COURSE OUTLINE

ABAP 415 - BEHAVIOROLOGICAL THANATOLOGY AND DIGNIFIED DYING

Prepared By: Dr. Stephen F. Ledoux
A. **TITLE**: Behaviorological Thanatology and Dignified Dying

B. **COURSE NUMBER**: ABAP 415

C. **CREDIT HOURS**: 3

D. **WRITING INTENSIVE COURSE**: No

E. **COURSE LENGTH**: 15 weeks face–to–face or asynchronous

F. **SEMESTER(S) OFFERED**: Fall or Spring

G. **HOURS OF LECTURE, LABORATORY, RECITATION, TUTORIAL, ACTIVITY**: 3 lecture hours per week

H. **CATALOG DESCRIPTION**: With an emphasis on the terminally ill and enhancing their dignity, this course examines the application of the natural science and technology of behavior, behaviorology, to the question of how we can improve end–of–life interactions between the dying and society, between the increasing numbers of the terminally ill and their survivors, between ourselves and our loved ones at those difficult times. The course first covers the scientific understanding of coercion and punishment as these inform many past and current social practices in such situations. The course then considers a range of scientifically grounded alternative, proactive practices capable of increasing and maintaining the human dignity of all parties in these circumstances. Which professional group (e.g., medical doctors, hospice personnel, funeral directors, behaviorologists) might best organize these improvements and new practices is explored. The historical context, and social contingencies affecting new practices, are included in the consideration of how to move from old to new practices.

I. **PRE-REQUISITES/CO-REQUISITES**:  
   a. Pre-requisite(s): Introduction to the Science and Technology of Behavior (ABAP 245) , or (FSAD 307) Human Response to Death, and 60 credit hours, or permission of instructor.

   b. Co-requisite(s): none

J. **GOALS (STUDENT LEARNING OUTCOMES)**: By the end of this course, the student will be able to:

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<th>Course Objective</th>
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| a. Analyze punishment and coercion scientifically as a problematic basis of many past and current practices in end–of–life situations | 1. Communication  
2. Crit. Thinking  
3. Prof. Competence  
4. Inter-Intrapersonal Skills |
| b. Evaluate the scientifically uninformed patterns in which the dying (i.e., the terminally ill) are currently treated by both themselves and others, | 2. Crit. Thinking  
3. Prof. Competence |
and the historical context from which these patterns derive

c. Apply behavior engineering design principles, concepts, and practices to the scientific development of new, more proactive interaction patterns that increase and maintain the dignity of the dying

2. Crit. Thinking
3. Prof. Competence

K. TEXTS:

• One articles by Dr. Murray Sidman: Preface to Coercion and Its Fallout.
• Another articles by Dr. Murray Sidman: Reinforcement in diplomacy: More effective than coercion.
• Dignified Dying – A Behaviorological Thanatology by Dr. Lawrence Fraley
• Study Questions for Fraley’s Dignified Dying – A Behaviorological Thanatology by Lisa Raymond
• Supplemented by other books and articles as appropriate.
(See references.)

L. REFERENCES:

(Paperback edition published by Free Press, 1965.)

**M. EQUIPMENT:** Smart classroom.

**N. GRADING METHOD:** A-F

**O. MEASUREMENT CRITERIA/METHODS:** To be determined by the instructor.

Possibilities include but are not limited to:
- assigned homework completion
- research papers
- book reports
- group oral/written reports
- individual oral/written reports
- essays
- class participation
- projects
- journals
- quizzes
- tests
- exams

**P. DETAILED COURSE OUTLINE:**

I. Scientific analysis and implications of punishment and coercion, especially as related to thanatology and dignified dying.

A. Behaviorological foundations.
   1. Natural science analysis.
      b. Laboratory contributions to knowledge.
   2. The coercive side of reality.
      a. Hostile community.
      b. Hostile environment.
   4. Coercion research.

B. Punishment, escape, and avoidance.
   1. Punishment facts.
      a. Punishing stimuli.
      b. Punishment control.
   2. Punishment side–effects.
      a. Short range (physiological responses).
      b. Long range (physical responses).
   3. Escape facts.
      a. Learning escape.
      b. Subtracted reinforcement and escape.
   4. Escape routes.
      a. Tuning out (of interest, responsibility, etc.).
b. Dropping out (of school, family, religion, society, life).
5. Avoidance facts.
   a. Causes.
   b. Prevention.
6. Avoidance results.
   a. Slow learning.
   b. Superstitions.
7. Avoidance techniques.
   a. Turning inward.
   b. Whistle blowing.
   a. Phobias.
   b. Anxiety.
   c. Amnesia.

