspectives that set the foundation for understanding why and how death affects mental health, and synthesize recent empirical studies, highlighting the psychosocial, religious, and contextual factors that may intensify or buffer the mental health

consequences of death and dying. We conclude by highlighting two practices that may mitigate against harmful mental health consequences of death and loss: advance care planning and hospice.

The social patterning of death and dying

In the first two decades of the 21st century, between 2.4 and 2.8 million persons died each year in the United States, with this number jumping to nearly 3.4 million deaths annually in 2020 and 2021 due to COVID-related mortality (Sabo and Johnson, 2022). Although death can strike at any age, three-quarters of all annual deaths in wealthy western nations occur to persons ages 65 and older, due to age-related biological changes including weakening immune and cardiovascular systems. How we die changes with age (see Fig. 1), influencing the mental health consequences for dying persons and their loved ones. Among midlife and older adults, the leading causes of death in the late 20th and early 21st centuries have been chronic illnesses including cancer, heart disease, cerebrovascular disease, diabetes, liver disease, and lung disease, with COVID-19 emerging as the third leading cause of death as of 2020. In stark contrast, sudden and unexpected events including unintentional injuries/accidents, suicide, and homicide rank among the leading causes of death among adolescents and young adults. Infants and youth are especially vulnerable to deaths due to congenital abnormalities, as well as accidents and illnesses.

Sudden and unexpected deaths, such as a death by accident or heart attack, may elicit symptoms like shock, intrusive thoughts, and post-traumatic stress disorder (PTSD) among bereaved family members (Kaltman and Bonanno, 2003), whereas deaths that occur after a prolonged period of chronic illness like cancer or Alzheimer's disease may render survivors vulnerable to anticipatory grief, or the feelings of loss and sadness that occur even prior to the death (Sweeting and Gilooly, 1990). Deaths that are perceived as unjust or preventable, such as homicide or deaths due to medical error, may trigger feelings of anger and resentment (Carr, 2009). Cause of death also may be related to other stressors that precede or follow the death; these stressors may be consequential for mental health. For instance, round-the-clock caregiving demands for persons living with Alzheimer's, or ongoing struggles with a loved one's addiction prior to their death by drug overdose may amplify the mental health consequences of loss for survivors. Deaths following complex medical conditions and lengthy hospitalizations may leave bereaved family members with overwhelming medical expenses that can compound the mental health threats of the loss (Lancaster and Johnson, 2020).

Grief and bereavement

Bereavement refers to the objective situation of having lost a loved one through death, whereas grief refers to emotional and physical reactions of distress in response to the loss. Grief has been described as "the cost we pay for being able to love in the way we do" (Archer, 1999: 5). Mourning, by contrast, refers to the public display or expression of grief, such as wearing black clothing or draping the coffins of deceased military personnel with American flags (Fontana and Keene, 2009). Anthropological research documents

					Age Groups						
Rank	**<1**	**1-4**	**5-9**	**10-14**	**15-24**	**25-34**	**35-44**	**45-44**	**55-64**	**65+**	**All Ages**
1	Congenital Abnormalities 4,043	Unintentional Injury 1,153	Unintentional Injury 881	Unintentional Injury	Unintentional Injury 15,117	Unintentional Injury 31,315	Unintentional Injury 31.057	Malignant Neoplasms 34,589	Malignant Neoplasms 110,243	Heart Disease 556,665	Heart Disease 696,962
2	Short Gestation 3,141	Congenital Abnormalities 382	Malignant Neoplasms 382	Suicide 581	Homicide 6,466	Suicide 8,454	Heart Disease 12,177	Heart Disease 34,169	Heart Disease 34,169	Malignant Neoplasms 440,753	Malignant Neoplasms 602,350
3	SIDS 1,389	Homicide 311	Congenital Abnormalities 171	Malignant Neoplasms 410	Suicide 6,062	Homicide 7,125	Malignant Neoplasms 10,730	Unintentional Injury 27,819	COVID-19 42,090	COVID-19 282,836	COVID-19 350,831
4	Unintentional Injury 1,194	Malignant Neoplasms 307	Homicide 169	Homicide 285	Malignant Neoplasms 1,306	Heart Disease 3,984	Suicide 7,314	COVID-19 16,964	Unintentional Injury 28,915	Cerebro-Vascular 137,392	Unintentional Injury 200,955
5	Maternal Pregnancy Comp. 1,116	Heart Disease 112	Heart Disease 56	Congenital Abnormalities 150	Heart Disease 870	Malignant Neoplasms 3,573	COVID-19 6,079	Liver Disease 9,503	Chronic Low. Respiratory Disease 18,816	Alzheimer's Disease 132,741	Cerebro-Vascular 160,264
6	Placenta Cord Membranes 700	Influenza & Pneumonia 84	Influenza & Pneumonia 55	Heart Disease 111	COVID-19 501	COVID-19 2,254	Liver Disease 4,938	Diabetes Mellitus 7,546	Diabetes Mellitus 18,002	Chronic Low. Respiratory Disease 128,712	Chronic Low. Respiratory Disease 152,657
7	Bacterial Sepsis 542	Cerebro-Vascular 55	Chronic Low. Respiratory Disease 54	Chronic Low. Respiratory Disease 93	Congenital Abnormalities 384	Liver Disease 1,631	Homicide 4,482	Suicide 7,249	Liver Disease 16,151	Diabetes Mellitus 72,194	Alzheimer's Disease 134,242
8	Respiratory Diseases 388	Perinatal Period 54	Cerebro-Vascular 32	Diabetes Mellitus 50	Diabetes Mellitus 312	Diabetes Mellitus 1,189	Diabetes Mellitus 2,904	Cerebro-Vascular 5,686	Cerebro-Vascular 14,153	Unintentional Injury 62,796	Diabetes Mellitus 102,188
9	Circulatory System Disease 386	Septicemia 43	Benign Neoplasms 28	Influenza & Pneumonia 50	Chronic Low. Respiratory Disease 220	Cerebro-vascular 600	Cerebro-Vascular 2,008	Chronic Low. Respiratory Disease 3,538	Suicide 7,160	Nephritis 42,675	Influenza & Pneumonia 53,544
10	Neonatal Hemorrhage 317	Benign Neoplasms 35	Suicide 20	Cerebro-Vascular 44	Complicated Pregnancy 191	Complicated Pregnancy 594	Influenza & Pneumonia 1,148	Homicide 2,542	Influenza & Pneumonia 6,295	Influenza & Pneumonia 42,511	Nephritis 52,547

Fig. 1 Leading causes of death in the United States by age group, 2020. Source: Centers for Disease Control and Prevention, 2021. https://www.cdc.gov/injury/wisqars/leadingcauses_images.html.

cross-cultural differences in mourning practices and cultural expressions of grief. For example, bereaved persons in Puerto Rico may exhibit symptoms of *ataque de nervios*, in which they lose emotional control, have attacks of crying or shouting uncontrollably, fainting, and in some cases having brief bouts of amnesia (Guarnaccia et al., 2010) (A full discussion of cultural variations in grief reactions is beyond the scope of this article, but see Robben, 2004 for a review).

Grief may encompass diverse and distinctive mental health symptoms including sadness, anxiety, yearning or pining for the deceased, anger, and intrusive or uncontrollable thoughts about the decedent or the death. Grief also may manifest as unhealthy behaviors used to dull one's emotional pain, such as excessive drinking, drug use, and overeating. These behaviors may intensify feelings of anxiety, guilt, or shame, or may create physical health problems like obesity or diabetes that further undermine survivors' physical and mental health (Stahl and Schulz, 2014).

Many researchers agree that grief symptoms, most notably sadness and yearning for a loved one, are a "normal" and expected reaction to loss, and that grief symptoms are indicative of a mental health disorder only when they persist for prolonged time periods or interfere with daily functioning. Symptoms of sadness and yearning are common during the first three to twelve months following loss, but then bereaved persons typically return to pre-loss levels of mental health. For example, in a series of influential studies tracking the depressive symptoms of bereaved spouses and parents, (Bonanno et al. 2002; Bonanno, 2010) found that the most common trajectory was "resilient," in which two-thirds of survivors experienced no substantial distress. Another 25% of bereaved persons experienced depressive symptoms either immediately prior to or following loss, yet these symptoms elapsed shortly after the death.