C. Coercion problems and alternatives.
1. Coercion and conditioned suppression.
   a. Becoming careless, then callous, then cruel.
   b. Economics of anxiety.
2. Coercion and conscience.
   a. Conscience origins.
   b. Conscience control.
3. Coercion breeding coercion.
   a. Aggression.
   b. Counteraggression.
4. Changeable independent variables of coercive behavior.
   a. Know thyself.
   b. Know thine environment.
5. Local alternatives to coercion.
   a. General level of added reinforcement.
   b. Added reinforcement in home and school.
6. Global alternatives to coercion.
   a. Added reinforcement in diplomacy.
   b. Added reinforcement in society and law enforcement.

II. Behaviorological Thanatology: foundations and implications.
A. Basic definitions and crucial concepts.
   1. Life.
   2. Person.
   3. Death.
   4. The abstract person.
B. Foundation principles.
   1. The nature of life.
      a. Mystical process?
      b. Natural process!
   2. Basic person / body dichotomy.
      a. Behavioral events.
      b. Nervous system, muscle, and bone mediation.
   3. Analysis of death.
b. Person death.
c. Slow dying.
d. Cultural considerations.
   i. Perspectives.
   ii. Superstition
   iii. Natural science.
4. Relevant values, rights, ethics, and morals.
   a. Definitions.
   b. Interrelations.

C. Practical distinctions between bodies and persons.
   1. Personhood essence involves behavior.
   2. The body’s mediation of the behaviors of personhood.
   3. The relativity of ethics.
   4. Questions of worth.
      a. Verbal capacity as a measure of worth.
      b. Codification based on person / body confusion.
      c. Cultural measures of worth.
   4. Variability in ranges of quality and quantity across intervals of personhood.

D. Contemporary ethics and practices.
   2. Universal social contingencies.
   3. Effectiveness of modern natural sciences.
   4. The legacy of nuisance emotional respondents.
      a. Discrepancy between intellectual knowledge and emotional reactions.
      b. Professionals enjoy no immunity from nuisance emotional and other behavioral effects.

E. Sudden death versus slow death.
   1. Myths and realities about slow dying.
      b. Algebraic dying.
      c. Forcing the “good show”.
         i. For general society.
         ii. For one’s intimate social circle.
      d. The gradual disappearance of the person during little bodily change.
   2. Person death prior to bodily death.

III. Behaviorological Thanatology: Ethics of medical practices during protracted dying.
A. Natural science philosophy vs traditional mystical philosophy.
   1. The superstitious approach to behavior.
   2. The natural science approach to behavior.
   3. The spontaneity fallacy.
B. The natural science perspective on values, rights, and ethics in the context of medical practices during protracted dying.
   1. Values.
   2. Ethics.
C. Ethicists and advocates of ethical agendas.
   1. “What is” versus “what ought to be”.
      a. Traditional philosophy.
b. Naturalistic philosophy.
2. Minimal practical outcomes.

D. Contemporary ethical practices to cope with death and dying.
   1. Cultural perspectives in the media.
   2. Perspectives in medical training.
   3. Medical versus ethical technologies.
      a. Alive and conscious.
      b. Alive vegetatively (post person death).
      c. Organ harvesting (post person death).
      d. Differential behavioral dying.
   4. Another overextended ethic: preserve “life”.
      a. Quality of life.
      b. General level of positive reinforcement.
      c. Humane principles about minimizing suffering.
      d. Questions of assisted suicide.
      e. The mix of these relations.

E. Medical reactions to the mix of those relations.
   1. The conflict between standard medical ethics and actual medical experiences.
   2. Related legal issues.
   3. Current legally approved medical termination practices (varieties of “doing nothing”).
      a. Starvation.
      b. Suffocation.
      c. Uremia / renal failure.
      d. ETC!
   4. Humane and compelling reasons for such “do nothing” actions.
   5. Understanding those humane and compelling reasons.
      a. Behaviorological analysis.
         i. Respondent emotional considerations.
         ii. Guilt, shame, and sin.
         iii. Operant contextual considerations.
         iv. Verbal behavior of practitioner and colleagues.
      b. Rationales.
         i. Self–deception.
         ii. Outsmarting one’s “conscience”.
      c. Other alternatives.
         i. Redefining appropriate treatment.
         ii. Redefining death.
         iii. Assistance from court decisions.
   6. The fallacy of doing nothing.
   7. The doctors dilemma.

F. End being rendered inhumane by the current, prevailing ethics.
G. Doctors need better ethics in the first place.
H. Scientifically grounded (i.e., more appropriate) ethics exist to be implemented.
I. Introduction to adopting/applying scientifically grounded ethics.