However, a minority of bereaved persons do not recover quickly, with some reporting intense depressive symptoms for more than one year after the loss, and difficulty managing their usual activities and responsibilities. These individuals may be diagnosed as having prolonged grief disorder (PGD). In 2022, PGD was officially added as a new clinical diagnosis in the *Diagnostic and Statistical Manual*; the *DSM* provides practitioners with a definition and treatment guidelines for mental health disorders. The PGD diagnosis is controversial and not universally accepted by bereavement researchers and practitioners, however. Advocates for establishment of a formal PGD diagnosis argue that recognizing the distinctive symptoms of this disorder helps practitioners to develop a precise and effective course of treatment for patients who are suffering (Prigerson et al., 2022). Critics counter that the diagnosis may "medicalize" or "pathologize" grief, and argue that feelings of profound sadness for more than one year may be a "normal" reaction among persons who experienced a particularly meaningful, painful, or life-altering loss (e.g., Wakefield, 2013).

Anticipatory grief

Grief is usually thought of as the mental health symptoms experienced by a bereaved person after their loved one dies. However, painful feelings of loss, sadness, and loneliness may strike months or even years prior to the death—especially among persons caring for a loved one who is dying from a long-term chronic illness like cancer or dementia. Anticipatory grief may occur as one witnesses a loved one suffering from pain or labored breathing, or whose personhood is slipping away as symptoms of Alzheimer's disease intensify (Chan et al., 2013; Rando, 1986). Anticipatory grief, like PGD, is a hotly debated concept with some arguing that the detection of pre-loss symptoms is critical for treating and protecting the mental health of caregivers (e.g., Rando, 1986). Critics counter that the concept erroneously suggests that grief has a "finite" amount and may mislead some caregivers into believing their symptoms of sadness will end upon the death (e.g., Fulton, 2003).

Empirical research on anticipatory grief is mixed, with some studies showing that it helps people to prepare emotionally for and adapt to loss, and others showing no long-term benefits. One study of older widows in Sweden found that 40% described the pre-loss period as more difficult than the post-loss period, reporting distress, preoccupation with their dying spouse, loneliness, tearfulness, cognitive dysfunction, irritability, anger, and social withdrawal prior to death (Johansson and Grimby, 2012). However, they also reported positive outcomes like resilience and effective coping post-loss, because the protracted dying period provided a time and space to prepare for the impending death. Conversely, one systematic research review found no long-term benefits of anticipatory grief, and some evidence that anticipatory grief symptoms were associated with more depressive symptoms, pessimism, and poorer health post-loss. However, being prepared for the death did offer practical benefits that may indirectly bear on survivor mental health (Nielsen et al., 2016). Death forewarning provides people an opportunity to make concrete preparations, like advance care and estate planning, which mitigate against confusion or disagreements regarding medical decisions prior to death and funeral arrangements post-death (Carr and Luth, 2017).

Theoretical perspectives on bereavement and mental health

It seems intuitive that the death of a loved one would undermine survivors' mental health, and that the physical pain and suffering that accompany long-term chronic illness would threaten the emotional well-being of dying patients. However, empirical research shows that death and loss are not uniformly distressing; the intensity, types, and duration of symptoms may vary based on the nature of the lost attachment, secondary strains associated with the loss, the context of the death, and psychosocial and interpersonal factors. Researchers and practitioners concur that there is *no single way to grieve, nor a single trajectory of symptoms that characterizes all bereaved or dying persons' experiences*. Contemporary research challenges outdated notions that loom large in popular culture and public discourse, like the Kübler-Ross (1973) stage model which delineates the sequential stages of denial, anger, bargaining, depression, and acceptance among both bereaved and dying persons (Corr, 2020). While some people may experience

some of these symptoms, most do not experience all five symptoms, nor do symptoms unfold in a uniform order. Heterogeneity, rather than a lockstep progression through a set of stages, is a hallmark of the most influential theories used in grief research and practice today.

Attachment theories

The recognition that the mental health consequences of loss vary based on the quality of one's relationship with the decedent has its roots in attachment theories (Archer, 1999). The core argument is that people develop close emotional bonds to important attachment figures. These attachments serve an important adaptive function, from an evolutionary perspective; close emotional bonds prevent extended separations, especially in the case of a parent or caregiver attached to their child (Bowlby, 1969/1982). Severed attachments may trigger a series of negative emotional reactions, reflecting the pain of the lost bond. Four stages have been identified: numbness and disbelief, protest, despair, and detachment. Bereaved persons do not necessarily pass through all four stages, nor do they necessarily do so in a set order; as Bowlby (1980: p. 85) observed, "these phases … are not clear cut, and any one individual may oscillate for a time back and forth between any two of them."

Contemporary bereavement research applies and advances core themes of attachment theory in two ways; first, by exploring whether attachment styles affect one's emotional reactions to loss, and second, by evaluating whether emotional reactions to loss vary based on the survivor's attachment to the decedent.

Researchers classify individuals by their levels of anxiety and avoidance about one's relationships (Cassidy and Shaver, 2016). Anxiety reflects watchful attention to signs of rejection whereas avoidance reflects favoring independence to compensate for expected rejection (Fraley et al., 2000; Fraley, 2019). Higher anxious attachment is consistently associated with more negative grief-related outcomes (Field and Sundin, 2001; Meier et al., 2013). Conversely attachment avoidance has a less straightforward association with bereavement outcomes, sometimes predicting worse outcomes (e.g., in the case of violent death, Meier et al., 2013; or among those who are high in *both* anxiety and avoidance, Mancini et al., 2009), but generally having few unique associations with bereavement outcomes (Meier et al., 2013).

Attachment styles refers to an individual's general ways of relating to others. However, the nature of one's relationship with a particular significant other also may affect how the survivor adapts psychologically to the loss. Attachment theory suggests that all losses are not equally distressing. The dissolution of emotionally and socially significant ties may elicit the strongest psychological reactions whereas the dissolution of strained, conflictual, or tenuous ties may elicit fewer or no symptoms (Archer, 1999). However, psychoanalytic perspectives counter, paradoxically, that survivors who had ambivalent or difficult relationships with the decedent would evidence the most serious mental health symptoms post-loss. Freud (1917/1959) proposed that a bereaved person with a troubled relationship would feel both anger toward and a strong attachment to the deceased. These conflicting feelings make it difficult for survivors to let go of their lost loved one, yet they would also feel anger and abandonment—emotions that could contribute to prolonged grief. Empirical assessments generally find that the dissolution of one's closest and most affirming attachments are most distressing in the short-term because the loss is mourned most deeply (e.g., Carr, 2000; Lee et al., 2022).

Dual-process model

Most writings on grief and loss emphasize the emotional anguish experienced when a close bond is severed. However, the Dual Process Model (DPM; Stroebe and Schut, 1999) was among the first perspectives to explicitly recognize that behavioral adaptations also are necessary for bereaved persons' well-being. The DPM places equal emphasis on practical—even mundane—daily life strains that follow from bereavement, such as mastering new household chores and establishing new relationships. In order to cope effectively, bereaved persons must "oscillate" between loss-oriented (LO) coping and restoration-oriented (RO) coping. The former refers to coping processes that focus directly on the pain of the loss itself, including symptoms of grief, loss, and sadness. The latter includes the processes one uses to cope with the stressors that arise upon the loss of a close loved one, most notably a spouse. Oscillation is essential for optimal adjustment and mental health; bereaved persons must attend to practical as well as emotional matters, and may turn to RO activities as respite from negative emotions associated with the lost attachment.

Formal evaluations of DPM are relatively scarce, yet researchers have found that successful management of RO tasks can help mitigate against distress and anxiety following a loss (Fiore, 2021). Likewise, unresolved stressors of everyday life can exacerbate the emotional strains of loss. For example, studies of spousal bereavement consistently show that the death of a spouse is associated with financial strains for widows, including a decline in standard of living, reduced wealth and income, and struggles to manage household finances (e.g., Streeter, 2020; Umberson et al., 1992). These strains, in turn, are linked to psychological distress. Widowers, by contrast, tend to have difficulty maintaining social ties with friends and children, because these ties had been previously sustained by their late wives; loneliness and lack of support are daily realities for widowed men which may undermine their mental health (Ha, 2008; Streeter, 2020). Widowers also may fail to maintain healthy behaviors like taking their medications or eating three meals daily, due to their reliance on their late spouses (Umberson et al., 2010; Vesnaver et al., 2016). These unhealthy behaviors may undermine their mental health and hasten their mortality (Martikanen and Valkonen, 1996). Conversely, effective management of RO tasks can enhance mental health upon bereavement. Carr (2004a) found that widowed persons' mental health improved post-loss most steeply for bereaved persons who had mastered the household tasks previously carried out their late spouse.