IV. Behaviorological Thanatology: New ethics and practices regarding dignified
dying and death.

A. Mystical concepts of life, behavior, and humankind.
   1. Current prevalence in largely superstitious culture.
   2. Prevalence leads to respect for implications.
   3. Respect for implications leads to impacts on social practice.
   4. Impacts on social practice leads to stifling of scientifically improved practices.
   5. Stifling of scientifically improved practices leads to horrible and unnecessary sufferings (through misguided cultural practices pertaining to slow dying / terminal illnesses).
      a. For the dying individuals.
      b. For their immediate loved ones.
      c. For their larger community.
      d. For the culture at large (e.g., economically).

B. Principles informing new ethics for managing dying and death.
   1. Behaviorological analysis of values, rights, ethics, and morals.
   2. Scientific understanding of human life pertaining to the behavioral person rather than to the physiological body.
   3. Medical training to take into account such new scientific findings and implications.
      a. Slowly dying person no longer to be maintained in prolonged agony, behavioral or physical.
         i. As a requirement of medically approved practice.
         ii. As a requirement of legally approved practice.
      b. Pain and suffering (nociceptive or emotional) of the terminally ill no longer encouraged.
         i. As an ethical or moral obligation.
         ii. As a “worthwhile” natural experience.
      c. Three kinds of death recognized...
   4. Training of professionals (all medical and others assisting the terminally ill and their surviving loved ones and community) to respect the three kinds of recognized death.
      a. Behavioral death of the person.
      b. Physiological death of the body.
      c. **Social death** (gradual comprehensive constriction of the person’s social contacts due to the natural realities of the decreasing behavioral and physiological functions).
         d. Reducing social death pain and suffering by maintaining / increasing the dignity of the dying person through gradual though mostly permanent ceremonial or ritualistic termination of social contacts.

C. Social death care as a new cultural practice.
   1. Social dying defined.
   2. Timing of dignified social dying.
      a. *After* medical establishment of terminal and irreversible status of approaching (person and) physiological death.
      b. But *before* person death.
      c. That is, *while* the person still retains at least a meaningful portion of the unique and characteristic repertoire that establishes personal identity.
3. Ceremony of social dying.
   a. Dying person terminates social relations with previously close individuals (says a comprehensive, rational, emotional, and capable, as well as a dignified, good-bye).
   b. A farewell ceremony in which the dying person can still participate in character in familiar social contexts.
   c. Variables supporting individual case differences.
   d. Current related ceremonial events.
      i. Visits from family members and/or old friends.
      ii. Meeting understood by all (whether made explicit or not) to be occurring for the last time.
4. Need for, and value of, new and more official ceremony.
   a. Have its own name the way other formal social ceremonies (e.g., christening, graduation, wedding) celebrating life’s turning points.
   b. Possibly call it a “foreniscon” (formal ending of intimate social contacts) or the equally descriptive but more obvious “exsociation” [or some other newly coined term].
   c. Possible forms (with details).
      i. Individual informal or formal meeting(s).
      ii. Informal or formal (even ritualistic) meeting(s) of small or larger groups.
   d. Post foreniscon contact arrangements.
   e. The wide range of potential events for inclusion in the foreniscon ceremony (from readings of select materials to ritualistic assisted suicide).
   f. A large range of explicit and implicit values and benefits of foreniscon for the dying person and for survivors…
   g. A wide range of potential problems (and some solutions) arising from events included in the foreniscon ceremony.
D. The question of which professionals can and/or should help arrange and/or assist at or facilitate a foreniscon ceremony.
1. Relevance of training curricula improvements being informed by natural science regarding issues of death, dying, dignity, and associated ethics and practices.
2. Medical personnel?
3. Hospice personnel?
4. Morticians/funeral directors?
5. Behaviorologists?
6. New professionals?
E. Characteristics shared with hospice movement.
F. Issues in schedule management.
   1. For the dying person.
   2. For the survivors.
   3. For the community.
   4. For the professional facilitators.
G. Issues in self management.
   1. Dilemmas for the terminally ill person.
   2. Some solutions for some dilemmas.
H. Some societal contradictions regarding death.
   1. Humane, painless death for convicted felons versus the best doctors can
currently do by “letting nature take its course” (makes doctors unjustifiably seem sadistic and cruel).

2. The legal lack of a right to die versus the large number of social organizations currently supporting the right to die.

3. Inevitable economic contingencies affecting end of life decisions at multiple levels in sometimes contradictory ways.

I. Major factors arising to remedy the problem of currently culturally enforced undignified dying for the growing number of societal members experiencing terminal illness.

1. The biological evolution of intellectual capacity.

2. The maturation of the human culture away from superstition and toward natural science.

3. The development of behaviorology, the natural science of human behavior.

4. The application of behaviorology to this problem.

J. The solution: new cultural practices arising to enable humane and dignified dying for the growing number of societal members experiencing terminal illness.

Q. **LABORATORY OUTLINE:** No laboratory