Stress and coping perspectives

Stress and coping perspectives provide a framework for identifying the personal traits and resources that may buffer against or intensify the mental health consequences of loss. The overarching theme is that the mental health impact of a stressful event, such as the death of a loved one, or a chronic stressor, like intensive caregiving, varies based on one's coping resources (Pearlin et al., 1981). Coping resources encompass the social and psychological attributes one can draw on to manage either the stressor or one's emotional reactions to that stressor (Taylor and Stanton, 2007). Social support is widely considered one of the most critical resources for adapting to stress. Social support refers to the assistance one receives from significant others, including family, friends, and colleagues. The types of support received may be instrumental, such as help with housework or rides to the doctor; financial, like helping to cover medical bills; emotional, such as listening to one's problems; or informational like providing advice (Thoits, 1995).

Emotional support from family and friends is essential for bereaved persons' well-being. Research on gender differences in the mental health impacts of bereavement rely heavily on stress models as an explanatory framework. For example, studies generally concur that women adjust better psychologically to spousal loss than men because they have closer and more supportive social ties with their children, friends, and siblings (Carr and Moorman, 2011). Older widows typically receive more practical and emotional support from their children than do widowers, given mothers' closer relationships with their children throughout the life course. Women also are more likely to have larger and more varied friendship networks than men, and these friendships are an important source of support as women cope with their loss (Ha, 2008). Men, by contrast, often seek support and assistance from new romantic partnerships, whether through dating or remarriage (Carr, 2004b).

Personal characteristics, including mastery, a sense of control over one's environment, and personality traits like extraversion, conscientiousness, and emotional stability also have been found to mitigate mental health symptoms in the face of bereavement (see Stroebe et al., 2008 for review). For example, Pai and Carr (2010), applying the Big-Five model of personality, found that highly extraverted and conscientious widowed persons had fewer depressive symptoms post-loss. Extraverts are particularly good at marshalling social support during prolonged periods of spousal illness and after the loss, which enhances their mental health. Conscientious people tend to be reliable, future-oriented, and self-disciplined—characteristics that help them anticipate and plan for predictable stressors. They may prepare financially for a spouse's eventual death and thus do not face the same financial strains that other widow(er)s face. Conversely, studies of bereaved parents found that those low on the trait of emotional stability were particularly vulnerable to intensive depressive symptoms (Wijngaards-de Meij et al., 2007). People low in emotional stability are prone to emotional distress and negative mood, which may alienate those friends and family members who could help them cope with their loss.

Religious beliefs, practices, and worldviews also are psychological resources that shape how people cope with dying and bereavement. Because religion is a multifaceted construct, researchers have moved away from evaluating whether religion buffers against distress, and instead delineate which dimension(s) of religion can be protective versus detrimental (Wortman and Park, 2008). The main aspects of religion and spirituality studied include denomination/affiliation, history of religious or spiritual experiences, public versus private participation in religious practices, support from one's religious community, beliefs and values about God and the afterlife, commitment to one's congregation, forgiveness of self and others, spiritual experiences, and religious intensity (Idler et al., 2003). The dimensions most closely linked to emotional adjustment post-loss include support from one's religious community, attendance at religious services, spirituality, and believing that religion is helpful. The linkage between behavioral aspects of religion like attending services and mental health also partly reflects reverse causation, such that those with the best mental health and most supportive ties are especially likely to participate in religious activities like attending services (Krause et al., 2002).

Meaning making is a set of beliefs and practices that are important resources facilitating adjustment to loss, which are related to, though distinct from, religion. Meaning making refers to the processes through which an individual comes to understand, interpret, or make sense of life events, especially difficult or unfair events like a death (Coleman and Neimeyer, 2010). Religious beliefs may provide a cognitive frame through which to find meaning, especially when one's understanding of the world may be challenged or shattered by a death (Lewis Hall and Hill, 2019). For example, the accidental death of a young child may challenge one's belief that the world is a fair and just place (Mancini et al., 2011). Meaning making is theorized to have three components: sense-making, benefit-finding, and identity reconstruction. Sense-making refers to one's ability to understand and make sense of the loss, such as accepting that death is a universal and inevitable aspect of life. Benefit-finding is the process of recognizing gains derived through of the process of loss, such as growing closer to a dying relative while providing care. Identity reconstruction is the process of creating and embracing a new identity after loss, such as re-identifying as a widow(er) or as an activist committed to fighting the disease that took their loved one's life (Coleman and Neimeyer, 2010). Most studies conclude that the capacity to find meaning in one's loss can reduce symptoms of depression and grief, and can enhance feelings of well-being and purpose (Lewis Hall and Hill, 2019).

Theoretical perspectives on dying and mental health

The vast majority of research and theory on death and mental health focuses on bereaved persons, rather than dying persons. The relative dearth of research on mental health of dying persons reflects methodological challenges. Researchers may use retrospective proxy reports, relying on bereaved family members' recollections of the patient's mental health during their final days, or

prospective reports, relying on dying persons' own reports of their mental health in the months leading up to death. Retrospective proxy reports are susceptible to both positive and negative recall bias (Fowler et al., 1999). Bereaved family members who are depressed or angry may offer negatively biased assessments, whereas those who were closely involved in caregiving may offer more positive appraisals to affirm their belief that they did all they could to help the decedent (Rao et al., 2009). Prospective studies typically use longitudinal survey data, and researchers identify study participants who have since died. They can then examine indicators like depressive symptoms from prior survey waves when the decedent was still alive, using those measures to capture well-being in the last year or two of the respondent's life (Gerstorf et al., 2010). Given data challenges along with ethical concerns about interviewing very ill persons, research on dying persons' mental health is sparse. However, theoretical models like terror management theory provide insights into the factors shaping mental health at the end of life.

Death anxiety and terror management theory

Terror management theory (TMT) is a popular, albeit contested, framework used to understand the mental health of dying persons. The theory proposes that because death is a universal certainty, much of human behavior is motivated by death anxiety and efforts to manage that anxiety (Pyszczynski et al., 2015). A core theme is that the tension between humans' instinct for self-preservation and the knowledge that death is inevitable can produce terror, which people manage through adherence to cultural beliefs that offer symbolic mortality. Belief in the afterlife is one obvious set of values that can assuage fear of death, but other less obvious ones include values like nationalism and personal achievement. The belief that someone is part of a larger collective or that one is creating or contributing to some legacy that will continue posthumously—such as a creative work or establishing a charitable foundation—are essential for self-esteem and a capacity to manage terror.

TMT is a complex theory and is difficult to test empirically. One experimental study sought to evaluate whether death anxiety caused mental health symptoms. Using a mortality salience experiment, researchers examined whether prompting study participants to think about death would lead to behaviors associated with mental health disorders, including compulsive handwashing, phobias, and social anxiety (e.g., Menzies et al., 2021; Strachan et al., 2007). However, other studies have either failed to replicate these findings or detected effects sizes that were dramatically smaller than those previously reported. Experimental studies designed to induce fear of death also may not adequately capture the emotions or anxieties experienced by persons who are actually dying (Maxfield et al., 2013).

Policies and practices to enhance mental health among bereaved and dying persons

Dying patients and their bereaved family members may experience fewer symptoms of distress in the context of a "good death" Practitioners define a good death as "one that is free from avoidable distress and suffering, for patients, family, and caregivers; in general accord with the patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards" (IOM, 1997: 4). Patients and their families similarly emphasize the importance of being prepared emotionally and practically for the death, and freedom from physical and emotional pain (Steinhauser et al., 2000). A good death and the mental health protection it provides can be facilitated by at least two practices: advance care planning, and the use of hospice services.

Advance care planning

Advance care planning (ACP) enhances well-being at the end of life because it helps to ensure that the medical care delivered adheres to the patient's and family members' values and treatment preferences, and reduces decision-making burden for family members (Carr and Luth, 2017). The centerpiece of ACP is an advance directive, which comprises a living will and durable power of attorney for health care (DPAHC) designation. A living will articulates the specific treatments an individual would want or reject at the end of life, such as ventilators or feeding tubes. A DPAHC legally designates an individual (also referred to as a "surrogate") to make decisions on behalf of the patient should he or she be incapacitated (Carr and Luth, 2017). Most adults select a spouse or long-term partner, followed by a child, or other close relative, presuming that their closest kin best understand and will carry out their preferences (Carr and Khodyakov, 2007).

ACP is linked with range of outcomes that may bear on patient and survivor mental health, including higher satisfaction with quality of care; improved communication among patient, family, and practitioners; shared decision-making; better preparation for what the dying process entails; and a greater likelihood of receiving care that is concordant with one's wishes (Silveira et al., 2014). Bereaved family members report less stress, anxiety, and depression when the decedent had a living will, which enhances their feelings of preparedness and role in decision-making (Detering et al., 2010).

Hospice

Hospice care also is a critical contributor to patient and family emotional well-being at the end of life (Silveira et al., 2014). Hospice is a comprehensive program that facilitates dying at home and emphasizes palliation (symptom relief) and comfort rather than aggressive or curative treatment. The benefits of hospice are widely documented. Patients receiving hospice services have less pain, fewer admissions to intensive care units, greater satisfaction with their medical care, and better mood relative to those not

using hospice (Meier, 2010). Family caregivers also report feeling supported during the dying process and have reduced risks of depression and anxiety post-loss, in part because they receive bereavement support services (Christakis and Iwashyna, 2003). One major limitation is that patients may enroll in hospice when they are very close to death, reducing the benefits for themselves and their families. Patients who have short hospice stays receive less pain relief, more breathing problems, and poorer quality care, which can undermine their mental health (Wright et al., 2008). Shorter stays also are less beneficial for family, who must provide care over a longer time period without the respite and emotional support hospice provides. Family caregivers of recent decedents with hospice stays of less than three days evidence higher rates of major depressive disorder, relative to those with longer stays (Schockett et al., 2005).

Despite the well-documented direct and indirect mental health benefits of advance care planning and hospice care for dying patients and their family, only a fraction of US adults engages in these practices. A systematic review of 150 studies based on nearly 800,000 subjects published between 2011 and 2016 found that just 37% of US adults had completed an advance directive (Yadav et al., 2017). However, rates are as high as 70% among adults age 65+, those with terminal illness, and recent decedents (Silveira et al., 2014). About half of all US deaths occur under the care of hospice (NHPCO, 2018). Rates of ACP and hospice utilization are dramatically lower among Black and Latinx persons than their White counterparts, contributing to race and ethnic disparities in quality of death, and consequently bereavement experiences. Thus, interventions to increase usage of both ACP and hospice, and eliminating structural obstacles is key for ensuring end-of-life well-being for dying patients and their families. Experts also call for racial equity in quality of hospice care, rather than just enrollment rates, in the effort to bring high quality end-of-life care to all (Rising et al., 2019).

Conclusion

Death is one of life's certainties, and the death of loved ones is among the most distressing of all experiences. Although most bereaved persons experience feelings of sadness, longing for the deceased, and daily struggles associated with losing the love and support of the decedent, the vast majority of bereaved persons find that their symptoms of distress are short-lived. However, a small fraction experiences intense or long-term symptoms, including prolonged grief disorder. Likewise, persons dying of long-term chronic illness may experience symptoms of pain and discomfort which undermine their mental health. The emotional trajectories of dying patients and their survivors vary dramatically on the basis of cause of death, nature of the relationship between the two persons, and characteristics of the survivor including their coping resources, personality, access to social support, and world views which facilitate meaning making. Practices to enhance the quality of one's death, like advance care planning and use of hospice, are important pathways to protecting the well-being of dying patients and to mitigate against the mental health symptoms of the bereaved. Policies and practices to enhance the use of both ACP and hospice—especially among under-served populations—are an important step toward adaptation to loss.

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